

2017 Model Practices

Applicant Information

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Model Practice Title

Please provide the name or title of your practice: *

Engagement of technical and scientific experts in LHD policy issues: the creation and utilization of NYC's Radiological Advisory Committee (RAC)

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category.

Please select all the practice areas that apply.: *

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> Access to Care | <input checked="" type="checkbox"/> Advocacy and Policy Making | <input type="checkbox"/> Animal Control | <input checked="" type="checkbox"/> Coalitions and Partnerships | <input type="checkbox"/> Communications/Public Relations |
| <input type="checkbox"/> Community Involvement | <input type="checkbox"/> Cultural Competence | <input checked="" type="checkbox"/> Emergency Preparedness | <input type="checkbox"/> Environmental Health | <input type="checkbox"/> Food Safety |
| <input type="checkbox"/> Global Climate Change | <input type="checkbox"/> Health Equity | <input type="checkbox"/> HIV/STI | <input type="checkbox"/> Immunization | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Informatics | <input type="checkbox"/> Information Technology | <input type="checkbox"/> Injury and Violence Prevention | <input type="checkbox"/> Marketing and Promotion | <input type="checkbox"/> Maternal-Child and Adolescent Health |
| <input checked="" type="checkbox"/> Organizational Practices | <input type="checkbox"/> Other Infrastructure and Systems | <input checked="" type="checkbox"/> Organizational Practices | <input type="checkbox"/> Primary Care | <input type="checkbox"/> Quality Improvement |
| <input type="checkbox"/> Research and Evaluation | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Vector Control | <input type="checkbox"/> Water Quality | <input type="checkbox"/> Workforce |
| <input type="checkbox"/> Conference Theme: Bridging Clinical Medicine and Population Health | | | | |

Other::

Is this practice evidence based, if so please explain. :

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly. Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following:: *

- | | | | | |
|---|--|--|----------------------------------|---|
| <input type="checkbox"/> Food Safety | <input type="checkbox"/> HIV in the U.S. | <input type="checkbox"/> Nutrition, Physical Activity, and Obesity | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Healthcare-associated Infections |
| <input type="checkbox"/> Motor Vehicle Injuries | <input type="checkbox"/> Teen Pregnancy | <input checked="" type="checkbox"/> None | | |

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
 - Were all of the objectives met?
 - What specific factors led to the success of this practice?
- Public Health impact of practice
- Website for your program, or LHD.

750 Word Maximum

New York City (NYC) is the most populated city in the United States, occupying 305 square miles with a population of approximately 8.4 million residents, increased to over 9 million on an average day with visitors and commuters. The average population density is roughly 43 people per acre. The building stock includes commercial, residential, and mixed-use with approximately 1 million structures in NYC, many built before modern building codes were implemented. Additionally, the metro region contains a population of approximately 22 million people with complex, interdependent critical infrastructure systems. NYC is made of a very diverse population in terms of languages spoken, ethnic and cultural backgrounds, economic backgrounds, and access and functional needs risks. Over 30 percent of all households have children under 18 and more than 10 percent of New Yorkers—approximately 1 million residents—are over the age of 65. Over 200 languages are spoken in NYC (with an estimated 23 percent of New Yorkers who speak and understand English less proficiently). Over 21 percent of the city's population lives below the Federal poverty line. An estimated 10 percent of New Yorkers have a disability (defined as sensory, physical, self-care, and go-outside-the-home disabilities). The structural aspects and population diversity, coupled with the heightened risk of terrorist threats, highlights the need and value of careful and considered emergency planning, especially for highly impactful events such as radiological events. The clinical and environmental considerations a public health agency must consider in such an event can quickly outstrip in-house expertise. Within the NYC Department of Health and Mental Hygiene (DOHMH), the Office of Emergency Preparedness and Response (OEPR) is charged with planning for radiological emergencies including radiological dispersal devices (RDDs), improvised nuclear devices (INDs) and other related radiological concerns that arise due to the proximity of the Indian Point Nuclear Power Plant 25 miles to the north. Due to the technical and specialized nature of radiological health issues such as these, New York City's Radiological Response and Recovery Plan (RRRP) incorporates the formation of a Radiological Advisory Committee (RAC) from which volunteer expertise can be drawn in whole or in part during an emergency or to provide planning support and fill a recognized gap the agency had identified. While DOHMH has radiological specialist staff members, potential members for the RAC were identified among radiological specialists from more varied fields that could provide not only technical expertise but also academic, remediation, medical and governmental perspectives to the anticipated radiological issues that would impact our ability to respond. Without the addition of RAC members, DOHMH is less able to address the complex and difficult questions that arise with a radiological event in a location as sensitive as NYC. The RAC is innovative and responsive to local needs by creating a formal standing committee of national experts focused on radiological events impacting New Yorkers able to help formulate agency and citywide policy during planning initiatives and assist with a response if such a need arises. Additionally, RAC members commit to making themselves available, in person or remotely, to assist with radiological decision-making, including during an emergency. While new, the RAC has already demonstrated that they are an effective expert group capable of advising on public health decisions involving the impact a radiological event would have in a dense urban area like NYC. Within DOHMH, the RAC program has been viewed as a model for the creation of other, similar technical advisory groups as a low-cost way to expand access to expertise during the planning and response phases of an emergency. NYC DOHMH's website is: <http://www1.nyc.gov/site/doh/index.page>

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR (2) **a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
 - What is the target population size?
 - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
 - Is it new to the field of public health
- OR**
- Is it a creative use of existing tool or practice:
 - What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)
- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

2000 Word Maximum

Cooperation between various City agencies through the Radiological Response and Recovery Committee (RRRC; an interagency committee that determines the response objectives for radiological incidences and coordinated citywide radiological planning) and the RAC highlight an overlooked component of emergency response: the engagement of technical and scientific expertise through a standing committee engaged in planning phase and response phases, allowing for innovated and integrated policy development. Prior to the creation of the RAC, radiological planning and responses to inquiries about radiological issues, particularly complex issues, were addressed by agency staff or informally speaking to local or national experts on an ad-hoc, as-needed basis. This is problematic as radiological experts are a very small and highly specialized set of professionals who may not always be available, thus to respond to spontaneous inquiries from LHDs. Furthermore, Agency staff would likely be unable to address the significant issues rising from a radiological incident in NYC, risking the ability to provide an adequate and comprehensive response for the City. An example of this gap is seen with the utilization of radiological safety officers: before the creation of the RAC, agency employees would discuss issues with hospital radiation safety staff, but during a radiological emergency this resource would be unavailable to the agency due to their commitments to their employers. Conversely, RAC members are consistently and reliably available during planning phases and have committed to being available during the response and remediation phases. Due to the complexities of a radiological event, there is no specific demographic that can be targeted with radiological planning and response, however the unique population densities and heighten risk associated with terrorism in NYC makes planning for such an event critical for all New Yorkers. The first meeting of the RAC was held in May 2015 with approximately 30 participants including Committee members and local emergency planning partners interested in radiological issues. The group was given an overview of the NYC Incident Management System and the New York State and federal assets that could be expected to be made available during a radiological event. Subsequent RAC meetings and engagement covered other issues with a meeting of the primary RAC members planned annually. To formalize membership and operational capability, a RAC membership handbook was written and shared with members indicating the committee's function and where it resided within the DOHMH incident command structure. Since the first meeting, RAC members have been further engaged in policy and planning discussions and membership has expanded through recurring e-mails. While the creation of the RAC was not directly based on evidence-based practices, DOHMH has researched the issue and submitted an abstract for presentation at the 2017 Preparedness Summit on the value of integrating scientific and technical expertise into the incident command system structure, of which the RAC is an example of.

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
 - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?
 - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

The RAC was created once a gap was identified in NYC's RRRP plan's outlining the role of a Radiological Advisory Committee, which had not been formed. Using a minimal outlay of accrual funding (approximately \$6,000 to cover the cost of travel, hotel, and food expenses for out-of-town members), DOHMH's radiological planning staff contacted national clinical and environmental radiological experts who were known to them through various conferences and previous collaborations to gauge their interest and if they knew of others who may wish to join. At this time, there are currently 19 formal members representing local, state, federal, academic, and research areas and more individuals who are less formally involved but who have either attended RAC meetings based on expertise or individual interest in particular issues or have provided comment on emerging issues. In parallel, planning staff developed a RAC membership handbook outlining the needed expert competencies for the committee, including:

- Environmental radiation measurements
- Dose assessment and interpretation
- Knowledge of Environmental Protection Agency (EPA) Protective Action Guides (PAGs) for sheltering and evacuation
- Knowledge of potential impacts to critical infrastructure and key assets
- Dose management using decontamination
- Mental health response
- Public communications

The handbook additionally described the planning and emergency structures the members would be engaged in and the expectations for the committee's participation and availability. Once interest in participating was established, the first, all-day workshop of the RAC was planned and executed within four months. The agenda included an overview of emergency response in NYC for radiological events, expected federal and state assets for such an event, and an overview of the Community Reception Center (CRC) response operation to be used to provide public monitoring and decontamination after an RDD event. The Committee was then broken into two groups: environmental policy and clinical policy in order to discuss outstanding issues DOHMH had about how to respond during a radiological emergency. Note takers captured the discussions and a document was provided to all the participants within a few weeks of the workshop that acted as the formal record of the discussions and outcomes. Subsequent to the initial workshop, RAC members have been regularly engaged through phone calls and emails and second workshop, similarly funded and documented with a special focus on discussing potassium iodine (KI) distribution a year later. The RAC is both informed on ongoing planning and policy discussions and tasked with reviewing documents and provide commentary on new research being published that might impact such planning in NYC. At this time, there are plans to hold another all-day workshop in the spring of 2017, to continue annually.

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
 - List any primary data sources, who collected the data, and how (if applicable)
 - List any secondary data sources used (if applicable)
 - List performance measures used. Include process and outcome measures as appropriate.
 - Describe how results were analyzed
 - Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Please enter the evaluation results of your practice (2000 Words Maximum): *

At this time there is no formal evaluation of the efficacy of the RAC due to its highly specialized nature. However, the utilization of the RAC for policy formation illustrated several advantages to having a standing committee of radiological experts that can be called upon to rapidly advise on a problem set: The second annual meeting of the RAC was structured around discussing the viability of protecting NYC residents from radioactive iodine released in a catastrophic incident at the Indian Point Nuclear Power Plant in Westchester County, NY. Specifically, an inquiry was made to DOHMH to research pre-staging of potassium iodide (KI) for a segment of the NYC population within a certain radius of the Indian Point facility. Initial policy inquiries were addressed by DOHMH staff; however, further questions requiring specialized knowledge motivated DOHMH to convene the RAC to formulate a citywide KI distribution policy. The RAC was uniquely qualified to respond to this problem set, with many members having responded to and advised the US government after the Fukushima Daiichi incident (2011), specifically had expertise in the use of KI as a countermeasure, and/or had deployed to Japan to analyze data or make measurements of radiation levels. DOHMH was additionally able to recruit into the RAC a nuclear engineer familiar with the risk of catastrophic accidents at nuclear facilities. The ability of the RAC to tap into such expertise illustrates how valuable a network of specialists can operate, easing the technical and expert knowledge needed by a local department in order to respond and protect its constituents. The result was that the Committee was able to be rapidly convene and address the sensitive policy issue authoritatively and was able to formulate a KI policy for NYC during a one day meeting based soundly on experience, science, and a perspective that included the history of domestic and international KI use. The Committee was able to form quickly due to a sense of professional obligation many individuals within the radiological academic, medical, safety, and response community have toward radiological response. Based on direct observation of the Committee meetings and noted by Agency leadership, the RAC was easily engaged and comfortable in a deliberative setting that included presentations of the issue, technical presentations concerning the scientific questions at hand, and discussions that involved sensitive and often disparate views. An indirect benefit of membership composed from several agencies and organizations is that it represents groups and experts DOHMH would not normally be in contact with. Such connections are invaluable for a LHD who would not normally have the internal expertise to advise on technical and scientific issues outside of what is normally supported work. As an example, a Committee member who is a physicist with an expertise in risk analysis, was able to articulate clearly the extremely low risks of nuclear power plant disaster coupled with environmental conditions that would bring about a scenario where NYC warranted the development of a KI distribution plan. This information was otherwise not easily obtainable by DOHMH and would have represented an unanswerable policy question by existing staff, possibly resulting in spending and planning inefficiencies.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation.*)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
 - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

Although the RAC is primarily utilized for DOHMH policy formulation and development, this Committee is also expected to inform partner City agencies during a radiological emergency. Additionally, the RAC has an emergency response role in the case of a radiological incident in NYC. Therefore, it is a citywide asset whose expertise can influence and inform other city agencies and their operations and represents a key planning and operational assets. A cost/benefit analysis was not conducted; however the cost of supporting annual meetings of the RAC, primarily used to cover the cost of travel, hotel, and food costs for visiting Committee members, is minimal and funded through the use of reallocated accrual funds. The rapid planning turn around needed for the annual meetings means that between January, when the funding is released and June, when the funds must be spent, DOHMH was able to fully spenddown the amount requested and allocated while provided a low-cost, high-impact benefit for both DOHMH and citywide emergency management. A RAC can be sustained on a relatively small budget especially if experts in radiological health and radiation medicine can be found locally. Several medical and environmental radiation expertise on the current NYC RAC work within the city or nearby on Long Island at Brookhaven National Laboratory. Similarly, other LHD can consider their local expert assets as a way to develop expertise depth. The existence of the RAC is mandated by the NYC Radiological Response and Recovery Plan (RRRP), as such, DOHMH is committed to maintain it. DOHMH additionally anticipates that there will be no issues in the future commitment of RAC members, indeed many RAC members have been very enthusiastically supportive of the work done and see it as a useful tool for not just local radiological policy development, but also providing a forum for experts to meet and discuss broader issues regularly, benefiting a larger, national conversation on these issues. The RAC program has been viewed as so successful that it has been use as a model at DOHMH for the creation of other, similar technical advisory groups as a low-cost way to expand access to expertise during the planning and response phases of an emergency. Similarly, other LHD could consider looking a location or scenario-specific issues they feel that they have internal gaps in and consider the feasibility of creating an advisory committee of local and/or national experts from the public and private sector to help formulate policy and provide advice during emergency responses.

How did you hear about the Model Practices Program?: *

☐ I am a previous Model Practices applicant

☐ At a Conference

☐ NACCHO Website

☐ Public Health Dispatch

☐ Colleague in my LHD

☐ Model Practices brochure

☐ NACCHO Exhibit Booth

☐ NACCHO Connect

☐ Colleague from another public health agency

☒ E-Mail from NACCHO

☐ NACCHO Exchange