Mohawk Area Public Health Coalition COVID-19 Response, March 2020 - July 2021

After-Action Report/Improvement Plan

1/31/2022

EXERCISE OVERVIEW

Exercise Name	COVID-19 AAR/IP
Exercise Dates	July 2021 – October 2021
Scope	This is an evaluation of a real-world response to COVID-19 during the first 18 months of the pandemic for eight emergency dispensing sites ("EDSes" or "sites") and the public health preparedness coalition that brings them together (Mohawk Area Public Health Coalition (MAPHCO)) in western Massachusetts.
Mission Area(s)	Response
Core Capabilities	• PHEP Capability 3: Emergency Operations Coordination • PHEP Capability 4: Emergency Public Information and Warning • PHEP Capability 6: Information Sharing • PHEP Capability 8: Medical Countermeasure Dispensing and Administration • PHEP Capability 15: Volunteer Management
Objectives	1. Coordinate with emergency management to direct and support a pandemic disease response in the MAPHCO service area by establishing a standardized, scalable system of oversight, organization, and supervision that is consistent with jurisdictional standards and practices and NIMS. 2. Develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel. 3. Conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among local and regional levels of government and the private sector. This includes the routine sharing of information as well as issuing public health alerts to all levels of government and the private sector in response to an incident of public health significance. 4. Provide medical countermeasures to targeted populations to mitigate the adverse health effects of a pandemic disease according to public health guidelines. Dispense and administer medical countermeasures, such as vaccine. 5. Coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support response activities.

Threat or Hazard	Coronavirus disease 2019 (COVID-19)
Scenario	The novel Coronavirus is an infectious disease caused by the SARS-CoV-2 virus first documented in China, in December of 2019. The virus leads to the development of COVID-19, a respiratory illness with mild to severe and sometimes fatal effects. Massachusetts confirmed its first COVID-19 case on February 2, 2020. By March 15, 2020, most states in the US and countries around the globe went into lockdown to slow the exponential spread of the virus. Between March 2020 and the summer of 2021, eight Franklin County, Massachusetts emergency dispensing sites affiliated with the Mohawk Area Public Health Coalition engaged in a variety of response efforts evaluated in this report.
Sponsor	Funding for this report was made possible (in whole or part) by the Centers for Disease Control and Prevention and/or the Assistant Secretary of Preparedness and Response. The views expressed in written materials or publications do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of the trade names, commercial practices, or organizations imply endorsement by the US Government.
Participating Organizations	EDSes: Hawlemont (Hawley, Charlemont, Rowe, Monroe, Heath), Mohawk (Buckland, Shelburne, Ashfield, Colrain), Greenfield, Greater Montague Area (Montague, Gill, Erving, Wendell), Frontier (Whately, Sunderland, Deerfield, Conway), Leverett, Shutesbury, and Williamsburg-Goshen (Hampshire County towns).
Point of Contact	Tracy Rogers Emergency Preparedness Program Manager Franklin Regional Council of Governments 413-774-3167 x118 emergencyprep@frcog.org

ANALYSIS OF CORE CAPABILITIES

Objective	Core Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
1. Coordinate with emergency management to direct and support a pandemic disease response in the MAPHCO service area by establishing a standardized, scalable system of oversight, organization, and supervision that is consistent with jurisdictional standards and practices and NIMS.	#3 Emergency Operations Coordination			X	
2. Develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel.	#4 Emergency Public Information and Warning		X		
3. Conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among local and regional levels of government and the private sector. This includes the routine sharing of information as well as issuing public health alerts to all levels of government and the private sector in response to an incident of public health significance.	#6 Information Sharing	X			
4. Provide medical countermeasures to targeted populations to mitigate the adverse health effects of a pandemic disease according to public	#8 Medical Countermeasures Dispensing and Administration			X	

Objective	Core Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
health guidelines. Dispense and administer medical countermeasures, such as vaccine.					
5. Coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support response activities.	#15 Volunteer Management		X		

Table 1 Summary of Core Capability Performance

Ratings Definitions:

- Performed without Challenges (P): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Performed with Some Challenges (S): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.
- Performed with Major Challenges (M): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Unable to be Performed (U): The targets and critical tasks associated with the core capability were not performed in a manner that achieved the objective(s).

Objective 1: Coordinate with emergency management to direct and support a pandemic disease response in the MAPHCO service area by establishing a standardized, scalable system of oversight, organization, and supervision that is consistent with jurisdictional standards and practices and NIMS.

Public Health Emergency Preparedness (PHEP) Capability 3: Emergency Operations Coordination

Strengths

The partial capability level can be attributed to the following strengths:

Strength 1: Two sites reported that their plan was helpful in their COVID response and that they have made or will make updates.

Areas for Improvement

The following areas require improvement to achieve the full capacity level:

Area for Improvement 1: While important information is contained in the EDS plan, in most cases, it was viewed as too long to navigate. All but two sites reported that their EDS plan was not helpful to their efforts. With an average plan length of 190 pages and a three-page table of contents, EDS members felt the plans were too long to locate helpful information. It is perhaps not surprising that many EDS teams have not read their plans and do not view them as a resource. One site said simply, “We’ve never read that plan. The only time we open it is when you tell us it’s a requirement.” All sites responded to the pandemic in some way, most without consulting their plan at all. The same problem was identified during a tabletop exercise held in March 2020.

Reference: Regional EDS plans

Analysis: The PHEP program is designed for professional health departments, at a county level or an urban municipal level, to implement. Therefore, EDS planning guidance developed by the CDC and adapted by state health departments assumes that those responsible for plan implementation have a certain level of education, experience, and amount of time available to dedicate to planning and preparing for public health emergencies. When volunteers in rural settings attempt to implement the same guidelines, they find them cumbersome and overwhelming.

MAPHCO hired a technical writer in 2012 to create a template for all EDS plans so they would essentially be the same with minor customization for each EDS location. The reason for this level of consistency was that EDS members understood that they would be called upon by other EDS locations to assist during an emergency because there were not that many people in each community trained in ICS and public health emergency response to begin with. The more that operations were all expected to run the same the easier it would be to step into another EDS and be just another cog in the wheel.

Since that time, the number of volunteers in the county, in general, has decreased. This is due to several demographic factors, not the least of which being that our population is aging. Following suit, the number of EDS volunteers and size of EDS leadership teams have decreased to the point where most, if not every, EDS plan has at least one empty position in its ICS organizational chart. No EDS has redundancy in each position at least three deep, which is recommended. There may be too many EDS locations within the MAPHCO region to rely on the small number of trained volunteers available to operate them simultaneously. (Interestingly, Leverett and Shutesbury decided within the last year to become two separate single-town sites rather than one regional site.)

Within the professional health departments that the CDC assumes are implementing the PHEP program, emergency preparedness and response are built-in to everyday operations. At the FRCOG, emergency preparedness and public health are nestled within two separate departments. This creates role confusion, confusion over lines of authority, sometimes duplication of efforts, and sometimes gaps in efforts where one department assumed the other was addressing an issue. Additionally, current EDS borders do not match the borders of regional public health staffing, providing additional challenges in getting investment in using the plans.

Objective 2: Develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel.

PHEP Capability 4: Emergency Public Information and Warning

Strengths

The capability level can be attributed to the following strengths:

Strength 1: All sites reported reaching most residents with COVID-19 communications.

Strength 2: All sites identified area-specific methods for reaching residents:

- Electronic road signs
- Reverse-911 calls
- Local publications
- Town websites and Facebook pages
- Senior center communications
- School emails, newsletters, and “backpack mail”
- US mail
- Discussion of COVID-19 at board of health and selectboard or city council meetings that were broadcast on community access channels
- Town email distribution lists
- Virtual question and answer sessions at the end of church services

Strength 3: EDS teams understood the specific needs and character of their communities and responded effectively.

Strength 4: All EDS teams reported appreciating the FRCOG's risk messaging materials even if they did not use them.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: No EDS has a communications plan in place nor did any EDS report involving their public information officer (PIO) in the response.

Reference: Regional EDS plans

Analysis: Except for the Greenfield EDS, no EDS teams have paid or volunteer staff with training in public communications. This is another result of trying to impose a plan intended for a large professional health department on a rural volunteer organization.

Objective 3: Conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among local and regional levels of government and the private sector. This includes the routine sharing of information as well as issuing public health alerts to all levels of government and the private sector in response to an incident of public health significance.

PHEP Capability 6: Information Sharing

Strengths

The full capability level can be attributed to the following strengths:

Strength 1: Emergency dispensing sites reported communicating within their group often and, by most accounts, effectively.

Strength 2: Emergency dispensing sites attributed their success to the relationships they developed over the past 15 years of emergency response planning and exercising.

Strength 3: All EDS teams reported finding some value in bi-weekly MDPH LBOH calls and emails.

Objective 4: Provide medical countermeasures to targeted populations to mitigate the adverse health effects of a pandemic disease according to public health guidelines. Dispense and administer medical countermeasures, such as vaccine.

PHEP Capability 8: Medical Countermeasure Dispensing and Administration

Strengths

The capability level can be attributed to the following strengths:

Strength 1: While vaccine clinics were not organized by EDS sub-region for efficiency's sake, and the plans were not used, many longtime EDS leaders were intimately involved in planning, executing, and publicizing the regional vaccine collaborative's clinics, using and adding to the lessons they had learned from previous drills.

Strength 2: EDS teams and local councils on aging did yeoman's work in their communities helping seniors sign up for vaccination appointments that were implemented exclusively online and required rapid deployment.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: When testing and vaccines became available, the state did not involve EDSes in distribution efforts, despite years of planning and exercising led by the state indicating that would be the case. In addition to making many local boards of health wonder what they had been training for over the last 15-20 years, this resulted in the nearest state mass vaccination site being situated 1.5 hours' driving distance from the most western town in MAPHCO's area. Residents of the western part of the service area are disproportionately elderly. While some seniors are comfortable driving short distances to a nearby grocery store, many do not feel safe driving long distances and may not have the support to do so.

Reference: Emergency dispensing sites: A guide for local health on planning for medical countermeasure (MCM) dispensing operations (2019). Massachusetts Department of Public Health, Office of Preparedness & Emergency Management.

Analysis: According to testimony from the Massachusetts Secretary of Health and Human Services, MDPH issued an electronic survey to all local health departments before vaccine was allocated to the state asking which departments felt they had the capacity to distribute vaccine in their communities. Only one-third of the boards in the state responded positively that they had capacity, leading MDPH to conclude that dispensing COVID vaccine through local EDSes was not practical.

Below is a brief review of MAPHCO EDS MCM dispensing drill data covering 2018 – 2020.

- In 2020, EDS teams opted for a coalition-wide tabletop exercise instead of dispensing drills, so sites were not tested operationally.
- In 2019:
    - Two of the nine sites did not drill at all.
    - The EDS covering the largest population only gathered three staff together for a site assembly drill.
    - One EDS gathered 12 people for its site assembly drill.
    - The remaining five sites gathered five to six people for their site assembly drills.
- In 2018:
    - All nine sites drilled.

- Three sites assembled at least eight staff.
- The remaining six sites assembled between zero and four staff.

MAPHCO's regional EDS plans call for 42 positions to be filled to operate an emergency dispensing site. Twelver staff is the maximum number any of the sites have mustered during drills over the last three years. Most have not mustered more than six and some have not drilled at all. Consequently, it is difficult to make the case that any of the existing sites would be capable of conducting operations on their own.

Area for Improvement 2: The first-come-first-served internet-based vaccination appointment structure disadvantaged the elderly and those without access to high-speed internet, computers, or cell phones.

Reference: None

Analysis: The Hawlemont and Mohawk sites hosted local vaccine clinics to meet the needs of their rural residents, especially senior citizens. However, people from across the state who were more tech-savvy and had good internet access took appointments that were designed to support local residents with limited mobility outside their local community. Some even came from eastern MA demonstrating that they could have used a mass-vaccination site closer to their homes rather than taking appointments away from western Franklin County residents for whom travel more than 20 miles was not an option. Additionally, the requirement to use PrepMod in real-time hampered the Hawlemont EDS, an area with limited internet and cellular access, in providing vaccines. The EDS has successfully provided at least one annual flu clinic in the past using paper forms. After a great deal of advocacy on the part of the EDS's town nurses, MDPH allowed a small number of paper vaccination forms to be used for COVID vaccine appointments.

For EDS volunteers used to using paper forms, the transition to mandatory online registration was a challenge and required entirely different considerations in setting up clinic sites to accommodate internet and electricity. On the plus side, pre-registration meant there were no 1.5-hour waits for residents like there had been in the flu drills the fall before.

Objective 5: Coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support response activities.

PHEP Capability 15: Volunteer Management

Strengths

The capability level can be attributed to the following strengths:

Strength 1: Most sites have worked with volunteers in the past, generally for drills and flu clinics. Some have an extensive list of long-time, committed volunteers. One EDS noted that they thought seeing local volunteers at COVID vaccine clinics helped to reduce patient anxiety.

Strength 2: Unlike state-sponsored vaccine clinics staffed by paid subcontractors, regional vaccine collaborative COVID vaccine clinics relied heavily on volunteers, organized largely through

the MRC. Strong relationships with the MRC made COVID vaccination clinics possible and cost-effective.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: At some COVID vaccine clinics, there were difficulties integrating EDS volunteers and MRC volunteers.

Reference: Regional EDS plans

Analysis: Despite a history of offering flu vaccine clinics, COVID vaccine clinics required specialized non-medical volunteer training because of the state software requirement. To reduce volunteer management burden and to ensure proper training and screening, all MAPHCO members agreed before the regional clinics began that using only MRC volunteers was preferred. All agreed they would require their EDS volunteers who were not enrolled in the MRC to do so. Despite this agreement, the Frontier EDS team chose to use a blend of MRC volunteers and its own EDS volunteers. This caused confusion and duplication of scheduling.

Appendix A: Improvement Plan

This IP has been developed specifically for MAPHCO and the Massachusetts Department of Health as a result of eight focus groups and several hours of one-on-one interviews conducted between July and September 2021.

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element	Primary Responsible Organization	Organization POC	Start Date	Completion Date
3: Emergency Operations Coordination	3.1. While important information is contained in the EDS plan, in most cases, it was viewed as too long to navigate.	3.1.1. Using the CDC's Operational Readiness Review, EDS teams should evaluate whether they have the resources necessary to operate an EDS on their own.	Planning	EDS teams FRCOG	PHEP planner	7/1/22	3/30/23
		3.1.2. EDS teams should explore other options to help them operate their sites, such as regional health district staff, pharmacies, and incident management teams.	Planning	EDS teams FRCOG	PHEP planner	7/1/22	3/30/23
		3.1.3. If through corrective action 3.1.1, EDS teams determine that they do not have the resources necessary to operate on their own, they should discuss merging EDS locations and teams to create fewer, more robust sites.	Planning	EDS teams FRCOG	PHEP planner	7/1/22	3/30/24
		3.1.4. Given the significant changes in local public health infrastructure since the EDS sub-regions were designed, the map of sub-regions should be redrawn to better align responsibilities with	Planning	EDS teams FRCOG	EDS team leadership PHEP planner	7/1/22	3/30/23

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element	Primary Responsible Organization	Organization POC	Start Date	Completion Date
		the staff available to support local boards in this work.			Randy Crochier		
		3.1.5. The FRCOG should examine combining its public health emergency preparedness program and its regional public health service to reduce confusion over roles and responsibilities.	Organizational	FRCOG	Linda Dunlavy	4/1/22	6/30/22
4: Emergency Public Information and Warning	4.1. No EDS has a communications plan in place nor did any EDS report involving their public information officer (PIO) in the response.	4.1.1. Consider recruiting a PIO who has completed, or will complete, the FEMA courses: *Public Information Officer Awareness* and *Public Information Basics*, or training a board of health member. Ideally, a PIO will complete the *Advanced Public Information Officer* course.	Training	EDS teams	EDS leadership	7/1/22	3/30/23
		4.1.2. Offer PIO courses.	Training	MAPHCO Steering Committee	PHEP Planner	7/1/22	6/30/23
8: Medical Countermeasure Dispensing	8.1. When testing and vaccines became available, the state did not involve EDSes in distribution efforts.	8.1.1. If EDSes want to be seen as viable tools for MCM dispensing during emergencies, they need to be able to fill their rosters and	Planning/ Exercises	EDS Teams FRCOG	EDS team leadership	7/1/22	3/30/24

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element	Primary Responsible Organization	Organization POC	Start Date	Completion Date
and Administration		successfully drill their plans regularly.			PHEP planner		
	8.2. The first-come-first-served internet-based vaccination appointment structure disadvantaged the elderly and those without access to high-speed internet, computers, or cell phones.	8.2.1. MDPH should ensure that equal access to vaccine appointments does not cause inequitable access.	Planning	MDPH			
15: Volunteer Management	15.1. At some COVID vaccine clinics, there were difficulties integrating EDS volunteers and MRC volunteers.	15.1.1. EDSes should each decide what their policy will be for future operations around using only MRC volunteers, only EDS volunteers, or a mixture of both. If a mixture is preferred, plans need to be updated to include clear procedures for how scheduling will occur to prevent duplication of efforts.	Planning	EDS Teams	EDS leadership team	7/1/22	3/30/23

APPENDIX B: EXERCISE PARTICIPANTS

Participating Organizations
Regional
Berkshire Regional Planning Commission (Franklin County MRC)
Franklin Regional Council of Governments (CPHS, HMCC, MAPHCO)
South County Emergency Medical Services
Local
Hawlemont EDS
Mohawk EDS
Greenfield EDS
Greater Montague Area EDS
Frontier EDS
Leverett EDS
Shutesbury EDS
Williamsburg-Goshen EDS

Acronym	Term
AAR	After Action Report
BOH	Board of Health
CPHS	Cooperative Public Health Service
EDS	Emergency Dispensing Site
HMCC	Health & Medical Coordinating Coalition
ICS	Incident Command System
IP	Improvement Plan
MAPHCO	Mohawk Area Public Health Coalition
MDPH	Massachusetts Department of Public Health
MEMA	Massachusetts Emergency Management Agency
MRC	Medical Reserve Corps
NIMS	National Incident Management System
OPEM	Office of Preparedness and Emergency Management (MDPH)
PHEP	Public Health Emergency Preparedness
PIO	Public Information Officer
PPE	Personal Protective Equipment
SNS	Strategic National Stockpile
TTX	Tabletop Exercise