UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES,	:	
BARBARA FLOOD,	:	CIVIL NO. 3:20CV594-JCH
VINCENT ARDIZZONE,	:	
GAIL LITSKY,	:	
CARSON MUELLER,	:	
On behalf of themselves and all other	:	
persons similarly situated,	:	
Plaintiffs	:	
v.	:	
NED LAMONT, Governor	:	
MIRIAM E. DELPHIN-RITTMAN,	:	
Commissioner of DMHAS,	:	
HAL SMITH, CEO of Whiting Forensic	:	
Hospital,	:	
LAKISHA HYATT, CEO Connecticut	:	
Valley Hospital,	:	
In their official capacities,	:	
Defendants	:	JULY 9, 2020

OBJECTION TO MOTION FOR PRELIMINARY INJUNCTION

The Defendants, Ned Lamont, Governor; Miriam E. Delphin-Rittman, Commissioner of DMHAS; Hal Smith, CEO of Whiting Forensic Hospital; and Lakisha Hyatt, CEO Connecticut Valley Hospital, in their official capacities, hereby object to the Plaintiff's Motion for Preliminary Injunction dated June 8, 2020 seeking an order directing the Defendants to take various actions including to move psychiatric patients from Whiting Forensic Hospital ("Whiting") and Connecticut Valley Hospital ("CVH") and urges the Court to deny the motion. [Dkt. # 24]. The bases for the Defendants' objection follow.

As addressed at length below, Plaintiffs' Motion and related filings level many grave charges of alleged malfeasance against the Defendants related to Defendants' response to the ongoing COVID-19 pandemic. While each of these ultimately unfounded allegations are in and of themselves serious, and Defendants have responded to each, in the broadest sense the real gravamen of Plaintiffs' allegations, filed almost two and half months ago, is that Defendants'

actions or inactions have put Plaintiffs in significant medical danger for some 70 or more days.[1] However, the tale told by the history of those 70 or more days at CVH and Whiting simply belies Plaintiffs' claims. For example, the date that a patient at CVH last tested positive for COVID-19 was on May 16, 2020. See Defs. Exs. D, Dr. Carvalho Decl. ¶ 13; Defs. Ex. B, Dr. Martinello Decl. ¶ 36. The date that a patient at Whiting last tested positive was on April 21, 2020. Two patients who tested positive at Whiting on May 19, 2020 had previously tested positive and did not represent new cases. Defs. Ex. C, Dr. Wasser Decl. ¶ 13; Defs. Ex. B, Dr. Martinello Decl. ¶ 9. As discussed more fully below, at CVH and Whiting the number of cases, the number of deaths, and the numbers of patients and staff testing positive all reflect a remarkable record of containment, which record would, as noted by Defendants' experts, be the envy of many health care congregate settings, let alone those who, like CVH and Whiting, serve seriously mentally ill patients.

While Youngberg v. Romeo, 457 U.S. 307, 323 (1982), and its progeny establish that a lack of success or efficacious outcomes does not in and of itself establish a violation of substantive due process, such outcomes are surely probative evidence that no such violation has occurred. The probative evidence here reflects success. Seventy days of effective control of the virus, in these challenging settings, with these challenging populations, cannot reasonably be attributed to accident or luck, and the Defendants respectfully urge this Court to so recognize.

[1] The Plaintiffs' filed their Complaint on April 30, 2020.

I. BACKGROUND

A. The Department of Mental Health and Addiction Services, Connecticut Valley Hospital and Whiting Forensic Hospital

The Connecticut Department of Mental Health and Addiction Services ("DMHAS") operates both Whiting and CVH. (Conn. Gen. Stat. § 17a-450(b)).[2] CVH and Whiting serve a variety of patients who manifest in-patient mental health needs. Patients come to these facilities via a number of routes.

At CVH, some patients are voluntarily admitted in order to address acute mental health or addiction issues. Other patients are committed to CVH by the Connecticut Probate Courts via the civil commitment process, having been adjudicated by clear and convincing evidence that they suffer from psychiatric disabilities and are either gravely disabled or a danger to themselves or others, pursuant to Conn. Gen. Stat. §§ 17a-495 *et seq*. Such civilly committed patients are entitled to at least annual review of their commitment status (Conn. Gen. Stat. § 17a-498), among other statutory rights.

Whiting serves, in addition to civilly committed individuals who require a high level of treatment, patients who have been charged with crimes but have been determined incompetent to stand trial. These individuals are committed to Whiting for the purpose of attempting to restore their competency to address their criminal charges pursuant to Conn. Gen. Stat. § 54-56d. Still other patients have been found by the courts to be not guilty of the crimes with which they have been charged by reason of insanity ("NGRI") pursuant to Conn. Gen. Stat. §53a-13, such that they then fall under jurisdiction of the statutorily created Psychiatric Security Review Board ("PSRB"). Conn. Gen. Stat. §§ 17a-581 *et seq*.

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[2] CVH is certified as a hospital to participate in Medicare and Whiting is licensed as a hospital by the Department of Public Health.

Notably, the PSRB, as informed by reports from the state hospitals, periodically review such cases (Conn. Gen. Stat. § 17a-585), can order conditional release or temporary leaves (Conn. Gen. Stat. §§ 17a- 587, 17a-588), and may order discharge from custody (Conn. Gen. Stat. § 17a-592), among other powers. PSRB orders are subject to judicial review (Conn. Gen. Stat. § 17a-597). Finally, some patients are sent to these facilities because their acute psychiatric needs cannot be adequately addressed in Department of Corrections facilities. Thus, while CVH and Whiting patients come to these facilities via a variety of routes, all require inpatient psychiatric hospitalization.

The named plaintiffs in this lawsuit, alleged to be suitable representatives of a putative class of similarly situated patients at Whiting and CVH, include two patients civilly committed to CVH (Thomas Wilkes, Barbara Flood) and three NGRI patients under the jurisdiction of the PSRB (Vincent Ardizzone, Carson Mueller, Gail Litsky) who receive treatment at Whiting. The Plaintiffs have also attached affidavits of two additional individuals who receive treatment at Whiting. . Francis Clarke came to Whiting for restoration to competency to stand trial, and was found by the Superior Court not to be restorable. Thereafter Mr. Clarke was civilly committed as a voluntary patient at Whiting. Mr. Rahab King was found NGRI and is under the jurisdiction of the PSRB.

B. COVID-19 Planning and Response

The Plaintiffs assert that the Defendants were slow to take action to protect Plaintiffs from COVID-19. Pls. Mem. at p. 4. Contrary to the Plaintiffs' assertion, the Defendants acted timely in responding to and implementing policies, procedures, and protocols in response to the COVID-19 pandemic. Certain State agencies including DMHAS have created Incident Command Teams ("ICT") to respond to and manage disasters or community incidents through a coordinated structure. Defs. Mem. Ex. F, DiLeo Decl. ¶ 4. The DMHAS ICT was activated in

response to the threat of the COVID-19 pandemic in the first week of March 2020. Defs. Mem. Ex. F, DiLeo Decl. ¶ 10. Since the start of the COVID-19 pandemic, the ICT has had frequent meetings, including daily meetings, meetings on the weekends. Defs. Mem. Ex. F, DiLeo Decl. ¶ 11. The ICT has worked with DMHAS facilities, including CVH and Whiting to implement response plans. Defs. Mem. Ex. F, DiLeo Decl. ¶¶ 13,14.

CVH utilizes a planning tool, the National Incident Management System ("NIMS"), issued/developed by the Federal Emergency Management Agency ("FEMA") to develop responses to all types of incidents that can affect CVH operations such as weather related emergencies, water or power systems failure, and health emergencies. Defs. Ex. H, Denier Decl. 3. When an emergency occurs or is anticipated, such as a storm, CVH activates the Hospital Incident Command System ("HICS"). Defs. Ex. H, Denier Decl. 4 -6. HICS was activated in response to the threat of COVID-19 in the first week of March 2020 and the response plans are constantly updated and revised in response to events and guidance from agencies, including but not limited to the Office of the Governor, the Connecticut DPH and the CDC. Defs. Ex. H, Denier Decl. ¶¶ 7, 8.

Whiting created its own Coronavirus Pandemic Incident Action Plan in response to the COVID-19 pandemic. Plaintiffs' experts opine that Whiting's Coronavirus Pandemic Incident Action Plan was not finalized until May 26, 2020. Pls. Ex. 2, Canavan and Jones Aff., ¶ 5. However, Whiting's plan was implemented in March 2020 and has been revised in response to the evolving guidance from the Connecticut DPH and the CDC. Defs. Ex. L.

II. APPLICABLE LEGAL STANDARDS FOR PRELIMINARY INJUNCTIONS

There are four basic requirements recognized in this Circuit for the granting of preliminary injunctive relief. "A plaintiff seeking a preliminary injunction must demonstrate...

[1] that they have some likelihood of success on the merits and [2] will suffer irreparable harm absent an injunction, [and] [3] that the "the balance of equities tips in his favor and [4] an injunction is in the public interest." Local 1159 of Counsel 4 AFSCME, AFL-CIO v. City of Bridgeport, 435 F. Supp. 3d 400 (D. Conn. 2020) (quoting Otoe-Missouria Tribe of Indians v. New York State Dep't of Fin. Servs., 769 F.3d 105, 112 n.4 (2d Cir. 2014) (citing Winter v. Natural Res. Def. Council, Inc., 555 U.S. 7, 20 (2008)). However, there are two important modifications to this standard that are applicable in this case given that the relief sought would enjoin government action and alter the status quo.

First, "when the preliminary injunction seeks to enjoin government action taken in the public interest pursuant to a statutory or regulatory scheme the moving party must satisfy the more rigorous likelihood of success on the merits standard." South Lyme Property Owners Association, Inc. v. Town of Old Lyme, 121 F.Supp.2d 195 (D. Conn 2000)(citing Able v. United States, 44 F.3d 128, 130 (2d Cir.1995)). Litigants seeking to enjoin the activity of a government agency also must contend with "the well-established rule that the Government has traditionally been granted the widest latitude in the dispatch of its own internal affairs." Allen v. Wright, 468 U.S. 737, 761 (1984) (quoting Rizzo v. Goode, 423 U.S. 362, 378–79 (1976)). See also Messier v. Southbury Training Sch., No. 3:94-CV-1706(EBB), 1999 WL 20910, at *21 (D. Conn. Jan. 5, 1999).

Second, "[w]here the injunction at issue will either alter, rather than maintain the status quo, or provide the movant with substantially all the relief sought, the injunction will be characterized as 'mandatory' rather than 'prohibitory.'" Pinckney v. Board of Education of Westbury Union Free School District, 920 F.Supp. 393, 399 (2000)(citing Tom Doherty Associates, Inc. v. Saban Entertainment, Inc., 60 F.3d 27,33-34 (2d Cir.1995)). "A party seeking

a mandatory injunction must make 'a 'clear' or 'substantial' showing of a likelihood of success" on the merits, in addition to a showing of irreparable harm." Illinois Tool Works Inc. v. J-B Weld Co., LLC, 419 F. Supp. 3d 382, 389 (D. Conn. 2019), modified, No. 3:19-CV-01434 (JAM), 2019 WL 7816510(quoting Jolly v. Coughlin, 76 F.3d 468, 473 (2d Cir. 1996)).

The relief the Plaintiffs seek would not "maintain the status quo," thus the injunction they seek is a mandatory one. In addition, the ultimate relief the Plaintiffs seek through the First Amended Complaint is to discharge patients requiring inpatient level of care into the community. Granting that relief as set forth in paragraphs 4 and 5 of their preliminary injunction memorandum would have that consequence. The Plaintiffs' preliminary injunction motion is therefore subject to the higher standard.[3] Thus the applicable standard that this Court must apply to the Plaintiffs' motion is that Plaintiffs must show irreparable injury and a clear/substantial likelihood of success on the merits of the complaint.

"[I]nterim injunctive relief is an 'extraordinary and drastic remedy which should not be routinely granted.'" Velez v. McGuire, 992 F.Supp. 125, 127 (D. Conn. 1998) (quoting Buffalo Forge Co. V. Ampco-Pittsburgh Corporation, 638 F.2d 568, 569 (2d Cir.1981)). "In addition, a federal court should grant injunctive relief against a state or municipal officer 'only in situations of most compelling necessity.'" Id. (quoting Vorbek v. McNeal, 407 F.Supp. 733, 739 (E.D. Mo.), *aff'd*, 426 U.S. 943 (1976)). The U.S. Supreme Court recently underscored this principle in denying an application for injunctive relief against an executive order issued by the Governor

[3] The Plaintiffs seek an order directing the Defendants to: "1. Conform their testing protocols to CDC standards; 2. Take steps to ensure that staff consistently wear masks and that Plaintiffs are encouraged and supported in wearing masks including through education, 3. Improve hygiene and decontamination practice, 4. Implement social distancing to the maximum extent possible including by reducing patient census; 5. Under take the clinical review described above in order to accelerate discharges. . .." Pls. Mem. at p. 39.

of California limiting the size of gatherings in the midst of the COVID-19 pandemic. Chief Justice Roberts supported the denial and reasoned that:

> [O]ur Constitution principally entrusts "[t]he safety and the health of the people" to the politically accountable officials of the States "to guard and protect." Jacobson v. Massachusetts, 197 U.S. 11, 38, 25 S.Ct. 358, 49 L.Ed. 643 (1905). When those officials "undertake[ ] to act in areas fraught with medical and scientific uncertainties," their latitude "must be especially broad." Marshall v. United States, 414 U.S. 417, 427, 94 S.Ct. 700, 38 L.Ed.2d 618 (1974). Where those broad limits are not exceeded, they should not be subject to second-guessing by an "unelected federal judiciary," which lacks the background, competence, and expertise to assess public health and is not accountable to the people. See Garcia v. San Antonio Metropolitan Transit Authority, 469 U.S. 528, 545, 105 S.Ct. 1005, 83 L.Ed.2d 1016 (1985). That is especially true where, as here, a party seeks emergency relief in an interlocutory posture, while local officials are actively shaping their response to changing facts on the ground.

South Bay United Pentecostal Church v Newsom, 140 S. Ct. 1613, (Mem)–1614 (2020).

Finally, the court is not required to accept a Plaintiff's allegations as true on a motion for preliminary injunction. Sinisgall v. Town of Islip Housing Authority, 865 F.Supp.2d. 307, 331(E.D.N.Y. 2012).

III. ARGUMENT

Plaintiffs bear the burden of proving that in the response to the COVID-19 pandemic, the conduct or decisions made at CVH and Whiting "[are] such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such judgment." Youngberg v. Romeo, 457 U.S. 307, 323 (1982).

Plaintiffs evidence in support their Motion for Preliminary Injunction is not sufficient to meet this burden. As set forth in Defendants' Motion In Limine or To Exclude Testimony of Patrick Canavan and Elizabeth Jones and Affidavit of Richard Gudis, testimony from Canavan and Jones and Attorney Gudis does not meet the requirements under Federal Rule of Evidence

702 and the U.S. Supreme Court decision in Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993) and its progeny. Defendants incorporate by reference the grounds set forth in said Motion and supporting memorandum of law which demonstrate that Canavan and Jones offer expert testimony in infectious disease control and responses to COVID-19 and other subjects without the requisite qualifications and expertise. Contrary to Federal Rule of Evidence 702, Canavan and Jones improperly borrow and apply the expert testimony of Dr. Manian to back stop their opinions. Pls. Ex. 2, Decl. of Canavan and Jones, ¶ 6, 12.

Canavan and Jones make assertions regarding the actions and omissions of CVH and Whiting solely in reliance of affidavits from three plaintiffs and two additional patients and 17 "State documents" of which 14 predate 2020 and only two relate to Defendants' COVID-19 response. Pls. Ex. 2, Decl. of Canavan and Jones, ¶ 3. They did not review the treatment records of any patient at the hospitals, including the plaintiffs. Canavan and Jones did review a single policy form Whiting regarding COVID-19, but none from CVH.

Canavan and Jones reliance on the six patients' affidavits providing anecdotal evidence of practices at CVH and Whiting is grossly insufficient for the Court to find due process violations justifying Plaintiffs' demands for systemic changes at both hospitals. Anecdotal stories and isolated incidents do not rise to the level of a constitutional violation. Society for Good Will, 737 F.2d 1239, 1245 (2d Cir. 1984) ("While there have been occasions when patients' specific medical problems have been treated improperly, the district court's decision should not have been based on isolated instances of improper treatment, but on a finding that medical care was inadequate on a class-wide basis. Isolated instances of inadequate care, or even of malpractice, do not demonstrate a constitutional violation."); United States v. Commonwealth of Pennsylvania, 902 F. Supp. 565, 589 (W.D. Pa. 1995), *aff'd sub nom.*, U.S. v. Ridge, 96 F.3d

1436 (3rd Cir. 1996)(citing Shaw v. Strackhouse, 920 F.2d 1135, 1143 (3rd Cir. 1992). Canavan and Jones reliance on the often incomplete and erroneous patient affidavits is demonstrated below. Defs. Ex. A, Decl. of Dr. Geller ¶¶ 19-20.

Although Attorney Gudis has no expertise in infectious diseases, medical diagnoses, psychiatric treatment, psychiatric hospitals or psychiatric hospital administration, he offers opinions about two patients' psychiatric and medical conditions as well as COVID-19-related risks. Pls. Ex. 8, Aff. Gudis ¶¶ 8-10, 13-15. Attorney Gudis also offers an opinion regarding DMHAS' obligations and shortcomings in responding to COVID-19 without any expertise in any relevant area. Id. ¶¶ 17-19.

Finally, Plaintiffs rely upon the declaration of Dr. Manian, who provides an extensive elucidation of his views of the required responses to COVID-19. Plaintiffs' sole expert in infectious disease makes no determinations regarding CVH or Whiting, including whether either facility departed from the standards he posits are controlling. Plaintiffs' evidentiary basis for their motion is facially inadequate to support the mandatory injunction sought, one that would have profound impacts on the operations of these two critically important hospitals.

A. The Plaintiffs Cannot Show a Likelihood of Success on the Merits

The Supreme Court has held involuntarily committed persons to state facilities have a Fourteenth Amendment substantive due process right to be protected from confinement in unsafe conditions, to adequate medical care and treatment, and to be free from the use of excessive force/bodily restraint. Youngberg v. Romeo, 457 U.S. 307, 315-19 (1982)[4]; Johnson v.

[4] In Youngberg, plaintiff was a severely retarded adult man who was committed to a state in-patient facility. Youngberg, 457 U.S. at 309. Plaintiff had the mental capacity of an eighteen-month-old child. Id. His mother sought his commitment after the death of plaintiff's father because she was unable to care for plaintiff or control his violent behavior. Id. Plaintiff was injured numerous times while a patient because of his own acts and because of other residents' reactions to his violent behavior. Id. at 310. Plaintiff, through his mother acting as next friend,

Newburgh Enlarged School Dist., 239 F.3d 246, 253 (2d Cir. 2001) (free from excessive force); See also, Olivier v. Robert L. Yeager Mental Health Ctr., 398 F.3d 183, 188-89 (2d Cir. 2005)(professional judgment standard applied to substantive due process violations alleged by involuntarily committed patients against professionals.)

The standard for determining whether an involuntarily committed patient's substantive due process rights have been violated by hospital administrators or licensed professionals calls for determining whether the conduct or decisions of such persons "[are] such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such judgment." Youngberg v. Romeo, 457 U.S. 307, 323 (1982). This standard is highly deferential to the decisions of the state's professionals and is intended to strike a balance between the "liberty interest of the individual" and the "legitimate interests of the State, including the fiscal and administrative burdens additional procedures would entail." Youngberg at 321-22, 102 S.Ct. 2452 (citing *Parham v. J.R.,* 442 U.S. 584, 599–600 (1979)). Under this standard, a "decision, if made by a professional, is presumptively valid." Id. at 323.

"It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." Id. at 321. A professional is defined as "a person competent, whether by education, training or experience, to make the particular decision at issue . . .

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brought an action against two hospital supervisors and the hospital director for injuries suffered by plaintiff on at least sixty-three different occasions. Id. The Supreme Court held that plaintiff's rights as a civilly committed patient stemmed from the Fourteenth Amendment's substantive Due Process Clause. Id. at 320–24. The Supreme Court noted that plaintiff abandoned his claim on appeal that the Eighth Amendment was the source of his constitutional rights and instead relied solely upon the Fourteenth Amendment's substantive Due Process Clause. Id. at 314, n.16. Plaintiff alleged, and the Court agreed, that he had both a right to be confined in a safe environment and a right to be free from physical restraints. Id. at 319–24.

[including] persons with degrees in medicine or nursing, or with appropriate training in areas such as psychology, physical therapy or the care and training of the retarded." Id. at 323 n.30.

When determining whether the state has complied with the standard, "decisions made by appropriate professionals are entitled to a presumption of correctness. Moreover, such presumption is necessary to enable institutions of this type -- -often, unfortunately, overcrowded and understaffed --to continue to function. . . The administrators, and particularly professional personnel, should not be required to make each decision in the shadow of an action for damages." Id. at 324-25

This standard acknowledges that administrative officials are also, "responsible to the state and to the public for making professional judgments of their own, encompassing institutional concerns as well as individual welfare." Cameron v. Tomes, 990 F.2d 14, 20 (1st Cir. 1993); See also LaShawn A. v. Dixon, 762 F. Supp. 959, 994 D.D.C. 1991) (courts must consider "any relevant state interests, including fiscal constraints and administrative burdens."). In this case, such practical constraints, including those imposed by this unprecedented public health emergency, surely qualify.

Even if there were deficiencies in care – which there are not -- notwithstanding plaintiffs' claims, such deficiencies alone would not establish a violation of their due process rights. The Fourteenth Amendment does not establish a negligence regime under which any "objectively unreasonable" action gives rise to a constitutional due process claim. Rather, the Supreme Court has emphasized that constitutional due process violations require more than mere negligence by government actors. Kingsley v. Hendrickson, 576 U.S. 389, 396 (2015) ("[L]iability for negligently inflected harm is categorically beneath the threshold of constitutional due process" (Court's emphasis)); Davidson v. Cannon, 474 U.S. 344, 347 (1986) ("[T]he Due Process Clause

of the Fourteenth Amendment is not implicated by the lack of due care of an official causing unintended injury to life, liberty or property."); accord Hargett v. Adams, Civil Action No. 02-1456, 2005 WL 399300, at *17 (N.D. Ill. Jan. 14, 2005) (observing that a due process action under Youngberg is "not a negligence case where any deviation from the standard of care could impose liability.")

The Court in Youngberg made explicit that while states have "a duty to provide certain services and care" to those who are institutionalized, "even then a State necessarily has considerable discretion in determining the nature and scope of its responsibilities." 457 U.S. at 317. In accord with this principle, in cases involving those involuntarily committed to the state's care, due process "only requires that the courts make certain that professional judgment in fact was exercised" by appropriate staff, without mandating that any specific judgment should have been made. Youngberg, 457 U.S. at 321. "[E]vidence establishing mere departures from the applicable standard of care is insufficient to show a constitutional violation." Patten v. Nichols, 274 F.3d 829, 845 (4th Cir. 2001). Rather, any given decision, "if made by a professional, is presumptively valid." Youngberg, 457 U.S. at 323. The inquiry "is whether the decision was so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one." Patten, 274 F.3d at 845 (citation and internal quotation marks omitted).

A constitutional violation cannot be inferred from challenging circumstances alone. Hanson v. Madison Cnty. Det. Ctr., 736 F. App'x 521, 539 (6th Cir. 2018) ("There is no res ipsa loquitur principle for constitutional torts."); Kent v. Sziebert, Civil Action No. 15-05553, 2016 WL 3248077, at *4 n.3 (W.D. Wash. Apr. 19. 2016) ("Res ipsa loquitur, if applicable, allows only for an inference of negligence, which cannot constitute a violation of the stricter standards of deliberate indifference or Youngberg's professional judgment standard."). Plaintiffs must

point to a specific decision and show that the decision itself—regardless of the result—was "so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one." Patten, 274 F.3d at 845. Plaintiffs have not and cannot make such a showing with respect to the Hospitals' infection control measures or for the provision of mental health treatment services and care.

1. The Defendants Are Providing Adequate Care and Safety

Plaintiffs are unlikely to succeed on their claim for relief under the Fourteenth Amendment's Due Process Clause. Am. Compl. Count One. First, Plaintiffs cannot show that they have at any point been denied "adequate" care or "reasonable safety." Youngberg, 457 U.S. at 324. The record demonstrates that DMHAS fully activated its ICT in the first week of March 2020 to prepare to respond to COVID-19. Defs. Ex. F, DiLeo Decl. ¶ 10. The record further reflects that as early as the first week of March 2020, DMHAS leadership began taking measures to guard against the spread of COVID-19, in accordance with public health guidelines. Defs. Ex. F, DiLeo Decl. ¶¶ 11-13. Visitation to these facilities was suspended on March 17, 2020. Defs. Ex. D, Dr. Carvalho Decl. ¶ 7; Defs. Ex. C, Dr. Wasser Decl. ¶ 7.[5] Patients and staff were educated and trained on proper hand-hygiene and social distancing. Defs. Ex. D, Dr. Carvalho Decl. ¶¶ 37, 66; Defs. Ex. C, Dr. Wasser Decl. ¶ 67. Staff received instruction on the proper use of personal protective equipment. Defs. Ex. D, Dr. Carvalho Decl. ¶ 35; Defs. Ex. C, Dr. Wasser Decl. ¶ 32. Patients received instruction on the proper use of personal protective equipment. Defs. Ex. D, Dr. Carvalho Decl. ¶ 37; Defs. Ex. C, Dr. Wasser Decl. ¶ 35. The facilities also have been cohorting patients based on their COVID-19 status. Defs. Ex. D, Dr. Carvalho Decl. ¶ 51; Defs. Ex. C, Dr. Wasser Decl. ¶¶ 48, 51, 55.

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[5] As of July 1, 2020, visitation has resumed subject to requirements and guidance from the Connecticut Department of Public Health ("DPH") and the Center for Disease Control. ("CDC").

With regard to treatment, treatment teams have continuously provided patients with individualized care throughout the pandemic. Defs. Ex. D, Dr. Carvalho Decl. ¶ 37; Defs. Ex. C, Dr. Wasser Decl. ¶ 35. Additionally, satellite offices were created for staff outside of Whiting to continue provide services to patients using digital technology while minimizing the number of people inside of Whiting. Defs. Ex. C, Dr. Wasser Dec. ¶ 64. Group therapy services continued to occur in smaller groups of five participants. Defs. Ex. D, Dr. Carvalho Decl. ¶ 61; Defs. Ex. C, Dr. Wasser Decl. ¶ 59. Plaintiffs cannot show that they are being subjected to inadequate care or treatment, unreasonable risks to their health and safety, or any other deficiencies. Indeed, the evidence demonstrates the opposite.

2. The Defendants Have Exercised Professional Judgment.

Plaintiffs fail to identify any decision falling outside the bounds of the exercise of professional judgment nor can they successfully assert any constitutional deficiency in any of the following professional decisions.

a) Testing

The Plaintiffs without an evidentiary basis of the testing performed make a conclusory statement that the Defendants have not conducted weekly testing of all staff and residents and that this is a substantial departure from professional judgment. Pls. Mem. at p. 31. The Plaintiffs identify specific guidelines issued by that the CDC that they assert as being the authority for COIVD-19 testing. Pls. Mem. at pp. 3-4, 9; Pls. Exs. 12, 13 and 15. The Plaintiffs' rely upon the CDC Guidelines as the minimally acceptable practice and make conclusory statements that the Defendants are not adhering to CDC Guidelines. Pls. Mem. at pp. 12, 13, 31, and 32. Specifically, the Plaintiffs state that the CDC requires a plan for screening and testing both staff and patients. Pls. Mem. at pp. 11-12, 31; Ex. 13 and 15. The Plaintiffs assert that the testing is only "on a voluntary basis" and that the Defendants have no "have no plan for regular testing of

residents." Pls. Mem. at p. 13. Additionally, the Plaintiffs state that according to Dr. Manian, professional standards require that CVH and Whiting perform baseline testing of all residents and staff, and test at least once a week all previously negative residents and staff until the testing identifies no new cases of COVID-19 for at least 14 days since the most positive result. Pls. Ex. 1, Manian Decl. ¶ 16.1. . While the declaration of Dr. Manian details the guidance that should be followed as to testing, the declaration does not reach conclusions about how the Defendants have not complied with the CDC guidelines. Without citation to their experts' opinion, the Plaintiffs' rely on their conclusory statements that the Defendants failed to exercise professional judgment with respect to testing.

Moreover, the Plaintiffs' only cite to a portion of the CDC Guidance with regard to testing and repeat testing by stating that "all residents and staff should be tested once there is a confirmed case and that repeat testing of all patients and staff should be performed." Pls. Mem. at p. 32. With regard to testing for new cases, the CDC Guidance additionally provides that "[i]f testing capacity is limited, CDC suggests directing testing to residents and Healthcare Providers ("HCP") on the same unit or floor of a new case. If testing all residents on the same unit or floor is also not possible, CDC suggests directing testing to symptomatic residents and HCP and residents who have known exposure." Pls. Ex. 15, p. 3. With regard to repeat testing, the CDC Guidance provides "[i]f testing capacity is limited, the CDC suggests directing repeat rounds of testing to residents who leave and return to the facility or have known exposure to a case. For large facilities with limited testing capacity, testing all residents on an affected unit could be considered, especially if a facility-wide serial testing demonstrates no new transmission beyond a limited number of units. If testing capacity is limited, CDD suggests directing repeat HCP testing to HCP who work at other facilities." Pls. Ex. 15, p. 3.

Importantly, as has been the case since the pandemic began, guidance on COVID-19 testing changes and continues to change. The CDC's Testing Guidelines for Nursing Home Residents and Healthcare Personnel was updated on July 2, 2020. Defs. Ex. T. The CDC separated its previous guidance that addressed testing of both patients and HCP by creating separate guidance for testing HCP. Defs. Ex. U. The updated CDC's Guidelines provides that if there is an outbreak in the facility, the facility should "[p]erform expanded viral testing of all residents if there is an outbreak in the facility. If viral testing capacity is limited, CDC suggests first directing testing to residents who are close contacts (e.g., on the same unit or floor of a new confirmed case or cared for by infected HCP)." Defs. Ex. T.

With regard to repeat testing of patients, the CDC suggests:

> Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. If viral test capacity is limited, CDC suggests directing repeat rounds of testing to residents who leave and return to the facility (e.g., for outpatient dialysis) or have known exposure to a case (e.g., roommates of cases or those cared for by a HCP with confirmed SARS-CoV-2 infection). For large facilities with limited viral test capacity, testing only residents on affected units could be considered, especially if facility-wide repeat viral testing demonstrates no transmission beyond a limited number of units.

Defs. Ex. T. The CDC's Interim Guidance for Testing Healthcare Professionals for SARS-CoV-2 advise:

> To test HCP with symptoms when there is a concern of potential COVID-19. Viral testing is recommended for HCP who have had close contact with persons with SARS-CoV-2 infection in the community. Expanded viral testing includes initial testing of all HCP with known or suspected exposure followed by repeat testing of all previously negative HCP, generally between every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. Testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 is recommended for HCP working in nursing homes as part of the recommended reopening process.

Defs. Ex. U. The Plaintiffs state that "Defendants' practices are contrary to accepted professional norms for fighting COVID-19." Pls. Mem. at p. 14; Pls. Ex. 2, Decl. Dr. Manian ¶ 16. However, Dr. Manian sets forth guidance as to testing, but is void of any opinion as to how, why or in what way the Defendants' practices are contrary to the guidance. In fact, as discussed more fully below, the Defendants have implemented policies and protocols related to the criteria set forth in ¶ 16 of Dr. Manian's declaration, such as staff and patient screening baseline testing, and repeat testing. Defs. Exs. B, C, D, L, and P.

Contrary to Plaintiffs' assertion that "as testing has become more available in the past two weeks, the number of confirmed infections has continued to increase, demonstrating that the failure to take comprehensive protections a month ago has contributed to several patients' deaths and an increase in the number of staff and patients becoming infected" Pls. Mem. at p. 14, the data demonstrates a decline in COVID-19 cases amongst patients and staff at CVH. Defs. Exs. X and Y. The data also demonstrates a decline in COVID-19 cases amongst patients and staff at Whiting. Defs. Ex. Z and AA.

In order to succeed in their Due Process claim, the Plaintiffs have the burden of providing evidence that the actions by the Defendants to provide testing has been and is such a departure from professional standards that in effect no professional judgment was exercised at all. As discussed below, Plaintiffs fail to meet their burden.

(1) Testing of the Patient Population

CVH and Whiting have been and continue to evaluate and test patients where appropriate based on applicable CDC Guidelines. As the guidelines have changed throughout the pandemic, CVH has adhered to and made changes in accordance with the guidelines.

CVH has protocols in place with regard to testing in response to the COVID-19 pandemic. The most recent update to these protocols was on June 29, 2020. Defs. Ex. P, CVH

COVID-19 Response Plan Testing Protocol; Defs. Ex. B, Dr. Martinello Decl. ¶ 35. CVH conducts daily COVID-19 screening of patients by checking temperatures, monitoring their breathing and oxygen saturation level with the use of pulse oximeters and asking series of questions about current COVID-19 symptoms. Defs. Ex. D, Dr. Carvalho Decl. ¶ 10. The questionnaire is frequently updated to reflect evolving CDC guidance. Defs. Ex. D, Dr. Carvalho Decl. ¶ 9. All new patients are tested prior to or upon entry to CVH and are quarantined for 14 days. Defs. Ex. D, Dr. Carvalho Decl. ¶ 10.

On March 19, 2020, CVH began monitoring all patients for COVID-19. Defs. Ex. D, Dr. Carvalho Decl. ¶ 11. All patients who are suspected for COVID-19 are tested. Defs. Ex. D, Dr. Carvalho Decl. ¶ 11. On March 21, 2020, CVH tested its first suspected case of COVID-19. Defs. Ex. C, Dr. Carvalho Decl. ¶ 11. Baseline testing of patients at CVH was completed on May 6, 2020. Defs. Ex. D, Dr. Carvalho Decl. ¶ 12; Defs. Ex. B, Dr. Martinello Decl. ¶ 36. Notably, the date that a patient at CVH last tested positive for COVID-19 was on May 16, 2020. Defs. Ex. D, Dr. Carvalho Decl. ¶ 13; Defs. Ex. B, Dr. Martinello Decl. ¶ 36. Since May 16, 2020, no new patients at CVH have tested positive for COVID-19. Defs. Ex. D, Dr. Carvalho Decl. ¶ 14.

As of July 1, 2020, a total of 63 patients out of 243 patients at CVH tested positive for COVID-19 since the pandemic began. Defs. Ex. D, Dr. Carvalho Decl. ¶ 15. As of July 1, 2020, a total of 57 patients who tested positive for COVID-19 have recovered from COVID-19 since the beginning of the pandemic. Defs. Ex. D, Dr. Carvalho Decl. ¶ 16. As of July 1, 2020, 239 CVH patients in total have been tested for COVID-19 since the pandemic began. The current CVH census is 217 patients. Defs. Ex. D, Dr. Carvalho Decl. ¶ 17.

If a patient tests positive for COVID-19, CVH conducts contract tracing and testing of staff and residents who may have been exposed to the patient. Defs. Ex. C, Dr. Carvalho Decl. ¶ 26; Defs. Ex. B, Dr. Martinello Decl. ¶¶ 19, 38. CVH cannot mandate patient testing for COVID-19. Defs. Ex. C, Dr. Carvalho Decl. ¶ 27. If a patient who displays COVID-19 symptoms refuses COVID-19 testing, CVH treats the patient as if he or she has COVID-19 and follows the hospital's protocol for treating COVID-19 positive patients. Defs. Ex. C, Dr. Carvalho Decl. ¶ 28. If a new admission refuses COVID testing, CVH treats the patient as if he or she has COVID-19 and follows the hospital's protocol for COVID-19 positive patients. Defs. Ex. C, Dr. Carvalho Decl. ¶ 29.

Whiting conducts daily screening of patients for COVID-19 by checking temperatures and monitors patients for COVID-19 symptoms. Defs. Ex. C, Dr. Wasser Decl. ¶ 9. New patients coming from the Department of Corrections or another hospital are tested for COVID-19 prior to admission. New patients from the community are offered a test for COVID-19 immediately upon admission. Defs. Ex. C, Dr. Wasser Decl. ¶ 10. All patients who are symptomatic for COVID-19 are tested. Testing of symptomatic patients began on March 16, 2020. Defs. Ex. C, Dr. Wasser Decl. ¶ 11. Among 30 symptomatic patients tested before May 19, 2020, 10 were found positive. Defs. Ex. B, Dr. Martinello Decl. ¶ 9. Baseline testing of patients at Whiting was completed on May 19, 2020. Defs. Ex. C, Dr. Wasser Decl. ¶ 12. The date that a patient at Whiting last tested positive for COVID-19 was on April 21, 2020. Two patients who tested positive on May 19, 2020 had previously tested positive and did not represent new cases of COVID-19. Defs. Ex. C, Dr. Wasser Decl. ¶ 13; Defs. Ex. B, Dr. Martinello Decl. ¶ 9. Since May 19, 2020, no new patients at Whiting have tested positive for COVID-19. Defs. Ex. C, Dr. Wasser Decl. ¶ 14.

As of July 1, 2020, a total of 10 patients out of 169 patients at Whiting tested positive for COVID-19 since the pandemic began. Defs. Ex. C, Dr. Wasser Decl. ¶ 15. As of July 1, 2020, a total of 10 patients who tested positive for COVID-19 have recovered from COVID-19 since the beginning of the pandemic. Defs. Ex. C, Dr. Wasser Decl. ¶ 16. As of July 1, 2020, 135 cumulative patients at Whiting have been tested for COVID-19 since the pandemic began. The current Whiting census is 169 patients. Defs. Ex. C, Dr. Wasser Decl. ¶ 17.

If a patient tests positive for COVID-19, Whiting conducts contact tracing and recommends testing of staff and residents who may have been exposed to the patient. Defs. Ex. C, Dr. Wasser Decl. ¶ 25. Whiting cannot mandate patient testing for COVID-19. Defs. Ex. C, Dr. Wasser Decl. ¶ 26. If a patient who displays COVID-19 symptoms refuses COVID-19 testing, Whiting treats the patient as if he or she has COVID-19 and follows the hospital's protocol for treating COVID-19 positive patients. Defs. Ex. C, Dr. Wasser Decl. ¶ 27. If a new admission refuses COVID-19 testing, Whiting treats the patient as if he or she has COVID-19 and follows the hospital's protocol for COVID-19 positive patients. Defs. Ex. C, Dr. Wasser Decl. ¶ 28.

Both CVH and Whiting have been and continue to evaluate and test patients where appropriate based on applicable CDC Guidelines. The testing protocols that CVH and Whiting are implementing follow CDC guidance which demonstrates that they have exercised professional judgment. The Plaintiffs have not provided any evidence to the contrary and thus have not carried their burden of showing likelihood of success on the merits.

(2) Testing the Staff

CVH and Whiting have been and continue to evaluate and test staff where appropriate based on applicable CDC Guidelines. As the guidelines have changed throughout the pandemic, CVH has adhered to and made changes in accordance with the guidelines.

CVH conducts daily COVID-19 screening of those entering the hospital, including staff, by checking temperatures and asking series of questions about current COVID-19 symptoms, potential COVID-19 exposures and recent travel. Defs. Ex. D, Dr. Carvalho Decl. ¶ 8; Defs. Ex. B, Dr. Martinello Decl. ¶¶ 34, 36. The questionnaire is frequently updated to reflect evolving CDC guidance. Defs. Ex. D, Dr. Carvalho Decl. ¶ 8. Baseline testing of staff at CVH was completed on May 28, 2020. Defs. Ex. D, Dr. Carvalho Decl. ¶ 18. On July 6, 2020, CVH began repeat testing of staff. Defs. Ex. D, Dr. Carvalho Decl. ¶ 19. The date that a direct care staff member at CVH last tested positive for COVID-19 was on May 19, 2020. Defs. Ex. D, Dr. Carvalho Decl. ¶ 20. The date that a non-direct care staff member at CVH last tested positive for COVID-19 was on May 21, 2020. Defs. Ex. D, Dr. Carvalho Decl. ¶ 21.

As of July 1, 2020, a total of 45 staff members out of 1095 staff members at CVH tested positive for COVID-19 since the beginning of the pandemic. Defs. Ex. D, Dr. Carvalho Decl. ¶ 22. As of July 1, 2020, a total of 44 staff members who tested positive for COVID-19 have recovered from COVID-19. Defs. Ex. D, Dr. Carvalho Decl. ¶ 23. As of July 1, 2020, 541 staff members out of 1095 staff members at CVH have been tested for COVID-19 since the pandemic began. Defs. Ex. D, Dr. Carvalho Decl. ¶ 24. As of July 1, 2020, 504 staff members of the 541 staff members at CVH who have been tested for COVID-19 since the pandemic began are direct care staff. Defs. Ex. D, Dr. Carvalho Decl. ¶ 25.

If a staff member tests positive for COVID-19, CVH conducts contract tracing and testing of staff and residents who may have been exposed to the patient. Defs. Ex. D, Dr. Carvalho Decl. ¶ 30. As of July 6, 2020, testing for COVID-19 is mandatory for direct care staff and those who regularly interact with patients. Defs. Ex. D, Dr. Carvalho Decl. ¶ 31.

WHITING conducts COVID-19 screening of all those entering the hospital, including staff, by checking temperatures and asking a detailed series of questions about possible COVID symptoms, potential COVID-19 exposures and recent travel. Defs. Ex. C, Dr. Wasser Decl. ¶ 8; Defs. Ex. B, Dr. Martinello Decl. ¶¶ 17, 34. The questionnaire is frequently updated to reflect evolving CDC guidance. Defs. Ex. C, Dr. Wasser Decl. ¶ 8. Baseline testing of staff at Whiting was completed on June 4, 2020. Defs. Ex. C, Dr. Wasser Decl. ¶ 18. On June 15, 2020, Whiting began repeat testing of staff. Defs. Ex. C, Dr. Wasser Decl. ¶ 19. The date that a direct care staff member at Whiting last tested positive for COVID-19 was on May 7, 2020. Defs. Ex. C, Dr. Wasser Decl. ¶ 20. The date that a non-direct care staff member at Whiting last tested positive for COVID-19 was on June 15, 2020. Defs. Ex. C, Dr. Wasser Decl. ¶ 21.

As of July 1, 2020, a total of 22 staff members out of 522 staff members at Whiting tested positive for COVID-19 since the beginning of the pandemic. Defs. Ex. C, Dr. Wasser Decl. ¶ 22. As of July 1, 2020, a total of 22 staff members who tested positive for COVID-19 have recovered from COVID-19. Defs. Ex. C, Dr. Wasser Decl. ¶ 23. As of July 1, 2020, 333 staff members out of 522 staff members at Whiting have been tested for COVID-19 since the pandemic began. Defs. Ex. C, Dr. Wasser Decl. ¶ 24. If a staff member tests positive for COVID-19, Whiting conducts contract tracing and recommends testing of staff and residents who may have been exposed to the patient. Defs. Ex. C, Dr. Wasser Decl. ¶ 29. As of June 22, 2020, testing for COVID-19 is mandatory for direct care staff and those who regularly interact with patients at Whiting. Defs. Ex. BB, Smith Decl. ¶ 6.

The testing protocols for patients and staff that both CVH and Whiting are implementing follow CDC guidance which demonstrates that it has exercised professional judgment. "The leadership and staff of CVH and Whiting exercised excellent professional judgement and were

most proactive in implementing measures to minimize the impact of COVID-19 on the residents and staff of the institutions. The relatively low occurrence of COVID-19 at both CVH and Whiting is the result of their highly effective response to COVID-19." Defs. Ex. B, Dr. Martinello Decl. ¶ ¶ 41, 42. The Plaintiffs have not provided any evidence to the contrary and thus have not carried their burden as set forth in Youngberg of showing likelihood of success on the merits.

b) Hygiene

The Plaintiffs identify specific guidelines issued by the CDC that they assert are "widely accepted" as being the authority for limiting the spread of COVID-19 citing guidance on testing, the use of PPE, frequent hand washing, social distancing, and disinfecting commonly used surfaces frequently. Pls. Mem. at pp. 3-4,9; Pls. Exs. 11, 12,13,15. Dr. Manian has opined that "[e]xperts agree that these guidelines should be followed in inpatient psychiatric facilities and that they are minimally acceptable practice and are essential for protecting Plaintiffs health and safety." Pls. Mem. at p. 10; Pls. Ex. 1, Decl. Dr. Manian, ¶ 10. This includes handwashing, daily cleaning and disinfecting of frequently touched surfaces. Pls. Mem. at p. 11; Pls. Ex. 1 Decl. Dr. Manian, ¶ 15,17; Ex. 11. The Plaintiffs conclude, based solely upon the affidavits of two of the five named Plaintiffs, that "proper hygiene and decontamination practices are not being consistently followed" and that the" Defendants' failure to ensure that CVH and Whiting are appropriately decontaminated and that patients have access to proper hand hygiene is a substantial departure from professional standards" such that it violates their Fourteenth Amendment Rights. Pls. Mem. at pp. 16, 33, 34, 35; Pls. Ex. 3, Mueller Aff.; Pls. Ex. 4, Ardizzone Aff. The Plaintiffs provide scant evidence to support their claim.

When one reads the declarations of Dr. Manian, Dr. Canavan and Ms. Jones, it becomes readily apparent that they do not reach conclusions about whether the Defendants have complied

with the CDC guidelines they identify as being "widely accepted" in the areas of hygiene and decontamination. Rather they list what practices should be followed. Without citation to their experts' opinion, for which there is none, the Plaintiffs' rely on their own statements to conclude that the Defendants did not exercise professional judgment with respect to hygiene and decontamination.

Specifically, the Plaintiffs' rely on Plaintiff Mueller's assertion that Dutcher South 3 was "not thoroughly cleaned". Pls. Mem. at pp. 16,34; Pls. Ex. 3, Mueller Aff., ¶ 12,39. A statement by Plaintiff Ardizzone that due to the number of individuals using the showers and rest room that it is "impossible to clean the fixtures and surfaces between each use by individual patient." was also cited to as proof that the Defendants are not following accepted guidelines. Pls. Mem. at pp. 17, 34; Pls. Ex. 4, Ardizzone Aff. ¶ 5. Both Plaintiff Muller and Ardizzone allege that the maintenance staff do not work on the weekend so that the "soap dispensers in the bathroom are not replaced when they become empty." Pls. Ex 3, Mueller Aff., ¶ 39; Pls. Ex. 4, Ardizzone Aff. ¶ 16. Such anecdotal stories and isolated incidents do not rise to the level of a constitutional violation. United States v. Commonwealth of Pennsylvania, 902 F. Supp. 565, 580 W.D. Pa. 1995, *aff'd sub nom*., U.S. v. Ridge, 96 F.3d 1436 3d Cir. 1996 (citing Shaw v. Strackhouse, 920 F.2d 1135,1143 (3rd Cir. 1992)). The Plaintiffs have the burden of offering evidence that the actions by the Defendants to provide supplies and opportunities for proper hand hygiene and to clean the facilities has been and is such a departure from professional standards that in effect no professional judgment was exercised at all. The Plaintiffs cannot meet this burden.

The custodial staff at CVH consists of 60 individuals. Defs. Ex. G, Lizotte Decl. ¶ 2. The custodial staff at CVH work Monday through Friday between 6:45 am and 10:00 pm Monday through Friday. Defs. Ex. G, Lizotte Decl. ¶ 3. During the weekend the custodial staff

work hours are from 6:00 am to 2:00 pm. Defs. Ex. G, Lizotte Decl. ¶ 4. When an issue arises that needs to be addressed when the custodial staff are not on duty, Ms. Lizotte, the Building Superintendent for CVH, responds, as she is on call for emergencies, or a member of the custodial "E-Man" group responds. Defs. Ex. G, Lizotte Decl. ¶ 5. The "E-Man" group is a made of custodial staff who volunteer to be on call for emergencies. Defs. Ex. G, Lizotte Decl. ¶ 5. The Plaintiffs' claim that custodial staff do not work on weekends, is simply incorrect. Pls. Mem. Ex 3, Mueller Aff., ¶ 2, 39; Ex. 4, Ardizzone Aff. ¶ 2, 16.

CVH has adopted and implemented Environmental Services Protocols in response to the COVID-19 pandemic. Defs. Ex. G, Lizotte Decl. ¶ 6. In accord with CDC guidance, CVH utilizes cleaning agents and sanitizers most of which are EPA registered products. Pls. Mem. at Ex. 13, p. 6, CDC "Preparing for COVID-19 in Nursing Homes", Updated May 19, 2020; Defs. Ex. G, Lizotte Decl. ¶ 7a-g. Defs. Ex. 2, Dr. Martinello Decl. ¶ .

There are different protocols for different areas. All bathrooms are cleaned thoroughly once daily or twice depending on circumstances that arise. Defs. Ex. G, Lizotte Decl. ¶ 8. Cleaning of patient occupied rooms is done on a daily basis utilizing Fusion Bleach or Virex. Defs. Ex. G, Lizotte Decl. ¶ 9. The common areas are cleaned daily and high touch areas are sanitized twice daily using the BioSpray D2 surface sanitizer; patient phones are also sanitized. Defs. Ex. G, Lizotte Decl. ¶ 10. Disinfecting wipes are available to patients. Defs. Ex. G, Lizotte Decl. ¶¶ 11,12. Soap dispensers are checked twice a day by the custodial staff; once in the morning and once before the end of their shift. Defs. Ex. G, Lizotte Decl. ¶ 14. The custodial staff will refill the soap dispenser if it is getting low or it is found to be empty. Id. When the custodial staff are not on duty and a soap dispenser runs out of product E-Man is called and they will refill the soap dispenser. Defs. Ex. G, Lizotte Decl. ¶ 15.

Specific cleaning procedures are utilized in those areas where patients are quarantined or are in isolation. Defs. Ex. G, Lizotte Decl. ¶ 16. The custodial staff don all PPE prior to the entry into the isolation unit. Defs. Ex. G, Lizotte Decl. ¶ 17. After cleaning is complete staff remove all PPE except gloves, all supplies and equipment are washed with an approved germicidal solution. Defs. Ex. G, Lizotte Decl. ¶ 15. Mop heads and linens are placed in a bag along with the gloves. Defs. Ex. G, Lizotte Decl. ¶ 17. The bag is tied off and labeled as biohazardous and disposed in the appropriate manner. Id.

The hygiene and decontamination processes that CVH has developed and implemented follow CDC guidance, which demonstrates that CVH staff have exercised professional judgment. Defs. Ex. 2, Dr. Martinello Decl. ¶¶ 23,39,41,42. The Plaintiffs have not provided any evidence to the contrary and thus have not carried their burden of showing likelihood of success on the merits.

As previously noted, the Plaintiffs rely on affidavits that allege deficits in hygiene and decontamination processes exist at Whiting, even though neither Dr. Manian, Dr. Canavan, nor Ms. Jones actually make conclusions to support that claim. The facts once again show that the Plaintiffs claims are not supported as Whiting, in adopting and implementing hygiene and decontamination protocols, has exercised professional judgment. Defs. Ex. 2, Dr. Martinello Decl. ¶¶ 24,39,41,42.

The custodial staff at Whiting consists of 16 individuals, including one supervisor with some assigned to Whiting Service and others to Dutcher Service. Defs. Ex. I, Crego Decl. ¶ 5. The custodial staff works from 4:45 am to 7:45 pm Monday through Friday. Defs. Ex. I, Crego Decl. ¶ 6. Contrary to the assertions of Plaintiffs Mueller and Ardizzone, there are custodial staff who work on the weekends. Pls. Mem. Ex 3, Mueller Aff. para 39; Ex. 4 Ardizzone Aff. ¶ 16.

On Saturday and Sunday, there are 3 custodial staff for all Whiting units between the hours of 4:45 am through 7:45 pm. Defs. Ex. I, Crego Decl. ¶ 7. Issues that occur at any time, including weekends, are covered by the custodial manager who will respond or send a staff member to respond. Defs. Ex. I, Crego Decl. ¶ 8.

Whiting has followed CDC guidance and utilizes cleaning agents and sanitizers that are EPA registered products. Pls. Mem. at Ex. 13, p. 6, CDC "Preparing for COVID-19 in Nursing Homes," Updated May 19, 2020; Defs. Ex. I, Crego Decl. ¶¶ 9a-d. To clean the bathrooms, the custodial staff utilizes the KaiVac 1750 touchless cleaning system and the procedures associated with its use. Defs. Ex. I, Crego Decl. ¶ 10; Ex. Q. If necessary, the custodial staff are able and in fact do more cleaning using appropriate disinfecting products. Defs. Ex. I, Crego Decl. ¶ 11.

The occupied patient rooms are cleaned on a daily basis utilizing Fuzion Bleach or Virex. Defs. Ex. I, Crego Decl. ¶ 13. All common and high touch areas are sanitized twice daily using the BioSpray D2 surface sanitizer including patient phones. Defs. Ex. I, Crego Decl. ¶ 14. Disinfecting wipes are available to patients. Defs. Ex. I, Crego Decl. ¶ 15. Soap dispensers which contain liquid soap are checked on a daily basis by the custodian assigned to the respective unit. Defs. Ex. I, Crego Decl. ¶ 16. The custodial staff will replace it if the product is low and feels it will not last through the next interval. Defs. Ex. I, Crego Decl. ¶ 16. However, if a patient or a staff member finds that the dispenser is empty, then the unit director or the nurse supervisor will contact the custodial staff or the nurse supervisor's office in the off hours to ensure a quick resolution is afforded. Defs. Ex. I, Crego Decl. ¶ 17. While Plaintiff Mueller asserts that the soap in the soap dispensers ran out on two occasions, once on a Sunday and then again on a Tuesday, he does not allege that they were not refilled in a timely manner or that hand soap was not available at all. Pls. Mem. Ex. 3, Muller Aff. ¶ 39, 45.

Specific cleaning procedures are utilized in those areas where patients are quarantined or are in isolation. Defs. Ex. I, Crego Decl. ¶ 19. The custodial staff don all PPE prior to the entry into the isolation unit. Defs. Ex. I, Crego Decl. ¶ 20. After cleaning is complete staff remove all PPE except gloves, and all supplies and equipment are washed with an approved germicidal solution. Defs. Ex. I, Crego Decl. ¶ 20. Mop heads and linens are placed in a bag along with the gloves. Defs. Ex. I, Crego Decl. ¶ 20. The bag is tied off and labeled as biohazardous and appropriately disposed. Defs. Ex. I, Crego Decl. ¶ 20.

The hygiene and decontamination processes that Whiting is implementing follow CDC guidance, which demonstrates Whiting staff have exercised professional judgment. The Plaintiffs have not provided any evidence to the contrary and thus have not carried their burden of showing likelihood of success on the merits.

c) Personal Protective Equipment ("PPE")

With respect to PPE, Plaintiffs concede that "[w]hile staff are now required to wear masks and patients are now offered one mask per week," they claim that "Defendants still do not ensure that PPE guidelines are practiced consistently or that residents are encouraged to wear masks." Pls. Mem. at 33. Plaintiffs further assert that "use of masks by both staff and patients remains intermittent and unenforced, resulting in ongoing but avoidable risk of infection to both." Id. Plaintiffs' Ardizzone's and Litsky's affidavits, while sometimes seemingly contradicting one another and the above assertions (*e.g.*, Ardizzone asserts staff do not always wear their masks (Pls. Ex. 4, Ardizzone Aff. ¶¶ 18, 32), while Litsky asserts staff are almost always wearing masks (Pls. Ex. 5, Litsky Aff. ¶ 33)), appear to be the factual foundation for plaintiffs' claims on this issue. It is well settled, however, that such anecdotal reports do not themselves constitute adequate or competent evidence of violation of Youngberg's standard requiring the exercise of professional judgment. Shaw v. Strackhouse, 920 F.2d 1135, 1143 (3d

Cir.1990); Casey v. Ohio Metal Products, 877 F.Supp. 1380, 1385 (N.D.Cal.1995); Bushore v. Dow Corning-Wright Corp., 1999 WL 1116920 at *5 (M.D.Fla.1999).

The declarations of Drs. Wasser and Carvalho), the Medical Directors of Whiting and CVH respectively, set forth that PPE use at the hospitals has evolved with CDC guidance on the subject, and that all direct care staff have available to them all the requisite PPE needed, and have received ongoing training in proper PPE use, including proper donning and doffing techniques. Defs. Ex. C, Decl. Dr. Wasser ¶¶ 30, 31, 32; Defs. Ex. D, Decl. Dr. Carvalho ¶¶ 32, 33, 34, 35, 36, 66, 68; Defs. Ex. I, Decl. Crego ¶¶ 3, 4; Defs. Ex. M; Defs. Ex. J, Decl. Boutin ¶¶ 2.3; Defs. Ex. N. In addition, staff have been mandated to wear surgical masks in all patient settings, and higher levels of PPE as may be needed to safely carry out various medical procedures or as they work with COVID-19 positive or exposed patients. Staff education is ongoing on these subjects, and staff have been reeducated where any noncompliance has been detected. Defs. Ex. C, Decl. Dr. Wasser ¶ 33 ; Defs. Ex. D, Decl. Dr. Carvalho ¶¶ 33, 35, 66, 68.

With respect to patients, Drs. Wasser and Carvalho describe that patients are provided masks weekly, and more often if they become soiled or damaged. All patients receive masks unless mask use is medically contraindicated, or providing a mask presents a risk of self-injury to the patient. Further, education for patients encouraging their use of their masks is ongoing. Defs. Ex. C, Decl. Dr. Wasser ¶¶ 34, 35; Defs. Ex. D, Decl. Dr. Carvalho ¶¶ 37, 67, 68.

Finally, despite the very serious challenges around PPE supplies that Connecticut and indeed the nation have experienced, especially earlier in the pandemic, the declarations of Messrs. Crego and Boutin establish that Whiting and CVH never lacked for needed PPE supplies, and currently have more than adequate supplies on hand. Defs. Ex. I, Decl. Crego; Defs. Ex. M; Defs. Ex. J, Decl. Boutin; Defs. Ex. N.

Dr. Geller's findings confirm these protective practices. Defs. Ex. A, Decl. Geller (¶¶ 4.b. (masks required upon entry); 4.k. (masks provided to staff); 4.m. (patients expected to wear masks when outside their rooms); 5.e.xiii. (4 of 8 patients wearing masks, all staff wearing masks); 5.e.xx. (new masks provided to patients weekly or more often if soiled or ripped); 34. (masks provided to all patients and staff with either the requirement or expectation that they will be used)). Dr. Geller also noted areas dedicated for donning and doffing PPE. Ex. A ¶ 4.c. Dr. Martinello found CVH focused on patient use of facemasks and ensuring that PPE is fully available, and its use is monitored. Defs. Ex. B., Decl. Martinello ¶15. Dr. Martinello observed that both CVH and Whiting had not run out of PPE, including eye protection, respirators, gloves and gowns, and that staff had received proper training on PPE use, further noting that facemasks are available for all patients and staff. Def. Ex. B. ¶¶ 31, 32.

Plaintiffs cannot demonstrate that the Youngberg standard has been violated with respect to PPE at CVH and Whiting.

d) Social Distancing

To support their conclusion that CVH and Whiting should, at all costs, release patients from CVH and Whiting, Plaintiffs claim that Defendants' social distancing efforts at CVH and Whiting have substantially departed from professional standards. Pls. Memo at pp. 1, 28. Plaintiffs' base this claim on inaccurate and unsupported claims about Defendants' social distancing practices, a wholesale attack on Defendants' unit-segregation practices at CVH and Whiting and the anecdotal claims of three plaintiffs. Pls. Memo at pp. 5, 6, 29; Pls. Ex. 4, Aff. of Ardizzone ¶¶ 1, 2; Pls. Ex. 5, Aff. of Litsky ¶¶ 1, 2; Pls. Ex. 3, Aff. of Mueller ¶¶ 1, 2. Plaintiffs' social distancing claim hinges on their inaccurate assertion that Defendants have not implemented social distancing and other CDC guidance at CVH and Whiting, but instead use "unit segregation" as a response to the pandemic. Id.

Plaintiffs and their experts reference CDC guidance[6] regarding long-term care facilities and nursing homes, but inexplicably fail to note that the CDC has issued guidance specific to psychiatric facilities. CDC infection prevention and control recommendations for COVID-19 apply to psychiatric hospitals; however, CDC has stated "as with any guidance, facilities can tailor certain recommendations to their setting. For example, inpatient psychiatric care includes communal experiences and group activities that may need to continue. If so, these activities might need to be adapted to align with social distancing recommendations." Defs. Exhibit R. CDC Healthcare Infection Prevention and Control FAQs for COVID-19 (Updated June 5, 2020) (emphasis added). Plaintiffs and their experts' insistence that unit segregation as a means of securing social distancing is unacceptable is inconsistent with CDC guidance that psychiatric hospitals can tailor the recommendations to their setting. On this basis alone, plaintiffs cannot establish that the unit segregation practices are such a substantial departure from professional judgment as to demonstrate that the person responsible actually did not base the decision on such judgment. Youngberg, 457 U.S. at 323. CDC calls on hospitals like CVH and Whiting to tailor the social distancing recommendation rather than mandate its strict application; and CVH and Whiting have answered that call through their treatment teams exercising professional judgment to balance the need to continue to provide inpatient care and prevent infections.

CDC does recommend that social distancing within a unit be implemented in facilities when cohorting of infected patients is not possible. Defs. Exhibit R., CDC Healthcare Infection Prevention and Control FAQs for COVID-19 p. 2. CVH and Whiting have implemented comprehensive cohorting plans and meaningful social distancing practices at both facilities.

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[6] Plaintiffs' expert, Dr. Manian, states that "[f]ollowing the CDC's guidelines is even more crucial during [this COVID-19 pandemic]…. Pls. Ex. 1, Decl. of Manian ¶ 10.

(1) CVH and Whiting are Following CDC's Patient Cohorting Guidance.

As suggested above by the referenced CDC psychiatric hospital guidance, cohorting is a preferred and important tool to combat COVID-19 in psychiatric facilities. After consulting with DPH and, in CVH's case a Middlesex Hospital Epidemiologist, CVH and Whiting implemented a system to cohort patients and keep them separate. Defs. Ex. D, Decl. of Dr. Carvalho ¶¶ 53, 54; Defs. Ex. C, Decl. of Dr. Wasser ¶ 48; Defs. Ex. A, Dr. Geller Decl. ¶ 11. Generally, CVH and Whiting use the same patient cohorting plan: (1) Patients who tests positive for COVID-19; (2) Patients who test negative for COVID-19 but were exposed to others who tested positive for COVID-19; and (3) Patients that test negative for COVID-19 who were not exposed to a person who tested positive for COVID-19.[7] Defs. Ex. D, Decl. of Dr. Carvalho, ¶¶ 53, 54; Defs. Ex. C, Decl. of Dr. Wasser ¶ 48.

Whiting isolates patients who test positive for COVID-19 and other members of their unit from other patients who have not tested positive; and cohorts all patients who have tested positive for COVID-19 together on the same unit. Defs. Ex. C, ¶ 51, 52, Decl. of Dr. Wasser. In addition to an isolation unit with its own bathroom and dining room, Whiting's isolation and cohorting plan includes, if necessary, using available facility space to create a negative pressure isolation unit and an isolation unit in a gymnasium. Id., ¶¶ 55, 56.

Whiting also isolates patients who have COVID-19 symptoms, as defined by the CDC, but who have not tested COVID-19 positive, from other patients and tests them for COVID-19. Id. ¶ 49. If the Whiting patient tests COVID-19 negative, but clinical suspicion for COVID-19 remains high, the Whiting patient is re-tested and remains in quarantine. Id. Whiting patients who have not tested positive for COVID-19 who are exposed to confirmed COVID-19 positive

[7] CVH also employs an enhanced protocol for patients who are exhibiting lack of behavior control. Defs. Ex. D, Decl. of Carvalho ¶ 59; Defs. Ex. B, Decl. of Dr. Martinello, ¶ 28.

patients are quarantined to their unit and prevented from interacting with patients in the other units for fourteen (14) days. Id. ¶ 52. Whiting also places new patients in an isolation unit away from other patients in the isolation unit until their COVID-19 test results return. Id., ¶ 53. At CVH, COVID-19 positive patients reside in one of the two isolation units, which are equipped with negative pressure rooms and enough space to allow for social distancing; people suspected of having COVID-19 ("PUIs"), based on CDC guidelines, reside in an isolation room with floor-to-ceiling walls and a separate bathroom. Def. Ex. D, Decl. of Carvalho ¶¶ 54, 55. Also, CVH places patients who are suspected of having COVID-19, based on CDC guidelines, in an isolation room with floor-to-ceiling walls and a separate bedroom. Id. ¶ 53. In addition, CVH cohorts and quarantines patients exposed to a COVID-19 positive person who tests negative for COVID-19 for fourteen (14) days. Id., ¶ 56.

Although CVH and Whiting have implemented comprehensive, CDC-recommendation-based patient cohorting strategies, both facilities have also implemented significant social distancing measures. Plaintiffs and their experts rely on a few vague anecdotes advanced by patients Ardizzone, Litsky and Mueller as the support for their claim that Defendants have not implemented and enforced social distancing measures at Whiting and CVH. As discussed below, these anecdotes do not reflect the reality at CVH or Whiting.

(2) CVH and Whiting have modified patient use of the physical space at CVH and Whiting to support cohorting and social distancing.

Consistent with CDC's guidance,[8] CVH and Whiting each reviewed their respective therapeutic patient groups to determine whether the groups should continue during the pandemic. Whiting performed an analysis to determine whether continuing a therapeutic group outweighs

[8] Defs. Ex. R, Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19) Healthcare Infection Prevention and Control FAQs for COVID-19 (updated June 5, 2020), p. 1, (discussing group therapy sessions and reducing group size).

the risk associated with COVID-19 transmission. Defs. Ex. C, Decl. of Dr. Wasser, ¶ 59. If this process did not lead to the closing of a Whiting therapeutic group, this process led to altering the group's frequency and meeting duration, limiting the group-size to five participants and limiting groups to members of the same unit (*i.e.*, no cross-unit member participation). Id., ¶ 59. CVH also went through a similar process. Defs. Ex. D, Decl. of Carvalho ¶ 61; Defs. Ex. B, Decl. of Dr. Martinello, ¶ 29. CVH employs unit-based, rather than congregate dining. Defs. Ex. D, Decl. of Carvalho, ¶ 58. Patients eat their meals in their rooms or other rooms within the unit. Id., ¶ 58. Also, to the extent possible, CVH staggers patient bathroom use and showering. Defs. Ex. D, Decl. of Carvalho, ¶¶ 58.

Whiting ceased multi-unit dining and organized the provision of meals into two separate dining spaces, one of which was newly created, so that each unit dines separately, and rearranged the physical space to maximize social distancing. Id., ¶ 60. Further, Whiting assessed the risks and benefits of continued elevator use, which usage Plaintiffs claim as a concern (see Pls. Mem., p. 18, and further discussion regarding elevator use below) and enacted a process to maximize stairwell use under staff supervision to account for reduced elevator occupancy due to social distancing requirements. Id., ¶ 61; Defs. Ex. B, Decl. of Dr. Martinello, ¶ 27.

Consistent with SAMHSA guidance, CVH and Whiting have also modified patient movement. Defs. Ex. S, SAMHSA Covid19: Interim Considerations for State Psychiatric Hospitals, p. 2. For example, Whiting enacted measures to prevent its patients from mingling with CVH patients. Defs. Ex. C, Decl. of Dr. Wasser ¶ 62.a, b. Whiting also enacted measures to keep members of separate units separate in the outdoor spaces. Id., ¶ 62 c, d. Similarly, CVH also limits courtyard use to members of a unit and limits the number of patients using it at any given time. Defs. Ex. D, Decl. of Carvalho, ¶ 62. CVH also prevents patients from congregating

in other areas and mingling with patients from other units at CVH and prevents patients from accessing other areas at CVH and Whiting. Id.

CVH and Whiting have also modified the time, place and frequency of on-site Probate Court proceedings to support social distancing. Rather than being held in a single location, CVH and Whiting now conduct probate proceedings at CVH and Whiting. Id., ¶ 63. In addition, CVH and Whiting instituting staff teleworking arrangements and use telemedicine where appropriate. Defs. Ex. D, Decl. of Dr. Carvalho, ¶ 63; Defs. Ex. C, Decl. of Dr. Wasser, ¶ 64; Defs. Ex. B, Decl. of Dr. Martinello, ¶ 30. As another example, CVH and Whiting have enabled patients to have meaningful visitor contact through virtual visitation in addition to in-person visitation. Defs. Ex. D, Decl. of Dr. Carvalho, ¶ 60; Defs. Ex. C, Decl. of Dr. Wasser, ¶ 58.

In addition, in double-occupant rooms at CVH, CVH placed beds so that the head of one bed faces the foot of the other bed to aid in social distancing within the room. Defs. Ex. D, Decl. of Dr. Carvalho, ¶ 58; Defs. Ex B, Dr. Martinello Decl., ¶ 26.

(3) CVH and Whiting have implemented significant staff and patient social distancing training and education.

CVH and Whiting have provided patients and staff with ongoing, updated relevant COVID-19 training that includes social distancing. Defs. Ex. A, Decl. of Dr. Geller, ¶¶ 4.b, c, k, m, 34; Defs. Ex. B, Decl. of Dr. Martinello, ¶ 41.

"Whiting staff and patients have been and continue to be instructed on an on-going basis to maximize social distancing opportunities and maintain social distancing to the greatest extent possible." Defs. Ex. C, Decl. of Dr. Wasser, ¶ 68. Whiting "provides staff with significant, ongoing social distancing training." Id., ¶ 65. In addition, Whiting patients "have been provided clear educational materials on COVID-19 precautions; posters and unit-based meetings also encourage the practice of approval precautions…" including social distancing. Id., ¶¶ 35, 57, 66,

67. This education has been provided multiple times through community meetings during which patients were provided educational materials on, among other things, social distancing. Id., ¶ 66.

At CVH, "CVH staff and patients are instructed to maximize social distancing opportunities and maintain social distancing to the greatest extent possible." Defs. Ex. D, Decl. of Dr. Carvalho, ¶ 70. CVH staff use the Talking Points Regarding Masks and PPE, which instructs staff to "[r]einforce social distancing…," among other things. Id., ¶ 66. All CVH staff have received frequent communication about providing patients with COVID-19 prevention education and modelling COVID-19 prevention measures for the patients. Id., ¶ 68.

CVH provides patients with ongoing social distancing education through handouts, posters and unit-based meetings. Id.,¶¶ 37, 64, 65. Each patient's chart contains documentation of social distancing training. Id., ¶ 37. In addition, CVH has provided patient reeducation regarding, among other things, social distancing and is implementing a CVH developed nine (9) session patient education program. Id., ¶¶ 67, 68.

(4) Defendants have failed to demonstrate that Defendants have failed to exercise professional judgment regarding social distancing.

Plaintiffs' claim that Defendants have been slow to protect Plaintiffs from COVID-19 and that Defendants' failure to ensure social distancing within facilities is placing Plaintiffs at great risk. Pls. Mem., pp. 4, 28. Plaintiffs also claim that, as of the date of the Memorandum, Plaintiffs are unable to practice social distancing at CVH and Whiting. Id. Given the comprehensive social distancing efforts at CVH and Whiting and their resulting effects, as discussed above, Plaintiffs claim lacks merit.

As discussed above, Plaintiffs' social distancing claims are based on their experts, Canavan and Jones, and Manian, and the affidavits of three plaintiffs. Pls. Mem., pp 5, 6, and 29 (citing to Pls. Ex. 4, Aff. of Ardizzone; Pls. Ex. 5, Aff. of Litsky and Pls. Ex. 3, Aff. of Mueller.

Canavan and Jones are not competent to provide the "expert" opinions on infectious disease control. See Defendants' Motion In Limine Or To Exclude Testimony In The Declaration Of Patrick Canavan And Elizabeth Jones And Affidavit Of Richard Gudis, dated July 9, 2020. Anecdotal stories and isolated incidents do not rise to the level of a constitutional violation. United States v. Commonwealth of Pennsylvania, 902 F. Supp. 565, 589 (W.D. Pa. 1995), *aff'd sub nom.*, U.S. v. Ridge, 96 F.3d 1436 (3rd Cir. 1996) (citing Shaw v. Strackhouse, 920 F.2d 1135, 1143 (3rd Cir. 1992). See also, Society for Good Will, 737 F.2d at 1245. The problem with reliance on anecdotal evidence is illustrated in these patient affidavits.

For example, regarding evidence of alleged lack of social distancing, Plaintiffs cite to the Mueller affidavit and claim that patient testimony is that there is an elevator in which up to 10 people crowd; however, Mueller actually only makes a vague assertion regarding the elevator without mentioning ten people crowding in. Pls. Mem. p. 18; Pls. Ex. 3, Mueller Aff., ¶¶ 13, 14. More importantly, Whiting has addressed social distancing in the elevator by maximizing supervised stairwell use to reduce elevator occupancy. Defs. Ex. C, Decl. of Dr. Wasser ¶ 61; Defs. Ex. B, Decl of Dr. Martinello, ¶ 27. Regarding Plaintiffs' anecdotal claims about dining, Whiting created two separate dining spaces so that each unit can dine separately and arranged the physical layout to maximize social distancing. Defs. Ex. C, Decl. of Dr. Wasser ¶ 60. Thus, even if some of the claims in plaintiffs' affidavits were true at some point in time, they do not reflect current practice at Whiting.

As Dr. Martinello, a board-certified infectious disease physician , after pointing out the numerous steps that CVH and Whiting have taken to support social distancing, Defs. Ex. B, Decl. of Dr. Martinello, ¶¶ 26-30, 33, opine that CVH and Whiting's " administrative actions have met or exceeded guidance provided by the CDC and CT DPH and … the leadership and

staff of CVH and WFH exercised excellent professional judgement and were most proactive in implementing measures to minimize the impact of COVID on the residents and staff of the institutions." Defs. Ex. B, Decl. of Dr. Martinello, ¶¶ 41.

For these reasons, the Plaintiffs have not demonstrated that the Defendants implementation of social distancing was such a departure from acceptable professional judgment as to demonstrate that the person responsible actually did not base the decision on such judgment. Youngberg, 457 U.S. at 323.

e) Patient Census Reduction.

Plaintiffs assert that census reduction must be implemented in order to maximize the overriding priority of social distancing in CVH and Whiting. They urge a reduction in admissions and accelerated discharge of inpatients at the hospitals. Pls. Memo at 21.

As previously noted, admission to CVH is through either voluntary admission pursuant to Conn. Gen. Stat. § 17a-506 or by involuntary commitment by order of a Probate Court finding by clear and convincing evidence that the person suffers from a psychiatric disabilities and is either gravely disabled or a danger to them self or others. Conn. Gen. Stat. §§ 17a-495 *et seq*. Whiting admits civilly committed individuals who require a high level of treatment and criminal defendants who have been determined incompetent to stand trial for restoration of competency. Whiting also admits NGRI patients. Conn. Gen. Stat. §53a-13. Whiting also admits inmates of the Department of Corrections whose acute psychiatric needs require treatment at a maximum-security psychiatric hospital. Conn. Gen. Stat. § 17a-517.

Plaintiffs assert that in order to maximize social distancing in CVH and Whiting, admissions should be restricted for all of these patients. Pls. Memo at 21; Pls. Ex. 2 Canavan & Jones Decl. ¶ 15,16. Plaintiffs do not assert that the admission of any individual patient was in violation of due process in the absence of the social distancing. Plaintiffs have failed to

demonstrate that the failure to cease or severely limit admissions is in violation of the acceptable minimum professional standards. Soc'y for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1248 (2d Cir. 1984).

Plaintiffs' experts have different opinions as to what is the minimum professional standard on restricting admissions to maximize social distancing. Two of plaintiffs' experts urge without limitation the "cessation of most civil admissions and discouraging forensic admissions." Pls. Ex. 2, Decl. Canavan & Jones, ¶ 15. Plaintiffs' infectious disease expert opines that stopping new admissions should be implemented only "when there is evidence for ongoing transmission of SARS-CoV-2 within the facility or when adequate staffing levels and PPE to manage COVID-19 positive resident cannot be assured." Pls. Ex. 1, Decl. of Manion, ¶ 19. This expert does not state that either circumstance exists at CVH or Whiting. Id. Defendants have established herein, these conditions do not exist in the facilities. Plaintiffs cannot prove a due process violation when their experts cannot even agree on the applicable professional standard.

Plaintiffs' provide an incomplete representation of the CDC's position on this issue. Plaintiffs point to a single reference in a single CDC guideline that nursing homes "**[c]consider** temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented" but fail to note that the recommendation applies only when the facility identifies a resident with new-onset suspected or confirmed COVID-19. It is unrelated to establishing social distancing. Pls. Ex. 14, CDC, Responding to COVID in Nursing Home, at p 3 (emphasis added). The same CDC guidance provides instruction on creating a plan for managing new admissions and readmissions of residents whose COVID-19 status is unknown. Id. at 2. More recently updated CDC guidance do not mention any restriction on admissions under any circumstances. Pls. Ex. 13, Preparing for COVID-19 in Nursing

Homes updated 5/19/20 and 6/25/20 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html); Pls. Ex. 10, Centers for Medicare & Medicaid Services, Nursing Home Reopening Recommendations for State and Local Officials, at 5-6.

The Plaintiffs' position that restricting admissions is the minimum professional standard is further inconsistent with the positions taken by other States. Massachusetts has adopted a "No Reject Admission Policy for COVID-19 Pandemic. Defs. Ex. V, Commonwealth of Massachusetts, Department of Mental Health, COVID-19 EMERGENCY GUIDANCE, Admission, COVID-19 Testing, and EPIA. It states that facility may deny admission to a patient only if such admission would result in a census exceeding the facility's operational capacity or if the admission has been determined by the facility medical director to exceed the facility's capability at the time admission is sought. Id. at 1.

Plaintiffs also rely upon guidance from SAMHSA[9] which they characterize as "during the pandemic, inpatient psychiatric care should be used only when absolutely necessary to protect the life or safety of the individual. In all other circumstances, outpatient arrangements should be utilized." Pls. Mem. at p. 20. However, SAMHSA's advice is more expansive. It states:

> SAMHSA is advising that outpatient treatment options, when clinically appropriate, be used to the greatest extent possible. Inpatient facilities and residential programs should be reserved for those for whom outpatient measures are not considered an adequate clinical option; i.e.: for those with mental disorders that are life threatening, (e.g.: the severely depressed suicidal person or persons with life threatening substance use disorders (e.g.: at high risk for overdose, complications from withdrawal). It is recommended that intensive outpatient treatment services be utilized whenever possible. Comprehensive long-term residential treatment programs, where COVID related precautions can be implemented (social distancing, isolating, testing, etc.) remain a viable treatment option when clinically indicated. Pls. Ex. 18, SAMSHA Guidance Considerations for Care and Treatment during COVID (dated May 7, 2020) (emphasis added).

[9] The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to address behavioral health.

The next day SAMSHA issued guidance specifically addressed to State Psychiatric Hospitals that contains this statement:

> While SAMHSA has preferentially recommended outpatient treatment during the COVID-19 crisis as telehealth technology and social distancing can be more effectively implemented, inpatient psychiatric care will inevitably be required for a number of patients. Psychiatric care on an inpatient service is typically reserved for the most severe conditions, and inpatient care at state psychiatric hospitals is typically reserved for the most refractory cases.

Defs. Ex. S, SAMHSA, Covid19: Interim Considerations for State Psychiatric Hospitals, (emphases added). Instead of cessation of admissions, SAMHSA recognizes the need for continued inpatient care in appropriate cases.

Plaintiffs have not demonstrated that a ban on admissions for social distancing purposes is required by minimum professional standards. If the Plaintiffs only prove a difference of professional opinion as to which practices are appropriate and which are not, this does not establish a constitutional deprivation. Doe by Roe v. Gaughan, 617 F. Supp. 1477, 1487 (D. Mass. 1985), *aff'd sub nom.* Doe v. Gaughan, 808 F.2d 871 (1st Cir. 1986). See also Thomas S. v. Flaherty, 902 F.2d 250, 252 (4th Cir.), *cert. denied*, 498 U.S. 951 (1990).

Plaintiffs do not consider the impact of the denial of care to patients determined to need care at a psychiatric hospital by either the Superior Court or the Probate. The Probate Court is required to consider whether a less restrictive placement is available in reaching the decision by clear and convincing evidence that an order of commitment should be issued. Conn. Gen. Stat. § 17a-498(c)(3). The Superior Court must find the hospital is the least restrictive placement appropriate in order to place a criminal defendant for restoration of competency in the hospital. Conn. Gen. Stat. § 54-56d(i). These orders turn on the court's determination that inpatient psychiatric hospital care is needed. Notwithstanding these judgments, plaintiffs assert social distancing trumps the need for care. If admission of patients under the jurisdiction of the PSRB

or sent for restoration of competency to stand trial was prohibited, the patients in almost all circumstances would remain in a correctional facility without the same level of treatment as provided at Whiting. Ex. C, Decl. of Dr. Wasser ¶ 47; Defs. Ex. A, Decl. of Dr. Geller, ¶ 25. From March 1, 2020 until June 30, 2020, CVH admitted 31 patients to the General Psychiatric Division and Whiting admitted 21 patients[10]. These patients almost of all whom were determined by courts to require inpatient hospitalization, would be barred by the Plaintiffs from the hospitals to maximize social distancing. "If CVH or WFH was the most integrated setting appropriate to a patient's need before the pandemic, then it is the most integrated setting appropriate to the persons need during the pandemic. There is no evidence there is increased safety, all things considered, for such patients outside of CVH or WFH, than inside." Defs. Ex. A, Decl. of Dr. Geller, ¶ 30.

The discharge process utilized by the hospitals' professionals is in accord with due process. Discharge of inpatients at CVH and Whiting follow similar processes. All patients at each hospital are part of a treatment team made up of clinicians that collaboratively plan and provide care to the patient. The team consists of a of a psychiatrist, medical doctor, psychologist, social worker, rehabilitation therapist, nurses, and mental health assistants (who assist in therapeutic engagements). Defs. Ex. C. , Decl. of Dr. Wasser, ¶ 36: Defs. Ex. D. , Decl. of Dr. Carvalho, ¶ 38.

[10] Plaintiffs erroneously criticize Whiting for cancelling patients on temporary leave making the hospital more crowded. Pls. Memo at 23. Beginning in March 2020, PSRB patients who had been granted temporary leaves of 7 nights in the community were allowed to remain in community placement except for those identified as posing too great a risk to remain in the community placement. Leaves for patients who were on less than 7-ovenight temporary leaves were cancelled rather than have them continuing short term leaves to avoid the risk of being infected in the community and returning to the hospital. Defs. Ex. C, Decl. of Dr. Wasser, ¶ 46.

Taking into account the limits of court-imposed confinement and in accord with governing policies, each hospital actively pursues the appropriate discharge of every patient deemed discharge ready by their treatment team. There is a monthly treatment meeting with the patient. Planning for discharge begins upon admission to the hospital. Treatment planning by the team addresses the particular considerations for each patient bearing on discharge and identifies barriers to discharge. Defs. Ex. C. , Decl. of Dr. Wasser, ¶¶ 37- 38; Defs. Ex. D. , Decl. of Dr. Carvalho, ¶¶ 39-40.

At every treatment plan review (which occur at least monthly), the treating physician will document in the chart and discuss with the patient the specific factors that the physician is considering to determine the patient's current clinical need for hospital level of care and the patient's readiness for discharge. Such factors include the patient's physical and mental status, results of medical/psychological tests, the patient's cognitive and behavioral status, the patient's functional capacities, and evaluative explorations or treatment protocols yet to be completed. Extrinsic factors which present barriers to discharge, such as the patient's willingness to leave the hospital or the availability of a residential placement must be documented in the chart. Defs. Ex. C. , Decl. of Dr. Wasser, ¶¶ 39-40; Defs. Ex. D. , Decl. of Dr. Carvalho, ¶¶ 41-42.

Each team includes a clinical social worker who maintains a knowledge base of community support services and provides oversight to the discharge planning process. Typically, the clinical social worker will be communicating with community providers regarding a patient's discharge in advance of the patient being determined as ready for discharge. Thus, each month, there has been a professional judgment by the physician informed by the team as to whether a patient is discharge ready. During the course of the pandemic, the treatment teams at both CVH and Whiting continued to address discharge readiness and barriers reflected in the treatment

plans including those posed by the COVID-19 pandemic. Defs. Ex. C, , Decl. of Dr. Wasser ¶¶ 41-43; Defs. Ex. D. , Decl. of Dr. Carvalho, ¶¶ 43-45.

The most significant component of the injunction Plaintiffs' seek would require Defendants to abandon the clinical and professional standards for determining when a psychiatric hospital inpatient can be safely and appropriately discharged. Plaintiffs' experts do not state that the provision of inpatient hospital level of care for any patient constitute a due process violation. Plaintiffs' demand for ordering these patients out of the hospital is solely based on the overriding goal of social distancing. Plaintiffs demand that both hospitals "apply a different standard than it would in ordinary times," Pls. Mem. at p. 22, because "the most important strategy for implementing social distancing is accelerating discharges." Id. Plaintiffs would displace the treatment team's application of professional judgment regarding a patient's discharge readiness for an alternative designed to expedite social distancing in the hospital buildings. Id. Plaintiffs' process is simply to find a place for the patient to live, including temporary housing such as hotels, provide access to food and medicines, assure the patient can take appropriate COVID precautions with available assistance in the community without being a danger to self or others. Pls. Ex. 2, Decl. of Canavan & Jones ¶ 22. Beyond medications no consideration is given to the inpatients' access to care to address their needs and the ability for community providers to address their needs. Id. at 22. Plaintiffs assert that due process requires moving from the physician's and treatment team's holistic evaluation of the patient's need for continued hospital care to an evacuation process to achieve social distancing.

Plaintiffs cannot secure such relief without first demonstrating that the failure to discharge otherwise appropriately placed hospital inpatients in order to secure social distancing violates acceptable minimum professional standards. Soc'y for Good Will to Retarded Children,

Inc. v. Cuomo, 737 F.2d at 1248. Plaintiffs ignore CDC guidance and other national organizations' guidance on responding to COVID-19. Neither Plaintiffs nor their experts cite to a single CDC guidance that states that health care facilities of any kind should discharge patients in order to secure social distancing. No CDC guidance recommends or even mentions discharging patients in health care facilities to achieve social distancing; this belies any argument that discharges for this purpose are required by accepted professional judgment, practice, or standards.

Contrary to the Plaintiffs' position that social distancing overrides professional standards and judgment on discharge readiness, the CDC has expressly recognized that in psychiatric hospitals, the CDC interim infection prevention and control recommendations may be adjusted to meet the needs of psychiatric patients. In response to the question of whether the "CDC interim infection prevention and control recommendations for COVID-19 apply to psychiatric hospitals or other behavioral health facilities" CDC stated the following:

> Yes. To keep patients and healthcare personnel (HCP) healthy and safe, CDC's infection prevention and control guidance applies to all settings where healthcare is delivered. **However, as with any guidance, facilities can tailor certain recommendations to their setting.** For example, inpatient psychiatric care includes communal experiences and group activities that may need to continue. If so, these activities might need to be adapted to align with social distancing recommendations.

Defs. Ex. R, CDC Healthcare Infection Prevention and Control FAQs for COVID-19 (emphasis added).

SAMHSA's COVID-19 guidance for State Psychiatric Hospitals does not mention discharging patients for social distancing purposes or changing professional standards that apply to discharging patients. Defs. Ex. S, SAMHSA, Covid19: Interim Considerations for State Psychiatric Hospitals. Rather SAMHSA recognizes "[w]hile SAMHSA has preferentially recommended outpatient treatment during the COVID-19 crisis as telehealth technology and

social distancing can be more effectively implemented, inpatient psychiatric care will inevitably be required for a number of patients." Id. at 1. Contrary to Plaintiffs' position that discharges should be expedited through lowering standards, SAMHSA states:

> Discharge planning may be more difficult. As many step down residential facilities and outpatient facilities are limiting intakes, social workers may find it more difficult to plan disposition of patients. This may result in longer lengths of stay. The treatment team as well as utilization review staff should adjust with this expectation. Also, questions may arise about the risk of the patient's exposure to those at the receiving facility.

Id. at 4. Rushing inpatients into temporary housing is not consistent with SAMHSA's caution regarding the community capacity to accept discharges. Likewise, the American Psychiatric Association (APA) has issued a guidance document addressing admissions and discharge of psychiatric patients during the pandemic. Defs. Ex. W, APA, Guidance on Admittance, Discharge of Psychiatric Patients During COVID-19. It also has no recommendation that inpatients be discharged to secure social distancing. The APA opposes expedited discharges. "Premature discharge of patients from psychiatric hospitals and inpatient psychiatric units is unreasonable as this practice exposes patients, families, and the community at large to the risks of harmful and adverse outcomes irrespective of communicable disease outbreaks." Id. at 2.

Plaintiffs burden in establishing a due process violation is to demonstrate that the treatment teams decision not to wholesale discharge patients to achieve social distancing "is such a substantial departure from *accepted professional judgment, practice, or standards* as to demonstrate that the person responsible actually did not base the decision on such a judgment." Soc'y for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d at 1248 (quoting Youngberg, 457 U.S. at 323). No violation of due process may be found where a plaintiff only proves a difference of professional opinion as to which practices are appropriate and which are not. Id.; Die v. Gaughan, 617 F.Supp. 1477, 1487 (D.Mass.1985), *aff'd,* 808 F.2d 871 (1st Cir.1986). In

this sense, the Court may not "weigh the decisions of treating professionals against the testimony" of plaintiffs' experts to decide which of several acceptable standards should apply. Messier v. Southbury Training Sch., No. 3:94-CV-1706(EBB), 1999 WL 20910, at *6 (D. Conn. Jan. 5, 1999). The CDC, SAMSHA and the APA do not endorse the practice of discharging patients to achieve social distancing and therefore, at best, Plaintiffs merely offer the unique views of their "experts."

Plaintiffs have not demonstrated that the responsible physician and the treatment teams at the hospitals failed to exercise professional judgment in their discharge decisions. At each monthly treatment team review, there has been a professional judgment by the physician informed by the team as to whether a patient is discharge ready. During the course of the pandemic, the treatment teams continued to address discharge readiness and barriers reflected in the treatment plans including those posed by the COVID-19 pandemic. Defs. Ex. C, Decl. of Dr. Wasser ¶ 41-43; Defs. Ex. D., Decl. of Dr. Carvalho, ¶ 43-45. The physicians and treatment teams had to consider the operational problems resulting from COVID-19 for community providers in making their discharge decisions. Plaintiffs fail to address whether the community residential or service providers could accommodate a massive discharge of patients who require inpatient level of care or whether the community provided a safer environment. Absent an evaluation of these factors which were part of the professional judgment of the patients' physicians and treatment teams, Plaintiffs have presented an incomplete evaluation of these judgments. Plaintiffs experts state: "Based on the conversations we have had, we are confident that community service providers would be willing to engage with the hospitals on planning and implementing discharges as part of such an effort at CVH and WFH." Pls. Ex. 2, , Decl. of Canavan & Jones ¶ 24. They fail to identify who they conversed with or provide any other

analysis of the community's capacity to receive the expedited discharge patients. In fact, the problems posed by COVID-19 in the community and ignored by the Plaintiffs are substantial.

The necessity that discharged patients must manage and maintain COVID-19 precautions (including reduced social interaction, adhering to cleaning protocols and the wearing of a mask) in the community requires that the discharge candidate be higher functioning in their ability to maintain their own safety and independence than in the absence of a pandemic. Defs. Ex. K, Decl. of Navaretta, ¶ 7.[11] Traditionally, inpatient discharges are accomplished with phased transition using day visits, overnight stays and temporary leaves to ease the relocation of the resident to the community provider. Due to the pandemic, this standard has been halted to avoid the potential for exposure of the patient at the community residence and then exposing others upon their return to the hospital. In some cases, community providers have been uncomfortable accepting a placement without this transition period and assurances that the patient has a hospital bed to return to if the transition is not successful. Id. at ¶ 10.

Plaintiffs do not address whether community placement will provide a safer environment than the hospitals. Community residential settings face challenges in maintaining social distance within their home style settings with limited numbers of bathrooms, common space and typically a communal kitchen. Id. ¶ 6. Community residential providers face significant challenges in the ability to maintain social isolation of residents. Community residential providers cannot prevent residents from leaving the home which increases the risks of exposure. Similarly, community providers can be challenged in preventing visitors into the residence. Id. ¶ 8. For community

[11] The last page attached to the affidavit of Vincent Ardizzone is a letter from his urologist, Dr. Meyer, who states: "My greatest concern is that if he is discharged into the community, he will not be compliant with social distancing (he has already expressed a desire to return to work), which will paradoxically (sp) increase his risk for acquiring COVID-19." Pls. Ex. 4, Ardizzone Aff. p. 27.

residential providers with multiple sites, staff may be working in multiple sites creating risk of transmitting infection among sites. Community providers do not have the purchasing power to secure large scale orders of PPE and infection control supplies. Id. ¶ 9.

Community residential providers face significant challenges in the ability to cohort and isolate residents with COVID-19 exposure, symptomatic COVID-19 or COVID-19 positive diagnosis. In many cases, especially small congregate settings, space is limited without the option to create or open up new space in these residential buildings. The consequence is the necessity to maintain a vacant bedroom for this purpose, if there happened to be a vacancy at the time of the COVID-19 surge in Connecticut, thereby reducing the number of available beds for new residents. Id. ¶ 5.

The extent to which community service providers experienced major scale-backs and cope with barriers to discharge are also detailed in the declaration of Dr. Geller. Defs. Ex. A, Decl. of Dr. Geller, ¶ 6. Dr. Geller also concluded that community options did not provide safer alternatives to CVH or WFH. Id. at ¶ 7. Dr. Geller opined:

> To have [accelerated discharges] …would have exposed patients to far greater risks of harm than keeping the patients at CVH and WFH. There were extraordinary limitations on services to discharge patients to. Even naturalistic services like libraries coffee shops, and churches/synagogues/mosques were closed. Even if defendants could have discharged more patients to residences than they did, there are no data that living in a group home in a small house is safer than being in a state hospital. To have accelerated discharges of patients who needed to be in CVH or WFH in the midst of the COVID-19 pandemic would not only have been below the standard of care, it would have been cruel.

Id. at ¶10. Plaintiffs falsely claim that "Defendants have failed to take even preliminary steps to identify patients who can safely return to the community, or to granting temporary leave or conditional discharges to those patients for whom such actions would be appropriate. Pls. Mem. at 22. Despite the problems posed by COVID-19's for community providers, between March 1, 2020 and June 30, 2020, 34 patients from CVH's General Psychiatric Division and 44 patients

from Whiting were discharged. Defs. Ex. C, Decl. of Dr. Wasser ¶ 44; Defs. Ex. D. , Decl. of Dr. Carvalho, ¶ 46.

The decisions made by professionals exercising their professional judgment regarding the care and treatment of class members are presumptively valid. Youngberg, 457 U.S. at 323. In determining whether individuals' rights have been protected, "the Constitution only requires that the courts make certain that professional judgment was in fact exercised." United States v. Commonwealth of Pennsylvania, 902 F. Supp. 565, 582 (W.D. Pa. 1995), *aff'd sub nom.*, U.S. v. Ridge, 96 F.3d 1436 (3rd Cir. 1996). Plaintiffs have not established that the minimum acceptable professional standard requires discharging psychiatric inpatients in order to maximize social distancing in a psychiatric hospital. Plaintiffs experts have provided an incomplete assessment of the hospital professionals' judgments by failing to evaluate whether the community setting is a safer environment or the capacity of the community providers to meet the needs of the hospital inpatients.

As Dr. Martinello, a board-certified infectious disease physician observed:

> Further, it is a challenge to balance the tradeoff of providing potentially lifesaving supervision and care to patients severely impacted by their mental health illness versus decanting the residents from the facility in an effort to minimize those at risk and support social distancing. Although decanting residents from the facility can improve the ability to provide social distance, the residents themselves, their families and friends and potentially the public may bear a heavy burden if the subsequent care received in the community is insufficient for the resident.

Defs. Ex. B, Decl. of Dr. Martinello, ¶ 38. "CVH and WFM only discharged patients who could be safely discharged with the limited existent resources, and they did not discharge patients to unsafe conditions simply to increase social distancing in the hospitals. What the plaintiffs ask the court to order Connecticut in terms of the discharge of patients to do would put CVH and Whiting functioning below the standard of care and jeopardize the lives of the same individuals the plaintiffs want to protect." Defs. Ex. A, Decl. of Dr. Geller, ¶ 35. The physicians and

treatment teams exercised their professional judgment in determining the tradeoff of social distancing and providing lifesaving supervision and care to their patients.

B. The Plaintiffs Fail to Show They Will Suffer Irreparable Harm

"An irreparable injury is one that is not remote or speculative but actual and imminent…and 'for which a monetary award cannot be adequate compensation.'" South Lyme Property Owners Association v. Town of Old Lyme, 121 F.Supp.2d 195,203 D.Conn. 2000). A substantial risk of serious illness or death has often been found to constitute irreparable harm. See, e.g., Innovative Health Systems, Inc. v. City of White Plains, 117 F.3d 37, 43-44 (2d Cir. 1997) (finding irreparable harm where the closure of a treatment program would pose serious risk of harm to plaintiffs, including "death, illness or disability"); Shapiro v. Cadman Towers, Inc., 51 F.3d 328, 332-33 (2d Cir. 1995) (upholding District Court's irreparable harm finding based on the "risk of injury, infection, and humiliation"). In the prison context, "[c]ourts across the country have concluded that the risk of contracting COVID-19 **as a result of unsafe conditions of confinement** constitutes irreparable harm." Martinez-Brooks v. Easter, No. 3:20-CV-00569 (MPS), 2020 WL 2405350, at *26–27 (emphasis added). "In the Second Circuit, it is well-settled that an alleged constitutional violation constitutes irreparable harm." Basank v. Decker, 2020 WL 1481503, at *4 (citing cases); Connecticut Dep't of Envtl. Prot. v. O.S.H.A., 356 F.3d 226, 231 (2d Cir. 2004) ("[W]e have held that the alleged violation of a constitutional right triggers a finding of irreparable injury." (internal quotation marks and citations omitted)).

The Plaintiffs assert that they are at great risk of being infected at CVH and Whiting because these are congregate facilities. Pls. Memo. at p. 2; Pls. Ex 1, Decl. Dr. Manian ¶ 8. They also argue that the Defendants alleged failure to implement all of the guidelines issued by the CDC puts them at increased risk of infection. Pls. Mem. at pp. 3-5, 9. The facts do not support these claims.

The date that a Whiting patient last tested positive for COVID-19 was April 21, 2020. Defs. Ex. C, Dr. Wasser Decl. ¶ 13; Defs. Ex. B, Dr. Martinello Decl. ¶ 9. Since May 19, 2020, no new Whiting patients have tested positive for COVID-19. Defs. Ex. C, Dr. Wasser Decl. ¶ 14. From June 1, 2020 until July 2, 2020 there have been no patients with COVID-19 at Whiting. From May 13, 2020 until July 2, 2020, there were 41 out of 51 days where there were no patients at Whiting who were COVID-19 positive.[12] Defs. Ex. Z.

The date that a CVH patient last tested positive for COVID-19 was May 16, 2020. Defs. Ex. D, Dr. Carvalho Decl. ¶ 13; Defs. Ex. B, Dr. Martinello Decl. ¶ 36. Since May 16, 2020, no new patients at CVH have tested positive for COVID-19. Defs. Ex. D, Dr. Carvalho Decl. ¶ 14. From June 1, 2020 until July 2, 2020 the daily number of patients with COVID-19 at CVH was one. Defs. Ex. X.

The Plaintiffs' remedy for reducing this risk is to reduce the patient census. Pls. Mem. at 21. They seek an order implementing a new process for determining discharge readiness and to discharge as many patients as possible. Pls. Mem. at pp. 3, 4; Pls. Ex. 1, Decl. Dr. Manian ¶ 12. Although they provide no supporting evidence, Plaintiffs believe that their risk of infection is less in the community than at the hospitals. A key factor present in prison COVID-19 cases, unsafe conditions of confinement, is not present at Whiting or CVH. The Defendants' evidence shows that the planning and implementation by CVH, Whiting, and DMHAS has reduced the risk of infection within the facilities and that the risk of harm is not less in the community. Instead the community providers would be severely handicapped by the COVID-19 pandemic to care for these newly discharged inpatients. Defs. Ex. K, Decl. of Nancy Navaretta ¶¶ 5-10; Defs. Ex. A, Decl. of Dr. Geller ¶¶ 6-7.

[12] Two patients who tested positive on May 19, 2020 had previously tested positive and did not represent new cases of COVID-19.

C. Balance of the Equities and the Public Interest

"Where the Government is the opposing party, the final two factors in the temporary restraining order analysis—the balance of the equities and the public interest—merge." Martinez-Brooks v. Easter, No. 3:20-CV-00569 (MPS), 2020 WL 2405350, at *27 (citing Coronel v. Decker, ––– F.Supp.3d ––––, ––––, 2020 WL 1487274, at *7 (S.D.N.Y. Mar. 27, 2020) (citing Planned Parenthood of New York City, Inc. v. U.S. Dep't of Health & Human Servs., 337 F. Supp. 3d 308, 343 (S.D.N.Y. 2018)). "[T]he court must ensure that the 'public interest would not be disserved' by the issuance of a preliminary injunction." Illinois Tool Works Inc. v. J-B Weld Co., LLC, 419 F. Supp. 3d 382, 389 (D. Conn. 2019), modified, No. 3:19-CV-01434 (JAM), 2019 WL 7816510)(quoting Salinger v. Colting, 607 F.3d 68, 80 (2d Cir. 2010)). "A preliminary injunction is 'in the public interest' if the preliminary injunction would not 'cause harm to the public interest.'" Local 1159 of Counsel 4 AFSCME, AFL-CIO v. City of Bridgeport, 435 F. Supp. 3d 400 (D. Conn. 2020) (quoting *U.S. S.E.C. v. Citigroup Global Mkts. Inc.*, 673 F. 3d 158, 163 n.1 (2d Cir. 2012)).

There is a public interest in having only those patients who have been deemed by the treatment team's professional judgment to be discharge ready, which includes the patient's ability to function in the community without risk of harm to themselves and others. See Martinez-Brooks v. Easter, No. 3:20-CV-00569 (MPS), 2020 WL 2405350, at *28. Whiting and CVH continued their assessments of patients' ability to be discharged in the midst of the COVID-19 pandemic and secured appropriate community placements.

There is also a public interest in making certain that all patients admitted to the hospitals, whether via civil commitment, a finding of NGRI, criminal pre-trial placement for restoration for competency, transfer permitted by statute from the DOC, or voluntarily admissions, receive appropriate treatment from the State. As Dr. Martinello observed, "[a]lthough decanting

residents from the facility can improve the ability to provide social distance, the residents themselves, their families and friends and potentially the public may bear a heavy burden if the subsequent care received in the community is insufficient for the resident." Defs. Ex. B, Decl. of Dr. Martinello, ¶ 38. An injunction restricting admissions or forcing unwarranted discharges would harm these public interests.

IV. CONCLUSION

The Defendants' response to the pandemic is ongoing due to the changing circumstances of the pandemic and the evolving body of knowledge about the disease. Defendants' response to Plaintiffs' Motion necessarily reflects a snapshot in time. Given the challenges of marshalling the Defendants' voluminous evidence and operating the hospitals in light of evolving practices, prior to argument some evidence may be superseded by changes in protocols. The Defendants respectfully reserve the right to update their submissions accordingly.

For the forgoing reasons, the Defendants urge the Court to deny the Plaintiffs' Motion for Preliminary Injunction.

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CERTIFICATION

I hereby certify that on July 9, 2020 a copy of the foregoing Objection to Motion for Preliminary Injunction, along with all attachments and Exhibits, was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's CM/ECF system.

/s/ Henry A. Salton
Henry A. Salton
Assistant Attorney General

Wilkes v. Lamont et al. Docket No.: 3:20CV594-JCH

Exhibit List to Defendants' Objection to Plaintiffs' Motion for Preliminary Injunction

Exhibits:

A. Dr. Geller Declaration

B. Dr. Martinello Declaration

C. Dr. Wasser Declaration

D. Dr. Carvalho Declaration

E. Mary Mason Declaration

F. Paul DiLeo Declaration

G. Michele Lizotte Declaration

H. Tim Denier Declaration

I. Jose Crego Declaration

J. Michael Boutin Declaration

K. Nancy Navaretta Declaration

L. Whiting Guidance on Confirmed and Suspected Covid-19 Cases

M. Whiting PPE Inventory as of July 1, 2020

N. CVH PPE Inventory as of July 1, 2020

O. Coronavirus (COVID-19) Fact Sheet

P. CVH COVID-19 Response Plan Testing Protocol

Q. KaiVac1750 Cleaning System

R. CDC Coronavirus Disease 2019 (COVID-19) Healthcare Infection Prevention and Control FAQs for COVID-19

S. SAMHSA Covid19: Interim Considerations for State Psychiatric Hospitals

T. CDC Testing Guidelines for Nursing Homes

U. CDC Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2

V. Mass Bulletin on Admission Psychiatric Facilities

W. APA Guidance Admittance, Discharge of Patients During COVID-19

X. CVH Patient Comparison Chart

Y. CVH Staff Comparison Chart

Z. Whiting Patient Comparison Chart

AA. Whiting Staff Comparison Chart

BB. Hal Smith Declaration

EXHIBIT A

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs* v. NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, In their official capacities, *Defendants*	:	CIVIL NO. 3:20CV594-JCH JULY 8, 2020

<u>DECLARATION JEFFREY GELLER, MD, MPH</u>

The undersigned declarant, Jeffrey Geller, MD,MPH, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am a board certified psychiatrist by the American Board of Psychiatry and Neurology. I received my medical degree from The University of Pennsylvania School of Medicine. I completed my residency in Psychiatry at Beth Israel Hospital and Harvard Medical School, Boston. I received a Masters of Public Health from Harvard University. I have 42 years of experience as an inpatient and outpatient psychiatrist and continue to practice both. My current CV is attached as Attachment 1.

2. I am currently Professor of Psychiatry at the University of Massachusetts Medical School. I practice and teach at Worcester Recovery Center and Hospital, a facility of the Massachusetts Department of Mental Health.
3. In preparing this declaration, I relied upon the documents and sources of information set forth in the attached list, attached hereto as Attachment 2.
4. I made the following observations and received the following information from a virtual tour of CVH.
    a. CVH has a total bed capacity of 361 patients. There are two divisions; General Psychiatry and Addiction Services. General Psychiatry is divided into acute, subacute, and chronic patient populations. The General Psychiatry occupancy is 209 patients and it was full.
    b. Battell Building had signage about COVID-19 precautions at front door and a mask is required for building entry. The elevator capacity is 4 people, one in each corner.
    c. Battell contains an Isolation room (Room 228) located between two units and thus isolated from all other areas with 1 bed and an adjoining bathroom. Staff is posted outside the room at all times. There is a separate room for donning and doffing PPE just outside isolation room. CDC Guidelines are posted. Battell never exceeded the capacity of its isolation room.
    d. Battell 2S [General Psych] has 22 patients. CVH repurposed some rooms to increase the number of bedrooms on the unit., e.g., staff breakroom, comfort room. There are some single rooms. Admissions are quarantined to a room for not less than 14 days.

e. There are two dorms on this unit with up to 2 patients per room. The rooms have ¾ walls. The beds in the dorms are parallel against the same wall with patients' heads at opposite ends so the patients' feet are 6 feet apart and their heads are 20 feet apart. There have never been any suspected cases on this unit. The dining area is locked. CVH decreased the number of patients in the dining room from 22 to 8 at any time by staggering each meal. When seated in the dining room patients are 6 feet apart. Some patients eat in their bedrooms.

f. The Woodward building [General Psych] has 4 units with capacity of 15 patients each. Three units are geriatric and one unit is for traumatic brain injury (TBI) patients. Everyone is screened at the building's front door and there is signage everywhere. The elevators have been limited to 4 maximum since early June; before that staff encouraged patients to limit the number in the elevator and encouraged the use of the stairwell. Staff controlled the number of geriatric patients on the elevator before official limit was set.

g. Woodward 2N is an all male unit of geriatric patients with 2 bathrooms. Bathroom usage was limited to one patient in the bathroom at a time if suspected case in the unit. The unit has an open RN station with its own sink and a treatment room with sink. There are 3 good sized single rooms; 6 double rooms with beds feet to feet as in Battell. The TV room limit is 2 people at a time. A lounge area has seating limited to 2 people at a time

h. The unit has a medication room with a Dutch door and only one patient is served at a time; if the patient is physically sick, medications are brought to the patients' room. The unit's dining area has 2 patients seated at opposite corners of a table

48" x 30". Covid suspicious patients eat in their rooms. The unit is totally cleaned by housekeeping twice a day.

i. Patients stay on the unit and only leave for medical appointments that could not be delayed for medical reasons; this began on all units in Woodward 3/17/2020. No patients were ever in the elevator since they never left their units. No congregate groups were held and no patients were allowed outside.

j. There were 3 patient deaths on this unit.

k. The Merritt building [Substance Abuse Services] had pre-COVID-19, 110 beds, 90 rehab and 20 detox. Since COVID-19, Merritt reduced its total capacity to 32 patients (71% decrease). There is signage at the front door and again on the inside door. Screening takes place immediately on the other side of second door. Masks are given to employees weekly or as needed. Housekeeping occurs 7 days per week 6:45 am – 10:00 pm (one shift works 6:45 am – 2:45 pm and a second shift works 2:45 pm – 10:00 pm). CVH has supplemented regular housekeeping staff with contract employees.

l. CVH's COVID-19 Positive Unit has a 13 patient capacity with surge capacity to 16. Only COVID-19 positive patients reside on this unit. The donning and doffing PPE area is before one enters the unit. An emergency cart is on the unit. The dorms pre-COVID-19 would hold four patients; since COVID-19 this has been reduced to two patients. The bedroom with two patients is really two single rooms with a shared door to the hallway. There are single rooms for female patients. Shower stalls were sanitized by housekeeping after each shower and staff used gowns.

m. Patients are expected to stay in their bedrooms and wear masks any time they are out of their own room. Patients were provided use of state cell phones. The phones are sanitized between each use [Per-Covid-19 no cell phones]. Phones were provided when visitors were stopped from entering CVH. Signage is everywhere on the unit. The unit changed administration of medication from a patient coming to med window pre-COVID-19 to patients receiving medication in their bedrooms. The last positive patient left this unit 6/15/2020.

5. I made the following observations and received the following information from a virtual tour of Whiting Forensic Hospital (WFH).

    a. WFH has a total of 11 units made up of (i) maximum security consisting of 5 units, with up to 91 patients total and up to 18 patients per unit; and (ii) enhanced security consisting of 6 units, with up to 138 patients total and 21-24 patients per unit. WFH's total capacity is 229 patients. The usual census is 210 – 225 patients but since COVID-19 the census has had a 25% reduction with the census on 6/25/2020 at 172 patients.

    b. Census reduction occurred through both fewer admissions as the court slowed down its activity and the occurrence of expected discharges.

    c. On 5/19/2020, WFH tested 110 patients, 75 others refused. Of 560 staff, 450 tests took place (200-300 staff; some staff tested more than once); Testing for staff became mandatory as of June 22, 2020.

    d. WFH has had no COVID-19 deaths. Only one COVID-19 positive case was medically hospitalized and he has returned to WFH.

e. WFH undertook the following Interventions to decrease the risk of COVID-19 infection:

   i. Screening included a questionnaire and taking temperatures
   ii. Vital signs taken of all patients daily; suspected cases or confirmed case taken twice a day
   iii. Converted rehab space into negative pressure isolation unit
   iv. Stopped using off unit rehab space
   v. Suspected cases isolated to bedroom and then when negative pressure unit set up moved suspected cases there but separated from positive cases; never had more than one patient per side.
   vi. Initially isolated cases for 7 days per CDC recommendations; when CDC recommended 10 days, WFH went to 14 days.
   vii. Divided very large courtyard so units would not mix when outside (previously all 5 units shared space); each unit has direct access to outdoor space.
   viii. Legal hearings done electronically
   ix. Housekeeping: hired additional 4 contract personnel and purchased and placed alcohol mist machines.
   x. Screening everyone at entrance as of 3/13/2020
   xi. Psychiatry staff: Platooning: 50% on unit, 50% satellite office each week
   xii. Whiting building Unit #1 usually has 8-9 patients and now has 3 females. It has 2 bathrooms with 2 sinks and 2 stalls per bathroom. Mostly single

bedrooms. Areas with 2 beds had at least 6 feet between beds. The dining room provides one patient per table, all facing the same direction

xiii. Dutcher building unit D2S has a 24 patient capacity; census today is 8 patients, 4 wearing masks; 4 without; all staff wearing masks.

xiv. Courtyard use is limited to one unit at a time (previously multiple units at a time)

xv. Dining room use was previously 2 units at a time; since COVID-19 there is one unit at a time and added second room, so space that previous had 52 patients eating now has 12 patients. A patient travels from unit to dining room only with other patients from her unit.

xvi. Bedrooms: double rooms have beds 5 feet apart and secured to ground; 2 single bedrooms per unit;

xvii. Group spaces on unit are limited to 5 patients at a time (previously 10 patients)

xviii. Bathrooms: 2 bathrooms with 3 sinks and 4 stalls per bathroom

xix. Shower room: 2 showers, each enclosed by walls on 3 sides

xx. New mask are provided weekly and whenever mask becomes soiled or ripped

6. Based upon the information gathered in my review, I conclude that community services experienced major scale-backs and presented the following barriers to discharge:

   a. Very significant decreased availability of services from residences, LMHA, psychiatrists, Teams, other supports.

   b. “Push-back” from all sectors against discharges

i. "Anticipatory anxiety": fear of taking new patients into a residence

c. No partial hospital programs operational

d. All social rehab programs closed

e. Clubhouses closed and services became virtual

f. Case managers only worked through telehealth, no face-to-face contacts

g. Supported apartment staff only worked through telehealth, no face-to-face contacts

h. Assertive Community Treatment (ACT) teams cut services way back and worked through phone calls and texting

i. Outpatient services available at only a fraction of pre-COVID-19 availability

j. Mobile crisis services "mostly stayed active" as demand for crisis services increased substantially

k. Medication appointments were virtual and this proved much harder for new patients

l. Most self- help groups stopped face-to-face meetings

m. Support from religious community mostly gone

n. Provider transportation "really at a minimum" and public transportation was high risk

o. Significant challenges for community residents to get money from Rep Payees

p. All naturalistic community resources were closed. e.g., library, coffee shop

q. Referrals possible but extremely difficult, negotiations case by case, took more time and extra administrative staff

r. "There is no comparison between the pre-COVID-19 level of community services and the community services during the pandemic"

7. Based upon the information gathered in my review, I conclude that community options did not provide safer alternatives to CVH or WFH for the following reasons:

   a. Community programs less able to get PPE than is hospital; "poor buying power" in the community

   b. Groups homes and congregate care usually in converted private homes presenting challenges to social distancing

      i. Narrow hallways
      ii. Shared small bathrooms
      iii. Small kitchen
      iv. Small dining area
      v. Little ability to isolate anyone

   c. Some group residences had to keep a vacant room open to run at decreased capacity to be able to accommodate any semblance of social distancing

   d. Unable to do any form of gradual transitioning to the community

   e. Covid-19 positive community residence went through 4 sites rapidly: residence→general hospital ED→general hospital inpatient unit→WFH exposing them to more high risk areas and COVID positive patients than would have been the case if they were CVH or WFH inpatients

   f. No medical personnel on site at any community program

   g. Challenges to get discharged patients in a new setting to adhere to residence's rules like social isolation in the residence, stay in the residence

h. Suspected cases in the community were sent to the general hospital where they were less able to deal with the psychiatric problems than the patient who stayed in CVH or WFI and was moved to another location in the hospital

i. At this time there are no reliable data on deaths of DMHAS clients in the community

8. The plaintiffs asked the court to order Connecticut to have CVH and WFH 1) conform their testing protocols to CDC standards; 2) take steps to ensure staff consistently wear masks; 3) improve hygiene and decontamination practices; 4) implement social distancing to the maximum extent possible including by reducing census; and 5) undertake a clinical review in order to accelerate discharge.

9. As the data show, defendants have, in fact, done 1-4. The fact plaintiffs are unaware of this is due to the fact their experts made minimal effort to ascertain what was actually taking place at CVH or WFH. Plaintiffs' experts read some documents. They did not speak to any staff at CVH or WFH, nor did they make any effort to do so. Connecticut received no request from any expert to interview staff. Nor did plaintiffs' experts make any effort to tour CVH of WFH, which they could have done safely through a virtual tour as defendants' expert did. Nor did plaintiffs' experts review any treatment plans or other clinical material of the named plaintiffs to ascertain what risks each patient's discharge would entail or what plans had been made for their discharges.

10. Defendants did not do #5, accelerate discharges. To have done so would have exposed patients to far greater risks of harm than keeping the patients at CVH and WFH. There were extraordinary limitations on services to discharge patients to. Even naturalistic services like libraries coffee shops, and churches/synagogues/mosques were closed. Even

if defendants could have discharged more patients to residences than they did, there are no data that living in a group home in a small house is safer than being in a state hospital. To have accelerated discharges of patients who needed to be in CVH or WFH in the midst of the COVID-19 pandemic would not only have been below the standard of care, it would have been cruel.

11. Plaintiff's expert, Manian, MD, MPH, an expert in medicine and infectious diseases, provides a primer on COVID-19 precautions. Much of what he states, no one would argue with as being relevant guidance; CVH and WFH are actually implementing all the well-founded steps. Dr. Manian states should be implemented. Dr. Manian makes no comparisons between what he believes is the standard of care for a psychiatric hospital during the COVID-19 pandemic and what CVH and WFM are actually doing.
12. Dr.Manian perhaps oversteps when he claims he has any expertise in what state hospitals are doing during the COVID-19 pandemic. He provides no background in this area. He claims some standards that no state hospital in the USA meets, nor for that matter would general hospitals. For example, he states the standard is that every patient should be tested for COVID-19 every week.
13. Dr.Manian opines on decreasing the census through discharge, an area far outside his scope of practice. He does not establish he has experience or expertise in conducting those risk assessments necessary to responsibly discharge a psychiatric patient.
14. Dr.Manian reaches the inaccurate conclusion that because there are no standards for psychiatric hospitals he can blindly apply nursing home standards. While I think that comparison is ill conceived, let's defer to Dr. Manian for a moment and say that one can

compare CVH to a nursing home. Let's look at the COVID-19 outcomes for CVH and for the three nursing homes in Middletown:

Nursing Home Comparison

Facility	Location	Census	Positive Cases	Deaths
CVH	Middletown	239	40	5
Apple Rehab	Middletown	70	46	18
Middlesex	Middletown	150	63	27
Waters Edge	Middletown	150	88	23

15. Based on these findings, CVH should be vastly expanding is admissions and its census, not contracting them.
16. Had Dr. Manian reviewed the five deaths of patients at CVH related to COVID-19, which he did not do, he would have found these were older, quite medically ill patients, who were handled in a clinically sound manner following proper protocols. All but one was treated for over 3 weeks in a general hospital. The fifth was treated there for one week.
17. Plaintiffs' experts Canavan and Jones provide a joint Declaration. In the same manner as Dr. Manian, they have reviewed a remarkably limited number of documents and have done no more than that. They did not conduct interviews or tours and hence have no knowledge of what CVH and WFH have actually done during the COVID-19 pandemic.
18. Their first point is they agree with Dr. Manian. However, neither one has any expertise in medicine nor infectious diseases, so it is difficult to understand how they have standing to agree or disagree with Dr. Manian.
19. Canavan and Jones depend on information in patients' affidavits. However, a comparison between the information in the affidavits and the information I obtained from

documents, interviews and tours, shows the patients are often ill informed. These experts make no attempt to verify any information contained in patients' affidavits, nor do they ask to see any clinical material about these patients.

20. Canavan and Jones indicate that the situations the patients describe in their affidavits "could be avoided if there were fewer people on the unit, if there was a scheduled use of bathrooms, if staff reinforced the need for masks while in public areas, and if the bedrooms were consistently cleaned and restocked." Had these experts asked, they would have found that all these interventions were and are being done.
21. Canavan and Jones' description of how the Dutcher dining room is being managed also has no relationship to how it is actually being managed. Again, they failed to inquire about the management and set up.
22. Canavan and Jones state at paragraph #13, "Numerous patients indicated that staff has not consistently worn masks…." They do not state what patients they are referring to. They did not report interviewing any patients. They read seven patient affidavits, most of which state nothing about staff and masks.
23. Canavan and Jones make recommendations about space between beds in patients' rooms, but have no information about what the space between beds is at CVH or WFH.
24. Canavan and Jones recommend census reduction through discharges to "community-based settings with supports." As the data in this affidavit indicate, there were very minimal supports. These two experts are disingenuous when they state they have vast experience transitioning patients into the community when, based on their CV's, they have no such experience during a viral pandemic.

25. Canavan and Jones' suggestions for forensic patients would have more patients end up in jail and jails have been shown to be a much greater risk for COVID-19 than state hospitals.
26. Canavan and Jones characterize patients' returns from leave to the hospital as a major problem, when the total number of people this applies to is two individuals.
27. Canavan and Jones state that DMHAS should make a whole range of services available to prospective patients instead of re-hospitalization when almost none of these services are operational. Agencies closed all these programs because it was unsafe for their staffs to work. Only CVH and WFH stayed fully operational despite the dangers to staff.
28. Canavan and Jones make recommendations about where the named plaintiffs might be discharged to, despite not knowing about these individuals except what the named plaintiffs attest to in their affidavits. Some of the patients have very serious risks; this information is left out of the patients' affidavits.
29. Canavan and Jones state that based on conversations they had, they are "confident" community providers would engage with the hospital on planning and implementing discharge. It is not clear what conversations Canavan and Jones had or whom they conversed with. Based on my conversations with those in leadership positions in DMHAS, listed in Attachment 2, this is just plain wrong.
30. If CVH or WFH was the most integrated setting appropriate to a patient's needs before the pandemic, then it is the most integrated setting appropriate to the persons needs during the pandemic. There is no evidence there is increased safety, all things considered, for such patients outside of CVH or WFH, then inside.

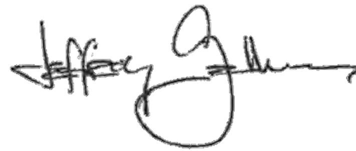
31. The plaintiffs ask Connecticut to fashion all manner of Rube Goldberg-like discharges and then "ensure" that necessary community-based services are provided. It is my professional opinion that the first ask is dangerous; the second ask is impossible.
32. The plaintiffs' paragraphs about each of the named plaintiffs lack so much significant information that for any psychiatrist to act on such scant data would be malpractice. None of the patients informs the court that he or she has committed arson, attempted murder, murdered his mother, or murdered his father.
33. In the plaintiffs' Amended Class Action Complaint and Petition for a Writ of Habeas Corpus, paragraphs #53 through # 58 list what the defendants have failed to do. Based on my review of all the materials I have listed in Attachment 2and that I used as the basis for my opinion, the defendants have, in fact, not failed to do these things. The plaintiffs can only have come to these conclusions because their experts had terribly inadequate information and so misinformed plaintiffs' counsel.
34. In my opinion CVH and WFH have functioned within what has been the standard of care for like faculties in other states during the COVID-19 pandemic. CVH and WFH have screened staff and patients; tested staff and patients; provided masks to staff and patients; set either requirement or expectations about wearing masks; decreased the census; decreased admissions; established and acted on procedures to quarantine known and suspected COVID positive patients; educated staff and patients through signage, training and modeling; restricted visitors; avoided comingling different units; established safer ways to feed patients and to administer medication; avoided to the maximal extent possible moving staff from one unit to another; platooned the psychiatry staff; and obtained repeated consultation from outside experts.

35. CVH and WFH only discharged patients who could be safely discharged with the limited existent resources, and they did not discharge patients to unsafe conditions simply to increase social distancing in the hospitals. What the plaintiffs ask the court to order Connecticut to do, in terms of the discharge of patients, would put CVH and WFH functioning below the standard of care and jeopardize the lives of the same individuals the plaintiffs want to protect.
36. Finally, the evidence that CVH and WFH have been and are acting in a medically sound fashion within the standard of care is in their outcomes. CVH and WFH have had far better outcomes than have facilities in the same city as CVH and WFH that plaintiffs put forward as a fair comparison to CVH and WFH.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this eighth day of July, 2020.



Jeffrey Geller, MD, MPH

ATTACHMENT 1

CURRICULUM VITAE

NAME: Jeffrey L. Geller, M.D., M.P.H.

HOME ADDRESS: 73 Twinbrooke Drive
Holden, MA 01520
(508) 829-0404

BUSINESS ADDRESS: 73 Twinbrooke Drive
Holden, MA 01520
(508-868-9361

BIRTH DATE: April 12, 1948

BIRTH PLACE: New York, NY

CITIZENSHIP: U.S.A.

EDUCATION AND TRAINING

UNDERGRADUATE

September 1966- June 1970	B.A. 1970 Psychology Williams College Williamstown, MA
January 1969- June 1969	Exchange Student Vassar College Poughkeepsie, NY

GRADUATE

September 1970- December 1973	M.D. 1973 University of Pennsylvania School of Medicine Philadelphia, PA Rotation at the Austen Riggs Center Stockbridge, MA, June, 1971-August, 1971 Rotation at Kaimosi Friends Hospital, Kisumu, Kenya, May, 1973-August, 1973
September 1976- June 1978	M.P.H. 1978 Harvard School of Public Health Boston, MA

POST GRADUATE

January 1974- June 1974	Internship Philadelphia General Hospital Philadelphia, PA
July 1974- June 1977	Psychiatric Residency Beth Israel Hospital Boston, MA
July 1977- June 1978	N.I.M.H. Fellowship Psychiatry in Primary Care Medicine Beth Israel Hospital Boston, MA

APPOINTMENTS AND POSITIONS

ACADEMIC APPOINTMENTS

1974-1978	Fellow Harvard Medical School Boston, MA
1979-1983	Assistant Professor University of Massachusetts Medical School Worcester, MA
1982-1984	Clinical Assistant Professor Smith School for Social Work Northampton, MA
1983-1984	Assistant Professor Harvard Medical School Cambridge, MA
1984, 1987, 1989	Adjunct Winter Study Faculty Williams College Williamstown, MA
1984-1986	Assistant Professor University of Pittsburgh, School of Medicine Pittsburgh, PA
1986-1991	Associate Professor University of Massachusetts Medical School Worcester, MA
1991-	Professor

	University of Massachusetts Medical School Worcester, MA
1993-1994	Robert Wood Johnson Health Policy Fellow
1995-2007	Adjunct Faculty, Professor Smith College School for Social Work Northampton, MA
9/01-12/01	Visiting Professor Psychology Department Williams College Williamstown, MA
2/10/03-2/14/03	Visiting Professor Department of Psychiatry University of Hawaii School of Medicine Honolulu, HI
4/12/10-4/17/10	Visiting Professor Tirana University Tirana, Albania
2/10-2/11/11	Visiting Professor Department of Psychiatry Makerere University College of Health Sciences School of Medicine Kampala, Uganda

ACADEMIC CLINICAL AND ADMINISTRATIVE POSITIONS

1979-1983	Director Psychiatric Regional Resource Unit/Northampton State Hospital Northampton, MA
1983-1984	Medical Director Westfield Community Support Services Westfield, MA
1984-1986	Law and Psychiatry Program Western Psychiatric Institute and Clinic Pittsburgh, PA Associate Director, 1986
1986-2012	Director of Public Sector Psychiatry Department of Psychiatry University of Massachusetts Medical School

	Worcester, MA
1986-2016	Westfield Area Mental Health Clinic Westfield, MA Interim Medical Director, 1987-1988
1988-1989	Interim Director, Continuing Treatment Service Worcester State Hospital Worcester, MA
1990-1992	Director, Open Units Service Worcester State Hospital Worcester, MA
1990-1998	Medical Director Department of Mental Health Central Massachusetts Area Worcester, MA
2012-	Medical Director Worcester Recovery Center and Hospital Worcester, MA

CERTIFICATION AND LICENSURE

SPECIALTY CERTIFICATION

1981	Diplomate, American Board of Psychiatry and Neurology

MEDICAL LICENSURE

1974-	Massachusetts, Board of Registration of Medicine
1984- (inactive)	Pennsylvania, Bureau of Professional and Occupational Affairs

MEMBERSHIPS IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

1974-	American Psychiatric Association
1974-1984, 1986-	Massachusetts Psychiatric Society
1980-1984	Western Massachusetts Psychiatric Society
1984-1988, 2004-	American Academy of Psychiatry and the Law
1984-1986	Pennsylvania Psychiatric Society

1984-2010	American Association for the History of Medicine
1984-	American Association of Community Psychiatrists
1987-	American Association for Social Psychiatry
1988-	American Association of Psychiatric Administrators
1988-2000	Group for the Advancement of Psychiatry
2011-	World Federation for Mental Health

HONORS

1969	Phi Beta Kappa, Williams College
1970	Summa cum Laude, Williams College
1970	Sigma Xi Science Honor Society
1989	Fellow, American Psychiatric Association
1990	Walter E. Barton Award The American College of Mental Health Administration
1992	Exemplary Psychiatrist Award National Alliance for the Mentally Ill
1993-1994	Robert Wood Johnson Health Policy Fellow
1994	Effective Legislative Fellow Award National Alliance for the Mentally Ill
1994	Board of Directors' Award Community Healthlink Inc.
1996	The Myers Center Award for the Study of Human Rights in North America
1997	Rothstein Award Massachusetts Alliance for the Mentally Ill
1999	President's Award for Public Service University of Massachusetts
2002	Distinguished Fellow, American Psychiatric Association
2003	Arnold L. van Ameringen Award for Psychosocial Rehabilitation

	American Psychiatric Association
2005	Torrey Advocacy Commendation Award Treatment Advocacy Center
2006	Ronald A. Shellow Award APA Assembly
2010	Distinguished Life Fellow, American Psychiatric Association
2010	Outstanding Psychiatrist Award for Public Sector Massachusetts Psychiatric Society
2012	Lifetime Achievement Certificate Pakistan Psychiatric Society
2014	Human Rights Award American Psychiatric Association

SERVICE

NATIONAL AND REGIONAL COMMITTEE ASSIGNMENTS:

1977-1978	Co-chairperson of Professional Advisory Board to Plaintiff's Legal Council, Brewster v. Dukakis
1978	Member, Harvard University Primary Care Delegation to the People's Republic of China
1979-1984	Member, Department of Mental Health Region I Research Review Committee, Commonwealth of Massachusetts
1980-1981	Member, Massachusetts Mental Health Committee, Clinical Committee
1981-1983	Member, City of Northampton Task Force on Deinstitutionalization
1984-1988	American Academy of Law and Psychiatry: Public Service Committee
1985-1996	American Psychiatric Association: Committee on International Abuse of Psychiatry and Psychiatrists Member 1985-1991 Vice Chairman, 1989-1991 Corresponding Member, 1991-1996
1985-1987	American Psychiatric Association: DSM III R Advisory Committee on Impulse Disorders Not Elsewhere Classified

1986-1987	American Psychiatric Association: Local Arrangements Committee, 1987 Institute on Hospital and Community Psychiatry
1987-1989, 2010-	Massachusetts Psychiatric Society: Public Sector Committee
1988-1994	American Psychiatric Association: DSM IV Advisory Committee on Impulse Disorders Not Elsewhere Classified
1990-1995	American Psychiatric Association: Committee on Psychiatric Services Resource Center Vice Chairman, 1991-1995
1991-2000	American Psychiatric Association: Council on International Affairs Consultant, 1991-1995 Assembly Liaison, 1995-1998 Member, 1997-2000 Vice Chairman, 1997-1998 Chairman, 1999-2000
1993-1996	American Psychiatric Association: Task Force on Psychiatry in U.S. Territories Chairman, 1993-1996
1993-2001	Massachusetts Psychiatric Society: District Branch Assembly Representative Lead Representative, 1996-2001
1993-1996	National Advisory Board of Pew Charitable Trust State Hospital Closing Project
1993-2006	American Psychiatric Association Assembly Committee on Public Psychiatry Chair 2004-2006
1996-1998	American Psychiatric Association History and Library Committee Corresponding Member, 1996-1998
1998-2003	Partners in CARE National Advisory Council National Mental Health Association,
1999-2000	Co-Chair, Scientific Program Committee of the Second Sino-American Conference on Psychiatry, Beijing, China, April 6-10, 2000
2000-2002	American Psychiatric Association: Commission on Global Psychiatry
2001-2006, 2012-2019	American Psychiatric Association: Assembly Deputy Area I Rep 2001-2002 Area 1 Rep 2002-2006

	Assembly Executive Committee 2002-2006, 2018-2019 Assembly Committee on Planning 2003-2006 AOL/ACROSS Rep, American Association of Community Psychiatry, 2012-2019 Assembly ACROSS Rep 2018-2019
2001-2006	American Psychiatric Association: Council on Social Issues and Public Policy
2003-2006	American Psychiatric Association: Intracouncil Workgroup on Inpatient Capacity
2004-2005	CMHS Acute Care Subcommittee
2004-2008	CMHS National Advisory Council Secretary (highest office), 2004-2008
2004-	American Psychiatric Association: Medicaid Advisory Group
2004-	NAMI Scientific Council
2004-	Treatment Advocacy Center, Board
2006-2011, 2012-	American Psychiatric Association: Board of Trustees Area 1 Trustee, 2006-2009 Vice President, 2009-2011 Area 1 Trustee, 2012-2018 President-Elect 2019-2020 President 2020-
2007-2011	American Psychiatric Association: Council on Advocacy and Public Policy
2008-	American Academy of Psychiatry and the Law: Developmentally Disabled Committee
2008-2009	Chair, APA Board Work Group on APA-Pharma Relationship
2008-2019	American Association of Community Psychiatrists: Area 1 Rep, Board of Directors 2008-2014 AOL Rep to APA Assembly 2012-2016, 2018-2019 At-Large Rep, Board of Directors, 2014-2019
2008-2009	American Psychiatric Association: Committee on Psychiatric Diagnosis and Assessment
2011-	Geneva Initiative on Psychiatry - USA, Board of Directors

2011-	World Federation for Mental Health, Vice President. Executive Board, 2016-
2012-	Clubhouse International, Board
2018-	SAMHSA National Advisory Council
2019-2020	APA Joint Reference Committee Chair 2019-2020
2019-2020	American Psychiatric Foundation Board

MEDICAL SCHOOL COMMITTEE ASSIGNMENTS:

University of Massachusetts:

1980-1983	Utilization Review Committee, Northampton State Hospital
1980-1983	Executive Council, Department of Mental Health Region I
1981-1982	Search Committee, Psychiatry Chair of University of Massachusetts Medical Center
1986-	Executive Committee, Department of Psychiatry
1986-1992	Residency Education Committee
1987-1993	Planning Committee, Psychiatric Treatment and Research Center
1987-1993	Planning Committee, Worcester Psychiatric Rehabilitation Center
1990-1994	Review Committee for Public Service Endowment Grants
1990-1991	Search Committee, Psychiatry Chair of the Medical Center of Central Massachusetts
1991-1992	Co-Director, Salute to Science
1991-1993	Medical School Library Committee
1993-1994	Review Committee for James P. Healey Awards
1993-1994	Search Committee, Psychiatry Chair of St. Vincent Hospital, Worcester, Massachusetts
1994-1998	Pappas Commission on Medical Services at Framingham MCI

1999-2001	Strategic Planning Committee: Community Benefits
2010-2013	Psychiatry Department Grand Rounds Committee Co-Chair, 2010-2011 Chair, 2011- 2013
2012-	Onboard Mentor

University of Pittsburgh:

1984-1986	Utilization Review Committee, Western Psychiatric Institute and Clinic
1984-1986	Ethics and Human Rights Committee, Presbyterian University Hospital

HOSPITAL COMMITTEE ASSIGNMENTS

Worcester Recovery Center and Hospital

2012-	Clinical Care: Chair
2012-	Pharmacy and Therapeutics
2012-	Professional Staff Organization Executive Committee
2012-	Planning
2012-	Morbidity and Mortality
2013-	End of Life
2014-	Department Directors, Chair

COMMUNITY BOARDS:

1991-	Genesis Club (Fountainhouse Clubhouse)
2003-2004	Sapling Project

EDITORIAL BOARDS AND JOURNAL REFEREE:

1978-	Referee, American Journal of Psychiatry
1986-	Referee, Psychiatric Services (formerly Hospital and Community Psychiatry)
1987-	Referee, Community Mental Health Journal
1988-	Referee, American Psychiatric Press
1991-	Referee, Journal of Nervous and Mental Disease
1991-	Referee, Behavioral Sciences and the Law

1992-2000	Editorial Board, Psychiatric Services
1994-	Column Editor, Psychiatric Services
1995-2016	Book Review Editor, Psychiatric Services
2001-	Referee, Lancet
2006-	Referee, Journal of Behavioral Health Services & Research
2007-	Referee, Israel Journal of Psychiatry
2007-	Referee, Psychology, Public Policy & Law
2008-	Referee, Biomedical Central Psychiatry
2008-	Special Issue Editor, "Transition to Adulthood Research: Process and Outcome Findings." Journal of Behavioral Health Services & Research
2009-	Referee, African Journal of History and Culture
2009-	Referee, Clinical Psychology Review
2010-	Referee, Journal of Psychopharmacology
2011-	Referee, Aggression and Violent Behavior
2012-	Referee, Australian and New Zealand Journal of Psychiatry
2012-	Referee, Health Affairs
2012-	Referee, Social Psychiatry and Psychiatric Epidemiology
2012-	Editorial Board, International Journal of Clinical Medicine
2012	Special Section Editor, "Navigating the Waters of Digital Technology." Psychiatric Times, December 7, 2012
2014-	Referee, Mental Health Review Journal
2014-	Referee, Comprehensive Psychiatry
2017-	Book Review Editor, Community Mental Health Journal
2018	Referee. Clinical Nursing Studies

TEACHING

1976-1977	Taught Introduction to Clinical Medicine, Harvard Medical School
1976-1978	Supervisor for Medical Students on clinical rotation in psychiatry, Harvard Medical School
1977-1978	Instructed and supervised primary care residents and primary care staff on psychiatric care, Harvard Medical School and Beth Israel Ambulatory Care Center
1979-1983	Directed required psychiatry rotation for third and fourth year medical students of UMass Medical School at Northampton State Hospital
1979-1983	Coordinator of Psychiatric Grand Rounds, U. Mass Medical School, Northampton State Hospital
1979-1983	Developed and taught patient interviewing utilizing video equipment, UMass Medical School at Northampton State Hospital
1981-1983	Co-Developed a Psychology Internship Program at Northampton State Hospital

1981-1984	Supervisor for Smith School for Social Work Students on placement at Northampton State Hospital
1984-1986	Supervision of Psychiatric Residents at Western Psychiatric Institute and Clinic for Psychotherapy and Community Psychiatry
1984-1986	Coordinate Law and Psychiatry rotation for psychiatric residents at Western Psychiatric Institute and Clinic
1984-1986	Coordinate medical student elective in Law and Psychiatry at U. of Pittsburgh School of Medicine
1984-1986	Teach medical students in required rotations and in clinical ethics at U. of Pittsburgh School of Medicine
1986-1989	Teach second year medical student course in Behavioral Science at UMass Medical School
1986-	Supervision of psychiatric residents at U. Mass Medical School PGY 2 and PGY 4: Psychotherapy PGY 3: Public Sector Psychiatry
1986-1992	Co-teach with Aaron Lazare, M.D., and Paul Barreira, M.D., seminar for PGY II residents in ongoing psychotherapy
1987-1994	Develop and direct didactic component of Public Sector Community Psychiatry rotation for PGY III & IV residents
1990-1992	Co-developed and supervise, with Paul Barreira, M.D., the "Adopt-A-Resident" Program
1998-2001	Responsible for Schizophrenia Module in PGY 1/2 Core Didactic Series
1998-2009	Coordinator of Clinical Case Conference Series at Quincy Mental Health Center, Quincy, MA
2002-2012	Responsible for Public Sector Didactic Series in PGY III/IV Core
2006-2012	Direct Continuing Education Seminar for Area Medical Directors
2006-2012	Co-direct, History of Psychiatry Seminar, PGY I/II/III/IV
2011-	Project Advisor, Forensic Fellows
2013-	Onboard Mentor, New Faculty

CONSULTANT/EXPERT

1977-1978	Expert on behalf of plaintiffs, Brewster v Dukakis (Treatment in the Least Restrictive Setting)
1981-1984	Franklin/Hampshire Community Mental Health Center
1982-1983	Center for Human Resources, Northampton, MA
1985-1989	U.S. Attorney, Western District of Pennsylvania
1985-2000	U.S. Dept. of Justice, Civil Rights Division (CRIPA)
1985-1990	New York State Office of Mental Health (Includes 2 CRIPA Cases)
1987-1989	Buffalo Psychiatric Center
1987-	Massachusetts Board of Registration in Medicine
1990-1991	Bliss Mental Health Center
1991-1993	Massachusetts Rehabilitation Commission
1991-2004	Geneva Initiative (International)
1992-1993	Expert on behalf of Milwaukee County, Joan S. v Jon Gudeman/Milwaukee County
1993-1994	Weston State Hospital/William R. Sharpe, Jr. Hospital, Weston, WV
1993-1996	Evaluation, Hawthorne Children's Psychiatric Hospital (Missouri state facility)
1993-1994, 1996-2003	Commonwealth of Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (Includes 4 CRIPA Cases)
1995-1997	District of Columbia's Commission on Mental Health Services
1995, 2001	District Attorney NYS, Washington County
1998	Expert on behalf of Pennsylvania, Kathleen S. v Pennsylvania, Department of Public Welfare (Olmstead Case)
1998-2001	Vermont Protection and Advocacy
2000	Department of Veterans Affairs, Board of Veterans Appeals, Washington, DC
2000-2005	New Jersey: Greystone Park Psychiatric Center

2001-2007	Tennessee Attorney General/Tennessee Department of Mental Health and Developmental Disabilities (CRIPA)
2001-2009	North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services and Attorney General's Office (CRIPA)
2002	Expert on behalf of Case Western Reserve, Hunt v University Psychiatrists of Cleveland
2002-2003	Expert on behalf of Pennsylvania, Frederick L. v. Department of Public Welfare of Pennsylvania (Olmstead Case)
2005-2009	New York State Attorney General, Disability Advocates Inc. v. New York State II (Olmstead Case)
2005-2010	Vermont Department of Health/Vermont State Hospital Consultant 2005-2012 Monitor 2006-2012
2005-2006	New Hampshire Department of Health and Human Services
2005-2008	Monitor, U.S. vs. North Carolina (CRIPA)
2006-2010	Connecticut Department of Mental Health and Substance Abuse Services (Includes CRIPA)
2006-2011	Oregon State Hospital and Attorney General's Office (Includes CRIPA)
2006-2011	World Health Organization (WHO), Albania
2007-2012	New Jersey Division of Mental Health Services (Includes CRIPA)
2007-2010	Georgia State Attorney General's Office and Division of Mental Health, Developmental Disabilities and Addictive Diseases (CRIPA)
2007-2009	Delaware Department of Health and Human Services (CRIPA)
2007-2008	Oklahoma Department of Mental Health
2007-2009	Washington State Mental Health Division
2008-2012	New York State Office of Mental Health/Kingsboro Psychiatric Center
2008-2010	Williams v. Quinn, Illinois (Olmstead Case)
2009-2010	Streamwood Hospital (Children's Psychiatric), Illinois

2009-2011	New York State Attorney General, Disability Advocates Inc. v. New York State III (Olmstead Case)
2011	The Lucas Group, Boston, MA
2013-2016	Massachusetts Attorney General's Office, Commonwealth v. JRC
2018-	Mississippi Department of Mental Health

PUBLICATIONS

REFEREED ARTICLES

Geller J: "The Development of Behavior Therapy with Autistic Children: A Review." Journal of Chronic Diseases 25:21-31, 1972.

Geller JL: "Treatment of Anorexia Nervosa by the Integration of Behavior Therapy and Psychotherapy." Psychotherapy and Psychosomatics 26:167-177, 1975.

Geller JL, Lister E: "The Process of Criminal Commitment for Pretrial Psychiatric Examination: An Evaluation." American Journal of Psychiatry 135:53-60, 1978.

Geller JL: "The Muddied Path Between the Criminal Court and the State Hospital." Journal of Psychiatry and Law 8:389-411, 1980.

Geller JL: "Sustaining Treatment with the Hospitalized Patient Who Refuses Treatment." American Journal of Psychiatry 139:112-113, 1982.

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Geller JL, Bertsch G: "Firesetting Behavior in the Histories of a State Hospital Population." American Journal of Psychiatry 142:464-468, 1985.

Geller JL: "Women's Accounts of Psychiatric Illness and Institutionalization." Hospital and Community Psychiatry 36:1056-1062, 1985.

Geller JL: "The Long-Term Outcome of Unresolved Grief: An Example." Psychiatric Quarterly 57:142-146, 1985.

Geller JL: "In Again, Out Again. A Preliminary Evaluation of a State Hospital's Worst Recidivists." Hospital and Community Psychiatry 37:386-390, 1986.

Geller JL, Erlen J, Pinkus R: "A Historical Appraisal of America's Experience with 'Pyromania'--A Diagnosis in Search of a Disorder." International Journal of Law and Psychiatry 9:201-229, 1986.

Geller JL: "Rights, Wrongs, and the Dilemma of Coerced Community Treatment." American Journal of Psychiatry 143:1259-1264, 1986.

Geller JL, Munetz MR: "The Process of Staff Change: Grappling with the Needs of the High-Management Patient." Hospital and Community Psychiatry 37:1047-1049, 1986.

Geller JL: "The Quandaries of Enforced Community Treatment and Unenforceable Outpatient Commitment Statutes." The Journal of Psychiatry and Law 14:149-158, 1986.

Mulvey EP, Geller JL, Roth LH: "Balancing the Promises and Perils of Involuntary Outpatient Commitment." American Psychologist 42:571-584, 1987.

Geller JL: "Fire-setting in the Adult Psychiatric Population." Hospital and Community Psychiatry, 38:501-506, 1987. Abstracted in Psychiatry Digest 1:3-5, 1988.

Geller JL: The "Elixir of Life?" The Journal of Irreproducible Results 33(2):20, 1987.

Geller JL, Lidz CW: "When the Subjects are Hospital Staff, is it Ethical (or Possible) to Get Informed Consent?" IRB 9:4-5, 1987.

McEvoy JP, Apperson LJ, Appelbaum PS, Ortlip P, Brecosky J, Hammill K, Geller JL, Roth L: "Insight in Schizophrenia: Its Relationship to Acute Psychopathology." Journal of Nervous and Mental Disease 177:43-47, 1989.

McEvoy JP, Freter S, Everett G, Geller JL, Appelbaum P, Apperson LJ, Roth L: "Insight and the Clinical Outcome of Schizophrenic Patients." Journal of Nervous and Mental Disease 177:48-51, 1989.

McEvoy JP, Appelbaum PS, Apperson LJ, Geller JL, Freter S: "Why Must Some Schizophrenic Patients be Involuntarily Committed? The Role of Insight." Comprehensive Psychiatry 30:13-17, 1989.

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Schmidt MJ, Geller JL: "Involuntary Administration of Medication in the Community - The Judicial Opportunity." Bulletin of the American Academy of Psychiatry and the Law 17:283-292, 1989.

Geller JL: "A Bite of AIDS? Institutional Line Staff and the Fear of HIV Contagion." Psychiatric Quarterly 60:243-251, 1989. Abstracted in Sociological Abstracts.

Geller JL, Erlen J, Kaye NS, Fisher WH: "Feigned Insanity in Nineteenth Century America: Tactics, Trials, and Truth." Behavioral Sciences and the Law 8:3-26, 1990.

Fisher WH, Geller JL, Wirth-Cauchon J: "Empirically Assessing the Impact of Mobile Crisis Capacity on State Hospital Admissions." Community Mental Health Journal 26:245-253, 1990.

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Geller JL: "Clinical Guidelines for the Use of Involuntary Outpatient Treatment." Hospital and Community Psychiatry 41:749-755, 1990. Abstracted in Sociological Abstracts.

Geller JL, Kaye NS: "Smoking in Psychiatric Hospitals: A Historical View of a Hot Topic." Hospital and Community Psychiatry 41:1349-1350, 1990.

Geller JL: "Any Place but the State Hospital. Examining Assumptions about the Benefits of Admission Diversion." Hospital and Community Psychiatry 42:145-152, 1991.

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Geller JL: "Communicative Arson." Hospital and Community Psychiatry 43:76-77, 1992.

Tonkonogy JM, Geller JL: "Hypothalamic Lesions and Intermittent Explosive Disorder." Journal of Neuropsychiatry and Clinical Neurosciences 4:45-50, 1992.

Geller JL: "Clinical Encounters with Outpatient Coercion at the CMHC: Questions of Implementation and Efficacy." Community Mental Health Journal 28:81-94, 1992.

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Geller JL: Commentary: Is CIT today's lobotomy? Journal of the American Academy of Psychiatry and the Law 36:56-58, 2008.

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Geller JL: If we only had a historiscope. The Action Paper 1(2):4-5, 2009.

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Geller JL: Book Review: Library of dust. Psychiatric Services 61:536, 2010.

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Geller JL: Book Review: Asylum: inside the closed world of state mental hospitals. Psychiatric Services 61:1048-1049, 2010.

Geller JL: Book Review: Room. Psychiatric Services 61:1266-1267, 2010.

Geller JL: Panacea or Pandora's Box: Electronic health record in psychiatry. Worcester Medicine 74(5):14-15, 2010.

Geller JL: Book Review: The roots of the recovery movement in psychiatry: Lessons learned. Psychiatric Services 62:225-226, 2011.

Geller JL, Satel S: Time to mandate reporting of mental health concerns. USA Today, January 19, 2011, p. 9A.

Geller JL: Book Review: The ethical way: Challenges and solutions for managed behavioral healthcare. Psychiatric Services 62(1):3, 2011.

Geller JL: Book Review: Unhinged: The trouble with psychiatry—A doctor's revelations about a profession in crisis. Psychiatric Services 62:1396-1397, 2011.

Geller JL: Book Review: Delirious. Psychiatric Services 62:1517, 2011.

Geller JL: Book Review: Netsuke. Psychiatric Services 62:1518, 2011.

Geller JL: Ltr to Edit: How many authors is too many? Psychiatric Services 63:293, 2012.

Geller JL: Book Review: Oxford Textbook of Community Mental Health. Psychiatric Services 63:329, 2012.

Geller JL: Book Review: Sybil Exposed: The extraordinary story behind the famous multiple personality case. Psychiatric Services 63:513-514, 2012.

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Geller JL: The Quest for Mental Health: A Tale of Science, Medicine, Scandal, Sorrow, and Mass Society. Psychiatric Services 64: February 1, 2013; doi: 10.1176/appi.ps.640403.

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Geller JL: Book Review. Preventing Patient Suicide: Clinical Assessment and Management. Psychiatric Services 64: April 1, 2013; doi: 10.1176/appi.ps.640404.

Geller JL: Book Review. Modern Community Mental Health: An Interdisciplinary Approach Psychiatric Services, May 2013; 64 (5); e01-e01. doi: 10.1176/appi.ps.640508

Geller JL: Ltr to Edit: The Need for Appropriate Use of Involuntary Commitment Psychiatric Services, May 2013; 64 (5); 496-496. doi: 10.1176/appi.ps.640501

Geller JL: Correspondence: Community Treatment Orders for Psychosis. Lancet 382:502, 2013.

Geller J: Ltr to Edit: Asylum Should be Available to All Who Need It. Psychiatric News 48 (18):21, 2013.

Geller J: Depression and Danger to Others. Community Psychiatrist 27 (2):7, 2013.

Geller, JL: Book Review. First Person Accounts of Mental Illness and Recovery. Psychiatric Services 2014; 65(1):e04-e04. doi: 10.1176/appi.ps.650106

Geller, JL. Book Review. The Painted Bridge. Psychiatric Services 2014; 65(3):e13-e13. doi: 10.1176/appi.ps.650309

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Geller J: Ltr to Edit. Can there b good mental asylums? New York Times, February 26, 2015, p. A26. http://www.nytimes.com/2015/02/26/opinion/can-there-be-good-mental-asylums.html?_r=0

Geller JL: Listening to patients with an open mind. Psychiatric News. 2015, 50(3):22, March 6, 2015.

Geller JL: What we knew and when we knew it. Community Psychiatry 29 (2): 8, 2015

Sacco C, Geller J: Mental Illness: Understanding the power of words, labels. Berkshire Eagle, Manchester Journal, Brattleboro Reformer, Bennington Banner, 2/19/16.

Sacco C, Geller J: Myth vs. Fact: Sorting out mental illness, violence relationship Berkshire Eagle, Manchester Journal, Brattleboro Reformer, Bennington Banner, The Sun: San Bernardino, San Valley Gabriel Tribune, The Daily Breeze, 3/18/2016.

Sacco C, Geller J: Myth vs. Fact: Understanding what autism means. Berkshire Eagle, Manchester Journal, Brattleboro Reformer, Bennington Banner, 4/15/16

Geller J, Sacco C: Trauma and health: Connecting the dots. Berkshire Eagle, Manchester Journal, Brattleboro Reformer, Bennington Banner, 5/20/2016 .

Geller J, Sacco C: Myth vs. Fact: Transcending barriers in the work place. Berkshire Eagle, Manchester Journal, Brattleboro Reformer, Bennington Banner, 6/17/16.

Geller J, Sacco C: Myth vs. Fact: Shades of Darkness: Recognizing Depression. Berkshire Eagle, Manchester Journal, Brattleboro Reformer, Bennington Banner 7/15/2016.

Sacco C, Geller J: Myth vs. Fact: Know the difference between grief, major depression. Berkshire Eagle, 8/12/2016.

Geller J: The aftermath of the folie a neuf. American Association of Community Psychiatrists Newsletter 30 (2):11-12, 2016.

Geller J, Sacco C: Myth vs. Fact: Not always a straight path when treating depression. Berkshire Eagle (Pittsfield, MA), Manchester Journal (Manchester, VT), Brattleboro Reformer (Brattleboro, VT), Bennington Banner (Bennington, VT), 9/19/2016.

Sacco C, Geller J: Myth vs. Fact: Nothing 'natural' about synthetic substances. Berkshire Eagle (Pittsfield, MA), Manchester Journal (Manchester, VT), Brattleboro Reformer (Brattleboro, VT), Bennington Banner (Bennington, VT), 10/24/2016.

Geller JL (Ltr to Edit): A Revised Debate Over Asylums. New York Times, March 18. 2018.

Geller JL: Twenty-one "Do Nots" in constructing a psychiatric hospital. American Association of Community Psychiatrists Newsletter 32(1):15-19, 2018.

Geller JL: The rise and demise of America's psychiatric hospitals: A tale of dollars Trumping Decency. Psychiatric News (54 (5): 8-9, March 1, 2019. Published Online:26 Feb 2019https://doi.org/10.1176/appi.pn.2019.3a36

Geller J: The Rise and Demise of America's Psychiatric Hospitals: a Tale of Dollars Trumping Sense. Psychiatric News 54 (6): 11-12, March15, 2019. Published Online:14 Mar 2019https://doi.org/10.1176/appi.pn.2019.3b29

Geller JL, Daou MBZ: Patients With SMI in the Age of COVID-19: What Psychiatrists Need to Know. Psychiatric News. Published Online:7 Apr 2020 https://doi.org/10.1176/appi.pn.2020.4b39

Geller J: Ltr to edit. Wherever the peak may be, our caution should not flag. Boston Globe, April 22, 2020, p. A9.

Geller J: COVID-19 and Advocacy—The Good and the Unacceptable.
Psychiatric News. Published Online:7 May 2020https://doi.org/10.1176/appi.pn.2020.5b13

Geller JL, Daou MBZ: COVID-19 and People With SMI: New Notes From the Field. Psychiatric News. Published Online:7 May 2020 https://doi.org/10.1176/appi.pn.2020.5b24

Geller J: Emailectomies During the COVID-19 Pandemic and Its Aftermath.
Pyshictaric News. Published Online:28 May 2020https://doi.org/10.1176/appi.pn.2020.6a26

Geller J: COVID-19 and Sensationalizing Inpatient Psychiatric Settings.
Psychiatric News. Published Online:9 Jun 2020https://doi.org/10.1176/appi.pn.2020.6b22

SYMPOSIUM AND PANEL PARTICIPATION

Speaker: "Gender and Gender Dysphoria." Grand Rounds, UMass Medical School, Worcester, MA, April 30, 1981.

Speaker: "The Impact of a Consent Decree on Hospital and Community Development." Conference: Planning for Care of the Seriously Mentally Ill in Times of Austerity. UMass Medical School, Worcester, MA, April 30, 1982.

Speaker: "Arson: An Unforeseen Sequela of Deinstitutionalization." Conference: Clinical Challenges in Crisis Intervention, Consortium Emergency Services Network, Springfield, MA, March 15, 1983.

Symposium: The Role of the Attorney and Guardian Ad Litem in Rogers - Type Guardianships. Hampshire County Bar Association, Northampton, MA, March 14, 1984.

Symposium: Mental Health Procedures Act, Commonwealth of Pennsylvania Department of Public Welfare, Pittsburgh, PA, February, April 1985.

Invited Participant: N.I.H. - U.C.S.F. Conference on Ethics Consultation. National Institute of Health, Bethesda, MD, October 7-8, 1985.

Co-Speaker: with Loren H. Roth: "Deinstitutionalization - Reinstitutionalization. Is There a Middle Ground?" ADMIT, Pittsburgh, PA, February 25, 1986.

Speaker: "Fire Setting in the Adult Psychiatric Population." Office of Education and Regional Planning, W.P.I.C., Warren, PA, April 4, 1986.

Speaker: "Iatrogenic Creation of Chronicity in Women." Presidential Symposium: "Issues in Treating Chronically Mentally Ill Women." 139th American Psychiatric Association Meeting, Washington, DC, May 12, 1986.

Co-Speaker: with Loren H. Roth: "Involuntary Commitment to Outpatient Treatment." Forum: "Reinstitutionalization: The Next Panacea?" 139th American Psychiatric Association Meeting, Washington, DC, May 14, 1986.

Speaker: "Overview of Mental Health Procedures Act in Pennsylvania." Office of Education and Regional Planning, W.P.I.C., Kitanning, PA, June 4, 1986.

Speaker: "Fire Setting in Adult Psychiatric Patients" Grand Rounds, Worcester State Hospital, Worcester, MA, October 9, 1986.

Speaker: "Interpretation and Treatment Implications of Risk Assessment in the System. The Adult Mental Health Committee of the Greater Worcester Area, Worcester, MA, October 23, 1986.

Speaker: "Involuntary Community Treatment and Its Derivatives." 38th Institute on Hospital and Community Psychiatry, San Diego, CA, October 29, 1986.

Speaker: "The Future of Institutional Treatment of the Mentally Ill." Wes-Ros-Park Community Mental Health Center, Boston, MA, November 6, 1986.

Speaker: "Involuntary Community Treatment: Panacea or Problem?" Veterans Administration Northeast Regional Medical Education Center Decentralized On-site Program, Boston, MA, February 25, 1987.

Conference Director: "Family and Community Treatment of Severe Mental Illness." Public Sector Division of University of Massachusetts Department of Psychiatry, Worcester, MA, May 1, 1987.

Speaker: "Diagnosing the Mentally Ill." Western Massachusetts Alliance for Mentally Ill Citizens, Holyoke, MA, June 8, 1987.

Speaker: "Overview of Treatment of the Chronically Mentally Ill." Central Massachusetts Alliance for the Mentally Ill. Worcester, MA, October 13, 1987.

Symposium Director: "The Scope of Public Sector Psychiatry in the 1980's. 39th Institute on Hospital and Community Psychiatry, Boston, MA, October 25, 1987.

Workshop Leader: "When the Federal Court Dictates Deinstitutionalization: The Brewster v. Dukakis Consent Decree 1978-1987. 39th Institute on Hospital and Community Psychiatry, Boston, MA, October 26, 1987.

Co-Speaker: with Paul Appelbaum: "Mandatory Outpatient Treatment: Legal and Clinical Issues." 39th Institute on Hospital and Community Psychiatry, Boston, MA, October 28, 1987.

Speaker: "Involuntary Outpatient Treatment." Community Psychiatry Seminar, Oregon Health Sciences Center, Portland, OR, October 30, 1987.

Speaker: "Involuntary Outpatient Commitment." Mental Health Division, Department of Human Resources, Salem, OR, October 30, 1987.

Keynote Speaker: "Outpatient Commitment: Trick of Treat." Annual Meeting of the Mental Health Association of Oregon, Portland, OR, October 31, 1987.

Co-Speaker: with Alan R. Kerr: "Intervention with Borderline Patients." Second Annual Western Massachusetts Conference on Human Services: Reaching Populations at Risk, Springfield, MA, November 5, 1987.

Speaker: "The Involuntary Treatment of Mental Illness, Models Old and New." Advances in Psychiatry Series, HLA Portsmouth Pavilion, Portsmouth, NH, February 19, 1988.

Keynote Speaker: "Outpatient Commitment." Nebraska Department of Public Institutions, Omaha, NE, April 11, 1988.

Conference Director: "Meeting the Needs of the Chronic Mentally Ill: Patients, Families, and Practitioners in Partnership." Public Sector Division of the University of Massachusetts Department of Psychiatry, Shrewsbury, MA, April 29, 1988.

Co-Speaker: with Marilyn Schmidt: "Involuntary Community Treatment in Western Massachusetts: Two Models. Public Sector Division of the University of Massachusetts Department of Psychiatry, Shrewsbury, MA, April 29, 1988.

Speaker: "The Massachusetts Experience with Involuntary Community Treatment." Metropolitan State Hospital Grand Rounds, Waltham, MA, May 24, 1988.

Speaker: "Involuntary Community Treatment and Its Benefit to the State Hospital." Westborough State Hospital Grand Rounds, Westborough, MA, October 3, 1988.

Co-Speaker: With Robert M. Factor: "'Asylum': Redirection or Misdirection?" 40th Institute on Hospital and Community Psychiatry, New Orleans, LA, October 25, 1988.

Poster Presentation: "The State Hospitals' Worst Recidivists: Who Are They and What's to be Done?" 40th Institute on Hospital and Community Psychiatry, New Orleans, LA, October 25, 1988.

Symposium: "Funded Deinstitutionalization: For Whom Does It Work?" 40th Institute on Hospital and Community Psychiatry, New Orleans, LA, October 27, 1988.

Speaker: "Firesetting in Children and Adults: Distinctions and Common Denominators." Center for Children and Youth, Westfield, MA, November 16, 1988.

Speaker: "Communicative Arson and the Adult Psychiatric Patient." Grand Rounds, Norwich State Hospital, Norwich, CT, November 17, 1988.

Speaker: "Firesetting and Servicing the Mentally Ill in the Community. Mt. Tom Institute, Holyoke, MA, March 6, 1989.

Speaker: "Involuntary Community Treatment and the Families of the Chronic Mentally Ill." National Alliance for the Mentally Ill, Newton-Wellesley Chapter, Newton, MA, March 28, 1989.

Speaker: "Prescriptions and Proscriptions in the Treatment of the State Hospital Recidivist." Northampton State Hospital Grand Rounds, Northampton, MA, April 6, 1989.

Speaker: "State Hospital Recidivism and the CMHC" Center for Adults and Families, Westfield, MA, April 26, 1989.

Conference Director: "The State Hospital and Its Alternatives: Myths and Realities." Fifth Annual Public Sector Psychiatry Conference, Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA, April 28, 1989.

Discussant: "Trafficking in Fire. Dangerous Statements, Dangerous Behavior and the Manipulation of Staff." Grand Rounds, University of Massachusetts Medical Center, Worcester, MA, May 25, 1989.

Speaker: "A Clinician's Primer on Involuntary Outpatient Treatment. 41st Institute on Hospital and Community Psychiatry, Philadelphia, PA, October 16, 1989.

Conference Director: "Violence and Mental Illness: Theory and Prevention." Sixth Annual Public Sector Psychiatry Conference, Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA, April 19, 20, 1990.

Speaker: "Contracting with Violent Patients in Outpatient Treatment." Public Sector Psychiatry Conference, Worcester, MA, April 20, 1990.

Speaker: "Pyromania, Communicative Arson, and Public Sector Psychiatry." Grand Rounds, Northampton State Hospital, Northampton, MA, May 31, 1990.

Conference Director: "The Asylum: Redirection or Misdirection" Public Sector Division, University of Massachusetts Medical School, Department of Psychiatry, Worcester, MA, June 1, 1990.

Co-Speaker: with Robert I. Paulson, D.S.W.: "Blowing Winds of Change into Academia: NAMI Recognizes Excellence in Training." Tenth Annual National Alliance for the Mentally Ill Convention, Chicago, IL, July 21, 1990.

Speaker: "The State and the State Hospital: Old and New Assumptions." Grand Rounds, Worcester State Hospital, Worcester, MA, September 25, 1990.

Speaker: "Revolvingvolvingvolving Door: Recidivism, Recidivism, and Recidivism." 42nd Institute on Hospital and Community Psychiatry, Denver, CO, October 9, 1990.

Speaker: "Firesetters and Treatment." 42nd Institute on Hospital and Community Psychiatry, Denver, CO, October 10, 1990.

Speaker: "'Any Place but the State Hospital.' Examining the Assumptions of Admissions Diversion." Grand Rounds, Northampton State Hospital, Northampton, MA, November 1, 1990.

Speaker: "Pathological Firesetting." Grand Rounds. Worcester State Hospital, Worcester, MA, November 6, 1990.

Speaker: "The State and Its State Hospitals: What's Been and What Might Be." Commonwealth of Pennsylvania Superintendent and Chief Physician Meeting, Harrisburg, PA, December 12, 1990.

Speaker: "Here Today, Gone Tomorrow, Back the Next Day: State Hospital Recidivism in Perspective." Grand Rounds, Westborough State Hospital, Westborough, MA, January 29, 1991.

Speaker: "Dilemmas of the Revolvingvolvingvolving Door Patient." Grand Rounds, Danvers State Hospital, Hathorne, MA, February 21, 1991.

Symposium: "Community/State Relations." Sixth Annual Pennsylvania Conference on Schizophrenia, Pittsburgh, PA, March 8, 1991.

Visiting Lecturer, Oregon Department of Human Services: "Arson: From Profit to Pathology," Oregon State Hospital, Salem, OR, April 8, 1991; "The Revolvingvolvingvolving Door," Oregon State Hospital, April 9, 1991; "The Revolvingvolvingvolving Door," Dammasch State Hospital, Wilsonville, OR, April 9, 1991; "Arson: From Profit to Pathology" and "Involuntary Outpatient Treatment in the Community" and "The Revolvingvolvingvolving Door," Eastern Oregon Psychiatric Center, Pendleton, OR, April 10, 1991.

Conference Director: "Controversies in Public Psychiatry: Commitment and Coercion." Seventh Annual Public Sector Psychiatry Conference. Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA, April 19, 1991.

Speaker: "Coercion in the Community: A Copacetic Contract or a Copout." Seventh Annual Public Sector Psychiatry Conference, University of Massachusetts Medical School, Department of Psychiatry, Worcester, MA, April 19, 1991.

Speaker: "Involuntary Outpatient Treatment: Promise and Peril." Fifth Annual Forensic Psychiatry Conference of the Penetanguishene Mental Health Centre and the Ontario Ministry of Health, Midland, Ontario, June 21, 1991.

Speaker: "From 'Asylum' to 'Loony Bin': American Women's Perspectives on Entering the Psychiatric Institution." 43rd Institute on Hospital and Community Psychiatry, Los Angeles, CA, October 22, 1991.

Speaker: "Assessing the Utilization Patterns of Community Residential Programs." 43rd Institute on Hospital and Community Psychiatry, Los Angeles, CA, October 23, 1991.

Co-Speaker: with Robert Factor: "Models and Applications of Coerced Community Treatment: Yeah! Nay! or Maybe?" 43rd Institute on Hospital and Community Psychiatry, Los Angeles, CA, October 23, 1991.

Speaker: "Psychosis and the Revolvingvolvingvolving Door." Grand Rounds, Newton-Wellesley Hospital, Newton, MA, November 7, 1991.

Speaker: "Public Sector Psychiatry and Worn Out Sneakers." Grand Rounds, Worcester State Hospital, Worcester, MA, January 14, 1992.

Speaker: "Historical Appraisal of the Demise of the State Hospital and the Rise of General Hospital Psychiatric Units: Maybe a Reason but No Rhyme." Grand Rounds, Wing Memorial Hospital, Palmer, MA, February 5, 1992.

Speaker: "Community Psychiatry in the 1990's: Confusion? Commitment: Choice!" Third Simposio Psiquiatrico de Puerto Rico, La seccion de Psiquiatria dela Asociacion Medica de Puerto Rico, San Juan, PR, April 11, 1992.

Speaker: "Use of Coercion to Keep People Out of Hospital: Paradigm or a Problem." Grand Rounds, Nassau County Medical Center, East Meadow, NY, April 24, 1992.

Symposium paper: "Romanian Psychiatry: Quest for Professional Freedom." 145th Annual Meeting of the American Psychiatric Association, Washington, DC, May 6, 1992.

Conference Director: "Right-Sizing Massachusetts' State Hospitals." Public Sector Division, University of Massachusetts Medical School, Department of Psychiatry, Worcester, MA, May 15, 1992.

Co-Speaker: with Charles Goldman, M.D.: "Model Training Programs in Psychiatry," as part of a conference: "Treating the Seriously Mentally Ill - Educating Professionals for the 21st Century." Medical College of Pennsylvania and National Alliance for the Mentally Ill, Philadelphia, PA, June 5, 1992.

Speaker: "Massachusetts' Experiments in Public Sector Psychiatry in the Nineties and Their Implications for Michigan." Annual Meeting of the Michigan Association of Neuro-Psychiatric Hospitals and Clinics Physicians, Novi, MI, July 17, 1992.

Speaker: "'Clinical coercion' in Post-Totalitarian Romania--Ethical Quagmire?" First International Conference of the Romanian Free Psychiatrists' Association, Bucharest, Romania, October 2, 1992.

Speaker: "A State's Response to Its Seriously Mentally Ill: A Comparison of the Massachusetts Commission Reports of 1855 and 1991." 44th Institute on Hospital and Community Psychiatry, Toronto, October 24, 1992.

Speaker: "A Disability Model of Schizophrenia and Psychosocial Modes of Rehabilitation." Harlem Valley Psychiatric Center Grand Rounds, Wingdale, NY, November 20, 1992.

Discussant: Workshop on Treatment of Violent Mentally Ill Persons in the Community: Issues of Research, Policy, and Services. Violence and Traumatic Stress Research Branch, Division of Epidemiology and Services Research, National Institute of Mental Health, Washington, DC, January 15, 1993.

Speaker: "A Patient with High Service Utilization." George B. Wells Human Service Center Mental Health Education and Training, Southbridge, MA, April 1, 1993.

Conference Director: Affective Disorders as Chronic Mental Illness. Public Sector Division, University of Massachusetts Medical Center, Worcester, MA, April 30, 1993.

Speaker: "Pathological Firesetting and the State Hospital." Norwich State Hospital Grand Rounds, Norwich, CT, May 13, 1993.

Co-Speaker: with Sheldon Benjamin, M.D.: "Post-Communist Psychiatry: Report on a Visit to Psychiatric Hospitals in Romania and Ukraine." Westborough State Hospital Grand Rounds, Westborough, MA, May 18, 1993.

Symposium Discussant: "Chronic Institutionalization: Current Status. 146th Annual Meeting of the American Psychiatric Association, San Francisco, CA, May 24, 1993.

Speaker: "Is Managed Care Changing Administrative Psychiatry?" 146th Annual Meeting of the American Psychiatric Association, San Francisco, CA, May 24, 1993.

Speaker: "Impinging on Community Practice: More Good than Bad." A Symposium co-sponsored by APA and AACP. 146th Annual Meeting of the American Psychiatric Association, San Francisco, CA, May 27, 1993.

Co-Speaker: with Trevor Hadley, Ph.D., Edna Kamis-Gould, Ph.D., and William Fisher, Ph.D.: Unbundling and Privatizing Psychiatric State Hospital Services: Doing the Right Thing and Doing It Right. 45th Institute on Hospital and Community Psychiatry, Baltimore, MD, October 9, 1993.

Symposium Organizer and Moderator: Medicaid Managed Care for Mental Health/Substance Abuse Services. 45th Institute on Hospital and Community Psychiatry, Baltimore, MD, October 10, 1993.

Symposium Presenter: Writing a Paper in Symposium: Writing for Journals. 45th Institute on Hospital and Community Psychiatry, Baltimore, MD, October 11, 1993.

Speaker: The Past and Present of National Health Reform and Mental Health Benefits. Meeting of the Delaware Psychiatric Society, Wilmington, DE, October 28, 1993.

Conference Director: Long-term Treatment of Long-term Patients. Public Sector Division, University of Massachusetts Medical Center, Worcester, MA, April 29, 1994.

Symposium Presenter: Writing for Journals. 46th Institute on Hospital and Community Psychiatry, San Diego, CA, September 30, 1994.

Symposium Presenter: Ethical Issues in Community Psychiatry. 46th Institute on Hospital and Community Psychiatry, San Diego, CA, October 1, 1994.

Symposium Presenter, with Joseph English, Laurie Flynn and Boris Astrachan: Providers and Consumers: Partners in Psychiatric Care. 46th Institute on Hospital and Community Psychiatry, San Diego, CA, October 1, 1994.

Co-Speaker: with Jay Cutler: On the Inside Looking In: The Mental Health/Substance Abuse Benefit in National Health Care Reform. 46th Institute on Hospital and Community Psychiatry, San Diego, CA, October 3, 1994.

Speaker: Health Reform on the Hill: A Capitol Perspective, Grand Rounds, University of Massachusetts Medical School, Worcester, MA, October 13, 1994.

Speaker: Juvenile and Adolescent Firesetting. Series sponsored by the Northern Berkshire Mental Health Association, North Adams, MA, November 22, 1994.

Speaker: Psychiatrist in Congress. Mid-Hudson (N.Y.) Branch of the American Psychiatric Association. Poughkeepsie, NY, January 12, 1995.

Speaker: From Long-Term Hospitalization to Community: Progress or Pratfall. Grand Rounds at Hudson River Psychiatric Center, Poughkeepsie, NY, January 13, 1995.

Speaker: National Mental Health Reform: To Be Or Not To Be. Grand Rounds at the Institute of Living/Hartford Hospital, Hartford, CT, January 25, 1995.

Co-Speaker: with William Fisher, Ph.D.: Assessing the Efficacy of Outpatient Commitment: A Case Control Study of Service Use by Committed and Non-committed Consumers. Fifth Annual Conference on State Mental Health Agency Services (SMHA) Research, San Antonio, TX, January 31, 1995.

Co-Speaker: with Laurie Flynn. Keynote Address: The Future of Public Psychiatry. The Ohio Institute on Community Psychiatry, Department of Psychiatry CWRU and Ohio Department of Mental Health, Cleveland, OH, March 24, 1995.

Speaker: National Health Reform and Public Sector Psychiatry. Grand Rounds, Westborough State Hospital, Westborough, MA, April 4, 1995.

Speaker: Psychiatric Services Under National Health Reform. Western Massachusetts Psychiatric Society, Springfield, MA, April 19, 1995.

Speaker: Revolution or Revision? Massachusetts' Lessons in Public Managed Care of Mental Illness. The Center for Psychiatric Medicine at St. Francis' Conference: Privatizing Public Mental Health Service Delivery: Promise or Peril, Pittsburgh, PA, April 22, 1995.

Speaker: How Washington Works: And If It Does, What Happens to Us Psychiatrists? Outpatient Psychiatry Annual Series, Massachusetts General Hospital, Boston, MA, April 15, 1995.

Conference Director: In Search of Parity: Mental Illness Care and Mental Illness Coverage. Public Sector Division, University of Massachusetts Medical Center, Worcester, MA, April 28, 1995.

Co-Speaker: with Jay Cutler: Evolving Federal Policy on Mental Illness and the Insurance Coverage. 148th Annual Meeting of the American Psychiatric Association, Miami, FL, May 24, 1995.

Speaker: Interfacephiliacs. 1995 National Conference on Mental Health Statistics. Center for Mental Health Services, Washington, DC, June 1, 1995.

Speaker: Who's committed to Involuntary Outpatient Treatment: The Psychiatrist or the Patient?" Grand Rounds, U. of South Dakota School of Medicine, Sioux Falls, SD, June 9, 1995.

Speaker: Managed Mental Health Care Has Arrived. Semi-Annual Meeting of the South Dakota Psychiatric Society, Sioux Falls, SD, June 10, 1995.

Speaker: Mental Health Services of the Future: Managed Care, Unmanaged Care, Mis-managed Care. Helen Pinkus Memorial Lecture. Smith College School for Social Work Supervisors' Annual Conference, Northampton, MA, July 21, 1995.

Co-Speaker: with Oleg Nasynnik, M.D. Issues in Compulsory Treatment in Forensic Psychiatry. Third Meeting of Reformers of Psychiatry, Prague, Czech Republic, September 1, 1995.

Speaker: Revolution in American Psychiatry: Managed Mental Health Care. Third Meeting of Reformers in Psychiatry, Prague, Czech Republic, September 2, 1995.

Co-Speaker: with Vladimir Tochilov, M.D. Managing a Psychiatric Facility – Models, Obstacles, Objectives. Third Meeting of Reformers of Psychiatry, Prague, Czech Republic, September 2, 1995.

Moderator and Speaker: Major Mental Illness, Women, and Reproduction: Innovative Programs. 47th Institute on Psychiatric Services, Boston, MA, October 9, 1995.

Conference Director: Pathological Firesetters: Who; Why; What's to be Done? Public Sector Division, University of Massachusetts Medical Center, Springfield, MA, November 13, 1995.

Speaker: Managed and Unmanaged Behavioral Health Care. Marian Health Center Grand Rounds, Sioux City, IA, January 12, 1996.

Speaker: Managed and Unmanaged Behavioral Health Care. University of South Dakota Medical School, Department of Psychiatry Grand Rounds, Sioux Falls, SD, January 12, 1996.

Speaker: History of the Treatment of Women in the Mental Health System. Conference: Women on the Threshold of Change: Issues in the Mental Health and Chemical Abuse Fields, Morris Plains, NJ, February 1, 1996.

Speaker: Compassion and Coercion in the Treatment of Women with Dual Diagnoses. Conference: Women on the Threshold of Change: Issues in the Mental Health and Chemical Dependence Fields, Morris Plains, NJ, February 1, 1996.

Speaker: Involuntary Outpatient Treatment: Who's Committed? ComCare Grand Rounds, Phoenix, AZ, April 16, 1996.

Conference Director: Treating the Dual Disorders: Mental Illness and Substance Abuse. Public Sector Division, University of Massachusetts Medical Center, Worcester, MA, April 27, 1996.

Co-Speaker: with Maureen Slade, R.N., M.S. and Glen Lawrence, M.A. Continuum: Comprehension, Compliance, Coercion. 73rd Annual Meeting of the American Orthopsychiatric Association, Boston, MA, May 1, 1996.

Speaker: Public Sector Psychiatric Services at the End of the Millennium: Repetition Compulsionsionsion. 3rd Annual Conference for Mental Health Policy Services and Clinical Research of the Connecticut MHC and Department of Psychiatry of Yale University School of Medicine, New Haven, CT, May 30, 1996.

Speaker: Involuntary Outpatient Treatment. Department of Mental Health Western Massachusetts Area, Pittsfield, MA, June 19, 1996.

Co-Speaker: with Maureen Slade, R.N., M.S. and Roland Gibson. Continuum: Comprehension, Compliance, Coercion. NAMI 1996 Annual Convention, Nashville, TN, July 8, 1996.

Co-Speaker: with Jay Cutler. Lobbying Governmental Organizations. IV Meeting of Reformers in Psychiatry, Madrid, Spain. August 29, 1996.

Speaker: Compulsory Outpatient Treatment. IV Meeting of Reformers in Psychiatry, Madrid, Spain. August 30, 1996.

Speaker: Video Workshop: The History of Psychiatry. 48th Institute on Psychiatric Services, Chicago, IL, October 18, 1996.

Speaker: What Does a CRIPA Expert Look For? Association of State Mental Health Attorneys Annual Conference, New Orleans, LA, October 22, 1996.

Speaker: Make 'em Do It in the Community! The Facts and Fantasies about Involuntary Outpatient Treatment. Special Programs in Community Psychiatry, Northeastern Ohio Universities College of Medicine, Akron, OH, April 17, 1997.

Speaker: Recidivism: Causes and Treatment. 2nd Annual Taunton Psychiatric Conference, Taunton, MA, April 25, 1997.

Conference Director: Clinical Management of Pathological Violence. Public Sector Division, University of Massachusetts Medical Center, Worcester, MA, May 2, 1997.

Speaker: Reflections on Reforms in Psychiatry. Subnetwork Role of Professional Psychiatric Associations. Geneva Initiative, Amsterdam. May 8, 1997.

Speaker: Human Rights and Psychiatric Care --Ideas and Realities in North America. Berzelius Symposium XXXVII, Swedish Society of Medicine and the Hastings Center, Stockholm, Sweden, June 17, 1997.

Speaker: Make 'Em Do It! Me? Yeah, You! Nineteenth Annual Inservice Training Conference, Association of Ohio Forensic Psychiatric Center Directors, Columbus, OH, June 20, 1997.

Speaker: The Massachusetts Medicaid Experience. 49th Institute on Psychiatric Services, Washington, D.C., October 26, 1997.

Speaker: The Ethics of Compulsory Outpatient Treatment, Geneva Initiative, Woudschoten, Zeist, Netherlands, Geneva, April 2, 1998.

Speaker: Involuntary Outpatient Treatment: Been There, Done That, or Not? Massillon Psychiatric Center and Northeastern Ohio Universities College of Medicine, Canton, OH, May 4, 1998.

Conference Director: Treatment and Mistreatment of Women with Chronic Mental Illness. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, May 8, 1998.

Discussant: Dealing with Psychopathy: The United States Supreme Court's Hendricks vs. Kansas Decision and Beyond. 151st Annual Meeting of American Psychiatric Association, Toronto, Ontario, June 2, 1998.

Conference Co-Chair: Long-Term Care. National Alliance for the Mentally Ill, Bethesda, MD, September 15, 1998.

Discussant: Innovations in Trauma Recovery Work. 50th Institute on Psychiatric Services, Los Angeles, CA, October 5, 1998.

Speaker: Competency Evaluations. Fall Judicial Education Conference, Plymouth, MA, October 23, 1998.

Speaker: Written Words by Women with Psychosis. Women and Psychosis Conference, Clarke Institute, Toronto, Ontario. February 25, 1999.

Conference Director: Care and Treatment of "Mentally Ill" Sexual Perpetrators. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, April 30, 1999.

Speaker: The Place of Treatment for Individuals with Chronic, Serious Mental Illness. Grand Rounds, UMDNJ-New Jersey Medical School, Newark, NJ, October 20, 1999.

Speaker: Whither Social Work? Or, Wither Social Work. Social Work Grand Rounds, Beth Israel Deaconess Hospital, Boston, MA, March 23, 2000.

Co-Chair: with Zou Yizhuang, M.D., Scientific Program Committee of the Second Sino-American Conference on Psychiatry, Beijing, China, April 6-10, 2000.

Conference Director: Implications of the Blurring Boundaries Between Mental Health and Criminal Justice Systems: Policies, Plans, and Practices. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, May 5, 2000.

Discussant: Patient Autonomy and Paternalism Across Cultures. 153 APA Annual Meeting, Chicago, IL, May 16, 2000.

Speaker: The Institution for Mental Disorders (IMD) Exclusion: The Federal Government's Impaired Vision in the Care and Treatment of its Citizens with Chronic Mental Illness. Robert Wood Johnson Health Policy Fellowship Program: Unintended Consequences of Health Policy Programs and Policies, Washington, DC, August 22, 2000.

Speaker: An overview of 50 years of Psychiatric Services. 52nd Institute on Psychiatric Services, Philadelphia, PA, October 26, 2000.

Debate Participant: Resolved: Outpatient Commitment is Likely to Do More Harm than Good in Facilitating Effective Treatment of Persons with Serious Mental Illness. 52nd Institute on Psychiatric Services, Philadelphia, PA, October 27, 2000.

Speaker: The Sham and Shamefulness of the Least Restrictive Alternative Concept as an Enabler of Empowerment. 8th Annual North Carolina Conference on Innovative Approaches in Psychiatric Rehabilitation, Butner, NC, November 2, 2000.

Conference Director: "Benevolent Coercion" to Facilitate Treatment of Persons with Chronic Mental Illnesses. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, April 27, 2001.

Speaker: From Right to Treatment to Needs Based Discharge Planning. Association of Public Developmental Disabilities Administrators, New Orleans, LA, February 20, 2002.

Speaker: Pathological Firesetting: Etiology and Treatment. Northeastern Ohio U. College of Med., Ohio Community Forensic Association and the Ohio Department of Mental Health, Columbus, OH, March 15, 2002.

Conference Director: Responding to Parasuicidal Behaviors, Suicide Threats, Suicide Attempts and Suicide. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, April 26, 2002.

Speaker: Extinction versus Adaptation: The Future of State Hospital Psychiatry: Building, Unbuilding, and Rebuilding America's State Hospitals. 155 APA Annual Meeting, Philadelphia, PA, May 20, 2002.

Speaker: The Past, Present and Future of Inpatient Psychiatry. NAMI Kansas, Topeka, KS, September 23, 2002.

Speaker: Advocating for Patients and Psychiatrists. 54th Institute on Psychiatric Services, Chicago, IL, October 11, 2002.

Conference Director: Addressing the Clinical Issues of Persons with Mental Illness and/or Mental Retardation and Co-occurring Disordered Sexual Behaviors. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, May 9, 2003.

Speaker: Treatment: Rights and Wrongs. Grand Rounds, University of Massachusetts Medical School, June 26, 2003.

Speaker: Secrets of the Therapeutic Relationship. Western Massachusetts Psychiatric Society, Springfield, MA, September 17, 2003.

Speaker: Living Together in Communities. NAMI-Western Massachusetts. Northampton, MA, October 14, 2003.

Discussant: Peer Review and Morbidity and Mortality in the Community: A Ten-Year Perspective. Institute on Psychiatric Services, Boston, MA, October 30, 2003.

Speaker: Forty Years of Neglect: The Federal Role in Caring for the Severely Mentally Ill. American Enterprise Institute for Public Policy Research, Washington, DC, October 31, 2003.

Speaker: Mental Illness Services: 1963 Looking Backwards and Forwards. Carson Center for Human Services Fortieth Anniversary Annual Meeting, West Springfield, MA, November 20, 2003.

Speaker: When Dollars Trump Sense. American Association of Community Psychiatrists Annual Meeting, Honolulu, Hawaii, February 20, 2004.

Speaker: Treatment and Care of Persons with Serious Mental Illness: Are we Winding Up or Winding Down? Grand Rounds, Westborough State Hospital, Westborough, MA, March 2, 2004.

Panelist: Medical Issues Concerning Involuntary Treatment. New England Journal on Criminal and Civil Confinement, Center for Law and Social Responsibility at the New England School of Law, and UMass Medical School, Boston, MA, March 5, 2004.

Panelist: The Civil Context – Involuntary Outpatient Commitment. New England Journal on Criminal and Civil Confinement, Center for Law and Social Responsibility at the New England School of Law, and UMass Medical School, Boston, MA, March 5, 2004.

Speaker: What Can You Advocate for and Why? NAMI of Central MA, Worcester, MA, March 18, 2004.

Speaker: They Live in My Head. A BI Resident Looks Back at his First Psychotherapy Cases. Beth Israel-Deaconess Grand Rounds, Boston, MA, March 30, 2004.

Speaker: State Hospital Psychiatry: Been Down So Long It Looks Like It's Up To Me. 157th APA Annual Meeting, New York, NY, May 3, 2004.

Panelist: Public Psychiatry: Leading the Way in Transforming Service Delivery in the 21st Century. 157th APA Annual Meeting, New York, NY, May 3, 2004.

Conference Director: Mad or Bad: When is it Psychopathy? Public Sector Division, University of Massachusetts Medical School, Worcester, MA, May 20, 2004.

Speaker: Can't Get No Respect. How'd the American State Hospital Get Here? First Annual Mental Health Conference, Larned State Hospital, Larned, Kansas, September 29, 2004.

Co-Speaker, with Debra Pinals, M.D. Police and Mental Health Professionals: Learning From Each Other. 56th Institute on Psychiatric Services, Atlanta, GA, October 10, 2004.

Speaker: They Live in My Head. Grand Rounds, University of Massachusetts Medical School, Worcester, MA, November 7, 2004.

Speaker and Panelist: Enhancing Personal Liberty for Persons with Serious Mental Illness: Legal and Clinical Perspectives. University of Vermont Department of Psychiatry and Vermont State Hospital, Montpelier, VT, December 9, 2004.

Speaker: Clinical Criteria for Involuntary, Coercive and Pseudo-Voluntary Treatment. 5th Annual International Association of Forensic Mental Health Services, Melbourne, Australia, April 19, 2005.

Conference Director: Making It in the Community: Best Practices. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, June 28, 2005.

Speaker: Involuntary Outpatient Treatment in the USA: Conundrum or Quagmire. 29th International Congress on Law and Mental Health, Paris, France, July 8, 2005.

Speaker with Fabian Saleh, M.D. and Gina Vincent, Ph.D: Dangerous Ones: Assessing and Treating Psychopaths, Pedophiles and Firesetters. 57th Institute on Psychiatric Services, San Diego, CA, October 7, 2005.

Speaker with Aaron Lazare, M.D. and David Spiegel, M.D.: The Theory and Practice of Apology. 159th Annual Meeting, Toronto, Canada, May 22, 2006.

Conference Director: Creating Sanctuary: Trauma-Informed Treatment and Why It Matters. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, June 9, 2006.

Speaker: Firesetting: A Burning Issue. Sixth Annual International Association of Forensic Mental Health Services, Amsterdam, Netherlands, June 16, 2006.

Speaker: Hearing Their Voices: A Resident's First Psychotherapy Case Three Decades Later. University of Vermont College of Medicine, Department of Psychiatry Grand Rounds, January 19, 2007.

Speaker: Soft Voices Can Speak Loudly: Listening to Psychiatric Patients to Avoid Adverse and Costly Outcomes. Mental Health in Development, World Psychiatric Association, Nairobi, Kenya, March 21, 2007.

Speaker: Faux Refusal and Pseudo Cooperation: Clinical Quagmires of Addressing Consent, Assent, Cooperation and Refusal. When, When Not and Why. University of Iowa/Carver College of Medicine/Iowa Psychiatric Society, Ames, Iowa, April 21, 2007.

Speaker: Conceptualizing Access to Psychiatric Care: DOD and VA. APA Annual Meeting, San Diego, CA, May 21, 2007.

Conference Director: Understanding and Treating the Dual Diagnoses of Chronic Mental Illness and Substance Abuse. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, June 1, 2007.

Speaker: Assisted Outpatient Treatment: A Psychiatrist's Perspective. National Alliance on Mental Illness Annual Meeting, San Diego, CA, June 22, 2007.

Speaker: Who Do You Work For? The Ethics of Agency. Grand Rounds, UT Southwestern Medical Center, Dallas, TX, January 30, 2008.

Speaker: The State Mental Health Authority's Role Before and After a Tragedy Involving Individuals with Mental Illness. What Role Do We Have? 161st APA Annual Meeting, Washington, DC, May 6, 2008.

Speaker: Keynote Address: Pyromania: A Hot Diagnosis Looking for its Fire. 2nd Annual Northeast Juvenile Firesetting Conference. Worcester, MA, May 9, 2008.

Speaker: History of State Hospitals. Midwestern Association of State Mental Health Organizations. Indianapolis, IN, May 22, 2008.

Conference Director: Rehabilitations and Recoveries. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, June 6, 2008.

Discussant: The Insanity Offense: How America's Failure to Treat the Seriously Mentally Ill Endangers Its Citizens (E. Fuller Torrey, M.D.). American Enterprise Institute for Public Policy Research, Washington, D.C., June 9, 2008.

Speaker: Where Is the State Hospital Today and How Did It Get There? Conference in celebration of the new Greystone Park Hospital: Wellness and Recovery in the New State Hospital: Clinical Challenges & Opportunities. Greystone Park, NJ, June 26, 2008.

Speaker: Worcester State Hospital in the Context of the History of American State Hospitals. American Psychology Association Annual Meeting, Boston, MA, August 16, 2008.

Speaker: Sending Patients to the Community vs. Community Integration – Lessons Learned from the U.S. W.H.O. Meeting: Mental Health Talks, Tirana, Albania, September 19, 2008.

Speaker: When Community Services Replace State Hospitals: Practical Tips and Typical Pitfalls. World Health Organization, Tirana, Albania, September 20, 2008.

Speaker: Pyromania: A Hot Diagnosis Looking for Its Fire. Grand Rounds, SUNY Downstate Medical Center, Brooklyn, NY, September 24, 2008.

Speaker: CRIPA and the Contemporary State Hospital. Northeastern Regional State Psychiatric Hospital Association (includes DE, NJ, NY, PA). Greystone Park, N.J., October 29, 2008.

Speaker, with Batool Kazim, M.D.: Psychological Challenges in New Immigrant Families – Role of Culture and Traditions. Al-Hamra Academy, Shrewsbury, MA, November 16, 2008.

Speaker: How Did So Many People with Mental Illness Get into My ED? South Carolina Hospital Association, Columbia, SC, March 4, 2009.

Panelist: How to Get Persons with Serious Mental Illness in the ED Out of the ED. South Carolina Hospital Association, Columbia, SC, March 4, 2009.

Speaker with Carrie Sacco, RN: The Psychiatrist and Nurse Partnership at the CMHC. All Ohio Conference on Community Mental Health, Cleveland, OH, March 21, 2009.

Speaker: Transitional Age Youth: What's to be Done? 39th National Council Conference, San Antonio, TX, April 7, 2009.

Speaker: Deinstitutionalization in the Past 40 Years in the U.S.A. 1st International Conference on Organization of Psychiatric Care, Prague, Czech Republic, April 20, 2009.

Conference Director: Health & Wellness for Persons with Serious Mental Illness: Challenges & Opportunities. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, June 17, 2009.

Speaker: Psychiatric Hospitals: Use, Misuse, Overuse. Bite the Bullet, Michigan State Bar, Elder Law Section, Traverse City MI, September 23, 2009.

Speaker: Support and Supervision to the Primary Health Care from the Specialized Services. National Conference by WHO, Albanian Ministry of Health and Tirana University, Tirana, Albania, October 7, 2009.

Speaker: Standards of Mental Health Care. National Conference by WHO, Albanian Ministry of Health and Tirana University, Tirana, Albania, October 8, 2009.

Speaker: Individualized Psychiatric Treatment and Rehabilitation at a Contemporary Psychiatric Hospital. Federal Neuro-Psychiatric Hospital – Yaba, Lagos, Nigeria, October 19, 2009.

Speaker: Are We Losing the Person in the Patient? World Psychiatric Association Regional Meeting, Abuja, Nigeria, October 22, 2009.

Speaker: Do We Need Long-Term Psychiatric Beds? World Psychiatric Association Regional Meeting, Abuja, Nigeria, October 23, 2009.

Course: Inpatient Practice of Psychiatry. World Health Organization and Tirana University. Vlora, Albania. April 12-14 and April 15-17, 2010.

Speaker: A New Era (Not Error) for Mental Health Services: Working Together Now in the Community. NAMI Roanoke Valley. Salem, Virginia, April 29, 2010.

Speaker: Virginia's Mental Health System: Past, Present, and Future. NAMI Roanoke Valley. Salem, Virginia, April 29, 2010.

Moderator and Discussant: The Tattered Safety Net: The Public Mental Health Crisis in an Economic Recession. American Psychiatric Association Annual Meeting, New Orleans, LA, May 25, 2010.

Conference Director: Young Adults in the Extended Mental Health Systems of Massachusetts in the 21st Century. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, June 16, 2010.

Speaker: Keynote Address: Understanding Long Term Illness. Mental Health and Long Term Illness: The Need for Continued and Integrated Care. Ministry of Health, Tirana, Albania, October 11, 2010.

Speaker: An Integrated System of Mental Health Care: Inpatient and Outpatient Services Towards Continuity of Care. Mental Health and Long Term Illness: The Need for Continued and Integrated Care. Ministry of Health, Tirana, Albania, October 11, 2010.

Speaker: Management of Psychiatric Emergencies. Mental Health and Long Term Illness: The Need for Continued and Integrated Care. Ministry of Health, Tirana, Albania, October 11, 2010.

Speaker: Peer Review Activities in Albania: Feasibility and Prevalence. Mental Health and Long Term Illness: The Need for Continued and Integrated Care. Ministry of Health, Tirana, Albania, October 12, 2010.

Speaker: Integration of psychiatry to achieve awareness and prevention. 18th International Conference of Pakistan Psychiatric Society, Islamabad Pakistan, December 18, 2010.

Workshop with Dr. Batool Kazim: Do You Hear Me? 18th International Conference of Pakistan Psychiatric Society, Islamabad Pakistan, December 19, 2010.

Speaker: Effective Psychiatric Treatment in the Context of Limited Resources. 18th International Conference of Pakistan Psychiatric Society, Islamabad Pakistan, December 19, 2010.

Workshop Leader: For Residents at Makerere College of Health Sciences/School of Medicine, Department of Psychiatry, Kampala, Uganda, February 10, 2011.

Discussant: More Than a Med Check: Making the Most of 15 Minutes. Western Psychiatric Institute and Clinic, WebEx meeting, March 3, 2011.

Conference Director: Using Mindfulness for Improving Care of Patients with Serious Mental Illness and Clinicians' Self-Care. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, June 15, 2011.

Speaker: Understanding Psychotropic Medication: Uses and Misuses. Changes and Choices, Elder Law & Disability Rights Section, State Bar of Michigan, Crystal Mountain, MI, September 21, 2011.

Panelist: Olmstead: What Does Least Restrictive Setting Really Mean? Changes and Choices, Elder Law & Disability Rights Section, State Bar of Michigan, Crystal Mountain, MI, September 22, 2011.

Speaker: Why Medical Students Interested in Psychiatry Should Understand the Last 200 Years in American Health Policy for Persons with Serious Mental Illness. PsychSIGN California Conference, San Francisco, October 29, 2011.

Chair and Discussant: There Is No Such Thing as a "Med Check." 63rd Institute of Psychiatric Services, San Francisco, CA, October 30, 2011.

Speaker: Understanding Pathological Firesetting in Community Settings. Center for Human Development, Springfield, MA, February 22, 2012.

Co-Presenter with Hunter McQuistion, Jacqueline Feldman, James Pierce. Person-Centered Planning and Shared Decision Making. American Association of Community Psychiatrists Winter Meeting, Phoenix, AZ, March 2, 2012.

Co- Presenter with Brian Stettin. Assisted Outpatient Treatment. American Association of Community Psychiatrists Winter Meeting, Phoenix, AZ, March 2, 2012.

Speaker: "Challenges in Delivering Mental Health Care: Then and Now. Challenges to Cure and Care, New Jersey Psychiatric Association, Iselin, NJ, March 31, 2012.

Symposium Chair and Discussant: "There Is No Such Thing as a 'Med Check." 165th APA Annual Meeting, Philadelphia, PA, May 8, 2012.

Speaker: Keynote Address: Southwestern Virginia Mental Health Institute in the Context of the Development of Public Psychiatry in Virginia and the Nation, 1768 to 2012. 125th Anniversary of the founding of Southwestern Virginia Mental Health Institute, Marion VA, May 18, 2012.

Conference Director: Moving to a Recovery-Based, Patient-Centered System of Care. . 28th Annual Public Sector Psychiatry Conference, University of Massachusetts Medical School, Worcester, MA, June 13, 2012.

Speaker: A Brief History of Recovery. Moving to a Recovery-Based, Patient-Centered System of Care. , 28th Annual Public Sector Psychiatry Conference, University of Massachusetts Medical School, Worcester, MA, June 13, 2012.

Speaker: Shared Decision Making as the Future of Psychiatry. The 21st Century Approach to Mental Health. The Seventh World Congress on the Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders, Perth, Australia, October 18, 2012.

Speaker: Prevention and Persons with Chronic Mental Illness: Are You Listening? The Seventh World Conference for the Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders. The Carter Center, World Federation for Mental Health and Clifford Beers Foundation. Perth, Australia, October 19, 2012.

Speaker: Listening to Preventing Fire-setting by Persons with Mental Illness: The World's Most Dangerous Behavior. The Seventh World Conference for the Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders. The Carter Center, World Federation for Mental Health and Clifford Beers Foundation. Perth, Australia, October 19, 2012.

Speaker: From Worcester Lunatic Asylum to Worcester Recovery Center and Hospital: 178 years and 29 weeks. First Grand Rounds at Worcester Recovery Center and Hospital, Worcester MA, November 13, 2012.

Speaker: Recovery-Based Care. NAMI of Florida Annual Meeting. Sarasota, FL, December 9, 2012.

Plenary Address: Talking to Psychotic Patients – A Necessary Skill for the Practicing Psychiatrist. 19th International Conference of the Pakistan Psychiatric Society with World Psychiatric Association Co-sponsorship. Islamabad, Pakistan, December 28, 2012.

Workshop: Improving Psychiatric Treatment in Afghanistan. 19th International Conference of the Pakistan Psychiatric Society with World Psychiatric Association Co-sponsorship. Islamabad, Pakistan, December 30, 2012.

Speaker: Advance Directives. Center Street Health Center, Somerville, MA, March 27, 2013.

Conference Director: Mitigating the Risk of….,. 29th Annual Public Sector Psychiatry Conference, University of Massachusetts Medical School, Worcester, MA, June 19 2013.

Speaker: Mitigating the Risks of Murder-Suicide. Public Sector Division, University of Massachusetts Medical School, Worcester, MA, June 19 2013.

Co-presenter with Brian Stettin, JD: The Medical Model Matters. 2013 NAMI National Conference. San Antonio, TX, June 29, 2013.

Co-presenter with Rita Larranaga: Casa del Parana and the Future of Clubhouses in Argentina. 2013 World Mental Health Congress of the World Federation for Mental Health. Buenos Aires, Argentina, August 27, 2013.

Co-presenter with Carol Caruso and Joseph Rogers: Advocacy: Can We Work Together for Change? 65th Institute on Psychiatric Services, American Psychiatric Association, Philadelphia, PA, October 10, 2013.

Plenary Speaker: Trends in Mental health Services that Can Positively Impact the Scope and Effectiveness of CIT. CIT International Conference, Hartford, CT, October 15, 2013.

Conference Director: Healing Environments. . 30th Annual Public Sector Psychiatry Conference , University of Massachusetts Medical School, Worcester, MA, June 18 2014.

Speaker: What is schizophrenia? International Congress of the World Federation for Mental Health & the Hellenic Psychiatric Association. Athens, Greece, October 10, 2014.

Speaker: What is Chronic about Chronic Mental Illness? Board of Directors of Clubhouse International. New York, New York, October 23, 2014.

Plenary Speaker with Melissa Harris, Randy Loss, Andrew Sperling & Jane Plapinger: Perspectives and Advice from our National Partners. USA National Clubhouse Conference, Silver Spring, MD, November 13, 2014.

Moderator and Speaker: Medicaid and Clubhouse. . USA National Clubhouse Conference, Silver Spring, MD, November 13, 2014.

Co-chair, Scientific Program Committee. . Mental Health for All, Connecting People and Sharing Experience. World Federation for Mental Health. Lille, France, April 28-April 30, 2015.

Co-presenter with Michael Flaum and Ken Thompson: The evolution of psychiatry in the US over the past 50 years: from institutionalization to integration and recovery. Mental Health for All. World Federation for Mental Health. Lille, France, April 29, 2015.

Co-presenter with Esko Hänni, Imran Haider, AAfzal Javed and Wander Reitsma. Activating use of psychosocial rehabilitation innovations. . Mental Health for All. World Federation for Mental Health. Lille, France, April 29, 2015.

Speaker: When is Involuntary Treatment Necessary in an Integrated System of Care?. Mental Health for All. World Federation for Mental Health. Lille, France, April 29, 2015.

Speaker: Mental Health: the American Perspective. Mental Health for All. World Federation for Mental Health. Lille, France, April 30, 2015.

Speaker: When a State Has No County Psychiatric Services. 168 Annual Meeting of the American Psychiatric Association. Toronto, CA. May 17, 2015.

Conference Director: Families' Roles in Mental Illness: Response & Resilience in Rehabilitation and Recovery. 31st Annual Public Sector Psychiatry Conference, University of Massachusetts Medical School, Worcester, MA, June 17 2015.

Speaker: World Dignity Project. 31st Annual Public Sector Psychiatry Conference, University of Massachusetts Medical School, Worcester, MA, June 17 2015.

Panelist: Pushing the Boundaries and Healing Hearts: The Shifting Roles of the 21st Century Psychiatrist. Institute on Psychiatric Services, New York, NY, October 10, 2015.

Speaker: The Role of the Hospital in the Care of Persons with Mental Illness in the 21st Century. 20th World Congress of the World Federation for Mental Health. Cairo, Egypt, October 19, 2015.

Conference Director: Where Mental Illness and Violence Intersect. 32nd Annual Public Sector Psychiatry Conference, University of Massachusetts Medical School, Worcester, MA, June 14 2016.

Co-Chair, Scientific Program Committee, Moving Toward a Mentally Healthy Community, World Federation for Mental Health, Cairns, Australia, October 17-19, 2016.

Speaker, with Carolyn Sacco, RN: Writing for the public. World Federation for Mental Health, Cairns, Australia, October 18, 2016.

Speaker: Depression, Suicide and Danger to Others. World Federation for Mental Health, Cairns, Australia, October 18, 2016.

Grand Rounds Speaker: Not Enough Money and Even Less Sense: No One in Psychiatry Is Immune. UT Southwestern, Dallas, TX, January 11, 2017.
Grand Rounds Speaker: Mitigating the Risks of Murder-Suicide. Medical University of South Carolina, Charleston, SC, April 21, 2017

Conference Director: Communicating With and About Persons with Mental Illness: The Tried-and-True and the New. . 33rd Annual Public Sector Psychiatry Conference, University of Massachusetts Medical School, Worcester, MA, June 13, 2017.

Speaker: Stigma: A Major Interference in Communication With and Amongst Persons with Serious Mental Illness. 33rd Annual Public Sector Psychiatry Conference, University of Massachusetts Medical School, Worcester, MA, June 13, 2017

Speaker with Dominic Sisti, PhD and Emanuel Trujillo, MD: Bring Back the Asylum? Manhattan Institute, New York City, May 8, 2018.

Speaker: From 19th Century Public Psychiatric Hospital Farms to 21st Clubhouses: Work Works. First Annual Dr. Ron Brown Memorial Grand Rounds, Jewish General Hospital/McGill Medical School, Montreal, Quebec, October 4, 2018.

Panelist: After Rikers: Course Change for people with Serious Mental Illness. Greenburger Center for Social and Crminal Justice. New York City, March 25, 2019.

Geller JL: Too Few Dollars and Even Less Sense: How the Economic Development of Psychiatry 1844-1944 Affects Us Now. . American Psychiatric Association Annual Meeting, San Francisco, CA , May 19, 2019.

Geller JL: A Rational, Reliable, Remission-focused, Reasonably Reimbursed, Readily Accessible Mental Health Care System. 8th Annual Psychiatric Society of Delaware Symposium, Newark, DE, September 21, 2019.

Geller JL: Discussant, The Mental Health Crisis in America: Recognizing Problems, Working Toward Solutions. Austen Riggs Center, Stockbridge, MA September 22, 2019.

Geller JL: Fixing a Frankly Feckless Mental Health System . North Dakota Psychiatric Society, Fargo, ND, November 2, 2019.

Geller JL: Hamilton Ford Lecture: The First 100 Years of America's Psychiatric Hospitals and How We Still Live the Legacy. Titus Harris Society, Galveston TX, January 25, 2020.

ATTACHMENT 2

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CVH Documents:

- Mask Protocol KN95 Memo
- COVID-19 Cohorting Memo
- COVID-19 Cohort Protocol 05140
- Points to Remember COVID-19
- Staff screening memo 5/12/2020
- COVID-19 Status Update Memo
- Manager Responsibilities for Transferring COVID-19 Patient 050420
- COVID-19 Required Policy Changes 042720
- Protective Mask protocol 042720
- N95 Respirator Replacement Protocol 042520 v1
- Patient Cloth Mask Protocol 042120 v3
- Cloth Masks Memo
- N95 Respirator Fit Testing Protocol Memo 041920 V4
- N95 Respirator Fit Testing Protocol Memo
- Protocol for Ordering of PPE for Units 041620
- DMHAS-CVH Protocols for COVID Q and I 4-12-20
- Patient Testing Protocol 4.14.20
- CVH Staff Screening Protocol.rev 4.13.20
- CVH PPE Protocol V4

Admissions and Discharge:

- Pending litigation admissions, information

- WFH discharges during COVID pandemic

Whiting Documents:

- Whiting Treatment Mail EOC Risk Assessment and Preparation for Use as Isolation Area New 4-9-20
- WFH Transfer-Return from Community Hospital and Transfer to Whiting Isolation Area New 4-3-20
- WFH Screening Tool Guide rev 3-29-20
- WFH Screening Protocol rev 3-29-20
- ZIX: FW:ZIX: PT COVID complaints - Email to Deborah Moore
    - Email Attachment 1 – COVID Sylvia F. Log

      Email Attachment 2 – 20 08 05 Alleged that a doctor continues to retaliate against him
    - Email Attachment 3 – 20 09 04 Patient alleged that staff aren't social distancing and are not wearing PPE
    - Email Attachment 4 – 20 29 03 Forced to take Elevator BS
    - Email Attachment 5 – 20 30 03 Eating on Unit
    - Email Attachment 6 – 20 31 03 Alleged that a Doctor retaliated against him
    - Email Attachment 7 – 2020.05.11 Gail Litsky MHA not wearing a mask – Copy
- WFH Screening Protocol rev 3-29-20
- WFH Guidance on Management Meeting on Suspected and Confirmed COVID19 in Patients and Staff 5-4-20
- WFH Guidance on Management Meeting on Suspected and Confirmed COVID19 in Patients and Staff 4-13-20
- WFH Guidance on Management Meeting on Suspected and Confirmed COVID19 in Patients and Staff 4-2-20

- WFH Guidance on Management Meeting on Suspected and Confirmed COVID19 in Patients and Staff 4-13-20
- WFH Guidance on Management Meeting on Suspected and Confirmed COVID19 in Patient…
- WFH Front Door Screening rev 4-8-20
- WFH Coronavirus Pandemic Incident Action Plan rev 3-26-20
- Staff Self-Monitoring Guide 3-20-20
- Procedure for N95 Respiratory Fit Test Tracking new 4-3-20
- Isolation Unit Environmental Safety Check 3-30-20
- Instructions for PPE Re-use 4-2-20
- Instructions for PPE Re-use 4-1-20
- HHC Guidelines for Ordering COVID19 Testing 3-26-20
- HHC Testing COVID19 DMHAS 3-26-20
- Gymnasium EOC Risk Assessment 3-30-20
- GymISOlayout
- Fit Kit Manual
- Donna-Doffing PPE in the Isolation Units Instructions – Poster 4-30-20
- DMHAS Protocol for Patients Exposed to COVID Positive Case 4-10-20
- CT DPH COVID Report Form
- COVID-19 Uniform Screening Tool revised 4-9-2020
- Covid19 Patient Use of Face Masks protocol 4-23-20
- Appendix H revised 5-4-20 updated
- Appendix H revised 4-15-20 updated

- Appendix H revised 4-9-20 updated
- Appendix H revised 4-1-20 updated
- Appendix H Patient Isolation protocol revised 4-16-20
- Acknowledgment Re: Use of Personal Masks 3-27-20 FINAL
- 2-WFH-COVID-19 ICS 214 Continuation
- 1-WFH-COVID-19 ICS-214
- WFH Screening Protocol rev 3-29-20
- WFH Screening Tool Guide rev 3-29-20
- WFH Transfer–Return from Community Hospital and Transfer to Whiting Isolation Area 4-3-20
- Whiting Treatment Mall EOC Risk Assessment and Preparation for Use as Isolation Area new 4-9-20
- 1 WFH COVID-19 ICS 214
- Dr. Wasser Notes re injunction
- King, Rehab PSRB July 2018 FINAL
- Litsky, Gail PSRB OCT 2019 FINAL
- Mueller.PSRB.11.19
- Clark, F. CR-JP-3, LH JG Rev 1-30-20 NC-NR
- Ardizzone PSRB.December 2019

Other Documents

- DMHAS supportive housing list
- Resource Guide update 7-13
- COVID Commissioner Order on Visitors Memo to Staff PNP Providers 5-12-20

- WFH Task Force Presentation by Hal Smith and Tobias Wasser June 17, 2019
- 5-26-20 Final Revised WFH Coronavirus Pandemic Incident Action Plan
- 17-6019 MDSX Hospital
- 17-6019-01 MDSX Hospital executed
- 17-6019-02 Executed
- Annual Report SFY2019
- Community Integration & Discharge from CVH
- CT Valley Hospital & Whiting Forensic Hospital Staff Educational & Training Presentation November 21, 2019
- CVH & Whiting Forensic Procedure manual, Community Integration & Discharge, June 11, 2015
- CVH Whiting Task Force presentation by Charles Dike and Vinneth Carvalho September 16, 2019
- DMHAS Commissioners Policy Statement of DMHAS Client Rights Policy,

  January 3, 2019
- DPH COVID-19 Guidance-for-Long-Term-Care-Facilities March 26, 2020
- Evolution of Forensic Services in CT IRCC presentation
- WFH Operational Procedural Manual on Community Integration & Discharge

  June 18, 2018
- Coronavirus CT: Deaths, Cases For All Elder Care, Nursing Homes.

  https://patch.com/connecticut/across-ct/coronavirus-ct-deaths-cases-all-elder-care-nursing-homes-2 (last visited June 20, 2020).

Guidance Relied Upon by CVH and Whiting:

- CDC and other Guidances CVH/Whiting Using

Plaintiff's Treatment Notes:

- CM Treatment plan
- VA Treatment plan
- GL Treatment plan
- TW Notes
- CLRP Suit BF 04-08-20 notes

Pleadings:

- Wilkes preliminary Injunction memo of law
- Wilkes Motion for preliminary injunction
- Exhibit 1 – Declaration of Dr. Farrin A. Manian, MD, MPH
- Exhibit 2 – Declaration of Dr. Patrick Canavan and Elizabeth Jones
- Exhibit 3 – Affidavit of Carson Mueller 052420
- Exhibit 4 – Affidavit of Vincent Ardizzone
- Exhibit 5 – Affidavit of Gail Litsky 052320
- Exhibit 6 – Affidavit of Francis Clarke 052320
- Exhibit 7 – Affidavit of Rehab King 052420
- Exhibit 8 – Affidavit of Richard Gudis
- Exhibit 9 – COVID-19 Guidance for Long Term Care facilities 32620
- Exhibit 10 – Nursing Home Reopening Recommendations for State and Local Officials 051820
- Exhibit 11 – How to Protect Yourself and Others
- Exhibit 12 – Key Strategies to Prepare COVID 19 in Long-Term-Care Facilities
- Exhibit 13 – Preparing COVID19 in Nursing Homes 051920
- Exhibit 14 – Responding to COVID 19 in Nursing Homes 050920

- Exhibit 15 – Testing Guidance for Nursing Homes 051920
- Exhibit 16 – Performing Facility-wide SARS – coV2-Testing in Nursing Homes

  05-19-20
- Exhibit 17 – Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID 19
- Exhibit 18 – Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic 032020 Rev 050720

<u>Root Cause Analyses of COVID-Deaths</u>

SV 4/29/20

RR 5/14/20

JJ 5/20/2020

TF 5/21/2020

CM 5/27/2020

<u>Interviews</u>

Vinneth Carvalho, MD, Medical Director, CVH, 6/23/2020, 12:30 pm – 1:50 pm

Tobias Wasser, MD, Medical Director, WFH, 6/25/2020, 2:30pm – 4:00 pm

Timothy Denier, Director of Accreditation & Regulatory Compliance, CVH, 6/26/2020

Nancy Navaretta, Deputy Commissioner, DMHAS, 4:00 – 4:45 pm

Simie Rosenthal-Whalen, Director of Admissions at DMHAS, 5:00 – 5:25 pm

<u>Tours</u>

CVH 6/26/2020 1:00 pm – 2:38 pm

WFH 6/25/2020 concurrent with interview

EXHIBIT B

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs* v. NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, In their official capacities, *Defendants*	:	CIVIL NO. 3:20CV594-JCH JULY 9, 2020

DECLARATION RICHARD MARTINELLO, MD

The undersigned declarant, Richard Martinello, MD, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am a medical doctor, and I am board certified in adult infectious diseases by the American Board of Internal Medicine and pediatric infectious diseases by the American Board of Pediatrics. I received my medical degree from Loyola University Chicago, Stritch School of Medicine. I completed my residency in internal medicine and pediatrics at the Indiana University School of Medicine. I completed my adult and pediatric infectious diseases fellowships at the Yale School of Medicine and a fellowship in healthcare epidemiology at Yale New Haven Hospital. I am licensed in

the state of Connecticut. I have 17 years of experience as a physician working in infectious diseases, infection prevention and public health. My current CV is attached as Attachment 1.

2. I currently serve as the Medical Director, Infection Prevention at Yale New Haven Hospital and Yale New Haven Health System. I am an Associate Professor, Departments of Internal Medicine and Pediatrics, Infectious Diseases at Yale School of Medicine.
3. In preparing this declaration, I relied upon the documents and sources of information set forth in the attached list, attached hereto as Attachment 2.
4. I understand that this declaration will be submitted to this Court in connection with the above-captioned case in support of the Defendants' Opposition to the Plaintiffs' Motion for Preliminary Injunction.

Background Regarding COVID-19-19

5. The COVID-19 pandemic, due to the virus SARS-CoV-2, has and continues to lead to extraordinary challenges for the all aspects of healthcare. Congregate settings of care such as nursing facilities and residential mental health facilities and the patients they care for have specifically borne a substantial burden. Patients/residents residing in these facilities are at such great risk because; 1) the high frequency of the presence of risk factors placing these residents at risks for more severe disease due to SARS-CoV-2, 2) the facilities are designed to encourage and support social interaction rather than social distancing and 3) routine practices among staff and patients alike favor such social interaction. Across the US to date, according to a report by the New York Times, 43% of all deaths due to COVID-19 occurred among residents of

nursing facilities.[1] The residents of nursing facilities in Connecticut have also experienced a substantial impact from COVID-19.[2] Patients residing in other congregant settings such as prisons and psychiatric facilities have too been heavily impacted by COVID-19.[3,4]

6. To prevent such devastating impact of a highly transmissible respiratory pathogen such as SARS-CoV-2 requires focused, disciplined effort to plan, execute and sustain the management of efforts to prevent spread of the pathogen. Such planning must occur both before a pandemic presents and then plans must be rapidly adapted as the realities of the pandemic become known. Facilities must be agile and quickly adapt their response as new information and guidance becomes available. This adaptation requires careful attention to guidance from public health authorities such as the Connecticut Department of Public Health and the Centers for Disease Control and Prevention, other federal government authorities such as SAMSHA and well respected national professional organizations such as the Infectious Diseases Society of America (IDSA), and other organizations.

7. While the exact mechanism(s) which allows SARS-CoV-2 to be readily spread from person to person remains incompletely known, it is strongly suspected that respiratory droplets are primarily responsible. Respiratory droplets are produced not only when persons cough or sneeze, but also during talking and even just breathing.[5] There has

[1] *New York Times*. "43% of U.S. Coronavirus Deaths Are Linked to Nursing Homes" https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html
[2] https://data.ct.gov/Health-and-Human-Services/Nursing-Homes-with-Residents-Positive-for-COVID-19-19/wyn3-qphu
[3] Ramgopal K. Coronavirus in a Psychiatric Hospital: 'It's the worst of all worlds'. NBC News. April 17, 2020.
[4] NPR. "'Shocking, Heartbreaking' Coronavirus Outbreak In Calif. Prison Alarms Health Experts" https://www.npr.org/2020/06/27/884149444/shocking-heartbreaking-coronavirus-outbreak-in-ca-prison-alarms-health-officials
[5] https://www.liebertpub.com/doi/abs/10.1089/jamp.2008.0720

been particular concern with SARS-COV-2 that singing may be especially risky for the spread of SARS-CoV-2.[6] It has been estimated that without the application of interventions to prevent spread of SARS-CoV-2, each person with COVID-19 typically spreads the infection to over 2 other persons.[7] When any infection spreads to more than 1 person on average, an outbreak is possible. With the application of public health measures such as social distancing, the use of personal protective equipment, hand washing and the separation of those sick and those who remain healthy, the transmission of an infectious disease can be controlled, and the impact of an outbreak limited. In the state of Connecticut, the peak of the pandemic thus far to date occurred in mid-April.[8]

Background Regarding COVID-19-19 at Whiting Forensic Hospital and Connecticut Valley Hospital

8. At the Connecticut Valley Hospital (CVH), the peak incidence of COVID-19 affecting their patient population occurred in mid-May. At the height of its impact, 10% of CVH's patient population was found positive for COVID-19 and the peak coincided with the pattern of COVID-19 identified among CVH GPD & ASD staff. CVH employs approximately 1100 staff. The peak of staff illness with COVID-19 occurred on May 7th, 2020 when 39 staff were known to be positive for COVID-19. No additional COVID-19 infections were identified during the month of June 2020.
9. At the Whiting Forensic Hospital (WFH) the pattern of COVID-19 among patients differed somewhat from CVH with the presence of 3 small peaks. The first peak of

[6] Hamner L, Dubbel P, Capron I, et al. High SARS-CoV-2 Attack Rate Following Exposure at a Choir Practice — Skagit County, Washington, March 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:606–610. http://dx.doi.org/10.15585/mmwr.mm6919e6external icon
[7] https://doi.org/10.1016/j.ijid.2020.02.033
[8] https://data.ct.gov/stories/s/COVID-19-19-data/wa3g-tfvc/

COVID-19 occurred the first week of April when a maximum of 6 patients were affected by COVID-19. A second peak occurred the last week of April when 3 patients were with COVID-19 and a third peak occurred with 2 patients positive for COVID-19 during the final week of May 2020. The last symptomatic patient with COVID-19 at WFH was identified on April 21, 2020 and the last asymptomatic patients found positive for COVID-19 were diagnosed May 19, 2020 as part of a mass testing effort. (Prior to May 19th, there was only capacity to test symptomatic patients. Among 30 symptomatic patients tested before May 19th, 2020, 10 were found positive.) This mass testing effort was voluntary for patients and 110 out of the 185 patients who had been at WFH for more than 14 days participated. Two of these 110 patients tested were found positive for COVID-19 and these 2 were previously known to have had COVID-19 so it was likely that these positive tests represented continued presence of SARS-CoV-2 genetic material rather than being new infections or suggesting that these 2 residents were contagious.[9,10,11,12] WFH also put forth a significant effort to have staff voluntarily be tested. By June 4, 2020, 203 staff were tested and starting June 15, 2020, staff were encouraged to get tested again. That week alone, showed 128 staff being tested for COVID-19.

10. Overall, during the first wave of the pandemic, WFH had a patient population of 213 patients. By June 1, 2020, 36 patients were moved from WFH leaving 177 patients. The peaks of COVID-19 among WFH staff coincided with the peaks of patients with COIVD. The second peak impacted the greatest number of staff and on April 27,

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[9] https://www.nejm.org/doi/full/10.1056/NEJMoa2008457
[10] https://www.nature.com/articles/s41586-020-2196-x
[11] https://academic.oup.com/cid/article/doi/10.1093/cid/ciaa638/5842165
[12] https://www.cdc.go.kr/board/board.es?mid=a30402000000&bid=0030&act=view&list_no=367267&nPage=1

2020, 13 WFH staff were out due to COIVD. During the month of June 2020, no additional COVID-19 infections were identified among patients though a few staff were newly ill due to COVID-19. WFH employs a total of 580 staff.

CVH and WFH Efforts to Prevent and Control COVID-19
Administrative – development and implementation of policies and procedures

11. CVH and WFH implemented a policy requiring patients to be segregated to different hospital units based upon their disease status. Three areas were developed; 1) patients testing positive for COVID-19, 2) patients testing negative for COVID-19 but who were known to be exposed and 3) patients were negative and not exposed. This plan is in alignment with recommendations from the CDC and Connecticut Department of Public Health. "Special Observation" isolation units were created to continue to provide the necessary mental health care needed by the patients in a manner minimizing the risk for the spread of COVID-19. This effort included the option for telehealth evaluation of the patient, the use of single rooms, direct observation from outside of a room by window or by electronic monitoring rather than requiring in-room direct observation for patients with this need. These units were under negative pressure to protect the rest of the facility and also provided the additional surge capacity needed to care for the patient population. At WFH, the isolation unit contains a dedicated bathroom and dining area.
12. Patients exposed to COVID-19 but who tested negative were cared for in an isolation area for 14 days to ensure they were not contagious before being moved back into the general CVH population. Fourteen days was chosen rather than the 10 days recommended by the CDC to provide an additional degree of protection for the rest of the resident population.

13. CVH makes every attempt to deploy staff to the same unit to minimize the number of staff residents potentially contact.

14. DMHAS implemented a screening protocol for all incoming patients, employees and visitors entering DMHAS buildings. The May 17, 2020 revision of this screening procedure requires staff performing the screening to question persons about the purpose of their visit, exposure to areas of high SARS-CoV-2 transmission during the past 14 days, fever and symptoms potentially suggestive of COVID-19. Routine visitors were banned March 17, 2020, with the exception of visitors for patients at the end of life, persons overseeing or investigating care as required by law, first responders and those performing emergency repairs. DMHAS frequently updates the screening protocol to reflect the most up to date guidance from the CDC.

Infection Prevention Program

15. The CVH Infection Prevention Program has developed a procedure for the containment and prevention of spread of SARS-CoV-2 within the institution. The purpose of this plan, dated March 23, 2020, is to protect staff and patients from COVID-19. It requires staff working directly with patients known or suspected of COVID-19 to complete a training ensuring knowledge of interventions to prevent the transmission of COVID-19 and institutional policy. The plan further notes which rooms in which patients known or suspected to have COVID-19 are to reside and how Nursing assignments are to be clustered to minimize the situation where Nursing staff are caring for both COVID-19 and non-COVID-19 patients and to minimize the staff potentially exposed to contagious patients. Additional actions focused on minimizing the risk for exposure to COVID-19 include; use of facemasks by patients, taking

meals in rooms, scheduling the use of the bathroom, and ensuring PPE is available and monitoring its use. The plan is divided into stages based upon the number of COVID-19 positive or suspected patients and the capacity of CVH to isolate these patients. Care is taken to isolate patients suspected of COVID-19 from those known to be infected.

16. WFH developed and implemented its "Coronavirus Pandemic Incident Action Plan" on March 26, 2020, and this plan was revised May 26, 2020. This plan clearly delineates actions, responsibilities and goals for specific phases of the pandemic. This plan is designed to be complimentary to WFH's Emergency Operations Plan. Within this Action Pan are detailed guides for Quarantine, including the management of PUI and persons with COVID-19 and contacts of persons known or suspected to have COVID-19.

17. The document also contains directions for the screening of patients and staff for signs and symptoms of COVID-19. Staff are directed to self-screen for these signs and symptoms prior to each shift. Also, staff are directed that if they develop signs or symptoms of an illness concerning for COVID-19 while at work, they should immediately speak with their supervisor, leave the premises and remain offsite for a 14-day period.

18. Appendix H outlines the plans for segregating patients. In brief, patients suspected of COVID-19 are to be cared for in private isolation rooms on the unit. Patients found positive for COVID-19 are to also be cared for in such isolation rooms. WFH developed an isolation ward to accommodate the care of up to 8 patients known to be positive for COIVD. If the number of COVID-19 positive patients exceed this figure,

the document delineates plans for caring for a larger number of COVID-19 positive patients in the gymnasium and Dutcher building activity center. Finally, WFH enacted changes to its visitation policy on March 10, 2020 limiting visitation in an effort to decrease the risk for introduction of COVID-19 into WFH.

19. At both CVH and WFH, contact tracing was performed when a staff member was identified with COVID-19. This contact tracing involved interviews to identify others most closely exposed to the positive staff member. Staff who were notified as being exposed were encouraged to pursue voluntary testing. These staff were only allowed to continue to work if they remained without signs or symptoms concerning for COVID-19. Staff who were asymptomatic but found positive on voluntary COVID-19 testing were sent home to self-isolate for 14 days. In order to return to work after that period the must have remained asymptomatic or, if ill, must have been afebrile and without significant respiratory symptoms for a minimum of 3 days prior to the return to work. Alternatively, they could be retested and return to work if they showed 2 negative tests obtained at least 24 hours apart.

20. At WFH, new patients presenting from the Department of Corrections or other hospitals were tested for COVID-19 prior to admission, and testing was also offered to newly hospitalized patients being admitted from the community.

Environmental Services

21. While the transmission of SARS-CoV-2 is thought to be primarily by respiratory droplets. These droplets may contaminate surfaces. Persons coming into contact with contaminated surfaces may pick up the virus on their hands and could be at risk of developing COVID-19 if their contaminated hands touch their eyes, nose or mouth. It

has been shown that the SARS-CoV-2 virus can remain infectious on a number of surface types for hours to possibly days.[13,14] Therefore, excellent environmental services is considered to be a priority for the effective prevention of the spread of COVID-19.[15]

22. To ensure optimal environmental cleaning and disinfection is performed, a number of critical elements are necessary; 1) policies and procedures outlining critical aspects of housekeeping practice, 2) training of staff and appropriate oversight and 3) the use of proper materials for cleaning and disinfection.
23. CVH's current "Environmental Services Protocol" dated April 24, 2020, clearly outlines the comprehensive expectations for housekeeping including the surfaces to be cleaned and disinfected and the products used for this work. The products selected for disinfection are appropriate and are either registered with EPA for use against SARS-CoV-2 or the EPA has noted that the active ingredients contained in the products are appropriate for use against SARS-CoV-2.[16] The CVH IP Manual is a 32-page document providing protocols and checklists directing EVS staff. This includes a detailed table directing the use of specific cleaning and disinfectant products and the frequency of cleaning and disinfection for types of rooms and specific surfaces.
24. WFH Environmental Services Department Isolation Unit policy document provides the policy and outlines the procedures and practices for housekeeping services. This document contains checklists used for maintaining occupied rooms and rooms from which patients have been discharged. The materials used for cleaning and disinfection

[13] https://www.nejm.org/doi/full/10.1056/nejmc2004973
[14] https://www.thelancet.com/action/showPdf?pii=S2666-5247%2820%2930003-3
[15] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
[16] https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-COVID-19-19

contain active ingredients recognized by the EPA for use against SARS-CoV-2. This extensive document provides direction to housekeeping staff and it is in alignment with CDC recommendations for environmental cleaning and disinfection.

Social Distancing and Personal Protective Equipment

25. A study by Chu, et al. recently published in *The Lancet* found that social distancing was likely to be a highly effective and important intervention to prevent the transmission of SARS-CoV-2.[17]
26. To support distancing between patients, CVH re-oriented the beds in double patient rooms such to maximize the distance between each resident's head- providing greater than 6 feet of distance. CVH also modified meal periods and had residents eat their meals within their rooms rather than the communal dining space. CVH also developed a bathroom schedule to stagger bathroom and shower use.
27. WFH carefully assessed their environment and while they decided to continue to use the elevator (with modifications to encourage sustained physical distances between individuals) use of the stairs were encouraged to decrease demand on the more confined elevator. WFH implemented policies regarding use of the grounds by patients in an additional effort to balance benefits while ensuring social distancing. As an example, in the WFH Max courtyard, cones were placed to divide the courtyard and use was restricted to residents from 2 units at any given time.
28. For patients with significant behavioral issues at CVH where social distancing was more challenging, these individuals were prioritized for placement in a single room.

[17] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/fulltext

29. Social distancing was also supported at CVH by their restriction of visitors, their placement of staff providing one-on-one patient observation outside of the room (observing by the window) and shifting toward individual rather than group sessions with the therapists, and smaller group sizes when group therapy was needed. Finally, some freedom of resident movement was restricted to prevent mingling in groups and exposure to residents from WFH.
30. Where possible, CVH and WFH supported telework for staff to decrease the number of persons in the building and increase the ability for those present to be physically distanced from each other.
31. While global shortages of personal protective equipment were noted globally, CVH and WFH did not run out of PPE during the months of March through June 2020. Staff received training on the use of PPE both for routine use of masks and, in addition, the use of respirators, eye protection, gloves and a gown during the care of patients known or suspected of COVID-19. Face masks were made available for all patients and staff throughout this March through June period.
32. On March 10, 2020, CVH issued guidance on the use of PPE and ensured that all necessary PPE was available, including; N95 respirators, face masks, eye protection, gloves and gowns. Staff directly caring for patients received additional training, including training in the proper donning and doffing of PPE. Educational posters and other printed material were made available to reinforce training.
33. WFH issued guidance on restricting visitors March 17, 2020, and this action remained in place through June 2020.

Testing

34. CVH and WFH began to screen all patients for signs and symptoms of COVID-19 on March 19, 2020 and began to test those suspected for COVID-19-19 by the screening.
35. CVH implemented a formal patient testing protocol by April 14, 2020 and this protocol was repeatedly revised to adapt to changes in the risk presented by COVID-19, the capacity for testing and new knowledge and guidance guiding the response to COVID-19. This protocol was most recently updated June 29, 2020 and guides staff to perform a daily assessment of each patient for signs and symptoms of COVID-19 based on the guidance from CDC. When a nurse identifies a patient with any new sign or symptoms, their concern is immediately escalated to the ACS provider or on-call physician, if after hours. The policy notes that the identification of a single new symptomatic patient, a response must occur as there may be other patients or staff infected. All of the patients and staff who have worked or resided on that unit within the past 48 hours will be considered to be exposed and will be tested. Staff and patients will then be re-tested weekly until 14 days after the exposure. If a patient refuses testing, they are placed on a persons under investigation (PUI) unit. Other patients are potentially relocated based upon the results from testing.
36. The last patient identified positive for COVID-19 at CVH was on May 16, 2020 and the last positive CVH staff was May 21, 2020. The baseline COVID-19 testing was completed for patients on May 6, 2020 and was completed for staff on May 28, 2020. For new patients refusing COVID-19 testing, they are treated as though they are positive for COVID-19 and are isolated from the patient population known not to be affected by COVID-19 for a period of 14 days. Of the 243 patients newly hospitalized while this policy was in place, only 4 (1.6%) refused testing for COVID-19. Overall,

63 of the 243 were found to have COVID-19. Staff who are symptomatic and refuse testing are assumed to be positive for COVID-19 and follow the same return to work policy as those who are lab positive for COVID-19. Asymptomatic staff who fail to volunteer for testing were allowed to continue to work and are, as with all staff, screened daily for signs, symptoms and exposure to persons with COVID-19. As of July 6, 2020, staff testing has become mandatory. Overall as of July 1, 2020 at CVH, 45 of 1095 staff have been found positive for COVID-19.

37. At WFH, as of July 1, 2020, a cumulative 10 of the 169 residents tested positive for COVID-19. As of July 1, 2020, among staff, 22 of the 522 tested positive since March 2020.

38. Contact tracing is performed when a patient or staff member is found positive for COVID-19 at both CVH and WFH. Residents who are identified as exposed to COVID-19 are encouraged to be tested are isolated for 14 days. Testing is mandatory for all direct care staff and those who regularly interact with patients.

Summary

39. An effective response to the pandemic to succeed in minimizing the spread of COVID-19 requires the development and implementation of new procedures, effective communication to ensure awareness and understanding and adequate supplies to ensure staff and patients are protected. At both CVH and WFH, their administration and staff did a remarkable job responding to the challenges of COVID-19. While residents and staff at both facilities were impacted, the proportion of patients and staff developing COVID-19 were markedly less compared with nursing facilities in the region.

40. Social distancing is considered to be a critical intervention to prevent the spread of COVID-19 and it is especially challenging to implement such distancing in a residential community where social interaction is part of the therapeutic intervention and in a facility designed to support social interaction. Further, it is a challenge to balance the tradeoff of providing potentially lifesaving supervision and care to residents severely impacted by their mental health illness versus decanting the residents from the facility in an effort to minimize those at risk and support social distancing. Although decanting residents from the facility can improve the ability to provide social distance, the residents themselves, their families and friends and potentially the public may bear a heavy burden if the subsequent care received in the community is insufficient for the resident.
41. The administrative actions have met or exceeded guidance provided by the CDC and CT DPH and these procedures and policies have been effectively implemented in due to the engagement of the staff, the communications from leadership and the frequent reinforcement through comprehensive education provided to patients and staff. In my opinion, the leadership and staff of CVH and WFH exercised excellent professional judgement and were most proactive in implementing measures to minimize the impact of COVID-19 on the residents and staff of the institutions.
42. The relatively low occurrence of COVID-19 at both CVH and WFH is the result of their highly effective response to COVID-19.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 9th day of July, 2020.

Richard Martinello, MD

ATTACHMENT 1

CURRICULUM VITAE

Date of Revision: 4/2020

Name: Richard Martinello, M.D.

Term: Primary Appointment: July 1, 2017 to June 30, 2022
Secondary Appointment: July 1, 2017 to June 30, 2022

School: Yale School of Medicine

Education:

B.S. Loyola University Chicago (Biology) 1991
M.D. Loyola University Chicago, Stritch School of Medicine 1995

Career/Academic Appointments:

1995-96 Intern, Departments of Internal Medicine and Pediatrics, Indiana University School of Medicine, Indianapolis, IN
1996-99 Resident, Departments of Internal Medicine and Pediatrics, Indiana University School of Medicine, Indianapolis, IN
1998-99 Chief Resident, Internal Medicine/Pediatrics training program, Indiana University School of Medicine, Indianapolis, IN
1999-02 Fellow, Infectious Diseases, Department of Internal Medicine, Yale School of Medicine, New Haven, CT
2000-03 Fellow, Infectious Diseases, Department of Pediatrics, Yale School of Medicine, New Haven, CT
2002-03 William Wirt Winchester Fellow in Healthcare Epidemiology, Quality Improvement Support Services, Yale New Haven Hospital, New Haven, CT
2003-06 Clinical Instructor, Departments of Internal Medicine and Pediatrics, Infectious Diseases, Yale School of Medicine, New Haven, CT
2003-19 Staff Physician, VA Connecticut Healthcare System, West Haven, CT
2006-12 Assistant Professor, Departments of Internal Medicine and Pediatrics, Infectious Diseases, Yale School of Medicine, New Haven, CT
2012-present Associate Professor, Departments of Internal Medicine and Pediatrics, Infectious Diseases, Yale School of Medicine, New Haven, CT

Administrative Positions:

2003-12 Hospital Epidemiologist, VA Connecticut Healthcare System, West Haven, CT
2009-12 Acting Senior Medical Advisor, Office of Public Health and Environmental Hazards, Veterans Health Administration, Department of Veterans Affairs, Washington, DC
2012-15 Chief Consultant, Clinical Public Health, Office of Public Health, Veterans Health Administration, Department of Veterans Affairs, Washington, DC
2015-present Medical Director, Infection Prevention, Yale New Haven Hospital, New Haven, CT
2017-present Medical Director, Infection Prevention, Yale New Haven Health System, New Haven, CT

Board Certification:

American Board of Internal Medicine, Internal Medicine, 1999
American Board of Pediatrics, Pediatrics, 1999

American Board of Infectious Diseases, 2002
American Board of Pediatrics, Pediatric Infectious Diseases, 2005
American Board of Pediatrics, recertified, Pediatrics, 2006
American Board of Internal Medicine, recertified, Infectious Diseases, 2012
American Board of Pediatrics, recertified, Pediatric Infectious Diseases, 2015

Professional Honors & Recognition

International/National

2015: Hispanic–Serving Health Professions Schools, Certificate of Appreciation
2013: Department of Veterans Affairs, Service Award
2011: Department of Veterans Affairs, Veterans Health Administration, Under Secretary for Health, Certificate of Appreciation
2009: Department of Veterans Affairs, Veterans Health Administration, VA Central Office, Special Contribution Award
2007: Department of Veterans Affairs, Veterans Health Administration, Veterans Integrated Service Network 1, Special Contribution Award
2006: Department of Veterans Affairs, Veterans Health Administration, Veterans Integrated Service Network 1, Certificate of Appreciation
2003: Society for Healthcare Epidemiology of America, 13th Annual Meeting Travel Award

Regional

2018: Best abstract/Performance Improvement category, Yale New Haven Health, Safety, Quality and Experience Conference. "Using Multidisciplinary Teamwork to Reduce Hospital Acquired *C. difficile*."

Grants and Clinical Trials:

Submitted Grants

Agency: Professional Disposables, Inc.
RFA NA
Title Prospective, Cross-Over Comparison of Prevantics vs. Isopropyl Alcohol Hub Disinfection for Preventing Catheter-Associated Bloodstream Infection and Blood Culture Contamination in Hematology-Oncology Patients
PI David Pegues, MD and Richard Martinello, MD
Role on Project: Co-PI
Direct Cost:
Total Cost: $206,000
Project Period: 2019 - 2021

Current Grants

Agency: DoD/DARPA
Contract #: N6001-17-2-4023
Title: Contagious Phenotypes of Acute Respiratory Infection: Identification, Characterization, and Biomarkers
PI: Donald K. Milton, MD, DrPH
Role on Project: Consultant

Percent effort: <5%
Direct cost: $1,102,749
Total cost: $1,527,351
Project Period: 01/01/17 – 12/31/18

Past Grants
Agency: VHA/ORD/HSR&D
ID#: HIR 08-374
Title: "Consortium for Health Informatics Research"
P.I.: Matthew Samore, M.D.
Percent effort: 10%
Direct costs per year: $2,750,000
Total costs for project period: $11,000,000
Project period: 01/01/09 – 12/31/14

Agency: VA/OI&T
ID#: 291
Title: "Reducing Health Care Associated Infections: Electronic Methods to Measure Medical Device Use"
P.I. Richard Martinello, M.D.
Percent effort: 10%
Direct costs per year: $567,158
Total costs for project period: $567,158
Project period: 10/01/11 – 09/30/12

Agency: VHA/COHIC
ID#: not-applicable
Title: "Carriage Patterns and Molecular Epidemiology to Optimize MRSA Prevention"
P.I. Kalpana Gupta, M.D.
Percent effort: 5%
Direct costs per year: $425,000
Total costs for project period: $425,000
Project period: 07/01/11 – 06/30/12

Agency: VHA/HSR&D
ID#: PPO 10-266
Title: "Ontology-Enhanced Information Retrieval to Improve Clinical Practice"
P.I. James A. McCart, Ph.D.
Percent effort: 5%
Direct costs per year: $100,000
Total costs for project period: $100,000
Project period: 10/1/11 – 9/30/12

Agency: VHA HSR&D SDR
ID#: HX-11-022
Title: "Consequences of Notifying Patients After Potentially Harmful Exposures, Large Scale Adverse Event Communications"
P.I. Rani Elwy, Ph.D.
Percent effort: 5%

Direct costs per year: $500,000
Total costs for project period: $500,000
Project period: 1/1/12 – 12/31/12

Agency: VHA/COHIC
ID#: NA
Title: "Aerosol Transmission of Influenza"
P.I.: Richard Martinello, M.D.
Percent effort: 10%
Direct costs per year: $250,000
Total cost for project period: $250,000
Project period: 10/1/10 – 9/30/11

Agency: VHA/Office of Public Health and Environmental Hazards
ID#: NA
Title: "VA H1N1 Response After Action Report"
P.I.: Richard Martinello, M.D.
Percent effort: 5%
Direct costs per year: $32,017
Total cost for project period: $32,017
Project period: 10/1/10 – 1/31/11

Agency: VHA/COHIC
ID#: NA
Title: "Effectiveness of disinfectants against H1N1 2009 influenza virus"
P.I.: Richard Martinello, M.D.
Percent effort: 5%
Direct costs per year: $50,000
Total cost for project period: $50,000
Project period: 1/1/09 – 12/31/11

Agency: NIH/NIAID
ID#: AI52251
Title: "Genetic Virulence Markers in Respiratory Syncytial Virus"
P.I.: Richard Martinello, M.D.
Percent effort: 75%
Direct costs per year: $122,875
Total cost for project period: $530,820
Project period: 9/1/03 – 8/31/07

Agency: VHA/Office of Public Health and Environmental Hazards
ID#: NA
Title: "Developing new competencies for pandemic flu response"
P.I.: Richard Martinello, M.D.
Percent effort: 5%
Direct costs per year: $5,000
Total cost for project period: $5,000
Project period: 7/1/07 – 6/30/08

Agency: VHA/Office of Public Health and Environmental Hazards
ID#: NA
Title: "Implementation of best practices to reduce ventilator associated pneumonia"
P.I.: Richard Martinello, M.D.
Percent effort: 5%
Direct costs per year: $5,000
Total cost for project period: $5,000
Project period: 7/1/05 – 6/30/06

Agency: VHA/ Office of Public Health and Environmental Hazards
ID#: NA
Title: "Improving health care worker hand hygiene performance"
P.I.: Richard Martinello, M.D.
Percent effort: 5%
Direct costs per year: $1,000
Total cost for project period: $1,000
Project period: 7/1/04 – 6/30/05

Other Support:

Agency: Infectious Diseases Section Research Incentive, Yale School of Medicine
Title: Case-control study of proton pump inhibitor exposure as a risk for healthcare associated *Clostridium difficile*
P.I.: Richard Martinello, M.D.
Percent effort: 5%
Direct costs per year: $10,000
Total cost for project period: $10,000
Project period: 2007

Agency: VHA Health Services Research and Development, Clinical Epidemiology Research Center grant
Title: Human metapneumovirus as a trigger for acute exacerbations of COPD
P.I.: Richard Martinello, M.D.
Percent effort: 5%
Direct costs per year: $25,000
Total cost for project period: $25,000
Project period: 2007

Invited Speaking Engagements, Presentations, Symposia & Workshops Not Affiliated With Yale:

International/National

2020: "COVID-19" US Embassy. US Department of State. Cairo, Egypt.
2020: "Defining Standards and Metrology Needs for Ultraviolet Disinfection Technologies & Healthcare Associated Infections through Industry and Federal Collaboration: a summary of the NIST/IUVA workshop". 2020 International Ultraviolet Association World Congress. Orlando, FL.

2020: Multiple Presentations. Workshop on Ultraviolet Disinfection Technologies & Healthcare Associated Infections: Defining Standards and Metrology Needs. Gaithersburg, MD. (Conference Organizing Committee)

2019: "Seasonal Influenza: When, Who, and How to Manage". Pri-Med East Conference. Boston, MA.

2019: "Cases in Infectious Disease: How the Recent Medical Literature Might Influence Your Clinical Practice". Pri-Med New York 2019 Conference. New York City, NY. (~1,300 attendees)

2019: "Cases in Infectious Disease: How the Recent Medical Literature Might Influence Your Clinical Practice". Pri-Med Midwest 2019 Conference. Rosemont, IL. (~800 attendees)

2019: "Cases in Infectious Disease: How the Recent Medical Literature Might Influence Your Clinical Practice". Pri-Med South 2019 Conference. Tampa, FL. (~600 attendees)

2019: "Cases in Infectious Disease: How the Recent Medical Literature Might Influence Your Clinical Practice". Pri-Med Atlanta 2019 Conference. Atlanta, GA. [>500 attendees]

2019: "Cases in Infectious Disease: How the Recent Medical Literature Might Influence Your Clinical Practice". Pri-Med Irving Conference. Irving, TX. [>600 attendees]

2019: "How UV-C Technologies and Standards Fit in the Fight Against HAIs". ASHRAE 2019 Annual Conference, Technical Conference 2.9 Ultraviolet Air and Surface Treatment. Kansas City, MO.

2019: "How UV-C Technologies and Standards Fit in the Fight Against HAIs". ASHRAE 2019 Annual Conference, Technical Conference 9.6 Healthcare. Kansas City, MO.

2019: "Seasonal Influenza: When, Who, and How to Manage". Pri-Med Southwest Conference. Houston, TX. [>1,800 attendees]

2019: "Minimizing Healthcare-Associated Infections in the United States through the Collaborative Development of Standards, Metrology and Technology" 2019 International Ultraviolet Association World Congress. Sydney, Australia.

2019: "Heterogeneity in the Reporting of UVC Surface Disinfection Interventions in the Medical Literature- A Potential Barrier to Implementation" 2019 International Ultraviolet Association World Congress. Sydney, Australia.

2018: "Current Concepts in the Management of Influenza". Pri-Med Conference. Atlanta, GA. [>900 attendees]

2018: "Current Concepts in the Management of Influenza". Pri-Med Conference. Los Angeles, CA. [>800 attendees]

2018: "Identifying Opportunities and Implementing Best Practices for Immunization Against Pneumococcal Disease in Adults". Virtual Expert Roundtable teleconference. Pri-Med.

2018: "How UV-C Technologies and Standards Fit in the Fight Against Hospital-Acquired Infections". International Ultraviolet Association Americas Meeting. Redondo Beach, CA.

2018: "Identification of barriers and research opportunities to improve the effective and efficient application of adjunct UVC surface disinfection in healthcare". SPIE Photonics West. San Francisco, CA.

2017: "Fighting Healthcare Associated Infections and Multi-Drug Resistant Organisms with UV-C Using Industry, Healthcare and Federal Collaboration". International Ultraviolet Association 2017 Americas Conference. Austin, TX.

2015: "Protecting Pregnant Women and Their Babies from Influenza". Moderator (Speaker, Dr. Sonja Rasmussen); Veterans Health Administration, National Public Health Teleconference. Washington, DC.

2014: "Ebola". Department of Veterans Affairs, National Partnership Council National Teleconference. Washington, DC.

2014: "Influenza Vaccination and Prevention". Veterans Health Administration, National Public Health Teleconference. Washington, DC.

2014: "MERS Coronavirus". Moderator (Speakers, Drs. Connie Savor-Price and Mary Bessesen), Veterans Health Administration, National Public Health Teleconference.

2014: "Water and high-risk populations". Water Safety in Healthcare Workshop. Department of Veterans Affairs, Veterans Health Administration. Cincinnati, OH.

2014: "Access to Vaccinations in the Department of Veterans Affairs". National Adult Immunization and Influenza Summit. Atlanta, GA. (Session moderator and presenter).

2014: "Healthcare Personnel Immunizations". Department of Veterans Affairs, National Occupational Health Grand Rounds. Washington, DC.

2013: "Reduction of Healthcare Associated Infections through Informatics". Department of Veterans Affairs, Veterans Affairs Innovation Program. Washington, DC.

2013: "Outbreak and Exposure Investigation Fundamentals", Veterans Health Administration, Mental Health and Psychology Fellows National Teleconference. Washington, DC.

2013: "Vaccinations and Pregnancy", Veterans Health Administration, joint VA Public Health and Women's Health National Teleconference. Washington, DC.

2012: "Hand Hygiene: Power, trust and obligation", Veterans Health Administration Hand Hygiene Summit, Chicago, IL.

2012: "Infection Control in the 21st Century", planning committee, Veterans Health Administration.

2012: "Influenza Transmission", Pandemic Sub-Interagency Policy Committee, National Security Staff, Executive Office of the President, The White House. Washington, DC.

2012: "Health care providers and influenza vaccination", Veterans Health Administration, Infectious Diseases National Teleconference. Washington, DC.

2012: "Influenza Vaccination and Health Care Providers: Attitudes and Challenges" Veterans Health Administration, 2012 VHA Influenza Summit. Washington, DC.

2012: "Decreasing the Impact of Influenza: Opportunities for Change". Department of Veterans Affairs, Joint Semi-Annual Labor Management Relations Meeting. Washington, DC.

2011: "Do masks work against influenza?" Veterans Health Administration, Sixth Annual VISN 23 Pandemic Influenza Conference. Bloomfield, MN.

2011: "Mitigating the impact of influenza in the future: Vaccine advances", Veterans Health Administration, Sixth Annual VISN 23 Pandemic Influenza Conference. Bloomfield, MN.

2011: "Seasonal Influenza Update". Veterans Health Administration, Office of Public Health National Teleconference. Washington, DC.

2011: "Influenza vaccine safety and efficacy" Veterans Health Administration, Office of Public Health National Teleconference. Washington, DC.

2011: "Promoting Influenza Vaccination: Reducing disparities and expanding use", Veterans Health Administration, Office of Public Health National Teleconference.

2011: "Climate Change and Health: Vulnerabilities and Actions". The White House Council on Environmental Quality, Inter-Agency Meeting, Executive Office of the President. Washington, DC.

2011: "VA Health Care Personnel Influenza Vaccination". Department of Health and Human Services, National Vaccine Advisory Committee, HCP Influenza Vaccination Subgroup. Washington, DC.

2011: "Expanding Access to Adult Vaccines". Department of Health and Human Services, National Vaccine Advisory Committee, Adult Immunization Stakeholders Meeting. Chicago, IL.

2011: "Health Care Providers and Influenza Vaccination: Considerations for Mandatory Vaccination Programs". Veterans Health Administration, Infection: Don't Pass It On conference. Biloxi, MS.

2011: "High Dose Influenza Vaccine: Barriers to Implementation". Veterans Health Administration, Infection: Don't Pass It On conference. Biloxi, MS.

2011: "Identifying and Prioritizing New Vaccines for Development". Institute of Medicine, Committee on Identifying and Prioritizing New Vaccines for Development. The National Academy of Sciences, Keck Center, Washington, DC.

2010: "Using evaluation to improve our work: A resource guide for After Action Reports". Veterans Health Administration, Health Services Research & Development National Cyberseminars. Washington, DC.

2010: "Respiratory Protection and Prevention of Influenza Infection". Veterans Health Administration, National Safety and Health Teleconference. Washington, DC.

2010: "Influenza Vaccination Update: Expanded Recommendations and an Introduction to the High Dose Influenza Vaccine". Veterans Health Administration, National Public Health Teleconference.

2010: "Preparedness in an Integrated Health Care Delivery System". Institute of Medicine, Forum on Medical and Public Health Preparedness for Catastrophic Events. Woods Hole, MA.

2010: "Medical and Public Health Preparedness: Efforts and Gaps". Institute of Medicine, Forum on Medical and Public Health Preparedness for Catastrophic Events. Woods Hole, MA, June 7, 2010.

2010: "Influenza Vaccine Efficacy, Effectiveness and Controversy". Influenza Summit, Veterans Health Administration. Washington, DC.

2010: "Pandemic Response", Emergency Management Leadership Conference. Department of the Interior. Shepardstown, WV.

2009: "Preventative measures: vaccination, infection control practices and personal protective equipment". National Pandemic Influenza Training. Veterans Health Administration. Washington, DC.

2009: "Wound Infections: Antimicrobial Therapy". Symposium on Advanced Wound Care. Association for the Advancement of Wound Care. Washington, DC.

2009: "New antibiotics for MRSA and Clostridium difficile". 8th Annual Needham Life Sciences Conference. New York City, NY.

2009: "Preventative measures: vaccination, infection control practices and personal protective equipment". National Pandemic Influenza Training, Veterans Health Administration. Washington, DC.

2009: "Seasonal and Pandemic Influenza". Veterans Health Administration, National Safety Conference, Department of Veterans Affairs. Las Vegas, NV.

2009: "Preparing for Pandemic Influenza". Veterans Health Administration, National Safety Conference, Department of Veterans Affairs. Las Vegas, NV.

2009: "Bloodborne Pathogens". Veterans Health Administration Occupational Health National Grand Rounds, Department of Veterans Affairs. Washington, DC.

2008: "Bloodborne pathogens, post-exposure prophylaxis and infection control for occupational health". National VA Safety Training Conference, Department of Veterans Affairs. Las Vegas, NV.

2008: "Methicillin resistant Staphylococcus aureus"National VA Safety Training Conference, Department of Veterans Affairs. Las Vegas, NV.

2008: "Legionella and Legionella Prevention". National VA Safety Training Conference, Department of Veterans Affairs. Las Vegas, NV.

2008: "Best Practices for Minimizing Exposure to Bloodborne Pathogens". National VA Safety Training Conference, Department of Veterans Affairs. Las Vegas, NV.

2008: "Bloodborne pathogens, post-exposure prophylaxis and infection control for occupational health". National VA Safety Training Conference, Department of Veterans Affairs. Las Vegas, NV.

2007: "Bloodborne Pathogens: HIV, Hepatitis B and Hepatitis C". National VA Safety Training Conference, Department of Veterans Affairs. Las Vegas, NV.

2007: "Infection Control for Occupational Safety and Health". National VA Safety Training Conference, Department of Veterans Affairs. Las Vegas, NV.

Regional

2018: "Hospital and Environmental Infections: An Interdisciplinary Approach". Connecticut Infectious Diseases Society Annual Meeting. Orange, CT.

2016: "Zika: An introduction and update". VA Boston Healthcare System, Medical Grand Rounds. West Roxbury, MA.

2014: "Emerging Viral Infections: Chikungunya, MERS & Ebola". Veterans Health Administration, VISN 1 Primary Care Teleconference. Bedford, MA.

2014: "Influenza". Veterans Health Administration, VISN 1 Primary Care Teleconference. Bedford, MA.

2012: "Influenza: impact, prevention and patient safety". Veterans Health Administration, VISN 3 Influenza Colloquium. New York City, NY.

2012: "Influenza Vaccination among health care providers: Opportunities for change". Veterans Health Administration, VISN 3 Influenza Colloquium. New York City, NY.

2012: "Ontology development and text processing for MRSA". Veterans Health Administration Consortium for Health Informatics Research conference. Salt Lake City, UT.

2011: "Influenza and its prevention". Veterans Health Administration, VISN 3 Influenza Conference. New York City, NY.

2010: "2009 Influenza Pandemic: Lessons Learned". Veterans Health Administration, VISN 23 Pandemic Influenza Summit. Minneapolis, MN.

2010: "Influenza 2010-11". Veterans Health Administration, VISN 1 Primary Care Grand Rounds. Bedford, MA.

2010: "Developing the MRSA Working Use Case". Consortium for Healthcare Informatics Research. Veterans Health Administration. Salt Lake City, UT.

2010: "Pandemic Response" Southern VISN Emergency Management Leadership Training. Veterans Health Administration. Atlanta, GA.

2009: "Influenza and HIV". Infectious Diseases Conference. Department of Internal Medicine, Brown University. Providence, RI.

2009: "Seasonal and Pandemic Influenza". State of Connecticut, Department of Mental Health and Addiction Services. Bridgeport, CT.

2009: "Influenza: Transmission, Prevention and Treatment". VA Boston Healthcare System, Department of Internal Medicine Grand Rounds. West Roxbury, MA.

2009: "MRSA". State of Connecticut, Department of Mental Health and Addiction Services. Bridgeport, CT.

2009: "Infection Control". State of Connecticut, Department of Mental Health and Addiction Services. Bridgeport, CT.

2009: "Seasonal and Pandemic Influenza". State of Connecticut, Department of Mental Health and Addiction Services. Bridgeport, CT.

2009: "Respiratory Virus Infections". State of Connecticut, Department of Mental Health and Addiction Services. Bridgeport, CT.

2009: "Avian Influenza and Influenza Pandemics". Togus VA Medical Center, Medical Center Grand Rounds. Togus, ME.

2006: "Avian influenza and influenza pandemics". Togus VA Medical Center Grand Rounds. Togus, ME.

Peer-Reviewed Presentations & Symposia Given at Meetings Not Affiliated With Yale

International/National

2020 SHEA abstracts

2020 APIC abstracts

2019 IDWeek 2019. Rathod SN, McManus D, Rivera-Vinas J, Topal JE, **Martinello RA**. Evaluating the Antibiotic Risk for *Clostridioides difficile* Infection (CDI): Comparing Piperacillin/Tazobactam to Cefepime and Ceftazidime.

2019 SHEA Spring 2019 Conference. Rathod S, Sussman LS, Peaper DR, Azar MM, Topal JE, Kashyap N, Tichy EM, McManus D, **Martinello RA**. Examining Clinicians' Rationale for Ordering *Clostridioides difficile* Testing in Patients Receiving Laxatives.

2019 American Academy of Orthopaedic Surgeons. Tyagi V, Kahan J, Rubin LE, Moore A, Whitbread M, Wysocki D, Fairweather I, Oliver P, Ruskis A, Golden M, **Martinello RA**, Topal JE, Spadaccino B, Novella L, Serra J, Morris J, O'Connor MI. Reducing Surgical Site Infection for Fragility Hip Fracture Patients at the Center for Musculoskeletal Care at Yale New Haven Hospital.

2018 Institute for Healthcare Improvement National Forum. Fillion S, Fischer A, Advani S, Barna J, Smith C, Walka C, Hittleman A, Leapman M, **Martinello RA**, Wagner J. Champions Changing Practice, Changing Culture: Cultivating Use of the CAUTI Prevention Bundle at Yale New Haven Hospital.

2018 International Ultraviolet Association Healthcare Workshop. Healthcare Associated Infections; Overview and Issues (panel facilitator).

2018 International Ultraviolet Association Healthcare Workshop. Healthcare Associated Infections Mitigation Programs (panel facilitator).

2018 International Ultraviolet Association Healthcare Workshop. **Martinello RA**. The burden of HAI, HAI surveillance, and HAI public reporting.

2018 SPIE Optics & Photonics. Poster DL, Miller CC, Obeng Y, Postek MT, Cowan TE, **Martinello RA**. Innovative Approaches to Combat Healthcare-Associated Infections Using Efficacy Standards Developed Through Industry and Federal Collaboration.

2018 Council for Optical Radiation Measurements, National Institute for Standards and Technology. Miller CC, Poster DL, Obeng Y, Postek MT, Cowan TE, **Martinello RA**. Innovative approaches to combat healthcare associated infections using efficacy standards developed through industry and federal collaboration.

2018 Annual Meeting of the Infectious Disease Society of America (IDSA) IDWeek 2018. Gao CA, Datta R, Smith C, **Martinello RA**, Dembry LM, Advani SD. The culture of culturing in catheterized patients: A Multi-Hospital Survey of Nurses and Physicians.

2018 Annual Meeting of the Infectious Disease Society of America (IDSA) IDWeek 2018. Pepe DE, Aniskiewicz A, Paci G, Sullivan L, Dembry LM, **Martinello RA**, Advani S. A Risk-Stratified Approach to Healthcare-Associated Tuberculosis Exposures Following the "Stone in the Pond" Principle.

2018 Annual Meeting of the Infectious Disease Society of America (IDSA) IDWeek 2018. Gao CA, Datta R, Smith C, Dembry LM, Dunne D, **Martinello RA**, Juthani-Mehta M, Advani S. Educational interventions improve trainee approach to obtaining urine cultures in catheterized patients.

2018 SHEA Spring 2018 Conference. Glanternik JR, Advani S, Aniskiewicz M, Murdzek C, Bizzarro M, Baltimore RS, **Martinello RA**. Impact of Active Surveillance for Vancomycin Resistant *Enterococcus* in the Neonatal Intensive Care Unit.

2018 SHEA Spring 2018 Conference. Pepe D, Advani S, Aniskiewicz M, Paci G, Macone E, Sullivan L, **Martinello RA**. Analysis of healthcare associated tuberculosis exposures at an academic medical center.

2018 SHEA Spring 2018 Conference. Advani S, Sann L, Smith C, Datta R, Leapman M, Hittelman A, Gao C, Sullivan L, Juthani-Mehta M, **Martinello RA**. Impact of Reflex Urine Cultures on Catheter-associated Urinary Tract Infections at an Academic Medical Center.

2018 SPIE-Photonics West, BioS. **Martinello RA**, Miller SL, Fabian MP, Peccia J. Identification of barriers and research opportunities to improve the effective and efficient application of adjunct UVC surface disinfection in healthcare.

2017 IDWeek 2017. Datta R, John B, Hellou E. **Martinello RA**, Malinis M. Evaluating the Risk of Viral Myocarditis following Influenza Infection among Hospitalized Patients during 2014- 2015 and 2015-2016 Influenza Seasons.

2017 IDWeek 2017. John B, Malinis M, Baltimore RS, Fairweather I, Rivera-Vinas J, **Martinello RA**. Improved Survival of Candida CLABSI by Adherence to Standard of Care and Involvement of Infectious Diseases Consultant: A 5-year Experience in a Single Academic Center.

2017 VHA HSR&D 2017, Crystal City, VA. Elwy AR, Maguire EM, Bokhour BG, Wagner TH, Asch SM, Gifford AL, Gallagher TH, Durfee JM, **Martinello RA**, Taylor TJ. Risk Communication in VA Healthcare: Preventing Unintended Consequences.

2017 APIC 2017 Conference, Portland, OR. Smith C, Fillion S, Williams E, **Martinello RA**. Using Data to Drive and Sustain Practice Changes in conquering Catheter-Associated Urinary Tract Infections.

2017 SHEA Spring 2017 Conference, St. Louis, MO. Acquarulo B, Sullivan L, Gentile AL, Boyce JM, **Martinello RA**. Mixed-Methods Analysis of Glove Use as a Barrier to Hand Hygiene.

2017 SHEA Spring 2017 Conference, St. Louis, MO. **Martinello RA**, Arbogast JW, Parker AE, Boyce JM. Nurse Preference for Alcohol-Based Hand Rub Volume.

2016 SHEA Spring 2016 Conference. Atlanta, GA. Boyce JM, Rillstone H, Colandrea N, Stout RW, Topal J, Ruskis A, **Martinello RA**, Davis KA. Reducing Colon Surgery-Related Surgical Site Infection (SSI) Rates Using a Bundle.

2016 SHEA Spring 2016 Conference, Atlanta, GA. St. Pierre C, McDevitt JJ, Milton DK, **Martinello RA**. Implementation of Upper Room Germicidal Irradiation in a Closed Dementia Long-Term Care Unit.

2015 NIH/AcademyHealth Dissemination & Implementation Conference. Washington, DC. McCullough MB, Maguire EM, George J, Bokhour BG, Asch SM, Gifford AL, Wagner TH, Durfee JM, **Martinello RA**, Elwy AR. Stakeholders' perspectives on disclosing large scale adverse events: A toolkit built on lessons from implementing a national policy.

2015 International Conference on Communication in Healthcare. New Orleans, LA. Maguire EM, Taylor TT, Gallagher TH, Bokhour BG, Asch SM, Gifford AL, Wagner TH, Durfee JM, **Martinello RA**, Elwy AR. Testing large-scale disclosure language and communication methods through an experimental online vignette survey.

2015 American Public Health Association Annual Meeting. Chicago, IL. Finley P, Beyeler W, Mitchell M, Kaslow RA, **Martinello RA**, Davey VJ. Evaluating Ebola Response Alternatives in the VA Healthcare System using a Computational Epidemiological Control Model.

2015 Council of State and Territorial Epidemiologists Annual Conference. Boston, MA. Brown PL, Akaka LK, Oda G, Ross DB, Durfee JM, Kotar T, **Martinello RA**. Survey of Veterans Health Administration (VHA) Infectious Disease Reporting to State, Local, and Territorial Public Health Authorities (PHA).

2015 Council of State and Territorial Epidemiologists Annual Conference. Boston, MA. Medina-Martinez G, Rivera-Colon A, Wu M, Akaka LK, Oda G, McFarland L, **Martinello RA**. Reducing the Complexity of Veterans Health Administration (VHA) Infectious Diseases Reporting to State, Local and Territory Public Health Departments.

2015 NIH/AcademyHealth Dissemination & Implementation Conference. Bethesda, MD. Elwy AR, Maguire EM, Bokhour BG, Asch SM, Gifford AL, Wagner TH, Gallagher TH, Durfee JM, **Martinello RA**, Jesse RL. Stakeholders' perspectives on disclosing large scale adverse events: A toolkit built on lessons from implementing a national policy.

2015 American Academy on Communications in Healthcare Research and Teaching Forum. Orlando, FL. Maguire EM, Bokhour BG, Durfee JM, **Martinello RA**, Asch SM, Gifford AL, Wagner TH, Gallagher TH, Elwy AR. Exploring Patient, Staff, and Leader Perceptions of Large Scale Adverse Event Notification Communication.

2014 IDWeek 2014. Philadelphia, PA. Schirmer P, Winters M, Lucero-Obusan C, Oda G, **Martinello RA**, Davey V, Holodniy M. Improperly Used Insulin Pen Lookback Investigation in Veterans Affairs (VA) Medical Center.

2014 IDWeek 2014. Philadelphia, PA. Schirmer P, Winters M, Lucero-Obusan C, Oda G, **Martinello RA**, Davey V, Holodniy M. Influenza Infection in the Department of Veterans Affairs (VA): 2013-2014.

2013 141st American Public Health Association Annual Meeting. Boston, MA. Goulet JL, **Martinello RA**, Bathulapalli H, Higgins D, Driscoll MA, Brandt CA, Womack JA. High STI rates among returning Veterans, but low rates of HIV testing.

2013 International Society for Diseases Surveillance 2013 Conference. New Orleans, LA. Lucero-Obusan CA, Winters M, Schirmer P, Oda G, **Martinello RA**, Davey VJ, Holodniy M. Influenza Surveillance in the Department of Veterans Affairs (VA): 2012-2013 Influenza Season.

2013 American Medical Informatics Association 2013 Annual Symposium. Washington, DC. Martins SB, Tu SW, **Martinello RA**, Rubin MA, Foulis PR, Luther SL, Forbush TB, Scotch M, Doebbeling BN, Goldstein MK, for the VA CHIR MRSA Project. Creating a MRSA Ontology to Support Categorization of MRSA Infections.

2013 Institute for Operations Research and the Management Sciences Conference. Minneapolis, MN. Finley PD, Lambert GJ, Huff AG, **Martinello RA**, Evans L, Moore T, Glass R, Mecher C, Davey VJ. Ranking Pandemic interventions via Multilevel Sensitivity Analysis of Model Results (No. SAND2013-8521C).

2013 NIH/Academy Health, Translation and Communications Interest Group. San Diego, CA. Maguire, E., Elwy AR, Bokhour BG, Gifford AL, Asch SM, Wagner TH, Gallagher TH, Durfee JM, **Martinello RA**. Communicating large scale adverse events: Lessons from media reactions to risk.

2012 IDWeek 2012. San Diego, CA. Sellick J, Lesse A, **Martinello RA**, Kralovic S, Watson E, McCabe L, Schoenhals K. An Outbreak of Invasive Group A Streptococcus Infections in Veterans Treated with Skin Substitute Grafts at a Podiatry Clinic.

2012 IDWeek 2012. San Diego, CA. Mortensen E, Schirmer P, Lucero C, Oda G, Winters MA, Durfee J, **Martinello RA**, Davey VJ, Holodniy M. Are Current Screening Protocols for Chronic HBV Infection Adequate?

2012 Institute for Operations Research and the Management Sciences Conference. INFORMS 2012: Informatics Rising. Phoenix, AZ. Moore T, Finley P, Jones K, **Martinello RA**, Mecher C, Davey V. Mitigating infectious disease outbreaks in medical facilities with incomplete vaccination.

2012 American Academy on Communication in Healthcare Research & Teaching Forum. Providence, RI. Maguire E, Elwy AR, Bokhour BG, Gifford AL, Asch S, Wagner T, Gallagher T, Burgess J, **Martinello RA**. Communicating Large Scale Adverse Events: Lessons from Media Reactions to Risk.

2011 American Medical Informatics Association 2011 Annual Symposium. Washington, DC. Garvin J, Doebbling B, Merchant M, **Martinello RA**, Mutalik P, Goldstein M, Luther S, Samore M, South B. An Informatics Approach to Methicillin Resistant Staphylococcus Aureus Surveillance in the Department of Veterans Affairs.

2011 Infectious Diseases Society of America Annual Meeting. Boston, MA. Gupta K, Young M, Strymish J, **Martinello RA**, Sokolovskaya G, Cho K, Lawler E. Long term persistence of the non-colonized with nasal MRSA state among hospitalized Veterans.

2011 Society for Healthcare Epidemiology of America 2011 Annual Scientific Meeting. Dallas, TX. **Martinello RA**, Cavaiuolo M, Johansen S, Campbell S. Use of common disinfectants to remove influenza virus from elastomeric respirators.

2010 International Society for Disease Surveillance 9th Annual Conference. Park City, UT. Rangel MC, **Martinello RA**, Lucero C, Oda G, Holodniy M, Peterson M, Davey VJ and the VA Gulf Coast Oil Spill Task Force. Adapting a Syndromic BioSurveillance System to Monitor Veterans' Health Impact Associated with the Gulf Coast Oil Spill.

2010 American Medical Informatics Association 2010 Annual Symposium. Washington, DC. Martins SB, Tu SW, Yeh GS, Garvin JH, **Martinello RA**, Rubin MA, Foulis PR, Friedlin J, Doebbeling BN, and Goldstein MK for the VA CHIR MRSA Project. Creating an MRSA Ontology to Support Natural Language Processing.

2010 American Medical Informatics Association 2010 Annual Symposium. Washington, DC. Scotch M, Martinello RA, Mutalik P, Brandt C. Use of Natural Language Processing and Machine Learning for Surveillance of MRSA at the VA.

2010 American Medical Informatics Association 2010 Annual Symposium. Washington, DC. Merchant M, Rubin MA, Martinello RA, Goldstein MK, Foulis PR, Samore M, Martins SB, Garvin JH, Friedlin J, South B, Gullans SK, Doebbeling BN. An Interdisciplinary Research & Development Collaborative for Enhancing MRSA Surveillance and Decision Support.

2010 Fifth Decennial International Conference on Healthcare-Associated Infections. Atlanta, GA. Schult T, Awosika E, Hodgson M, **Martinello RA**. VHA Clinical and Non-Clinical Staff Differences in Sick Leave Usage: A Flu Effect?

2010 Fifth Decennial International Conference on Healthcare-Associated Infections. Atlanta, GA. Hirsch P, **Martinello RA**, Davey VJ, Hodgson M. Seasonal Influenza Vaccination: Results of a Four-Year Campaign.

2008 48th Annual ICAAC/IDSA 46th Annual Meeting. Washington, DC. **Martinello RA**, Wattier RL, Rubino J, Mayo DR, Griffith B, Radonovich L, Milton DK. Investigation of a nursing home outbreak of H3N2 influenza using HA gene nucleotide sequences.

2008 48th Annual ICAAC/IDSA 46th Annual Meeting. Washington, DC. Saharia K, Mayo DR, Griffith B, **Martinello RA**. Identification of norovirus gastroenteritis among hospitalized veterans in the absence of an outbreak.

2008 48th Annual ICAAC/IDSA 46th Annual Meeting. Washington, DC. Miller H, Campbell S, **Martinello RA**, Towle D. Validation of NucliSENS® easyMAG™ Automated Nucleic Acid Extraction for Use with DiversiLab™ Microbial Strain-Typing System for Methicillin Resistant *S. aureus*.

2008 Seasonal and Pandemic Influenza 2008. Arlington, VA. **Martinello RA**, Wattier RL, Rubino J, Mayo DR, Griffith B, Radonovich L, Milton DK. Investigation of a nursing home outbreak of H3N2 influenza using HA gene nucleotide sequences.

2008 Society for Healthcare Epidemiology of America 18th Annual Scientific Meeting. Orlando, FL. **Martinello RA**, O'Neil K, Kotansky B, Concato JC. Proton Pump Inhibitor Use is Not a Risk for Healthcare Associated *Clostridium difficile* Associated Diarrhea.

2007 Pediatric Academic Societies Annual Scientific Meeting. Toronto, ON. Lazar I, Kanungo N, Weibel C, **Martinello RA**, Kahn JS. The Magnitude of Induction of IL-6 by Clinical Isolates of Respiratory Syncytial Virus is Strain Specific.

2007 Pediatric Academic Societies Annual Scientific Meeting. Toronto, ON. Meyers R, Alvarez R, Tripp R, Hadwiger P, Roehl I, Elbashir S, Nechev L, Toudjarska I, **Martinello RA**, Kahn JS, DeVincenzo J. ALN-RSV01, an RNAi Therapeutic for the treatment of Respiratory Syncytial Virus (RSV) infection.

2007 Society for Healthcare Epidemiology of America 17th Annual Scientific Meeting. Baltimore, MD. Perkal K, Welch B, Rubino MJ, Swan K, Levey M, Cain H, **Martinello RA**. Use of Goal Sheets Reduces the Incidence of VAP.

2006 Society for Healthcare Epidemiology of America 16th Annual Scientific Meeting. Chicago, IL. Benin AL, Learsy-Cahill D, Das R, Kancir S, Welch B, **Martinello RA**. Veterans' perception of urgency due to influenza vaccine shortage and its impact on vaccination, 2004-2005.

2005 RSV Symposium 2005. Keble College, Oxford University, United Kingdom. **Martinello RA**, Weibel C, Lazar I, Shapiro ED, Kahn JS. Association between RSV genotype and severity of disease in children.

2004 Society for Healthcare Epidemiology of America Annual Meeting. Philadelphia, PA. **Martinello RA**, Benin AL, Welch B, Cooper T, Ehrenkranz RA, Baltimore RS, Dembry LM. Risk Factors Associated with MRSA Colonization in Patients in a Neonatal Intensive Care Unit.

2004 Society for Healthcare Epidemiology of America Annual Meeting. Philadelphia, PA. **Martinello RA**, Reagan-Cirincione P, Dembry LM Risk Factors associated with the Identification of Methicillin Resistant Staphylococcus aureus in Hospitalized Patients.

2004 42nd Annual Meeting of the Infectious Diseases Society of America. Boston, MA. **Martinello RA**, Esper F, Weibel C, Ferguson D, Landry ML, Kahn JS. Human metapneumovirus and exacerbations of chronic obstructive pulmonary disease.

2003 Society for Healthcare Epidemiology of America Annual Meeting. **Martinello RA**, Topal JE, Cooper T, Dembry LM, Kahn JS. Molecular Epidemiology of a Nosocomial Parainfluenza Virus Outbreak.

2003 Society for Healthcare Epidemiology of America Annual Meeting. **Martinello RA**, Esper F, Boucher D, Weibel C, Kahn JS. Nosocomial Transmission of the Human Metapneumovirus.

2003 Society for Healthcare Epidemiology of America Annual Meeting. **Martinello RA**, Welch BA, King S, Topal JE, Dembry LM. An Outbreak of Norwalk-like Virus (NLV) in a Psychiatric Hospital. Society for Healthcare Epidemiology of America Annual Meeting. April, 2003.

2001 Infectious Disease Society of America Annual Meeting. San Francisco, CA. **Martinello RA**, Cooney EL. Cerebellar brain abscess associated with tongue piercing.

2001 Infectious Disease Society of America Annual Meeting. San Francisco, CA. **Martinello RA**, Chen MD, Weibel C, Kahn JS. Correlation between respiratory syncytial virus genotype and illness severity.

2001 Society for Healthcare Epidemiology of America Annual Meeting. Toronto, ON. **Martinello RA**, Jones L, Topal JE. Assessment of healthcare worker attitudes toward influenza vaccination.

Regional

2019 Yale New Haven Health Safety, Quality, and Experience Conference, Wallingford, CT. Clemons C, Advani S, Aniskiewicz M, Brien P, Brophy C, Dahlberg S, DeWitt M, Fairweather I, Figoras AM, Hall A, Katz J, Landry M, **Martinello R**, Malone R, Owen M, Parwani V, Peaper D, Saxa T, Scarpetti E, Sevilla M, Shapiro M, Sullivan S, Ulrich A. MRSA Optimization: Reducing Unnecessary MRSA Precautions for 11,000 patients improves Patient Care and Value.

2019 Yale New Haven Health Safety, Quality, and Experience Conference, Wallingford, CT. Rathod S, Sussman LS, Azar MM, Tichy EM, Topal JE, Murdzek C, Kashyup N, McManus D, Peaper DR, **Martinello RA**. Examining Clinicians' Rationale for Ordering *Clostridioides difficile* Testing in Patients Receiving Laxatives.

2018 Yale New Haven Health Safety, Quality, and Experience Conference, Wallingford, CT. Advani S, Aniskiewicz M, Branson B, Brien P, Brophy C, Clemons C, Dahlberg S, Dewitt M, Fairweather I, Figoras AM, Hall A, Katz J, Landry ML, **Martinello RA**, Malone R, Owen M, Parwani V, Peaper DR, Saxa T, Scarpetti E, Sevilla M, Shapiro M, Sullivan L, Ulrich A. Emergency Department implementation of rapid influenza PCR provides more accurate, timely care.

2018 Yale New Haven Health Safety, Quality, and Experience Conference, Wallingford, CT. Susman LS, Williams J, Kozakiewicz J, Peaper D, Martinello RA, Holmes M, Murdzek C, Topal JE, et al. Using multidisciplinary teamwork to reduce hospital acquired *C. difficile*.

2018 Yale New Haven Health Safety, Quality, and Experience Conference, Wallingford, CT. Fischer A, Advani S, Amell N, Ashman A, Barna J, Carroll L, Costa S, Depukat D, Edwards L, Fillion S, Gowisnock S, Hittleman A, Leapman M, **Martinello RA**, Rossetti RM, Smith C, Strouse MR, Whitbread M, Walka C, Wagner J. Champions changing practice changing culture: Cultivating use of the CAUTI prevention bundle.

2018 Yale New Haven Health Safety, Quality, and Experience Conference, Wallingford, CT. Gao CA, Datta R, Smith C, **Martinello RA**, Dembry LM, Advani SD. The culture of culturing in catheterized patients: A Multi-Hospital Survey of Nurses and Physicians.

2018 Yale New Haven Health Safety, Quality, and Experience Conference, Wallingford, CT. Implementation of a bundle protocol to reduce surgical site infection for hip fracture patients at YNHH Center for Musculoskeletal Care. Tyagi V, Kahan J, Moore A, Whitbread M, Wysocki D, Oliver P, Ruskis A, Golden M, **Martinello R**, Topal J, Spadaccino B, Novella L, Serra J, Morris J, O'Connor MI, Rubin LE.

2017 35th Annual Conference of the Connecticut Infectious Disease Society, West Haven, CT. Laurent-Rolle M, Poonawala H, Montero N, Golden M, **Martinello R**, Aoun-Barakat L. *Mycobacterium abscessus* Skin and Soft-Tissue Infections Following Plastic Surgery Procedures in the Dominican Republic.

2007 Veterans Integrated Service Network 1 Emergency Preparedness Forum. Nashua, NH. **Martinello RA**. The Canadian SARS Experience: Lessons Learned.

Professional Service

Peer Review Groups/Grant Study Sections:

2018 Ad hoc reviewer, Kuwait Foundation for the Advancement of Sciences.

2011-15 Review Panel. QUERI Service Directed Projects. Health Services Research and Development, Office of Research and Development, Veterans Health Administration, Department of Veterans Affairs.

2011-15 Review Committee. QUERI Research and Methodology Committee. Health Services Research and Development, Office of Research and Development, Veterans Health Administration, Department of Veterans Affairs.

2015 Member, Review Panel, CHIKV Challenge, Defense Advanced Research Projects Agency, Department of Defense.

2009 Review Committee, Pandemic Influenza Grants, Public Health Strategic Health Care Group, Veterans Health Administration, Department of Veterans Affairs.

2008 Ad hoc member, Microbiology & Infectious Diseases study section, NIAID, NIH.

2007 Ad hoc member, Microbiology and Infectious Diseases B Research Review Committee, NIAID, NIH.

Journal Service:

Reviewer

Reviewer for; *JAMA, Pediatrics, Clinical Infectious Diseases, American Journal of Managed Care, Journal of Infection, Pediatric Infectious Diseases Journal, American Journal of Tropical Medicine and Hygiene, American Journal of Respiratory and Critical Care Medicine, Vaccine, American Journal of Infection Control, Archives of Medical Research, Infection Control and Hospital Epidemiology, Influenza Drug Discovery Today, Yale Journal of Biology and Medicine, Pediatric Research, The Lancet, American Journal of Public Health, BMC Research Notes, Evolution Medicine and Public Health, Infection Genetics and Evolution,* and *Journal of Infection.*

Professional Service for Professional Organizations:

Federal Government

2009-15 Member, Pandemic Sub-Interagency Policy Committee, National Security Staff, Executive Office of the President

2010-15 Ex Officio Member, National Vaccine Advisory Committee Department of Health and Human Services

2010-12 Member, Health Care Provider Immunization Work Group, National Vaccine Advisory Committee, Department of Health and Human Services

2010-12 Member, Adult Immunization Work Group, National Vaccine Advisory Committee, Department of Health and Human Services

2011-12 Member, Anthrax Vaccine Working Group, National Biodefense Science Board, Department of Health and Human Services

2011-12 Member, Anthrax Vaccine Distribution Federal Interagency Working Group, Departments of Homeland Security and Health and Human Services

2012-15 Member, National Vaccine Advisory Committee, Global Immunization Working Group, Department of Health and Human Services

2012-15 Ex Officio Member, National Biodefense Science Board, Department of Health and Human Services

2012-15 Member, National Vaccine Advisory Committee, Maternal Immunization Working Group, Department of Health and Human Services

2013-14 Member, HIV Care Continuum Initiative Working Group, Recommendations Sub-Committee, Office of National AIDS Policy, Executive Office of the President and the Department of Health and Human Services

2013-15 Combatting Antimicrobial Resistant Bacteria Interagency Policy Committee, National Security Staff, Executive Office of the President

State Government

2015-current Healthcare Associated Infections Advisory Group, Connecticut Department of Public Health

2015-current Member, Antimicrobial Resistance/Antimicrobial Stewardship Multidisciplinary Advisory Group, Connecticut Department of Public Health

Yale University Service:

2015-present Biosafety Committee
2017-2018 Quality Committee, Yale Medicine
2018-present Quality Committee, Yale Medicine/Yale New Haven Health
2020-present COVID-19 Advisory Board
2020-present COVID-19 Public Health Committee

Departmental Committees

2003-14 Member, Internal Medicine/Pediatrics Residency Selection Committee
2006-09 Member, Internal Medicine Residency Selection Committee
2015 Ad hoc interviewer, Internal Medicine/Primary Care Program Residency Selection Committee

Hospital Boards & Committees

Local

2003-12 Chair, Infection Control Committee, VA Connecticut Healthcare System
2003-12 Member, Emergency Management Council, VA Connecticut Healthcare System
Chair, Patient Surveillance & Tracking Sub-Committee
2007-15 Member, Research & Development Committee, VA Connecticut Healthcare System
2007-12 Member, Medication Management Committee, VA Connecticut Healthcare System
2008-12 Member, Peer Review Committee, VA Connecticut Healthcare System
2015-present Chair, Infection Control Committee, Yale New Haven Hospital
2016-2019 Infection Prevention Sponsor, Central Line Associated Blood Stream Infection Performance Improvement Team, Yale New Haven Hospital
2016-2019 Infection Prevention Sponsor, Catheter Associated Urinary Tract Infection Performance Improvement Team, Yale New Haven Hospital
2016-present Infection Prevention Sponsor, Hand Hygiene Performance Improvement Team, Yale New Haven Hospital
2016-present Infection Prevention Sponsor, Trans-Abdominal Surgery Performance Improvement Team, Yale New Haven Hospital
2016-2019 Infection Prevention Sponsor, Orthopedic Surgery Surgical Site Infection Performance Improvement Team, Yale New Haven Hospital
2016-2019 Infection Prevention Sponsor, *C. difficile* Performance Improvement Team, Yale New Haven Hospital
2016-present Co-Chair, System Infection Prevention Committee, Yale New Haven Health
2017-present Member, System Quality Council, Yale New Haven Health
2017-present Member, Clinical Governance Committee, Yale New Haven Health
2017-present Member, Quality Committee, Yale Medicine
2018-present Member, Executive Leadership Group, Yale Medicine-United Health Care
2018-present Member, Readmissions committee, Yale New Haven Health
2019-present Member, Serious Event Review Committee, Yale New Haven Hospital
2019-present Member, Sepsis Working Group, Yale New Haven Health, Clinical Redesign
2019-present Co-Sponsor, Central Line Associated Blood Stream Infection-Catheter Associated Urinary Tract Infection Performance Improvement Team, Yale New Haven Health
2019-present Co-Sponsor, *C. difficile* Performance Improvement Team, Yale New Haven Health
2019-present Sponsor, Arthroplasty and Spine Surgery Surgical Site Infection Prevention Performance Improvement Team, Yale New Haven Hospital

2020-present Executive Team, Medical Technical Specialist, COVID-19 System Incident Management Team, Yale New Haven Health System.

Regional

2003-10 Chair, VISN 1 Infection Control Council; Veterans Health Administration, Veterans Integrated Service Network 1

2003-12 Member, Emergency Preparedness Sub-Council; Veterans Health Administration, Veterans Integrated Service Network 1,

2003-12 Chair, Biologics Subcommittee; Veterans Health Administration, Veterans Integrated Service Network 1, Emergency Preparedness Sub-Council

2004-09 Member, VISN 1 Network Safety Leadership Sub-Council; Veterans Health Administration, Veterans Integrated Service Network 1

2005-06 Member, Network Safety Task Force; Veterans Health Administration, Veterans Integrated Service Network 1

National

2008-10 Member, Emergency Medical Management and Public Health Advisory Sub-Committee; Department of Veterans Affairs, Veterans Health Administration

2009-12 Co-Director, Public Health Medical Operations Group, Department of Veterans Affairs

2010-15 Member, Infectious Diseases Field Advisory Committee, Veterans Health Administration, Department of Veterans Affairs

2012-15 All-Hazards Emergency Cache Committee, Veterans Health Administration, Department of Veterans Affairs

2014-15 Water Safety Oversight Committee, Veterans Health Administration, Department of Veterans Affairs

2019-presentMember, Public Policy and Government Affairs Committee, Society for Healthcare Epidemiology of America

2019-presentMember, Council for Outbreak Response: Healthcare Associated Infections and Antimicrobial Resistant Pathogens. Council of State and Territorial Epidemiologists

Board of Directors

2015-present Member, Quinnipiack Valley Health District, North Haven, CT

2015-present Member, Board of Directors Executive Committee, Quinnipiack Valley Health District, North Haven, CT

2019-present Member, Board of Directors, Appointments sub-committee, Quinnipiack Valley Health District, North Haven, CT

2019-present Member, International Ultraviolet Association, Chevy Chase, MD

Bibliography:

Peer-Reviewed Original Research

1. **Martinello RA**, Chen MD, Weibel C, Kahn JS. Correlation between respiratory syncytial virus genotype and illness severity. *Journal of Infectious Diseases* 2002;186:839-42.
2. **Martinello RA**, Cooney EL. Cerebellar brain abscess associated with tongue piercing. *Clinical Infectious Diseases* 2003;36(2) e-32-4.
3. Esper F, Boucher D, Weibel C, **Martinello RA**, Kahn JS. Human matapneumovirus infection in the United States: clinical manifestations of a newly emerging respiratory disease in children. *Pediatrics* 2003;111(6):1407-1410.

4. **Martinello RA**, Jones L, Topal JE. Assessment of healthcare worker attitudes toward influenza vaccination. *Infection Control and Hospital Epidemiology* 2003;24(11):845-847.
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8. **Martinello RA,** Esper F, Weibel C, Ferguson D, Landry ML, Kahn JS. Human metapneumovirus and exacerbations of chronic obstructive pulmonary disease. *Journal of Infection* 2006;53:248-25.
9. **Martinello RA.** Preparing for avian influenza. *Current Opinion in Pediatrics* 2007:64-70.
10. Benin AL, Learsy-Cahill D, Das R, Kancir S, Welch B, **Martinello RA**. Veterans' perceptions of urgency due to influenza vaccine shortage and its impact on vaccination, 2004-2005. *Human Vaccines* 2009;5(4):237-41.
11. Alvarez R, Elbashir S, Borland T, Toudjarska I, Hadwiger P, John M, Roehl I, Shulga-Morskaya S, **Martinello RA,** Kahn JS, Van Ranst M, Tripp RA, Pandey R, Maier M, Nechiv L, Manoharan M, Koteliansky V, and Meyers R. RNAi-mediated silencing of the respiratory syncytial virus nucleocapsid defines a potent anti-viral strategy. *Antimicrobial Agents and Chemotherapy* 2009;53:3952-3962.
12. Schult T, Awosika E, Hodgson M, **Martinello RA.** 2009 Influenza pandemic impact on sick leave use in the Veterans Health Administration: Framework for a health care provider-based national syndromic surveillance system. *Disaster Medicine and Public Health Preparedness* 2011;5:S235-241.
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15. Gupta K, **Martinello RA**, Young M, Strymish J, Cho K, Lawler E. MRSA nasal carriage patterns and subsequent risk of conversion between patterns, infections and death. *PLoS ONE* 2013;8(1):e53674.
16. Schacht-Reisinger H, Yin J, Radonovich L, Knighton VT, **Martinello RA,** Hodgson MJ, Perencevich E. Comprehensive survey of hand hygiene measurement and improvement practices in the Veterans Health Administration. *American Journal of Infection Control* 2013:41:989-993.
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Health and Researchers: A VA Case Study. *Journal of General Internal Medicine* 2014:29(4):831-834.

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43. Jamieson DJ, Steinberg JP, **Martinello RA**, Perl TM, Rasmussen SA. Obstetricians on the COVID-19 front lines and the confusing world of personal protective equipment (PPE). *Obstetrics & Gynecology* 2020. (in press)

Chapters, Books, and Reviews

1. **Martinello RA**, Dembry LM. Educational needs and opportunities for the hospital epidemiologist. In A Practical Handbook for Hospital Epidemiologists, 2nd edition, eds. K. Wojetle and E. Lautenbach, SLACK Incorporated, Thorofare, NJ, 2004.
2. **Martinello RA**, Cappello M. Acute Pericarditis. In Clinical Infectious Diseases, 1st edition, ed. D. Schlossberg, Cambridge University Press, New York, NY, 2008.
3. Women's Health: A Guide to Preventing Infections, eds. P. Hayes and **R. Martinello,** Veterans Health Administration, Department of Veterans Affairs, Washington, DC, 2012.
4. Bullis E, **Martinello RA**. Antibiotic Use in Primary Care. In: Talwalkar JS, Fenick AM, eds. Yale Primary Care Pediatrics Curriculum, 8th Edition, 2014.
5. VHA Seasonal Influenza Manual, eds. V.T. Knighton and **R. Martinello**, Veterans Health Administration, Department of Veterans Affairs, Washington, DC, 2014. http://www.publichealth.va.gov/docs/flu/va-flu-manual.pdf
6. Disaster Preparedness Manual. Eds. K. Etminani, M. Gosch, J. Lopez, C. Lucero-Obusan, **R. Martinello**, K. Ricci, C. Raab, P. Schirmer, and B. O'Hanley-Selzer. Veterans Health Administration, Department of Veterans Affairs, Washington, DC, 2015.

7. Bullis E, **Martinello RA**. Antibiotic Use in Primary Care. In: Talwalkar JS, Fenick AM, eds. Yale Primary Care Pediatrics Curriculum, 9th Edition, 2015.
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9. Bullis E, **Martinello RA**. Antibiotic Use in Primary Care. In: Talwalkar JS, Fenick AM, eds. Yale Primary Care Pediatrics Curriculum, 10th Edition, 2016.
10. Gupta S, **Martinello RA**. Zika Virus Epidemic Through the Americas: Epidemiology, Clinical Guidelines, and Review of New Developments. Connecticut Medicine 2017;81(8):487-497.
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13. Bullis E, **Martinello RA**. Antibiotic Use in Primary Care. In: Talwalkar JS, Fenick AM, eds. Yale Primary Care Pediatrics Curriculum, 13th Edition, 2019. Available from http://pcpc.yale.edu
14. **Martinello RA**. Outbreak Investigations. In: Friedland G, Golden M, Obuagu O, eds. *Current Diagnosis and Treatment – Infectious Diseases*. McGraw-Hill; (submitted).
15. **Martinello RA**, Davis K. Prevention of Surgical Site Infections. In: Friedland G, Golden M, Obuagu O, eds. *Current Diagnosis and Treatment – Infectious Diseases*. McGraw-Hill; (submitted).
16. **Martinello RA**, Cappello M. Acute Pericarditis. In Clinical Infectious Diseases, 3rd edition, ed. D. Schlossberg, B. Cunha. Cambridge University Press, New York, NY (submitted).

Peer-Reviewed Educational Materials

17. Maguire E, **Martinello RA**, Durfee J, Elwy R. Large Scale Disclosure Toolkit. Veterans Health Administration, Office of Research and Development, Health Services Research and Development, 2014.

Peer-Reviewed Publications

18. **Martinello RA**. Acute Exacerbations of Chronic Bronchitis. *British Medical Journal, Epocrates* 2008.
19. **Martinello RA**. Acute Exacerbations of Chronic Bronchitis. *British Medical Journal, Epocrates* 2010.
20. **Martinello RA,** Rochester C. Acute Exacerbations of Chronic Bronchitis. *British Medical Journal, Epocrates* 2011.
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26. Cowan TE, **Martinello RA**. Fighting HAIs and MDROs with UV-C Using Industry, Health Care and Federal Collaboration. *IUVA News* 2017;19(2):26-27.
27. **Martinello RA**. Testing for UV-C Antimicrobial Efficacy in the Healthcare Setting. *IUVA News* 2018;20(4):12-16.
28. DiMartino L, **Martinello RA**. Mobile Device Use in Healthcare: New Opportunities for UV Disinfection. *UV Solutions* 2020;2(1):18-21.

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29. National Biodefense Science Board. Challenges in the use of anthrax vaccine adsorbed (AVA) in the pediatric population as a component of post-exposure prophylaxis (PEP). A Report of the National Biodefense Science Board. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. October, 2011.
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32. National Vaccine Advisory Committee. Protecting the Public's Health: Critical Functions of the Section 317 Immunization Program—A Report of the National Vaccine Advisory Committee. *Public Health Reports* 2013;128(1):78-95.
33. National Vaccine Advisory Committee. Enhancing the Work of the Department of Health and Human Services National Vaccine Program in Global Immunization: Recommendations of the National Vaccine Advisory Committee. *Public Health Reports* 2014;129(S3):12-20.
34. National Vaccine Advisory Committee. Recommendations from the National Vaccine Advisory Committee: Standards for Adult Immunization Practice. *Public Health Reports* 2014;129:115-123.

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36. Gosch M, **Martinello RA**, Meyer E, Post LA, Radonovich L. VHA response to the 2009 H1N1 pandemic: Final after-action report. 2012.
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Scholarship in Press and Submitted

38. Taylor TJ, Maguire EM, Gallagher TH, Bokhour BG, Asch SM, Gifford AL, Wagner TH, Durfee JM, **Martinello RA**, Elwy AR. Communicating High-Risk Information about Potentially Low-Risk Healthcare Events: A Randomized Survey. (submitted)
39. Gao CA, Datta D, Dunne D, Dembry LM, **Martinello RA**, Juthani-Mehta M, Advani S. Comparison of Traditional Instruction versus Non-Traditional Learning to improve Trainee Knowledge of Urine Culture Practices in Catheterized Patients. (submitted)
40. Elwy AR, Maguire EM, McCullough M, George J, Bokhour BG, Durfee JM, **Martinello RA**, Walker Y, Sharpe VA, Geppert C, Holodniy M, West G, SCALE and CERT teams. From implementation to operational sustainment: A large-scale adverse event disclosure toolkit and support program generated through embedded research in the Veterans Health Administration. (submitted)

41. Kenney P, Chan BK, Kortright K, Cintron M, Havill N, Russi M, Epright J, Lee L, Balcezak T, **Martinello RA**. Hydrogen Peroxide Vapor Sterilization of N95 Respirators for Reuse. (submitted)

ATTACHMENT 2

Wilkes v Lamont

Documents Reviewed
Richard Martinello, MD
July 7, 2020

1. First Amended Complaint 5-7-2020
2. Wilkes prelim injunction memo 6-8-2020
3. Wilkes Dr. Manian Affidavit 6-8-2020
4. CDC LTC guidance 3-26-20 [Ex 9]
5. CMS guidance relax restrictions LTC 5-18 [10]
6. CDC COVID protect yourself [Ex 11]
7. CDC LTC key strategies [Ex 12]
8. CDC preparing COVID NH [Ex 13]
9. CDC responding COVID in NH 4-30 [Ex 14]
10. CDC COVID testing NH 5-18-20 [Ex 15]
11. CDC guidance fac wide testing NH 5-19 [Ex 16]
12. CDC IC assessment tool [Ex 17]
13. SAMSHA COVID psych hosp guide [Ex 18]
14. Ardizzone affidavit
15. Wilkes Atty Gudis Affidavit
16. Wilkes canavan jones affidavit
17. Wilkes mueller affidavit
18. Wilkes King affidavit
19. Wilkes Clark affidavit
20. Wilkes Litsky affidavit
21. COVID-19 uniform screening tool
22. DMHAS Protocols for COVID Q/I 5-17/20
23. DMHAS Employee FAQs
24. CVH Environmental Services Protocol
25. WFH Housekeeping
26. WFH Biospray
27. CVH Inf Prevention Containment
28. WFH Coronavirus Pandemic Incident Action Plan
29. Testing Protocol 6.29.20 [CVH]
30. Revised Testing Protocol Memo 6.29.20
31. COVID-19 Uniform Screening Tool 5-17
32. COVID-19 Required Policy Changes 4-27
33. CVH IP Manual
34. CVH Staff-Patient Testing Response 6.18.20
35. Declaration of Vinneth Carvalho
36. Exhibit 2 of Defendants' Motion to Dismiss, Declaration Charles Dike
37. WFH Sanitizing Agents
38. WFH KaiVac1750
39. Telephone discussion with Dr. Tobias Wasser (June 26, 2020)
40. Tour of WFH (June 26, 2020)

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EXHIBIT C

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs* v. NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, In their official capacities, *Defendants*	:	CIVIL NO. 3:20CV594-JCH JULY 1, 2020

DECLARATION OF TOBIAS WASSER, MD

The undersigned declarant, Tobias Wasser, MD, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am employed by the State of Connecticut Department of Mental Health and Addiction Services as the Chief Medical Officer at Whiting Forensic Hospital ("WFH") in Middletown, CT. I have held this position since May 1, 2018. Prior to this I was the Medical Director of the Whiting Forensic Division of Connecticut Valley Hospital from July 1, 2017 to April 30, 2018. A current copy of my CV is attached as Attachment 1 hereto.

2. I make this Declaration based upon personal knowledge, and I understand that it will be submitted to this Court in connection with the above-captioned case in support of the Defendants' Opposition to the Plaintiffs' Motion for Preliminary Injunction.

3. WFH is a state-operated inpatient facility providing services to individuals involved in the criminal justice system as well as through the civil commitment process.

4. WFH employs on site medical doctors ("MDs"), advanced practice registered nurses ("APRNs") and nurses and on every shift who address medical needs of patients.

5. As part of my job duties, I am responsible for the management and oversight of the daily clinical operations and patient care at WFH.

6. WFH has protocols in place with regard to testing in response to the COVID-19 pandemic. The most recent update to these protocols was May 19, 2020. See Defs. Ex. L, Whiting Guidance on Management of Suspected and Confirmed Cases in Patients and Staff.

7. From March 17, 2020 to June 30, 2020, there was a prohibition of visitors at WFH. As of July 1, 2020, visitation has resumed subject to requirements and guidance from the Connecticut Department of Public Health and the Center for Disease Control.

8. WFH conducts COVID-19 screening of all those entering the hospital, including staff, by checking temperatures and asking a detailed series of questions about possible COVID symptoms, potential COVID -19 exposures and recent travel. The questionnaire is frequently updated to reflect evolving CDC guidance.

9. WFH conducts daily screening of patients for COVID-19 by checking temperatures and monitors patients for COVID-19 symptoms.

10. New patients coming from the Department of Corrections or another hospital are tested for COVID-19 prior to admission. New patients from the community are offered a test for COVID-19 immediately upon admission.

11. All patients who are symptomatic for COVID-19 are tested. Testing of symptomatic patients began on March 16, 2020.

12. Baseline testing of patients at WFH was completed on May 19, 2020.

13. The date that a patient at WFH last tested positive for COVID-19 was on April 21, 2020. Two patients who tested positive on May 19, 2020 had previously tested positive and did not represent new cases of COVID-19.

14. Since May 19, 2020, no new patients at WFH have tested positive for COVID-19.

15. As of July 1, 2020, a total of 10 patients out of 169 patients at WFH tested positive for COVID-19 since the pandemic began.

16. As of July 1, 2020, a total of 10 patients who tested positive for COVID-19 have recovered from COVID-19 since the beginning of the pandemic.

17. As of July 1, 2020, 135 cumulative patients at WFH have been tested for COVID-19 since the pandemic began. The current WFH census is 169 patients.

18. Baseline testing of staff at WFH was completed on June 4, 2020.

19. On June 15, 2020, WFH began repeat testing of staff.

20. The date that a direct care staff member at WFH last tested positive for COVID-19 was on May 7, 2020.

21. The date that a non-direct care staff member at WFH last tested positive for COVID-19 was on June 15, 2020.

22. As of July 1, 2020, a total of 22 staff members out of 522 staff members at WFH tested

positive for COVID-19 since the beginning of the pandemic.

23. As of July 1, 2020, a total of 22 staff members who tested positive for COVID-19 have recovered from COVID-19.

24. As of July 1, 2020, 333 staff members out of 522 staff members at WFH have been tested for COVID-19 since the pandemic began.

25. If a patient tests positive for COVID-19, WFH conducts contact tracing and recommends testing of staff and residents who may have been exposed to the patient.

26. WFH cannot mandate patient testing of COVID-19.

27. If a patient who displays COVID-19 symptoms refuses COVID-19 testing, WFH treats the patient as if he or she has COVID-19 and follows the hospital's protocol for treating COVID-19 positive patients.

28. If a new admission refuses COVID-19 testing, WFH treats the patient as if he or she has COVID-19 and follows the hospital's protocol for COVID-19 positive patients.

29. If a staff member tests positive for COVID-19, WFH conducts contract tracing and recommends testing of staff and residents who may have been exposed to the patient.

30. The use of personal protective equipment at WFH has evolved in conformity with CDC guidelines.

31. WFH staff have available for their use all appropriate PPE, including but not limited to: surgical masks, face shields, N95 masks, eye protection, gowns, gloves and probe covers, in addition to hand sanitizer.

32. All staff have received web-based training on proper PPE use, including donning and doffing protocols. Live tutorials have also been provided. Training is ongoing.

33. Staff are required to wear surgical masks in all patient areas and higher levels of PPE based upon staff activities or medical procedures. Staff who violate this requirement have undergone reeducation and counseling.

34. WFH patients are provided masks at least weekly, and more often if they become soiled or damaged, consistent with assessments to ensure no unwarranted medical risk or risk of self -injury is present.

35. Patients have been provided clear educational materials on COVID-19 precautions; posters and unit-based meetings also encourage the practice of appropriate precautions, including proper mask use. Educational efforts are ongoing.

36. All patients at WFH are cared for by a treatment team made up of clinicians that collaboratively plan and provide care to the patient. The team consists of a psychiatrist, medical doctor, psychologist, social worker, rehabilitation therapist, nurses, and mental health assistants (who assist in therapeutic engagements).

37. Taking into account the limits of court-imposed confinement and in accord with governing policies, WFH actively pursues the appropriate discharge of every patient deemed discharge ready by his or her treatment team.

38. Planning for discharge to the most integrated community setting begins upon admission to the inpatient service and treatment planning by the team addresses the particular considerations for each patient bearing on discharge and identifies and attempts to overcome barriers to discharge.

39. At every treatment plan review (which occur at least monthly), the treating physician will document in the chart and discuss with the patient the specific factors that the physician is considering to determine the patient's current clinical need for hospital level of care and

the patient's readiness for discharge. Such factors should include the patient's physical and mental status, results of medical/psychological tests, the patient's cognitive and behavioral status, the patient's functional capacities, and evaluative tools or treatment protocols yet to be completed.

40. The physician will also document in the patient's chart the treatment interventions the hospital will provide to address each factor in order to discharge the patient from the hospital in a timely manner once the patient is deemed discharge ready by the treatment team. Extrinsic factors which present barriers to discharge, such as the patient's willingness to leave the hospital or the availability of a residential placement must be documented in the chart.

41. On each team is a clinical social worker who maintain a knowledge base of community support services and provides oversight to the discharge planning process. Typically, the clinical social worker will be communicating with community providers regarding a patient's discharge in advance of the patient being determined as ready for discharge.

42. This process ensures that each month, there has been a professional judgment by the physician and informed by the team as to whether a patient is discharge ready.

43. During the course of the pandemic, the treatment teams continue to address discharge readiness and barriers to discharge (reflected in the treatment plans) including those posed by COVID 19 pandemic.

44. From March 30, 2020 until June 30, 2020, 43 patients were discharged from WFH.

45. From March 1, 2020 until June 30, 2020, 21 patients were admitted to WFH.

46. Beginning in March 2020, PSRB patients who had been granted temporary leaves of 7 nights in the community were allowed to remain in community placement except for

those identified as posing too great a risk to remain in the community placement. Leaves for patients who were on less than 7-overnight temporary leaves were cancelled rather than have them continuing short term leaves to avoid the risk of being infected in the community and returning to the hospital. All patients who could be safely transitioned from less than 7 overnight temporary leaves to 7 overnight temporary leaves were transitioned to such in collaboration with community providers in order to maximize the number of patients in the community, minimize the hospital census, and reduce the movement of patients back and forth from the hospital to the community.

47. If admission of patients under the jurisdiction of the PSRB or sent for restoration of competency to stand trial was prohibited, the patients in almost all circumstances would remain in a correctional facility without the same level of treatment as provided at WFH.

48. WFH has established separate cohorts (COVID-19 Positive, Negative/Unexposed, Negative/Exposed) for WFH patients in accordance with CDC and Department of Public Health guidelines. See Department of Public Health, COVID-19 Infection Control and Testing Guidance for Nursing Homes, Updated Guidance, June 5, 2020.

49. Patients who have COVID-19 symptoms, as defined by the CDC, but who have not tested positive for COVID-19 are isolated from other patients and tested. If a test is negative but clinical suspicion is still high, the patient remains in quarantine and gets re-tested.

50. Patients who test positive for COVID-19 along with members of the unit are isolated from other patients who have not tested positive. These patients are provided with in-unit meals, masks and, to the extent possible, single occupant room. These patients do not get ground privileges, but do take fresh air breaks as a unit separate from other patients.

51. All patients who have tested positive for COVID-19 are cohorted together on the same unit.

52. Patients who have not tested positive for COVID-19 who are exposed to confirmed COVID-19 positive patients, are quarantined to their unit and prevented from interacting with patients on other units for fourteen (14) days from when the positive patient began having symptoms.

53. New patients are placed in an isolation unit away from other patients on isolation unit until test results return. Unless precluded by a patient's behavioral presentation, a patient is in quarantine for fourteen (14) days on admission. New patients who refuse testing are placed in quarantine for fourteen (14) days on admission.

54. WFH releases patients from COVID-19 positive isolation based on a more conservative adaptation of CDC's symptom-based criteria for discontinuing isolation precautions which includes: No fever for seventy-two (72) hours without the use of fever reducing medications; resolution of symptoms; and fourteen (14) days have passed since the onset of symptoms. The CDC recommends ten (10) days; however, out of abundance of caution, WFH adheres to fourteen (14) days and requires resolution, rather than diminution of symptoms. On rare occasions when individuals have had severe symptoms, WFH utilized the test-based criteria (2 negative tests at least 24 hours apart) in addition to the symptom-based criteria (symptom free for 14 days) for discontinuing isolation precautions.

55. WFH's Isolation and Cohorting Plan also includes, if necessary, utilizing available facility space to create a negative pressure isolation unit and a gymnasium isolation unit and includes isolation on the patient's unit of origin.

56. The isolation unit has its own bathroom and dining room.

57. To further combat COVID-19, WFH provides patients and staff with training regarding social distancing and has enacted several measures to promote social distancing at WFH.

58. In accordance with social distancing, WFH enabled patients to continue to have meaningful visitor contact through virtual visitation in addition to in person visitation.

59. WFH did an analysis for each therapeutic group to assess whether the risk of conducting group therapy outweighed the risk associated with transmission of COVID-19. If a group was not closed, when therapeutically appropriate, WFH modified the group to increase social distancing, including limiting the group size to five participants, prohibiting cross unit participants, and altering the frequency and duration of group meetings.

60. In buildings where multiple units previously dined together, WFH has organized the provision of meals into two separate dining spaces (dining room and the activity room) so that each unit dines separately and arranged the physical layout in each room to maximize social distancing.

61. WFH has examined the risk and benefits of other facility use practices. For example, WFH opted to continue using the elevator, and modifying use of it to create as much social distance as possible and has enacted a process for maximizing stairwell use under staff supervision to account for reduced elevator occupancy due to social distancing requirements.

62. WFH weighed the therapeutic benefits and the risks associated with COVID-19 and modified its patient grounds privileges as follows:

   a. The common areas in the combined campus used by CVH and WFH patients

who have grounds privileges has been separated so that only WFH patients use designated WFH space;

b. WFH patients with passes can no longer go and mingle with CVH patients;

c. The courtyard used for WFH patients without ground privileges has been changed so that only one unit can go to the building courtyard at a time; and

d. In addition, the large Whiting Max courtyard, which used to accommodate all five inpatient units, pre-COVID-19, has been modified. WFH separated it in half with cones and only permits two units to go there at a time: one unit on each side and patients are prohibited from mingling with patients from other units.

63. WFH has amended the time, place and frequency of Probate Court Proceedings to allow staggered times for the proceedings. WFH and CVH previously held Probate Court in a single location (pre-COVID) but have now separated into a WFH-specific and a CVH-specific location. Probate court hearings are conducted via videoconferencing to limit exposure from Probate Court staff to WFH patients.

64. WFH instituted teleworking arrangements for as many staff as possible and utilizes telemedicine to further reduce the number of people working on-site at WFH.

65. In addition, WFH provides staff with significant, ongoing social distancing training. WFH staff received several on-line trainings regarding social distancing and other measures to protect patients and staff from COVID-19. For example, WFH distributed the "COVID-19 Pandemic Response" electronically. Additionally, as CDC, the State of Connecticut Department of Public Health ("DPH") and DMHAS distributed new information, WFH assimilated the new information into the WFH plan and disseminated

the plan to all staff members electronically. DMHAS has also disseminated to all WFH staff an FAQs, which includes social distancing education.

66. WFH has actively and continuously provided patients with COVID-19 prevention strategies, including social distancing. On multiple occasions, each WFH unit director held community meetings during which patients were provided educational materials on COVID-19, including the importance of social distancing.

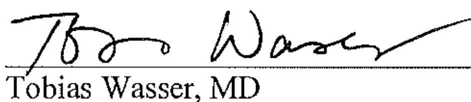
67. WFH also posted materials at WFH to remind staff and patients to perform basic hygiene, social distancing, and proper use of personal protective equipment ("PPE"). For example, WFH posted the CDC's "What you should know about COVID-19 to protect yourself and others" which poster includes social distancing and other relevant information and is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019ncovfactsheet.pdf#:~:text=COVID%2D19%20can%20spread,has%20COVID%2D19. (last accessed June 30, 2020). WFH also posted the Substance Abuse and Mental Health Services Administration (SAMHSA) Fact Sheet "Taking Care of Your Behavioral Health" which also includes information regarding social distancing and can be accessed at https://store.samhsa.gov/product/Taking-Care-of-Your-Behavioral-Health-Tips-for-Social-Distancing-Quarantine-and-Isolation-During-an-Infectious-Disease-Outbreak/PEP20-01-01-007 (last accessed June 30, 2020).

68. Throughout the pandemic, WFH staff and patients have been and continue to be instructed on an on-going basis to maximize social distancing opportunities and maintain social distancing to the greatest extent possible.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 1st day of July, 2020.



Tobias Wasser, MD

ATTACHMENT 1

Date of Revision: 6/18/20

Tobias Wasser, M.D.

70 O'Brien Drive, Middletown, CT 06457
Phone: (860) 255-8399
Fax: (860) 262-5485
tobias.wasser@gmail.com

Education:

B.A.	Wesleyan University (Psychology) 2006
M.D.	University of Connecticut School of Medicine 2010

Career/Academic Appointments:

2010-13	Resident, Psychiatry, Yale School of Medicine, New Haven, CT
2013-14	Program-Wide Chief Resident and Chief Resident for Medical Education, Psychiatry, Yale School of Medicine, New Haven, CT
2014-15	Fellow, Forensic Psychiatry, Yale School of Medicine, New Haven, CT
2015-16	Fellow, Public Psychiatry, Yale School of Medicine, New Haven, CT
2016-present	Assistant Professor, Psychiatry, Yale School of Medicine, New Haven, CT
2016-present	Assistant Clinical Professor, Yale School of Nursing, New Haven, CT

Administrative Positions:

Clinical

2018-present	Chief Medical Officer, Whiting Forensic Hospital, Middletown, CT
2017-18	Division Medical Director, Whiting Forensic Division of Connecticut Valley Hospital, Middletown, CT

Educational

2020-present	Associate Program Director, Psychiatry Residency Program, Yale School of Medicine, New Haven, CT
2018-20	Director of Forensic Clinical Curriculum, Psychiatry Residency Program, Yale School of Medicine, New Haven, CT
2016-20	Associate Program Director, Fellowship in Public Psychiatry, Yale School of Medicine, New Haven, CT
2016-20	Director of Quality Improvement and Patient Safety Education, Psychiatry Residency Program, Yale School of Medicine, New Haven, CT
2016-17	Director of Education for Inpatient Services, Connecticut Mental Health Center, New Haven, CT

Other Employment:

2016-17	Inpatient Attending Psychiatrist, Connecticut Mental Health Center, New Haven, CT
2015-present	Forensic Psychiatry Private Practice, New Haven, CT
2015-17	Per Diem Forensic Psychiatrist, Connecticut Department of Mental Health and Addiction Services, Middletown, CT
2013-present	Psychiatrist on Duty, VA Connecticut Healthcare System, West Haven, CT

Board Certification:

American Board of Psychiatry and Neurology, Psychiatry, 2014
American Board of Psychiatry and Neurology, Forensic Psychiatry, 2015
American Association of Community Psychiatrists, Community and Public Psychiatry, 2016

Professional Honors & Recognition:

International/National/Regional

2018: Visiting Scholar, Eastern Virginia Medical School, Norfolk, VA
2018: American Psychiatric Association Assembly Resident-Fellow Member Mentor Award
2016: Best Resident/Fellow Paper, American Association of Psychiatric Administrators
2015: SAMHSA Behavioral Health Leadership Development Program
2014: Laughlin Foundation Merit Award

University

2015: Medical Education Fellowship, Yale School of Medicine
2014: Poster Award for Excellence in Medical Education Research, Yale School of Medicine
2014: Howard Zonana Award, Yale School of Medicine
2013: Benjamin S. Bunney Award, Yale School of Medicine

Grant/Clinical Trials History:

Past Grants

Agency: American Academy of Psychiatry and the Law Institute for Education and Research (AIER)
Title: "Introduction to Forensic Psychiatry – A National Model for an Interactive Module-Based Curriculum"
P.I.: Tobias Wasser, M.D.
Percent effort: 5%
Direct costs per year: $5,000
Total costs for project period: $15,000
Project period: 02/01/2016 – 01/31/2019

Invited Speaking Engagements, Presentations, Symposia & Workshops:

International/National

2020: The University of Oklahoma-Tulsa (Tulsa, OK), Psychiatry Residency Program, "Confidentiality and Duties to Third Parties"

2020: American Psychiatric Association (Washington, DC), 2020 APA On Demand, "Television and Podcast Series: Teaching Forensic Psychiatry and Using Narrative Medicine Through True-Crime and Fiction"

2020: Veterans Health Administration Emergency Medicine Mental Health Leads (Washington, DC), Monthly National Teleconference, "Emergency Holds and Commitments"

2019: CME Outfitters (Washington, DC), Initiating Medication-Assisted Therapy for OUD in Diverse Settings: Clinical Pearls for Navigating the Process, "Correctional Settings"

2018: CME Outfitters (Washington, DC), Opioid Use Disorder in Special Populations: Making Recovery a Goal, "Forensic Populations"

2018: Eastern Virginia Medical School (Norfolk, VA), Department of Psychiatry Grand Rounds, "*Tarasoff* Warnings and Duties to Third Parties"

2018: Kawea District Healthcare (Visalia, CA), Psychiatry Residency Program, "Confidentiality and Duties to Third Parties"

2018: Duke University (Durham, NC), Psychiatry and Law Podcast Series, "Duties to Third Parties"

2018: Duke University (Durham, NC), Psychiatry and Law Podcast Series, "Confidentiality"

2016: National Public Radio (NPR), interviewed on *All Things Considered*: "Insanity Acquittee Recidivism in Connecticut" (http://wnpr.org/post/study-looks-recidivism-among-insanity-acquittees-connecticut)

Regional

2020: Western Connecticut Mental Health Network (Waterbury, CT), Invited Lecture, "Understanding Psychiatry and the Law in the Outpatient Setting"

2018: Western Connecticut Mental Health Network (Waterbury, CT), 3rd Annual Innovations in Behavioral Health Symposium on Violence, "Violence Risk Assessment and Management"

2018: Institute of Living (Hartford, CT), Department of Psychiatry Grand Rounds, "Confidentiality and Duties to Third Parties"

2018: Middlesex Hospital (Middletown, CT), Department of Psychiatry Medical Staff Seminar Series, "Risk Assessment and Management"

2018: Middlesex Hospital (Middletown, CT), Department of Psychiatry Grand Rounds, "*Tarasoff* Warnings and Duties to Third Parties"

2018: Jersey Shore University Medical Center (Neptune, NJ), Forensic Psychiatry Symposium, "Confidentiality and Duties to Third Parties"

2018: Berkshire Medical Center (Pittsfield, MA), Psychiatry Residency Program, "Confidentiality and Duties to Third Parties"

2016: Western Connecticut Mental Health Network Monthly Staff Meeting (Waterbury, CT): "A Novel Approach to Morbidity and Mortality Analysis"

2016: VA Connecticut Healthcare Services Monthly Staff Meeting: "Graduate Medical Education in Quality Improvement"

2016: Yale Program Directors' Annual Retreat: "Evaluating Adverse Events and Near Misses Using Root Cause Analysis"

2016: New Haven Community Services Network Quarterly Leadership Meeting: "Planning for Community Safety"

2016: VA Connecticut Healthcare System Mental Health Service Line Monthly Meeting: "Redesigning Quality Improvement Education"

2015: New Haven Community Services Network Leadership Meeting: "Understanding Violence Risk"

2015: Yale Psychiatry and Cinema: "The Stanford Prison Experiment"

Peer-Reviewed Presentations & Symposia:

International/National

2020: 2020 American Psychology-Law Society Annual Conference, New Orleans, LA, "The Inventory of Legal Knowledge (ILK): What Does the Research Say"

2019: 50th Annual Meeting of the American Academy of Psychiatry and the Law, Baltimore, MD, "Using Technology to Improve Residents' Forensic Education"

2019: 50th Annual Meeting of the American Academy of Psychiatry and the Law, Baltimore, MD, "Entertainment Media Reviews: Fluff or Forensic Teaching Tool?"

2019: 50th Annual Meeting of the American Academy of Psychiatry and the Law, Baltimore, MD, "Should Forensic Patients Have Access to Violent Video Games?"

2019: 50th Annual Meeting of the American Academy of Psychiatry and the Law, Baltimore, MD, "A Fifty-State Survey of Insanity Acquittals"

2019: American Psychiatric Association 2019 Annual Meeting, San Francisco, CA, "Crossing the Psychiatric Quality Chasm From Different Angles: Perspectives for Administration, Education, and Clinical Practice"

2019: American Psychiatric Association 2019 Annual Meeting, San Francisco, CA, "Diverse Career Pathways in Psychiatry: A Career Panel for Students and Residents"

2019: American Psychiatric Association 2019 Annual Meeting, San Francisco, CA, "Assessing Leadership Opportunities: A Workshop for Residents, Fellows, and Early Career Psychiatrists"

2019: American Psychiatric Association 2019 Annual Meeting, San Francisco, CA, "Clinically Relevant Forensic Psychiatry: A Practical Review"

2018: 49th Annual Meeting of the American Academy of Psychiatry and the Law, Austin, TX, "Forensic Mental Health Legislation: A Primer and Update"

2018: Annual Convention of the American Psychological Association 2018, San Francisco, CA, "Improving Competency Restoration Through Placement Decisions: A Critical Review"

2018: American Psychiatric Association 2018 Annual Meeting, New York, NY, "Understanding *Tarasoff* Duties"

2018: American Psychiatric Association 2018 Annual Meeting, New York, NY, "Assessing Career Opportunities: A Workshop for Residents and Fellows"

2018: American Psychiatric Association 2018 Annual Meeting, New York, NY, "Systems Change Innovations in Psychiatry: Using Technology and Stakeholder Engagement for Meaningful Quality Improvement"

2018: American Psychiatric Association 2018 Annual Meeting, New York, NY, "Diverse Career Pathways to Leadership in Psychiatry"

2018: American Psychology Law Society - AP-LS Conference 2018, Memphis, TN, "Competency Restoration for Adult Defendants in Different Treatment Environments A Future Direction for Research and Policy"

2017: Association for Academic Psychiatry 2017 Annual Meeting, Denver, CO, "Disability Evaluations in Residency Education"

2017: 48th Annual Meeting of the American Academy of Psychiatry and the Law, Denver, CO, "So You're All Grown Up? Transitioning from Trainee to Expert"

2017: 48th Annual Meeting of the American Academy of Psychiatry and the Law, Denver, CO, "Corrections: An Early Intervention Opportunity in Psychosis"

2017: American Psychiatric Association 2017 Annual Meeting, San Diego, CA, "Decriminalizing Mental Illness Using the Sequential Intercept Model: An Overview and Update on Recent Trends"

2017: American Psychiatric Association 2017 Annual Meeting, San Diego, CA, "Confidentiality: What Every Resident Needs to Know"

2017: American Psychiatric Association 2017 Annual Meeting, San Diego, CA, "Innovation and Progress in Public Psychiatry"

2017: American Psychiatric Association 2017 Annual Meeting, San Diego, CA, "Engaging in Meaningful Quality Improvement Using Root Cause Analysis as a Novel Approach to M&M Conferences in Psychiatric Training"

2016: 47th Annual Meeting of the American Academy of Psychiatry and the Law, Portland, OR, "A Tale of Two PSRBs: Thirty Years of Outcome Data Explored"

2016: 47th Annual Meeting of the American Academy of Psychiatry and the Law, Portland, OR, "Forensic Rotations for Residents: Navigating the Challenges"

2016: Institute for Psychiatric Services: The Mental Health Services Conference, Washington, D.C., "Designing Effective Jail Diversion Programs and Identifying Relevant Outcome Measures"

2016: American Psychiatric Association 169th Annual Meeting, Atlanta, GA, "Disentangling Guns and Mental Illness: The Sandy Hook Effect"

2016: American Psychiatric Association 169th Annual Meeting, Atlanta, GA, "Managing Violence Risk and Interview Safety: A Primer for Residents"

2015: 46th Annual Meeting of the American Academy of Psychiatry and the Law, Fort Lauderdale, FL, "Is Jail Diversion Effective? And for Whom?"

2015: 46th Annual Meeting of the American Academy of Psychiatry and the Law, Fort Lauderdale, FL, "Novel Approach to Teaching Residents About Violence and Safety"

2015: Institute for Psychiatric Services: The Mental Health Services Conference, New York, NY, "A Novel Approach to Morbidity and Mortality Analysis in Psychiatric Training"

2015: Association for Academic Psychiatry Annual Meeting, San Antonio, TX, "A Novel Approach to Morbidity and Mortality Analysis in Psychiatric Training"

2015: American Psychiatric Association 168th Annual Meeting, Toronto, Canada, "The American Journal of Psychiatry Residents' Journal: How to Get Involved"

2015: 24th Annual Conference of the International Association for Forensic Psychotherapy, New Haven, CT, "The Impact of Violence on Trainees: An Educational Intervention"

Regional

2015: Yale-New Haven Hospital Quality and Safety Series, New Haven, CT, "When "Whose fault is it?" doesn't get to the root of the problem. Using RCA to improve systems"

Professional Service

Journal Service:

Editorial Board

2018-present Associate Editor, *World Journal of Psychiatry*
2017-20 Deputy Editor, *Journal of Psychiatric Administration and Management*
2017-present Book Review Editor, *Journal of the American Academy of Psychiatry and the Law*
2014-15 Deputy Editor, *American Journal of Psychiatry Residents' Journal*

Ad Hoc Reviewer

2019-present *Cambridge University Press*
2018-present *Oxford University Press, World Journal of Psychiatry*
2017-present *Advances in Medical Education and Practice, BMJ Open, Psychiatric Services, Journal of Psychiatric Administration and Management*
2016-present *Journal of Gerontological Social Work*
2015-present *Academic Psychiatry, Journal of the American Academy of Psychiatry and the Law*

Professional Service for Professional Organizations:

American Academy of Psychiatry and the Law (AAPL)

2019-present Co-Chair, Forensic Training of Psychiatry Residents
2019 Member, Task Force on Committee Reform
2018-present Co-Chair, Government Affairs Committee

2017-19 Member, Forensic Recovery Committee
2017-present Member, Forensic Hospital Services Committee
2015-20 AAPL Young Physician Delegate to the AMA House of Delegates
2015-19 Member, Forensic Training of Psychiatry Residents Committee
2015-17 Member, Community Forensics Committee

American Association of Psychiatric Administration and Leadership
2020-present President-Elect, Executive Council
2019-20 Secretary, Executive Council
2018-19 Treasurer/Secretary, Executive Council
2017-20 Chair, Early Career Psychiatrists Committee
2017-18 Councilor-at-Large, Executive Council

American Medical Association
2016-19 Member, Academic Physicians Section
2016-17 Member, Young Physician Section Committee on Maintenance of Certification/Licensure

American Psychiatric Association (APA)
2020-present Corresponding Member, Ethics Committee
2020-present Program Director, APA/APAF Leadership Fellow's Project
2019 Member, Ethics Committee Task Force on Extrinsic Evidence
2019-present Early Career Psychiatrist Representative for Area 1, APA Assembly
2018-19 Early Career Psychiatrist Member, Committee on Voter Turnout of the APA Assembly
2018-19 Early Career Psychiatrist Member, Committee on Education of the APA Assembly
2018-19 Consultant, Committee on Judicial Action
2018-20 Consultant, Ethics Committee
2017-19 Early Career Psychiatrist Deputy Representative for Area 1, APA Assembly
2017-present Early Career Psychiatrist Member, Awards Committee of the APA Assembly
2017-present Member, State Hospital Psychiatrists Caucus
2016-present Fellow of the APA

Association for Academic Psychiatry
2015-19 Member, Fellow and Resident Training Committee

Connecticut Psychiatric Society
2020-present President-Elect, Executive Council
2019-20 Treasurer, Executive Council
2016-19 Councilor-at-Large, Executive Council

Group for the Advancement of Psychiatry (GAP)
2019-present Member, Administration and Leadership Committee
2018-19 Invited Guest, Administration and Leadership Committee

National Association of State Mental Health Program Directors (NASMHPD)
2018-present Northeast Representative, Forensic Division Executive Committee
2017-present Member, Forensic Division

Physicians for Criminal Justice Reform

2020-present Director, Mental Health Task Force
2016-20 Member, Research Committee

Yale University Service:

Medical School Committees

2017-present Reviewer, Teaching and Learning Center Medical Education Day abstract submissions

Departmental Committees

2016-18 Chair, Quality Improvement Collaborative, Dept. of Psychiatry, School of Medicine
2016-17 Council Member, Yale Psychiatry Global Mental Health Program, Dept. of Psychiatry, School of Medicine
2016-17 CMHC Representative, Medical Student Education Committee, Dept. of Psychiatry, School of Medicine
2016-present Member, Quality Improvement Educational Task Force, Dept. of Psychiatry, School of Medicine
2016-present Member, Resident Interview Committee, Dept. of Psychiatry, School of Medicine
2015-present Member, Forensic Fellowship Interview Committee, Dept. of Psychiatry, School of Medicine
2013-14 Member, Graduate Education Committee, Dept. of Psychiatry, School of Medicine
2013-14 Co-Director, Resident Grand Rounds Series, Dept. of Psychiatry, School of Medicine
2012-14 Member, Resident Selection Committee, Dept. of Psychiatry, School of Medicine
2011-12 Co-President, Psychiatry Residents Association, Dept. of Psychiatry, School of Medicine

Hospital Committees

2018-present Chair, Ethics Committee, Whiting Forensic Hospital
2018-present Chair, Grand Rounds Committee, Whiting Forensic Hospital
2018-present Member, Governing Body, Whiting Forensic Hospital
2018-present Member, Forensic Review Committee, Whiting Forensic Hospital
2017-18 Member, Whiting Forensic Hospital Implementation Committee, Connecticut Department of Mental Health and Addiction Services
2017-18 Member, Forensic Review Committee, Connecticut Valley Hospital
2017-18 Member, Division Review Committee, Connecticut Valley Hospital
2017-18 Member, Hospital Review Committee, Connecticut Valley Hospital
2017-18 Member, Critical Incident Review Committee, Connecticut Valley Hospital
2017-18 Member, Quality Risk and Safety Committee, Connecticut Valley Hospital
2017-18 Member, Whiting Forensic Division Executive Council, Connecticut Valley Hospital
2016-17 Co-Chair, Medication Safety Committee, Connecticut Mental Health Center
2016-17 Co-Chair, Education and Training Committee, Connecticut Mental Health Center
2016-17 Facility Lead, DMHAS Electronic Health Record Workgroup, Connecticut Mental Health Center
2016-17 Member, Peer Review and Privileging Committee, Connecticut Mental Health Center
2016-17 Member, Ethics Committee, Connecticut Mental Health Center
2016-17 Member, Graduate Education Committee, Connecticut Mental Health Center

Professional Consultation:

2019-present Forensic Psychiatry Inpatient Services Consultant, Brattleboro Retreat, Brattleboro, VT

2018-present Forensic Education Consultant, Mental Health Technology Transfer Center Grant for Northwest Region, Seattle, WA
2018-present Consultant on Forensic Service Development, Vermont Department of Mental Health
2018-present Forensic Psychiatry Consultant, Middlesex Hospital, Middletown, CT

Educational Activities:

Educational Program Development

2017-present Co-Director, Public Psychiatry Seminar, Forensic Psychiatry Fellowship, School of Medicine
2016-present Co-Director, Introduction to Public Sector Mental Health and Administration, Yale Fellowship in Public Psychiatry, School of Medicine
2016-present Co-Director, PGY4 Leadership Course, Dept. of Psychiatry, School of Medicine
2016-17 Director, Inpatient Interdisciplinary Seminar, Connecticut Mental Health Center
2014-16 Mental Health System Improvement Series, VA Connecticut Healthcare System and Connecticut Mental Health Center
2014 Clinical Rotation in Forensic Psychiatry, Dept. of Psychiatry, School of Medicine
2014 Social Security Disability Evaluations, Dept. of Psychiatry, School of Medicine
2013-present Understanding Violence Risk, Dept. of Psychiatry, School of Medicine
2013-14 Psych 101 "Cheat Sheets", Dept. of Psychiatry, School of Medicine

Supervision and Mentorship

2015-19 Supervisor of PGY3 resident and MS4 medical student in developing modules for AIER grant, Dept. of Psychiatry, School of Medicine
2015-present Forensic evaluation supervisor for residents and forensic fellows, Dept. of Psychiatry, School of Medicine
2012-17 Medical student interview tutor, Dept. of Psychiatry, School of Medicine

Teaching Experience

2017-present Sequential Intercept Model, Forensic psychiatry fellows
2017-19 Criminal Law, Forensic psychiatry fellows
2016-present Quality Improvement Seminar, PGY1-4 psychiatry residents
2016-19 "A New Take on M&Ms" –Quality Improvement Workshop, MS3 medical students
2015-19 Recovery Movement Workshop, PGY2 psychiatry residents
2015-17 Evaluation of Psychosis, MS3 medical students
2015-17 Violence and Suicide Risk Assessment, MS3 medical students
2015-16 Introduction to Forensic Psychiatry, PGY1 psychiatry residents
2015 Forensic Psychiatry Case Conference, PGY2 psychiatry residents
2015 Quality Improvement Workshop, PGY4 psychiatry residents
2014-present Suicide Prevention Workshop, PGY2 psychiatry residents
2014 Assessment and Treatment of Bipolar Disorder, PGY2 psychiatry residents
2013 Ethics Workshop, PGY2 psychiatry residents
2013 The One-Minute Preceptor Workshop, PGY2 psychiatry residents
2013-14 Therapeutic Communication: Termination, PGY1 psychiatry residents
2013-14 Suicide and Violence Risk Assessment, PGY1 psychiatry residents

Professional Memberships

2010-present American Medical Association

2012-present American Psychiatric Association
2012-present Connecticut Psychiatric Society
2014-present American Academy of Psychiatry and the Law
2015-present American Association of Psychiatric Administrators
2015-present American Association of Community Psychiatrists
2015-present Physicians for Criminal Justice Reform
2018-present International Initiative for Mental Health Leadership

Other Licensure and Certification:

Connecticut State Medical License, 2012
Buprenorphine DEA Waiver Registration, 2014

Bibliography:

Peer-Reviewed Original Research

1. Ford J.D., **Wasser T.,** Connor D. Identifying and determining the symptom severity associated with polyvictimization among psychiatrically impaired children in the outpatient setting. *Child Maltreat* 2011, 16:216-226.
2. **Wasser T.,** Fox P.K.. For whom the bell tolls: Silver Alerts raise concerns regarding individual rights and governmental interests. *J Am Acad Psychiatry Law* 2013, 41:421-429.
3. **Wasser T**. How do we keep our residents safe? An educational intervention. *Acad Psychiatry* 2015, 39:94-98.
4. **Wasser T.**, Richards M., Radhakrishnan R., Freedman R. The American Journal of Psychiatry Residents' Journal: Training the Next Generation of Academic Psychiatrists. *Am J Psychiatry* 2016, 173:461-464.
5. **Wasser T.,** Grunschel B.D., Stevens A., Capurso N.A., Ralevski E., Barkil-Oteo A., Trevisan L. Transforming systems of care through a novel resident-led approach to morbidity and mortality conferences. *Acad Psychiatry* 2016, 40:893-897.
6. **Wasser T.,** Ross D.A. Another step forward: A novel approach to the clinician-educator track for residents. *Acad Psychiatry* 2016, 40:937-943.
7. **Wasser T.** Gaining administrative experience during residency – identifying and exploring opportunities. *Journal of Psychiatric Administration and Management* 2016, 5:9-12.
8. Norko M., **Wasser T.**, Magro H., Leavitt-Smith E., Morton F., Hollis T. Assessing insanity acquittee recidivism in Connecticut. *Behav Sci Law* 2016, 34:423-443.
9. Radhakrishnan R., **Wasser T.**, Picon F., Puspanathan P., da Costa MP., Nakamae T., Elkholy H. Editorial training models for early-career psychiatrists. *Lancet Psychiatry* 2017, 4:515-516.
10. **Wasser T.,** Pollard J., Fisk D., Srihari V. First-episode psychosis and the criminal justice system: Using a sequential intercept framework to highlight risks and opportunities. *Psychiatr Serv* 2017, 68:994-996.
11. Michaelsen K., Lewis A., Morgan P., McKee S., **Wasser T.** The barriers and benefits to developing forensic rotations for psychiatry residents. *J Am Acad Psychiatry Law* 2018, 46:322–328.
12. de Similien R., Dooley E., **Wasser T.** Public service psychiatry in the age of social determinants: Why psychiatry trainees should join in. *Journal of Psychiatric Administration and Management* 2018, 6:39-44.
13. de Similien R., Hairston D., Kumari S., Matthews G., **Wasser T.**, Malik M., Manalai P. Sociodemographic and clinical correlates of the frequently hospitalized African American patients with severe persistent mental illness. *Ann Clin Psychiatry* 2018, 30:305-310.

14. **Wasser T.**, Sun A., Chandra S., Michaelsen K. The benefits of required forensic clinical experiences in residency. *Academic Psychiatry* 2019, 43:76-81.
15. Danzer G., Wheeler E., Alexander A., **Wasser T.** Competency restoration for adult defendants in different treatment environments: A future direction for research. *J Am Acad Psychiatry Law* 2019, 47:68-81.
16. Li L., Gupta N., **Wasser T.** A novel initiative contextualizing quality improvement and systems based practice in psychiatric clinical teaching settings, *Journal of Mental Health Training, Education and Practice* 2019, 14:156-163.
17. Cerny-Suelzer C.A., Ferranti J., **Wasser T**., Janofsky J.S., Michaelsen K., Alonso-Katzowitz J.S., Cardasis W., Noffsinger S., Martinez R., Spanggaard M. Practice resource for forensic training in general psychiatry residency programs. *J Am Acad Psychiatry Law* 2019, 47:266, S1-S14.
18. **Wasser T.**, Chandra S., Michaelsen K. Enhancing forensic exposures in residency training. *Journal of Mental Health Training, Education and Practice* 2019, 15:13-19.
19. **Wasser T.**, Hu J., Danzig A., Yarnell-Mac Grory S., Rodriguez-Guzman J., Michaelsen K. Teaching forensic concepts to residents using interactive online modules. *J Am Acad Psychiatry Law* 2020*,* 48:77-83.
20. Chaffkin J., **Wasser T.** The impact of teaching internal medicine residents about decision-making capacity. *Academic Psychiatry* 2020, [Epub ahead of print]. doi: 10.1007/s40596-020-01219-8.
21. Pollard J.M., Ferrara M., Lin I.H., Kucukgoncu S., **Wasser T.,** Li F., Srihari V. Analysis of early intervention services on adult judicial outcomes. *JAMA Psychiatry* 2020, [Epub ahead of print]. doi: 10.1001/jamapsychiatry.2020.0448.

Books

22. Psychiatry and the Law: Basic Principles, 1st edition, ed. **T. Wasser**, Springer, NY, NY, 2017.

Chapters and Reviews

23. **Wasser T.** A relevant review of violence risk for the psychiatric trainee. *Am J Psychiatry Residents' Journal* 2014, 9:5-7.
24. **Wasser T.** Attending to safety in the psychiatric interview. *Am J Psychiatry Residents' Journal* 2014, 9:3-5.
25. **Wasser T**. Chapter 9: Recognizing and managing the agitated patient, in A Resident's Guide to Surviving Psychiatric Training, 3rd Edition. Edited by Foreman T, Dickstein LJ, Garakani A, Jordan AM, Richards M. American Psychiatric Association Publishing, Arlington, VA, 2015, pp. 53-62.
26. **Wasser T**. Chapter 36: Ethics (Capacity Evaluation), in Essential Psychiatry Board Review. Edited by Tampi R, Zdanys K, Oldham M. Oxford University Press, NY, NY, 2017, pp. 335-338.
27. **Wasser T.**, Michaelsen K. Introduction: Why Understanding the Law Matters. In Psychiatry and the Law: Basic Principles, 1st edition, ed. **T. Wasser**, Springer, NY, NY, 2017, pp. 1-8.
28. Sun A., **Wasser T.** Confidentiality and Privilege. In Psychiatry and the Law: Basic Principles, 1st edition, ed. **T. Wasser**, Springer, NY, NY, 2017, pp. 21-34.
29. **Wasser T.** Conclusion: How to Learn More About Forensic Psychiatry. In Psychiatry and the Law: Basic Principles, 1st edition, ed. **T. Wasser**, Springer, NY, NY, 2017, pp. 183-188.
30. Sun A., **Wasser T.** Chapter 1: Cognitive-Behavioral Therapy, Imipramine, or Their Combination for Panic Disorder. In 50 Studies Every Psychiatrist Should Know, 1st edition, eds. **I. Bhalla, R. Tampi, V. Srihari**, Oxford University Press, NY, NY, 2018, pp. 1-6.

31. Habecker E., **Wasser T.** Chapter 2: Fluoxetine, Comprehensive Cognitive-Behavioral Therapy, and Placebo for Generalized Social Phobia. In 50 Studies Every Psychiatrist Should Know, 1st edition, eds. **I. Bhalla, R. Tampi, V. Srihari**, Oxford University Press, NY, NY, 2018, pp. 7-13.
32. **Wasser T.**, Papapietro D., Kapoor R. Chapter 22: Self-disclosure in forensic settings: Therapeutic intervention vs. boundary violation. In Therapeutic Self-Disclosure, 1st edition, ed. Danzer G., Brunner-Routledge, NY, NY, 2018, pp. 168-177.

Peer-Reviewed Educational Materials

33. **Wasser T.,** Ross D. Recognizing and Managing Safety in the Psychiatric Interview: A Brief Intervention. Peer-reviewed and selected by the American Association of Directors of Psychiatric Residency Training as a Milestones Toolkit; August 2014.
34. Kopelovich S., Michaelsen K., **Wasser T.** Violence Risk Assessment & Management in Community Mental Health Settings. Published by the Mental Health Technology Transfer Center Network; June 2019. Available at https://mhttcnetwork.org/centers/northwest-mhttc/training-launch-violence-risk-assessment-management-community-mental-health.
35. **Wasser T.,** Yarnell-Mac Grory S., Michaelsen K. Understanding Confidentiality: Protecting Your Patient, Third Parties and Yourself. Peer-reviewed and selected by the American Association of Directors of Psychiatric Residency Training as a Model Curriculum; 2020.

Invited Editorials and Commentaries

36. **Wasser T**. A day in the life of a resident: Yale psychiatry. *Psychiatric Times* 2013, http://www.psychiatrictimes.com/blogs/residents-blog/day-life-resident-yale-psychiatry.
37. **Wasser T**, Grunschel B. A novel approach to morbidity and mortality analysis in psychiatry residency. *Psychiatric Times* 2014, http://www.psychiatrictimes.com/residents-corner/novel-approach-morbidity-and-mortality-analysis-psychiatry-residency
38. Richards M., **Wasser T.**, Radhakrishnan R. Residents' Journal: An Opportunity to Get Involved. *Psychiatric News* 2014, http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1901733. doi: 10.1176/appi.pn.2014.8b1.
39. **Wasser T**. One head, multiple hats. *AAPL Newsletter* 2015; 40 (2):10, 25.
40. **Wasser T**. The ripple effect – psychiatric admissions and gun ownership following sandy hook. *Connecticut Psychiatrist*. Spring 2015; 54 (1): 1, 4-5.
41. **Wasser T.**, Michaelsen K., Ferranti J. Developing forensic clinical experiences for general psychiatry residents: Navigating the obstacles. *AAPL Newsletter* 2016; 41(1): 21, 26, 28.
42. **Wasser T**. 2015 AAPL presidential address – Graham Glancy, MBChB, FRCPsych, FRCP(C):: Witness protection program: A matter of training. *AAPL Newsletter* 2016; 41(1): 1-2.
43. Wall B., Gruenberg L., Piel J., **Wasser T.** American Medical Association 2015 interim meeting highlights. *AAPL Newsletter* 2016; 41(1): 14.
44. Wall B., Gruenberg L., Piel J., **Wasser T.** American Medical Association 2016 annual meeting highlights. *AAPL Newsletter* 2016; 41(3): 19, 31.
45. Wall B., Gruenberg L., Piel J., **Wasser T.** American Medical Association 2016 interim meeting highlights. *AAPL Newsletter* 2017; 42(1): 17, 34.
46. Wall B., Gruenberg L., Piel J., **Wasser T.** American Medical Association 2017 interim meeting highlights. *AAPL Newsletter* 2018; 43(1): 22.
47. Wall B., Gruenberg L., Piel J., **Wasser T.** American Medical Association 2018 annual meeting highlights. *AAPL Newsletter* 2018; 43(3): 15.
48. **Wasser T**. Becoming the medical director of a forensic hospital. *AAPL Newsletter* 2018; 43(2): 25-26.
49. **Wasser T.**, Thompson, C. Expanding AAPL's scope. *AAPL Newsletter* 2018; 43(3): 19, 35.

50. Wall B., Piel J., **Wasser T.** American Medical Association 2018 interim meeting highlights. *AAPL Newsletter* 2019; 44(1): 25, 31.
51. **Wasser T.,** Michaelsen K. Engaging general psychiatry residents: Forensic educators as storytellers. *AAPL Newsletter* 2019; 44(1): 24, 31.
52. Wall B., Piel J., **Wasser T.** American Medical Association 2019 annual meeting highlights. *AAPL Newsletter* 2019; 44(3): 1-2.
53. Rosenbaum K., Friedman SH., Cerny-Suelzer C., Weiss K., **Wasser T.** Entertainment media reviews: Fluff or forensic teaching tool? *AAPL Newsletter* 2020; 45(1): 19. 26.

Case Reports, Technical Notes, Letters

54. **Wasser T.**, Edwards L. Mentally ill in police custody: subjective standard denied. *J Am Acad Psychiatry Law* 2013, 41:121-123.
55. **Wasser T.,** Trueblood K. Forced meds to restore competency. *J Am Acad Psychiatry Law* 2015, 43:9-11.
56. Charoensook J., Sidaros R., Pier K., Millard H., **Wasser T**., Richards M., Radhakrishnan R.: Reflections on an innovation: The first trainee-led academic psychiatry journal. *Acad Psychiatry* 2016, 40:564-565.
57. **Wasser T.**, Ross D.A.: Resident grand rounds. *Med Educ* 2016, 50:1157-1158.
58. Yarnell S., **Wasser T.** Is “some” enough in special education? *J Am Acad Psychiatry Law* 2018, 46:119-121.
59. Abellard J., **Wasser T.** Parens patriae liability prevented by governmental immunity. *J Am Acad Psychiatry Law* 2019, 47:109-111.
60. Mathew M., **Wasser T.** Religious rights in the criminal justice system. *J Am Acad Psychiatry Law* 2020, 48:119-121.

In Press

61. **Wasser T.**, Zhong R., Mufson J., Danzig A., Koka L., Kapoor, R. Violent video games in forensic psychiatric hospitals. *J Am Acad Psychiatry Law* 2020*, In press*.
62. Danzer G., **Wasser T.** The Inventory of Legal Knowledge (ILK): A literature review. *J Am Acad Psychiatry Law* 2020, *In press.*
63. Sapra M., Alvarado G., **Wasser T.** Chapter 5: Organized psychiatric healthcare systems: Private practices, community-based clinics, hospitals, and health Systems. In Textbook of Psychiatric Administration and Leadership, 3rd edition, ed. Saeed S., Lauriello J. & Roberts L., APA Publishing, Washington, D.C., *In press*.
64. **Wasser T.,** Dike C., Norko M. Chapter 12: The forensic unit. In Textbook of Hospital Psychiatry, 2nd edition, ed. Travedi H. & Sharfstein S., APA Publishing, Washington, D.C., *In press*.
65. **Wasser T.,** Hauser L., Kapoor R. The management of COVID-19 in forensic psychiatric institutions. *Psychiatr Serv* 2020, *In press*.

EXHIBIT D

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs* v. NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, In their official capacities, *Defendants*	:	CIVIL NO. 3:20CV594-JCH JULY 6, 2020

DECLARATION OF VINNETH CARVALHO, MD

The undersigned declarant, Vinneth Carvalho, MD, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am employed by the State of Connecticut Department of Mental Health and Addiction Services as the Chief Medical Officer at Connecticut Valley Hospital ("CVH") in Middletown, CT. I have held this position since April 22, 2019. A copy of my CV is attached as Attachment 1 hereto.

2. I make this Declaration based upon personal knowledge, and I understand that it will be submitted to this Court in connection with the above-captioned case in support of the

Defendants' Opposition to the Plaintiffs' Motion for Preliminary Injunction.

3. CVH is a state-operated psychiatric inpatient facility providing mental health services to individuals.

4. CVH employs on site medical doctors ("MDs"), advance practice registered nurses ("APRNs"), Physician Assistant and nurses on every shift who address medical needs of patients.

5. As part of my job duties, I am responsible for the management and oversight of the daily clinical operations and patient care at CVH.

6. CVH has protocols in place with regard to testing in response to the COVID-19 pandemic. The most recent update to these protocols was on June 29, 2020. See Exhibit P, CVH COVID-19 Response Plan Testing Protocol.

7. From March 17, 2020 to June 30, 2020, there was a prohibition of visitors at CVH. As of July 1, 2020, visitation has resumed subject to requirements and guidance from the Connecticut Department of Public Health ("DPH") and the Center for Disease Control. ("CDC").

8. CVH conducts daily COVID-19 screening of those entering the hospital, including staff, by checking temperatures and asking series of questions about current COVID-19 symptoms, potential COVID-19 exposures and recent travel. The questionnaire is frequently updated to reflect evolving CDC guidance.

9. CVH conducts daily COVID-19 screening of patients by checking temperatures, monitoring their breathing and oxygen saturation level with the use of pulse oximeters

and asking series of questions about current COVID-19 symptoms. The questionnaire is frequently updated to reflect evolving CDC guidance.

10. All new patients are tested prior to or upon entry to CVH and are quarantined for 14 days.

11. On March 19, 2020, CVH began monitoring all patients for COVID-19. All patients who are suspected for COVID-19 are tested. On March 21, 2020, CVH tested its first suspected case of COVID-19.

12. Baseline testing of patients at CVH was completed on May 6, 2020.

13. The date that a patient at CVH last tested positive for COVID-19 was on May 16, 2020.

14. Since May 16, 2020, no new patients at CVH have tested positive for COVID-19.

15. As of July 1, 2020, a total of 63 patients out of 243 patients at CVH tested positive for COVID-19 since the pandemic began.

16. As of July 1, 2020, a total of 57 patients who tested positive for COVID-19 have recovered from COVID-19 since the beginning of the pandemic.

17. As of July 1, 2020, 239 CVH patients in total have been tested for COVID-19 since the pandemic began. The current CVH census is 217 patients.

18. Baseline testing of staff at CVH was completed on May 28, 2020.

19. On July 6, 2020, CVH began repeat testing of staff.

20. The date that a direct care staff member at CVH last tested positive for COVID-19 was on May 19, 2020.

21. The date that a non-direct care staff member at CVH last tested positive for COVID-19 was on May 21, 2020.

22. As of July 1, 2020, a total of 45 staff members out of 1095 staff members at CVH

tested positive for COVID-19 since the beginning of the pandemic.

23. As of July 1, 2020, a total of 44 staff members who tested positive for COVID-19 have recovered from COVID-19.

24. As of July 1, 2020, 541 staff members out of 1095 staff members at CVH have been tested for COVID-19 since the pandemic began.

25. As of July 1, 2020, 504 staff members of the 541 staff members at CVH who have been tested for COVID-19 since the pandemic began are direct care staff.

26. If a patient tests positive for COVID-19, CVH conducts contract tracing and testing of staff and residents who may have been exposed to the patient.

27. CVH cannot mandate patient testing for COVID-19.

28. If a patient who displays COVID-19 symptoms refuses COVID-19 testing, CVH treats the patient as if he or she has COVID-19 and follows the hospital's protocol for treating COVID-19 positive patients.

29. If a new admission refuses COVID testing, CVH treats the patient as if he or she has COVID-19 and follows the hospital's protocol for COVID-19 positive patients.

30. If a staff member tests positive for COVID-19, CVH conducts contract tracing and testing of staff and residents who may have been exposed to the patient.

31. As of July 6, 2020, testing for COVID-19 is mandatory for direct care staff and those who regularly interact with patients.

32. The use of personal protective equipment ("PPE") at CVH has evolved consistent with CDC guidelines.

33. In particular, as early as March 10, 2020, CVH issued guidance on PPE use, including the requirement of mask use at the point of presentation of any COVID-19 like symptoms.

34. CVH staff have available to them all necessary PPE, including, but not limited to: surgical masks, face shields, N95 masks, eye protection, gowns, gloves and probe covers, in addition to hand sanitizer.

35. Direct care staff have received web-based training on PPE use including proper donning and doffing protocols. Live tutorials have also been offered. Training for staff on these issues is ongoing.

36. Staff are required to wear surgical masks in all patient areas. CVH patients are provided face masks at least weekly, and more often if they become soiled or damaged, consistent with individual medical assessments to ensure no unwarranted medical risk or risk of self-injury is present.

37. Patients have also been provided education on proper mask use through handouts, posters and unit-based meetings. Educational efforts are ongoing. There is documentation regarding the education on the proper use of mask, hand hygiene and social distancing in each patient's medical chart.

38. All patients at CVH are part of a treatment team made up of clinicians that collaboratively plan and provide care to the patient. The team consists of a psychiatrist, medical doctor, psychologist, social worker, rehabilitation therapist, nurses, and mental health assistants (who assist in therapeutic engagements).

39. Taking into account the limits of court-imposed confinement and in accord with governing policies, CVH actively pursues the appropriate discharge of every patient deemed discharge ready by their treatment team.

40. Planning for discharge to the most integrated community setting begins upon admission to the inpatient service and treatment planning by the team addresses the particular considerations for each patient bearing on discharge and identifies barriers to discharge.

41. At every monthly treatment plan review the treating physician will document in the patient's chart and discuss with the patient the specific factors that the physician is considering to determine the patient's current clinical need for hospital level of care and the patient's readiness for discharge. Such factors should include the patient's physical and mental status, results of medical/psychological tests, the patient's cognitive and behavioral status, the patient's functional capacities, and evaluative explorations or treatment protocols yet to be completed.

42. The physician will also document in the patient's chart the treatment interventions the hospital will provide to address each factor in order to discharge the patient from the hospital in a timely manner once the patient is deemed discharge ready by the treatment team. Extrinsic factors which present barriers to discharge, such as the patient's willingness to leave the hospital or the availability of a residential placement must be documented in the chart.

43. On each team is a clinical social worker who maintains a knowledge base of community support services and provides oversight to the discharge planning process. Typically, the clinical social worker will be communicating with community providers regarding a patient's discharge in advance of the patient being determined as ready for discharge.

44. As a result of this process, each month, there has been a professional judgment by the physician informed by the team as to whether a patient is discharge ready.

45. During the course of the pandemic, the treatment teams continue to address discharge readiness and barriers (reflected in the treatment plans) including those posed by COVID 19 pandemic.

46. From March 1, 2020 until June 30, 2020, 34 patients were discharged from the CVH General Psychiatric Division.

47. From March 1, 2020 until June 30, 2020, 23 patients were admitted to the CVH General Psychiatric Division.

48. CVH is comprised of two campuses with four clinical buildings: two (2) addiction services buildings, a geriatric building and a general psychiatric building.

49. The physical space as well as the reduction in census of the two addiction services buildings has allowed for appropriate social distancing throughout the pandemic.

50. Social distancing is more of a challenge in the General Psychiatric and Geriatric Services buildings; however, CVH has taken numerous steps to work with the challenges to achieve the goals of social distancing.

51. CVH, in consultation with the State of Connecticut Department of Public Health ("DPH") and a Middlesex Hospital Epidemiologist, established three patient cohorts: (1) Patients who tests positive for COVID 19; (2) Patients who test negative for COVID-19 but were exposed to others who tested positive for COVID-19; and (3) Patients that test negative for COVID-19 who were not exposed to a person who tested positive for COVID-19.

52. CVH assigns COVID-19 positive patients to one of the two isolation units that CVH established to treat COVID-19 positive patients, one of which has a surge capacity and each of which is equipped with negative pressure rooms and enough space to allow for social distancing.

53. CVH places people suspected of having COVID-19 ("PUIs") based on CDC guidelines in an isolation room with floor-to-ceiling walls and a separate bathroom.

54. In addition, patients exposed to a COVID-19 positive person who test negative for COVID-19 are cohorted and quarantined for fourteen (14) days.

55. CVH utilizes a more conservative adaptation of the Center for Disease Control's symptom-based criteria for discontinuing isolation precautions: No fever for seventy-two (72) hours without the use of fever reducing medications; resolution of symptoms; and fourteen (14) days since the onset of symptoms. The CDC recommends ten (10) days but out of abundance of caution, CVH uses fourteen (14) days. CVH also requires resolution of, rather than diminution of symptoms as the guidepost. Also, older CVH patients who experience complicated recoveries are tested twice, twenty-four hours apart. This protocol is in addition to the resolution of symptoms and the fourteen (14) day period.

56. Based on CDC and DPH recommendations, CVH consistently deploys staff to the same unit or, if not possible, to the same cohort. CVH makes every attempt to avoid deploying staff from a positive cohort unit to a negative cohort unit.

57. To further support social distancing, the beds in double-occupant rooms at CVH are placed so that the head of one bed faces the foot of the other bed thereby creating more than six (6) feet of distance between the heads of the patients.

58. Instead of congregate dining, CVH employs unit-based dining. CVH patients eat meals in their bedrooms or other rooms within patient units and, to the extent possible, staggers bathroom use and showering activity.

59. CVH has an enhanced protocol for patients who are exhibiting lack of behavior control, which includes: (a) onsite staff management; (b) assigning these patients to single occupant rooms when possible; and (c) for COVID-19 positive patients, conducting patient observation through a window or if there is no window, placement of a staff in proximity with appropriate PPE donned to permit timely intervention, if necessary.

60. In accordance with social distancing, CVH has continued to have meaningful visitor contact through virtual visitation.

61. To further support social distancing, from the end of March through mid-May, CVH ceased group therapeutic sessions and, instead, provided patients with individual therapy sessions via unit-based therapists. Since mid-May, CVH has performed risk benefit analyses for the previously available therapy groups to determine whether the benefits of a therapeutic group outweigh the risks associated with the pandemic if groups are limited to participants within a unit and group size is limited to three (3) to five (5) patients. This process has resulted in resuming some unit-based therapeutic groups of three (3) to five (5) patients.

62. CVH has altered CVH patient movement privileges. CVH limits courtyard use to members of a unit and limits the number of patients using it at any given time. CVH also prevents patients from congregating in other areas and mingling with patients from other units at CVH and prevents patients from accessing other areas at CVH and Whiting Forensic Hospital ("WFH").

63. CVH has instituted staff teleworking arrangements, to the extent possible, postponed non-critical staff training, and continues to utilize telemedicine to further reduce the number of people at CVH and maximize social distancing.

64. CVH has provided and continues to provide staff and patients with meaningful, ongoing education regarding COVID-19 prevention strategies, included social distancing.

65. CVH has provided and continues to provide patients with COVID-19 education in individual and small, unit-based group sessions. CVH uses the Coronavirus (COVID-19) FACT SHEET, See Exhibit O, as the basis for patient education. CVH also posts COVID-19 patient education posters in the bathroom (male and female) and hallways walls within patient care units.

66. CVH's "Talking Points Regarding Masks and PPE," guides staff communications with patients, in very simple terms. The guideline provides talking points for staff to use as follows:

- If you are wearing PPE that has been issued to you by DMHAS and is clinically indicated, please inform patients and other staff that you are wearing PPE because a risk has been identified and the PPE has been issued to you by DMHAS to protect you from exposure.
- We ask that if you choose to wear your own PPE, please convey to clients and other staff that your use of your personal PPE is not required and is a personal choice.
- Reassure clients that DMHAS and staff are doing everything they can to ensure the safety and health for all clients and staff on the unit.
- Reinforce social distancing and hand hygiene
- Remind patients that CVH will be sure to provide a mask to patients whenever they are needed
- Achieving Excellence & Conquering COVID TOGETHER!!

67. In addition, over a two-day period, CVH provided patients with enhanced COVID-19 reeducation in the following areas:

a. How is COVID-19 spread? Person-to-person through respiratory droplets;
b. COVID-19 may be spread by people who are not showing symptoms;

c. Clean your hands often by washing for at least 20 seconds or using hand sanitizer;
d. Cover your mouth and nose with a cloth face mask when around others; and
e. Avoid close contact – stay six feet (about two arm's length) away from others

68. All CVH staff have received frequent communications about the importance of providing patient COVID-19 prevention education and modelling COVID-19 preventive measures for the patients.

69. To further reinforce the CVH-provided patient education, CVH is also implementing a CVH developed, nine (9) session patient education program.

70. CVH staff and patients are instructed to maximize social distancing opportunities and maintain social distancing to the greatest extent possible.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 6th day of July, 2020.

Vinneth Carvalho, MD

ATTACHMENT 1

6/28/20

VINNETH V. CARVALHO, M.D.
Connecticut Valley Hospital
Middletown, CT. 06457
Telephone :(860) 262-7030
Email: vinneth.carvaho@ct.gov

LICENSURE/CERTIFICATION

Medical Licensure:
Connecticut (2006-current) #043469

Certification:
Board Certified in Psychiatry and Neurology (05/2007-current)
Board Certified in Forensic Psychiatry (06/2009-current)

EMPLOYMENT HISTORY

4/22/2019-current
Chief Medical Officer
Connecticut Valley Hospital
1000 Silver Street
Middletown, Connecticut 06457

01/05/2018-04/21/2019
Service Medical Director
Whiting Forensic Hospital
70 Obrien Drive
Middletown, Connecticut 06457

10/05/2012-01/04/2018
Assistant Chief of Psychiatry
University of Connecticut Health Center-CMHC
263 Farmington Avenue
Farmington, Connecticut 06030

12/31/2010-10/05/2012
Principal Psychiatrist
Whiting Forensic Division
Connecticut Valley Hospital
70 Obrien Drive

Middletown, Connecticut 06457

11/15/2006 – 12/30/2010
Principal Psychiatrist
University of Connecticut Health Center
York Correctional Institution
201 West Main Street
Niantic, Connecticut 06357

ACADEMIC APPOINTMENT

07/01/2006-current
Clinical Instructor in Psychiatry
Yale Law and Psychiatry Division
Yale University
34 Park Street
New Haven CT 06519

10/2012-01/2018
Clinical Instructor in Psychiatry
University of Connecticut School of Medicine
Farmington, CT 06030

POST GRADUATE TRAINING

07/01/2005 - 06/30/2006
Forensic Psychiatry Fellowship PGY V
Yale University - Law and Psychiatry Division
34 Park Street
New Haven CT 06519

07/01/2001 – 06/30/2005,
Psychiatry Resident PGY I-IV
Mount Sinai School of Medicine – Elmhurst Hospital Center
79-01 Broadway, Elmhurst, NY 11373

MEDICAL EDUCATION

08/01/1991 – 07/19/1997
Doctor of Medicine Diploma (M.D.)
Institution of Higher Education of Medical Sciences of Havana
Hospital Salvador Allende
University of Havana
Havana, Cuba

09//01/1997 – 06/30/1999
Locum Physician-Internship
Cornwall Regional Hospital
Montego Bay, Jamaica.

PROFESSIONAL MEMBERSHIP

American Psychiatric Association
American Association of Psychiatry and Law
National Commission on Correctional Health Care

PROFESSIONAL ACTIVITIES

O4/22/2019-current: Chair QRS subcommittee (Critical Incident Review), Connecticut Valley Hospital

04/22/2019-current; Co-Chair Clinical Management Committee, Connecticut Valley Hospital

05/2018-current: Co-Chair Pharmacy, Therapeutics and Nutrition Committee-Whiting Forensic Hospital

2012-2017: Chair, Staff Development Workshop, York Correctional Institution

2012-2017:
Policy and Procedures Executive Committee UConn Health-Correctional Managed Health Care

2012-2017:
Pharmacy and Therapeutics Committee UConn Health Correctional Managed Health Care

July 2003-June 2005
Chief Resident in Psychiatry, Mt. Sinai School of Medicine, Elmhurst Hospital, NY.

TEACHING/ACADEMIC SUPERVISION EXPERIENCE

2018-current
Forensic Psychiatry Fellows
Yale University-Law and Psychiatry Division
New Haven, CT

2012-2018
Psychiatric APRNs, Medical Students, Forensic Psychiatry Fellows

Yale University
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Medical Students, Psychiatry Residents
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Carvalho, Vinneth MD,: The Fine Art of Court Testimony**,** Connecticut Valley Hospital Grand Rounds, February 5, 2020 **.**

Carvalho, Vinneth MD, Smoyer, Amy PhD: Why Food Matters: Impact of Food on the Physical and Psychosocial Health of Incarcerated Females. National Conference on Correctional Health Care, Las Vegas NV: October 24, 2016.

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FORENSIC PSYCHIATRY CONSULTATIONS/TESTIMONIES:

Performed over 200 forensic evaluations including Competency to Stand Trial Evaluations (CST), Not Guilty by Reason of Insanity (NGRI), Competency to Make a Will, Pre-sentence Evaluations, Risk Management Assessments of Youths for Community Placement, and Psychiatric Evaluation of Adults in child custody cases.

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LANGUAGES

English, Spanish

EXHIBIT E

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs* v. NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, In their official capacities, *Defendants*	:	CIVIL NO. 3:20CV594-JCH JULY 7, 2020

DECLARATION OF MARY MASON

The undersigned declarant, Mary C. Mason, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am employed by the State of Connecticut Department of Mental Health and Addiction Services ("DMHAS") as an Executive Assistant. I have held this position since 2015.

2. I make this Declaration based upon personal knowledge, and I understand that it will be submitted to this Court in connection with the above-captioned case in support of the Defendants' Opposition to the Plaintiffs' Motion for Preliminary Injunction.

3. As part of my duties, I am responsible for managing public information, media relations, issues management and public affairs, and internal communications.

4. As part of my job duties, I was assigned to the DMHAS Incident Command Team in response to the COVID-19 pandemic.

5. As part of a member of the Incident Command Team, I tracked and compiled data reflecting the COVID-19 testing of DMHAS staff and patients as well as the COVID-19 testing results of DMHAS staff and patients.

6. The data is constantly tracked and updated in response to the receipt of new information and new testing results of DMHAS staff and patients.

7. I directed staff to compile the data into a table and/or chart.

8. I have reviewed the table and/or chart and represent that the data depicted in this table and/or chart is true, complete, and accurate.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 7 day of July, 2020.

Mary Mason

EXHIBIT F

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs* v. NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, *Defendants*	:	CIVIL NO. 3:20CV594-JCH July 2, 2020

DECLARATION OF PAUL DILEO

The undersigned declarant, Paul DiLeo, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am employed by the State of Connecticut Department of Mental Health and Addiction Services and currently serve as the Chief Operating Officer and have held this position since February 20, 2004. I also served as Deputy Commissioner for DMHAS for part of the first term of the Malloy Administration. A copy of my current CV is attached as Attachment 1 hereto.

2. I make this Declaration based upon personal knowledge, and I understand that it will be submitted to this Court in connection with the above-captioned case in support of the Defendants' Opposition to the Plaintiffs' Motion for Preliminary Injunction.
3. As the Chief Operating Officer, I am responsible for assisting DMHAS to plan and to respond to incidents that can affect DMHAS operations.
4. In 2006, the Department of Administrative Services required state agencies to be trained in Incident Command. State agencies such as DMHAS have created an Incident Command Team to respond to and manage disasters or community incidents through a coordinated structure.
5. When an emergency occurs or is anticipated, the DMHAS Commissioner or her designee activates the Incident Command Team ("ICT").
6. The composition of DMHAS' ICT corresponds to the structure used in the National Incident Management System (NIMS).
7. DMHAS' command structure includes the Commissioner's Executive Group, Senior Managers, and the Chief Executive Officers (CEO's) of each DMHAS facility.
8. The purpose of the ICT is to: respond to the mental health needs of Connecticut citizens following disasters; prepare and train DMHAS facilities to maintain business operations following a disaster; manage DMHAS' disaster response to ensure that DMHAS agency functions and operations continue after a disaster; link to state's emergency response framework in order to provide behavioral health support to the state response and to link to the state's emergency response framework to obtain assets and supplies from the state necessary to maintain operations.

9. I currently serve as the Incident Commander of the ICT.

10. The ICT was activated in response to the threat of the COVID-19 pandemic in the first week of March 2020.

11. Since the start of the COVID-19 pandemic, the ICT has had frequent meetings, including daily meetings and meetings on the weekends, from March 16, 2020 to May 22, 2020. Since May 23, 2020, the ICT continued to meet several times a week. As of June 8, 2020, the ICT has weekly meetings. Additional meetings may be scheduled subject to the status of the COVID-19 pandemic and DMHAS' response to the COVID-19 pandemic.

12. The ICT has addressed and continues to address the management of issues related to COVID-19, including, but not limited to: management of quarantine and isolation in inpatient and residential Programs; safety procedures for staff and patients; work-at-home protocols; state-operated service delivery in the community and in inpatient and residential facilities; service delivery related to private-not-for profit providers ("PNPs"); Acquisition of supplies and Personal Protective Equipment ("PPE") for state-operated facilities and PNPs; Staff and Provider Communications; Staffing and Human Resources; Information Technology; Staff Training necessitated by COVID; and Preparation for re-opening.

13. The ICT has worked with DMHAS facilities to implement policies and procedures in response to COVID-19 including, but not limited to, quarantine and isolation; social distancing; cleaning and decontamination; hygiene, patient and staff testing for COVID-19; and use of PPE, including education to staff and patients as to the use of PPE.

14. The response plans are constantly updated and revised in response to events and guidance from agencies including but not limited to the Office of the Governor, the Connecticut Department of Public Health ("DPH") and the Centers for Disease Control ("CDC").

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 2nd day of July 2020.

Paul DiLeo

ATTACHMENT 1

PAUL J. DI LEO, MS, FACHE

CHIEF OPERATING OFFICER

Mr. Di Leo is a Fellow of the American College of Healthcare Executives and a Board Certified Healthcare Executive. He is a volunteer faculty member of Yale University's School of Medicine, Department of Psychiatry. He is a high-energy, results-oriented leader with proven success in managing a multimillion-dollar healthcare system and has an outstanding background of leadership within government, corporate and community organizations. Mr. Di Leo's expertise includes crisis management, strategic and structural contributions related to healthcare reform and managed care environments as well as initiation and control of organizational change, managing systems operations and facilities, creation of healthcare alliances, and negotiation of contracts. He has full budget and business planning experience with cost effective direction of resources and has extensive new business initiative and development background. He's an accomplished and dynamic speaker, lecturer and trainer on healthcare management issues within academic, business and medical communities.

PROFESSIONAL EXPERIENCE

STATE OF CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES (1997- *present*)
A statewide behavioral healthcare system incorporating hospitals and ambulatory care
Chief Operating Officer

(Direct Reports: Chief Financial Officer until 3/1/20, Director of Human Resources 4/1/20, Director of Information Systems, Chief of Safety Services, Director of Forensic Services until 6/1/20, Director of Legal Services until 5/1/20, Director of Auditing until 7/1/20, Director of Healthcare Information Technologies (vacant))

- Directly managed statewide clinical/recovery healthcare operations and programs in a cost effective manner while achieving the agency mission of delivering quality healthcare to a diverse patient population in a politically and fiscally challenging environment.
- Directs a $700 million annual budget, oversees the Fiscal Division including, healthcare financing, budgeting, engineering, plant operations (until 3/1/20) and auditing (until 7/1/20).
- Responsible for the Agency Human Resources Division including, recruitment, retention, labor relations (seven labor unions) and payroll. Dramatically increased nursing and doctor recruitment and retention and determines appropriate staffing levels (until 4/1/20).
- Managed provider networks, implemented healthcare financing mechanisms and quality improvement measures in a managed care environment.
- Oversees Agency Information Systems Division including management information systems, electronic medical record system, and all hardware and software packages.
- Responsible for DMHAS Safety Services Division (agency police force).
- Manages the Legal Unit, which coordinates the successful resolution of pending and active litigation with CT Attorney General's Office (until 5/1/20).
- Manages and creatively advances the State/Academic Partnership with Yale University (until 3/1/20).
- Responsible for the Division of Forensic Services which implements and coordinates specially-skilled evaluation and treatment services for individuals with serious mental illness and/or substance use disorders who become involved in the criminal justice system (until 6/1/20).
- Incident Commander since 1997. Designed, directed and coordinated the State of Connecticut's Behavioral Health response to the Lottery Shooting, 9/11, Hurricane Sandy, Sandy Hook and COVID19 crises.

- Previously provided testimony to CT Legislative Committees. Propose and analyze impact of pending political/legislative initiatives. Provides testimony on budgetary and policy matters.
- Previously oversaw DMHAS' community clinical and recovery service contracts.
- Previously chaired the International Recovery Council, designed and facilitated the annual international recovery conference in Connecticut in partnership with Quebec Province and other international partners.
- Previously oversaw the Agencies HealthCare Reform initiatives including the CT Behavioral Health Partnership (in collaboration with the State's Medicaid Authority).
- Directed closure of Cedarcrest Hospital placed of over fifty clients in community settings.
- Previously supervised 3 hospitals (over 800 beds).
- Provided quality care for over 80,000 individuals annually and manage a staff of 3,600 individuals annually Managed over 300 contracts, 7 regional systems of care.

Previous Experience

- BENOVA\HEALTHCHOICE, Portland, Oregon (1995-1997)
  Acting Vice President, Eastern United States
- HILL HEALTH CENTER/SOUTH CENTRAL REHABILITATION CENTER, New Haven*,* CT (1992-1995)
  Director of Counseling and Clinical Support Services
- ETP, INC., East Hartford*, CT* (1990-1992), Behavioral Healthcare Manager

EDUCATION

- Master of Sciences, Counseling, Western Connecticut State University, Danbury, CT
- Bachelor of Arts, Communications, Western Connecticut State University, Danbury, CT

Publications

- The 2012 Sandy Hook Elementary School Shooting: Connecticut's Department of Mental Health Crisis Response, **Paul DiLeo**, Michael Rowe, Barbara Bugella, Lauren Siembab, James Siemianowski, Jennifer Black, Patricia Rehmer, Frank Baker, Christa Morris, Miriam Delphin- Rittmon & Thomas Styron, Journal of School Violence, DOI: 10.1080/15388220.2017.1387129, 2017
- Bearing Witness to Change: Forensic Psychiatry & Psychology Practice, Chapter 5, Politics & Money as Change-Agents in Forensic Systems, **Paul Di Leo** & Larry Davidson, CRC Press 2016
- The CT Mental Health Center: Celebrating 50 Years of a Successful Partnership Between the State and Yale University, Steiner, **Di Leo,** Jacobs et al, Psychiatric Services A Journal of the American Psychiatric Association, 10.1176/appi.ps.201600373, October 3rd 2016
- Yale Textbook of Public Psychiatry, Chapter 2, The Service System of Public Psychiatry, Jacobs, Barkil-Oteo, **Di Leo,** Rehmer, & Davidson. Oxford University Press 2016
- Yale Textbook of Public Psychiatry, Chapter 3, Recovery & Recovery-Oriented Practice, Davidson, Tondora, O'Connell, Bellamy, Pelletier, **Di Leo,** & Rehmer. Oxford University Press 2016
- The Global Model of Public Mental Health through the WHO Quality Rights Project, Pelletier, Fortin, Laporta, Pomey, Roelandt, Guézennec, Murray, **Di Leo**, Davidson, Rowe, Journal of Public Mental Health, Vol. 12 Issue: 4, pp.212 – 223, 2013
- Case and Care Management Improves Outcomes while Reducing Costs and Service Demand, Kirk, **Di Leo**, Rehmer, Moy and Davidson. Psychiatric Services Journal May 2013 Vol. 64 No.5
- Hebergement Lodgement et Retablissement en SanteMentale (Housing and Recovery in Mental Health), Part 1, Chapter 2, Creation of a System Centered on Recovery, Thomas A. Kirk and **Paul J. Di Leo.** Presses De L'Universite Du Quebec 2009
- Forty Years of Academic Public Psychiatry, Chapter 7, A Public-Academic Partnership at the CT Mental Health Center, Dailey, Kirk, Cole & **Di Leo**. John Wiley & Sons LTD 2007

EXHIBIT G

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs* v. NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, In their official capacities, *Defendants*	:	CIVIL NO. 3:20CV594-JCH JULY 8, 2020

DECLARATION OF MICHELE LIZOTTE

The undersigned declarant, Michele Lizotte, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am employed by the State of Connecticut Department of Mental Health and Addiction Services as the Building Superintendent 3 at Connecticut Valley Hospital ("CVH") in Middletown, CT. I have held this position since January of 2017.

2. The custodial staff at CVH consists of 60 individuals, including supervisors with some individuals assigned to Battell Hall, Merritt Hall, Page Hall, Shew/Beers Hall, Transitional Cottage, Woodward Hall, the Cottages, Dutton Home (River Valley Services), and Leak Hall (River Valley Services). Twenty-five of these individuals are outside contractors.

3. The custodial staff work hours are from 6:45am through 10:00 pm Monday through Friday.

4. On Saturday and Sunday, the hours of coverage are 6:00 A.M. – 2:00P.M.

5. Emergent issues that occur at any time are covered by myself, or "E-Man" which is a group of CVH's custodial staff who volunteer on a monthly basis to accept emergency calls after hours.

6. CVH has Environmental Services Protocols in place in response to the COVID-19 pandemic. The most recent update to these protocols was April 24, 2020.

7. CVH utilizes seven primary cleaning agents and sanitizers:

a. BioSpray D2 Surface Sanitizer (EPA Registered)

b. Virex II 256 (EPA Registered).;

c. Super Sani-Cloth Germicidal Disposable Wipes (EPA Registered);

d. MP-32 All Purpose Cleaner;

e. AP-64 All Neutral Cleaner;

f. Window Cleaner; and

g. Clorox Healthcare Fuzion Bleach (EPA Registered).

8. All bathrooms are cleaned thoroughly once daily or twice depending on the situations that arise. To clean the bathrooms, the custodial staff utilizes a pre-mixed solution of Fuzion Bleach or Virex. There are specific procedures for cleaning sinks, commodes, urinals, showers and tubs.

9. The standard occupied patient rooms are cleaned on a daily basis utilizing Fuzion Bleach or Virex; including damp dusting bed tables, telephones, chairs, ledges, light switches, lamps, and damp mopping the bathroom floor.

10. All common areas are cleaned daily and high touch areas are sanitized twice daily using the BioSpray D2 surface sanitizer including patient phones.

11. Disinfecting wipes are available to patients. Patients can ask that staff wipe a phone.

12. Patient phones are cleaned daily Monday – Friday.

13. Hand soap and paper towels are always available on units at all times.

14. The custodial staff are to check the soap dispensers twice a day once in the morning and then once before the end of their shift. They will refill the soap dispenser if it is getting low or empty.

15. When the custodial staff are not on duty and a soap dispenser runs out of product E-Man is called and they will refill the soap dispenser if necessary.

16. Specific cleaning procedures are utilized in those areas where patients are quarantined or are in isolation.

17. The custodial staff don all PPE prior to the entry into the isolation unit. After cleaning is complete staff remove all PPE except gloves, all supplies and equipment are washed with an approved germicidal solution. Mop heads and linens are placed in a bag along with the gloves. The bag is tied off and labeled as biohazardous and is disposed of as such.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 8TH day of July,2020.

Michele Lizotte
Building Superintendent 3
Connecticut Valley Hospital

EXHIBIT H

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs*	:	CIVIL NO. 3:20CV594-JCH
v.	:	
NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, In their official capacities, *Defendants*	:	JULY 2, 2020

DECLARATION OF TIMOTHY DENIER

The undersigned declarant, Timothy Denier, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am employed by the State of Connecticut Department of Mental Health and Addiction Services("DMHAS") as the Director of Accreditation and Regulatory Compliance at Connecticut Valley Hospital ("CVH") in Middletown, CT. I have held this position since August, 2008.

2. As part of my duties, I am responsible for assisting CVH plan and respond to incidents that can affect CVH operations.

3. CVH utilizes a planning tool, the National Incident Management System ("NIMS"), issued/developed by the Federal Emergency Management Agency ("FEMA") to develop responses to all types of incidents that can affect CVH operations such as weather related emergencies, water or power systems failure, and health emergencies. I have received formal training in the use of this tool from FEMA and the Connecticut Department of Emergency Management and Homeland Security.

4. When an emergency occurs or is anticipated CVH activates the Hospital Incident Command System ("HICS"). HICS was developed by the Emergency Medical Services Authority (EMSA) of California and is consistent with NIMS principles.

5. HICS assigns specific responsibilities to specific CVH staff for the duration of the emergency.

6. The Incident Command Leader is the Chief Executive Officer of CVH Lakisha Hyatt.

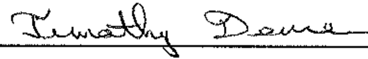
7. HICS was activated in response to the threat of COVID-19 in the first week of March 2020. As part of my duties, I have taken a lead role in utilizing the NIMS tool to assist in CVH's planning for the impact(s) of COVID-19 on CVH operations.

8. The response plans are constantly updated and revised in response to events and guidance from agencies including but not limited to, the Office of the Governor, the Connecticut Department of Public Health ("DPH") and the Centers for Disease Control ("CDC")

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 2nd day of July, 2020.



Timothy Denier

EXHIBIT I

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs* v. NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, *Defendants*	:	CIVIL NO. 3:20CV594-JCH July 1, 2020

DECLARATION OF JOSE CREGO

The undersigned declarant, Jose Crego, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am a Connecticut licensed clinical social worker and alcohol and drug counselor. I serve as the Chief Operating Officer of Whiting Forensic Hospital ("WFH") and have held this position for approximately one- and one-half years.

2. My responsibilities in this position include but are not limited to programming and the environment of care at WFH, which encompasses WFH's supply of personal protective equipment ("PPE") and oversight of the Environmental Services Department which performs custodial functions at WFH.

3. During the current Covid-19 pandemic WFH has put in place several measures to ensure responsible usage of PPE. While during this pandemic WFH has experienced some challenges in obtaining stock of various PPE due to market conditions, at no time has WFH ever reached the point where any type of PPE was either depleted or unavailable.

4. As of the date of this declaration, WFH's supplies of PPE, including how many days of supply for each item are available based on WFH's "burn rate," are set forth in Exhibit M. The burn rate for each item of PPE is calculated using the following factors: i) current inventory divided by average daily use; ii) units required for a thirty (30) day supply, which is average daily use times 30; and iii) units required to meet 30-day need, which is units required for a 30-day supply subtracted from current inventory.

5. The custodial staff at WFH consists of 16 individuals, including one supervisor with some assigned to Whiting Service and others to Dutcher Service. Four of these individuals are outside contractors.

6. The custodial staff works from 4:45 am through 7:45 pm Monday through Friday.

7. On Saturday and Sunday, the hours of coverage are 4:45 am through 7:45 pm with 3 staff available for all units at WFH.

8. Emergent issues that occur at any time are covered by the custodial manager who will respond or send a staff member to respond.

9. WFH utilizes four primary cleaning agents and sanitizers:

a. BioSpray D2 Surface Sanitizer (EPA Reg. No. 73232-1-83022);

b. Virex II 256 (EPA Reg. No. 70627-24);

c. Super Sani-cloth germicidal disposable wipes (EPA Reg. No. 61178-4-9480); and

d. Clorox Fuzion Bleach (EPA. Reg. No. 67619-30)

10. To clean the bathrooms, the custodial staff utilizes the KaiVac 1750 touchless cleaning system and the procedures associated with its use. All staff have been trained in the use of the equipment. This is a high temperature water-based cleaning system.

11. The custodial staff are able and in fact do more cleaning as may be required by specific need using appropriate disinfecting products.

12. The floors and walls of bathrooms are tiled and are cleaned between 4:45 am and 6:45 am every day.

13. The standard occupied patient rooms are cleaned on a daily basis utilizing Fuzion Bleach or Virex including damp mopping the floor.

14. All common and high touch areas are sanitized twice daily using the BioSpray D2 surface sanitizer including patient phones.

15. Disinfecting wipes are available to patients. Patients can ask that staff wipe a phone, or depending on the status of the patient, staff may be able to give them a wipe to do it themselves.

16. The standard process ensures that the soap dispensers which contain liquid soap are checked on a daily basis by the custodian assigned to the respective unit. The custodial staff will replace it if the product is low and feels it will not last through the next interval.

17. However, if a patient or a staff member finds that the dispenser is empty, then the unit director or the nurse supervisor will contact the custodial staff or the nurse supervisor's office in the off hours to ensure a quick resolution is afforded.

18. Hand soap and paper towels are always available on units at all times.

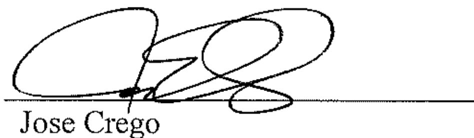
19. Specific cleaning procedures are utilized in those areas where patients are quarantined or are in isolation.

20. The custodial staff don all PPE prior to the entry into the isolation unit. After cleaning is complete staff remove all PPE except gloves, all supplies and equipment are washed with an approved germicidal solution. Mop heads and linens are placed in a bag along with the gloves. The bag is tied off and labeled as biohazardous and is disposed of as such.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 1st day of July, 2020.



Jose Crego

EXHIBIT J

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs*	:	CIVIL NO. 3:20CV594-JCH
v.	:	
NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, *Defendants*	:	July 1, 2020

DECLARATION OF MICHAEL BOUTIN

The undersigned declarant, Michael Boutin, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am a nurse by professional training and I currently serve as a Compliance Officer and Performance Improvement Manager for Connecticut Valley Hospital ("CVH"). My duties involve all areas of Performance Improvement at CVH. My responsibilities in this position include but are not limited to overseeing and reporting on CVH's supply of personal protective equipment ("PPE").

2. During the current Covid-19 pandemic CVH has put in place several measures to ensure responsible usage of PPE. While during this pandemic CVH has experienced some

challenges in obtaining stock of various PPE due to market conditions, at no time has CVH ever reached the point where any type of PPE was either depleted or unavailable.

3. As of the date of this declaration, CVH has in stock the PPE supplies set forth in Exhibit N, which reflects the number of days' supply for each item based on the historic "burn rate." The burn rate for each item of PPE is calculated using the following factors: i) current inventory divided by average daily use; ii) units required for a thirty (30) day supply, which is average daily use times 30; and iii) units required to meet 30 day need, which is units required for a 30 day supply subtracted from current inventory.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 1st day of July 2020.

Michael Boutin

EXHIBIT K

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

THOMAS WILKES, BARBARA FLOOD, VINCENT ARDIZZONE, GAIL LITSKY, CARSON MUELLER, On behalf of themselves and all other persons similarly situated, *Plaintiffs* v. NED LAMONT, Governor MIRIAM E. DELPHIN-RITTMAN, Commissioner of DMHAS, HAL SMITH, CEO of Whiting Forensic Hospital, LAKISHA HYATT, CEO Connecticut Valley Hospital, *Defendants*	:	CIVIL NO. 3:20CV594-JCH July 7, 2020

DECLARATION OF NANCY NAVARRETTA

The undersigned declarant, Nancy Navarretta, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am a Connecticut licensed professional counselor and serve as the Deputy Commissioner of the Department of Mental Health and Addiction Services (DMHAS) and have held this position for approximately five years. A copy of my current CV is attached as Attachment 1 hereto.
2. I make this Affidavit based upon personal knowledge, and I understand that it will be submitted to this Court in connection with the above-captioned case in support of the Defendants' Opposition to the Plaintiffs' Motion for Preliminary Injunction.

3. As Deputy Commissioner, my responsibilities in this position include but are not limited to serving as the liaison to DMHAS funded private non-profit providers (160+ providers) and for oversight of several Divisions, including the Community Services Division, which implement and monitor contracted behavioral health services and initiatives statewide.
4. As a result of these responsibilities, I am knowledgeable of the impact of the COVID 19 pandemic on the operations of community-based service and residential providers that serve DMHAS clients including patients eligible for discharge from Connecticut Valley Hospital and Whiting Forensic Hospital.
5. Community residential providers face significant challenges in the ability to cohort and isolate residents with COVID 19 exposure, symptomatic COVID 19 or COVID 19 positive diagnosis. In many cases, especially small congregate settings, space is limited without option to create or open up new space in these residential buildings. The consequence is the necessity to maintain a vacant bedroom for this purpose, if there happened to be a vacancy at the time of the COVID surge in Connecticut, reducing the number of available beds for new residents.
6. Community residential settings face challenges in maintaining social distance within their home style settings with limited numbers of bathrooms, common space and typically a communal kitchen.
7. The necessity that discharged patients must manage and maintain COVID 19 precautions (including reduced social interaction, adhering to cleaning protocols and the wearing of a mask in public spaces) in the community requires that the discharge candidate be higher

functioning in their ability to maintain their own safety and independence than in the absence of a pandemic.

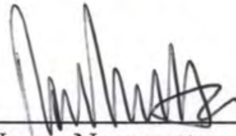
8. Community residential providers face significant challenges in the ability to maintain social isolation of residents. COVID 19 closed or severely modified social rehabilitation programs which previously provided opportunities for residents to have social interactions and support. Community residential providers cannot prevent residents from leaving the home which increases the risks of exposure. Similarly, community providers can be challenged in preventing visitors into the residence.
9. For community residential providers with multiple sites, staff may be working in multiple sites creating risk of transmitting infection among sites. Community providers do not have the purchasing power to secure large scale orders of PPE and infection control supplies. The State has had to extend PPE support to the providers.
10. Traditionally, inpatient discharges are accomplished with phased transition using day visits, overnight stays and temporary leaves to ease the relocation of the resident to the community provider. Due to the pandemic, this standard has been halted to avoid the potential for exposure of the patient at the community residence and then exposing others upon their return to the hospital. In some cases, community providers have been uncomfortable accepting a placement without this transition period and assurances that the patient has a hospital bed to return to if the transition is not successful.
11. On July 6, 2020, the Governor of Connecticut using his emergency powers issued an executive order that modified the statutory minimum number of hours of rehabilitation services required to be provided by certain group homes that serve DMHAS clients in order for the provider to receive Medicaid reimbursement by more than 35%. This

reduction is an accommodation allowed providers due to the challenges of the group homes in providing the minimum monthly service hours for reasons, including, but not limited to: isolation and quarantine of residents due to COVID 19, social distancing requirements restricting the ability to run group programs, residents who may chose not to participate in certain programs due concerns about COVID-19, and staffing which was limited due to reallocations in workforce to monitoring and other tasks, as well as staff sicknesses and absences. This modification was made retroactive to the beginning of the COVID-19 public health emergency in Connecticut.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 7th day of July 2020.



Nancy Navarretta

ATTACHMENT 1

Nancy Navarretta, M.A., LPC, NCC
Hamden, CT 06518
navarretta@comcast.net
nancy.navarretta@ct.gov
(203) 671-0170 cell

Summary of Qualifications

Extensive experience in public and private program development, strategic planning, leadership, process improvement and analysis of revenue cycles, resulting in the delivery of effective, recovery-oriented, and integrated community healthcare systems.
National Certified Counselor: #51610
CT Licensed Professional Counselor: #000026

Professional Experience

7/15-present **Connecticut Department of Mental Health and Addiction Services (DMHAS)**
Deputy Commissioner

- Direct report to the Commissioner of DMHAS
- Responsible for active participation and project management related to the Commissioner's Executive Group, Commissioner's Budget Group and Departmental Strategic Planning
- Responsible for leadership of the Opioid Response, Community Services (Contracted Community Providers), Managed Services (ASO Contract Management, Behavioral Health Homes), Research Division (Program Evaluation), Statewide Services (Housing Supports, Long Term Services and Supports, Women and Children's Programs, Problem Gambling), Evidenced Based Practices and Grants Unit (Application and Implementation) and the Legal Division within the Office of the Commissioner
- Responsive liaison to state funded private non-profit providers (160+ providers)
- Participate in partnerships with other State agencies, consumers and providers in the delivery of evidenced-based, recovery-oriented behavioral healthcare

7/13- 7/15 **Connecticut Department of Mental Health and Addiction Services (DMHAS)**
Director of Behavioral Health Services

- Direct report to the Chief Operating Officer of DMHAS
- Responsible for leadership of the Community Services, Managed Services and Veteran's Services, Research Division and Statewide Services within the Office of the Commissioner
- Participate in partnerships with other State agencies, consumers and providers in the delivery of evidenced-based, recovery-oriented behavioral healthcare

4/12-6/13 **Liberation Programs, Inc., Norwalk CT**
Chief Operating Officer

- Direct report to CEO of a private, non-profit, behavioral health system of care
- Responsible for leadership of all clinical business units and quality department
- Strategic development of behavioral solutions to achieve agency mission and revenue maximization of all lines of business
- Lead in developing community partnerships in healthcare (integrating behavioral health and primary care)
- Manage all aspects of healthcare service delivery systems and CARF accreditation cycle

5/00-3/12 **Cornell Scott-Hill Health Corporation (CS-HHC), New Haven, CT**
Chief of Behavioral Health Services

- Direct report to CEO of a private, non-profit, Federally Qualified Health Center with an annual budget of $50M

- Responsible for approximately 30 cost centers (200+ employees) with a net revenue of $22M providing a full continuum of behavioral healthcare services
- Strategic development of co-located and integrated services (MH, SA, Primary care)
- Led Joint Commission compliance efforts in behavioral health through four successful cycles of accreditation
- Responsible for improved clinical standards of care, operational efficiencies, increased productivity (30,000 encounters to 80,000 encounters), and collection rates
- Led program development through focused growth and recruitment of strong program specific leadership to become the strongest profit center in the organization

7/99-5/00 **Cornell Scott-Hill Health Corporation (CS-HHC), New Haven, CT**
Clinical Coordinator Grant Street Partnership

- Program Director of a CS-HHC Mental Health and Substance Abuse Facility providing Intensive Day Treatment and Transitional Housing
- Supervision and recruitment of all staff (clinical, case management, paraprofessional, facilities, food service and support staff)
- Administrative management, utilization review, funding/accreditation compliance and provision of direct services

1/96-present **Private Practitioner, Hamden, CT**

- Licensed Professional Counselor trained in mental health and addiction, specializing in the treatment of addictions and trauma related disorders
- Manage all clinical and business requirements of practice.

3/94-7/99 **Fairfield Community Services, Fairfield, CT**
Clinical Director of Mental Health and Substance Abuse Programs

- Responsible for clinical operation of outpatient mental health and substance use facility
- Maintained full caseload
- Internally promoted from position of **Coordinator of Substance Abuse Programs/Staff Psychotherapist**
- Served as **Acting Director** of agency responsible for all clinical and administrative operations

5/93-3/94 **The Center for Family Development, Beverly, MA**
Staff Psychotherapist

- Part-time member of Outpatient and Trauma Teams

10/89-3/94 **The Psychological Center, Lawrence and Andover, MA**
Staff Psychotherapist

- Full-time outpatient therapist
- Initiated trauma sensitive treatment and program development

6/88-9/88 **Upward Bound, Fordham University, Bronx, NY**
Instructor/Counselor

6/87-6/88 **New York Hospital/Cornell Medical Center, Westchester Division, White Plains, NY**
Project Coordinator/Research Assistant

Supervised Professional Experience

10/88-10/89 **APA Accredited Internship in Clinical Psychology**
Franklin Delano Roosevelt Veterans Administration Hospital, Montrose, NY

9/86-5/87 **Practicum in Counseling and Psychotherapy**

	Counseling Center, Fordham University, Bronx, NY
9/85-5/86	**Clerkship in Clinical Psychology/Psychological Testing**
	Goldwater Memorial Hospital, Roosevelt Island, NY

Graduate Assistantships/Fellowships

9/86-5/87	**Graduate Teaching Fellow**
	Fordham University, Bronx, NY
9/84-5/86	**Graduate Assistant**
	Fordham University, Bronx, NY

Current Professional Affiliations

1996-2020	American Counseling Association
1996-2020	Connecticut Counseling Association
1986-2020	Kappa Phi Honor Society Member

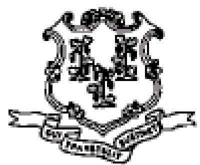
Awards, Presentations and Publications

9/18	*Community of Caring Award*
	Cornell Scott Hill Health Center
5/17	A Symposium of the International Recovery and Citizen Council
	Treatment of Substance Use Disorders: Current Policy and Practice & Emerging Trends
6/11	FQHCs and Health Care Reform: Models for Collaboration CHCACT Forum
	Collaborating to Integrate Behavioral Health and Primary Care
1/11	The Joint Commission BHC News Issue One 2011
	Behavioral healthcare organizations get 'physical'

Education

1986	**Fordham University, Bronx, NY**
	M.A. in Clinical Psychology/PhD. Program Clinical Psychology (ABD)
	Graduate Academic Record: Overall Index 3.94/4.0
1984	**Boston College, Chestnut Hill, MA**
	B.A. in Psychology, Summa Cum Laude
	Concentration in Speech-Language Pathology
	Undergraduate Academic Record: Overall Index 3.7/4.0 Major Index 3.94/4.0
1980	**Sacred Heart Academy, Hamden, CT**
	Valedictorian

EXHIBIT L



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
WHITING FORENSIC HOSPITAL
70 O'Brien Street Middletown, Connecticut 06457

MEMORANDUM

TO: All WFH employees and contracted staff

FROM: Hal Smith, Chief Executive Officer
Tobias Wasser, Chief Medical Officer
Jan Bergin, Chief Nursing Officer
Elizabeth Tillman, ACS Service Medical Director

DATE: May 19, 2020 (updated)

SUBJECT: Instructions for managing WFH patients and staff suspected or confirmed positive for COVID-19.

Please follow these instructions when managing patients and staff suspected or confirmed positive for COVID-19. These instructions are based on CDC guidelines and DMHAS protocols that were reviewed and approved by CT DPH and adapted to our setting.

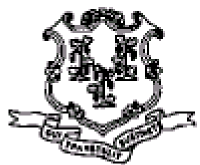
Infection Control General Recommendations:

• All staff will be continuously reminded to follow CDC guidelines for transmission- based precautions. See: https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html.

• WFH leadership will post materials to remind staff to perform basic hygiene, social distancing, and proper use of personal protective equipment (PPE). These materials can be found on the T drive at: T:\COVID19.

Additionally, WFH will:

1. Obtain vital signs, including temperature, of all patients at least daily.
2. Limit the use of "floating" staff who move between inpatient units and buildings.
3. Evaluate unit programming with a focus on limiting group activities where possible to support social distancing.
4. Confine programming to each unit and limit mixing of patients from other units.
5. If there are no exposures, communal dining can continue but patients from different units should not mix.
6. Close contact is defined as being within 6 feet of another person, in a closed room for more than 10 minutes. This is important as we consider patient movement during these limiting situations. We should continue to encourage patients to get fresh air on the campus within the guidelines of their respective privilege level.



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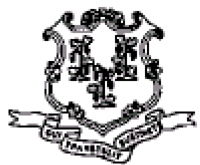
PPE Use: General Guidelines for Use of Face Masks
Masks must be worn in combination with good hand hygiene and keeping social distance. When interacting directly with a patient with suspected or confirmed COVID-19, masks, gloves, gown, and face mask are required as noted below.

It is expected that staff will use surgical masks when:

- Working in patient care areas. For WFH, we are defining patient care areas as anywhere past the sally port in Whiting and anywhere in the Dutcher building. Exceptions to this include private offices, chart rooms, nursing stations, break rooms and bathrooms.
- Screening individuals for COVID-19, including during intake of new admissions.
- Asymptomatic staff directly (within 3-6 feet) exposed to a suspected or confirmed case of COVID-19, who continue to work should wear a mask, maintain social distance of 6ft and perform hand hygiene frequently.
- Person is persistently coughing or sneezing
- Housekeeping staff cleaning and disinfecting room or area previously occupied by an individual with suspected or confirmed COVID-19*

Guidance for Face Mask Re-Use (Surgical and N95):

a. ***Never*** touch the front of the mask with ungloved hands. The front is contaminated.
b. Remove mask last (after removal of all other PPE).
c. On typical inpatient psychiatric units (surgical masks)
    a. Remove mask carefully by handling the straps only. Place mask in a ***paper*** bag with the outer surface facing the bottom of the bag. (That way, when you reach in to retrieve your mask, you don't risk touching the outer surface.) Fold the straps into the mask so that they can't touch the outer surface.
    b. Label the bag with your name and date mask was issued.
    c. Masks may be re-used for up to one week or until visibly soiled or damaged.
        i. After one week, please request new mask and paper bag and re-label
d. On Isolation Unit (N95)
    a. ***Never*** touch the front of the mask with ungloved hands. The front is contaminated.
    b. Remove mask last (after removal of all other PPE).
    c. ***The maximum duration of use for N95 masks is 8 hours.*** Thus, if a staff member wears the mask for an entire 8 hour shift, the mask must be disposed of at the end of the shift. If a staff member wears it for fewer than 8 hours, please keep track of the amount of time used, re-use it per instructions below, and discard at the 8 hour mark.
    d. If re-using the mask, remove carefully by handling the straps only. Place mask in a ***paper*** bag with the outer surface facing the bottom of the bag. (That way,



when you reach in to retrieve your mask, you don't risk touching the outer surface.) Fold the straps into the mask so that they can't touch outer surface.

e. Label the bag with your name and number of hours used.
f. Any damaged or soiled masks must be discarded.
g. Dispose of N95 mask upon exiting the isolation unit in the appropriately marked N95 recycling receptacle so that they may be saved for sterilization and repurposing.

For patients with suspected or confirmed COVID-19:

According to CDC and DPH guidelines: when caring for patients with confirmed COVID-19 infection and for housekeeping staff performing a cleaning and disinfection of a room of a confirmed COVID-19 patient, use facemask (procedure **or** surgical mask **or** N95) AND gown AND gloves AND eye protection (goggles **or** face shield). N95 respirators should be conserved for colleagues who perform aerosol-generating procedures, including intubation, open suction, and administration of nebulizer treatments.

CDC Stratification of risks following exposure to COVID-19

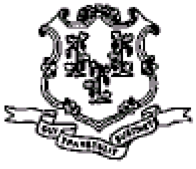
- **Low risk**: walking by an asymptomatic person who tested positive for COVID
- **Mild risk**: Being in the same room and within 6 ft of a symptomatic COVID+ person but exposure time less than 10 minutes.
- **Medium risk**: Prolonged exposure (10 minutes or longer) within 6 ft of a symptomatic COVID+ person.
- **High risk**: Close household contact of person suspected or confirmed COVID+

Note:

In all situations, risk is reduced if one or both parties have face mask on during the exposure
A contact with a contact of someone who is suspected or confirmed COVID positive (i.e. a person twice removed from the COVID case) is at low risk, and does not require additional monitoring or restrictions

Use of Decontaminated N95 Respirator Masks

- There is an international shortage of N95 respirator masks, making critical supplies extremely limited during the COVID pandemic. To address our supply need, DHMAS has partnered with Battelle Memorial Institute to decontaminate used, unsoiled, undamaged N95 respirator masks.
- The State of Connecticut and DMHAS have partnered with BATTELLE to take advantage of the BATTELLE Critical Care Decontamination System (CCDS) to sterilize non-cellulous N95 respirator masks. The BATTELLE system for the decontamination of the N95 masks has been FDA approved. The BATTELLE system utilizes a mobile CONEX box based Vapor Phase Hydrogen Peroxide (VPHP) generator to decontaminate and sterilize over 20,000 N95 masks



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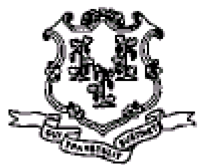
daily. Using this system, N95 masks can be decontaminated up to 20 times. Battelle tracks and notes on the mask the number of times a mask has been recycled.

- Decontaminated N95 masks are effective and safe. Staff using these masks should note the following: Clean hands with soap and water or an alcohol-based hand sanitizer with at least 60% alcohol before and after touching or adjusting the N95 mask.
    - Avoid touching the inside of the mask.
    - Use a pair of clean (non-sterile) gloves when donning the mask and performing a user seal check.
    - Visually inspect the mask to determine if its integrity has been compromised.
    - Check that mask components such as the straps, nose bridge, and nose foam material did not degrade, which can affect the quality of the fit, and seal.
    - If the integrity of any part of the mask is compromised, or if a successful user seal check cannot be performed, discard the mask and try another mask.
    - Users should perform a user seal check immediately after they don each mask and should not use an N95 mask on which they cannot perform a successful user seal check.
- Please refer to DMHAS "Decontamination N95 Respirator Fact Sheet" for additional information and details on this process



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GUIDANCE REGARDING PATIENTS:

Patient with Confirmed Close Contact to asymptomatic person who subsequently develops symptoms and test positive for COVID-19 (or direct contact with potential secretions of such a person), but initial patient remains asymptomatic

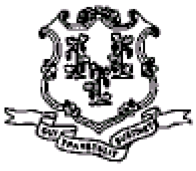
- Continue treatment as usual
- No need to mask patient
- Monitor temperature and respiration at least daily
- Monitor at least daily for signs of infection, fever, cough, shortness of breath, sore throat or GI symptoms
- No need to test for COVID-19 unless patient becomes symptomatic
- If patient becomes symptomatic, please proceed as described below for symptomatic patients

Individual Patient with Confirmed Close Contact to a COVID-19-Positive Person, but Initial Patient Remains Asymptomatic:

NOTE: Patients who have been in **close** contact with another individual who him/herself has been in close contact ("two degrees of separation") with a COVID-19-positive person **DO NOT** have to follow the below precautions.

The following apply **only** to a patient who has **close** contact directly (e.g. was within 3- 6 feet of the individual continuously for greater than 10 minutes, rode in a car with a COVID-19-positive individual) with another person who has tested positive for COVID- 19 (a CONFIRMED case, not just suspected):

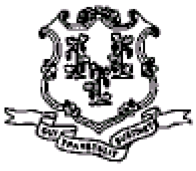
1. Quarantine the patient for up to 14 days per the WFH Medical Isolation Protocol (attached) in a single room (with own bathroom if available) and close door.
2. Monitor the patient's vital signs at least two times per day and monitor for signs of infection, fever, cough, shortness of breath, sore throat or GI symptoms .
3. Immediately inform the CNO, CMO and Infection Prevention Physician.
4. Place mask on patient when outside the room. Encourage hand hygiene
5. Maintain droplet and standard precautions: Staff wears mask, gloves, gown and face shield or goggles to enter room, plus frequent hand hygiene and social distance
6. Patient may have fresh air break, coordinated with staff so no contact with others.



7. Housekeeping staff clean and disinfect areas patient went or touched.
8. If patient becomes symptomatic or patient has confirmed COVID-19, please proceed as described below in each relevant section.

Patient with Suspected COVID-19:

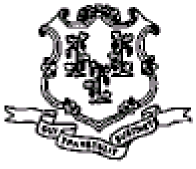
1. Isolate the patient per the WFH Medical Isolation Protocol (with own bathroom if available). **Do not** cluster patients with similar symptoms because they may ultimately have different diagnosis.
2. Staff in direct contact with the patient should wear gloves, surgical masks, face shields, and gowns.
3. Test the patient for COVID-19.
4. Immediately inform the CNO, CMO and Infection Prevention Physician.
5. Place mask on patient whenever outside the room. Encourage frequent hand hygiene
6. Monitor the patient's vital signs every shift, including pulse oximeter, encourage fluids, discontinue NSAIDS, and avoid introduction of new corticosteroids.
7. If the patient requires nebulizer treatments, staff should don N95 masks instead of surgical masks (as well as gloves, gown, and eye protection (either goggles or face mask)).
8. Limit the number of staff treating infected patient to mitigate spread. Ensure sufficient PPE for designated staff.
9. Patient may have fresh air break, coordinated with staff so no contact with others
10. Minimize travel outside of isolation room
11. Designated housekeeping staff to clean and disinfect patient's room, areas patient visited or things touched
12. Serve the patient's meals in the medical isolation room. While serving the food leave the hard plastic tray which holds the individual food serving plates outside of the isolation room. Open the tray and serve the patient in his/her room using the individually wrapped plates. This will ensure the tray remains unexposed and can safely



be moved through the building.

13. Restrict all patient movement off the unit and monitor vital signs and pulse oximeter of all other patients on the unit at least twice daily
14. ACS medical personnel to monitor patient daily. ACS clinicians and psychiatrists should consult with the Infection Prevention Physician and CMO to determine when a patient with COVID-19 should be transferred to a medical hospital for treatment when treatment needs exceed the capacity of inpatient psychiatric hospital.

    NOTE: Elderly and medically frail patients are at higher risk for more severe forms of COVID-19. Physicians and APRNs should have a lower threshold for sending these patients to a medical hospital.
15. If the patient tests negative for COVID-19, he/she may resume usual activity and isolation protocol and unit restricted movement status can be discontinued.
16. If the patient tests positive for COVID-19, see below for additional instructions.
17. If the patient refuses to comply with tests, Connecticut General Statute **Sec. 19a-131c. Enforcement of order of quarantine or isolation,** empowers the DMHAS facility to obtain tests over the patient's objection. However, consider the risks and benefits of forcing patient to have test done. Attempting to engage the patient in physical methods to obtain test could be risky; in such instances, it would be better to assume patient has COVID-19 and proceed accordingly.
18. If the patient refuses to comply with quarantine/isolation, inform the Service Medical Director and CMO. For patients refusing isolation, the unit psychiatrist and the Service Medical Director will evaluate the patient to determine if acute symptoms of mental illness have impaired the patient's ability to adhere to requests to stay in isolation, and immediately institute appropriate treatment. If the patient remains unable or unwilling to stay in isolation despite treatment, immediately inform the CMO. The CMO will then contact the regional public health director for Middletown. Isolation can be enforced by order of the regional public health director pursuant to Sec. 19a-131c of CT general



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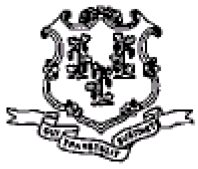
statutes. This request would be made to the regional health director for Middletown through the CMO.

Patient with a Confirmed Positive COVID-19 Test:

1. Isolate the patient per the WFH Medical Isolation Protocol. May cluster patients with similar documented diagnosis
2. Inform the WFH Infection Prevention Physician, CMO and CNO immediately, who will then inform and consult with DPH for additional guidance.
3. Staff in direct contact with the patient should wear gloves, surgical masks or N95 (if available and fit testing has been completed by individual staff member utilizing N95), face shields, and gowns.
4. Monitor the patient's vital signs every shift, including pulse oximeter, encourage fluids, discontinue NSAIDS, and avoid introduction of new corticosteroids.
5. If the patient requires nebulizer treatments, staff should don N95 masks instead of surgical masks (as well as gloves, gown, and face mask).
6. Patient should be masked whenever someone is coming into the room. For patients who cannot do so for themselves, patient's mask should be placed in a paper bag in the room. Staff will put on PPE at the door, enter the room and then place the mask on the patient.
7. All staff working on the unit will wear a surgical mask while working on the unit (utilizing 1 mask per week unless it becomes visibly soiled) until the period of isolation has ended
8. All patients on the unit will wear a surgical mask (utilizing 1 mask per week unless it becomes visibly soiled) until the period of isolation has ended.
9. Limit the number of staff treating infected patient to mitigate spread. Ensure sufficient PPE for designated staff. Minimize/ limit use of float staff as much as possible.
10. Monitor all staff for temp twice/day
11. Monitor all patients' temperature on the unit at least twice a day



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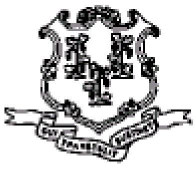
12. Minimize entry into patient's room
13. Minimize movement of other patients outside the room.
14. Serve the patient's meals in the medical isolation room. While serving the food leave the hard plastic tray which holds the individual food serving plates outside of the isolation room. Open the tray and serve the patient in his/her room using the individually wrapped plates. This will ensure the tray remains unexposed and can safely be moved through the building.
15. Restrict all patient movement off the unit.
16. ACS medical personnel to monitor patient daily. ACS clinicians and psychiatrists should consult with the Infection Prevention Physician and CMO to determine when a patient with COVID-19 should be transferred to a medical hospital for treatment when treatment needs exceed the capacity of inpatient psychiatric hospital.

    NOTE: Elderly and medically frail patients are at higher risk for more severe forms of COVID-19. Physicians and APRNs should have a lower threshold for sending these patients to a medical hospital.



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GUIDANCE REGARDING STAFF:

A. **Staff with direct exposure to (or direct contact with potential infectious secretions of) an asymptomatic person who subsequently (at a later time/date after the exposure) develops symptoms and tests positive for COVID;** ***Staff remains asymptomatic***

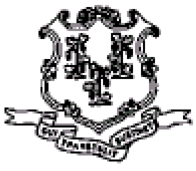
- *If exposure occurred* ***48 hours or less*** *before onset of symptoms,* ***proceed directly to B (below)***
- *If exposure occurred* ***greater than 48 hours*** *before onset of symptoms, return to work as usual*
- Monitor temperature daily
- Maintain social distance and frequent hand hygiene
- If temperature is 100F or higher, or if respiratory symptoms develop, do not come to work
- Call your supervisor
- Call your Primary Care Physician (PCP)
- Report Doctor's recommendation to your supervisor

B. Staff with direct exposure to (or direct contact with potential infectious secretions of) a suspected or confirmed case of COVID; ***staff is asymptomatic***

- For **high risk** exposure - Self-quarantine for 14 days
- For **mild or medium risk** exposure, return to work wearing a facemask and monitor temperature twice a day for 14 days from time of the last exposure
- Schedule staff for COVID-19 testing if available
- Maintain social distance as much as possible and *frequent hand hygiene*
- Be alert to development of respiratory or gastrointestinal symptoms, fatigue, chills or sore throat. If any of them develops, stay home or leave work immediately if at work.
- Call your PCP or 911 for severe symptoms
- Call your supervisor
- Follow additional steps as stated in c (below)

C. Staff with suspected COVID-19 infection

- Stay home or if at work, inform supervisor and leave immediately with face mask on
- The Infection Prevention Physician should be notified by the person in receipt of this information (860/262-1274). If the symptoms are consistent with possible COVID,



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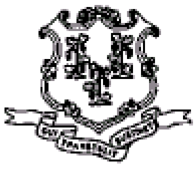
the reporting individual will be directed to speak with the CMO (860/706-4399), who will make the final decision regarding the staff member's quarantine status versus continued work within the facility.

- The employee will be directed to seek COVID-19 testing from their PCP or schedule themselves for rapid testing at a Rapid Testing Center. The employee should inform his/her supervisor of the results as soon as finalized.
- Housekeeping staff will complete terminal disinfection and cleaning of staff's work space, including desks, chairs and computer, following CDC/DPH protocol
- Supervisor or designee will identify close contacts of staff and proceed according to ***B** above*. Supervisor will call staff to get list of close contacts in last ***48** hours*
- Supervisor or designee will inform the staff's colleagues and patients from the staff's unit (through community meeting)
- Monitor patients twice daily for fever or respiratory symptoms
- If the staff's tests come back positive, staff will stay at home and staff's close contacts will maintain self-quarantine at home for the remainder of the 14 days. If staff's contacts develop symptoms anytime during that period, they should call their PCP and ask to be tested.
- If the tests are negative, staff's contacts will return to work immediately, and staff will return when recovered enough to work.

D. Return to Work: For staff with confirmed COVID+ test

- Staff will call supervisor to give updates of symptoms at mutually agreed frequency
- Staff will return to work if:
  - No fever for 72 hours without the use of fever reducing medications; **and**
  - Respiratory symptoms have improved; **and**
  - 14 days have passed since symptoms first appeared
- For staff with access to repeated testing, two consecutive tests conducted 24 hours apart at minimum, should be negative. Staff who choose to get repeated tests cannot return to work until both test results are obtained. However, if staff have met the above clinically based return to work guidelines, repeated testing is not necessary to be cleared to return to work.
- Supervisor will contact CNO and CMO prior to staff member returning to work to ensure compliance with our COVID-19 guidelines for return to work.



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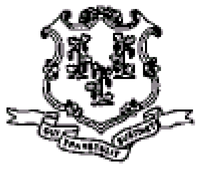
Homemade Facemasks

****According to CDC: In settings where facemasks are not available, Healthcare Providers (HCP) might use homemade masks (e.g., bandana, scarf, cloth) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face*** *when used in the care of COVID-19 patients.*

Guidelines:

- Staff will use approved facemasks (N95 or surgical as appropriate and available) when in patient care areas
- When there is shortage of surgical masks, homemade masks could be used in patient care areas to be placed on top of N95 (or the scarce surgical) masks to protect them and to extend their period of usefulness
- Staff in non-patient care areas working in close proximity with other staff should wear surgical masks. Homemade masks may be worn if surgical masks are not available, and should be combined with as much social distancing as possible, along with frequent hand hygiene
- Staff in non-patient care areas working mostly at a distance with other staff (6 ft or greater) may wear cloth masks. However, cloth masks may be appropriate during brief exposures to other staff at distances less than 6 ft.
- Staff working in the community may wear homemade masks. However, if the work includes close contact with patients or staff, they should wear approved facemasks
- Staff should always observe social distance and hand hygiene as appropriate.



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Emergency Situations

Behavioral Codes (including Restraint/Seclusion) or Cardiopulmonary Respiration (CPR)

- To protect patients and colleagues during restraint and seclusion or CPR involving a patient with suspected/confirmed COVID19, staff should wear the following:
- **Behavioral Code/Restraint/Seclusion:** Surgical mask, gloves, and eye protection (face shields/goggles)
- **Cardiopulmonary Respiration:** N95 mask (or surgical mask if not available), face shield, gloves and gown
- *Emergency cart should include PPEs such as facemasks (N95 and surgical), face shields, gowns and gloves*

All staff working in a suspected or confirmed COVID-19 unit should wear appropriate PPE (including N95 or surgical masks if N95 not available) when engaged in the procedures described above

For more detailed exposure risk guidelines for healthcare workers, see:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

EXHIBIT M

WFH PPE Inventory as of July 1, 2020

Item	Current Inventory	Estimated days Supply
Face Shield	3000	2900
ISOLATION GOWNS- Yellow-Single Use-BEESANA	870	78
TOTAL ALL GOWNS-ALL SIZES	870	545
TOTAL ALL GLOVES, SMALL	20400	123
TOTAL ALL GLOVES, MEDIUM	31600	58
TOTAL ALL GLOVES, LARGE	32800	52
TOTAL ALL GLOVES, X-LARGE	37600	51
PDI Wipes, tub	99	32
*Hand Sanitizer, 2 liter bottle	78	47
Probe Covers - Braun Therm	3400	64
Masks, procedure Staff/Patient	1850	67
Masks, molded surgical Staff/ Patient	95700	1285
Mask, N95 - 8000	230	363
Mask, N95 - KN95, ZYB11,	580	65
*Mask, N95 - 3 NMF4 (FDA) Battelle	900	123
*Mask, N95-1860, Regular (FDA) Battelle	500	63
Mask, N95-1860s, small (FDA) Battelle	180	97

EXHIBIT N

CVH Inventory as of July 1, 2020		
Item	**Current Inventory**	**estimated days' supply**
Face Shield	4,280	779.0
Gowns	1,386	49.1
GLOVES, SMALL	24,700	40.8
GLOVES, MEDIUM	44,500	37.7
GLOVES, LARGE	58,900	50.4
GLOVES, EXTRA LARGE	55,100	43.1
PDI Wipes	176	26.3
Hand Sanitizer	145	78.5
TYMPANIC PROBE COVERS	26,400	34.7
Masks, procedure	6,700	46.2
Masks, molded surgical	22,420	149.2
Mask, Orich KN95	9,085	
Mask, N95 - 8000	1,314	43.7
Mask, N95 - 9010	75	
Mask, N95 - 8210	4,420	452.2
Mask, N95-1860, Regular	60	
Mask, N95-1860s, small	840	378.6

Michael Boutin

EXHIBIT O

Coronavirus (COVID-19)
FACT SHEET

Watch for symptoms

These symptoms may appear **2-14 days after exposure** (based on the incubation period of MERS-CoV viruses).

- Fever
- Cough
- Shortness of breath

If you develop **emergency warning signs** for COVID-19 get **medical attention immediately**. Emergency warning signs include*:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion or inability to arouse
- Bluish lips or face

*This list is not all inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

Take steps to protect yourself

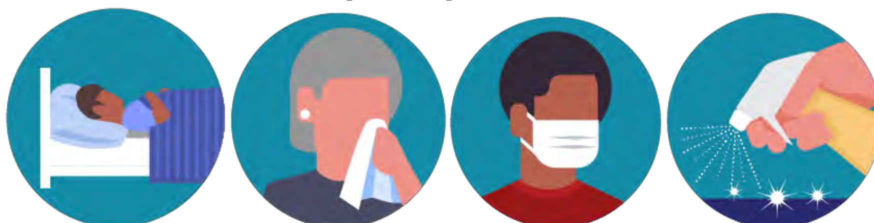
Clean your hands often

- Wash your hands often with soap and water for at least 20 seconds especially after you have been in a public place or after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry.
- Avoid touching your eyes, nose, and mouth with unwashed hands.

Avoid close contact

- Avoid close contact with people who are sick
- Put distance between yourself and other people if COVID-19 is spreading in your community. This is especially important for people who are at higher risk of getting very sick.

Take steps to protect others



Stay home if you're sick

- Stay home if you are sick, except to get medical care.

Cover coughs and sneezes

- Cover your mouth and nose with a tissue when you cough or sneeze or use the inside of your elbow.
- Throw used tissues in the trash.
- Immediately wash your hands with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol.

Recommendations for Healthcare Professionals

How COVID-19 Spreads
There is much to learn about the newly emerged COVID-19, including how easily it spreads. Based on what is currently known about COVID-19 and what is known about other coronaviruses, spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts.
Close contact can occur while caring for a patient, including:

- Being within approximately 6 feet (2 meters) of a patient with COVID-19 for a prolonged period of time.
- Having direct contact with infectious secretions from a patient with COVID-19. Infectious secretions may include sputum, serum, blood, and respiratory droplets.

If close contact occurs while not wearing all recommended PPE, healthcare personnel may be at risk of infection.

How should healthcare personnel protect themselves when evaluating a patient who may have COVID-19?
Although the transmission dynamics have yet to be determined, CDC currently recommends a cautious approach to persons under investigation (PUI) for COVID-19. Healthcare personnel evaluating PUI or providing care for patients with confirmed COVID-19 should use, Standard Transmission-based Precautions.

Strategies for social distancing in an inpatient psychiatric hospital

Social distancing means remaining out of congregate settings, avoiding mass gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

Someone who has completed quarantine or has been released from isolation does not pose a risk of infection to other people.

Perform hand hygiene with alcohol-based hand rub before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.

Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.

There is a current Web Based Training on**:**
Donning Doffing PPE and Hand Hygiene on LMS.
Class #: 0000105979

Who to call on campus if you have questions or concerns

IP Nurse: Raeann Paparello (860) 262-6046
Medical Director: Dr. Vinneth Carvalho (860) 262-7030
Asst. Medical Director: Dr. Lynne Manning (860) 262-5104

Name and number of our HR affiliate

Anne Dana (860) 262-7190

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

EXHIBIT P

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

CONNECTICUT VALLEY HOSPITAL	
COVID-19 Response Plan	
PROTOCOL:	**Patient Testing**
REVISED:	**4/14/20, 5/11/20, 6/18/20, 6/29/20**

The testing information gathered from existing and newly admitted patients at CVH will be used to cohort similar patient populations (i.e. positive, negative, PUI). The Quarantine and Isolation process will be implemented as described in the protocol in an attempt to limit the spread of the disease.

Even after the total population testing is completed all patients will be assessed on a daily basis using the patient screening record, which is based on the current CDC symptom guidance:

- Temp. > 100.0°
- New cough
- Difficulty Breathing/SOB
- Chills/Shaking
- Muscle Pain
- Headache
- Sore Throat
- Loss of Taste/Smell).

For the duration of the pandemic response plan the unit RN will call the ACS provider (during regular business hours), or on-call physician (during off hours, holidays, and weekends) to have any newly symptomatic patient evaluated for treatment and potential re-testing.

A single new case of COVID-19 is considered an outbreak. When one case is detected, there are often already other patients or staff infected who can potentially spread the virus.

Therefore, whenever a symptomatic patient or a staff member who has worked on a unit within the last 48 hours tests positive for COVID-19 a cohort unit will be changed to exposed status. All patients residing on the unit and staff who worked on the unit within the last 48 hours will be tested. The need for testing on additional units or building wide will be determined by the Infection Control team based on the results of contact tracing.

Repeat testing of the cohort of patients and staff identified above who initially tested COVID-19 negative will be conducted weekly, until a period of fourteen days has passed since the last detection of a COVID-19 positive patient or staff member.

SYMPTOM POSITIVE PATIENT RESPONSE PROTOCOL

1. The provider will write an order for isolation
2. The nurse will contact IP for patient placement into one of the pre-identified precaution room
3. The Person under Investigation (PUI) will be restricted to their room with the door closed unless clinically contraindicated.
4. The PUI must don a mask whenever they are outside of the bedroom.
5. Staff working directly with the PUI will wear a mask, gown, gloves and face shield or goggles to enter room, plus conduct frequent hand hygiene.

TESTING PROCEDURE

Specimens collected at CVH will be sent to the Hartford Healthcare Lab (HHC) for testing.

During regular business hours (Monday-Friday dayshift) the unit RN calls the assigned ACS physician to report the case. A Provider/RN will obtain the sample. The unit will then call the lab office in Haviland Hall who will arrange for courier pick-up of the sample.

During off hours (Evenings, Nights and Weekends) the unit RN calls the assigned on–call physician to report the case. A Provider/RN will obtain the sample. the unit RN calls HHC Client services line at 1-800-286-9800 and enters Option 2. They then notify the lab person handling the call of the stat lab sample that needs to be picked up. A courier will be dispatched by HHC Lab to pick up the specimen and deliver it to the lab for processing:

1. Symptomatic patients should be tested for COVID 19 using E-Swabs we currently have in house, which are the 220245 BD Swab Regular Collection Kit (White) swabs. These are most suitable for collecting Oropharyngeal specimen.
2. The E Swabs Oropharyngeal Specimen Collection Process:
   A. Provider/RN collects specimen using all recommended PPE (i.e. Goggles OR Safety glasses plus face shield, N95 Mask, Gloves, Gown).
   B. Take a dry polyester swab; use a tongue depressor to keep the tongue from interfering with specimen collection.
   C. Insert swab into mouth, and swab the posterior pharynx and tonsillar areas. (Avoid the tongue and teeth.)
   D. After collection, place the tip of swab into sterile viral transport media tube and snap/cut off the applicator stick.
   E. Close the cap tightly and place the closed specimen container inside of the biohazard specimen transport bag.

3. The Nasopharyngeal swabs #220532 (Blue) and 220246 (Green) collection kit can also be used when available.
4. Nasopharyngeal Specimen Collection Process:
   A. Ask the patient to blow their nose to clear nasal passage of excessive mucus – have the patient dispose of the used tissue in a waste receptacle.
   B. Tilt the patient’s head back 70 degrees. It may be helpful to have the pt. rest their head against a wall or hard surface during specimen collection.

C. Insert swab into the nostril. (Swab should reach depth equal to the distance from nostril to outer opening of the ear).
D. Leave swab in place for 5-10 seconds to absorb secretions.
E. Slowly remove swab while rotating it.
F. Place the tip of swab into sterile viral transport media tube and snap/cut off the applicator stick. Ensure lid is tightly closed.
G. Place specimen container in a biohazard transport bag.

ADDITIONAL INSTRUCTIONS:

- On your Lab requisition: write in COVID 19 (actual test codes not necessary).
- These additional labs should be ordered as stat: CBC w/Diff, CMP, CRP, UA w/Reflux Culture
- Label specimen and lab requisition as **STAT**
- The Courier delivers the specimens to HHC (order is entered into their system & testing performed at HHC Lab in Newington)
- Results reported within 48 hours (subject to change as case volume increases)

PATIENT REFUSAL:

Whenever a patient refuses to participate in testing the following process should be followed:

- Staff should continue to explain the importance of the test and encourage patient to participate
- The treatment team will consult with the IP team to determine if an alternative testing method should be offered and employed.
- If the patient continues to refuse testing they will be placed on an appropriate cohort unit based on their current medical condition and potential exposure history.