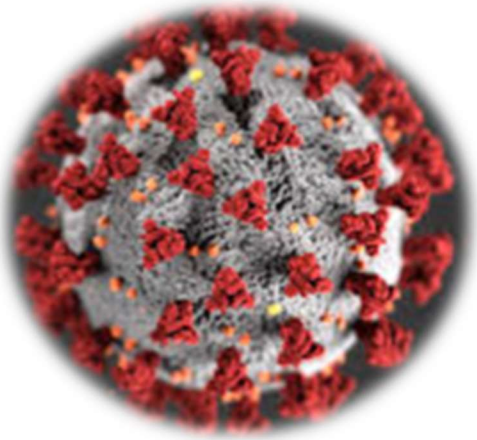

Region Five  COVID-19

After-Action Report/Improvement Plan

December 2022

The After-Action Report/Improvement Plan (AAR/IP) aligns with Homeland Security Exercise and Evaluation Planning Guidance (HSEEP) and related preparedness frameworks.

Contents

EXECUTIVE SUMMARY

On March 13, 2020, the President signed an emergency declaration for all states, tribes, territories, and the District of Columbia. Governor Lamont (CT) signed an emergency order in response to the worldwide COVID-19 Pandemic.

FEMA announced that federal emergency aid had been made available to supplement the state, tribal, and local recovery efforts in the areas affected by the Coronavirus Disease 2019 (COVID-19) pandemic beginning on January 20, 2020.

As the Pandemic impacted the United States, many states faced sudden lockdowns. Populations were confined to their homes, and organizations of all types had to change how they operated or shut down entirely, with little or no time to prepare.

With a lack of county government structure in Connecticut, Department of Emergency Management and Homeland Security (DEMHS) developed with its local partners emergency preparedness regions in 2007. These regions were created to facilitate emergency management and homeland security planning and regional collaboration. The Regional Emergency Planning Team (REPT) in each Region operates under bylaws that address their mission, membership, and procedures. The multi-jurisdictional REPTs are supported by Regional Emergency Support Functions (RESF). These RESFs are discipline-oriented working groups that provide collaborative planning and resource support within each discipline. Each REPT is therefore made up of members from each municipality and tribal government in the DEMHS Region as well as each emergency management discipline.

The five DEMHS Regional Offices serve as direct points of contact to local jurisdictions to provide: distribution of warning and emergency information to local jurisdictions; on-site monitoring of localized emergencies; collection, verification, and consolidation of local emergency reports and requests for assistance; assistance to local jurisdictions in regional budget development and funding requests; assistance to local governments in requesting aid in training and exercise development; guidance and assistance to local governments in Local Emergency Operations Plan (LEOP) development, review, and revision including annexes such as school security planning; oversight of the development of Regional Emergency Support Plans; and coordinate a regional response to ongoing emergency situations.

In response to the COVID-19 Pandemic, Region 5 Local Health Departments and Districts (LHDs)implemented a unified command structure, activating the Emergency Operations Plan by opening a virtual Emergency Operation Center. LHDs responded rapidly. They collaborated with local, regional, and state officials as well as community and health partners.

Local Health Departments/Districts implemented guidelines provided by the State of Connecticut, Connecticut Department of Public Health (DPH) and the Centers for Disease Control (CDC) that included recommendations for organizations and workers to manage the public health risks and advise organizations on resuming and modifying operations. LHDs demonstrated remarkable adaptability during the COVID19 Response. LHDs successfully managed extensive Contact Tracing, established vaccination processes, and supported countless vaccination clinics, mobilized

volunteers, successfully partnered with existing and new partners, and mobilized a community-wide response.

Acute Care Hospitals curtailed non-emergent and elective surgeries and procedures. They implemented surge capacity plans that required hospitals and local municipalities to assess and identify alternate care site locations within their communities. Hospitals increased surge capacity by expanding to non-traditional patient spaces within the hospital. Intensive Care Units expanded, more than doubling the standard number of critical care beds and obtaining resources such as PPE, ventilators, non-invasive ventilators, and high-flow oxygen systems. Staff scheduling models were flexible and adapted to the situation. There were four twenty-five-bed mobile field hospitals, with two twenty-five-bed mobile field hospitals set up within Region Five. The mobile field hospital(s) were located at Danbury and Sharon Hospital.

CT DPH established five COVID-19 Recovery Centers. The purpose of these centers was to alleviate stress on long-term care, assisted living facilities and hospitals. COVID-19 positive patients were transferred there for care. Region Five's long-term care facilities were in Torrington and Sharon. These locations were supported by the local municipalities and Local Health Departments and Districts.

Emergency Medical Services (EMS) were challenged to obtain personal protective equipment and maintain staffing. Policies and guidelines were developed to support the incident response and protect staff. EMS agencies established continuity of operations plans to continue to provide services to the communities served.

Vaccination efforts began in December 2020, focusing on the vulnerable populations and critical workforce. The initial group targeted for vaccination was healthcare workers and long-term care facility residents. Planning efforts moved from the original planning that targeted the critical workforce redirecting mass vaccination to those most susceptible to COVID-19, phasing in high-risk groups, including educators and daycare providers.

LHDs were challenged with reaching out to the vulnerable and at-risk populations. Vulnerable and at-risk populations included immigrants, seniors, and those with disproportionate outcomes. The barriers the population faced included transportation to clinic sites, language barriers, lack of familiarity with technology, and hesitancy of communicating with government staff due to immigration status and fear of deportation. Public health overcame these challenges by community outreach, creating partnerships with local healthcare and community agencies, increasing accessibility by offering homebound visits (through partnerships with local community agencies), conducting clinics at long-term care facilities, and educational campaigning through social media, radio, and video in various languages. Immigration status fears were addressed through local cultural centers and places of worship to assure the community that vaccine efforts did not have any connection to immigration status.

Timeline

12/31/2019	China reported cluster of pneumonia cases in Wuhan • Wuhan Municipal Health Commissioner, China, reported a cluster of cases of pneumonia in Wuhan, Hubei Province
1/9/2020	Outbreak was identified as novel coronavirus
1/10/2020	Infectious Disease began to monitor for COVID-19
1/11/2020	First death from COVID-19 in China
1/13/2020	First case of COVID-19 outside of China – Thailand • Officials confirm the first case of COVID-19 in Thailand, first recorded case outside of China
1/13/2020	State CDC calls started
1/15/2020	CT Department of Public Health (DPH) sent out advisories to local public health
1/17/2020	CDC started screenings at SFO, JFK and LAX on airplanes from Wuhan CDC sent out a HAN notice
1/21/2020	First US travel-related confirmed COVID-19 Case • United States announced its first confirmed COVID-19 case – a man in his 30s in Washington State
1/23/2020	China placed Wuhan under quarantine
1/24/2020	Partial activation and Battle Rhythm set up
	CDC added US airports: ATL and ORD to their screening list
1/27/2020	Governor Lamont Tells Residents State Closely Monitoring for Possible Cases of Coronavirus ASPR discussion on recommendations to prepare for COVID-19 DPH COVID-19 webpage went live
1/29/2020	ICS 201 was created DPH set up briefings with LHDs DPH calls with Connecticut Hospital Association (CHA) started CT Department Emergency management and Homeland Security (DEHMS) pre-activation meetings
1/30/2020	DPH prepared a COVID-19 briefing for Gov. CT Health Care Coalition (HCC) hold discussion on supply chain issues CDC confirms person-to-person spread of COVID-19 in U.S.
1/30/2020	WHO declared the outbreak a global public health emergency • WHO's situation report for January 30th reported 7818 total confirmed cases worldwide, with the majority of these in China, and 82 cases reported in 18 countries outside China

1/31/2020	First COCA call Second CT patient tests negative White House: ban entry for most foreign nationals who had traveled to China within the last 14 days (3 Wuhan Briefings set up, Av – questions response)
2/2/2020	First COVID-19 Death outside of China - Philippines
2/4/2020	CDC published Returning Traveler call and guidance
2/5/2020	ASTHO COVID-19 calls began CT added novel coronavirus to its list of reportable diseases
2/6/2020	First death in the US in CA
2/14/2020	R 5 -Local Health Departments/ districts began working with provider industries, CHA, LTC associations, the alliance –simultaneously did presentations with LTC related to COVID
2/26/2020	First update on COVID-19 since 1/31/20
2/27/2020	DEMHS pre-activation meeting and an agenda was set up First DPH COVID-19 Commissioner's Briefing WHO published guidance on the rational use of PPE due to shortages
2/28/2020	COVID-19 meeting at Capitol called by Governor Lamont's Staff (Room 208)
2/28/2020	State Public Health Lab (SPHL) approved to run diagnostic testing for COVID-19
2/29/2020	Weekend CDC calls began President announced additional travel restrictions – Iran and increased warnings about Italy and South Korea
3/2-3/3/2020	Surgeon General visits CT On 3/3 WHO issued a call to increase PPE manufacturing by 40% to meet global demand
3/4/2020	CDC travel guidance
3/5/2020	Gov Lamont requests CDC provide additional COVID-19 testing kits COOP meeting with Commissioner to finalize plan Stood up COVID19.dph and Commctr1, 2, 3, 4, 5 emails
3/5/2020	First DPH Blast Fax to All Healthcare Facilities relating to COVID-19
3/7/2020	NY resident works in CT tested positive for COVID-19 • New York resident who is a Physician at Bridgeport Hospital testing positive for COVID-19 WHO – surpassed 100,000 cases globally
3/8/2020	First positive case for CT resident, (1 positive case and 29 tests) First CDC HAN released regarding COVID-19
3/9/2020	Daily WebEOC posts started, including Incident Briefing and Activity Log ECC Activated First call with Governor and municipal leaders R5 LHD(TAHD) notified of positive cases- Contact tracing begun

	Memo issued to nursing homes and convalescent homes on visitor restrictions
3/10/2020	Governor Lamont declared civil preparedness and public health emergency
3/11/2020	WHO characterized COVID-19 as a pandemic CT State requested additional PPE from SNS – the state has requested additional PPE from the SNS Third case in CT
3/12/2020	Six cases in CT Governor prohibits all events over 250 and now visitor restrictions at nursing/convalescent homes • Prohibits all events over 250 people • Modifies state law requiring schools to be in for 180 days • Visitor restrictions at all nursing and convalescent homes • Authorizes DMV to extend renewal deadlines • Relaxing attendance rules for police academy trainees Executive Order (EO) 7: limiting size gatherings, waiving 180 school day requirement
3/13/2020	President Trump declared national emergency 11 cases, 136 tests in CT Students to receive meals even though schools are closed Department of Social Services (DSS) expanding telemedicine coverage for those under HUSKY/Medicaid Department of Economic and Community Development (DECD) working with small businesses Several state agencies are rolling out broad measures to promote social distancing that protect Connecticut residents and state employees. Additional restrictions to nursing homes EO 7A: Grants the commissioner of CT DPH the authority to restrict visitation at nursing homes and similar facilities
3/14/2020	The State requests assistance from the Connecticut National Guard EO 7B • Relaxes in-person open meeting requirements to minimize large gatherings, with safeguards to provide remote public access • Allows pharmacists to compound and sell hand sanitizer • Waives requirements for pharmacists to use certain personal protective equipment when working with non-hazardous, sterile compounds • Internet providers are increasing support to provide internet access to families as schools and businesses are closed

	Governor Lamont has directed telework requirements to be eased for certain executive branch state employees, allowing an increased number of employees to work from home. He is also providing executive branch state employees who cannot report to work due to COVID-19 14 days of paid time off.
3/15/2020	EO 7C: Public Schools Closed – Governor Lamont signs executive order to close public schools statewide effective March 17th through at least March 31st Anyone who loses employment qualifies for health insurance through AccessHealthCT CDC recommends cancel/postpone events of 50 or more
3/16/2020	EO 7D: Limits social gatherings • Revises the previously enacted prohibition on large gatherings to a capacity of 50 people and adds religious gatherings to the list of activities subject to the limit • Limits restaurants to non-alcoholic beverage and take-out/delivery services only, effective 8PM tonight • Requires closure of on-side operations at off-track betting facility operations, effective 8PM tonight • Requires closure of gyms, fitness studios, and movie theaters, effective 8PM tonight Drive-through testing has been approved at seven Connecticut hospitals. State Department of Education has been working with school districts on developing distance learning plans, as well as ensuring students have access to nutritious meals. Close of casinos President issued guidelines to avoid large social gatherings San Francisco became the first to introduce extreme measures in response US researchers administered the first shot to the first person in a test of an experimental coronavirus vaccines
3/17/2020	EO 7E – further modification of 180-school day requirement
3/18/2020	EO 7F - Governor closes large indoor malls and places of amusement Access Health CT opening special enrollment for those uninsured CT to receive PPE from SNS in the next couple of days Canada and the US agreed to close its borders to all non-essential traffic
3/19/2020	15 alternative sites in CT that are offering drive-through testing Directs the temporary closure of barbershops, hair salons, tattoo or piercing parlors, and related business effective on 8:00 pm on Friday China reported no new domestic cases US raised the global travel advisory to level 4

	EO 7G – permits certain restaurants and other eating establishments to sell alcohol with take-out food orders under certain conditions
3/20/2020	EO 7H "Stay Safe, Stay Home" The state has launched a framework for the donation of Personal Protective Equipment (PPE). Those looking to donate should fill out a form on 2-1-1's website The Department of Public Health is taking over responsibilities from the FDA to approve all COVID-19 testing at commercial laboratories in the state. Governor Lamont and Department of Economic and Community Development Commissioner David Lehman conducted a conference call with more than 5,000 small businesses owners and leaders throughout the state to begin a discussion on the impact of COVID-19 on businesses. Businesses experiencing issues regarding supply chains, delivery of goods, or business continuity should contact FEMA's emergency operations center.
3/21/2020	Daily DPH Epidemiological Reports started EO 7I: This order provides broad relief for municipalities regarding procedures, notice requirements, and deadlines for various proceedings and decisions. In addition, it enacts several DSS modifications, student privacy, visitation in Department of Children and Families facilities, pharmacy regulations, and corporate meetings. The state has received responses from more than 100 entities since launching its request for Personal Protective Equipment yesterday.
3/22/2020	EO 7J – clarification of "Stay Safe, Stay Home"
3/23/2020	ECC staffed with volunteers EO 7K – modification of DPH regulatory requirements
3/24/2020	EO 7L: Extension of class cancellations
3/25/2020	EO 7M: Suspension of mandatory statutory filing PPE distribution to multiple state agencies with direct client contact
3/26/2020	EO 7N: further reduction of social and recreational gatherings
3/27/2020	US surpassed Italy and China with cases EO 7O: suspensions of license renewals and inspections by DPH
3/28/2020	CDC issued travel advisory for NY, NJ and CT EO 7P: Authorization to provide for non-congregant housing for persons at risk
3/29/2020	President extended social distancing until April 30th Gov. Lamont placed order for 100 ventilators with Guilford manufacturing company Bio-Med Devices
3/30/2020	EO 7Q: Requirement of limited group sizes in childcare – no more than 10 children in one space

	Check children and staff before entering, such as coughing, respiratory distress and temperature
3/31/2020	CT National Guard deployed mobile medical station at Southern CT State University (SCSU) Restrictions on entrance to state parks, forests, and other lands EO 7R: Continuation of payment of public-school staff
4/1/2020	EO 7S: Safe stores
4/1/2020	First CT Nursing Home Data Report
4/2/2020	EO 7T: Prohibition on non-essential lodging
4/3/2020	CDC recommends the use of facemasks
4/5/2020	EO 7U: Protection from civil liability for actions or omissions
4/7/2020	EO 7V: Safe workplaces in essential businesses
4/9/2020	EO 7W: Suspension and modification of tax deadlines
4/10/2020	EO 7X: Extension of closures, distancing, and safety measures
4/11/2020	EO 7Y: Establishing COVID-19 Recovery Centers
4/13/2020	National Guard activated Adaptive Battle Staff Northeast Governors announce multistate council
4/14/2020	EO 7Z: modification of state contracting statutes to facilitate the emergency Piloted long term care surveillance with Yale School of Public Health
4/15/2020	Governor submitted supplementary request for enhanced federal support in response to the pandemic EO 7AA: approval of temporary additional nursing home beds for COVID-19 recovery Protests started over the stay-at-home orders
4/17/2020	EO 7BB: Cloth face coverings or higher level of protection required in public wherever close contact is unavoidable CT established first Rapid COVID-19 Testing Center Mass fatality management – refrigerated trucks, delivering post-mortem bags to the hospitals Worked with DEEP to suspend air pollution permitting of crematories – increased capacity
4/19/2020	CT DPH began site visits to all Nursing Homes and Long-Term Care Facilities (LTC)
4/20/2020	Working with National Guard to set up 6 recovery centers from April 20-24
4/21/2020	EO 7CC: Applicability of EO
4/22/2020	EO 7DD: additions to the definition of telehealth provider
4/23/2020	EO 7EE: Mandatory reporting by managed residential communities
4/24/2020	EO 7FF: additional flexibility for Medicaid-enrolled providers to perform telehealth through audio-only methods for new patients.

4/25/2020	Coordination w/ National Guard, logistics – support of LTC/ALSA/RCH testing initiative
4/30/2020	First Assisted Living Facilities Data Report Gov Lamont outlined phased in approach to reopening CT's economy EO 7GG: Extension of payment time for sealed ticket revenue
5/1/2020	EO 7HH: mandatory suspension of annual town meeting
5/5/2020	EO 7II: Extension of school closures
5/6/2020	Gov Lamont recommendations for phased reopening of colleges and universities was released EO 7JJ: Applicability of EO No. 7S
5/7/2020	EO 7KK: pharmacists to order and administer COVID-19 tests Gov Lamont released criteria for phase 1 reopening
5/9/2020	Gov. Lamont released sector rules for phase 1
5/11/2020	DPH distributed first allotment of remdesivir to ACH EO 7LL: Modifications to the petitioning process for the August primary
5/12/2020	CT receives its largest shipment of PPE
5/13/2020	EO 7NN: Waiver of statutory vote on supplemental federal block grant,etc.
5/14/2020	CVS Health opened 12 new drive-thru COVID-19 testing sites EO 7OO: Procedures for local appointments and elections requiring in-person vote Roll-out of point prevalence surveys 5/14-5/19
5/15/2020	Gov Lamont announced 50k infrared thermometers
5/18/2020	Contact tracing through ContaCT, an electronic system, (DPH and LHDs) is rolled out for trial testing Government Lamont releases dental guidance EO 7PP: reopening phase 1
5/20/2020	EO 7QQ: Modifications to permit the use of absentee ballots Phase 1 of Reopening Restaurants (outdoor only), museums and zoos outdoor online, remaining retail, outdoor recreation, limited capacity
5/21/2020	EO 7RR: Protection of public health and safety during covid-19 pandemic and response – refunds by deep, birth-to-three coverage, waiver of guest book requirement
5/27/2020	EO 7SS: Permits the creation of a temporary nurse aid positions
5/29/2020	EO 7TT: Reopening of barbershops and hair salons on June 1; and amended prohibitions on large gatherings
6/1/2020	EO 7UU: Mandatory COVID-19 testing for staff of private and municipal nursing homes…etc.

	Hair salons and barbershops open
6/2/2020	EO 7VV: Amended limitation on program sizes in childcare.
6/4/2020	Schools permitted small-scale in-person graduations would be allowed July 6
6/5/2020	EO 7WW: technical clarifications regarding ballot…. etc.
6/6/2020	EO 7XX: Modification of safety rules for drive-in…. etc.
6/10/2020	EO 7YY: resumption of court filing deadlines, etc. US COVID cases surpass 3 million.
6/16/2020	Lamont expands social gathering limits to 25 indoors and 100 outdoors for private events. EO 7ZZ: Modifications to adapt to Phase 2 reopening
6/17/2020	Phase 2 of Reopening – restaurants (indoor), sports, sports clubs and complexes, gyms, fitness centers and pools, amusement parks, libraries, museums, zoos, aquariums EO 7AAA: Technical correction to EO 7ZZ Implementation of ContaCT and telephony system
6/19/2020	CT has the lowest rate of COVID transmission in the country
6/23/2020	CT is 10th in the nation for per capita testing
6/24/2020	Gov of CT, NY and NJ announce 14-day quarantine for travelers from some states that are experiencing high levels of COVID infections EO 7BBB: safety advisory regarding travel from states…. etc.
6/25/2020	CT unveils its preliminary fall back-to-school plan EO 7CCC: clarification of time periods in EO 7I
6/28/2020	CT drops below 100 patients hospitalized for first time
6/29/2020	EO 7DDD: Extended protections for residential renters affected by…etc.
6/30/2020	Travel advisory for 16 states EO 7EEE: authorization for DSS to provide funding…etc.
7/2/2020	COVID-19 metrics only reported Mon-Fri
7/6/2020	Lamont suspends Phase 3 Reopening EO 7FFF: Modifying minimum service hours for private non-medical institutions for adults.
7/7/2020	Zero deaths from COVID in CT Regional travel advisory to 19 states
7/8/2020	State campgrounds open
7/13/2020	EO 7GGG: Authorization for temporary rental housing program, etc.
7/14/2020	CT regional travel advisory expands to 22 states EO 7HHH: authorization continued for temporary suspension of the requirements…. etc. Early Moderna data points to vaccination candidates' efficacy

7/21/2020	EO 7III: Gov imposes mandatory self-quarantine for travelers from states with high COVID-19 infection levels.
7/22/2020	Stood up Commctr7 email for Travel Advisory
7/24/2020	EO 7JJJ: Rebuttable presumption…etc.
7/27/2020	Moderna Vaccine begins phase 3 of clinical trial Pfizer and BioNTech announce the beginning of Phase 3 Trial
7/28/2020	EO 7LLL: Resumption of requirements and deadlines…etc.
8/14/2020	EO 7NNN: Modifications to face coverings…etc.
8/21/2020	EO 7OOO: Extension of expanded outdoor dining…etc.
8/28/2020	AstraZeneca vaccine begins phase 3 First known case of COVID-19 reinfection in the US
9/1/2020	Extension of Declaration of Civil Preparedness and Public Health Emergencies
9/4/2020	EO 9: Commissioners of Early Childhood and Education may issue…. etc.
9/8/2020	EO 9A: Reissuance and extension of COVID-19 EOs to Nov. 9…etc.
9/14/2020	US airports stop screening international travelers
9/15/2020	EO 9B: Amendments to mandatory self-quarantine…etc.
9/16/2020	EO 9C: Amendments to the mandatory self-quarantine for travelers from states…etc.
9/23/2020	A new more contagious strain of covid-19 is discovered
9/25/2020	EO 9D: extension of prohibition on sale of alcohol by certain permittees.
9/28/2020	State to allow indoor visits at nursing homes Global COVID-19 deaths reach 1 million
9/30/2020	EO9E: Extension of eviction moratorium... etc.
10/8/2020	Phase 3 Reopening EO9F: Amendments to size restrictions on certain gatherings, etc.
10/13/2020	EO9G: Municipality authority to revert to more restrictions pre 10/8/20, …etc.
10/20/2020	EO9H: Remote participation in agency and municipal meetings, etc.
10/27/2020	EO9I: Amendment to mandatory self-quarantine for travelers from states with high COVID-19 levels
10/29/2020	EO9J: Municipality authority to revert to more restrictions pre 10/8/20, …etc.
11/5/2020	EO9K: Repeal of municipal authority – return to statewide protective measures Connecticut rolls back Coronavirus Reopening to Phase 2 Connecticut Department of Public Health issues statewide COVID-19 advisory recommending all residents limit non-essential trips outside the home from 10PM to 5AM
11/9/2020	EO9L: Extension COVID-19executive orders to 2/9/21..., etc.

11/20/2020	EO9M:DECD authority to enact rules for all sports activities, etc.
11/24/2020	EO9N: Additional enforcement authority regarding violations of size and capacity restrictions Commissioner of Public Health measures to ensure enforcement.
11/30/2020	Connecticut passes 5,000 COVID-19 Related Deaths
12/1/2020	EO9O: Flexibility in hiring short-term substitute teachers Sale of alcoholic liquor at virtual events by charitable organizations permitted Resumption of certain Judicial Branch requirements and deadlines
12/4/2020	EO9P: Increase in weekly benefit amount and qualification for Lost Wages Assistance Remote licensing examination for subsurface sewage disposal system cleaner and installer
12/7/2021	EOI9Q: Administration of COVID-19 vaccine by licensed pharmacists Reporting of influenza vaccine administration to patients younger than 18 Out-of-network COVID-19 immunization
12/15 or 16/2020	First doses of Pfizer administered in Connecticut
12/16/2020	EO9R: Suspension and modification of tax deadlines and collection efforts for tax bills that become due and payable on January 1, 2021, etc.
12/18/2020	EO9S: Amendments to mandatory self-quarantine for travelers from states with high COVID-19 levels Authorization for continued temporary suspension of the requirements for licensure, certification, or registration of out-of-state providers
12/21/2020	First doses of Moderna arrive in Connecticut
12/23/2020	EO9T: Extension of eviction moratorium
12/26/2020	TAHD (R5 LHD) has 1st LHD public vaccination clinic in R5
1/14/2021	COVID-19 Vaccine open to 75+
2/4/2021	EO10: Use of commuter parking facilities as needed for COVID-19 testing and vaccination…,etc.
2/8/2021	EO10A: Extension of COVID-19 Executive Orders
2/11/2021	COVID-19 Vaccine open to 65+
3/1/2021	COVID-19 Vaccine open to 55+, teachers, school staff and childcare
3/3/2021	Johnson and Johnson Vaccine arrives in Connecticut
3/14/2021	EO10C: Extension of legislative action to expand access to telehealth services
3/18/2021	EO10D: Relaxation of capacity limits for religious, spiritual, or worship gatherings
3/19/2021	Connecticut Relaxes more COVID-19 Restrictions

	• All capacity limits will be eliminated for the following businesses, while face coverings, social distancing, and other cleaning and disinfecting protocols will continue to be required • Restaurants (8-person table capacity and 11PM required closing time for dining rooms continues) • Retail • Libraries • Personal services • Indoor recreation (excludes theaters, which will continue to have a 50% capacity) • Gyms/fitness centers • Museums, aquariums, and zoos • Offices • Houses of worship • Gathering sizes will be revised to the following amounts: • Social and recreational gatherings at private residence – 25 indoors/100 outdoors • Social and recreational gatherings at commercial venues – 100 indoors/200 outdoors • All sports will be allowed to practice and compete, and all sports tournaments will be allowed, subject to Department of Public Health guidance Connecticut's travel advisory will be modified from a requirement to recommended guidance
3/29/2021	Capacity limits on early childhood classes will increase from 16 to 20
4/2/2021	• Outdoor amusement parks can open • Outdoor event venues can increase to a 50% capacity, capped at 10,000 people • Indoor stadiums can open at 10% capacity • Summer camps and summer festivals are advised to begin the planning stages to open for the upcoming season
4/5/2021	CT has administered 2,081,751 doses of vaccine
4/19/2021	Extension of Declaration of Civil Preparedness and Public Health Emergencies EO11: Extends to May 20 various executive orders that have been identified as critical to pandemic response and recovery, except for those covered by Executive Orders No. 11A through 11D EO11C: Consolidates and renews authority for relevant agency heads to restrict visitation at congregate facilities in order to limit the risk of transmission of COVID-19 EO11D: Consolidates and renews contracting flexibility to procure essential goods, services, and real estate to respond to the pandemic
4/20/2021	EO11E: Extends to May 20 executive orders that have been identified as critical to pandemic response and recovery
5/18/2021	Extension of Declaration of Civil Preparedness and Public Health Emergencies

	EO12: Revised order for masks and face coverings
5/20/2021	EO12A: Revised order for masks and face coverings EO12B: Extension and expiration of COVID-19 orders
5/25/2021	EO12C: Modification of thirty-six month age limit for Birth-to-Three services
7/13/2021	Extension of Declaration of Civil Preparedness and Public Health Emergencies
7/19/2021	EO13: Extends the duration of the following previously issued executive orders to September 30, 2021
8/5/2021	EO13A: Authorization for municipal leaders to implement universal mask requirements
8/6/2021	EO13B: Requirement of employees of long-term care facilities to receive COVID-19 vaccinations
8/19/2021	EO13C: Access to COVID-19 Immunization Information
9/3/2021	EO13E: Establishment of temporary nurse aide program EO13F: Modification of deadline for long-term care facility of receive vaccinations
9/10/2021	EO13G: Replaces and clarifies Executive Order No. 13D on COVID-19 vaccination requirements for state employees, school employees, and childcare facility staff
9/28/2021	EO14: Extends the duration of the following executive orders to February 15, 2022
9/30/2021	EO14A: Revised version of Executive Order No. 14
11/22/2021	Order regarding conditions and environments requiring universal masking for the prevention of COVID-19 on and after May 19, 2021

Summary of Notable Strengths and Opportunities for Improvement

Region 5 LHDs and health partners successfully responded to the COVID 19 World-Wide Pandemic, one of the most significant emergencies in generations. Region 5 LHDs, EMS, hospitals vulnerable populations were identified and supported, the healthcare system and providers were supported and optimized, and sick patients were restored to health. This allowed the far-reaching impacts of this pandemic to be a primary focus that has continued through the recovery stage.

Major Strengths of the Response Include:

- The rapid and effective mobilization of volunteers, both medically and non-medically trained.
- The informal sharing of information and other resources, strengthening the response during times of uncertainty.
- Successful partnerships with existing partners, and new partners, to build a true community-wide response.

Primary Opportunities for Improvement Include:

- Some of the Local Health Departments/ Districts had not prioritized the threat of a Pandemic through their regular Hazard Vulnerability Analysis (HVA)
- There were moments where coordination on a regional level lacked, leaving most Health Departments and Districts to work independently form one another.
- Information management is often a challenge in emergencies, and this response was no exception. Getting the right information to the right people at the right time to make well-informed decisions and to take appropriate actions was a challenge.

Conclusion:

As in any emergency response, there are lessons to be learned in the Region 5 COVID-19 Response – lessons to be repeated and codified, and lessons learned that should not be repeated in the future. This work provides a non-biased assessment of the response, captures the lessons to be learned, and provides the framework from which to improve future emergency responses. It is a fitting tribute to the countless heroes who selflessly contributed to this response.

INTRODUCTION

The Region 5 Public Health Emergency Response Plan was recently completed and approved by the Region 5 Emergency Support Function # 8 Public Health and Medical Service committee in March 2022. This plan was also submitted to the regional Emergency Planning Team (REPT) and accepted in March 2022

This After-Action Report will assess the regional response of local health departments and districts, acute care hospitals, and emergency medical services. The analysis and data collection focused on validating the Region 5 Public Health Emergency Response Plan and will be used to help make appropriate revisions.

Information used to develop the After-Action Report is limited to those agencies that participated in the data collection and feedback processes for the report.

Geography

Connecticut Municipalities and two tribal nations are divided into five emergency preparedness planning regions. Region 5 consists of 43 municipalities. Two are densely populated urban environments while the remainder of Region 5 is suburban and rural in nature.

Methodology

The process used to develop the after-action report includes a review and analysis of information collected within Region Five: from the Region Five COVID-19 Survey (local health departments/districts and acute care hospitals), multiple interviews with Emergency Support Function # 8 Public Health and Health Service partners, Northwest Cares: Learning From COVID-19, (written by *Alison Coates, MS, MBA (Ph.D. Candidate), Carrie Roseamelia, Ph.D.) and* Hartford HealthCare Emergency Medical Services, COVID-19 EMS Response Lessons Learned & Best Practices (Spring 2020), (Kevin Ferrarotti Senior System Director: EMS Network Development at Hartford HealthCare).

Organization of Report

The findings are categorized into the six Public Health Domains; these domains are further broken down into capabilities. Local and state public health systems worked to develop plans supporting these domains to better prepare for a public health emergency. The report is aligned with these domains and capabilities and Region Five's Public Health Emergency Response Plan.

EVENT OVERVIEW

Name	**COVID-19**
Dates	**March 01, 2020 – December 31, 2021***
Scope	This After-Action Report assesses and evaluates the real-world response to COVID-19. Furthermore, it will validate the Region Five Public Health Emergency Response Plan
Focus Area(s)	**Response**
Domains	**1. Community Resilience** **2. Incident Management** **3. Information Management** **4. Countermeasures and Mitigation** **5. Surge Management** **6. Biosurveillance**
Capabilities	**Capability 1: Community Preparedness** **Capability 3: Emergency Operations Coordination** **Capability 4: Emergency Public Information and Warning** **Capability 6: Information Sharing** **Capability 8: Medical Countermeasures Dispensing and Administration** **Capability 9: Medical Material Management and Distribution** **Capability 10: Medical Surge** **Capability 11: Nonpharmaceutical Interventions** **Capability 13: Public Health Surveillance and Epidemiological Investigation** **Capability 14: Responder Safety and Health** **Capability 15: Volunteer Management**
Threat or Hazard	COVID-19 Pandemic
Scenario	Real World Incident
Sponsor	Center for Disease Control Public Health Emergency Preparedness Cooperative Agreement
Participating Organizations	The list of participating agencies is documented in Appendix B.

Name	COVID-19
Point of Contact	**Torrington Area Health District** 350 Main Street Torrington, CT 06790 Robert Rubbo, MPH, RS Director of Health 860.489.0436 x321 rrubbo@tahd.org Megan McClintock, MS Emergency Management Coordinator 860.489.0436 x 322 mmcclintock@tahd.org

*Though this time reflects the report, this does not reflect the end of the COVID-19 pandemic. The pandemic is still ongoing and Region 5 ESF 8 continues to respond through operation and recovery periods.

ANALYSIS OF CAPABILITIES

Aligning exercise objectives and capabilities provides a consistent evaluation taxonomy that transcends individual exercises to support preparedness reporting and trend analysis. Table 1 includes the exercise objectives, aligned capabilities, and performance ratings for each capability observed during the incident and determined by the evaluation team.

Domains	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
Community Resilience		X		
Incident Management		X		
Information Management		X		
Countermeasures and Mitigation		X		
Surge Management		X		
Biosurveillance		X		

Table 1. Summary of Core Capability Performance

Rating Definitions:

Performed without Challenges (P): The targets and critical tasks associated with the capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. The performance of this activity did not contribute to additional health and/or safety risks for the public or emergency workers, and it was conducted per applicable plans, policies, procedures, regulations, and laws.

Performed with Some Challenges (S): The targets and critical tasks associated with the capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. The performance of this activity did not contribute to additional health and/or safety risks for the public or emergency workers, and it was conducted per applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.

Performed with Major Challenges (M): The targets and critical tasks associated with the capability were completed in a manner that achieved the objective(s), but some or all the following were observed: demonstrated performance harmed the performance of other activities; contributed to other health and/or safety risks for the public or emergency workers; and/or was not conducted per applicable plans, policies, procedures, regulations, and laws.

Unable to be Performed (U): The targets and critical tasks associated with the capability were not performed in a manner that achieved the objective(s).

COMMUNITY RESILIENCE

Develop, maintain, and leverage collaborative relationships among government, community organizations, and individuals that enable them to respond to and recover from disasters and emergencies effectively.

Associated PHEP Capabilities

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Capability 1: Community Preparedness

Vulnerable and At-Risk Populations/Access and Functional Needs

Findings from *Northwest Cares: Learning From COVID-19*

Alison Coates, MS, MBA (Assistant Research Professor, Clarkson University; Ph.D. Candidate, University of Ottawa).

Carrie Roseamelia, Ph.D. (Assistant Dean of Rural Medicine, SUNY Upstate Medical University)

Strengths

Strength 1: Organizations in northwestern Connecticut were creative and resilient in response to challenging changing conditions.

Strength 2: Organizational strengths related to flexibility: proactivity, creativity, ability to pivot and act quickly.

Strength 3: Many respondents identified partnerships and relationships as key factors in their organizations' responses.

Strength 4: Insurance companies are reimbursing for telehealth for the first time.

Strength 5: Front-line workers, those most at-risk due to close contact with our youth and families, did a tremendous job through adversity and uncertainty. When our staff became ill, others volunteered to step up.

Strength 6: Highlighted vulnerable populations in monthly meetings through outreach and giving them space to present on their organization.

Opportunities for Improvement

Opportunity for Improvement 1: Organizations that participate in the NW Cares Coalition felt they lacked clear communication and outside support.

Analysis: Despite an overwhelming focus by respondents on the strengths and assets that underpinned their own organizations' responses, questions that probed inter-organizational connections and community assets revealed gaps and potential opportunities. Many respondents indicated that their response to COVID-related

challenges could have been better if they had connections with other organizations in their communities that faced similar challenges.

Recommendation: Strengthen existing partnerships with the Region Five Emergency Support Function # 8 Public Health and Medical Services and local, regional, and statewide emergency management representatives. Coordinate and build community relationships within the Emergency Support Function # 8 Public Health and Medical Services group. Support activities focused on intra-agency connections.

Opportunity for Improvement 2: Communication channels were often noted not to extend to other community-based health and social care organizations. This gap was acknowledged by respondents both within and outside of the town services spheres.

Analysis: In the early days of the Pandemic, many organizations felt that they lacked clear communication and outside support. Community-based organizations sought information elsewhere, finding value in the information provided by their state and federal representatives and using resources provided by the Governor's office, including using state hotlines for guidance.

Recommendation: Fostering new relationships and strengthening existing relationships within the Region Five Vulnerable and At-Risk Population Workgroup. Expand the Northwest Cares membership enrollment to the Community Outreach and Information Network and foster relationship building within Region Five.

Opportunity for Improvement 3: Community organizations regret not being aware of potential assistance and available resources.

Analysis: Most non-municipal-based community organizations do not staff emergency management personnel. Data revealed a substantial difference between towns and municipal services perceptions compared to the perceptions of non-municipal community-based organizations.

Recommendation: Coordinate and assist all hazard-planning activities within Region Five Emergency Support Function # 8 Public Health and Medical Services. Align state and local training and education, supporting emergency management planning efforts within Region Five. Coordinate regional educational and training opportunities for the organizations and agencies representing the vulnerable and At-Risk Populations.

Opportunity for Improvement 4: Develop agency-specific emergency management plans and establish a relationship with the emergency management directors within the communities where they provide services.

Analysis: Agencies representing vulnerable and at-risk populations and the access and functional needs (vulnerable and at-risk populations) are nongovernment and non-profit organizations. These agencies typically do not staff Emergency Managers and do not necessarily have staff adequately trained to fill this need. Employees tend to have multiple responsibilities and are required to triage the workload. Agencies in small rural communities do not have ongoing relationships with the local emergency management directors. These ties become invaluable during an emergency incident occurs.

Recommendation: Non-government and non-profit agencies would benefit from developing emergency management plans, engaging the local communities—emergency Management Director(s) within the communities they provide services for, and joining the Emergency Support Function # 8 Public Health and Medical Services. Data revealed a substantial difference between towns and municipal services perceptions compared to the perceptions of non-municipal community-based organizations.

Opportunity for Improvement 5: Invite agencies representing populations at risk for disproportionate outcomes with the regional Emergency Support Function # 8 Public Health and Emergency Management committee and provide an opportunity for public health planning and response efforts to better incorporate these vulnerable and At-Risk populations.

Analysis: Many local agencies provide essential services to the communities. Many of these organizations provide essential services that align with the FEMA Lifelines for the residents within the community. During the response to COVID-19 Pandemic, some agencies reported feeling disconnected from the local emergency management directors during the early response stages.

Recommendation: Increase the opportunities for engagement of the agencies representing the vulnerable and At-Risk populations/Access and Functional Needs groups. Local agencies reported feeling as though they were disconnected from local municipalities and Emergency Management Directors.

Local Health Departments and Districts

The Local Health Departments and Districts demonstrated remarkable adaptability during the COVID19 Response. Local Health Departments and Districts successfully managed extensive Contact Tracing, established vaccination processes, and supported countless vaccination clinics, mobilized volunteers, successfully partnered with existing and new partners, and mobilized a community-wide response. Examples include reaching out to congregate living and others; supporting the vaccination of the homebound population; and supporting organizations that support vulnerable populations (e.g., elderly housing, senior centers, soup kitchens).

Strengths

Strength 1: Torrington Area Health District facilitated weekly calls with congregate living communities. They provided education and training, updates on CDC guidelines, and answered questions.

Strength 2: Newtown Health District ensured that residents with COVID-19 were able to care for themselves and had adequate resources.

Strength 3: All Local Health Departments and Districts successfully managed multiple streams of volunteers (e.g., medically trained, non-medically trained, CERT, community partners).

Opportunities for Improvement

Opportunity for Improvement 1: The Local Health Department and Districts (LHDs) relied on local partners to help identify people that were vulnerable or in need, but even local partners did not have a complete list; some people were simply not on lists. As the LHDs and/or partners learned of these people, they were given support.

Recommendation: The LHDs and local partners need to be deliberate in identifying potentially vulnerable individuals and maintaining up to date lists. Such work is labor-intensive and costly and so additional funding or support is likely to be needed.

Opportunity for Improvement 2: Facilitate communication with private partners and agencies that work with vulnerable populations, engage Northwest Cares, and social service agencies to provide frequent public health information for their website

Analysis: Most local health departments/districts engaged vulnerable and at-risk populations through information distribution, coordination of services, assisting with developing COVID-19 plans, and vaccinating these populations (by themselves or with community partners). These vulnerable and at-risk populations included: immigrants (legal and illegal), seniors, homeless, behavioral health clients, substance users, children, those with disproportionate income. Challenges were lack of transportation, language barriers, distrust, mixed information, and limited resources, especially in rural areas. Public health overcame these challenges by community outreach, creating partnerships with local healthcare and community agencies, increasing accessibility by offering homebound visits by LHD's or through partnership with local community agencies, conducting clinics at long-term care facilities and other sites, and educational campaigning through social media, radio, and video in various languages. Immigration status fears were addressed through local cultural centers and places of worship to assure the community that vaccine efforts did not have any connection to immigration status.

Recommendation: Build partnership and membership throughout ESF 8 and allow outside organizations to become involved in the group. LHDs can also engage their at-risk and functional needs organizations and bring them in to educate on the services they provide.

Reference: Region 5 LHD survey and Interviews and Northwest Care: Learning From COVID-19 (Final Report)

Capability 14: Responder Safety and Health: Emergency Medical Services (EMS)

Findings from *Hartford HealthCare Emergency Medical Services, COVID-19 EMS Response Lessons Learned & Best Practices* (Spring 2020).

Kevin Ferrarotti Senior System Director: EMS Network Development at Hartford HealthCare.

Strengths

Strength 1: Based on Pre-hospital screening questionnaires, Emergency Medical Services (EMS) providers were alerted by dispatch before arriving on the scene that the caller was exhibiting symptoms of COVID-19. The responding EMS providers had time to prepare better and allocate first responder resources before arriving at the scene.

Strength 2: EMS agencies developed checklists like those created by high-reliability organizations. These checklists were used by the on-scene EMS personnel while maintaining social distancing before providing hands-on patient care. This supported the conservation of Personal Protective Equipment (PPE) and improved the allocation of supplies, Basic Life Support (BLS), and Advance Life Support (ALS) staffing resources.

Strength 3: Minimizing the number of EMS responders improved the agency's ability to contact trace and protect first responders. It also supported the allocation of scarce resources such as PPE.

Strength 4: EMS agency's collaboration with local health departments and sponsor hospitals supported the facilitation of information sharing from federal, state, and local partners.

Strength 5: Rural volunteer EMS agencies maintained a flexible staffing model**,** implementing continuity of operations planning and improving the allocation of EMS resources due to potential staffing shortages attributed to potential disease exposure and individual risk category.

Opportunities for Improvement

Opportunity for Improvement 1: The need for standard operating procedures for high-impact infectious diseases. The COVID-19 Pandemic created challenges for many organizations to quickly adapt to frequently changing guidelines, ranging from droplet precautions to airborne and contact precautions. Appropriate PPE allocation during the shortage required clear and concise standard operating procedures to be implemented on short notice.

Analysis: Many EMS agencies were quickly overwhelmed with the frequent revising and updating of standard operating procedures and creating and updating

infectious disease policies. Many were without an adequate supply of PPE for the Pandemic. Many staffing models were also based on the individual risk factors of the aging volunteer EMS workforce.

Recommendation: EMS agencies should develop and regularly train and drill the response to a high-impact infectious disease. Standardizing contagious disease protocols will better support EMS providers responding as mutual aid or activating a continuity of operation plan with individual EMS providers from different agencies making up an EMS crew.

Opportunity for Improvement 2: Volunteer and rural EMS agencies struggled to respond to EMS calls and relied on mutual aid. Staffing shortages have impacted EMS, especially with the rural volunteer agencies. EMS providers with comorbidities discontinued volunteering for their local EMS agency. This shifted the staffing burden onto a small number of volunteers or necessitated the need to hire through staffing agencies.

Analysis: Extended scene times, in some cases, hospitals instructed EMS to wait in the ambulance with the patient as beds in the emergency department was cleared for incoming patients. Hospitals needed to activate full and partial diversionary status, utilizing out-of-region hospitals as the accepting facility, further burdening the EMS system with extended transport times and delays in transferring patients to the emergency department staff.

Recommendation: Explore opportunities to develop continuity of operation plans and regionalized and sustainable mutual aid agreements.

Opportunity for improvement 3: Mental Health and wellness resources are stretched thin and not readily accessible. Healthcare providers felt the burden the Pandemic put on their mental health. Individual sacrifices made by healthcare providers were initially recognized, but as the Pandemic wore on, public support began to wane. The stresses of the sacrifices made by healthcare workers extend to their families.

Analysis: Few EMS agencies have mental health plans in place. Typical EMS mental health is limited to critical incident debriefing and Employee Assistance Programs and does not engage licensed mental health providers.

Recommendation: Establish mental health wellness plans that include assessment tools for EMS agencies to identify staff exhibiting signs of mental health stress. Develop health and wellness plans with local municipalities, sponsor hospitals, and Employee Assistant Programs. EMS culture of supporting mental health awareness. Benefited from the recent recognition of increased suicidality.

Capability 14: Responder Safety and Health

Strengths

Strength 1: Each of the Local Health Districts and Departments (LHDs) distributed Personal Protective Equipment (PPE) to its staff.

Strength 2: Four of seven LHDs (57%) provided practical (live and/or virtual) training and education on the appropriate selection of PPE, donning and doffing, etc. to local ESF 8 partners, schools, and or other community agencies.

Opportunity for Improvement

Opportunity for Improvement 1: Two of seven LHDs (28%) did not have staff trained to perform respirator (N95 mask) fit testing.

Recommendations: All LHDs should have staff trained to provide practical training and education on the appropriate selection of PPE, donning and doffing, etc. All LHDs should also have staff trained to perform respirator fit testing.

Opportunity for improvement 2: Mental Health and wellness resources are stretched thin and not readily accessible. Healthcare providers felt the burden the Pandemic put on their mental health. Individual sacrifices made by healthcare providers were initially recognized, but as the Pandemic wore on, public support began to wane. The stresses of the sacrifices made by healthcare workers extend to their families.

Analysis: Local health department workers and volunteers were on the front lines. They worked long hours and were stressed.

Recommendation: Establish mental health wellness plans that include assessment tools for LHDs and healthcare agencies to identify staff exhibiting signs of mental health stress. Develop health and wellness plans with local municipalities, sponsor hospitals, and Employee Assistant Programs.

Opportunity for improvement 3: Volunteers who worked at multiple sites, received site dependent vaccination and infection control training.

Analysis: Region 5 LHD's do not have standardized POD plans. Standardized processes and training would help prevent administration errors and assure a competent workforce.

Recommendations: Develop standardized process and protocols for vaccination and infection control training for all R5 LHD's.

Reference: Region 5 POD Plans, LHD POD Plans, Immunization Action Coalition Skills Checklist, CDC Vaccine Administration e-learn

Capability 15: Volunteer Management

Strengths

Strength 1: Strong response to the request for volunteers. Volunteers were part of Community Emergency Response Team (CERT), Medical Reserve Corps (MRC), or community partners, and some were non-affiliated volunteers. Volunteers were successfully used as a much needed "force multiplier" and helped with administration, logistics, and clinical support.

Strength 2: Volunteers were used successfully to move supplies, assist with clinical sites (e.g., vaccination sites), and more.

Opportunity for Improvement

Opportunity for Improvement 1: Appropriate training for volunteers can be a challenge. It is important that volunteers have initial training in their specific role, the mitigation of hazards they might face in that role, and a general understanding of Incident Management and Response, so that they can appreciate the system/structure/ coordination and understand their part in that.

Analysis: Region 5 has 3 Medical Reserve Corps (MRCs) units that were not available to all LHD's. Some volunteers did not have background training. Not all R5 LHDs had enough qualified clinical personnel/volunteers to sustain long-term vaccination services.

Recommendation: Develop, or at least the curriculum/outline of a course, appropriate for general volunteers being used in an emergency response that can be standardized regionally. The course should consider the volunteers' specific roles and a general understanding of the overall Incident Management/Response, for the volunteers to understand their role in that.

Opportunity for Improvement 2: Improving the user friendliness of CT Responds. Non-tech savvy volunteers, struggled with signing up on CT Responds.

Analysis: Feedback from volunteers. This took time away from LHD staff who had to walk them through process.

Recommendation: Provide suggestions to DPH and State of CT to review and revise CT Responds to make easier to navigate.

INCIDENT MANAGEMENT

Healthcare and public partners must coordinate an effective response through all phases of the incident using NIMS ICS and integrating with Emergency Support # 8, Public Health, and Medical Services.

Associated PHEP Capabilities

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Capability 3: Emergency Operation Coordination

Strengths

Strength 1: Each Local Health Departments and Districts successfully identified "Top Priorities and Initial Goals/Objectives" that were used to create the foundation of the COVID 19 Incident Response (Incident Action Plan). Examples include communications; testing; vaccinations; reduce illness; keep staff safe; recruit volunteers; etc. It is noted that although many of the LHDs goals and objectives were similar, they were not consistent.

Strength 2: LHDs agreed that information was generally shared successfully, although some of the LHDs noted that the information sharing was informal, rather than according to existing plans. The successful sharing of information increased efficiency and optimized the COVID19 response(s).

Strength 3: The COVID19 response successfully incorporated existing partners (e.g., local EM, Fire, EMS, Police, Hospitals, LTCs) and new ones (e.g., social services, schools, churches, private industry).

Opportunity for Improvement

Opportunity for Improvement 1: There was an inconsistent understanding and appreciation for the Incident Command System and general Incident Management Tactics.

> **Recommendation:** A training and exercise program should be developed for the LHDs and others, to learn, refine, and practice Incident Management skills and techniques. The program should, over time, build confidence and competence in the skills and techniques, and should include increasing complexity as the program matures.

Opportunity for Improvement 2: Information management was challenging: information at times was inconsistent; during emergencies in particular, information must be consistent. For example, LHDs reported schools releasing information on the COVID19 response to students and families before the LHDs were aware of the information, leading to questions or inconsistencies of messaging.

> **Recommendation:** Community partners should regularly engage in information sharing and develop streamlined and efficient pathways for use during normal and emergency operations.

Opportunity for Improvement 3: Each LHDs, in some ways, seemed to operate independently despite there being regular Health Department and District calls and virtual meetings. Although it is important that the LHDs be intimately connected to their

local community's response, it is also important that there is obvious and consistent coordination across the entire Region 5.

Recommendation: Processes and pathways should be developed that promote and ensure entire Region 5 coordination during emergency responses. The training and exercise program should be used to continually refine, optimize, and reinforce those processes and pathways.

INFORMATION MANAGEMENT

Strengthen information sharing among healthcare and public health partners.

Associated PHEP Capabilities

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Capability 6: Information Sharing

Strengths:

Strength 1: EMS intra-agency communications within the region were well organized and included mass text messaging to the EMS chiefs, the sponsoring hospital, and the local health district.

Strength 2: LHDs agreed that information was generally shared successfully, although some of the LHDs noted that the information sharing was informal, rather than according to existing plans. The successful sharing of information increased efficiency and optimized the COVID-19 response(s).

Strength 3: LHDs successfully used a wide spectrum of communication streams including (but not limited to): social media, emailing, LHDs website, community website, virtual meetings, press releases, and text messaging.

Opportunity for Improvement

Opportunity for Improvement 1: Receiving hospitals should provide EMS agencies updates on COVID-19 EMS and visitor guidelines. Most EMS agencies were unaware of the receiving hospital's COVID-19 Policies and visitor guidelines. Patients' families often would seek clarification on visitor guidelines.

Analysis: The CDC's guidelines changed almost daily during the early phase of the COVID-19 response. EMS agencies took the lead with Charlotte Hungerford Hospital and were able to communicate changes with the CDC guidelines, best practices, and sharing of resources. The CT DPH OEMS implemented statewide EMS Guidelines, addressing the modification of dispatch protocols, risk assessment of patients, aerosol-generating procedures, advanced airway management, and protocols that kept people home and out of hospital Emergency Departments. Most acute care hospitals' communications focused on protecting hospital staff and the facility. Communications from hospitals were directed to EMS Sponsor Agencies.

EMS Agencies transport patients to hospitals other than the EMS sponsor hospital. EMS was impacted by total hospital Emergency Department diversions, trauma, stroke, and behavioral health diversions.

Recommendation: Recruitment of EMS agencies to become part of the Emergency Support Function # 8 Public Health and Medical Services Committee utilizing the communications annex. EMS systems and agencies play an integral role during a public health emergency; examples include Chemical, Biological, Radiological, Nuclear, and Explosive incidents (CBRNE) and the COVID-19 Pandemic. These events may result in numerous casualties. EMS crews were not familiar with the receiving hospital COVID-19 guidelines. Emergency Medical Services transport patients outside of their sponsor hospital. ESF # 8 has revised the Public Health Emergency Response plan and has a communications annex.

Reference: Hartford Hospital EMS Lessons Learned COVID-19, Waterbury Hospitals Response to COVID-19 EMS CME, CT DPH OEMS Guidelines, interviews with EMS responders, Region Five EMS Council, and the TAHD.

Opportunity for Improvement 2: Information management was challenging: information at times was inconsistent; during emergencies in particular, information must be consistent. For example, LHDs reported schools releasing information on the COVID 19 response to students and families before the LHDs were aware of the information, leading to questions or inconsistencies of messaging.

Analysis: Coordination and communication with all partners was challenging, including local, regional, and state partners

Recommendation: Community partners should regularly engage in information sharing and develop streamlined and efficient pathways for use during normal and emergency operations.

Opportunity for Improvement 3: LHDs had differing opinions of the various Incident Management/Support IT Tools; for example, some thought the MRC web-based Platform CTResponds was easy and helpful, while others described it as “a lot of Red Tape so didn’t use.”

Recommendation: The LHDs should develop confidence and competence in the selected IT response platforms (e.g., CTResponds, WebEOC, LTC-MAP). Not all need to be selected but there should be a coordinated and consistent approach to which platforms will be used, and then competency built and maintained to use those tools well.

COUNTERMEASURES AND MITIGATION

Strengthen mitigation activities to coordinate the administration of pharmaceutical and non-pharmaceutical interventions effectively.

Associated PHEP Capabilities

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Capability 8: Medical Countermeasures and Mitigation

Strengths

Strength 1: Those vulnerable to COVID-19 were triaged and included in the high priority groups.

Strength 2: Some LHDs were able to partner with the local Visiting Nurse Association in order to provide homebound vaccinations and/or to support vaccination clinics.

Strength 3: Some LHDs used and benefited from ELC funding. Some uses included supporting staff, renting clinic spaces, purchasing supplies and equipment, etc.

Strength 4: All of the LHDs used CT Electronic Disease Surveillance System (CT EDSS).

Opportunity for Improvement

Opportunity for Improvement 1: The Visiting Nurse Association was not used by all LHDs and a consistent, coordinated use may have been a COVID Response optimizer.

Recommendation: Plans should be developed to partner with the Visiting Nurse Association across the entire Region.

Opportunity for Improvement 2: Some LHDs did not use the ELC funding because it was felt that there was “too much paperwork.”

Recommendation: Processes should be optimized, and training provided so that all LHDs can benefit from ELC funding.

Opportunity for Improvement 3: Engage visiting nurse agencies, private health partners, and/or volunteers to assist with public health initiatives for homebound populations.

Analysis: Developing homebound vaccination teams in some of the communities was a challenge prior to VEPF grant. This was labor and time intensive. LHDs have limited resources to provide homebound services. Visiting nurses and private health agencies have ready access to many of homebound clients. Engagement of these agencies would greatly assist in improving the response.

Recommendation: Develop MOUs with visiting nurses and private health agencies to assist with homebound vaccination and distribution of information. May need to explore regional and or state coordinated approach.

Reference: Region 5 LHD survey and interviews with local health

Capability 9: Medical Material Management and Distribution

Strengths

Strength 1: Support from the local Municipality (Torrington), private business (Doyle's Medical), and units from Region 5 Medical Reserve Corps.

Strength 2: Expand the regional communications network to include local primary care providers, congregate living, school-based medical clinics, dental, and chiropractors.

Strength 3: The strengthening of existing relationships and development of new partnerships within the vulnerable and at-risk population groups and local health departments/districts.

Opportunity for Improvement

Opportunity for Improvement 1: *PPE Distribution Regional Level***:** Lack of staffing support from the regional distribution site's local health departments and districts in Region Five. The TAHD managed and staffed the regional distribution site and distributed the Personal Protective Equipment to the local health departments and districts within Region Five; there was little to no regional support from the health departments/districts at the regional distribution site.

Analysis: The Torrington Area Health District identified a regional distribution site at Doyle's Medical Supply located in Torrington, CT. Initially, Torrington Area Health District and the Torrington Area Health District MRC assumed responsibility for staffing the weekly distribution of PPE, which began on April 17, 2020; this continued thru July 2020. Several additional distributions were scheduled to support the vaccination clinics. The TAHD requested additional support from the local health departments and districts within region five. There was only one day of distribution that additional personnel from a regional health department/district assisted.

Recommendation: Plans should be further refined, and coordination optimized to maximize staffing and support.

Opportunity for Improvement 2: *PPE Distribution Local Level***:** Local health departments and districts do not have access to the lists of local providers and their contact information. This created difficulties with providing PPE to the providers within the regional jurisdiction. The scarce amounts of PPE would not have been adequate to support any equitable distribution.

Analysis: CT DPH instructed Local health departments/districts to distribute PPE to local healthcare providers, urgent care centers, and dental offices providing emergency services. CT DPH could not provide local health departments/districts with the contact information. Local health departments/districts do not regulate these providers and do not maintain their contact information. Licensed Providers do provide their contact information when completing the annual licensure renewal.

Recommendation: CT DPH can collect the provider's contact information during their annual licensure renewal and obtain permission from the licensed provider to share it with local health departments/districts during a public health emergency.

Opportunity for Improvement 3: Distribution of Regional resources (equipment and disposable supplies) during the onset of COVID-19. Early on during the Pandemic response, all the regional PAPR(s) were distributed to one healthcare agency. This impacted the other healthcare agencies within the Region that needed these same resources.

Analysis: All the regional PAPRs were distributed to one Hospital. When Waterbury Hospital requested some of the PAPRs during the COVID-19 surge, there were no PAPRs to distribute to other ESF # 8 partners in Region Five. PAPRs were return with missing disposable supplies.

Recommendation: Follow the instructions within the Public Health Emergency Support Plan for sharing regional resources (equipment, reusable, and disposable supplies). This is located under Appendix B- Quick Reference Guide- *Allocation of Emergency Support Function # 8 Resources – Loaning and Sharing.* Connected to these procedures, an approved invoice/ loan form should be created and used to keep track of the inventory used.

SURGE MANAGEMENT

Strengthen coordination among healthcare and public health partners to address medical surge needs.

Associated PHEP Capabilities

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Capability 10: Medical Surge

Strengths

Strength 1: The revision of the Department of Public Health Office of Emergency Medical Services (DPH OEMS) protocols to better manage the COVID 19 pandemic. The revision addressed general guidance for EMS responders, aerosol-generating procedures, advanced airway management, and non-transport guidance.

Strength 2: DPH OEMS communications for EMS providers continued throughout the early pre-vaccination stages of the pandemic response. DPH distributed information that impacted EMS providers' communications using the State's Everbridge system. CT DPH Weekly phone calls included EMS Agencies.

Strength 3: Many state hospitals began to offer online EMS educational opportunities, providing EMS providers with continuing education and meeting local, state, and national educational requirements. Many of these opportunities were open to non-hospital EMS agencies.

Strength 4: A communication strategy was established in the Charlotte Hungerford Hospital area, allowing for rapid dissemination of information, including COVID-19 guidance and best practices.

Strength 5: Hospitals and municipalities within Region Five had alternate care sites identified and set up with cots.

Opportunity for Improvement

Opportunity for Improvement 1: Earlier communications with the municipal Emergency Management Director and local public health. Shuttered long-term care opened facilities and required regulatory inspections, including fire safety, public safety, and food safety. Municipal Emergency Management Directors needed to allocate scarce resources to support these functions. CT DPH should have communicated to the local emergency management directors earlier in the planning stages.

Recommendations: Policies and procedures for supporting Surge Management through better communication should be developed and regularly exercised.

BIOSURVEILLANCE

Conduct epidemiological surveillance and investigations and perform laboratory testing to detect emerging threats.

Associated PHEP Capabilities

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Capability 13: Public Health Surveillance and Epidemiological Investigation

Strengths

Strength 1: Contact Tracing was successfully accomplished on large numbers of patients simultaneously.

Strength 2: Information was shared between the LHDs, LTCs, and schools, particularly at the beginning of the COVID 19 response. As the pandemic continued, case reporting decreased.

Areas for Improvement

Opportunity for Improvement 1: There were testing delays due to a lack of available appointments.

Recommendation: Continue planning with medical providers to increase capacity during a public health emergency.

Opportunity for Improvement 2: Urgent Care Centers were not all integrated with CT EDSS.

Recommendation: Continue planning with Urgent Care Centers to ensure connectivity, competence, and confidence using Public Health tools (e.g., CT EDSS).

Opportunity for Improvement 3: Residents did not want to share at-home rapid testing results.

Recommendation: Develop packaged communication campaigns that explain the importance of sharing home test results with LHDs, provide a pathway for that communication to occur, and have these tools available for rapid deployment when needed during public health emergencies.

APPENDIX A: IMPROVEMENT PLAN

Capability	Issue/Area for Improvement	Corrective Action	Capability Element	Primary Responsible Organization	Organization POC	Start Date	Completion Date
Capability 14: Responder Safety and Health	1. Mental Health for workers	Establishing wellness plans for responders during and after responses	14.4a	Region 5 Local Health Departments and Districts	Local Health Directors	1/1/2023	
Capability 6: Information Sharing	1. Information Management	Create a streamlined pathway for communication and collaboration	6.1a-b	Region 5	Region 5 PHEP Coordinator	10/1/2022	
Capability 15: Volunteer Management	2. Improving user-friendliness of CT Responds	Create a unit-based approach on how to assist volunteers in navigating the system	15.2a-d	MRCs in Region 5	MRC Unit Coordinators	1/1/2023	
Capability 14: Responder Safety and Health	2. Standard operating procedures for high-impact infectious disease and PPE allocation during these times	Create regional infectious disease plan annex in Region 5 ESF 8 PHERP	14.2a and 14.2b	Region 5	Region 5 PHEP Coordinator	1/1/2023	
Capability 10: Medical Surge	1. Improve communications with Emergency Management Directors and local public health	Create a streamlined pathway for communication and collaboration	**10.3a-f**	Region 5	Region 5 PHEP Coordinator	10/1/2022	
Capability 3: Emergency Operation Coordination	1. LHDs work independently and are not collaborating regionally	Consistent coordination across the region in deliverables and plans	**3.2a-e**	Region 5 LHDs	Region 5 Local Health Department and Districts	1/1/2023	

This Improvement Plan is developed specifically for Region Five Emergency Support Function # 8 Public Health and Medical Services as a result of COVID-19 Pandemic.

APPENDIX B: AFTER-ACTION REPORT CONTRIBUTORS

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Naugatuck Valley Health District
New Fairfield Health Department
Newtown Health District
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Ridgefield Health Department
Sharon Health Department*
Torrington Area Health District
Waterbury Health Department
*Did not participate in survey
Hospitals
Charlotte Hungerford Hospital – Hartford Healthcare
Danbury Hospital (New Milford Hospital)
Saint Mary's Hospital
Sharon Hospital
Waterbury Hospital
State
CT Department of Public Health Office of Emergency Medical Services
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