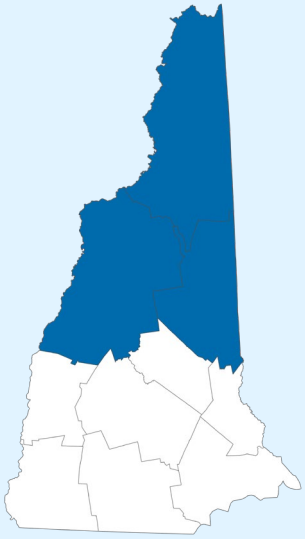
COVID-19 Rural Vaccination Success Story: North Country, NH



Percentage of total population that have completed a primary COVID-19 vaccine series (November 2022)

73.2%

Population (U.S. Census Bureau)

Total North Country: 172,493
- Carroll County: 50,107
- Coos County: 31,268
- Grafton County: 91,118

Demographics* (U.S. Census Bureau)

American Indian or Alaska Native (non-Hispanic): 0.2%
Asian (non-Hispanic): 2.2%
Black (non-Hispanic): 1.1%
Hispanic or Latino: 2.2%
White (non-Hispanic): 92.4%
*Percentages include combined data from Carroll, Coos, and Grafton counties

Health Department Governance

Largely centralized

Key Vaccination Strategies

Background

North Country is a region in northern New Hampshire comprised of three counties: Carroll, Coos, and Grafton. The population of all three combined is 172,493. Demographically, the region is 92.4 percent white, non-Hispanic, and 22.6 percent of residents are age 65 or older.

The region has several notable features:

- New Hampshire's Department of Health and Human Services (DHHS) funds 13 regional Public Health Networks (PHNs). These PHNs support an infrastructure of local partnerships that coordinates to deliver a range of public health services, such as access to substance use prevention and treatment, public health emergency preparedness, and health promotion activities.
- New Hampshire's culture upholds community involvement and active citizen-run government. COVID-19 vaccination partners saw their efforts to support COVID-19 vaccination as an extension of these values.
- Because North Country has many older residents, there was a core of retired individuals—many of whom had medical backgrounds—willing to volunteer for local vaccination efforts.

Methods

We interviewed representatives from eight organizations involved in the North Country's COVID-19 vaccination efforts. They included the DHHS, PHNs, critical access hospitals, and health centers. We also interviewed 10 residents about their COVID-19 vaccination experiences.

January 2023

Core Partners

The following partners worked together to vaccinate the greatest possible number of residents:

- PHNs
- Public Health Advisory Councils
- (a subset of PHNs)
- Visiting Nurses Association
- Medical Reserve Corps
- National Guard
- Volunteer emergency medical services, fire and police departments
- Health clinics and hospitals
- Local businesses, employers, and Chambers of Commerce
- Local schools, school districts, and school nurses
- Nursing homes
- Housing authorities
- Faith-based organizations

Key Strategies

Working with Partners

Local Partners

DHHS provided considerable decision-making authority to PHNs, local hospitals, and health care clinics, allowing them to determine how best to vaccinate individuals in their own communities.

These organizations leveraged existing community partnerships to launch COVID vaccination clinics and outreach. Regional PHNs engaged local partners, and the community, to implement vaccine rollout strategies.

Concurrently, local hospitals and clinics coordinated with DHHS and regional PHNs to receive vaccine doses and align strategies for public outreach. These efforts facilitated community outreach and engagement, created additional vaccination sites, and reduced barriers to access.

Close, daily communication was critical to success. DHHS shared updates and coordinated its statewide response via a daily call with PHNs, local hospitals, and other key partners. In the Androscoggin Valley and the town of Berlin, leaders from the PHN, business community, hospitals, nursing homes, schools, and local prisons, also held a daily conference call to share information and

"We met weekly with the hospital association and DHHS. They let us know ahead of time what [vaccine] we were going to have. It felt very pragmatic and thoughtful, and they focused a lot on making sure that it was equitable and fair… They [DHHS] never allocated doses preferentially. But, a few times when they [had extra vaccine], they looked at the group and said 'Hey, if we gave you additional doses, can you get them administered?' Each time, we knew there was demand, so we said 'Yep, we can do that. Bring them on.'"

– Memorial Hospital

strategize. They set up a community webpage that was updated weekly and included an online dashboard with local area transmission rates, talking points, information resources, and updates on partner activities.

State & National Partners

DHHS acts as a "super agency," encompassing public health, human services, and Medicaid. This super-agency structure facilitated collaboration and support between state-level agencies as they established a systematic vaccine effort across the state.

The Bureau of Emergency Preparedness, Response, and Recovery, part of the DHHS Division of Public Health Services, took the lead on coordinating the community response. It oversaw 11 vaccination sites supported by the National Guard, first responders—including local police and

fire departments—and the Medical Reserve Corps. Individuals from these organizations were often familiar faces within the community, reinforcing trust and comfort in vaccination.

"[When it came to COVID-19 vaccination], the population in rural areas really wanted and needed support from the systems that they're used to getting it from, because they're so far removed from the state, so to speak."

– DHHS Bureau of Emergency Preparedness Response and Recovery

On two occasions, DHHS ran "Booster Blitz" events at additional vaccination sites in local schools, colleges, storefronts, and liquor stores. Booster Blitzes were events that sought to increase booster uptake and were widely publicized on mainstream and social media. These events resulted in over 6,000 sign-ups for booster-shot appointments.

Conducting Community Outreach & Engagement

Leaders began communicating with the public well before the vaccines were available, seeking to field questions—especially from those who were highly motivated to get vaccinated—dispel misinformation, and create demand. As vaccines became available, DHHS, PHNs, and local organizations began to raise awareness through events,—including live virtual events—and outreach through traditional and social media channels.

State-level communicators provided updates on the statewide response, and the latest available science. The governor held weekly press conferences—which often included the state epidemiologist—signaling involvement and support from leadership at the highest levels. These messages were further amplified by the state's official website and social media handles. Statewide health promotion primarily used messaging developed by the Centers for Disease Control and Prevention.

At a local level, partners generally adopted the state's talking points to retain consistent, evidence-based messaging about the science behind, and rollout of, vaccines. However, local partners also tailored messages to their own communities—frequently using photographs of local people and locations— and emphasized personal choice when it came to vaccination.

To provide information specific to their communities and respond to questions, local organizations hosted town hall meetings and live virtual events via Zoom and Facebook. This and other social media outreach helped reinforce messaging and reach a broader audience. It was coupled with traditional media approaches including newspaper advertisements, flyers, and public service announcements on radio and television.

In terms of one-on-one outreach, organizers at vaccination sites took to the phones, using interpersonal outreach and networking to inform community members that vaccines were available at clinics.

Some organizations created communications featuring local leaders and champions to amplify their area's "rural voice." For example, the North Country Health Consortium's #MyWhy campaign showcased six medical staff who explained why they decided to get vaccinated. By engaging locally recognizable people to tell their stories, campaigns like #MyWhy reinforced the importance of vaccination in their own community as people were beginning to tune out broader messaging efforts due to pandemic fatigue.

"The hyper-local approach in the rural space is really important, because I think rural residents… know what they see closest in front of them and they often are living in a paucity of resources or a paucity of information that's part of their built environment. And so they know who they know, and they know who they trust. And when a trusted primary care provider shows up at a vaccination clinic to vaccinate kids, the whole family lines up."

– North Country Public Health Network

Using Trusted Messengers

The region's vaccination initiative benefitted from using powerful and trusted messengers to share COVID vaccine information, respond to vaccine misinformation, and listen to the concerns of those who are unsure about getting vaccinated. One-on-one conversations that responded to misinformation with facts, and communicated the value of getting vaccinated, were particularly effective when delivered by someone whom the concerned party already knew, be it a neighbor, friend, family member, or respected health provider. Recognizing this, the Northern New Hampshire Medical Reserve Corps recruited over 100 volunteers, many of whom were retirees with medical backgrounds, to distribute vaccines and serve as de facto ambassadors.

"It's really about taking a non-judgmental, open approach with people. Asking them to talk about what's behind the basis for their decisions—the pros and cons of their decisions—and doing it in a way that conveys acceptance, and leaves room for a continued conversation."

– Coos County Family Health Services

When it came to addressing vaccine confidence, local organizations emphasized the importance of one-on-one conversations between those who were unsure about the vaccine and people they trusted. Health care providers and volunteer nurses who engaged in such one-on-one conversations reported that effective conversations were respectful and non-judgmental,

acknowledged the individual's particular health or access situation, used factual information to address concerns or counter misinformation or myths, and underscored the value of personal choice.

Offering Mobile, Off-site & Drive-Through Clinics

To increase access throughout the state, DHHS offered and oversaw mobile vaccine clinics. During the largest vaccination push, seven mobile vaccination teams held roughly two to three clinics per week. Organizations could request a mobile clinic on the DHHS website. Mobile clinics were held at and in:

- Apartment complexes
- Senior living facilities
- Low-income housing
- Malls and shopping centers
- Town fairs
- Worksites

PHNs, hospitals, and health centers also held their own community vaccination clinics, often in familiar locations like stores or at health clinics. In North Conway, Memorial Hospital worked with DHHS and local partners to host a vaccination clinic in the Mount Washington Observatory's Weather Discovery Center, a science museum that had permanently closed. In Colebrook, the Upper Connecticut Valley Hospital transformed a local garage into a drive-through vaccination site. This drive-through approach allowed people to maintain social distancing and remain comfortable, especially during New Hampshire's coldest winter months when maximum daily temperatures can be 15 degrees Fahrenheit and below.

Overcoming Transportation & Other Access Barriers

Because the region is geographically dispersed and lacks public transit, getting to a vaccination clinic was a challenge for a number of older adults and people with mobility issues. North Country PHN screened people to assess transportation challenges, and then housing authority and social service organizations, like the Tri-County Community Action Program, coordinated transportation. For those who had trouble leaving their homes, DHHS' Home-based Initiative program partnered with the Visiting Nurses Association and On-Site Medical Services to provide vaccination and booster shots in peoples' homes.

Another, initial accessibility issue was that the earliest versions of an online central scheduling system created usability challenges for some older adults, as well as for those with limited internet connectivity. To mitigate this, the state began scheduling vaccination appointments via its 2-1-1 call number and Vulnerable Populations Call Center. Many vaccination sites also permitted walk-in appointments.

Offering Vaccine Choice

As personal choice is a tenet of the local culture, a number of vaccine clinics found that they were able to increase their numbers by offering individuals their choice of vaccine (Pfizer, Moderna, or Johnson & Johnson while it was recommended), even for walk-in appointments. While logistically challenging, in some cases being able to choose their preferred vaccine was what it took to sway someone who was unsure about getting vaccinated into doing so on the spot.

Community Member Vaccination Experiences

We conducted in-depth interviews with 10 residents. They reported initially having trouble accessing the vaccine, specifically noting that they had problems with online registration and transportation. Many also had to overcome concerns about the vaccine, including the short timeline for vaccine development and lack of information about both short- and long-term effects. Others reported a lack of trust in the medical establishment and the government.

Interviewees said that the following factors helped convince them to get vaccinated:

Talking with peers—especially family members—who were familiar with vaccine research

Hearing from family members and friends who received the vaccine without any adverse consequences

Getting encouragement and reassurance from their personal health care providers about the safety of the vaccine

Seeing familiar faces like school nurses or local leaders at vaccine clinics

Takeaways for Other Rural Communities

1. Invest in infrastructure between state and local public health partners.

When it came to COVID-19 vaccination, New Hampshire's approach to public health administration—centralized with regional public health networks—offered important benefits. This structure was the bridge that allowed DHHS to rapidly deliver information, resources, and vaccines from national- and state-level partners to local communities. Because this existing infrastructure had allowed for trusted relationships and partnerships to evolve over time, they could be rapidly deployed for the COVID-19 vaccination efforts. It also empowered local leadership to make decisions about the best ways to vaccinate their own communities.

2. Partner with local health care organizations to deliver and promote vaccination.

In North Country, local health care organizations were a critical piece of the initiative's success. In these small, rural communities, residents trusted what their health care providers said about COVID-19 and the vaccines. These local health organizations also had the necessary expertise in handling, managing, and administering the vaccines.

3. Employ multiple strategies to address access barriers and meet each community's unique needs.

New Hampshire used multiple strategies and tactics tailored to the communities to nimbly, creatively, and flexibly overcome access barriers. Approaches included assisting with registration and scheduling, arranging transportation, visiting individuals in their homes, offering opportunities for open discussion to address concerns about the Covid vaccine, and—in some clinics—offering walk-in appointments and/or choice of vaccine.

4. Communicate frequently with partners ,to enhance coordination.

At the height of vaccine outreach, DHHS held daily conference calls with the PHNs and key community partners. These calls relayed critical information about vaccine availability, surveillance data, and the latest guidance or recommendations. The calls also helped DHHS identify high-performing sites, and areas that needed additional resources.

5. Engage hyper-local messengers for health promotion, and to respond to misinformation.

Health promotion communications that featured local people in recognizable community locations helped cut through the noise of COVID myths, addressed uncertainty, and mitigated COVID fatigue. Respectful one-on-one conversations with trusted messengers—like health care providers, volunteer nurses, and friends and family who had been vaccinated without side effects—also proved effective in overcoming these hurdles.

Methodology

On behalf of the Centers for Disease Control and Prevention (CDC), NORC at the University of Chicago (NORC) and East Tennessee State University (ETSU) conducted a qualitative study to better understand vaccine confidence and demand in rural communities. The study explored the following topics related to COVID-19 vaccination in rural communities: factors influencing COVID-19 vaccine confidence; strategies implemented to address vaccine demand and access barriers to increase COVID-19 vaccination rates; individual-level perspectives on COVID-19 vaccination in rural areas; and lessons learned related to COVID-19 vaccination efforts for rural communities. The qualitative study included case studies in six rural communities. Between April and July 2022, NORC/ETSU interviewed organizations involved in COVID-19 vaccination efforts and community members who had received the COVID-19 vaccine. Organizations and community members were recruited from the following study sites: Leflore and Jefferson Counties, MS; Marshall County, IA; North Country Region (Carroll, Coos, and Grafton Counties), NH; Perry County, KY; Rio Arriba County, NM; and Starr County, TX.