# Berkshire County Initial Public Health Response to a Pandemic

## BCBOHA After-Action Report/Improvement Plan

2022.04.21

This After-Action Report/Improvement Plan (AAR/IP) focuses on the initial response to a large-scale and ongoing Pandemic. It aligns response objectives with preparedness doctrine to include the National Preparedness Goal and related frameworks and guidance. Exercise information required for preparedness reporting and trend analysis is included; users are encouraged to add additional sections as needed to support their own organizational needs.

# RESPONSE OVERVIEW

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| **Response Name** | Berkshire County Initial Public Health Response to the COVID-19 Pandemic |
| **Response Dates** | January 2020 – April 2020 |
| **Scope** | This real time response is still ongoing. This AAR/IP focusses on the initial response actions. |
| **Mission Area(s)** | Mitigation and Response |
| **Public Health Core Capabilities** | #3 Emergency Operations Coordination<br>#4 Emergency Public Information and Warning<br>#6 Information Sharing |
| **Objectives** | 1. Identify the successes and gaps in the initial response and coordination by Berkshire County public health agencies, local boards of health and other responder groups to the COVID-19 pandemic and identify strategies to fill those gaps.<br>2. Identify the successes and gaps in initial Berkshire Public Information coordination and Risk Communications to the public and identify strategies to fill those gaps.<br>3. Identify the regional successes and gaps in initial Berkshire Information Sharing coordination among responder groups and identify strategies to fill those gaps. |
| **Threat or Hazard** | Pandemic Coronavirus/COVID-19 disease and the public health and societal impacts of implemented Non-Pharmaceutical Interventions (NPI) |
| **Scenario** | In January 2020, there were warnings that a pandemic was developing and had reached or was about to reach the United States. The Federal response was slow, fragmented, and ineffective. While the Massachusetts Department of Public Health (DPH) had a very recent and robust Pandemic Plan, it went unutilized and there was confusion as to who was in charge or how the Massachusetts Emergency Management Agency (MEMA) and DPH were or should be coordinating. Once the Governor and the Command Center assumed leadership for the response, local Public Health had almost no input into the mitigation or non-pharmaceutical interventions (NPI) decisions made and often had to take action in a last-minute reactionary manner. Berkshire County's Pandemic Plans were about 14 years old and not recently exercised with no practical plans for coordinating a Berkshire-wide response, including information sharing and public information. While many organizations individually stepped up to fill gaps such as food shortages, there was little or no official public health coordination in the county or State. While regional EDS plans did not fully address mass vaccinations during a highly contagious disease outbreak, they were extremely useful and effective when DPH asked the Berkshire PHEP Coalition (BCBOHA) to distribute vaccines in December 2020 |
| **Sponsor** | Berkshire County Boards of Health Association (BCBOHA) with funding and support from the Public Health Emergency Preparedness (PHEP) grant. |

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| **Response Name** | Berkshire County Initial Public Health Response to the COVID-19 Pandemic |
| **Participating Organizations** | Berkshire County Boards of Health Association (BCBOHA), local Boards of Health, and staff. |
| **Point of Contact** | Allison Egan, Senior Planner, BCBOHA, Berkshire Regional Planning Commission's Public Health Program,1 Fenn Street, Pittsfield, MA 01201, aegan@berkshireplanning.org |

# ANALYSIS OF CORE CAPABILITIES

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

| Objective | PH Core Capability | Performed without Challenges (P) | Performed with Some Challenges (S) | Performed with Major Challenges (M) | Unable to be Performed (U) |
|---|---|---|---|---|---|
| #1 Identify the successes and gaps in initial Berkshire public health response coordination | # 3 Ops Coord. | | | M | |
| #2 Identify the successes and gaps in initial Berkshire Public Information coordination | # 4 Public Info | | | M | |
| #3 Identify the regional successes and gaps in initial Berkshire Info Sharing coordination. | # 6 Info Sharing | | S (Local and Berkshire Public Health) | | |

**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).

## Response Overview:

Because of its proximity to New York State and an outmigration to rural, second-home areas as the New York metropolitan area experienced an early COVID-19 surge, Berkshire County, Massachusetts had the first community spread of COVID-19 in Massachusetts and high caseloads earlier than many other areas. Berkshire Medical Center first started asking to have an inpatient tested for COVID at the end of February. They were finally given permission after several requests and the first patient was formally diagnosed on Saturday, March 7, 2020, with several additional tests pending.

Berkshire Medical Center Command Center immediately reached out to Laura Kittross, the Director of Berkshire County Boards of Health Association (BCBOHA) which is the Berkshire Public Health Emergency Preparedness (PHEP) Coalition, to ask about access to personal protective equipment (PPE) and how contact tracing and community mitigation would be handled. This and other Berkshire partnerships formed an ongoing, though sporadic, and informal regional information sharing system throughout the response. This information sharing system was bolstered by Laura Kittross' representation on the Coalition of Local Public Health (CLPH). CLPH is made up of representatives from the six statewide public health professional organizations (MHOA, MPHA, MAPHN, MEHA, MAHB and WMPHA) and had frequent access to, although limited influence on, DPH and Command Center officials. Regional emergency response funding made available to Public Health Districts (Berkshire Public Health Alliance and Tri-Town Health Department in Berkshire County) and "Affiliates" (organizations that picked up unaffiliated municipalities, such as Berkshire Regional Planning Commission in Berkshire County) and associated meetings also gave regular access to DPH and occasionally the Command Center a couple times per week early in the pandemic.

By summer many thought the pandemic had burned itself out so various structures initially established to respond to the emergency were stood down or not maintained. By late summer and fall, the Delta variant was again surging, but the informal structures did not re-activate to manage the surge until vaccines were suddenly ready for local vaccine distribution in early December 2020. Formal, effective public information coordination was never really established or sustained until the vaccination efforts began in early December.

Although COVID-19 is ongoing, this AAR/IP will focus on the initial response (January – April 2020) to this public health emergency. The scope of this AAR/IP had to be limited to be able to effectively develop an implementable improvement plan. In addition, only areas within our power to change in Berkshire County are generally considered, even though the state and federal response also needs an effective AAR/IP process to improve future response coordination with local public health.

The decision to focus on the initial response was prompted by the general observation that there was not a coordinated, accepted regional public health response plan with an identified unified command structure. Often, multiple, and different systems for the initial response, including information sharing and public information, were at play across Berkshire County. Response actions often depended heavily on the personalities of individuals in leadership positions, resulting in a sporadic, inconsistent response that was not well coordinated nor sustained as many Boards of Health (BOH) waited to be told what to do by the Department of Public Health

(DPH) instead of immediately activating and working together to formalize a plan to coordinate and sustain a Berkshire response.

Leaders from both the Southern and Northern Regional Emergency Planning Committees (REPC) activated Emergency Operations Centers (EOC) to begin the task of managing information sharing and the distribution of some resources such as PPE. In Central County the REPC was not activated; however, a Central County Emergency Operations Center was activated and led by the City of Pittsfield Police Chief. Although information sharing was robust among the three regions, public information coordination was never formally coordinated and the REPC seemed initially unsure of their role in a public health emergency. Public Health was included in the command structure of all three EOC, though mostly in a supporting role.

BCBOHA staff planned an isolation and quarantine training combined with a situation update in February 2020, although it was not offered until the second week in March due to a lack of support from DPH. This meeting was heavily attended by Boards of Health and first responders. A planning meeting was also held for local BOH staff and a few members to start to coordinate the Berkshire response in early March. This group eventually evolved into the Friday Working Group which has continued meeting to this day.

It is each Board of Health's (BOH) responsibility to create, enact, and enforce regulations and issue advisories to protect the public health and safety in their communities, especially during a public health emergency. BOHs were often given information by the Massachusetts Department of Public Health (DPH) in an ever-changing, last-minute way for the first year, forcing BOH to constantly change and issue complicated new guidance to the public which in turn caused increasing public unrest and distrust of LBOH directives and advisories. Although the Friday Working Group regularly discussed their response with the aim of having consistent enforcement and messaging across the county, and some public information was regionally coordinated, such as the letters sent in March 2020 to short-term rental owners, the mixed messaging from the state and lack of a formal Berkshire Joint Information System (JIS), kept Berkshire County from creating a robust regional public health information system response until vaccinations began in late fall 2020.

It is well established that during an actual emergency, the first few hours, days and weeks are critical to establishing a robust, coordinated, regional Incident Command or Unified Command structure as the place for the Responders, media, and the public to get reliable information. A lack of early and frequent official and well-coordinated information creates gaps that are filled by social media and rumors.

Regional response coordination also saves scarce human resources and provides a structure to assign, share, and coordinate roles and responsibilities. This is especially important when there are 32 local jurisdictions in a relatively small media market, each with a mandate to protect the public health and safety and each trying to figure out key issues like PPE, Public Information and consistent messaging, Logistics, Planning, Operations and Finance. The saying is, it is easier to ramp down than it is to ramp up.

During the AAR/IP process there was a great deal of discussion regarding the lack of consistent, effective public health leadership at the State and Federal levels as well as the often conflicting

and last-minute orders and directives that demonstrated little understanding of effective public health practice. This might be due to a lack of planning and exercises at the State and Federal levels that included local health, and lack of clear, practiced communication networks and capacity between DPH and local health. To make up for these deficiencies, Berkshire County Public Health must be proactive and plan to coordinate a Berkshire response.

It was also noted by many that the Department of Public Health and its Office of Preparedness and Emergency Management (OPEM) was largely missing from this response, despite having spent almost two years in 2015-2017 developing a robust planning process to create a Pandemic Response Plan and more than 10 years of Emergency Dispensing Site Planning (EDS) planning. The State's pandemic planning process included local public health as well as hospitals, clinics, long term care and EMS. The State's Pandemic Plan was never referred to during the response. The EDS plans were useful for the relationships built, but DPH repeatedly told Boards of Health they would not be doing vaccinations any time soon, so these plans largely went unused until vaccines suddenly became available to local health in late 2020 (and in most parts of the state they were never used at all). Private contractors were hired to do contact tracing instead of giving resources to the local Public Health Nurses to ramp up, resulting in delays, inconsistencies, and large expenses for the State that did little to build local health capacity until much later in the response.

## Initial Response Analysis:

In the beginning, Health Departments were asking, "what should I be doing?" They did not have a clear emergency response plan or emergency response training to guide them and DPH did not initially provide any clear, actionable directions for establishing local or regional command structures. Despite the experience with H1N1 in 2010-2011, over the last ten years, Berkshire's Boards of Health and local Health Departments, along with their partner agencies and other responder groups, have been mostly focused on responding to shorter term imminent threats and emergencies such as weather disasters, chemical spills, fires, active shooters, etc. Few were focused on preparing for a sustained public health emergency such as a pandemic. The only annual requirements for public health to prepare for and respond to an emergency revolve around anthrax or a similar event where Emergency Dispensing Sites (EDS) could be stood up and down quickly to provide vaccines or medications to the population over a period of days. There are no exercise or planning requirements for a large-scale, long-term event such as a pandemic.

The Public Health Emergency Preparedness planning and exercise process should be expanded to include pandemics as well as other large scale public health threats and training and exercises for infectious disease should occur at least annually. EDS plans could be updated to include a Pandemic Annex with clear steps for BOH to take in the initial response to a public health threat. In an ideal world, in addition to robust local health response plans, DPH and OPEM would focus on coordinating closely with local public health to update their pandemic response plans to ensure there are clearly defined roles, communication plans, and processes so that the state and locals can collaborate on a response. In addition, there needs to be a clear Berkshire County Public Health Emergency Response Plan including basic agreement on agencies involved and how a response will be coordinated, including Risk Communications, Public Information, Information Sharing, NPI, and vaccinations or other medical response actions

## Capability Analysis:

The following sections provide an overview of the performance related to each response objective and associated core capability, highlighting strengths and areas for improvement. The strengths and areas for improvement for each core capability aligned to this objective are described in this section.

## Core Capability # 3 Emergency Operations Coordination

### Strengths

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

**Strength 1:** BCBOHA and the local Boards of Health Agents, and Public Health Nursing Staff have a long history of cooperation as well as jurisdiction and sub-regional level Emergency Dispensing Site (EDS) plans and policies to distribute mass prophylaxis that have built strong relationships and included annual planning and exercise components which generally created a culture that supports regional coordination and provided the basis for mass vaccinations in late 2020 and early 2021.

**Strength 2:** The Berkshire Public Health Alliance, Berkshire Regional Planning Commission and Tri-Town Health were able to get emergency funding quickly from the state that allowed the Alliance to ramp up their public health nursing capability. With this funding, the Alliance was able to cover on an emergency basis not only the four or five municipalities that were not on MAVEN at that time, but also the seven municipalities that were stranded without services when Porchlight VNA unexpectedly went out of business in late March 2020. The Alliance PH Nurses coordinated with the Public Health Nurses at the Berkshire Visiting Nurse Association (BVNA), Community Health Association of Richmond and West Stockbridge (CHARWS) and the City of Pittsfield, ensuring that cases were not lost across municipal lines and that messaging to cases and contacts was consistent**.** Because of the early cases in Berkshire County, and because of the increase of cases in nursing homes, DPH temporarily assigned an epidemiologist to work directly with the Berkshire County Public Health Nurses. A lack of previous relationships and familiarity with the area limited the usefulness of this assignment. It would be a best practice to have an epidemiologist permanently assigned to Western Mass or for Berkshire County to fund their own epidemiologist to advise and support the PHN and BOH.

**Strength 3:** There were existing regional structures to leverage in this large-scale response, including the three Regional Emergency Planning Committees (REPC), Berkshire County Boards of Health Association (BCBOHA) which is the regional Public Health Emergency Preparedness (PHEP) Coalition, Tri-Town Health Department (Lee, Lenox and Stockbridge shared services district), the Berkshire Public Health Alliance (a 24-jurisdiction shared services coalition), Berkshire Health Systems' (BHS) regional hospital network, Berkshire Medical Reserve Corp (BMRC), and the Berkshire Sheriff's Department. Many of these regional structures were used during H1N1 and were again leveraged and sustained for this response, though not uniformly and consistently throughout the county.

**Strength 4:** When it became obvious that the State and DPH were not going to help coordinate the local public health response, regional groups eventually used these existing county-wide structures to coordinate a county response with leadership from BCBOHA and other partners. Tom Matuszko, Executive Director of Berkshire Regional Planning Commission (BRPC) and the

BRPC Commission Board were very supportive of the BCBOHA and BRPC Public Health Program and the use of the substantial staff time and resources needed to support this response. When polled, the majority of BOH feel that this leadership should continue and be part of a Berkshire Pandemic Response Plan.

**Strength 5:** There was general agreement among Boards of Health that public health and Boards of Health should be in charge of a public health emergency response, though this did not actually happen in many jurisdictions where the Chief Elected Official, Town Manager or Town Administrator often took charge in the same manner as the Governor took charge at the State level.

**Strength 6**: The Northern Berkshire REPC set up and sustained an effective, regional Incident Command System (ICS) Command Structure and EOC that included local public health, first responders, local government officials, social services, schools, and EMS, among others, in north county. This response structure should be considered for other areas of the county.

**Strength 7:** Many larger communities with robust Emergency Response Teams (ERT), met early and often regarding the emergency to identify actions and activies to mitigate the pandemic in their communities. This was a general strength throughout the response, though in smaller communities the ERT often was one dedicated Board of Health member.

**Strength 8:** Many local community organizations, including the United Way, the Councils on Aging and other community partners, stepped up to provide food and other supplies to at-risk households, including the elderly, families with school age children, those without incomes and those under isolation and quarantine orders. Community groups also set up childcare/remote education classrooms so that parents could go back to work when schools were closed, especially in healthcare and other essential services.

**Strength 9:** A functioning Berkshire Medical Reserve Corps was active and ready to assist the response with trained and vetted volunteers. Although not well used in the first few months, the BMRC became an essential part of the response by supporting food distribution, shelters, testing, and vaccinations and were able to on-board hundreds of additional volunteers during the pandemic, especially during the vaccination distribution.

**Strength 10:** Many Berkshire communities consulted their existing Emergency Plans and Pandemic Plans. However, they were very out of date and weren't very useful to this response, especially as DPH was not clear about the role of local Boards of Health (BOH).

**Strength 11:** BCBOHA began quickly to provide a weekly situation update to local Boards of Health who in turn shared relevant information with other municipal officials and residents. Unfortunately, the Situation Update was very time-intensive to produce, especially as guidance and conditions continually shifted and changed in unpredictable ways, and the Situation Update became a victim of a lack of staff resources in the summer of 2020. In future responses a way to continue to provide that level of detailed information as long as it is needed should be developed.

## Areas for Improvement

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

**Area for Improvement 1: ICS and Command and Control.** Boards of Health, Health Agents, and Public Health Nurses (PHN) have little experience managing large scale emergencies and no

experience with regional or unified command structures. Incident Command or formal ICS structures were not often established, or ICS positions officially appointed and maintained at all levels of the response. There was a general lack of understanding of ICS and how to use it effectively to manage and coordinate a large-scale emergency by having one group in charge of coordinating the response and making the response more sustainable by delegating responsibilities to Section Chiefs as no one person can do it all or effectively manage more than five to seven people (span of control).

This lack of a formal ICS structure and organization were also evident in the Public Health Emergency Preparedness Coalition (BCBOHA) that by default ended up coordinating the regional public health response. Even in communities where the Health Department Director had ICS training, ICS was typically not thought of until much later in the response. For example, it wasn't until the FEMA reimbursements were due that municipalities realized that they should have appointed a Finance Section Chief to track all the expenditures and resources such as volunteer hours to help them qualify for FEMA reimbursements. Also, Logistics and Planning were not well coordinated with the many groups attempting to find the same resources such as PPE and Operations didn't have the consistent support of the other Section Chiefs and Command Staff suffered as a result.

**Area for Improvement 2**: **Local Command and Control.** In most communities there is a general understanding of who would be in charge of a chemical spill, weather event, active shooter, etc., but no existing plan or general agreement on who would be in charge of a public health response. In many communities, the Town Manager or Chief Elected Official took charge of the response with little understanding of ICS, public health, risk communications or costs and tradeoffs associated with non-pharmaceutical interventions (NPI). Many smaller communities didn't know what they should or could be doing to respond to this type of emergency and were waiting for DPH to take charge or tell them what to do. Few communities actually activated an Emergency Operations Center (EOC) for very long, took part in a Unified Command, or formally appointed Section Chiefs that functioned through-out the response.

**Area for Improvement 3**: **Regional Command and Control Coordination.** There was no existing agreement, structure, or plan to regionally coordinate a public health emergency response resulting in Berkshire's 32 communities duplicating efforts, wasting scarce resources (usually staff time), and confusing the public with inconsistent messaging. While lead agencies were prompt in answering questions and giving support, guidance was sporadic and not universal. Many smaller communities didn't know what they should or could be doing or how to organize their efforts or be part of the county response. There was a general feeling among informants interviewed for this AAR that a Berkshire Unified Command should consist of the three REPCs, BCBOHA and the hospital with roles assigned to the Public Health Shared Services Districts, larger health departments, qualified BOH members, and other community partners.

**Area for Improvement 4: WebEOC.** There was no mention of using WebEOC and little understanding or guidance about how the Boards of Health could leverage this Massachusetts Emergency Management Agency (MEMA) based system or how it could be used to manage resources or ensure situational awareness for a response. Using WebEOC on a regular basis would likely make this capability more useful. In order to do that, the public health coalitions need an account in much the same manner as the Health and Medical Coordinating Coalition (HMCC) has one. Without that this will not be widely used to coordinate a Berkshire public health emergency. Additionally, the state has separate WebEOC systems for DPH and local

emergency responders –limiting overall communications across public health and response groups, which was especially important for PPE coordination and distribution.

**Area for Improvement 5: Resource Management.** While every Berkshire community is now covered by a public health nurse (PHN) and the PHN worked well together to ensure contact tracing was universal, they were vastly under resourced and there was no Berkshire Epidemiologist to assist them in outbreak analysis and prevention early on. It would be a best practice to have a permanent regional epidemiologist in Berkshire County or perhaps housed at the Western Health and Medical Coordination Coalition (HMCC) in Franklin County to serve all of Western Mass along with our cache of PPE and other emergency supplies.

**Area for Improvement 6**: **Harassment of Public Official.** Many Boards of Health, with and without professional staff, experienced a growing lack of civil discourse and a significant level of angry demands and threats from their community members, making it more difficult to provide a consistent, coordinated, practical, effective response to the pandemic. A more immediate, coordinated, county-wide response might have mitigated some of these issues by providing Boards of Health (BOH) with consistent county-wide talking points, including policies local Boards of Health have jointly determined are necessary to protect the public health and safety, based on the current science. Also, additional training in how to effectively and safely manage BOH meetings would be useful. At a minimum a regional coordinated response to these threats would likely create a culture and expectation of civil discourse and make them less prevalent.

**Reference:** EDS Plans and Pandemic Annex, CEMP, MACC/REPC plans, WRHSAC NPI Plan

**Analysis:**

1. **ICS and Command and Control General:** Annual ICS training followed by short mini-ICS exercises to reinforce the training concepts and role assignments for Boards of Health and Town Officials. Mini ICS training and exercises should also be integrated into Response Partner meetings at least annually as a review of the common response steps to establishing command and control, assigning roles and responsibilities, and rotating the roles among the attendees to promote Continuity of Operations Planning (COOP).

2. **Local Command and Control:** Annual training and exercises among EMD/REPC/MACC, town officials, and BOH to strengthen relationships, facilitate regional response coordination to improve plans and achieve general agreement on how public health emergency incidents are managed in the community.

3. **Regional Command and Control Coordination:** Create plans that clearly identify a regional command and control coordination structure with roles and responsibilities. This plan should be exercised at least annually during flu clinic season.

4. **WebEOC:** Public Health WebEOC is not routinely used by Boards of Health or nurses and is not well interfaced with the EMD WebEOC. Work with local EMD to practice integrating the two WebEOC systems to provide Situational Awareness and support resource management. In order for WebEOC to be used effectively at the regional level, the Public Health Emergency Preparedness (PHEP) Coalitions must be given a WebEOC account in the same manner as the HMCCs.

5. **Resource Management**: Find the resources to hire a permanent Berkshire epidemiologist or convince DPH to assign a permanent epidemiologist to Berkshire County. Create

plans, trainings and exercises on resource management and Logistics with the EMD/REPC and HMCC to ensure Logistics coordination in a Pandemic response.

6. **Harassment Prevention**: Provide training to BOH on managing meetings as well as training ad exercises on a Joint Information System to help ensure consistent messaging coordination to promote civil discourse. This could happen annually during flu clinic season.

## Core Capability # 4 Emergency Public Information/Warning

### Strengths

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

**Strength 1:** There was a general recognition that public information coordination and a Joint Information System (JIS) are important parts of a successful pandemic response, though no regional plans exist to establish and maintain such a system.

**Strength 2:** The hospitals, medical care, and larger communities were interested in being part of a regional public information initiative, though none of them were willing or able to take the lead of a Joint Information System (JIS).

**Strength 3:** BCBOHA released weekly or bi-weekly correspondence to the local newspaper and radio reporting representatives, as well as a weekly situational update to LBOHs (who then shared with other municipal officials) early on in the pandemic, although this process became cumbersome and hard to continue with lack of funding and staff capacity by summer 2020. Good relationships with local media outlets, including the Berkshire Eagle and WAMC were maintained throughout the pandemic and were helpful in getting appropriate messaging out to county residents.

**Strength 4**: Later in the response during the county vaccination efforts, the coordinated messaging system was more organized, consistent, and effective, demonstrating the value of consistent messaging.

### Areas for Improvement

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

**Area for Improvement 1: Joint Information System Plan.** There was no general agreement or plan for activating, coordinating, or sustaining a Joint Information System (JIS) early in the response and no one was appointed to stand up a JIS or coordinate public information including questions/talking points at various stages of the initial response. A JIS plan should be created, agreed on and used regularly to coordinate messaging in ways that could be expanded to meet the needs of the next large-scale response. The JIS could have also been helpful in sifting and summarizing the great deal of information that flooded local health and provide them with talking points, handouts, and social media ready press releases.

**Area for Improvement 2: Joint Information System Coordination.** There were no plans, policies or procedures that identified the regional agencies that should be part of a JIS or who would regionally monitor and respond to social media. This should be part of an active JIS Plan that is used and exercised frequently or used at least monthly to disseminate public health

information to practice and improve the JIS. The JIS should be as inclusive as possible and include the schools, BCBOHA/BOH, hospitals, Councils on Aging (COA), REPCs, and other essential response partners.

**Area for Improvement 3: JIS Lead Agencies.** While informal information coordination has occurred in the past through the Berkshire Health Systems PIO, the City of Pittsfield, BCBOHA, Fairview Hospital, and the NBREPC among others, regional public health coordination was not routinely mentioned as part of this informal network, was not officially activate, and had no designated lead agency. While the REPCs were identified as possible partners to manage a Joint Information System, there was little appetite to do this for a public health response. BCBOHA became the de-facto JIS lead and did not have the resources or ability to assign a staff person to take on the role of organizing and managing the JIS.

**Area for Improvement 4: JIS Training and Exercises.** In the past, there were frequent Public Information Officer (PIO) trainings and exercises held by DPH and the Western Region Homeland Security Advisory Council (WRHSAC) in Western Mass as well as the availability of MEMA trainings in Framingham and FEMA trainings in Emmitsburg. These should be held and promoted again on a regular basis as well as exercised at least annually.

**Reference:** EDS Plans and Pandemic Annex, CEMP, MACC/REPC plans, WRHSAC NPI Plan

**Analysis:**

1. **Joint Information System Plan.** A JIS Plan should specify a standing committee of partner agencies that will meet regularly to discuss Public Information Coordination and are activated once a year at a minimum during flu clinic season to coordinate messaging to keep the JIS plan active and relevant.
2. **Joint Information System Coordination.** While each agency is monitoring its own public information messaging and social media websites, identified agencies should be formally delegated to regionally coordinate these efforts and monitor the general social media platforms for the JIS to ensure consistent messaging and manage rumor control. This will also help establish the JIS as a source of trusted information.
3. **JIS Lead Agencies.** A lead/PIO agency for public health information should be immediately appointed by the JIS and triggers identified for scaling up the JIS to manage large-scale public health emergencies.
4. **JIS Training and Exercises.** Provide training to BOH on Crisis and Emergency Risk Communications (CERC) and training for Public Health Public Information Officers (PIO) as part of regional JIS Plan training and exercise plan. Ideally the JIS should be used monthly to provide public health updates in the form of newsletters, press releases and other regional public health advisories. The entire JIS should be activated at least annually during flu clinic season to practice and test the plan and system.

## Core Capability # 6 Information Sharing

### Strengths

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

**Strength 1:** Early in March BCBOHA along with Berkshire Health Systems (BHS) and other partners hosted a 100-person training on Isolation and Quarantine, along with a situation update. BCBOHA also facilitated a March meeting of about 30 Health Agents and Health Department Directors to discuss the regional response to the pandemic. This later became the Friday Workgroup, which met by Zoom weekly and grew to include BOH members, BOH staff, Public Health Nurses and other staff to share information, needs and best practices. This Friday Workgroup call was very successful for info-sharing and continues to this day. BCBOHA later helped establish weekly calls with the BOH conducted by the Alliance Medical Advisor, Dr. Daniel Doyle, where he shared hospital data and where medical innovations, treatments and vaccine development were discussed, as well as regional coordination and best practices. , Initially, BCBOHA also published a weekly newsletter/situation update for the first few months to share information, though this practice was discontinued when the staff member organizing the newsletter went out on maternity leave an nobody was found to take her place.

**Strength 2:** The Southern and Northern REPCs stood-up to manage some resources during the initial COVID response. Northern Berkshire REPC did an outstanding job in Northern Berkshire of consistently operating an Emergency Operations Center (EOC) during the response. When the Central REPC chose not to activate, the City of Pittsfield took on the role of operating a regional EOC under the leadership of Police Chief Michael Wynn and became the county central hub for materials and supplies, as well as for information-sharing. During the early response, Chief Wynn sent a daily situation update.

**Strength 3:** In local communities, information sharing was both formal and informal and worked well for the most part by leveraging local websites, newsletters, and outgoing phone alert systems. In some communities there were standing Emergency Response Teams that met to discuss the emergency. These Teams met weekly and were inclusive of Boards of Health for the most part.

## Areas for Improvement

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

**Area for Improvement 1: Local Information Sharing Plan.** While local information sharing systems seems to have worked well in most communities, less than half of people who responded to the BCBOHA AAR Poll mentioned connecting with their response partners in the first few weeks of the pandemic. In larger communities with professional staff, this was much more likely to happen sooner.

**Area for Improvement 2: Regional Information Sharing Plan.** There is a need to improve and formalize regional info sharing partnerships and connections among response partners and to determine how a formal, regional info-sharing network would be vetted and managed, and information disseminated in a consistent, effective manner.

**Area for Improvement 3: Regional Information Sharing Partners.** Plans and checklist should be made to help ensure that all appropriate partner agencies are included or considered in regional info-sharing initiatives.

**Area for Improvement 4: Information Sharing Coordination Exercises.** Individual agencies focused on their local response and did not have a plan for regional coordination. Regional

coordination plans for MACC/REPC have not been adequately tested or practiced with public health having the lead in a Unified Command with clear roles and responsibilities assigned.

**Reference:** EDS Plans and Pandemic Annex, CEMP, MACC/REPC plans, WRHSAC NPI Plan

**Analysis:**

1. **Local Info Sharing Plan**. Local info-sharing could be improved by having a clear, step-by-step, short plan or checklist that outlines the initial steps to be taken to set-up and maintain a consistent info-sharing capability. For many communities this might mean taking opportunities to improve relationships with local, regional, and State response partners including DPH, HMCC, REPC, BCBOHA, Social Service Agencies, etc.
2. **Regional Info Sharing Plan.** Regional Plans should be updated or created to identify the mechanism for a regional information sharing network, including vetting, managing, and coordinating a regional system to deliver effective, consistent methods of sharing and disseminating information.
3. **Regional Info Sharing Partners** Plans should identify agencies that should be part of the public health information sharing system. The current regional, weekly BOH Workgroup phone/Zoom conference calls should be continued and added to existing and/or new plans via an Information Sharing Annex. To meet and greet before the next emergency, BOH should attend regional emergency preparedness meetings on a regular basis. Many of them have remote attendance options:
    a. REPC monthly meetings
    b. HMCC annual meetings
    c. PHEP/BCBOHA monthly meetings
    d. Friday Workgroup meetings
    e. MRC quarterly meetings
    f. DPH BOH webinars
4. **Information Sharing Coordination Exercises.** One or more regional public health groups such as BCBOHA, the Berkshire Public Health Alliance, Southern Berkshire Public Health Collaborative or other regional agency should be considered as the primary lead agencies in a Regional Public Health Information-Sharing Plan and system to work with the hospitals, REPC, and other Response Partners to help ensure a robust, effective public health info-sharing system in public health emergencies. This system should be practiced during flu clinic season each year.

# Appendix A: IMPROVEMENT PLAN

| Public Health Core Capability | Issue/Area for Improvement | Corrective Action | Capability Element[1] | Primary Responsible Organization | Lead Organization POC | Start Date | Completion Date |
|---|---|---|---|---|---|---|---|
| #3. Emergency Operations Coordination | 1. Understanding/experience of ICS and Command and Control in Public Health emergencies | Provide/request annual ICS Trainings and Exercises<br>Short ICS Checklist | **Training**<br>**Exercises** | MEMA<br>PHEP Coalition | Bob Barry<br>PHEP Staff | Summer 2022 | Ongoing |
| | 2. Local Command and Control Plans and Exercises for pandemic response | Create template/guides and help update local plans and exercise them | **Planning**<br>**Exercises** | PHEP Coalition<br>LBOH/EMD | PHEP Staff | Fall 2023 | Summer 2026 |
| | 3. Regional Command and Control Plans and Exercises | Update Plans to include Public Health as lead in a Unified Command Coordination Group and conduct Training and Exercises | **Planning**<br>**Training**<br>**Exercises** | PHEP Coalition<br>REPC/EMD | PHEP Staff<br>REPC | Fall 2022 | Ongoing |
| | 4. Regional access, knowledge, and experience of WebEOC capabilities resulting in them not well integrated into existing C&C structures or practices | Explore adding PHEP Coalition to PH WebEOC and using it to manage regional events and conduct drills. | **Planning**<br>**Training**<br>**Exercises** | PHEP Coalition<br>DPH/OPEM | PHEP Staff | Spring 2022 | Ongoing |
| | 5. Regional coordination of Logistics and Resource Management with clear lines of authority to coordinated regionally. | Develop regional resource management plans and exercise Logistics and Resource Management | **Planning**<br>**Training**<br>**Exercises** | PHEP Coalition<br>REPC/EMD | PHEP Staff | Fall 2024 | Spring 2026 |
| | 6. BOH and other officials were harassed for doing their jobs. | Develop and provide training in managing meetings to | **Training** | PHEP Coalition<br>MAHB | PHEP Staff<br>Police Chiefs | Spring 2022 | Fall 2023 |

[1] Capability Elements are: Planning, Organization, Equipment, Training, or Exercise.

| Public Health Core Capability | Issue/Area for Improvement | Corrective Action | Capability Element[1] | Primary Responsible Organization | Lead Organization POC | Start Date | Completion Date |
|---|---|---|---|---|---|---|---|
| | | prevent and manage harassment/deescalate. | | | | | |
| **#4 Emergency Public Information and Warning** | 1. Formal plans for regional public information coordination/JIS | Create a JIS work group & lead agency to develop a JIS Plan | **Planning** | PHEP<br>Coalition<br>REPC | PHEP Staff | Fall 2022 | Summer 2024 |
| | 2. Regional Public Information Coordination practice | Exercise JIS Plan during flu clinics or COVID Clinics to practice JIS Coordination | **Exercise** | PHEP<br>Coalition<br>REPC | PHEP Staff<br>HMCC Staff<br>OPEM Staff | Fall 2023 | Fall 2024 |
| | 3. Designated Lead Agencies for a regional JIS | Agree on an agency or agencies to coordinate JIS. Could be a rotating leadership as long as it was exercised frequently | **Planning** | PHEP<br>Coalition<br>REPC | PHEP Staff | Fall 2022 | Winter 2024 |
| | 4. JIS training and exercises | Provide training and exercise opportunities for JIS and Public Information. | **Training**<br>**Exercises** | PHEP<br>Coalition<br>DPH<br>MEMA | PHEP Staff<br>DPH/MEMA | Winter 2023 | Spring 2024<br>Ongoing |
| **#6 Info Sharing** | 1. Local plans for info sharing | Agree on and create a plan for who and how local info sharing should work | **Planning** | PHEP<br>Coalition<br>BOH | PHEP Staff | Winter 2023 | Winter 2024 |
| | 2. Regional plan for info sharing | Agree on and create regional info sharing plans and how info sharing should work | **Planning** | PHEP<br>Coalition<br>WAG | PHEP Staff | Winter 2023 | Winter 2024 |
| | 3. Clear understanding of regional info sharing Partners | Agree on core, regional Info-Sharing Partners and create a short guide. | **Planning** | PHEP<br>Coalition<br>REPC | PHEP Staff | Winter 2023 | Winter 2024 |
| | 4. Training and exercises for regional info sharing coordination | Provide training and exercise opportunities during flu clinic season | **Training**<br>**Exercises** | PHEP<br>Coalition<br>REPC | PHEP Staff | Winter 2023 | Winter 2024<br>Ongoing |

This IP has been developed specifically for Berkshire County as a result of an actual response to a Pandemic in 2020.

# APPENDIX B: RESPONSE PARTNERS

| Participating Organizations |
| --- |
| **State/Region** |
| Berkshire County Boards of Health Association and Member BOH |
| Berkshire Public Health Alliance and Member BOH |
| Tri-Town Health Department |
| Berkshire Public Health Nurses |
| BOH Friday Workgroup |
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