Eastern Highlands Health District
Board of Directors Regular Meeting
Agenda
ZOOM MEETING*
Thursday April 23, 2020, 4:30 PM

Call to Order

Approval of Minutes (January 16, 2020 & March 13, 2020)

Public Comments

Old Business - none

New Business

1. Appointment of Auditor FY 19/20
2. Director Signature annual authorization resolution

Committee Reports

3. Finance Committee

    A. Financial Report period ending 3/31/2020
    B. Adopted FY20/21 Budget

Town Reports

Directors Report

4. COVID-19 Response – Update
5. ViewPoint Cloud – Update

Communications/other

6. Dr. Matt Cartter (DPH) re: Contact Tracing
7. NACCHO re: Contact Tracing
8. CPHA re: Statement of Recognition

Adjournment

Next Board Meeting- June 18, 2020, 4:30PM

*In accordance with Governor Lamont's Executive Order 7B and social distancing guidelines recommended by the CDC to slow community spread of COVID-19, this meeting is physically closed to the public. The public may join the meeting via telephone. If you plan to join the meeting via phone, please email Millie Brosseau at mbrosseau@ehhd.org or call 860-429-3325 for the call in information.

Eastern Highlands Health District
Board of Directors Regular Meeting Minutes - DRAFT
Coventry Town Hall Annex
Thursday, January 16, 2020

Members present: J. Elsesser (Coventry), E. Paterson via phone (Mansfield), M. Rosen (Tolland), T. Nuccio (Tolland), D. Walsh (Coventry), M. Walter (Columbia)

Staff present: R. Miller, C. Trahan, K. Dardick, M. Brosseau

Others: E. Anderson (Andover), E. Wiecenski (Willington)

Scheduled Item: EHHD Public Hearing – Proposed FY 20/21 Operating Budget, Proposed FY 20/21 CNR Budget, Proposed FY20/21 Fee Schedule

J. Elsesser called the public hearing to order at 4:37pm. R. Miller read the notice into the record. (See attached) R. Miller noted that there were no written comments received. Hearing no public comment, J. Elsesser closed the public hearing at 4:40pm.

As there was no quorum, R. Miller gave his Directors report

Directors Report

View Permit Cloud Launch

R. Miller reported that an issue with the data migration from ViewPermit to View Point Cloud has delayed the launch.

Cosmetology permitting and inspection program

R. Miller reported that the January 6th, Public forum was well attended. 14 establishments were represented. The timeline was reviewed. There was discussion about when the state code went into effect. R. Miller stated that the state statute went into effect about 14 years about. The standards for inspection are new. T. Nuccio inquired as to whether anything should be done to notify local establishments. R. Miller noted that mailings and emails have been sent out. And communication will continue. D. Walsh asked if another forum will be held. R. Miller stated that if necessary another will be held. E. Anderson questioned whether this applied to mobile vendors. R. Miller noted that the standards apply to brick and mortar establishments.

Sodium/Chloride private well contamination-public education/state workgroup

R. Miller reported that the group at the state discussed at the last meeting is not a task force, but a workgroup. R. Miller is now part of the workgroup. R. Miller extended the invitation for anyone to attend with him.

R. Miller informed the board that online information is being updated.

J. Elsesser requested that information articles be send out via social media and local newsletters.

FDA Food Code transition – Inspector Certification Extension

R. Miller informed the board that this will likely be extended another year.

Call to Order

E. Paterson joined the meeting via phone at 5:14pm and J. Elsesser called the meeting to order.

T. Nuccio made a MOTION seconded by D. Walsh to approve the minutes of the December 12, 2019 meeting as presented. MOTION PASSED unanimously.

Proposed Fiscal Year 20/21 Operating Budget, Proposed FY 20/21 CNR Budget, Proposed FY 20/21 Fee schedule, and FY 20/21 employee medical insurance cost share.

R. Miller outlined the following proposed amendments to the proposed budget:

- 4.8% reduction in medical insurance premiums to $135,540.
- Member town rate increase of 4.9% changing the town contribution per capita rate to $5.685.
- Reduction in appropriation of fund balance to $50,920.
- Total operational spending of $883,540.

E. Paterson made a MOTION, seconded by D. Walsh to amend the proposed FY 20/21 budget as presented. MOTION PASSED unanimously. J. Elsesser noted for the record that this concurs with the finance committee recommendations.

J. Elsesser made a motion, seconded by D. Walsh to adopt the proposed FY 20/21 budget as amended. MOTION PASSED unanimously.

D. Walsh made a motion, seconded by T. Nuccio to adopt the proposed FY 20/21 CNR budget as presented. MOTION PASSED unanimously.

R. Miller informed the board that based on feedback from owners on an inequity of fees for independent contractor vs an establishment an amendment has been made to the fee schedule, adding a new fee of $25 for independent cosmetology contractors.

D. Walsh made a MOTION seconded by E. Paterson to amend the proposed FY 20/21 fee schedule to add the fee of $25 for independent contractors. MOTION PASSED unanimously.

D. Walsh made a MOTION seconded by T. Nuccio to adopt the proposed FY 20/21 fee schedule as amended. MOTION PASSED unanimously.

E. Paterson made a MOTION, seconded by M. Walter to set the employee medical insurance premium cost share for the PPO at 18.5%. MOTION PASSED unanimously.

Finance Committee – Quarterly financial report for the period ending 12/31/19

R. Miller provided an overview of the quarterly financial report for the period ending 12/31/2019. D. Walsh made a MOTION, seconded by T. Nuccio to accept the quarterly financial report as presented. MOTION PASSED unanimously.

Communications

R. Miller noted the resignation letter from former member R. DeVito. D. Walsh noted that the Personnel Committee had already instructed the Director to establish an exit interview program.

Adjournment

E. Paterson made a MOTION, seconded by D. Walsh to adjourn the regular meeting at 5:47pm. MOTION PASSED unanimously.

Town Reports

Report from Dr. Dardick

Dr. Dardick reported on the mumps outbreak at UConn. R. Miller noted that there are 6 cases that are epidemiologically linked. Of particular importance is the incubation period of 21 days.

Dr. Dardick expressed that influenza in the area is sporadic.

Meningococcal case is significant because if there are 2 separate cases at the Storrs campus in a 6 month period, then mass vaccination will be necessary.

DPH re: Vaping associated lung injury

R. Miller reported that CDC has published an association of THC and vitamin e-acetate in vaping products with lung injury.

Andover
E. Anderson reported that there is an Andover resident who has started a septic pumping business at his residence. This has been referred to the Health District and the Zoning department.

Willington

E. Wiecenski informed the board that there is still no resolution in the situation where a homeowner is looking to connect to a public water system.

Tolland

M. Rosen reported that the town of Tolland is in conversations with DEEP regarding the NaCl issue. There is potential that DEEP will hold a meeting in Tolland on the issue.

Next Board Meeting – February 20, 2020, 4:30 PM at Coventry Town Hall Annex

Respectfully submitted,

Robert Miller
Secretary

Eastern Highlands Health District
Board of Directors Special Meeting Minutes - DRAFT
Mansfield Community Center, Community Room
Friday, March 13, 2020

Members present: E. Anderson (Andover), J. Carrington (Mansfield), J. Kelly (Bolton), T. Nuccio (Tolland), E. Paterson (Mansfield), M. Rosen (Tolland), B. Syme (Scotland) D. Walsh (Coventry), M. Walters (Columbia),

Staff present: R. Miller, C. Serazo, M. Brosseau**,** A. Gonzalez, K. Dardick (5:35 pm)

Others: E. Wiecenski (Willington), K. Zito (Andover), R. Dougherty (Andover), W. Hooper (Chaplin), G. Greenberg (Scotland), B. Derring (Columbia)

Call to Order: E. Paterson called the meeting to order at 9:03 am.

R. Miller welcomed everyone and thanked them for attending.

R. Miller presented an overview of the COVID-19 outbreak. He noted that some of the information in the Powerpoint presentation, while updated today, is already outdated.

R. Miller informed the board that the State health department testing only hospitalized

Introduced Dr. Dardick, medical advisor for Eastern Highlands Health District.

R. Miller informed the board that a primary concern is the senior population and has compile a list of contacts for senior centers and programs. If you represent a senior program and are not on the list, tell Millie or Cecile.

T. Nuccio asked why schools are being closed for only 2 weeks when it is expected that in 6-8 weeks 20-25% of the population may be infected. R. Miller noted that this is a preemptive move with the intent of effecting the initial transmission. A reassessment will be done after 2 weeks. D. Dardick added that the 6-8 weeks is if we do nothing. that the intention is to blunt the peak. And while the number of cases may be the same they may be spread further apart. W. Hooper noted that blunting the peak will aid in not overwhelming the health care system.

R. Miller noted that his office will support each municipality's decision regarding closures.

R. Miller encouraged planning for continuity of operations.

R. Miller noted that his office is compiling tactics and strategies other public buildings are using.

Tolland has declared Local Civil Preparedness & Public Health Emergency; Coventry may soon follow as will the town of Mansfield. The Town of Mansfield may be closing some buildings for an undetermined time.

W. Hooper inquired as to whether

G. Greenberg inquired as to whether there is any coordination between DPH and people in charge of FOIA regarding public hearings continuing. Legal task force has been activated by the State Health Department. R. Miller will forward the question to the legal task force.

R. Miller noted that schools are not closed, students are dismissed.

E. Anderson inquired about timelines for applications and protocols for hearings. R. Miller requested that he send the question in an email. That email will be forwarded to the legal task force.

R. Miller informed the board that everyone should be tracking expenses related to COVID-19.

R. Miller stated that the State has requested assets from Strategic National Stockpile.

E. Paterson questioned what Windham Hospital is doing. R. Miller informed the board that all acute care facilities are preparing their EDs, reviewing patient surge plan, setting up alternative places for screening and testing symptomatic patients; labs are trying to ramp up for testing.

W. Hooper asked what will happen when local hospitals are overwhelmed. Will EMTs be doing triage in the field?

D. Walsh inquired as to whether there has been any discussions at the hospitals to reopen closed wings. R. Miller noted that it is his understanding that it is part of the surge plan.

E. Anderson questioned whether town facilities would be used for sheltering. R. Miller responded not at this time.

T. Nuccio expressed concern that we are not aggressive enough in our efforts to protect the senior population. She wanted to know what could be done to be more proactive and encourage seniors to stay home and put plans in place to help make that happen. R. Miller noted that all ideas will be considered.

W. Hooper suggested the use of the reverse 911 system or setting up a non-emergency number for people to utilize.

R. Dougherty inquired about how to handle distribution of food from food pantries. R. Miller suggested employing tactics to encourage social distancing. E. Wiecenski noted that Willington is planning to set up appointments.

E. Paterson inquired about whether the community center rentals at her condominium complex should be ceased. R. Miller stated that any efforts for social distancing will be supported.

R. Miller noted that we all can model calming behavior to help allay the fears and concerns of the public. He further noted that there is an emotional risk to seniors as we discourage social gathering.

E. Paterson requested that contact information be added to the flyer "Plan Don't Panic", and redistribute flyer to senior programs.

M. Walter suggested that an Everbridge message be sent out regularly.

D. Walsh asked if Sars has a vaccine. Dr. Dardick responded no.

D. Walsh inquired as to the symptoms that people should be aware of. Dr. Dardick noted that there are no unique symptoms. The severity of the symptoms is the concern, such as high temp and difficulty in breathing.

R. Miller informed that board that the agency may need to support mass vaccination clinics and if that happens, he will need the full support of the board.

E. Anderson asked if there are specific guidelines for EMDs regarding personal protective gear. R. Miller noted that the CDC has guidelines and referred the board to that site.

T. Nuccio asked what is done to treat those that are ill. Dr. Dardick informed that it is supportive treatment.

B. Syme suggested EHHD share simple information on social media.

E. Anderson asked what increases someone's vulnerability. Dr. Dardick noted that we do not know.

R. Miller gave the closing message that our focus needs to be on protecting the elderly. This means coming up with tactics to support them, getting information to them and supporting their emotional, behavioral and physical needs. This also means protecting the healthcare system. R. Miller stated we need to remain calm do our part to model behavior. There will be life after COVID-10.

A listserve will be set up to distribute information to the elderly.

R. Miller invited all to attend the weekly conference calls that he participates in. These are Wednesdays at 1pm.

E. Paterson thanked everyone for coming and noted that he will keep everyone informed. She then **adjourned** the meeting at 10:10

Respectfully submitted,

Robert Miller
Secretary

Town of Mansfield
Department of Finance

To: Eastern Highlands Health District

Elizabeth Paterson, Chairperson

From: Cherie Trahan, Director of Finance

Date: April 23, 2020

Re: Audit Services – FY 2019/20

Article VII of the Bylaws requires that the District annually designate an independent public accounting firm to audit the books and accounts. This audit was performed last year by Blum Shapiro & Company, P.C. Services were bid out in 2016/17. A three year contract (with an option to extend for two years) was awarded to Blum Shapiro & Company, P.C. The FY 2019/20 audit will be the fourth year of the contract.

The Eastern Highlands Health District Adopted 2020/21 Budget includes $6,900 to cover the audit fee. The Board's approval is respectfully requested.

Eastern Highlands Health District

4 South Eagleville Road ♦ Mansfield CT 06268 ♦ Tel: (860) 429-3325 ♦ Fax: (860) 429-3321 • Web: www.EHHD.org

Memo

To: Board of Directors

From: Robert L. Miller, Director of Health

Date: 4/21/2020

Re: Resolution for Signature Authorization

Attached for adoption by the Board of Directors is a resolution giving the Director of Health the authority to sign contracts with the Connecticut Department of Public Health (DPH). For those of you that may not be familiar with this, the Connecticut DPH requires the Director's authorization to sign and execute grant contract documents on behalf of the health district be affirmed with the adoption of a resolution stipulating such. Because we typically execute such contracts every year, the resolution is adopted annually about this time. The current contract that required such documentation include the Policy/Environmental Change to Prevent Chronic Disease grant.

I respectfully recommend adoption of this resolution.

Recommended Motion: Move, to adopt the "Resolution for Signature Authorization" for fiscal year 2020/2021 contracts with the Connecticut Department of Public Health, as presented on April 23, 2020.

Eastern Highlands Health District

4 South Eagleville Road ♦ Mansfield CT 06268 ♦ Tel: (860) 429-3325 ♦ Fax: (860) 429-3321 • Web: www.EHHD.org

RESOLUTION FOR SIGNATURE AUTHORIZATION

RESOLVED:

That Robert L. Miller, Director of Health, and in his absence, Elizabeth Paterson, Board Chairperson, has been empowered to sign contracts and amendments hereto, on behalf of the Eastern Highlands Health District between the Eastern Highlands Health District and the Connecticut Department of Public Health or its successor agency, for the period of July 1, 2020 to June 30, 2021

Adopted this 23rd day of April, 2020

_____

Mark Walter
Assistant Treasurer

Eastern Highlands Health District
General Fund
Comparative Statement of Revenues, Expenditures
and Changes in Fund Balance
March 31st, 2020
(with comparative totals for March 31, 2019)

	Adopted Budget 2019/20	Amended Budget 2019/20	Estimated Actuals 2019/20	2020	Percent of Adopted Budget	2019
Revenues						
Member Town Contributions	$ 437,590	$ 437,590	437,590	$ 328,200	75.0%	$ 321,945
State Grants	119,990	119,990	134,429	134,429	112.0%	133,327
Septic Permits	52,840	52,840	52,840	34,080	64.5%	36,730
Well Permits	13,890	13,890	13,890	11,685	84.1%	11,275
Soil Testing Service	35,610	35,610	35,610	30,215	84.8%	27,510
Food Protection Service	77,340	77,340	77,340	66,959	86.6%	72,111
B100a Reviews	29,680	29,680	29,680	20,330	68.5%	20,550
Septic Plan Reviews	31,750	31,750	31,750	23,205	73.1%	22,320
Other Health Services	4,681	4,681	4,681	9,771	208.7%	2,060
Miscellaneous	6,800	6,800	6,800			
Appropriation of Fund Balance	26,211	26,211	11,772	-	0.0%	-
Total Revenues	836,382	836,382	836,382	658,873	78.8%	647,829
Expenditures						
Salaries & Wages	585,660	585,660	585,660	398,274	68.0%	415,248
Grant Deductions	(40,938)	(40,938)	(40,938)	(36,050)	88.1%	(67,015)
Benefits	187,270	187,270	187,270	133,376	71.2%	152,676
Miscellaneous Benefits	8,360	8,360	8,360	7,775	93.0%	3,804
Insurance	15,800	15,800	15,800	13,870	87.8%	14,351
Professional & Technical Services	16,020	16,020	16,020	26,913	168.0%	7,652
Vehicle Repairs & Maintenance	3,200	3,200	3,200	1,951	61.0%	2,474
Health Reg*Admin Overhead	29,170	29,170	29,170	21,878	75.0%	21,090
Other Purchased Services	19,640	19,640	19,640	19,381	98.7%	14,103
Other Supplies	5,600	5,600	5,600	3,534	63.1%	3,385
Equipment - Minor	3,600	3,600	3,600	893	24.8%	1,007
Total Expenditures	833,382	833,382	833,382	591,795	71.0%	568,776
Operating Transfers						
Transfer to CNR Fund	3,000	3,000	3,000	-	0.0%	-
Total Exp & Oper Trans	836,382	836,382	836,382	591,795	70.8%	568,776
Excess (Deficiency) of Revenues	-	-	-	67,078		79,053
Fund Balance, July 1	432,295	432,295	432,295	432,295		358,081
Fund Balance plus Cont. Capital, Mar. 31	$ 432,295	$ 432,295	432,295	$ 499,373		$ 437,134

Eastern Highlands Health District
Capital Non-Recurring Fund
Balance Sheet
March 31, 2020
(with comparative totals for March 31, 2019)

	2020	2019
Assets		
Cash and Cash Equivalents	$ 119,980	$ 128,780
Total Assets	119,980	128,780
Liabilities and Fund Balance		
Liabilities		
Accounts Payable	-	-
Total Liabilities	-	-
Fund Balance	119,980	128,780
Total Liabilities and Fund Balance	$ 119,980	$ 128,780

Eastern Highlands Health District
Capital Non-Recurring Fund
Comparative Statement of Revenues, Expenditures
and Changes in Fund Balance
March 31, 2020
(with comparative totals for March 31, 2019)

	2020	2019
Revenues		
General Fund	$ -	$ 1,910
Total Revenues	-	1,910
Operating Transfers		
General Fund	-	-
Total Operating Transfers	-	-
Total Rev & Oper Trans	-	1,910
Expenditures		
Professional & Technical Services	-	-
Office Equipment	11,800	-
Total Expenditures	11,800	-
Excess (Deficiency) of Revenues	(11,800)	1,910
Fund Balance, July 1	131,780	126,870
Fund Balance plus Cont. Capital, Mar. 31	$ 119,980	$ 128,780

Eastern Highlands Health District
General Fund
Balance Sheet
March 31, 2020
(with comparative totals for March 31, 2019)

	2020	2019
Assets		
Cash and Cash Equivalents	$ 499,602	$ 437,269
Total Assets	499,602	437,269
Liabilities and Fund Balance		
Liabilities		
Accounts Payable	228	135
Total Liabilities	228	135
Fund Balance	499,373	437,134
Total Liabilities and Fund Balance	$ 499,602	$ 437,269

EASTERN HIGHLANDS HEALTH DISTRICT
ESTIMATED STATEMENT OF REVENUES, EXPENDITURES AND
CHANGES IN FUND BALANCE

Roll Forward FY 2020/21

	Actual 13/14	Actual 14/15	Actual 15/16	Actual 16/17	Actual 17/18	Actual 18/19	Adopted & Amended 19/20	Estimated 19/20	Adopted 20/21	Projected 21/22	Projected 22/23	Projected 23/24	Projected 24/25	Projected 25/26
Revenues:														
Member Town Contributions	377,577	390,841	405,820	423,080	429,282	429,260	437,590	437,590	457,530	468,968	480,692	492,710	505,028	517,653
State Grant-in-Aid	151,852	149,857	142,234	133,164	149,985	133,327	119,990	134,430	133,600	133,600	133,600	133,600	133,600	133,600
Services Fees	188,798	197,796	212,942	224,874	234,393	257,937	252,591	245,791	241,490	248,735	256,197	263,883	271,799	279,953
Local Support				800	-									
Total Revenues	718,227	738,495	760,996	781,918	813,660	820,525	810,171	817,811	832,620	851,303	870,489	890,192	910,427	931,206
Expenditures:														
Salaries & Benefits	613,970	656,060	644,630	686,253	691,797	658,453	734,252	697,550	775,400	790,908	806,726	822,861	839,318	856,104
Insurance	13,826	15,607	15,607	15,599	15,599	14,351	15,800	15,800	15,800	15,800	15,800	15,800	15,800	15,800
Professional &Technical Services	12,242	14,961	13,162	47,455	46,954	45,014	48,390	66,140	48,890	49,134	49,380	49,627	49,875	50,125
Other Purchased Services & Supplies	43,157	43,382	46,162	11,713	15,879	24,092	31,340	34,050	36,850	39,176	41,514	41,722	41,930	42,140
Equipment	1,132	645	762	300	1,612	1,401	3,600	3,600	3,600	4,000	4,000	4,000	4,000	4,000
Sub-total Expenditures	684,327	730,655	720,323	761,320	771,841	743,311	833,382	817,140	880,540	899,019	917,420	934,009	950,923	968,169
Operating Transfers Out	142,000	-	-	-	-	3,000	3,000	3,000	3,000	6,000	9,000	12,000	15,000	18,000
Total Expenditures and Operating Transfers Out	826,327	730,655	720,323	761,320	771,841	746,311	836,382	820,140	883,540	905,019	926,420	946,009	965,923	986,169
Excess/(Deficiency) of Revenues over Expenditures	(108,100)	7,840	40,673	20,598	41,819	74,214	(26,211)	(2,329)	(50,920)	(53,716)	(55,931)	(55,817)	(55,497)	(54,962)
Fund Balance, July 1	355,251	247,151	254,991	295,664	316,262	358,082	432,296	432,296	429,967	379,047	325,332	269,400	213,583	158,087
Fund Balance, June 30	$247,151	$254,991	$295,664	$316,262	$358,082	$432,296	$406,085	$429,967	$379,047	$325,332	$269,400	$213,583	$158,087	$103,124

Assumptions:									
	Expenditures per Above	746,311	836,382	820,140	883,540	905,019	926,420	946,009	965,923	986,169
Member Town increase of 2.5% per year	Grant Deduction	80,234	40,938	49,000	49,681	49,681	49,681	49,681	49,681	49,681
State Grant-in-Aid: FY19 8% below CGA budget, held flat each year af	Total Expenditures	826,545	877,320	869,140	933,221	954,700	976,101	995,690	1,015,604	1,035,850
Service Fee revenue increase of 3% annually	FB as a % of Total Exp	52.30%	46.29%	49.47%	40.62%	34.08%	27.60%	21.45%	15.57%	9.96%
Salary & Benefit increases of 2% per year										
Grant Deduction line for salaries held flat at $90,000 per year starting FY21 (per Rob $49,681 in FY2021)										
Professional & Technical increase of .5% per year										
Purchased Services increase of .5% per year										

Eastern Highlands Health District
Summary of Revenues and Expenditures for FY20/21

Fund: 634 Eastern Highlands Health District
Activity: 41200

Object	Description	Adopted/amend 19/20	Estimated 19/20	Adopted Budget 20/21	% change	Dollar change
Revenues:						
40220	Septic Permits	52,840	52,840	43,930	(16.9)	(8,910)
40221	Well Permits	13,890	13,890	9,970	(28.2)	(3,920)
40491	State Grant-In-Aid	119,990	134,430	133,600	11.3	13,610
40630	Health Inspec. Service Fees	3,301	3,301	3,500	6.0	199
40633	Health Services-Bolton	26,640	26,640	27,800	4.4	1,160
40634	Health Services-Coventry	67,420	67,420	70,570	4.7	3,150
40635	Health Services-Mansfield	140,440	140,440	146,770	4.5	6,330
40636	Soil Testing Service	35,610	35,610	36,760	3.2	1,150
40637	Food Protection Service	74,900	74,900	84,170	12.4	9,270
40638	B100a Review	29,680	29,680	24,410	(17.8)	(5,270)
40639	Engineered Plan Rev	30,700	30,700	27,240	(11.3)	(3,460)
40642	Health Services - Ashford	23,000	23,000	24,220	5.3	1,220
40643	Health Services - Willington	32,090	32,090	33,470	4.3	1,380
40645	Nonengineered Rev	-	-	-		-
40646	GroupHome/Daycare inspection	1,380	1,380	1,210	(12.3)	(170)
40647	Subdivision Review	1,050	1,050	1,000	(4.8)	(50)
40648	Food Plan Review	2,440	2,440	2,500	2.5	60
40649	Health Services - Tolland	79,790	79,790	83,310	4.4	3,520
40685	Health Services - Chaplin	12,150	12,150	12,830	5.6	680
40686	Health Services - Andover	17,600	17,600	18,370	4.4	770
40687	Health Services - Columbia	29,370	29,370	30,610	4.2	1,240
40688	Health Services - Scotland	9,090	9,090	9,580	5.4	490
	Cosmotology Inspections	6,800	-	6,800	-	-
40999	Appropriation of Fund Balance	26,211	2,329	50,920	94.3	24,709
	Total Revenues	836,382	820,140	883,540	5.6	47,158
Expenditures:						
51050	Grant deductions	(40,938)	(49,000)	(49,681)	21.4	(8,743)
51601	Regular Salaries - Non-Union	585,660	560,000	597,361	2.0	11,701
52001	Social Security	36,320	35,000	37,040	2.0	720
52002	Workers Compensation	10,160	10,160	10,150	(0.1)	(10)
52007	Medicare	8,500	8,100	8,620	1.4	120
52010	ICMA (Pension)	31,260	30,000	31,200	(0.2)	(60)
52103	Life Insurance	2,250	2,250	2,270	0.9	20
52105	Medical Insurance	98,130	98,130	135,540	38.1	37,410
52117	RHS	2,260	2,260	2,250	(0.4)	(10)
52112	LTD	650	650	650	-	-
52203	Dues & Subscriptions	2,000	2,000	2,100	5.0	100
52210	Training	3,500	3,500	3,500	-	-
52212	Mileage Reimbursement	600	600	600	-	-
53120	Professional & Tech	7,120	18,870	7,120	-	-
53122	Legal	2,000	8,000	2,000	-	-
53125	Audit Expense	6,900	6,900	6,900	-	-
53303	Vehicle Repair & Maintenance	3,200	3,200	3,200	-	-
53801	General Liability	15,800	15,800	15,800	-	-
53924	Advertising	1,000	1,000	1,000	-	-
53925	Printing & Binding	1,000	1,000	1,150	15.0	150
53926	Postage	1,500	1,500	1,500	-	-
53940	Copier maintenance	1,000	1,000	1,000	-	-
53960	Other Purchased Services	11,340	14,050	16,200	42.9	4,860
53964	Voice Communications	3,800	3,800	3,800	-	-
54101	Instructional Supplies	800	800	800	-	-
54214	Books & Periodicals	200	200	200	-	-
54301	Office Supplies	2,000	2,000	2,000	-	-
54601	Gasoline	2,600	2,600	3,000	15.4	400
55420	Office Equipment	3,000	3,000	3,000	-	-
55430	Equipment - Other	600	600	600	-	-
56302	Admin. Overhead	29,170	29,170	29,670	1.7	500
56303	Other General Expenditures	-	-	-	-	-
56312	Contingency	-	-	-	-	-
58410	Capital Nonrecurring Fund	3,000	3,000	3,000	na	-
	Total Expenditures	836,382	820,140	883,540	5.6	47,158

EASTERN HIGHLANDS HEALTH DISTRICT
FUND BALANCE ANALYSIS

FY 2020/21 - Projected FY 2025/26

	Actual 16/17	Actual 17/18	Actual 18/19	Adopted & Amended 19/20	Estimated 19/20	Proposed 20/21	Projected 21/22	Projected 22/23	Projected 23/24	Projected 24/25	Projected 25/26
General Fund											
Operating Expenditures	761,320	771,841	746,311	836,382	820,140	883,540	905,019	926,420	946,009	965,923	986,169
Grant Deduction	86,938	80,234	80,234	40,938	49,000	49,681	49,681	49,681	49,681	49,681	49,681
Total Expenditures	848,258	852,075	826,545	877,320	869,140	933,221	954,700	976,101	995,690	1,015,604	1,035,850
Fund Balance	316,262	358,082	432,296	406,085	429,967	379,047	325,332	269,400	213,583	158,087	103,124
FB as a % of Total Expenditures	37.28%	42.02%	52.30%	46.29%	49.47%	40.62%	34.08%	27.60%	21.45%	15.57%	9.96%
Capital Non-Recurring Fund											
Total Expenditures	-	34,696	-	33,000	38,800	31,000	27,000	27,000	5,000	22,000	5,000
Fund Balance	161,566	126,870	131,780	104,780	98,980	73,480	54,480	39,480	46,480	42,480	55,480
FB as a % of Total Expenditures	n/a	365.67%	n/a	317.52%	255.10%	237.03%	201.78%	146.22%	929.60%	193.09%	1109.60%
All Funds											
Total Expenditures	848,258	886,770	826,545	910,320	907,940	964,221	981,700	1,003,101	1,000,690	1,037,604	1,040,850
Fund Balance	477,828	484,952	564,076	510,865	528,947	452,527	379,812	308,880	260,063	200,567	158,604
FB as a % of Total Expenditures	56.33%	54.69%	68.24%	56.12%	58.26%	46.93%	38.69%	30.79%	25.99%	19.33%	15.24%
Service Fees & State Grant Revenue	358,038	384,378	391,265	372,581	380,221	375,090	382,335	389,797	397,483	405,399	413,553
Target Fund Balance - 50% of Service Fees & State Grant Revenue	179,019	192,189	195,632	186,291	190,111	187,545	191,167	194,898	198,741	202,700	206,777
General Fund - Fund Balance	316,262	358,082	432,296	406,085	429,967	379,047	325,332	269,400	213,583	158,087	103,124
Variance	137,243	165,893	236,663	219,794	239,857	191,502	134,164	74,502	14,842	(44,613)	(103,652)

Eastern Highlands Health District
COVID-19
Response Activities Overview
April 20, 2020

Activation of Public Health Emergency Response Plan

Currently implementing a weekly planning cycle with a weekly staff zoom meeting. Incident Action Plan updated each week.

Contact Tracing

Investigating all laboratory confirmed cases within our Jurisdiction. As of April 20th there are 45 completed and 28 active cases. The basic process includes identifying potentially exposed contacts. Notifying contacts of potential exposure. Provide contacts with guidance to quarantine and self-monitor. Link individuals with resources if needed. Coordinate with employers on work place exposures if needed.

Surveillance

Regular case counts reported to member towns and other community Partners. The DPH secure surveillance tracking system is regularly updated by staff with local case information. Local modelling of Epidemiological outbreak curve reviewed regularly.

PPE distribution

CT DPH tasked local health departments with distributing PPE to local area private healthcare providers. We have been informed that there will be weekly allocations. We picked up our first allocation at Mohegan Sun on Thursday April 16th.

Governors Executive Orders - Application and Interpretation

Providing modified inspections and infection control guidance for food service establishments (Approximately, 120 still open and 110 are closed). Providing consultations to grocery stores, and other businesses deemed essential. Ensuring non-essential businesses understand, and comply with rules as needed. Updating public sector employers as needed.

Infection control and exposure assessments for First Responders

Contact exposure, and sick worker guidance and assessments for both essential employers, and first responders. This office is acting as an infection control consult resource for a number of first responder agencies. We have conducted workplace exposure assessments, and investigations for five (5) first responder agencies and public sector employers in our jurisdiction to date.

Public Health Education, Communications, Messaging

EHHD aligned with Governors and CDC Messaging. Regular public information updates to website, and social media (FB & Twitter).

Pushing out information and updates on access to testing of general public and first responders.

Regular agency reports to community partners.

Medical Reserve Corps retention and recruitment

We have recently sworn in 30 new volunteers for a total of 61 on our roster, with another 30 or so in various stages of the vetting process. We are in the process of integrating our local unit roster with the new state-wide volunteer management platform, CTResponds!

COVID-19 Crisis Response Funding for State and Local Health Departments

Local public health departments are receiving COVID-19 Crisis Response Funding from the CDC. Currently, the funding is reimbursing 100% for over-time, response supplies, and communications. As most of the staff time expended on the response is regular-time, and not over-time our reimbursable expenses are relatively small at this time. We are nonetheless tracking all COVID related expenses.

What does the future hold?

Contact Tracing

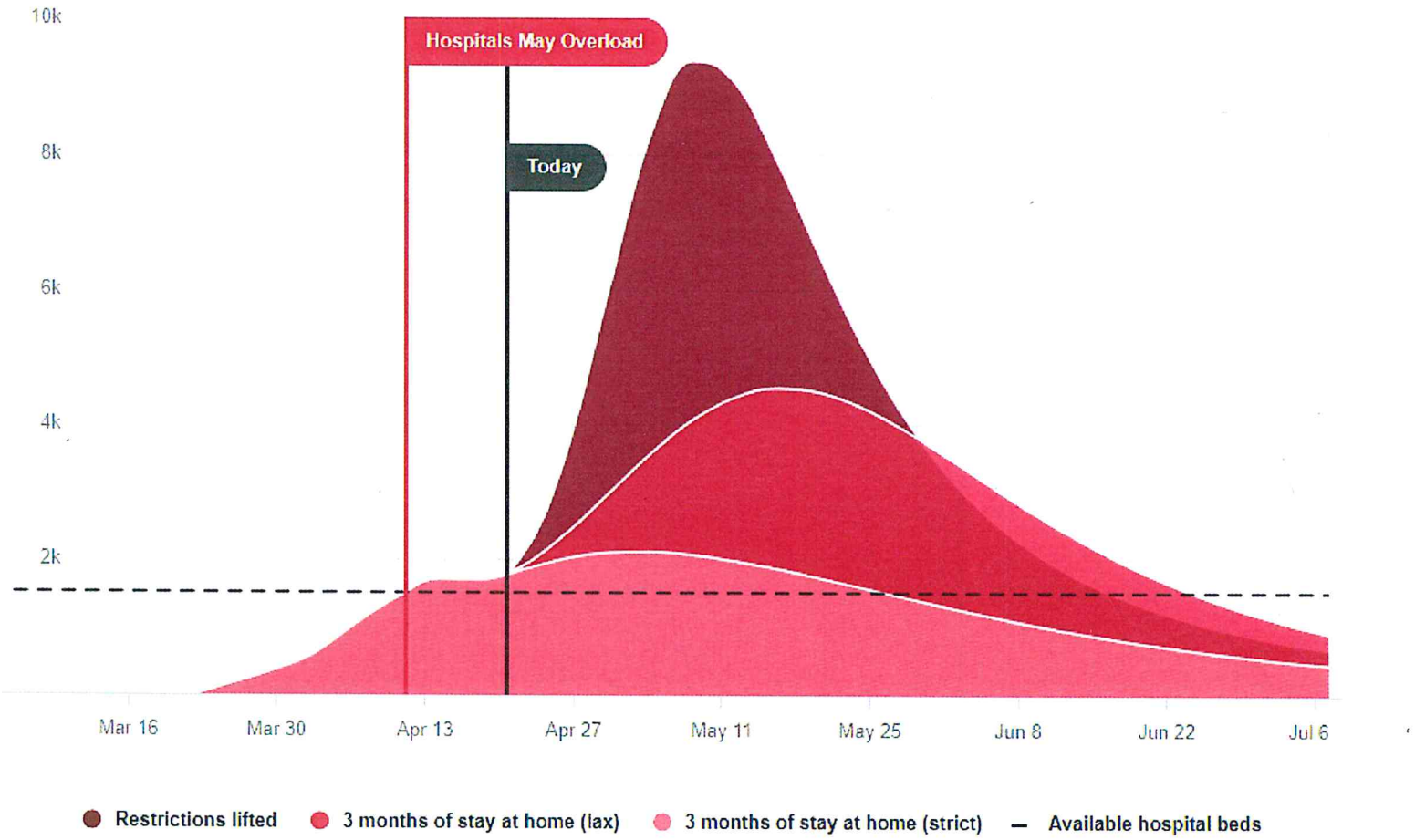
Connecticut is designing and developing a robust contact tracing program. Such a program may include a significant ramp up in staffing, enhanced protocols, user friendly surveillance software platform, and diagnostics (testing) and support resources for identified contacts. Local Public Health Departments are currently engaged in contact tracing. Program implementation should occur prior to the relaxation of social distancing rules. Such a program may be active for many months to a year, or more.

Mass Vaccination

Similar to our experience in 2009 during the H1N1 pandemic when the EHHD spearheaded an effort to vaccinate 9000 residents, local public health departments will once again be called onto action to stand up and activate a community level mass vaccination campaign to combat COVID-19. Pending the development and mass production of a vaccine, this campaign could begin as early as the fall of 2020.

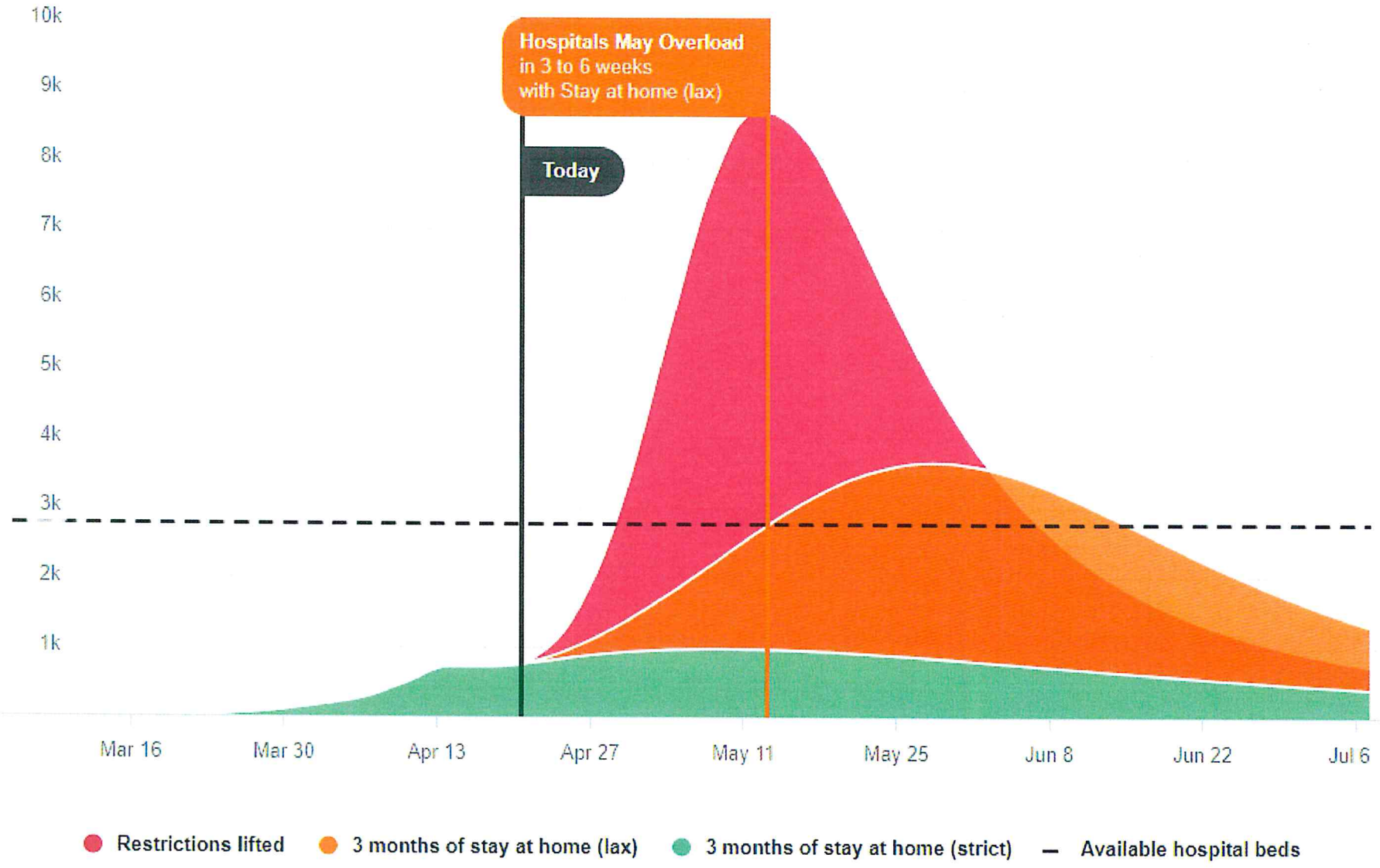
Projected hospitalizations

Fairfield County, Connecticut



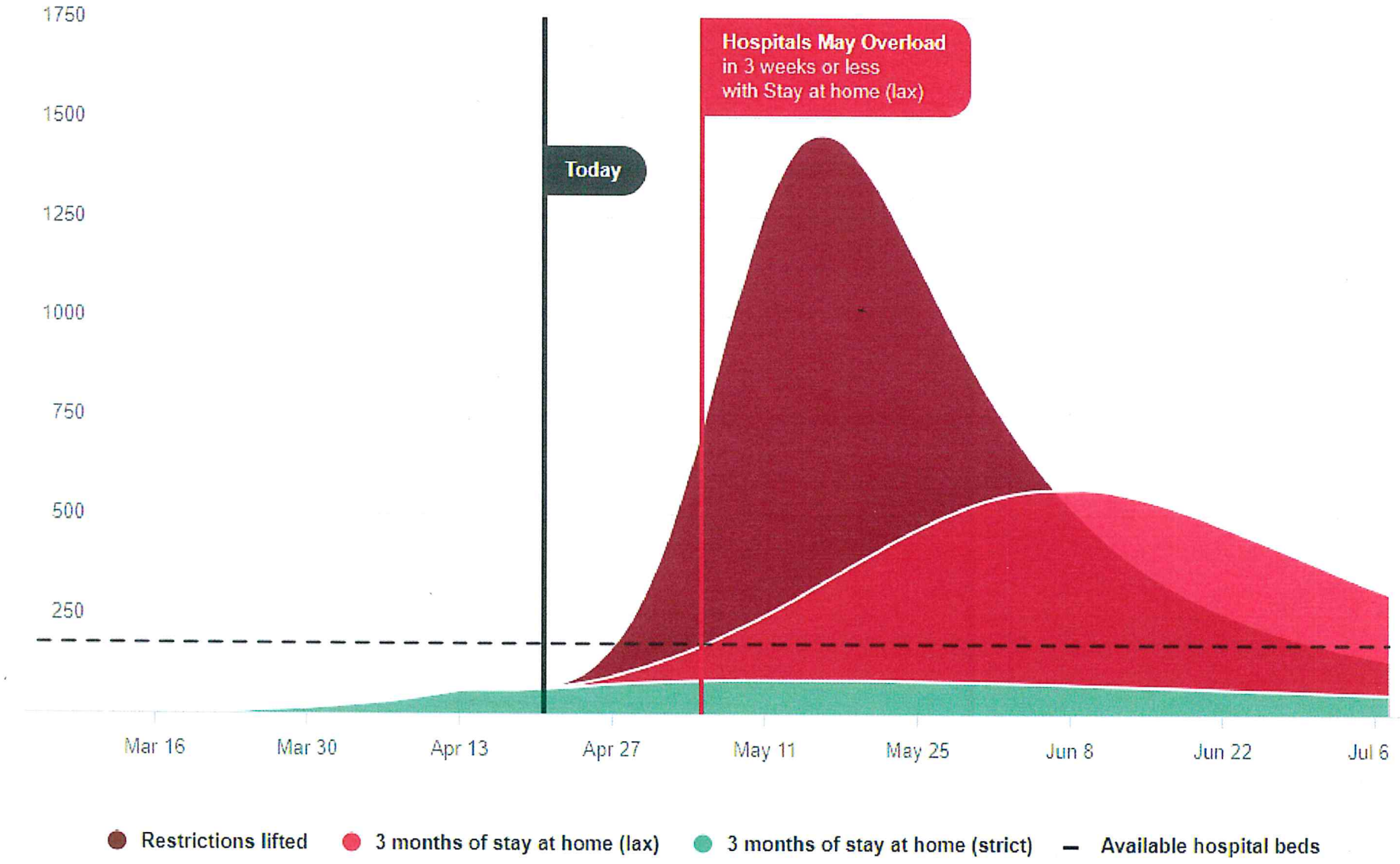
Projected hospitalizations

Hartford County, Connecticut



Projected hospitalizations

Tolland County, Connecticut



COVID-19 Update April 20, 2020

As of **April 20, 2020**, a total of **19815** laboratory-confirmed cases of COVID-19 have been reported among Connecticut residents (Figure 1). **One thousand nine hundred one** patients are currently hospitalized. There have been **1331** COVID-19-associated deaths. Today's report includes catch up of cases and deaths reported since Thursday, April 16.

Day-to-day changes reflect newly reported cases, deaths, and tests that occurred over the last several days to week. All data in this report are preliminary; data for previous dates will be updated as new reports are received and data errors are corrected. Hospitalization data were collected by the Connecticut Hospital Association. Deaths* reported to either the OCME or DPH are included in the daily COVID-19 update.

*For public health surveillance, COVID-19-associated deaths include persons who tested positive for COVID-19 around the time of death and persons who were not tested for COVID-19 whose death certificate lists COVID-19 disease as a cause of death or a significant condition contributing to death.

Overall Summary	Total	Change Since Yesterday
Laboratory-Confirmed COVID-19 Cases	19815	+1853
COVID-19-Associated Deaths	1331	+204
Patients Currently Hospitalized with COVID-19	1919	+18
Patients tested for COVID-19	62806	+3047

COVID-19 Cases and Associated Deaths by County of Residence
As of 04/20/20 2:30pm. Includes patients tested at the State Public Health Laboratory, hospital, and commercial laboratories.

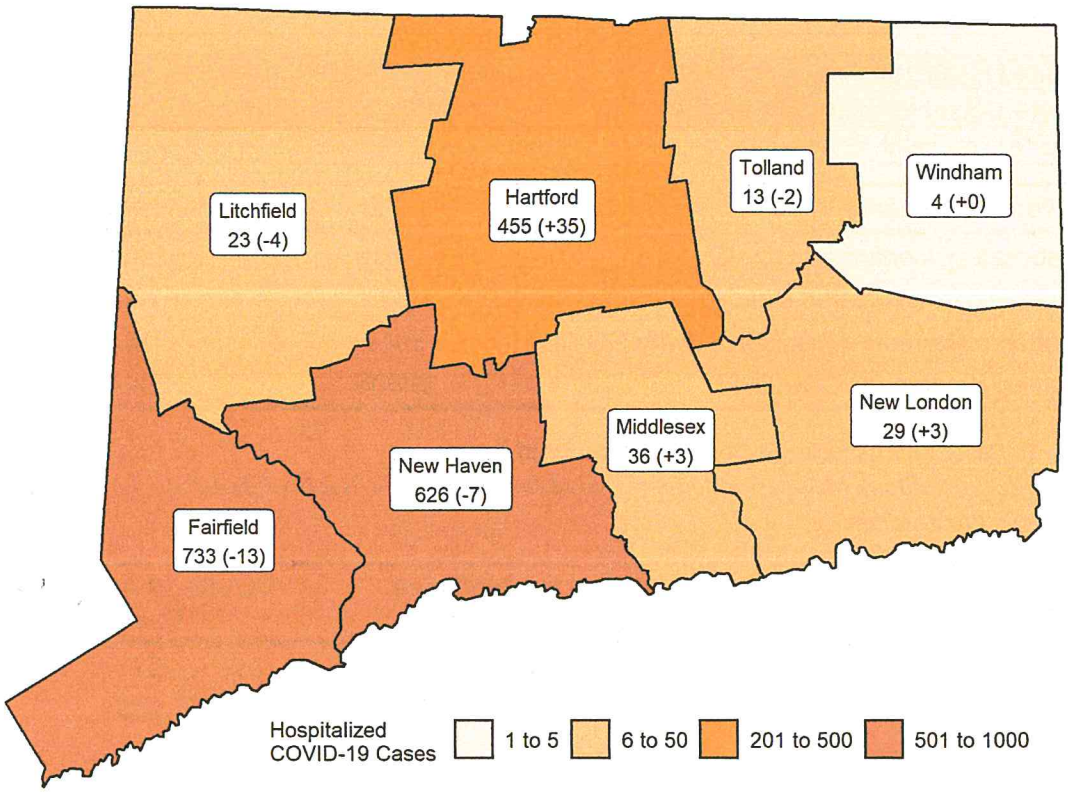
County	Laboratory-Confirmed COVID-19 Cases	COVID-19-Associated Deaths
Fairfield County	8320	512
Hartford County	3823	369
Litchfield County	639	58
Middlesex County	484	45
New Haven County	5272	301
New London County	356	13
Tolland County	299	27
Windham County	108	2
Pending address validation	514	4
Total	**19815**	**1331**

National COVID-19 statistics and information about preventing spread of COVID-19 are available from the Centers for Disease Control and Prevention.

Hospitalization Surveillance

The map below shows the number of patients currently hospitalized with laboratory-confirmed COVID-19 by county based on data collected by the Connecticut Hospital Association. The distribution is by location of hospital, not patient residence. The labels indicate the number of patients currently hospitalized with the change since yesterday in parentheses.

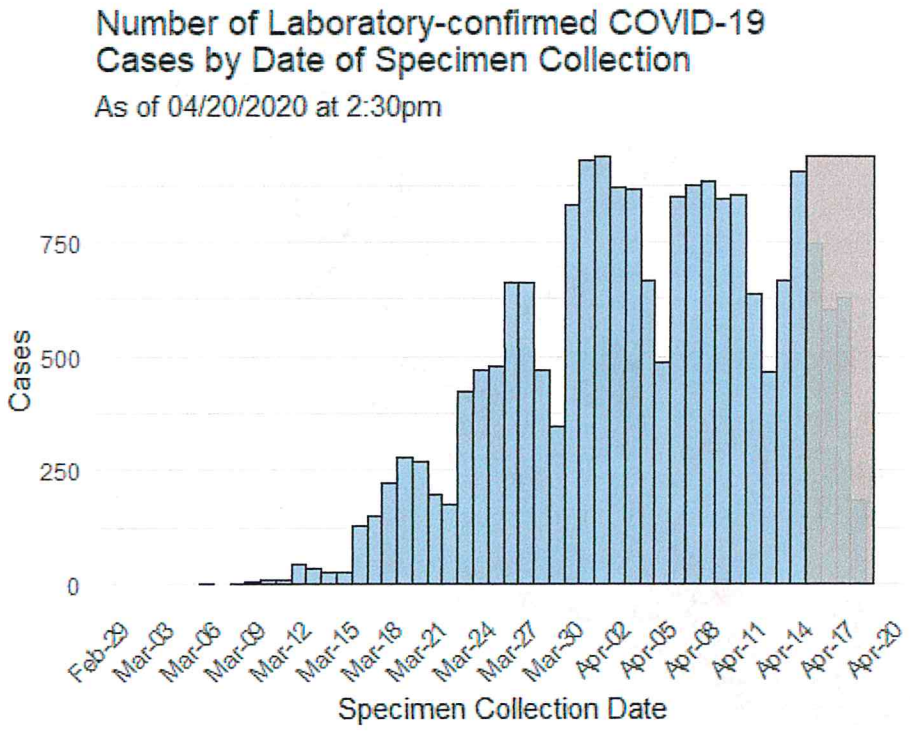
Patients Currently Hospitalized by Connecticut County
Distribution by location of hospital not patient residence. Data from the Connecticut Hospital Association.

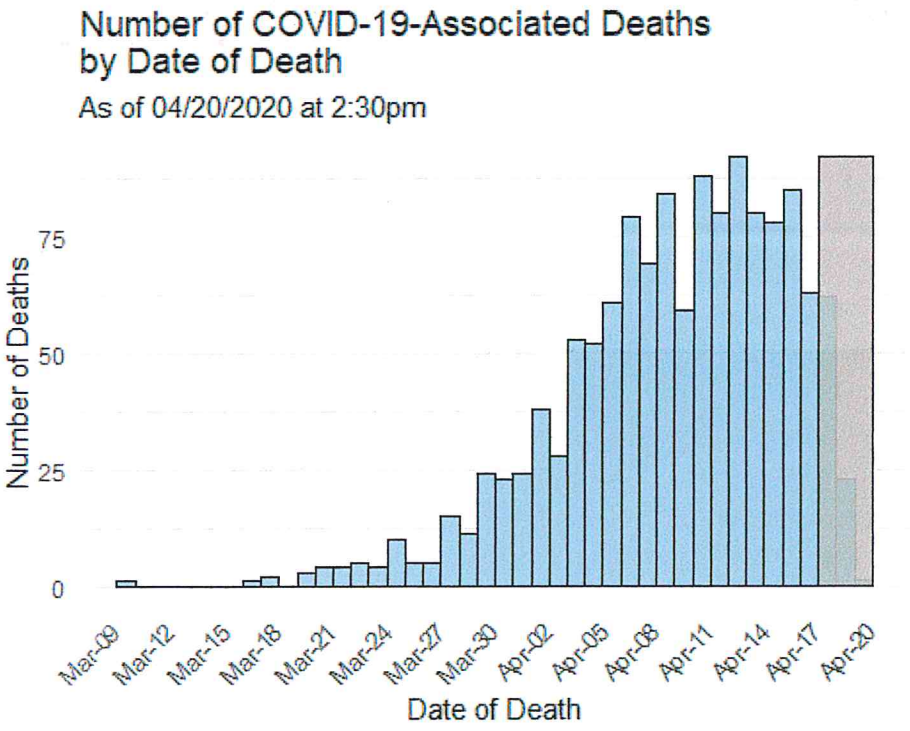


More information about hospitalized cases of COVID-19 in New Haven and Middlesex Counties is available from COVID-NET.

Characteristics of Laboratory-Confirmed COVID-19 Cases and Associated Deaths

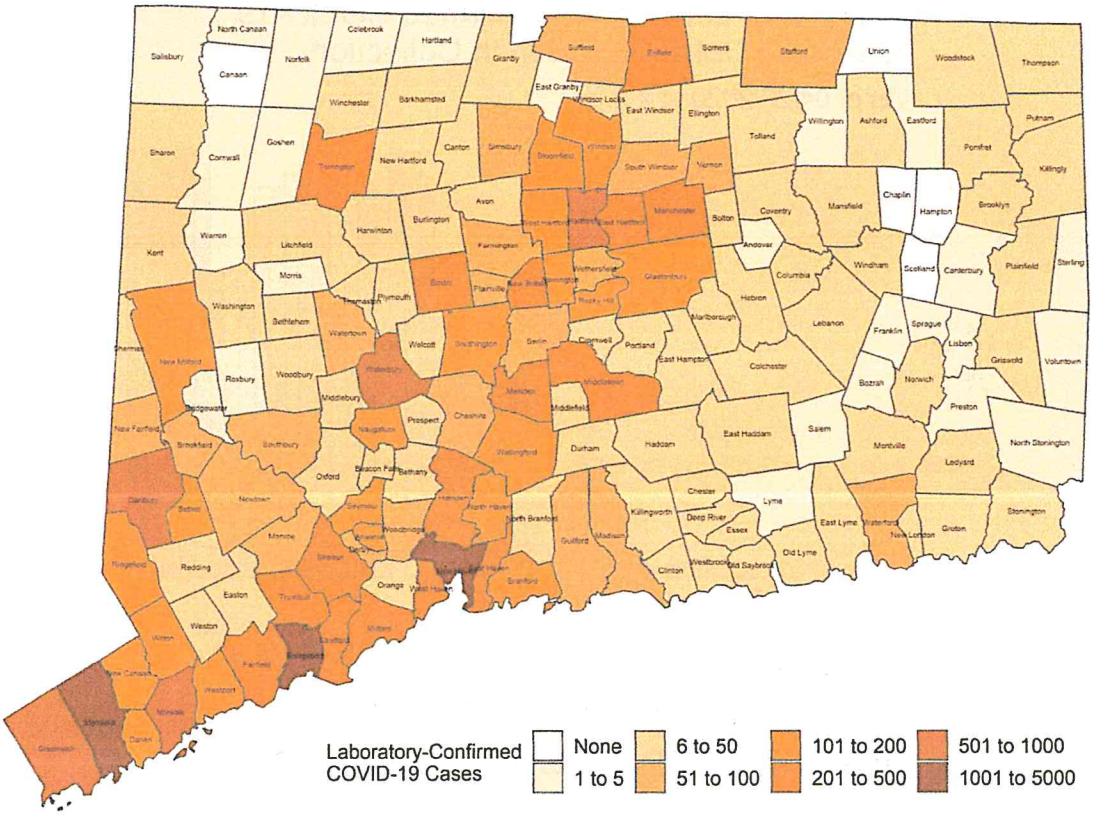
Test results may be reported several days after the result. Data are incomplete for most recent dates shaded in grey. Data from previous dates are routinely updated.





Connecticut Towns with Confirmed Cases of COVID-19

Map does not include 514 cases pending address validation



All data are preliminary and subject to change.

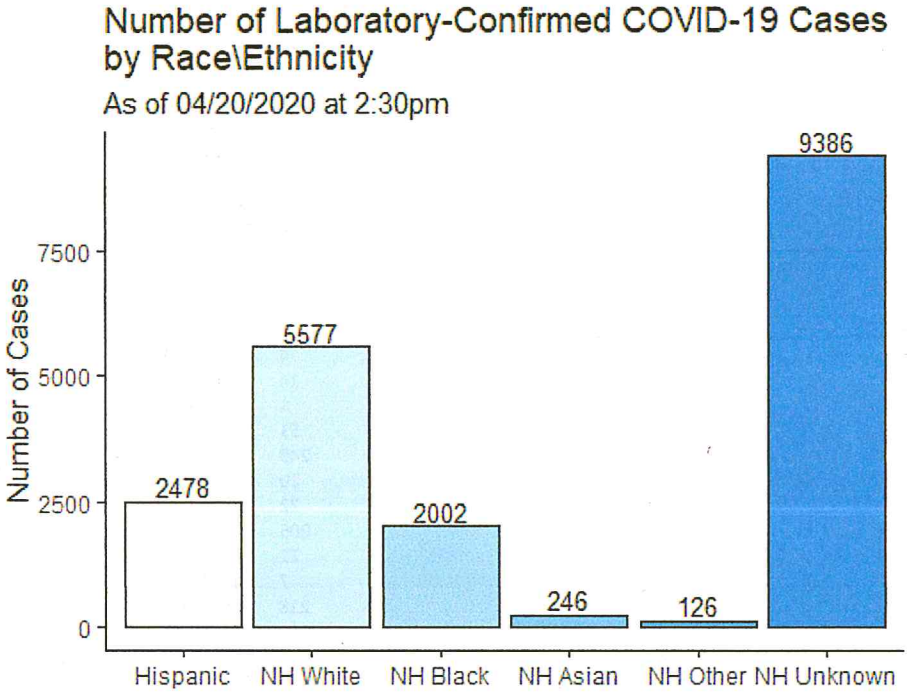
APPENDIX A. Towns with Confirmed Cases of COVID-19

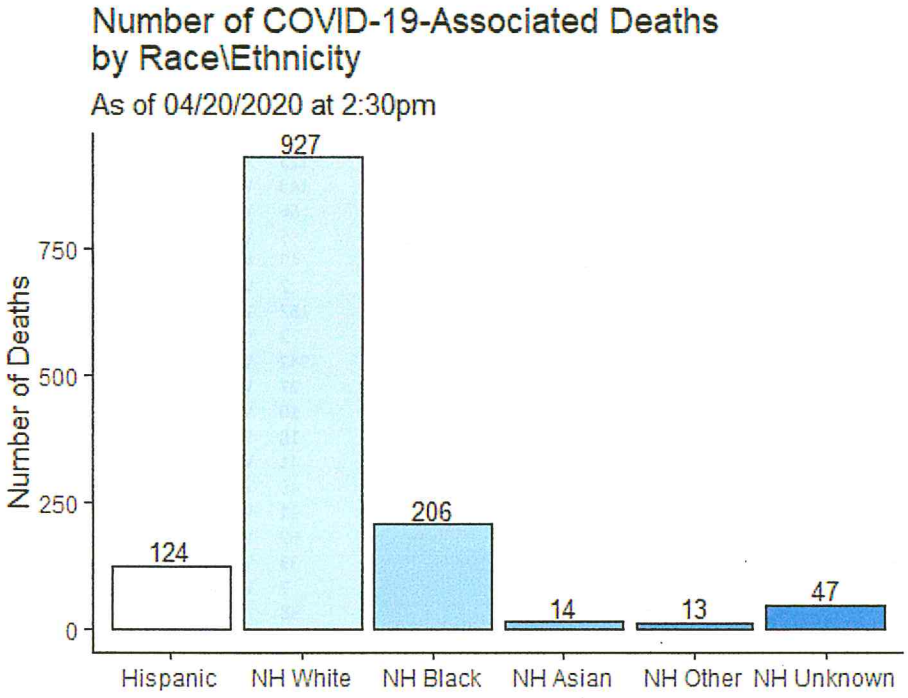
Table does not include 514 cases pending address validation

Town	Cases	Town	Cases	Town	Cases
Andover	2	Griswold	10	Prospect	26
Ansonia	128	Groton	36	Putnam	6
Ashford	8	Guilford	59	Redding	35
Avon	35	Haddam	16	Ridgefield	146
Barkhamsted	10	Hamden	424	Rocky Hill	159
Beacon Falls	22	Hampton	0	Roxbury	5
Berlin	71	Hartford	704	Salem	3
Bethany	15	Hartland	1	Salisbury	5
Bethel	129	Harwinton	18	Scotland	0
Bethlehem	8	Hebron	11	Seymour	129
Bloomfield	189	Kent	6	Sharon	10
Bolton	9	Killingly	17	Shelton	351
Bozrah	4	Killingworth	10	Sherman	10
Branford	197	Lebanon	9	Simsbury	56
Bridgeport	1356	Ledyard	8	Somers	32
Bridgewater	5	Lisbon	4	South Windsor	57
Bristol	271	Litchfield	14	Southbury	99
Brookfield	100	Lyme	1	Southington	129
Brooklyn	8	Madison	51	Sprague	2
Burlington	18	Manchester	249	Stafford	62
Canaan	0	Mansfield	10	Stamford	2046
Canterbury	2	Marlborough	22	Sterling	2
Canton	44	Meriden	205	Stonington	23
Chaplin	0	Middlebury	21	Stratford	421
Cheshire	82	Middlefield	7	Suffield	73
Chester	31	Middletown	218	Thomaston	31
Clinton	26	Milford	369	Thompson	10
Colchester	13	Monroe	61	Tolland	26
Colebrook	1	Montville	41	Torrington	215
Columbia	6	Morris	5	Trumbull	240
Cornwall	1	Naugatuck	110	Union	0
Coventry	19	New Britain	284	Vernon	93
Cromwell	34	New Canaan	115	Voluntown	3
Danbury	836	New Fairfield	72	Wallingford	137
Darien	149	New Hartford	13	Warren	1
Deep River	8	New Haven	1134	Washington	15
Derby	73	New London	50	Waterbury	872
Durham	18	New Milford	125	Waterford	82
East Granby	3	Newington	148	Watertown	54
East Haddam	10	Newtown	66	West Hartford	192
East Hampton	23	Norfolk	5	West Haven	499
East Hartford	260	North Branford	49	Westbrook	14
East Haven	231	North Canaan	2	Weston	46
East Lyme	24	North Haven	132	Westport	197
East Windsor	21	North Stonington	2	Wethersfield	94
Eastford	1	Norwalk	942	Willington	4
Easton	25	Norwich	27	Wilton	115
Ellington	25	Old Lyme	10	Winchester	29
Enfield	223	Old Saybrook	18	Windham	26
Essex	13	Orange	41	Windsor	200
Fairfield	300	Oxford	48	Windsor Locks	29
Farmington	90	Plainfield	11	Wolcott	48
Franklin	2	Plainville	69	Woodbridge	71
Glastonbury	124	Plymouth	33	Woodbury	24
Goshen	4	Pomfret	7	Woodstock	10
Granby	8	Portland	38		
Greenwich	562	Preston	2		

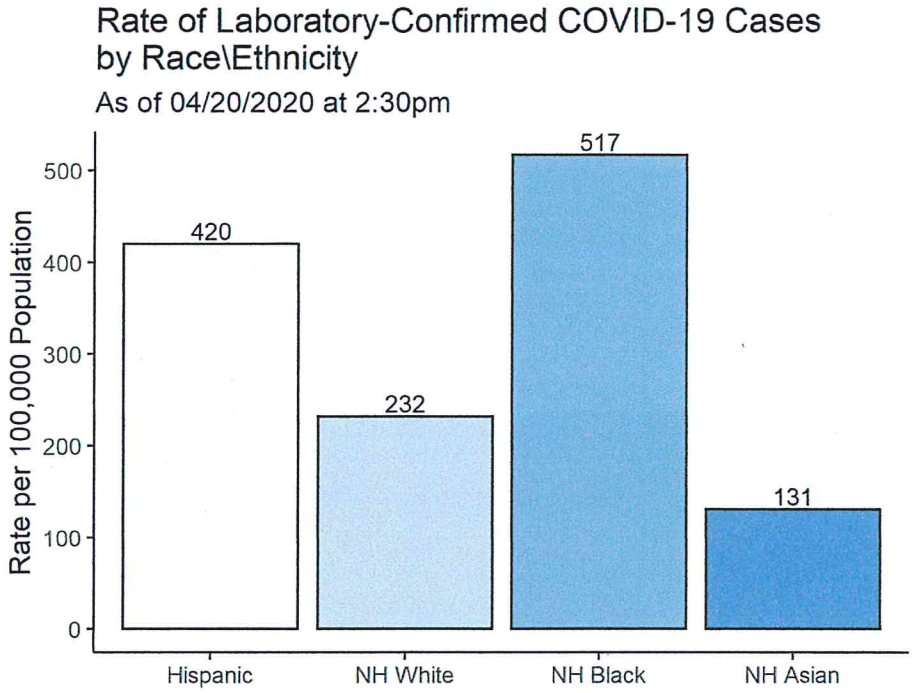
All data are preliminary and subject to change.

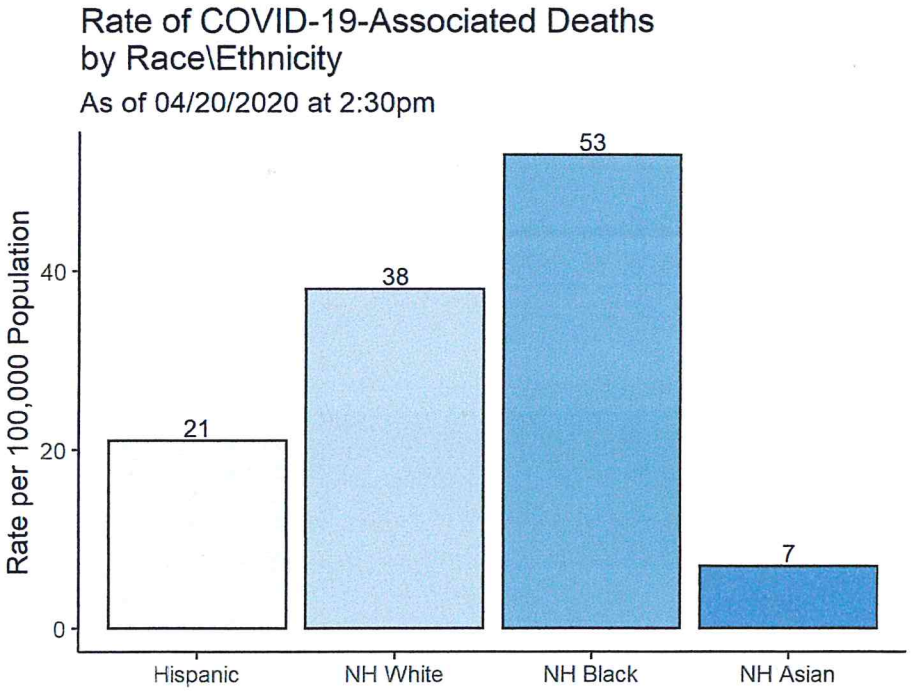
APPENDIX B. The following graphs show the number of cases and deaths by race and ethnicity. *Categories are mutually exclusive. Cases answering 'yes' to more than one race category are counted as 'other'. Counts may not add up to total case counts as data on race and ethnicity may be missing. NH=Non-Hispanic*





The following graphs show the rate of cases and deaths per 100,000 population by race and ethnicity. Population estimate from: DPH Population Statistics. *Categories are mutually exclusive. Cases answering 'yes' to more than one race category are counted as 'other'. Counts may not add up to total case counts as data on race and ethnicity may be missing. NH=Non-Hispanic*





CDC COVID-19 Communications Highlights
Coronavirus Disease 2019 ("COVID-19") Pandemic
April 20, 2020 as of 9:30 pm

Updated text is shown in colored text.

Please note that the COVID19 Communication Highlights (previously Daily Key Points) will be published on Monday, Wednesday, and Friday. CDC may issue an off-schedule Communication Highlights update if there is urgent information to share.

SNAPSHOT

- CDC has reported:
  - 746,625 confirmed and probable cases of COVID-19
  - 39,083 confirmed and probable COVID-19-related deaths
- All 50 states, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands have reported cases of COVID-19.
- Most U.S. states report some community spread of COVID-19. Of those, 27 states report COVID-19 cases are "widespread." See CDC's map to stay up to date on what is happening in your state.
- As of 4/14, CDC's official counts include both confirmed and probable cases and deaths. CDC has added a footnote under the map on its Cases in the U.S. web page to explain this change.
- CDC also added demographic characteristics to the U.S. Cases page.
- Visit CDC's COVIDView for a weekly summary and interpretation of key indicators tracking the COVID-19 pandemic in the United States.
- Visit CDC Coronavirus Interactive to explore and understand COVID-19 data.

MAIN KEY POINTS

- The United States is in the acceleration phase of the COVID-19 pandemic.
- The White House Task Force on Coronavirus is asking Americans to Slow the Spread through April 30.
  - All segments of U.S. society have a role to play.
    - People across the country should stay home as much as possible and otherwise practice social distancing.
    - CDC recommends that everyone use a cloth face covering in community settings to help reduce the spread of COVID-19.
      - Children under the age of 2 should not use a cloth face covering.
- Older people and people of any age with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
- If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
- CDC and federal partners recommend that people and health care providers postpone routine medical or dental care at this time. This will help to reduce the burden on the healthcare system.
  - If you cannot postpone medical treatment, call your provider before visiting to see if they offer consultations by phone or telemedicine.
- People who get a fever or cough should consider whether they might have COVID-19, depending on where they live, their travel history, or other exposures.
  - Most people have mild illness and are able to recover at home without medical care.
  - People who are ill with COVID-19, but are not sick enough to be hospitalized, should follow CDC guidance to care for themselves and reduce the risk of spreading illness to others.

- People who are sick should follow CDC guidance on recovering at home and follow the new guidance for when it's OK to interact with other people again.

- If you traveled to an affected area or have been exposed to someone sick with COVID- 19 in the last 14 days, you will face some limitations on your movement and activity.
  - Please follow instructions during this time.
  - Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.
- The U.S. government announced new guidance to help the most critical workers serving on the front lines to quickly return to work after potential exposure to someone with COVID-19, provided those workers are symptom-free.

TESTING

- As of April 20, 97 state and local public health labs in 50 states, the District of Columbia, Guam, Puerto Rico, and U.S. Virgin Islands verified they are successfully using COVID-19 diagnostic tests.
  - See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- As of April 19, CDC and local and state public health laboratories had tested a total of 386,398 specimens.
  - Private laboratories are also increasing their testing capacity.

RECENT MMWR PUBLICATIONS

- On April 20, MMWR published Cleaning and Disinfectant Chemical Exposures and Temporal Associations with COVID-19 — National Poison Data System, United States, January 1, 2020–March 31, 2020.
  - This report describes a temporal association between COVID-19 cleaning recommendations—from public health agencies and the media—and an increase in reports related to cleaners and disinfectants reported to the National Poison Data System (NPDS).
  - CDC and the American Association of Poison Control Centers surveillance team compared the number of exposures reported for the period January–March 2020 with the number of reports during the same 3-month period in 2018 and 2019.
  - During January–March 2020, poison centers received 45,550 exposure calls related to cleaners (28,158) and disinfectants (17,392). This represented an overall increases of 20.4% and 16.4% from January–March 2019 (37,822) and January–March 2018 (39,122), respectively.
  - Although NPDS data do not provide information showing a definite link between exposures and COVID-19 cleaning efforts, there appears to be a clear temporal association with increased use of these products.
  - The daily number of calls to poison centers increased sharply at the beginning of March 2020 for exposures to both cleaners and disinfectants.
  - The increase in total calls was seen across all age groups. Exposures among children 5 years old and younger consistently represented a large percentage of total calls in the 3-month study period for each year.
  - Further analysis of the increase in calls from 2019 to 2020 (3,137 for cleaners, 4,591 for disinfectants) was conducted to look at the type of product used.
  - In the cleaner category, bleaches accounted for the largest percent change; in the disinfectant category, nonalcoholic disinfectants and hand sanitizers accounted for the largest percentage change.
  - Inhalation represented the largest percentage increase from 2019 to 2020 among all exposure

routes.
- Always read and follow directions on the labels of cleaning products.
  - Only use water at room temperature for dilution (unless stated otherwise on the label).
  - Avoid mixing chemical products.
  - Wear eye and skin protection.
  - Ensure adequate ventilation.
  - Store chemicals out of the reach of children.

CDC GUIDANCE AND RESOURCES UPDATES

- Guidance documents and resources posted since April 17 to the CDC website included:
  - FAQs on how various professions can protect themselves and others, and how their employers can help.
    - What Mail and Parcel Drivers Need to Know About COVID-19
    - What Food and Grocery Pick-up and Delivery Drivers Need to Know About COVID-19
    - What Rideshare, Taxi, Limo, and Other Passenger Drivers-for-Hire Need to Know About COVID-19
    - What Airline Catering Kitchen Workers Need to Know About COVID-19
    - What Airport Retail or Food Service Workers Need to Know About COVID-19
    - What Firefighters and EMS Providers Need to Know about COVID-19
  - Considerations for state and local health departments when Investigating and Responding to COVID-19 Cases at Homeless Service Provider Sites.
  - COVID-19 Forecasts for the United States, including a forecast of COVID-19 deaths in the U.S.
  - Advice for people Caring for Someone Sick at Home (or Other Non-healthcare Settings).
  - Strategies to protect those who are most vulnerable in Households Living in Close Quarters.
  - Steps to Stay Safe that every American and community can take now to decrease the spread of the coronavirus.
- CDC has updated existing guidance documents and resources, including:
  - Healthcare Prevention and Infection Control FAQs
  - Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities
  - Symptoms of Coronavirus
  - Institutes of Higher Education - FAQs for Administrators
  - Information for Pediatric Healthcare Providers
- CDC has updated the Communities, Schools, Workplaces, and Events section of CDC's COVID-19 website with new content and a new design intended to make it easier to find resources.

For more information please visit CDC's Coronavirus Disease 2019 Pandemic page at www.cdc.gov/coronavirus.

From: matt.cartter@ct.gov <ctdphhan@ct.gov>
Sent: Wednesday, April 15, 2020 10:40 AM
To: Robert L. Miller
Subject: CT DPH: Planning for widespread community COVID-19 testing and contact tracing
Attachments: Comprehensive-COVID-19-case-finding-and-contact-tracing-in-the-US.pdf; Final+Contact+Tracing+ASTHO+Memo.pdf

Every state in the country will be developing a plan for widespread community COVID-19 testing and contact tracing (see attached). Many states have already started, including Connecticut. We are working with Governor Lamont's Reopen Connecticut Advisory Group to develop the plan for Connecticut.

Traditional contact tracing is very labor intensive and difficult to sustain, especially when there is widespread community transmission of COVID-19 and COVID-19 testing remains limited. Widespread community COVID-19 testing and contact tracing will happen once we pass the peak of COVID-19 transmission -- on the downward slope of the pandemic curve. This will be needed to drive down the curve to close to zero.

The Yale School of Public Health (YSPH) has established a team of MPH students and medical students to assist the Yale-New Haven Hospital and the City of New Haven Department of Health with contact tracing: https://news.yale.edu/2020/04/14/yale-stands-new-haven-responding-covid-19

This opinion piece by two Yale authors that was published yesterday might be of interest: https://www.usatoday.com/story/opinion/2020/04/14/coronavirus-aggressive-testing-before-economy-reopens-column/2978684001/

Sent by: Matthew L. Cartter, MD, MPH; State Epidemiologist & Director of Infectious Diseases; Connecticut Department of Public Health; 410 Capitol Avenue, MS #11EPI, P.O. Box 340308, Hartford, Connecticut 06134-0308; P: (860) 509-7995|F: (860) 509-7910|E: matt.cartter@ct.gov

TO: Members of Congress
FROM: Association of State and Territorial Health Officials
Date: April 10, 2020
RE: Contact Tracing Workforce

Background: In order to appropriately address the COVID-19 outbreak and potentially move to gradually reduce community mitigation efforts, we encourage Congress to ensure sufficient national capacity for COVID-19--this includes reagents for COVID-19 testing, personal protective equipment for both rapid COVID-19 tests and point of care and serological testing for COVID antibodies, and electronic data systems to rapidly share and receive laboratory data by public health. We also encourage a robust contact tracing workforce that builds on existing state and territorial health agency disease investigation programs to find COVID-19 cases and isolate them.

Congress must provide flexible long term and emergency supplemental funding to expand the scale of disease investigation specialists (DIS) and the contact tracing workforce within our local, state, territorial, tribal and federal public health agencies.

Principles: Below is an outline of principles Congress should consider when drafting legislative language:

1) Contact tracing workforce should be scaled using existing capacity at the state, local, and territorial public health departments. This workforce exists in health agencies and their communities. The ultimate goal should be to increase DIS and add lay contact investigator support using existing DIS. Commensurate expansion of federal, state and territorial epidemiology and laboratory capacity is also necessary.
2) Congress **should not** set up a system outside of existing public health agency response (i.e. FEMA) for hiring or placing new contact tracing volunteers. Volunteer management systems are in place in state emergency operation centers and new efforts must be integrated with current capabilities and capacity at CDC, federal, state, local, tribal, and territorial health departments to assure coordinated planning of volunteer deployment and consistent implementation of liability protections and safety measures.
3) The federal funding must provide maximum flexibility to enable public health agencies the support needed to recruit and retain staff.
4) The response and recovery will vary city by city and state by state. Workforce capacity cannot be based on a one size fits all approach and must be led by the state and territorial public health departments in partnership with local, federal, and tribal public health and emergency management stakeholders.
5) Workforce capacity must be built for the long-term. COVID-19 will not be the last time the United States experiences an infectious disease outbreak. We encourage recruitment from the existing workforce—this includes MPH students, established public health fellows, community health workers, and medical assistants. Support to forgive student loans for the public health workforce is necessary to recruit and retain existing and new staffing.

Workforce Numbers: Currently only 2,200 DIS are employed throughout the entire country in local and state health agencies. Based on preliminary research generated by Johns Hopkins University, it's believed an additional 100,000 contact tracing employees are needed to address COVID-19 in the immediate future. Additionally, a minimum of 1,200 new epidemiologist are needed to support full

epidemiologic capacity as document in the 2017 Epidemiology Capacity Survey by the Council of State and Territorial Epidemiologists (CSTE).

Current Challenges: Due to state revenue short falls because of the economic downturn, some health departments furloughed staff which equates to lost capacity at the state and local health departments. These staff must be rehired expeditiously using supplemental and stimulus funding to support public health priorities. Furloughed public health department staff possess technical and content expertise to assist with the immediate COVID-19 response and eventual recovery efforts.

Funding: ASTHO encourages Congress to create three funding streams. One which will provide long term sustainability via a mandatory public health infrastructure fund, a short-term emergency supplemental funding, and finally a loan repayment program to quickly scale up the workforce.

- **Public Health Infrastructure Fund: $4.5 billion** in additional annual mandatory funding for CDC, state, local, tribal and territorial core public health infrastructure to pay for such essential activities. This includes disease surveillance; epidemiology; laboratory capacity, all-hazards preparedness and response; policy development and support; communications; community partnership development; and organizational competencies. This funding should be in addition to the annual discretionary appropriations.
- **Emergency Supplemental Funding:** Based on modeling generated by Johns Hopkins University, approximately **$3.6 billion** at a minimum is needed for state and local health departments to hire this staff. The mechanism to get this funding quickly out the door could be through the CDC Crisis CoAg. Programs at CDC that support this type of work include the Infectious Disease Division, STD, HIV, and TB line items. Again, it is critical that funding is not restrictive and as flexible as possible.
- **Loan Repayment:** Another critical step to invest in the public health workforce is enacting and implementing a loan repayment program at the Health Resources and Services Administration, for public health professionals who agree to serve two years in a local, state, or tribal health department. **$200 million** in appropriations is needed to establish such a program.

Supporting Organizations: The approach outlined in this document is supported by the Association of Public Health Laboratories, the Council of State and Territorial Epidemiologists, and the National Coalition of STD Directors.

Contact: Carolyn Mullen ASTHO's Senior Vice President, Government Affairs & Public Relations
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NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

FOR IMMEDIATE RELEASE

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National Association of County and City Health Officials' Position Statement on Public Health Capacity for COVID-19 Contact Tracing Surge

Massive scale up of health department workforce, supports needed to achieve goals

Washington, DC, April 16, 2020 – The National Association of County and City Health Officials (NACCHO), on behalf of the nation's nearly 3,000 local health departments, released the position statement, "*Building COVID-19 Contact Tracing Capacity in Health Departments to Support Reopening American Society Safely*," laying out key considerations to surge contact tracing capacity to support communities as they dial back strict social distancing orders during the next phase of the COVID-19 response. To do this, we will need a massive expansion of professionals and trained volunteers equipped with the appropriate skills, training, and technology, distributed equitably across the country to help identify, notify, and support those who may have been exposed, and help them self-quarantine to stop the spread.

The full statement can be found here.

A summary of the key recommendations includes:

Workforce

For the COVID-19 response, a strong, scalable network is needed to test, isolate, contact trace, and conduct follow up. Contact tracing pulls from an extensive list of skillsets, including, but not limited to, disease investigation specialists, public health nurses, community health workers, public health social workers, and epidemiologists. Therefore, it

is critical that any plan allow for flexibility of staff roles that can be hired to take on contact tracing duties during this surge.

Volunteers

While a strong influx of public health workers must be hired to support this surge, volunteers may also be an important asset as we scale up testing and contact tracing capacity across the country. We note that many (but not all) regions are currently served by Medical Reserve Corps (MRC), which connect community members to health departments to help bolster preparedness and response activities. This is a mechanism that should be strengthened, resourced, and leveraged to facilitate volunteer support for public health activities.

Training

Local health departments and their staff are uniquely positioned to train and manage any newly-added surge professional or volunteer workforce because they already do this work in their communities and are a trusted partner, allowing them to design and target the style of outreach to best reach their residents (including non-English speaking, communities distrustful of government, and other special populations). However, standing-up the significant number of contact tracers required to address COVID-19 will require funding and support to expand health department training capacity.

Capacity

Given global experience with contact tracing, as well as staffing needs at local, state, tribal, and territorial health departments across the many disciplines needed for contact tracing, we estimate a surge capacity of at least 100,000 individuals will be needed. This number is a baseline estimate based on a ratio of 30 professionals per every 100,000 Americans and will need to be revisited as we learn more about the virus and develop improved cases count estimates.

Distribution

While the overall number of the contact tracer surge workforce is critical, so too is how they are distributed across the country. COVID-19 is affecting every community across the country—large urban centers, the suburbs, as well as rural and frontier areas. Therefore, we strongly recommend a formula for distribution of the surge workforce that takes into account a baseline number of contact tracers as well as a per capita calculation to ensure that smaller communities are not inadvertently missed in this national effort to scale up contact tracing.

Supports and Services

Once a case is identified, contact tracers must reach out to those who may have been exposed to the confirmed case to have them self-quarantine for 14 days. Local health departments saw very early in the COVID-19 response that it is critical to have the services

and supports in place that make it easier for individuals to follow public health department directives. Therefore, clear, comprehensive wrap-around policies and services must be enacted, including:

- Safe housing for quarantine or isolation
- Paid time off
- Childcare
- Behavioral health services to address stress on the individual and family
- Access to essentials such as food, medications, laundry, etc.
- Transportation and/or access to routine medical care or emergency care
- Materials, such as a reliable thermometer, masks and gloves, and internet access

Resource Needs

Federal resources are needed to quickly ramp up surge capacity for contact tracing, as well as shore up the public health system that will support it. We will not be successful if we continue to ignore the underlying deficits in health departments that have plagued the response since it began. Local health departments budgets and workforce were hard hit by the 2008 recession, losing nearly 25% of their workforce since that time. This means fewer staff to pull from to respond to challenges like COVID-19, but also fewer employees in key roles for this response. Today, local health departments are already facing the budgetary impacts of reduced local and state tax revenues due to the economic impacts of the COVID-19 response, with health department staff being furloughed as funding evaporates.

Therefore, we recommend:

- **At least $3.7 billion in emergency supplemental funding to local, state, territorial, tribal, and federal public health agencies to support a force of at least 100,000 contact tracers.** This includes $100 million to scale up and support the MRC program to help facilitate volunteer support for this critical function (an average award of about $100,000 per MRC unit), as well as $3.6 billion to support the surge of contact tracers.

- **$200 million to enact and implement a loan repayment program for public health professionals** who agree to serve two years in a local, state, or tribal health department, which could support over 6,000 new hires in local and state health departments across the country. This is a critical mechanism to retain individuals who will gain important experience and expertise as part of the contact tracing surge stay in the health department workforce.

- **$4.5 billion in additional annual mandatory funding for local, state, tribal, and territorial core public health infrastructure,** in addition to existing annual discretionary appropriations. The contact tracing surge can only be as successful as the public health infrastructure that supports it. By building the core public health

infrastructure of localities, states, tribal governments, and territories the nation will be better prepared for the next threat.

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About NACCHO

The National Association of County and City Health Officials (NACCHO) represents the nation's nearly 3,000 local governmental health departments. These city, county, metropolitan, district, and tribal departments work every day to protect and promote health and well-being for all people in their communities. For more information about NACCHO, please visit www.naccho.org.

CONNECTICUT PUBLIC HEALTH ASSOCIATION

Statement in Recognition of Public Health Response to the COVID-19 Pandemic in Connecticut

The COVID-19 pandemic has abruptly and dramatically altered the lives and profoundly threatened the health of people throughout the world, including the population of Connecticut. Responses to the crisis across the globe and in our nation have been uneven, with competing assessments and visions of risk, scientific evidence and appropriate actions.

In Connecticut we have witnessed a conscientious and coherent response to the rapid spread of the pandemic, founded in effective leadership, reliance on proven expertise, inclusive deliberations, open communication and unwavering fidelity to available science. In recognition of this effort, the Officers, Directors, and Members of the *Connecticut Public Health Association* take this opportunity to recognize those responsible for public health and health care in our state, who are engaged in real-time management of a developing and evolving challenge. Specifically, the Association commends Governor Ned Lamont; Commissioner of the Connecticut Department of Public Health Renée D. Coleman-Mitchell; the entire staff of the Connecticut Department of Public Health; the Directors who lead and the public health professionals who work in local health departments throughout the state; hospitals and healthcare agencies; and the uncountable members of the healthcare workforce for their determined, humane and unrelenting response to the novel coronavirus.

To all of these individuals, and others whom we have neglected to name,
who stand at the front line in ongoing efforts to protect the residents of Connecticut:

We thank you for your commitment and diligence. At every level of assessment, planning and implementation you are functioning admirably under the most difficult of conditions. As guardians and caregivers, you have demonstrated strength and determination by acting swiftly and boldly to attend to those who are already sick and to prevent illness in those who are well—doing so with little rest or care for yourselves. We acknowledge that your decisions and actions have been singularly focused on the health of Connecticut, with the priority of keeping the population safe. The *Connecticut Public Health Association* supports your work and believes the public must be made aware of your untiring and outstanding efforts that conform to the latest available scientific evidence, knowledge of the emerging disease and best practices for public health.

Signed, on behalf of the Association,

Jonathan Noel, PhD, President

4/3/2020
Date