Eastern Highlands Health District
Board of Directors Regular Meeting*
Agenda
Thursday October 20, 2022, 4:30 PM
1712 Main Street, Coventry
Town Hall Annex

Call to Order

Approval of Minutes (August 18, 2022)

Public Comments

Old Business – None

New Business

1. Proposed 2023 Regular Meeting Schedule

Subcommittees

2. Finance Committee – Proposed FY 2022/2023 Budget Changes
3. Personnel Committee – Director of Health performance evaluation

Town Reports

Directors Report

4. Changes to Private Well Testing Laws – CGS Sec. 19a-37
5. Implementing Overdose Prevention Strategies at the Local Level – NACCHO Grant
6. Uganda Ebola Outbreak- Local health department response to travelers
7. Staffing update (no attachment)
8. COVID-19 Response Activity Update

Communications/other

9. NBC CT re: Well Water Woes: Report Breaks Down Salt Intrusion Caused in Neighborhood
10. DPH re: Reinstatement of Licensing Renewal Requirements
11. BrownGreer, Directing Administrator re: National Opioid Settlements – Allocation Notice
12. DPH re: Monkeypox Information (for schools & daycares)
13. DPH re: Stage 3 Drought Declaration for Windham and New London Counties
14. Ray Sullivan, MD re: Lamont's "Hero Pay" Bonus Snubs Local Public Health Employees

Executive Session – Personnel in accordance with CGS 1-200(6)(a), Director of Health Performance Review

15. Director of Health Performance Evaluation, Action

Adjournment

Next Board Meeting – December 8, 2022 (FY 23/24 budget presentation)

***Virtual Meeting Option:** In accordance with PA 22-3, this will be a hybrid meeting. Please email mbrosseau@ehhd.org or call 860-429-3325 by 3:00 PM on the day of the meeting to receive instructions for how to view, listen, or comment live. A video recording of the meeting will be available at EHHD.ORG within seven (7) days after the meeting.

Public comment will be accepted by email at mbrosseau@ehhd.org or by USPS mail at 4 South Eagleville Road, Mansfield, CT 06268 and must be received by 3:00 PM on the day of the meeting to be shared at the meeting (public comment received after the meeting will be shared at the next meeting).

Eastern Highlands Health District
Board of Directors Regular Meeting Minutes – Draft
Coventry Town Hall Annex
Thursday, August 18, 2022

Members present:

In Person J. Elsesser (Coventry), J. Rupert (Bolton) D. Walsh (Coventry)

Virtual R. Aylesworth (Mansfield), H. Evans (Mansfield), T. Nuccio (Tolland), S. Powers (Scotland), M. Walter (Columbia)

Staff present: R. Miller, M. Brosseau, K. Dardick (virtual)

J. Elsesser opened the meeting at 4:30PM

D. Walsh made a MOTION, seconded by T. Nuccio to approve the minutes of the June 16, 2022 meeting as presented. MOTION PASSED with H. Evans and J. Rupert abstaining.

Per Capita Grant in Aid Funding Application for SFY 2023

R. Miller provided an overview of the grant and the use of funding.

D. Walsh made a MOTION, seconded by M. Walter to authorize the execution and submittal of the Eastern Highlands Health District's Fiscal Year 2022/2023 State of Connecticut Department of Public Health Per Capita Funding Application as presented August 18, 2022. MOTION PASSED unanimously.

Tolland Employee Wellness Service Agreement – Ratification

T. Nuccio made a MOTION, seconded by D. Walsh to ratify the Town of Tolland/Eastern Highlands Health District Employee Wellness Service Agreement, as presented August 18, 2022. MOTION PASSED unanimously.

Town Reports

Columbia M. Walter informed the board that the Economic Development Commission and Planning and Zoning department are working together to review the regulations and discuss how to make them easier to understand for people who want to do business in Columbia.

Scotland S. Powers following reported that a new garage has been built for Public Works.
S. Powers informed the board that Scotland and Canterbury are looking at combining ambulance services.
S. Powers noted that Scotland and Hampton are in discussions to merge the elementary schools.
S. Powers reported that drought conditions have resulted in at least one house in Scotland losing fresh water.

Mansfield
R. Aylesworth reported that movement forward continues on the completion of the consolidated elementary school.
R. Aylesworth informed the Board that Phase 1 of Mansfield facilities needs assessment has been completed.

Bolton J. Rupert informed that board that the Bolton Board of Selectmen has expressed interest in having him remain in the role of Town Administrator permanently.

J. Rupert reported that the town of Bolton has been experiencing staff shortages and are finally back to full staff.

J. Rupert was happy to report that there were no issues with Bolton Lake this year.

Coventry J. Elsesser reported that Coventry Lake had a Health Advisory in place for 18 days due to blue-green algae. The condition of the lake is improving. They continue to watch the thermocline change.

J. Elsesser noted that he been asked to speak at an International City Managers Association panel on regional health districts.

J. Elsesser provided an update on the project to tie into Bolton sewers.

J. Elsesser noted that money is expected for a facilities plan to look at the current sewer plant.

J. Elsesser reported that the town is building a new transfer station.

J. Elsesser informed the board that the town is working with Hytone Farm on a food recycling plan. Hytone farm has an anaerobic digester and will be processing food waste around town.

J. Elsesser noted that capital projects include softball fields, addressing ADA and equity issues; methane venting at old landfill; Roof replacement at the High School and Robertson School.

J. Elsesser expressed sadness that the Channel 3 Kids Camp has closed and is going up for sale.

Finance Committee Report

R. Miller reported that the finance committee met prior to the full board meeting where they reviewed and accepted the report for the period ending 6/30/2022.

J. Elsesser noted that the finance committee will be meeting prior to the next Board meeting to discuss possible amendments to the budget.

Personnel Committee Report

R. Aylesworth presented an overview of the timeline for conducting the annual review of the Director of Health.

Directors Report

Monkeypox – LHD role/responsibilities

R. Miller presented a brief overview of Monkeypox in Connecticut and the roles and responsibilities of local health.

Dr. Dardick noted that nationally and internationally cases continue to rise. There are 2 vaccines and diagnostic test available.

COVID-19 Response Activities Report - Update

R. Miller noted that the district is seeing an extended plateau in the weekly case counts.

Dr. Dardick reported that they are still receiving calls in his office from people who have tested positive at home.

T. Nuccio inquired about school guidance and whether it has been provided to schools. R. Miller informed the board that the state has issued guidance. R. Miller noted that the clinic office staff have met to review and discuss the document to be ready to provide the best guidance and support to the schools.

NACCHO Annual Conference

R. Miller gave a brief overview of the NACCHO annual conference he attended.

Staff Vacancies
R. Miller reported that the position of Public Health Emergency Coordinator and the field staff vacancy have been filled. The field staff vacancy has been filled with as an entry level position.

Quarterly activity report, period ending 6/30/22

R. Miller noted the highlights of the quarterly activity report.

CT DPH re: Status of FDA Food Code Regulations

R. Miller informed that board that while this is still moving forward there is still uncertainty in the timeline of final implementation.

J. Rupert made a MOTION, seconded by D. Walsh to adjourn at 5:55pm. MOTION PASSED unanimously.

Next Board Meeting – October 20, 2022, 4:30 PM

Respectfully submitted,

Robert Miller
Secretary

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: 10/12/2022

Re: Proposed 2023 Regular Meeting Schedule

Respectfully submitted for your review and approval is the proposed regular meeting schedule for 2023 calendar year:

January 19 (Typically, Budget Public Hearing)

February 16

April 20

June 15

August 17

October 19

December 14

The time of each meeting will be scheduled for 4:30 pm. The Coventry Town Hall Annex will be booked as the physical location for these meetings, with the understanding that a virtual option may be provided for these meetings until such time board leadership determines it is appropriate go back to full in-person meetings. (With the exceptions of December 14, all dates fall on the third Thursday of the Month.)

Recommended Motion: Move to adopt the Eastern Highlands Health District Board of Directors 2023 regular meeting schedule as presented.

Eastern Highlands Health District

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Memo

To: Board of Directors
Cc: Charmaine Bradshaw-Hill, Director of Finance
From: Robert Miller, Director of Health
Date: October 17, 2022
Re: Proposed FY 22/23 Budget Changes

Background

Due to changes in staffing enrollment, and a lower than anticipated actual premium rate the FY22/23 adopted appropriation for the Medical Insurance account is $34,335 higher than the final calculated figure.

To address this and adjust our operating budget accordingly, attached for your review is a cover memorandum to the Finance Committee, and a budget document detailing proposed FY22/23 budget changes. These changes are driven by the following:

Revenues
- A proposal to adjust the member town per capita assessment *holding it flat to the FY21/22 rate* at $5.685
- Reduction of $21,217 in the appropriation from fund balance needed to balance the FY22/23 operating budget

Expenditures
- Decrease of $34,335 in the Medical Insurance account

Recommendation

At an October 12, 2022 special meeting and after a discussion regarding the above matter, the Finance Committee passed the following motion, "Move, *to recommend the full board approve the changes to the FY22/23 operating budget as presented on October 12, 2022, with total authorized spending of $927,862."*

If the board concurs with this recommendation, then the following motion is in order: *Move, to approve the changes to the FY22/23 operating budget as presented on October 20, 2022, with total authorized spending of $927,862.*

Eastern Highlands Health District

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Memo

To: Finance Committee

Cc: Charmaine Bradshaw-Hill, Director of Finance

From: Robert Miller, Director of Health

Date: October 12, 2022

Re: Proposed FY 22/23 Budget Changes

Attached for your review, and consideration is a document detailing proposed FY22/23 budget changes. These changes include:

Revenues
- A proposal to adjust the member towns per capita assessment *holding it flat to the FY21/22 rate*.
- Reduction in appropriation from fund balance needed to balance the FY22/23 operating budget.

Expenditures
- Decrease in Health Insurance premiums that occurred after the budget was adopted.

If the Finance Committee Concurs with the proposed changes, then the following motion is in order: *Move, to recommend the full board approve the changes to the FY22/23 operating budget as presented on October 12, 2022, with total authorized spending of $927,862.*

Eastern Highlands Health District
Summary of Revenues and Expenditures for FY22/23

Fund: 634 Eastern Highlands Health District
Activity: 41200

Object	Description	Adopted Budget 22/23	Change 22/23	Proposed Amendment 22/23
Revenues:				
40220	Septic Permits	48,950		
40221	Well Permits	12,590		
40491	State Grant-In-Aid	206,500		
40630	Health Inspec. Service Fees	3,500		
40633	Health Services-Bolton	28,480	(810)	27,670
40634	Health Services-Coventry	71,590	(2,020)	69,570
40635	Health Services-Mansfield	151,420	(4,280)	147,140
40636	Soil Testing Service	48,830		
40637	Food Protection Service	80,000		
40638	B100a Review	18,480		
40639	Engineered Plan Rev	28,150		
40642	Health Services - Ashford	24,480	(688)	23,792
40643	Health Services - Willington	32,570	(920)	31,650
40645	Nonengineered Rev	-		
40646	GroupHome/Daycare inspectior	1,200		
40647	Subdivision Review	1,500		
40648	Food Plan Review	2,500		
40649	Health Services - Tolland	85,130	(2,400)	82,730
40685	Health Services - Chaplin	12,520	(350)	12,170
40686	Health Services - Andover	18,420	(520)	17,900
40687	Health Services - Columbia	30,790	(870)	29,920
40688	Health Services - Scotland	9,220	(260)	8,960
	Cosmotology Inspections	6,800		
40999	Appropriation of Fund Balance	38,577	(21,217)	17,360
	Total Revenues	962,197	(34,335)	927,862

Expenditures:				
51050	Grant deductions	(63,514)		
51601	Regular Salaries - Non-Union	648,735		
52001	Social Security	40,560		
52002	Workers Compensation	11,000		
52007	Medicare	9,485		
52010	ICMA (Pension)	33,354		
52103	Life Insurance	2,830		
52105	Medical Insurance	156,610	(34,335)	122,275
52117	RHS	2,400		
52112	LTD	697		
52203	Dues & Subscriptions	2,100		
52220	Vehicle allowance	5,400		
52210	Training	3,500		
52212	Mileage Reimbursement	600		
53120	Professional & Tech	7,845		
53122	Legal	3,000		
53125	Audit Expense	6,900		
53303	Vehicle Repair & Maintenance	2,500		
53801	General Liability	14,800		
53924	Advertising	1,000		
53925	Printing & Binding	1,150		
53926	Postage	1,500		
53940	Copier maintenance	1,000		
53960	Other Purchased Services	20,475		
53964	Voice Communications	4,850		
54101	Instructional Supplies	800		
54214	Books & Periodicals	200		
54301	Office Supplies	2,000		
54601	Gasoline	2,500		
55420	Office Equipment	3,000		
55430	Equipment - Other	600		
56302	Admin. Overhead	31,320		
56303	Other General Expenditures	-		
56312	Contingency	-		
58410	Capital Nonrecurring Fund	3,000		
	Total Expenditures	962,197	(34,335)	927,862

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

ENVIRONMENTAL HEALTH AND DRINKING WATER BRANCH

EHDW Circular Letter #2022-60

TO: Commercial Environmental Laboratories, Local Health Directors, Connecticut Association of Realtors

FROM: Lori J. Mathieu, Branch Chief Lori J. Mathieu '22

DATE: 10/05/2022

SUBJECT: Changes to Private Well Testing Laws – CGS Sec. 19a-37

Section 60 of Public Act 22-58 made various revisions to Section 19a-37 of the Connecticut General Statutes, which are the laws for testing of private wells and semipublic wells. Provided below is a list of key changes that are required of the new law, effective October 1, 2022.

- Any laboratory or firm that conducts testing on a private well serving a residential property or a semipublic well shall report the results within 30 days to the local health department where the well is located. The law previously only required results associated with a real estate transaction to be reported; however with the current changes effective 10/1/22, all results need to be reported.

- The law requires that results need to be reported to the Department of Public Health (DPH), in a format prescribe by the Department. Effective 10/1/22, commercial laboratories that are approved to test drinking water need to continue to send results all results for private wells and semipublic wells to the local health department and to DPH using a newly created email address: DPH.PrivateWellTestResults@ct.gov. Please include the property address in the subject line of the email.

  Please note that emailing lab reports to DPH for private and semipublic wells is an interim measure. DPH is actively working on developing an electronic reporting database for reporting of results for private and semipublic wells to DPH. DPH will be coordinating a meeting with Commercial Environmental Laboratories that conduct testing of private and semipublic wells before the end of the year. The meeting will outline the timeframe when Commercial Environmental Laboratories will be expected to start using the new electronic reporting database for reporting results to DPH for private and semipublic wells.

- The law makes the reported test results confidential, as well as any information obtained from a DPH or local health department investigation concerning the reported results, or any DPH or local health department study of the reported results.

- As of 10/1/22, the law requires all newly constructed private or semipublic wells to be tested for coliform, nitrate, nitrite, sodium, chloride, iron, lead, manganese, hardness, turbidity, pH, sulfate, apparent color, odor, arsenic, and uranium. Required testing for arsenic, uranium, and lead were added to the list of tests that were previously required of newly constructed wells. Testing for lead should be done within the plumbing system of the building supplied by the private or semipublic well. Property owners are required to report results of newly constructed wells to DPH.
    - Lab reports with results from newly constructed private wells and semipublic wells can be emailed to DPH.PrivateWellTestResults@ct.gov. The email subject should include the property address and the words "New well test results" to allow DPH staff to distinguish between results from an existing well or a newly constructed well that was recently tested for the first time.

- The law now requires a real estate licensee to provide educational materials on private well testing to a prospective buyer or tenant if the property owner has hired a real estate licensee to facilitate a property transaction. If a real estate licensee has not been hired, then the property owner is responsible for providing educational materials on private well testing. The educational materials need to include information on testing for coliform, nitrate, nitrite, sodium, chloride, iron, lead, manganese, hardness, turbidity, pH, sulfate, apparent color, odor, arsenic and uranium and any other recommendation concerning well testing that the Department of Public Health deems necessary. Recommendations for private well testing are available on the Department's Private Well Program webpage: https://portal.ct.gov/DPH/Environmental-Health/Private-Well-Water-Program/Private-Well-Testing

Please contact the DPH Private Well Program by calling 860-509-8401 or through email DPH.PrivateWellProgram@ct.gov with any questions.

c: Heather Aaron, MPH, LNHA, Deputy Commissioner, DPH
Jim Vannoy, Section Chief, Environmental Health Section
Ryan Tetreault, Supervisor, DPH Private Well Program

Robert L. Miller

From: Robert L. Miller
Sent: Wednesday, October 5, 2022 4:43 PM
To: Tetreault, Ryan; Mathieu, Lori
Cc: 'DPH.privatewellprogram@ct.gov'; D'Amore, Deanna (DDAmore@norwalkct.org); Lisa Morrissey; Trent Joseph; 'Tanguay, Veronica'; Lynette S. Swanson; John Elsesser
Subject: FW: EHDW Circular Letter #2022-60 : Changes to Private Well Testing Laws – CGS Sec. 19a-37
Attachments: EHDW_CL-2022-60_Changes_19a-37_Private_Well_+SemiPublic_Well_Testing_Laws.pdf

Hi Ryan and Lori – While I have other questions regarding this new statute, there is one pressing issue that has immediate implications on how we at the LHD receive, manage, and store information. Specifically, I am referring to the provision in ***PA 22-58 that establishes all private well water test results submitted to the LHD as confidential information pursuant to CGS section 19a-25***. I and my LHD colleagues have number of questions on this matter. Questions from other LHD may be passed on in due course. Below are the questions I have for you in the interim:

- Base on the reading of the PA 22-58, only test results submitted to a LHD by a "laboratory or firm" are considered confidential. Therefore, does that mean that test results submitted by others (e.g. CT DEEP, property owner, restate agent, well driller, builder, or anyone else) to the LHD are not considered confidential?

- If a test result submitted by an entity other than a "laboratory or firm" is considered confidential, then pursuant to 19a-25 the LHD cannot consult or confer with that entity (e.g. prospective buyer) or any other entity on the interpretation/implications of those specific confidential test results, correct?

- With few exceptions, CGS 19a-25 prohibits LHD from disclosing any protected information to any other entity, other than CT DPH. What are the implications for any test results we provide CT DEEP? Can we confer with and provide such results to DEEP or any other state agency knowing that any such results obtained by DEEP then become public information; and, are therefore no longer protected by 19a-25?

- A similar concerns exists for private wells serving in home daycares. Can we confer and share this information with OEC?

- How does this affect a recently passed Public Act which requires LHD to provide NaCl test results to CT OPM? These public acts appear to be in conflict. Please advise.

- Is a LHD permitted to confer with and provide test results to a local building officials seeking evidence that the private water supply well complies with the Residential Building Code?

- Is a LHD permitted to confer with and provide test results to a prospective property buyer, or their representative, seeking to make an informed decision on a property purchase?

- If a private well test result submitted in accordance with PA 22-58 exceeds the standards set forth by Sec 19-13-101, which constitute a violation of the CT public health code, is the resulting notice of violation issued to the property owner that cites the test result still protected information under 19a-25?

- Is a LHD permitted to confer with and provide test results to the current owner of the property, and/or the tenant? And if so, what would be the recommended way to confirm that status? Can we provide such results to a representative of the owner, or tenant? If so, what would be the recommended way to confirm that status?

- LHD's have decades of private well results stored in hard copy street files, and electronic databases. Does PA 22-58 apply retroactively to water test result information submitted prior to October 1, 2022? If such older results are considered confidential, and assuming that results not submitted by a "laboratory or firm" are not confidential as suggested above, then how do we treat older results in which there is no record of who made the submission?

Establishing private well test results as confidential pursuant to the 19a-25 constitutes a paradigm shift in how LHD process and manage this information. Such information has been in the public realm for decades. Pending the answers to the above questions, implementing this new statute may poses challenges for LHD that will require a process to overcome, which would take time.

Given that this law is effective October 1st, and drives many of our day to day routine services and activities, any effort to expedite answers to the above questions would be greatly appreciated.

Respectfully,
Rob

Robert L. Miller, MPH, RS
Director of Health
Eastern Highlands Health District
4 South Eagleville Road
Storrs, CT 06268
860-429-3325
860-429-3321 (Fax)
Twitter: @RobMillerMPH
www.ehhd.org

In order to prevent the spread of COVID-19 stay home and get tested if you're sick, and stay up to date with COVID-19 vaccines. For the most current updates and recommendations, visit ct.gov/coronavirus.

EHHD
Eastern Highlands Health District

Preventing Illness and Promoting Wellness in the Communities We Serve

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From: Lori.Mathieu@ct.gov [mailto:noreply@everbridge.net]
Sent: Wednesday, October 5, 2022 9:52 AM
To: Robert L. Miller <MillerRL@ehhd.org>
Subject: EHDW Circular Letter #2022-60 : Changes to Private Well Testing Laws – CGS Sec. 19a-37

Eastern Highlands Health District

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

September 8, 2022

Patrice A. Sulik, Director of Health
North Central District Health Department
31 North Main Street
Enfield, CT 06082

RE: Letter of Support: NACCHO Funding, Implementing Overdose Prevention Strategies at the Local Level (IOPSLL)

Dear Patrice,

On behalf of the Eastern Highlands Health District (EHHD), I fully support the North Central District Health Department's application for funding for the prevention of opioid abuse in Windham and Mansfield. In addition to our past collaborations through our joint service on the Board of the Connecticut Association of Directors of Health (CADH), we routinely collaborate on public health emergency preparedness in our shared region. During the height of COVID response, we partnered on a Vaccine Equity Program Funding grant to ensure access to vaccine for our most underserved. We look forward to the opportunity to collaborate on the critical topic of opioid misuse/abuse.

The IOPSLL grant program offers us the opportunity to put "boots on the ground" as well as to share data and best practices with other towns and health departments/districts, and ultimately improve the capacity to prevent opioid misuse in our community. EHHD will participate on the Opioid Advisory Group for the grant, engage in the messaging campaign to our broader community and facilitate Narcan training within our jurisdiction.

The new IOPSLL funding will enhance our ability to reach the underserved, at-risk populations in our community, and I look forward to a favorable review of your application.

Best of luck with your proposal!

Sincerely,

Robert L. Miller
Director of Health

North Central District Health Department

Enfield—31 North Main Street, Enfield, CT 06082 * (860) 745-0383 Fax (860) 745-3188
Vernon—375 Hartford Turnpike, Room 120, Vernon, CT 06066 * (860) 872-1501 Fax (860) 872 1531
Windham—Town Hall, 979 Main Street, Willimantic, CT 06226 * (860) 465-3033 Fax (860) 465-3034
Stafford—Town Hall, 1 Main Street, Stafford Springs, CT 06076 * (860) 684-5609 Fax (860) 684-1768

Patrice A. Sulik, MPH, R.S.
Director of Health

FOR IMMEDIATE RELEASE:

DATE: October 14, 2022
CONTACT: PATRICE SULIK
860-745-0383, x117

North Central District Health Department Receives $300,000 Opioid Abuse Prevention Grant, "Implementing Overdose Strategies at the Local Level"

The North Central District Health Department (NCDHD) was awarded a grant to address opioid abuse and overdoses. This opportunity was made possible by the National Association of County and City Health Officials (NACCHO), a national non-profit association representing nearly 3,000 local health departments in the United States, including city, county, metro, district, and tribal agencies. The Health District was 1 out of 15 grants awarded nationwide.

The funding will be utilized for a collaborative effort to provide substance abuse and overdose prevention services within NCDHD's Member-Towns; East Windsor, Ellington, Enfield, Stafford, Suffield, Vernon, Windham, and Windsor Locks, as well as towns served by the Eastern Highlands Health District and Manchester Health Department. Hartford Healthcare and the CT Harm Reduction Alliance are also partners in this project. The project team will include local prevention councils, Member-Town first responders, and Public-School Superintendents.

According to the Connecticut Department of Public Health, there have been 692 drug overdose deaths since 2015 in the communities targeted under the proposed project. Over 50% percent of those deaths were reported since 2019. The number of fatal drug overdoses in the target area has increased 2-fold since 2019. Approximately 71% of the fatal overdose deaths occurred among individuals residing in Enfield, Manchester, Mansfield, Vernon, Tolland, and Windham.

"This proposal was successful due to the partners that stepped up to work with us", stated Patrice Sulik, NCDHD Director of Health. "This award also provides us with the opportunity to remind people about National Drug Take Back Day on October 29th . We encourage everyone to dispose of expired or unused medications at an approved drop box in the region".

This project will focus on four strategy areas: surveillance and data sharing, partnership with public safety and first responders, a communications campaign, and harm reduction.

"The Health District has been combatting opioid abuse for several years; this funding will support increased prevention activities in the region and increase our capacity to collaborate with first responders and local prevention councils," said NCDHD Board Chair Diane Wheelock.

About NCDHD

The North Central District Health Department (NCDHD) serves the communities of Enfield, East Windsor, Ellington, Stafford, Suffield, Vernon, Windham, and Windsor Locks. NCDHD is a full-time public health department with a full-time staff funded by its member towns and an annual per capita grant from the Connecticut State Department of Public Health. NCDHD provides professional public health services in the areas of health education and disease prevention, environmental health, and emergency preparedness. The mission of NCDHD is to prevent disease, injury, and disability by promoting and protecting the health and well-being of the public and our environment.

For more information about NCDHD visit www.ncdhd.org.

Interim Guidance on Risk Assessment and Management of Persons with Potential Ebola Virus Exposure

Updates to this guidance

October 7, 2022: Updated to incorporate guidance issued in response to the outbreak of *Sudan ebolavirus in Uganda* for which health departments are recommended to follow-up with travelers.

Specific updates include:

- Guidance for monitoring persons with no known high-risk exposures
- Travel guidance for persons being monitored who have no known high-risk exposures

Key Points

- If certain triggers are met, CDC may recommend public health risk assessment and post-arrival management of travelers from countries with Ebola virus disease (EVD) outbreaks to mitigate the risk of potential imported cases.
  - Recommendations below reflect guidance issued in response to the 2022 outbreak of *Sudan ebolavirus* in the Republic of Uganda.
- For U.S.-based healthcare or emergency response workers returning from EVD outbreak countries, health departments may elect to delegate post-arrival management to the response worker's sponsoring organizations. CDC has issued separate guidance for this purpose.
  - If monitoring is conducted by a sponsoring organization, it should be in accordance with guidance below.

Who is this guidance for?

- State, territorial, tribal, and local health departments

What is the purpose of this guidance?

- To provide U.S. health departments minimum expectations and guidance for post-arrival management of travelers arriving in their jurisdictions from countries with EVD outbreaks

Introduction

If certain triggers are met, CDC may recommend public health risk assessment and post-arrival management of travelers from countries with Ebola virus disease (EVD) outbreaks to mitigate the risk of spread by facilitating early identification and management of potential imported cases. Triggers will be based on various factors including but not limited to the size of the outbreak, the volume of air travel between the outbreak country and the United States, and border health measures implemented in the outbreak country. To facilitate the recommended risk assessment and management, CDC will provide contact information for air passengers from countries with Ebola outbreaks to U.S. health departments.

On September 20, 2022, the Ugandan Ministry of Health confirmed an outbreak of EVD (Sudan virus) in Mubende District, in central Uganda. This guidance provides specific recommendations for post-arrival risk assessment and management of travelers from Uganda as part of the domestic U.S. response to this outbreak.

Definitions

Ebola outbreak area means a geographic area where Ebola virus transmission has occurred in the previous 42 days, as determined by surveillance conducted by national health authorities, NGOs, and the World Health Organization (WHO). The list of designated outbreak areas for which CDC recommends post-arrival risk assessment and management of travelers will be maintained according to available information (Box 1). CDC will notify health departments of any changes to the list.

Close contact means being within approximately 3 feet (1 meter) of a person with symptomatic EVD while not wearing recommended personal protective equipment (PPE).

Direct contact means physical contact with a person with EVD (alive or dead) or with objects contaminated with the body fluids of a person with EVD (alive or dead) while not wearing recommended PPE.

Person Under Investigation (PUI) for EVD is defined as on this webpage.

Public health orders are legally enforceable directives issued under the authority of a relevant federal, state, or local entity that, when applied to a person or group, may place restrictions on the activities undertaken by that person or group, potentially including movement restrictions or a requirement for monitoring by a public health authority, for the purposes of protecting the public's health. Federal public health orders may be issued to enforce isolation, quarantine or conditional release. The list of quarantinable communicable diseases for which federal public health orders are authorized is defined by Executive Order and includes EVD.

Isolation means the separation of a person or group of people reasonably believed to be infected with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease. A person could be reasonably believed to be infected if he or she displays the signs or symptoms of the communicable disease of concern and there is some reason to believe that an exposure had occurred. Isolation for public health purposes may be voluntary or compelled by federal, state, or local public health order.

Quarantine in general means the separation of a person or group of people reasonably believed to have been exposed to a communicable disease, but not yet symptomatic, from others who have not been so exposed, to prevent the possible spread of the communicable disease.

International Air Passenger Contact Information

CDC will obtain contact information for travelers from countries with Ebola outbreaks and provide it electronically to health departments through established secure mechanisms.

Risk Assessment and Post-arrival Management

Health departments should establish contact with travelers arriving in their jurisdictions from a country with an Ebola outbreak to conduct an initial assessment of exposure risk, provide health education, conduct symptom monitoring (as specified below), and track overall success in monitoring incoming travelers, according to resources available in the jurisdiction. The initial assessment should occur as soon as feasible, ideally within 24 hours of receiving CDC's notification of the traveler's arrival. A summary of these recommendations is provided in the table below.

CDC has issued separate guidance for organizations sending US-based healthcare or emergency response workers to areas with Ebola outbreaks, including recommendations for a structured pre-departure assessment and post-arrival management. Health departments that maintain contact with these organizations may elect to accept risk assessment and/or monitoring of these workers by the sponsoring organization; they may also request updates from the sponsoring organization or assume direct responsibility for risk assessment and/or monitoring of these workers. If monitoring is conducted by the sponsoring organization, it should be in accordance with guidance below.

Box 1. Designated Ebola Outbreak Areas as of October 7, 2022

See map for designated outbreak area in Uganda.

For questions about potential exposures in individual travelers, including those outside of designated outbreak areas, health departments may contact CDC's Viral Special Pathogens Branch (VSPB) by calling the Emergency Operations Center (770-488-7100) and asking to speak to VSPB's on-call epidemiologist, or by emailing spather@cdc.gov.

Box 2. High-risk Exposure Definition

- Percutaneous (i.e., piercing the skin), mucous membrane (e.g., eye, nose or mouth), or skin contact with blood or body fluids[1] of a person with known or suspected EVD
- Direct contact with person who has known or suspected EVD
- Providing health care to a patient with known or suspected EVD without use of recommended personal protective equipment (PPE)[2], or experiencing a breach in infection control precautions that results in the potential for percutaneous, mucous membrane, or skin contact with the blood or body fluids of a patient with EVD while working in an Ebola treatment hospital or associated facility (e.g., laboratory) or while taking care of a patient with EVD
- Direct contact with or the occurrence of a breach in infection control precautions while handling a dead body in an Ebola outbreak area, the body of a person who died of EVD or had an illness compatible with EVD, or who died of unknown cause after any potential exposure to Ebola virus
- Living in the same household as a person with symptomatic known or suspected EVD

[1] Body fluids include but are not limited to feces, saliva, sweat, urine, vomit, sputum, breast milk, tears and semen.

[2] Recommended PPE should be sufficient to prevent skin or mucous membrane exposure to blood or body fluids. State and local authorities have primary jurisdiction for isolation and other public health orders within their borders. Federal public health authority primarily extends to international arrivals at ports of entry and to preventing interstate spread of communicable diseases.

State and local authorities have primary jurisdiction for isolation and other public health orders within their borders. Federal public health authority primarily extends to international arrivals at ports of entry and to preventing interstate spread of communicable diseases.

CDC recognizes that decisions and criteria to use such public health measures may differ by jurisdiction. Consistent with principles of federalism, state and local jurisdictions may choose to make decisions about isolation, other public health orders, and monitoring that provide a greater level of public health protection than recommended in federal guidance.

Risk Assessment

An initial risk assessment for Ebola virus exposure should include whether the traveler:

- was present (other than just transiting en route to airport) in a designated Ebola outbreak area (see Box 1)
- had any epidemiologic risk factors for exposure to Ebola virus or a person with EVD, e.g., as a caregiver, healthcare provider, laboratory worker, or burial worker
- used personal protective equipment and other recommended infection control measures during any potential exposure
- had any potential high-risk exposures (see Box 2)

A sample exposure screening and assessment tool is available here. [PDF – 2 pages]

Travelers should also be assessed for signs and symptoms of EVD during the initial evaluation.

Health departments can consult CDC's Viral Special Pathogens Branch (VSPB, call CDC's Emergency Operations Center [770-488-7100] and ask to speak to VSPB's on-call epidemiologist or email spather@cdc.gov) if they identify symptomatic or potentially exposed travelers. CDC requests notification regarding any travelers identified with potential high-risk exposures.

Health Education

Health departments should ensure all travelers from a country with a designated Ebola outbreak know:

- know the signs and symptoms of EVD
- to self-isolate immediately if symptoms develop
- how to notify public health officials should symptoms develop

CDC has posted After Travel recommendations for travelers from countries with Ebola outbreaks (available in English and French). Health departments may choose to use this resource as part of their health education activities.

Monitoring and Other Public Health Interventions

Health departments should conduct symptom monitoring for people with potential Ebola virus exposure by phone, video conferencing, other electronic means (e.g., text message, email, app, web form), or in person, according to resources available in that jurisdiction. The frequency of monitoring should be guided by the results of the risk assessment, as specified below.

High-risk Exposures

People with high-risk exposures (see Box 2) should be:

- Quarantined
- Monitored daily
- Restricted from traveling by commercial transport

CDC requests notification regarding any individuals identified with high-risk exposures. To make these notifications, health departments should call CDC's Emergency Operations Center (770-488-7100) and ask to speak to the on-call epidemiologist for the Viral Special Pathogens Branch, or email spather@cdc.gov. See additional information in the section below.

Presence in a Designated Ebola Outbreak Area but no High-risk Exposures

People who have been in a designated Ebola outbreak area (see Box 1) within the previous 21 days should be monitored for symptoms at least **twice weekly** until 21 days after they departed Uganda.

Presence in Country with Ebola Outbreak but not in Designated Outbreak Area

People who were present in Uganda but not in a designated outbreak area and who have no other epidemiologic risk factors should be monitored at least **weekly** until 21 days after they departed Uganda.

Travel by People with No Known High-risk Exposures

People who are being monitored, have **no high-risk exposures**, and are **asymptomatic**, do not need movement restrictions and may travel. If they plan to travel to another jurisdiction during the 21-day monitoring period, they should notify the monitoring health department. The health department should notify the destination health department (for travel within the United States). The two health departments should agree as to whether responsibility for monitoring will be transferred, depending on the timing within the 21-day period and the duration of travel.

Table. Summary of Post-arrival Management Recommendations for Asymptomatic Travelers by Exposure Category

Intervention	Reported High-risk Exposure	Present in Designated Outbreak Area	Present in Outbreak Country but not Designated Outbreak Area
Initial Risk Assessment	Yes	Yes	Yes
Health education	Yes	Yes	Yes
Symptom monitoring	Daily	At least twice weekly until 21 days after departure from Uganda	At least weekly until 21 days after departure from Uganda
Movement restrictions	Quarantine	None	None
Travel	Not permitted	Advance notification to health department and coordination with destination health department	Advance notification to health department and coordination with destination health department

Symptomatic people with suspected or confirmed EVD, and asymptomatic travelers with reported high-risk exposures

Health departments should conduct an assessment of any potentially exposed person with signs or symptoms compatible with EVD to determine if the definition for person under investigation (PUI) for EVD is met and coordinate additional medical evaluation as needed. The purpose of the public health assessment is to ensure appropriate infection control precautions are in place during transport and at the healthcare facility for a patient who meets the definition of PUI for EVD. The assessment is also intended to minimize potential unintended consequences in managing a symptomatic traveler as a PUI if the exposure risk is very low, including unnecessary implementation of infection control precautions suitable for EVD or delayed recognition and management of other potentially life-threatening conditions while ruling out EVD. CDC has published clinical guidance for assessing viral hemorrhagic fever risk in an international traveler.

If a diagnosis of EVD is considered, state/local public health officials should coordinate with CDC to ensure appropriate precautions are taken to help prevent potential spread of EVD and to arrange for testing. As a resource for public health departments, CDC's Viral Special Pathogens Branch (VSPB) is available 24/7 for consultations regarding suspected viral hemorrhagic fever or EVD cases by calling the CDC Emergency Operations Center at 770-488-7100 and requesting VSPB's on-call epidemiologist, or by emailing spather@cdc.gov.

Symptomatic people with suspected or confirmed EVD should remain in isolation until they have been determined not to have EVD (if suspected) or to be no longer infectious (if confirmed). Asymptomatic people with high-risk exposures to Ebola virus (see Box 2) should remain in quarantine until 21 days after their last high-risk exposure. Quarantine or isolation may be voluntary or under public health orders, at the discretion of the health department of jurisdiction. Health departments may request use of federal public health travel restrictions for individuals with suspected or confirmed EVD or with high-risk exposure, if they intend to travel before being cleared to do so by public health authorities, by contacting the CDC quarantine station with jurisdiction for the area where the person is located.

People with suspected (i.e., meets PUI definition) or confirmed EVD, and asymptomatic persons with high-risk exposures, are not permitted to travel by commercial transport until cleared by public health officials. If travel is necessary (e.g., to obtain medical care that is not available locally), transportation should be conducted in a manner that does not expose operators (e.g., air crews, bus drivers) or other travelers. The mode of transportation (e.g., ground vs. air transportation) should be determined by distance to final destination as well as the clinical condition of the traveler (i.e., whether medical care may be needed en route).

- People with suspected or confirmed EVD should be transported only by medical transport (i.e., ground or air ambulance) with infection control precautions in place to protect medical personnel.
  - CDC has issued separate guidance for air medical transport for patients with suspected or confirmed EVD.
  - For more information on developing interfacility transport plans see: Guidance for Developing a Plan for Interfacility Transport of Persons Under Investigation or Confirmed Patients with Ebola Virus Disease in the United States
- Options for transport of asymptomatic people with a high-risk exposure to Ebola virus are private vehicle or chartered or private aircraft with precautions in place to protect air crews.

For international air transport of a person with suspected or confirmed EVD or high-risk exposure to a destination within the United States, per CDC regulations (42 Code of Federal Regulations, Part 71: Foreign Quarantine), the aircraft operator must notify CDC in advance through the CDC quarantine station with jurisdiction for the port of entry or the CDC Emergency Operations Center (770-488-7100 or eocreport@cdc.gov). The aircraft operator should also coordinate with the U.S. embassy or consulate for the country where the individual is located, CDC, the Federal Aviation Administration, and U.S. Customs and Border Protection, as well as appropriate foreign, state, local, territorial, and tribal governments to ensure compliance with all applicable laws and regulations.

Last Reviewed: October 7, 2022
Source: Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Global Migration and Quarantine (DGMQ)

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
October 6, 2022, 10:45 AM ET
CDCHAN-00477

Outbreak of Ebola virus disease (*Sudan ebolavirus*) in Central Uganda

Summary
The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Advisory about a recently confirmed outbreak of Ebola virus disease (EVD) in Uganda caused by Sudan virus (species *Sudan ebolavirus)* to summarize CDC's recommendations for U.S. public health departments and clinicians, case identification and testing, and clinical laboratory biosafety considerations. **No suspected, probable, or confirmed EVD cases related to this outbreak have yet been reported in the United States**. However, as a precaution and to remind clinicians about best practices, CDC is communicating with public health departments, public health laboratories, and healthcare workers in the United States to raise awareness of this outbreak.

Background
On September 20, 2022, the Ministry of Health of Uganda officially declared an outbreak of EVD due to Sudan virus (species *Sudan ebolavirus)* in Mubende District, Central Uganda.

The first confirmed case of EVD was a 25-year-old man who lived in Mubende District and quickly identified as a suspect case of viral hemorrhagic fever (VHF) and isolated in the Mubende Regional Referral Hospital. Blood collected from this patient tested positive for Sudan virus by real-time reverse transcription polymerase chain reaction (rRT-PCR) on September 19, 2022, at the Uganda Virus Research Institute (UVRI). The patient died the same day, and a supervised burial was performed by trained staff wearing proper personal protective equipment (PPE). Further investigation into this case revealed a cluster of unexplained deaths occurring in the community during the previous month. As of October 6, 2022, a total of 44 confirmed cases, 10 confirmed deaths, and 20 probable deaths of EVD have been identified in Uganda.

CDC is working closely with the Ministry of Health of Uganda, the World Health Organization (WHO), and other partners to support the response to this outbreak.

This is the fifth outbreak of EVD caused by Sudan virus in Uganda since 2000. The current outbreak is in the same area as Uganda's most recent EVD outbreak caused by Sudan virus, which occurred in 2012. During the 2012 outbreak, limited secondary transmission was reported, and the outbreak was effectively contained.

As of October 6, 2022, no suspected, probable, or confirmed EVD cases related to this outbreak have been reported in the United States or other countries outside of Uganda. The geographic scope of this outbreak in Uganda is currently limited to five districts in central Uganda and not the capital Kampala or the travel hub of Entebbe. While there are no direct flights from Uganda to the United States, travelers from or passing through affected areas in Uganda can enter the United States on flights connecting from other countries. As a precaution, CDC is communicating with public health departments, public health laboratories, and healthcare workers in the United States, and educating travelers, to raise awareness of this outbreak. **It is important for clinicians to obtain a detailed travel history from patients with suspected EVD, especially those that have been in affected areas of Uganda. Early consideration of EVD in the differential diagnosis is important for providing appropriate and prompt patient care, diagnostics, and to prevent the spread of infection.** Healthcare providers should be alert for and evaluate any patients suspected of having EVD, particularly among people who have recently traveled to affected areas in Uganda.

Ebola Virus Disease
A person infected with EVD is not contagious until symptoms appear (including fever, headache, muscle and joint pain, fatigue, loss of appetite, gastrointestinal symptoms, and unexplained bleeding). Sudan virus is spread through **direct contact** (through broken skin or mucous membranes) with the body fluids (blood, urine, feces, saliva, droplet, or other secretions) of a person who is sick with or has died from EVD, infected animals, or with objects like needles that are contaminated with the virus. EVD is **not** spread through airborne transmission.

There is currently no FDA-licensed vaccine to protect against Sudan virus infection. The Ebola vaccine licensed in the United States (ERVEBO,® Ebola Zaire Vaccine, Live, also known as V920, rVSVΔG-ZEBOV-GP or rVSV-ZEBOV) is indicated for the prevention of EVD due to Ebola virus (species *Zaire ebolavirus*), and based on studies in animals, it is not expected to protect against Sudan virus or other viruses in the *Ebolavirus* genus. Also, there is currently no FDA-approved treatment for Sudan virus.

In the absence of early diagnosis and appropriate supportive care, EVD is a disease with a high mortality rate; occasional outbreaks have occurred mostly on the African continent. With intense supportive care and fluid replacement, mortality rates may be lowered. EVD most commonly affects humans and nonhuman primates (such as monkeys, gorillas, and chimpanzees). The genus *Ebolavirus* is known to comprise the following six species:

- Ebola virus (species *Zaire ebolavirus*)
- Sudan virus (species *Sudan ebolavirus*)
- Taï Forest virus (species *Taï Forest ebolavirus*, formerly *Côte d'Ivoire ebolavirus*)
- Bundibugyo virus (species *Bundibugyo ebolavirus*)
- Reston virus (species *Reston ebolavirus*)
- Bombali virus (species *Bombali ebolavirus*)

Of these, only four (Ebola, Sudan, Taï Forest, and Bundibugyo viruses) are known to cause EVD in humans. Infection with any Ebola species presents as clinically similar disease. Previous outbreaks of Sudan virus have had a mortality rate of approximately 50%.

Recommendations for Public Health Departments and Clinicians
Clinicians who evaluate patients with clinical symptoms such as fever, headache, muscle and joint pain, fatigue, loss of appetite, gastrointestinal symptoms, and unexplained bleeding should suspect possible VHF or EVD on the differential diagnosis and clinicians should be prompted to immediately take a travel history. Healthcare providers should be alert for and evaluate any patients suspected of having VHF or EVD, particularly among people who have recently traveled to affected areas in Uganda, and place in a private room while performing clinical evaluation. If performing an aerosol generating procedure, conduct in an Airborne Infection Isolation Room (AIIR) when feasible. Testing for diseases in returning travelers which may present similarly to EVD, such as malaria, should be considered, but clinical consultation should be pursued if there is still a high index of suspicion for EVD.

U.S. clinicians with concerns about a patient with suspected EVD should contact their state, local, tribal, or territorial health department immediately (24-hour contact numbers for state and large jurisdiction health departments) and follow jurisdictional protocols for patient assessment. Early recognition and identification of a suspected EVD patient under investigation (PUI) is critical. If a diagnosis of EVD is considered, clinical teams should coordinate with state/local public health officials and CDC to ensure appropriate precautions are taken to help prevent potential spread of EVD.

As a resource for public health departments, CDC's Viral Special Pathogens Branch (VSPB) is available 24/7 for consultations regarding suspected VHF or EVD cases by calling the CDC Emergency Operations Center at 770-488-7100 and requesting VSPB's on-call epidemiologist, or by e-mailing spather@cdc.gov.

Healthcare personnel can be exposed to Ebola virus by touching a patient's body fluids, contaminated medical supplies and equipment, or contaminated environmental surfaces. Splashes to unprotected mucous membranes (for example, the eyes, nose, or mouth) are particularly hazardous. Procedures that can increase environmental contamination with infectious material or create aerosols should be

minimized. CDC recommends a combination of measures to prevent transmission of EVD in hospitals including PPE.

Eight laboratories within the Laboratory Response Network (LRN) are able to test using the Biofire FilmArray NGDS Warrior Panel, with more LRN laboratories working toward the ability to test. The Warrior Panel can detect Ebola, Sudan, Tai Forest, Bundibugyo, and Reston viruses.

Clinical and Laboratory Biosafety Considerations
All personnel handling specimens from patients with suspected EVD (especially patients with travel history to Uganda three weeks before symptom onset) should adhere to recommended infection control practices to prevent infection and transmission among laboratory personnel.

As a component of the Occupational Safety and Health Administration's (OSHA's) Bloodborne Pathogens Standard, laboratories handling blood and body fluids must have an Exposure Control Plan in place to eliminate or minimize employees' risk of exposure to pathogens.

Laboratories should conduct extensive risk assessments to identify and mitigate hazards associated with handling Ebola specimens to create the safest environment.

The proper PPE needs to be identified, available, and staff trained to properly don and doff their PPE. Staff need to be specially trained, have passed competency testing, and attended drills to safely receive, handle, and process these specimens.

A laboratory should have dedicated space, equipment for handling and testing specimens from ill patients, and plans for minimizing specimen manipulation.

A waste management plan needs to be in place for lab reagents and Category A waste, including PPE and sample material.

If a facility does not have the appropriate risk mitigation capabilities, then the specimen should be forwarded to another facility that does.

For More Information
General Ebola Information
General Resources for Ebola Virus Disease

Clinician Resources
- Ebola Virus Disease Information for Clinicians in U.S. Healthcare Settings
- Screening Patients for Ebola Virus Disease
- Considerations for Discharging People Under Investigation (PUIs) for Ebola Virus Disease

Infection Prevention Resources
- Interim Guidance for U.S. Hospital Preparedness for Patients Under Investigation (PUIs) or with Confirmed Ebola Virus Disease
- Infection Prevention and Control Recommendations for Hospitalized Patients Under Investigation (PUIs) for Ebola Virus Disease (EVD) in U.S. Hospitals
- Personal Protective Equipment (PPE) | Public Health Planners | Ebola (Ebola Virus Disease) | CDC Cleaning and disinfecting
- Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus
- Procedures for Safe Handling and Management of Ebola-Associated Waste

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Eastern Highlands Health District
COVID-19
Response Activity Update
October 17, 2022

On-going Response Planning and Coordination

The internal staff meeting frequency continues to be every two weeks for this and other EHHD operating matters. Local health directors continue to meet virtually bi-weekly with DPH officials. This office also participates with monthly meetings with State Department of Education on COVID related matters, with the start of the school year.

The health district recently completed our section of the DEMHS Region 4 after Action Report for the pandemic response.

Public Health Surveillance

We continue to issue weekly reports to 86 community partners and stakeholders, in an effort to keep community partners updated on disease prevalence and other response activates. Our latest weekly report dated October 14, 2022 is attached to this report.

COVID Testing

The health district continues to provide detailed listing of regional testing sites on agency website, which are updated weekly.

The health district continues to coordinate with the CT DPH, local partners, and state vendors to be prepared for the next increase in testing demand. Towards that end, a state sponsored back up testing site has been identified in Tolland, and the Windham testing site is prepared to ramp up capacity on short notice.

We continue to support daycares, and schools seeking additional self-test kits.

Outbreak and Cluster Investigation

The health district contact traced every confirmed case within our Jurisdiction that are not UConn students through the end of February 2022. At that point in time, pursuant to guidance from both the CDC and CT DPH, efforts transitions away from universal community contact tracing to case investigation and rapid outbreak response. We continue to stay updated with bi-weekly modifications to the new state-wide web based contact tracing system called *ContaCT*. Below are updates to the case investigation and outbreak response program that represent, in part, our on-going efforts to respond to this pandemic:

- During the month of August and September we supported and responded to 6 clusters/outbreaks at 3 schools and 3 daycare providers.
- During August and September 2022 we investigate and supported the town response to approximately **3** town governmental affiliated cases.
- During the month of August and September 2022 an average of 73 community cases per week were received and/or supported up in some fashion.

University of Connecticut Storrs

For the Fall 2022 semester positive cases will isolate in place. Point of care testing will be administered. There are currently no plans to mandate additional boosters.

Schools

In the period leading up to school reopening and since, this agency continues to respond to questions from school nurses, principles, and superintendents. The topics include but are not limited to student and staff exclusion guidance, symptom screening criteria, communications and notifications, confidentiality, interpretation and implementation of SDE guidance, vaccination clinic coordination, and many other COVID related matters. We provide thoughtful, researched responses on a routine basis.

With the transition away from contract tracing to outbreak response the EHHD hosted a superintendents meeting on 2/23, and issued its own updated guidance to schools on February 28, 2022.

In response to BA.2 surge in May, this agency re-distributed the February updated outbreak/cluster guidance from both DPH and EHHD to all schools.

Updated DPH/SDE guidance for the Fall 2022 academic year was issue early August. Subsequent to an internal staff review, the EHHD aligned agency messaging and support with new school guidance.

PPE Distribution

CT DPH tasked local health departments with distributing PPE to local area private healthcare providers. We no longer receive allocations from the DEMHS Region 4 distribution site automatically. However still have a moderate inventory left, and additional inventory can be ordered if needed. We continue to provide PPE to area providers and other when needed.

Governors Executive Orders and other state guidance

We continue to track executive orders as they are updated, providing consultation and interpretation to stakeholders, and other entities as requested.

Public Health Education, Communications, Messaging

EHHD is aligned with the CT DPH and CDC Messaging; providing regular public information updates to website, and social media (FB & Twitter).

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

Agency updates routinely provided to community partners.

We are now pushing out information on COVID-19 Booster vaccine access and eligibility to the public and community partners via website, and social media.

Our vaccination messaging is now supporting efforts to promote vaccination of kids age 5 to 11, and boosters all eligible persons.

We continue to maintain our social media presents with 6 to 8 social media posts per week as of the September 2022.

Providing support to United Services COVID-19 outreach initiative targeting families to address vaccine hesitation. We are recruiting college student ambassadors in support of the program.

Medical Reserve Corps retention and recruitment

We continue to recruit and vet new MRC volunteers. To date, a total of approximately 200 volunteers have received field experience or training.

MRC volunteers continue to support our pop up clinics as needed to fill staffing gaps during this late summer and fall seasons.

In partnership with DPH, we are in the process of updating background checks for all volunteers.

COVID-19 Vaccination Activities

Here are the latest salient updates on distribution and administration.

- *As of the writing of this report, the EHHD has administered over 13,394 doses in 260+ clinics throughout the Eastern Highlands Health District. 20 clinics have been hosted during the month of August and September 2022. We've conducted pop up clinics at the Bolton Library, Mansfield Drive-in, Celebrate Tolland festival, Celebrate Mansfield festival, the Coventry Town Hall Annex during this period.*
- *As of May 2022, the health district has administered 174 doses to homebound residents since March 2021. Here is the break down by town: Andover (4), Ashford (15), Bolton (23), Chaplin (4), Columbia (34), Coventry (14), Mansfield (29), Scotland (6), Tolland (29), and Willington (16).*
- *We expanded our COVID-19 vaccine inventory to include Pfizer and Moderna Bivalent booster shot.*
- We continue to hold weekly vaccine clinic hours to Monday 10am to 1pm & Thursday 12 noon – 3pm for ages 5 and up at the Main Health District office.
- The EHHD is leveraging the use of DPH funded mobile vaccination units made available by the DPH for pop-up clinic opportunities when it makes since to do so. We have coordinated or supported a number of clinics using the DPH Griffin Health mobile vaccination units as of January 2022.

Plans for the Future

- Due to a recent state 2022 mandate we must transition from VAMAS to CT Wiz to manage immunization records.
- We plan to expand all of our clinics to include strong educational component this winter.
- Apply lessons learned, and update all emergency response plans.
- Continue outbreak/cluster investigation program.
- Provide guidance to partners on appropriate mitigation measures as new variants continue to pose changes in risk.

Eastern Highlands Health District

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

Eastern Highlands Health District COVID-19 Update

DATE: 10/14/2022 TIME: 9:00 AM COMPLETED BY: A. Bloom

TOWN LEVEL DATA

TOWN	Andover	Ashford	Bolton	Chaplin	Columbia	Coventry	Mansfield	Scotland ++	Tolland	Willington	EHHD Totals
Cumulative Cases	558	808	844	463	1,069	2,328	3,201	132	2,529	907	**12,839**
Change from last week	3	2	3	0	5	13	18	0	12	7	**63**
Two week change	6	6	7	1	12	35	32	0	25	16	**140**
Deaths	6	5	6	4	13	13	34	2	27	5	**115**

NOTE: UConn cases for the Fall 2022 semester to date (including self-reported positive tests) were 467 (from https://coviddashboard.uconn.edu)

CONNECTICUT TOTALS (October 13, 2022)

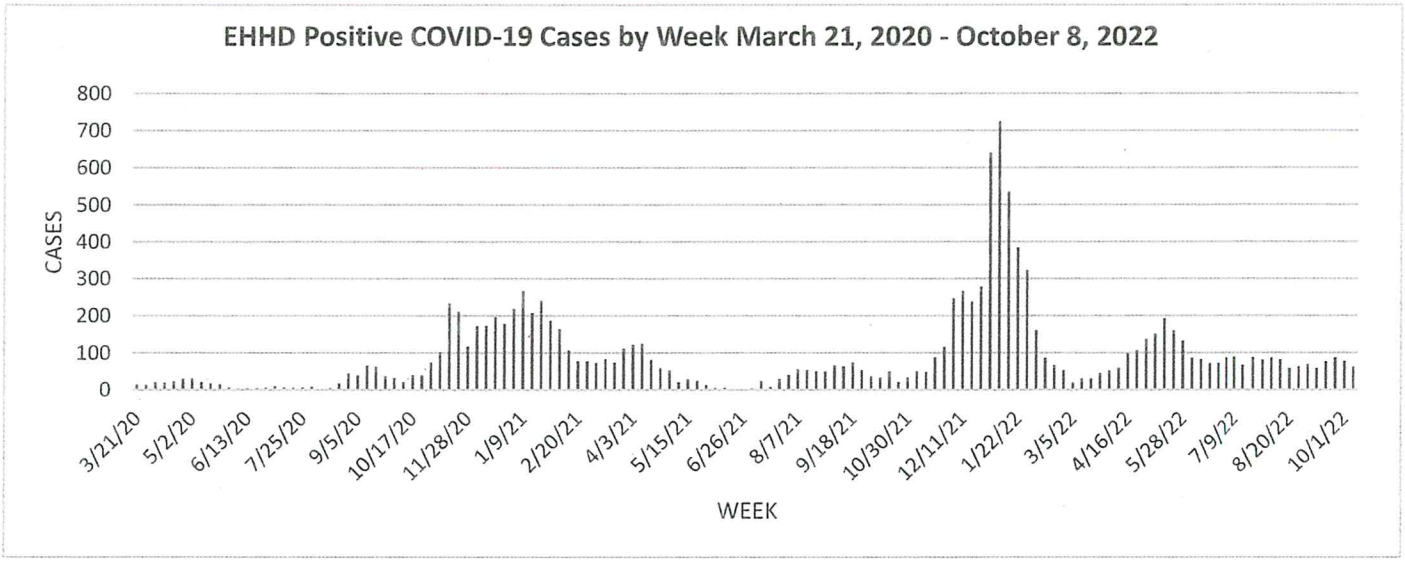
Number of cumulative cases	Change from last week	Change from two weeks	Current hospitalizations*	Two week change in hospitalizations	Deaths
904,258	**3,758**	**8114**	**405**	**22**	**11,402**

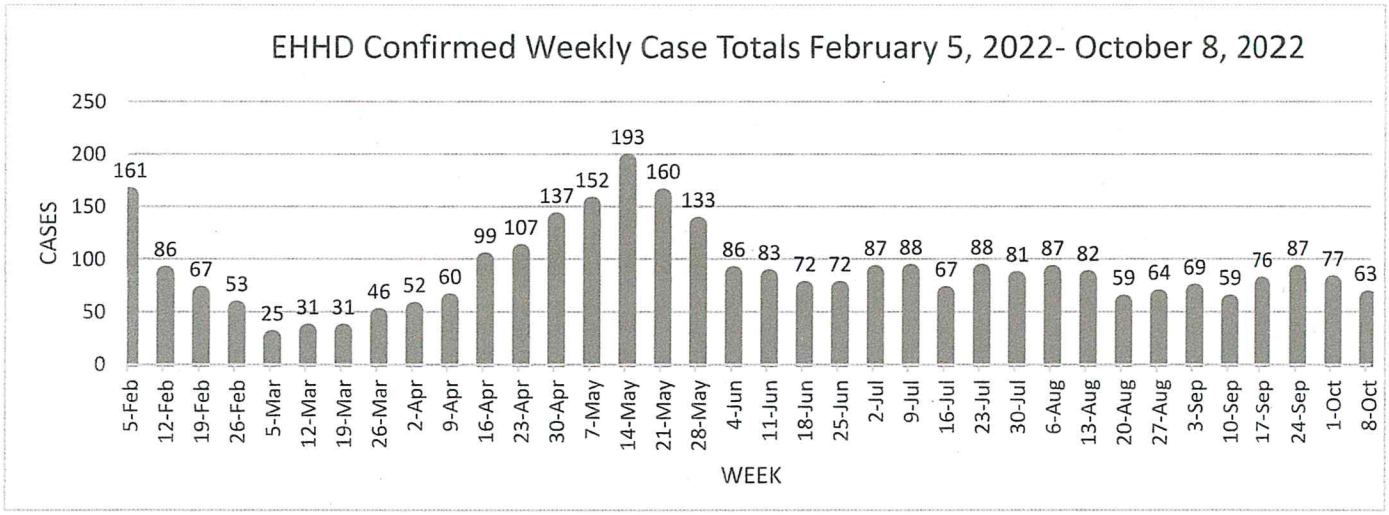
Data Sources: CTEDSS and CT DPH; cumulative town counts as of 10/13/2022; reporting period for two week town level case counts is 9/25/2022 through 10/8/2022.
*Current (net) number of hospitalizations; it is not a cumulative count. ++ Scotland case count likely lower than actual positive cases due to residents using Baltic, North Windham and Hampton as a mailing address.

EHHD RESIDENTS WHO RECEIVED COVID-19 VACCINE+

TOWN Est. population	AGE GROUP														
	5-11 years		12-17 years		18-24 years		25-44 years		45-64 years		65+ years		Total pop.		
	% 1 dose	% Full vax	% 1 dose	% Full vax	% 1 dose	% Full vax	% 1 dose	% Full vax	% 1 dose	% Full vax	% Full vax	% booster	% 1 dose	% Full vax	% booster
EHHD 80,041	45	42	71	69	86	80	84	78	80	77	100	96	82	77	54
CT 3,631,470	**	**	**	**	**	**	90	80	95	88	91	71	85	77	45

Data Source: Connecticut immunization registry CT DPH as of 10/12/2022; ^Vaccination data for Mansfield includes 5/6/2022 data from UCONN (previously reported at https://coviddashboard.uconn.edu). +Downward changes from prior weeks are likely due to de-duplication or re-assignment of cases to different towns associated with UConn student residency changes. **State vaccination numbers are not broken down into the same age groups as the town level data and cannot be reported here.
NOTE: census estimates for 65 and older is likely low, resulting in 100% rates based on actual number of vaccines provided to this age group.





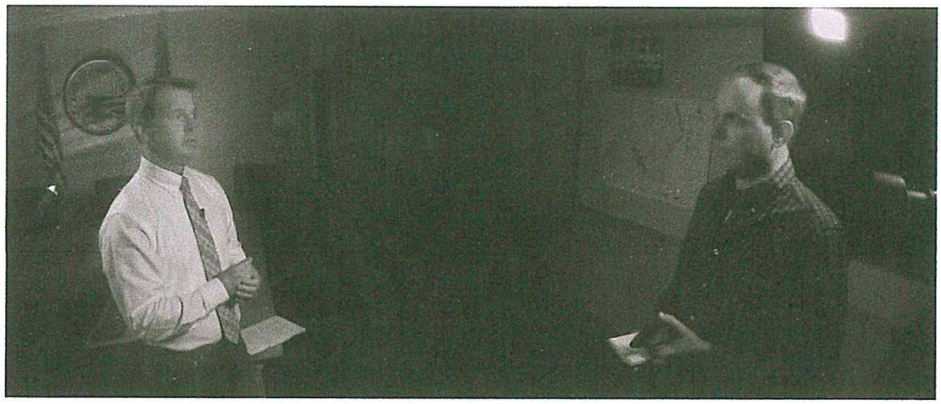
NOTE: All counts by town are cumulative and include confirmed cases and antigen-positive cases; counts can change from previous weeks due to the state reassigning a case to a different town once further information is gathered on the case, or due to lab reporting delays.

WELL WATER

Well Water Woes: Report Breaks Down Salt Intrusion Cause in Neighborhood

A recent study by the state Department of Energy and Environmental Protection provides some interesting insights into an issue hundreds across Connecticut must contend with.

By **Len Besthoff** • Published October 11, 2022 • Updated on October 11, 2022 at 6:43 pm



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A recent study by the state Department of Energy and Environmental Protection provides some interesting insights into an issue hundre across Connecticut must contend with.

There has been no solution yet for salt showing up in private wells across the state - a problem for homeowners that can cost tens of thousands of dollars to eliminate.

However, scientists have been getting a better idea of what is causing the problem, and it may not be everything you think.

NBC Connecticut Investigates introduced you to Gabbi Mendelsohn last summer.

The school teacher told us shortly after moving into her Ellington home, she began noticing her drinking water tasted salty, and her appliances got crusty, rusty, and in some cases, stopped working.

"It's just eating away at the pipes and corrosion. Just recently, I had to have my hot water heater replaced again, it's about six times in the space of 11 years," Mendelsohn said.

Well Water Contamination: Lawmaker Seeks Solutions to Road Salt Runoff

Connecticut is suffering from an excess of salt on the roads which is affecting some residents' water supply. Sodium chloride from the brine used to pre-treat roadways before a snowfall is creeping into wells, making the water undrinkable.

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Mendelsohn got an analysis of her water, and learned it has a lot of salt, also known as sodium chloride.

Local

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MIDDLETOWN • 3 HOURS AGO

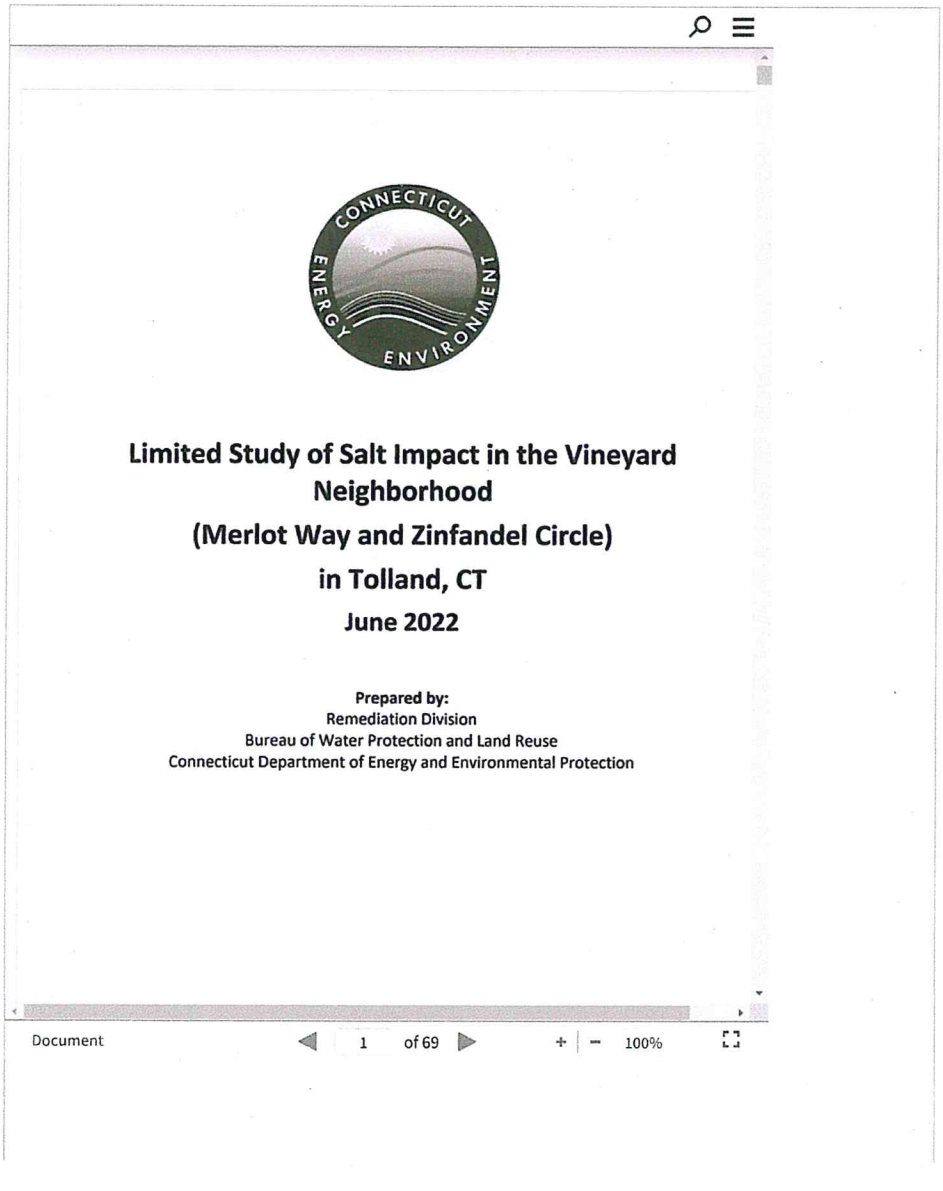
Fire Breaks Out at Kleen Energy Plant in Middletown

The town of Ellington, even though it has not said it is at fault, is providing her with bottled water - for now.

"Unfortunately, if I did need to sell my home, I wouldn't be able to. It's, it's one of those things," Mendelsohn said.

The cause? People often point at what's evident to the naked eye - the tons of salt spread on our snowy, icy New England roads.

A recent study by the Connecticut Department of Energy and Environmental Protection (DEEP), while it only examines one cluster of homes dealing with the problem in Tolland, which borders Ellington, provides some interesting insights into an issue hundreds across Connecticut must contend with.



Weather Forecast

HARTFORD, CT

72°

Partly Cloudy

0% Precip

TONIGHT

54°

TOMORROW

72°

The report said while salt spread on roads is a contributing factor, the amount and frequency of salt released into the ground by water softening systems that many homeowners use also has an impact.

Tolland Town Manager Brian Foley shared the report with us and addressed some of its conclusions.

"Everyone dumps big bags of salt into those systems and that salt should be responsibly maintained. But a lot of times it's not and put right back into our environment. And that has an effect on the groundwater," Foley said.

Foley pointed out his team is attacking this issue on all fronts. He said his plow crews have gone through training which teaches road salt applicators how to minimize its use, but still keep the roads safe.

Foley added the town is also considering bringing some sand back into the road treatment mix to lower salt use, along with other efforts to prevent road salt from getting into the soil.

"Here's some other things we can do. We can seal all the cracks in the roadway where the salt gets put down and we can make sure that sealed. We can make sure there's curving to the storm drains. We can clean out our storm drains more frequently. And look, because of the ARPA (American Rescue Plan Act) funds, we just bought a street sweeper and we bought a machine to clean out and vacuum out our storm drains.

Problem is, the amount of salt that gets in well systems builds up over years and years, and presumably, takes years to decrease.

That's why leaders like Senator Saud Anwar have been trying to act now, coming up just short the past three legislative sessions with bills offering incentives to towns and cities that get training to reduce the amount of salt they put on roads.

Anwar said while the DEEP report identified multiple sources of salt intrusion in a Tolland neighborhood, he still believes it generally comes from one primary source.

"If I was to bet, I believe that the high salt content of use that has been for snow management is the major culprit. Now there are other culprits but statistically and probability, the chances are that water softening is a smaller component of this issue," Anwar said.

There is certainly motivation for local and state leaders to solve this problem on the front end.

The report on the Tolland homes also said that the most effective long-term, reliable solution is to get them on a municipal water system - an expensive proposition.

This article tagged under:

WELL WATER • TOLLAND • NBC CT INVESTIGATES • HOMEOWNERS • WELL WATER CONTAMINATION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

EHDW Circular Letter #2022-61

TO: Department Public Health (DPH) Certified Water System Operators
Community and Non-Transient Non-Community Public Water Systems

FROM: Lori J. Mathieu, Public Health Branch Chief
Environmental Health and Drinking Water Branch Lori J. Mathieu '22

DATE: October 4, 2022

SUBJECT: Reinstatement of Licensure Renewal Requirements
– 38 Days Remaining to November 10, 2022 Certification Expiration

The commissioner has ordered the resumption of certification renewal requirements effective May 10, 2022 and specified a final certification expiration date of November 10, 2022. Certified operators whose certification renewal was due to expire during the Governor's COVID-19 Declaration of Public Health and Civil Preparedness Emergencies **now have 38 days remaining to renew their certification**. Certified Operators should not wait and should prepare to submit their renewal application in advance of the November 10, 2022 expiration date.

No additional extension or modification of the renewal deadline is expected. The filing of an application will not extend the renewal deadline. If you file an application without leaving sufficient time for the department to process the application, your certification will expire November 10, 2022.

The Operator Certification Program has emailed out renewal applications to each operator whose certification renewal requirements were suspended. Operators may request their renewal application by sending an email to dph.opcert@ct.gov. Operators are to print and fill out their renewal application and mail it to the below mailing address along with the required application fee (payee "Treasurer, State of Connecticut", bank check, personnel check or money order) and where applicable copies of training course certificates and/or transcripts.

While the renewal cycle of a "Suspended Renewal" has been extended, the next renewal cycle will be shortened by an equivalent amount. This means that operators will have less time to accumulate the required training contact hours or completed required device tests in their next renewal cycle and it is therefore advantageous to renew sooner than later in this renewal cycle.

Water Treatment Plant, Distribution System and Small Water System Operators are to note the following web links to lists of CT DPH Approved Training Courses:

CT DPH Approved Water Operator Internet or Correspondence Training Courses
CT DPH Approved Water Operator Classroom Training Courses

Operators are reminded that they may view the status of their certification and expiration date, without password, on the eLicense website (click on "Online Services", click on "Lookup a License", enter in First Name and Last Name, click "Submit".

Phone: (860) 509-7333• Fax: (860) 509-7359
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, MS#12DWS, P.O. Box 340308
Hartford, Connecticut 06134-0308
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National Opioid Settlements

BROWN GREER
Directing Administrator

ALLOCATION NOTICE

Payment Year: 2
Date of Notice: 9/27/2022
Deadline to Dispute Allocation: 10/18/2022
Expiration of 50 Days: 11/16/2022

Settling State	Connecticut

I. PAYMENT ALLOCATION DETERMINATION

This Notice is an official communication from the Directing Administrator of the National Opioid Settlements. A copy of this Notice has been sent to the Enforcement Committee and Settling Distributors pursuant to Section IV.B of the Distributor Settlement Agreement, dated as of July 21, 2021, as amended, between and among the Settling States, the Settling Distributors, and Participating Subdivisions (the "Distributor Settlement Agreement"). All capitalized terms used in this letter have the meanings ascribed to them in the Distributor Settlement Agreement.

Pursuant to Section IV.B and Exhibit M of the Distributor Settlement Agreement, Connecticut's Total Payment Year 2 amount is **$13,500,663.99**, which is broken down in Table 1 in Attachment 1 to this Allocation Notice.

As provided under Section V.C of the Distributor Settlement Agreement, Connecticut has instructed the Directing Administrator to calculate the intrastate allocations pursuant to the national default. Using the default provisions, the Directing Administrator has allocated the Annual Payment as follows: (i) 15% to the State Fund, (ii) 70% to the Abatement Accounts Fund, and (iii) 15% to the Subdivision Fund, to be paid directly to the Subdivisions per the allocation percentages provided in Exhibit G of the Distributor Settlement Agreement. Connecticut has further instructed the Directing Administrator to allocate the Additional Restitution Amount in full to the State Fund. The intrastate allocations are included as Attachment 1 to this Allocation Notice.

Undisputed amounts allocated to the State Fund, the Abatement Accounts Fund, and Subdivision Fund for Participating Subdivisions will be paid no later than the date that is 50 days after the date of this Allocation Notice.

II. YOUR RIGHT TO DISPUTE

Section IV.B.4 of the Distributor Settlement Agreement provides that within twenty-one (21) calendar days of receiving notice any party may dispute the calculation of the amount to be received by a Settling State or its Participating Subdivisions listed on Exhibit G as inconsistent with the terms of the Agreement. Written notice must be provided to the Settlement Fund Administrator, the Enforcement Committee, any affected Settling State, and the Settling Distributors identifying the nature of the dispute, the amount of money that is disputed, and the Settling State(s) affected.

A party has until the Deadline to Dispute Allocation listed at the top of this Allocation Notice to deliver a written notification of dispute. The amounts listed in this Allocation Notice will be deemed accepted if the Directing Administrator has not received a party's dispute before midnight Eastern Time on the deadline date. Submit your written request by email to DirectingAdministrator@NationalOpioidOfficialSettlement.com.

Any party affected by the dispute may object to the notification of dispute. Depending on the nature of the dispute, contested disputes must be resolved in either the court that entered a state's Consent Judgment or the National Arbitration Panel. The Directing Administrator will not disburse any funds potentially affected by a contested dispute until the dispute is resolved by the court or the National Arbitration Panel.

III. To Accept Payment

If you do not dispute the payment and you have previously created a Portal Account and completed your Payment Election Forms and W-9 Forms, no further action is needed. The Directing Administrator will begin issuing payments after the applicable deadlines have passed using the existing payment instructions. If you have not previously created a Portal Account, please do so and complete the Payment Election Forms and W-9 Forms to create payment instructions for any Settlement Payments. **Keep your payment instructions current in the Portal as the Directing Administrator will use these forms to issue settlement payments.**

IV. To Reallocate Payment

If you wish to reallocate your portion of the allocation to another Participating Subdivision or the Abatement Accounts Fund, you may do so by emailing DirectingAdministrator@NationalOpioidOfficialSettlement.com before the Deadline to Dispute Allocation included on the Allocation Notice. The Directing Administrator will not treat a reallocation request as a dispute.

Sincerely,

BrownGreer PLC
Directing Administrator
250 Rocketts Way
Richmond, VA 23231

ATTACHMENT 1 - DISTRIBUTORS YEAR 2 PAYMENT ALLOCATION TO CONNECTICUT
(As of 9/27/2022)

TABLE 1: YEAR 2 SUMMARY[1]

		Restitution/ Abatement	Additional Restitution	Total Payment 2
1.	**Total Allocation**	**$11,115,121.29**	**$2,385,542.69**	**$13,500,663.99**
2.	**Allocation Method**	**National Default**		
3.	15% to State Fund	$1,667,268.19	$0.00	**$1,667,268.19**
4.	70% to Abatement Accounts Fund	$7,780,584.91	$0.00	**$7,780,584.91**
5.	15% to Subdivision Fund	$1,667,268.19	$0.00	**$1,667,268.19**
6.	Additional Restitution 100% to State Fund	$0.00	$2,385,542.69	**$2,385,542.69**

TABLE 2: ALLOCATION TO SUBDIVISIONS

	Subdivision	Exhibit G State Allocation Percentage	Restitution/ Abatement	Total Payment 2
1.	Andover Town	0.0513214640%	$855.67	**$855.67**
2.	Ansonia City	0.5316052437%	$8,863.29	**$8,863.29**
3.	Ashford Town	0.1096965130%	$1,828.94	**$1,828.94**
4.	Avon Town	0.5494886534%	$9,161.45	**$9,161.45**
5.	Barkhamsted Town	0.0620629520%	$1,034.76	**$1,034.76**
6.	Beacon Falls Town	0.1953947308%	$3,257.75	**$3,257.75**
7.	Berlin Town	0.5215629385%	$8,695.85	**$8,695.85**
8.	Bethany Town	0.1039156068%	$1,732.55	**$1,732.55**
9.	Bethel Town	0.3522422145%	$5,872.82	**$5,872.82**
10.	Bethlehem Town	0.0078647202%	$131.13	**$131.13**
11.	Bloomfield Town	0.4888368136%	$8,150.22	**$8,150.22**
12.	Bolton Town	0.1520831395%	$2,535.63	**$2,535.63**
13.	Bozrah Town	0.0582057867%	$970.45	**$970.45**
14.	Branford Town	0.8903816954%	$14,845.05	**$14,845.05**
15.	Bridgeport City	3.2580743095%	$54,320.84	**$54,320.84**
16.	Bridgewater Town	0.0118125935%	$196.95	**$196.95**
17.	Bristol City	1.3355768908%	$22,267.65	**$22,267.65**
18.	Brookfield Town	0.3087903124%	$5,148.36	**$5,148.36**
19.	Brooklyn Town	0.1880661562%	$3,135.57	**$3,135.57**
20.	Burlington Town	0.2348761319%	$3,916.02	**$3,916.02**

[1] Final payments to the State and/or Abatement Accounts Funds may vary by +/- $0.01-$0.05 to account for rounding to the nearest cent during Subdivision calculations.

National Opioid Settlements

BROWN GREER
Directing Administrator

21.	Canaan Town	0.0343343640%	$572.45	**$572.45**
22.	Canterbury Town	0.1354310071%	$2,258.00	**$2,258.00**
23.	Canton Town	0.2669011966%	$4,449.96	**$4,449.96**
24.	Chaplin Town	0.0523959290%	$873.58	**$873.58**
25.	Cheshire Town	0.9783113499%	$16,311.07	**$16,311.07**
26.	Chester Town	0.0772387574%	$1,287.78	**$1,287.78**
27.	Clinton Town	0.5348726093%	$8,917.76	**$8,917.76**
28.	Colchester Town	0.6134395770%	$10,227.68	**$10,227.68**
29.	Colebrook Town	0.0296870114%	$494.96	**$494.96**
30.	Columbia Town	0.1005666237%	$1,676.72	**$1,676.72**
31.	Cornwall Town	0.0486027928%	$810.34	**$810.34**
32.	Coventry Town	0.3460011479%	$5,768.77	**$5,768.77**
33.	Cromwell Town	0.4750451453%	$7,920.28	**$7,920.28**
34.	Danbury City	1.1556465907%	$19,267.73	**$19,267.73**
35.	Darien Town	0.6429649345%	$10,719.95	**$10,719.95**
36.	Deep River Town	0.0924563595%	$1,541.50	**$1,541.50**
37.	Derby City	0.3503125449%	$5,840.65	**$5,840.65**
38.	Durham Town	0.0079309232%	$132.23	**$132.23**
39.	East Granby Town	0.1455975170%	$2,427.50	**$2,427.50**
40.	East Haddam Town	0.3145696377%	$5,244.72	**$5,244.72**
41.	East Hampton Town	0.4637546663%	$7,732.03	**$7,732.03**
42.	East Hartford Town	1.2645454069%	$21,083.36	**$21,083.36**
43.	East Haven Town	0.8590923735%	$14,323.37	**$14,323.37**
44.	East Lyme Town	0.6375826296%	$10,630.21	**$10,630.21**
45.	East Windsor Town	0.2419743793%	$4,034.36	**$4,034.36**
46.	Eastford Town	0.0446651958%	$744.69	**$744.69**
47.	Easton Town	0.1354961231%	$2,259.08	**$2,259.08**
48.	Ellington Town	0.4010047839%	$6,685.83	**$6,685.83**
49.	Enfield Town	0.9173431190%	$15,294.57	**$15,294.57**
50.	Essex Town	0.1431870357%	$2,387.31	**$2,387.31**
51.	Fairfield Town	1.4212308415%	$23,695.73	**$23,695.73**
52.	Farmington Town	0.6572091547%	$10,957.44	**$10,957.44**
53.	Franklin Town	0.0446032416%	$743.66	**$743.66**
54.	Glastonbury Town	1.0420644550%	$17,374.01	**$17,374.01**
55.	Goshen Town	0.0030464255%	$50.79	**$50.79**
56.	Granby Town	0.2928405247%	$4,882.44	**$4,882.44**
57.	Greenwich Town	1.5644702467%	$26,083.91	**$26,083.91**
58.	Griswold Town	0.3865570141%	$6,444.94	**$6,444.94**

National Opioid Settlements

BROWN GREER Directing Administrator

59.	Groton Town	1.4033874500%	$23,398.23	**$23,398.23**
60.	Guilford Town	0.8399392493%	$14,004.04	**$14,004.04**
61.	Haddam Town	0.0151716553%	$252.95	**$252.95**
62.	Hamden Town	1.7724359413%	$29,551.26	**$29,551.26**
63.	Hampton Town	0.0429454985%	$716.02	**$716.02**
64.	Hartford City	5.3268549899%	$88,812.96	**$88,812.96**
65.	Hartland Town	0.0359782738%	$599.85	**$599.85**
66.	Harwinton Town	0.0126363764%	$210.68	**$210.68**
67.	Hebron Town	0.1593443254%	$2,656.70	**$2,656.70**
68.	Kent Town	0.0835899976%	$1,393.67	**$1,393.67**
69.	Killingly Town	0.6116898413%	$10,198.51	**$10,198.51**
70.	Killingworth Town	0.2652963170%	$4,423.20	**$4,423.20**
71.	Lebanon Town	0.2746607824%	$4,579.33	**$4,579.33**
72.	Ledyard Town	0.5514380850%	$9,193.95	**$9,193.95**
73.	Lisbon Town	0.1156355161%	$1,927.95	**$1,927.95**
74.	Litchfield Town	0.3481982974%	$5,805.40	**$5,805.40**
75.	Lyme Town	0.0023141411%	$38.58	**$38.58**
76.	Madison Town	0.7594223560%	$12,661.61	**$12,661.61**
77.	Manchester Town	1.3929765818%	$23,224.66	**$23,224.66**
78.	Mansfield Town	0.3058754037%	$5,099.76	**$5,099.76**
79.	Marlborough Town	0.0766010346%	$1,277.14	**$1,277.14**
80.	Meriden City	1.8508778149%	$30,859.10	**$30,859.10**
81.	Middlebury Town	0.0276033951%	$460.22	**$460.22**
82.	Middlefield Town	0.0075627554%	$126.09	**$126.09**
83.	Middletown City	1.5343128975%	$25,581.11	**$25,581.11**
84.	Milford City	1.8215679630%	$30,370.42	**$30,370.42**
85.	Monroe Town	0.4307375445%	$7,181.55	**$7,181.55**
86.	Montville Town	0.5806185940%	$9,680.47	**$9,680.47**
87.	Morris Town	0.0099785725%	$166.37	**$166.37**
88.	Naugatuck Borough	1.0644527326%	$17,747.28	**$17,747.28**
89.	New Britain City	1.5740557511%	$26,243.73	**$26,243.73**
90.	New Canaan Town	0.6136187204%	$10,230.67	**$10,230.67**
91.	New Fairfield Town	0.2962030448%	$4,938.50	**$4,938.50**
92.	New Hartford Town	0.1323482193%	$2,206.60	**$2,206.60**
93.	New Haven City	5.8061427601%	$96,803.97	**$96,803.97**
94.	New London City	1.0536729060%	$17,567.55	**$17,567.55**
95.	New Milford Town	1.0565475001%	$17,615.48	**$17,615.48**
96.	Newington Town	0.7132456565%	$11,891.72	**$11,891.72**

National Opioid Settlements

BrownGreer Directing Administrator

97.	Newtown Town	0.5964476353%	$9,944.38	**$9,944.38**
98.	Norfolk Town	0.0442819100%	$738.30	**$738.30**
99.	North Branford Town	0.4795791623%	$7,995.87	**$7,995.87**
100.	North Canaan Town	0.0913148022%	$1,522.46	**$1,522.46**
101.	North Haven Town	0.7922543069%	$13,209.00	**$13,209.00**
102.	North Stonington Town	0.1803885830%	$3,007.56	**$3,007.56**
103.	Norwalk City	1.5918210823%	$26,539.93	**$26,539.93**
104.	Norwich City	1.1639182124%	$19,405.64	**$19,405.64**
105.	Old Lyme Town	0.0247921386%	$413.35	**$413.35**
106.	Old Saybrook Town	0.4181170767%	$6,971.13	**$6,971.13**
107.	Orange Town	0.3683598812%	$6,141.55	**$6,141.55**
108.	Oxford Town	0.3955127994%	$6,594.26	**$6,594.26**
109.	Plainfield Town	0.5352043161%	$8,923.29	**$8,923.29**
110.	Plainville Town	0.3937549612%	$6,564.95	**$6,564.95**
111.	Plymouth Town	0.4213382978%	$7,024.84	**$7,024.84**
112.	Pomfret Town	0.1174722050%	$1,958.58	**$1,958.58**
113.	Portland Town	0.3205523149%	$5,344.47	**$5,344.47**
114.	Preston Town	0.1319895374%	$2,200.62	**$2,200.62**
115.	Prospect Town	0.3056173107%	$5,095.46	**$5,095.46**
116.	Putnam Town	0.2953254103%	$4,923.87	**$4,923.87**
117.	Redding Town	0.1726435223%	$2,878.43	**$2,878.43**
118.	Ridgefield Town	0.6645173744%	$11,079.29	**$11,079.29**
119.	Rocky Hill Town	0.3929175425%	$6,550.99	**$6,550.99**
120.	Roxbury Town	0.0037924445%	$63.23	**$63.23**
121.	Salem Town	0.1075219911%	$1,792.68	**$1,792.68**
122.	Salisbury Town	0.1052257347%	$1,754.40	**$1,754.40**
123.	Scotland Town	0.0395212218%	$658.92	**$658.92**
124.	Seymour Town	0.5301171581%	$8,838.47	**$8,838.47**
125.	Sharon Town	0.0761294123%	$1,269.28	**$1,269.28**
126.	Shelton City	0.5601099879%	$9,338.54	**$9,338.54**
127.	Sherman Town	0.0494382353%	$824.27	**$824.27**
128.	Simsbury Town	0.6988446241%	$11,651.61	**$11,651.61**
129.	Somers Town	0.2491740063%	$4,154.40	**$4,154.40**
130.	South Windsor Town	0.7310935932%	$12,189.29	**$12,189.29**
131.	Southbury Town	0.0581965974%	$970.29	**$970.29**
132.	Southington Town	0.9683065927%	$16,144.27	**$16,144.27**
133.	Sprague Town	0.0874709763%	$1,458.38	**$1,458.38**
134.	Stafford Town	0.3388202949%	$5,649.04	**$5,649.04**

National Opioid Settlements

BrownGreer Directing Administrator

135.	Stamford City	2.9070395589%	$48,468.15	**$48,468.15**
136.	Sterling Town	0.0949826467%	$1,583.62	**$1,583.62**
137.	Stonington Town	0.5576891315%	$9,298.17	**$9,298.17**
138.	Stratford Town	0.9155695700%	$15,265.00	**$15,265.00**
139.	Suffield Town	0.3402792315%	$5,673.37	**$5,673.37**
140.	Thomaston Town	0.2664061562%	$4,441.71	**$4,441.71**
141.	Thompson Town	0.2673479187%	$4,457.41	**$4,457.41**
142.	Tolland Town	0.4342020371%	$7,239.31	**$7,239.31**
143.	Torrington City	1.3652460176%	$22,762.31	**$22,762.31**
144.	Trumbull Town	0.7617744403%	$12,700.82	**$12,700.82**
145.	Union Town	0.0153941764%	$256.66	**$256.66**
146.	Vernon Town	0.7027162157%	$11,716.16	**$11,716.16**
147.	Voluntown Town	0.0733181557%	$1,222.41	**$1,222.41**
148.	Wallingford Town	1.5350353996%	$25,593.16	**$25,593.16**
149.	Warren Town	0.0489758024%	$816.56	**$816.56**
150.	Washington Town	0.1553517897%	$2,590.13	**$2,590.13**
151.	Waterbury City	4.6192219654%	$77,014.82	**$77,014.82**
152.	Waterford Town	0.7608802056%	$12,685.91	**$12,685.91**
153.	Watertown Town	0.6868118808%	$11,451.00	**$11,451.00**
154.	West Hartford Town	1.6216697477%	$27,037.58	**$27,037.58**
155.	West Haven City	1.4026972589%	$23,386.73	**$23,386.73**
156.	Westbrook Town	0.2586999280%	$4,313.22	**$4,313.22**
157.	Weston Town	0.3664201329%	$6,109.21	**$6,109.21**
158.	Westport Town	0.8921084083%	$14,873.84	**$14,873.84**
159.	Wethersfield Town	0.6208707168%	$10,351.58	**$10,351.58**
160.	Willington Town	0.0975268185%	$1,626.03	**$1,626.03**
161.	Wilton Town	0.6378099925%	$10,634.00	**$10,634.00**
162.	Winchester Town	0.3760305376%	$6,269.44	**$6,269.44**
163.	Windham Town	1.0108949901%	$16,854.33	**$16,854.33**
164.	Windsor Locks Town	0.3174167624%	$5,292.19	**$5,292.19**
165.	Windsor Town	0.7548324123%	$12,585.08	**$12,585.08**
166.	Wolcott Town	0.5443693820%	$9,076.10	**$9,076.10**
167.	Woodbridge Town	0.2435300513%	$4,060.30	**$4,060.30**
168.	Woodbury Town	0.3411988605%	$5,688.70	**$5,688.70**
169.	Woodmont Borough	0.0173159412%	$288.70	**$288.70**
170.	Woodstock Town	0.1817110623%	$3,029.61	**$3,029.61**
171.	**TOTALS**	**100.0000%**	**$1,667,268.19**	**$1,667,268.19**

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

TO: School Superintendents, School Nurses, and Child Care Providers

FROM: Lynn Sosa, MD, Acting State Epidemiologist

DATE: August 26, 2022

SUBJECT: Monkeypox Information

While the risk for monkeypox among children and adolescents in the United States is low, we want to provide you with information about monkeypox and the precautions that you can take to protect your community and athletic programs.

As of August 23, 2022, there have been 84 confirmed cases of monkeypox in Connecticut. To date, monkeypox has been rare in children nationwide; in Connecticut, most people with monkeypox have been 20-50 years old.

Monkeypox is a disease caused by infection with the monkeypox virus. Disease can spread through close contact including:

- Direct skin-to-skin contact with monkeypox rash or scabs.
- Body fluids from a person with monkeypox.
- Sexual or intimate contact including kissing a person infected with monkeypox.
- Touching objects, fabrics (clothing, bedding, or towels), and surfaces that have been used by someone with monkeypox.
- Exposure to respiratory secretions during prolonged face-to-face contact with a person infected with monkeypox.

Illness usually begins about 6-13 days after exposure, and can include: fever, chills, headache, muscle aches, swollen lymph nodes and fatigue. Within 1-5 days of illness, a rash develops progressing from red bumps to fluid filled sores (vesicles) and pustules. There may only be a few sores, or the sores may be widespread. The rash may be located on or near the genitals or anus but could also be on other areas like the hands, feet, chest, face, or mouth. Infected individuals can have the rash without any other symptoms.

The Centers for Disease Control and Prevention (CDC) recently released monkeypox FAQs for schools. Schools and child care settings can be prepared for possible monkeypox exposures by continuing to follow protocols that reduce transmission of infectious diseases generally. This includes students and staff staying home when they are

sick, continuing routine cleaning and disinfection practices, ensuring spaces are available for persons to be isolated and evaluated and making sure staff have the appropriate personal protective equipment. Schools, school districts and child care providers should work with their local health departments on planning for possible monkeypox cases in their settings.

If a student/child or staff person has a **new or unexplained rash or symptoms** consistent with monkeypox, they should seek medical care from a healthcare provider. Schools and child care settings should follow their standard illness policies for students/children and staff with fever or rash without a known exposure to monkeypox. Rash illnesses such as hand, foot and mouth disease and chickenpox are much more likely to affect children than monkeypox. The CDC recommends monkeypox vaccinations for people who have been exposed to monkeypox and for those who are more likely to contract monkeypox. Given that children and adolescents are at lower risk of exposure to monkeypox, there is no need for widespread monkeypox vaccination among children or staff in K-12 schools or early child care settings at this time. Asymptomatic students/children, staff, and volunteers who are exposed to a person with monkeypox do not need to be excluded from school, child care or athletic settings in most cases.

The CDC's What You Need to Know about Monkeypox if You are a Teen or Young Adult is a good resource to educate your communities about monkeypox. Please visit www.ct.gov/dph/monkeypox for additional monkeypox information. Thank you for your efforts to support a healthy learning environment.

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ENVIRONMENTAL HEALTH AND DRINKING WATER BRANCH

EHDW Circular Letter #2022-51

TO: Windham and New London County Public Water Systems, Certified Water Operators

FROM: Lori J. Mathieu, Branch Chief Lori J. Mathieu '22

DATE: August 24, 2022

SUBJECT: Stage 3 Drought Declaration for Windham and New London Counties

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On August 18, 2022, Governor Lamont declared Stage 3 drought conditions for New London and Windham, Counties. The Interagency Drought Workgroup (IDW) met on August 18, 2022 and voted to recommend to the Governor that Windham and New London Counties be placed in Stage 3 Drought based on current conditions. Stage 3 is the 3rd stage of 5 increasingly severe stages of drought. Based on CT's Drought Preparedness and Response Plan, the following actions are listed for Stage 3 for water suppliers in Windham and New London counties:

- Coordination & Management
  - Review operations to ensure that conservation efforts are maximized. Non-critical utility uses of water should be reviewed to eliminate, reduce, or be delayed. Such uses include but are not limited to routine flushing; clearwell, clarifier or storage tank cleaning; and meter testing.
  - Initiate preparation for mandatory conservation, including necessary enforcement mechanisms.
  - Determine where temporary interconnections between water utilities are needed and coordinate with DEEP and DPH for expedited permitting.
  - Consider preparations to activate "emergency" and "inactive" sources of water supply for potential use and coordinate with DPH.
- Public Outreach & Education
  - Voluntary conservation should be promoted in residential, commercial, and industrial facilities to reduce demand.
- Data Collection, Monitoring, & Preparedness
  - Review adequacy of water monitoring and consumption records and invest in increased monitoring capabilities where needed.

- Evaluate potential funding needs for actions required under severe or extreme drought conditions to ensure the availability of adequate funding through budgets or emergency measures.
- Initiate increased reservoir level monitoring and reporting as directed by DPH.

Community Water Systems

The Department of Public Health Drinking Water Section (DWS) continues to request that all community water systems:

- Report any water quality issues immediately to the DWS
- Update WEBEOC with any status changes or issues.
- Report any outages of water service and any related rehabilitation to services and source that may happen as a result of the current drought to the DWS and relevant local officials through the MDL.
- Review all back up and emergency sources and/or interconnections.
- Notify the DWS of the activation of any emergency sources and/or interconnections.
- Record all consumer complaints regarding quality and quantity of water per § 19-13-B102(l)(l)(F) of the Regulations of Connecticut State regulations (RCSA).
- Notify the DWS of any water hauling per RCSA § 19-13-B46.
- Use licensed haulers per Connecticut General Statutes Section 20-278h.
- Review your current emergency contingency plan to assess its adequacy and timeliness in response to developing drought conditions. Assess your current drought triggers to determine if they remain appropriate in having a timely and effective response to developing drought conditions.
- Notify the DWS of any drought stage changes and any voluntary or mandatory consumption restrictions.
- Report weekly their weekly groundwater and surface water readings by submitting their groundwater and surface water reporting forms to the DPH by email to DPHWaterSupplyCapacity@ct.gov.
- Work as feasible with the municipalities you serve on drafting and enacting local water use restriction ordinances.

Please do not hesitate to reach out to the DPH Drinking Water Section by electronic mail at DWDcompliance@ct.gov, if you have any questions or run into any issues with respect to your public water system.

c: Heather Aaron, MPH, LNHA, Deputy Commissioner, DPH

LETTERS TO THE EDITOR

LAMONT'S 'HERO PAY' BONUS SNUBS LOCAL PUBLIC HEALTH EMPLOYEES

A couple weeks ago, Gov. Ned Lamont was proud to announce the availability of "hero pay" for healthcare workers and other essential workers who have been on the front lines in the fight against COVID-19 since its appearance in 2020. He also provided an extra stipend of $3,500 to state employees, most of whom worked from home during this two-and-a-half-year battle against a disease that proved entirely different from anything we had previously confronted in public health. The governor made the so-called "hero pay" available to a large sector of the "essential worker" population, with the caveat that employees of federal, state and *local* governments were exempt from applying for the "bonus."

Thus, most local public health employees were completely left out of the equation, despite the fact that they were the real "boots on the ground" throughout this pandemic, providing vaccinations, contact tracing, home visits, countless meetings, preparedness, PPE distribution, inspections, food service inspections and numerous other tasks required of them while putting themselves at risk of contracting the disease! Local public health has been the backbone of the fight against this new virus since its inception, devoting countless hours of overtime — not working from home, but directly in the trenches! They, along with healthcare workers and others, have been sticking to their jobs, facing numerous stresses and work overloads, and yet are totally excluded as "heroes" and hence from applying for "hero pay." There is simply no excuse for such omission on the part of the governor.

In addition, I have yet to hear in any of the governor's press conferences any laudatory remarks directed to local public health. Every citizen of Connecticut should be extremely grateful that such a dedicated workforce exists in this state, and they deserve acknowledgment and extreme praise for the "stick-to-itness" that they so admirably exhibited during the last two and a half years of fighting.

Raymond E. Sullivan
Brookfield

The writer is Brookfield's director of health.

We welcome your letters. They should be brief and refer to current or recent events. Writers are limited to one letter every 30 days. Please include your name, street address and daytime telephone number for verification.

For your convenience, a form for writing letters is available at: **www.rep-am.com/opinion**

Letters also may be emailed to: **opinion@rep-am.com**

Or they may be addressed to:

Letters to the editor
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