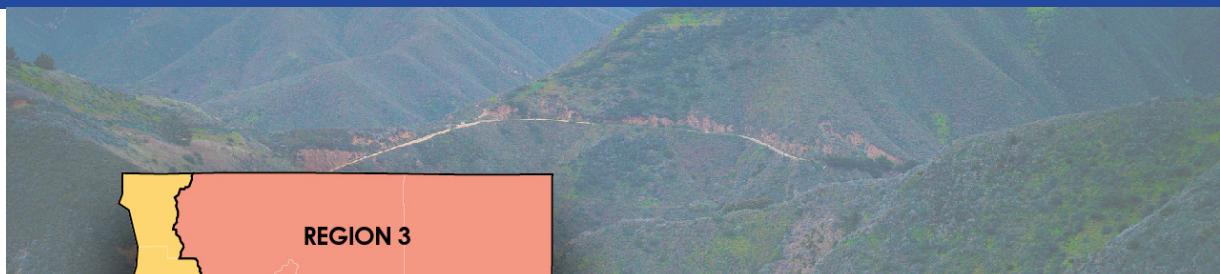
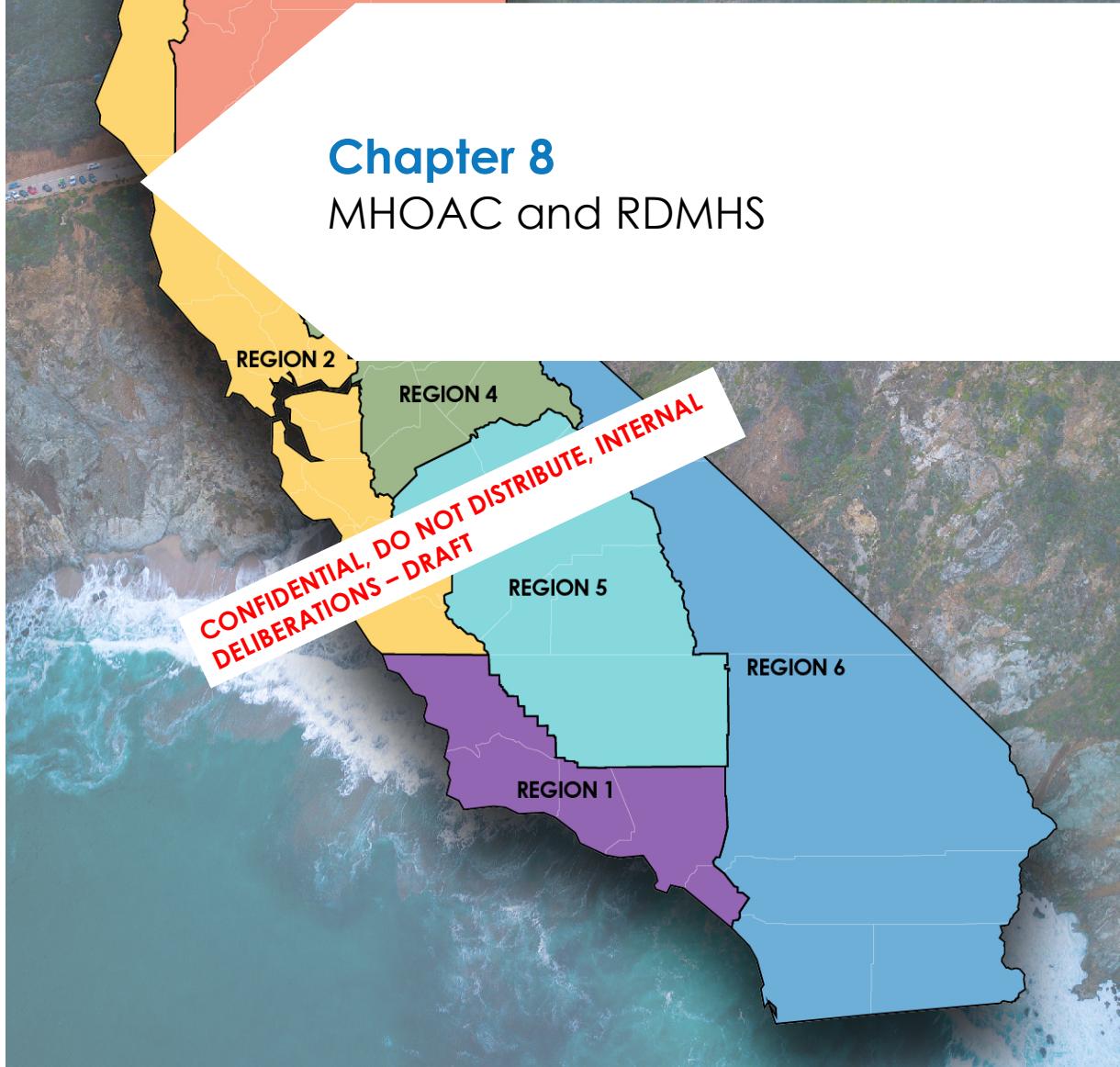


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Chapter 8 – MHOAC and RDMHS

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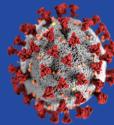


Chapter 8
MHOAC and RDMHS



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The map of California is divided into six regions: Region 1 (purple), Region 2 (yellow), Region 3 (orange), Region 4 (green), Region 5 (cyan), and Region 6 (light blue). The regions are separated by thin black lines. The map is set against a background of a coastal mountain range and ocean waves.



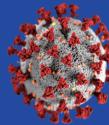
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Version History

| Version # | Date | Notes |
|-----------|------------|---|
| 0.1 | 11/13/2023 | First Draft submitted to CPR Team |
| 0.2 | 4/10/2024 | Final Draft submitted per Expert Review and CPR Leadership review |

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CDPH COVID-19 After Action Report Chapter 8 – MHOAC and RDMHS

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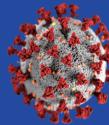
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8. MHOAC and RDMHS

Related CDPH AAR chapters: Local Response

In this chapter, some abbreviations may be used interchangeably with their respective full spellings for ease of reading.

Throughout this chapter, MHOACs and RDMHSs are referred to interchangeably as “MHOAC/RDMHS respondents,” “respondents,” “MHOACs/RDMHSs,” and “MHOAC and RDMHS representatives.”

Chapter Summary

Overview

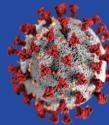
This section provides a high-level overview of the approach to this chapter and identifies key themes.

In early 2023, in order to obtain local and regional input for this CDPH COVID-19 After Action Report, CDPH distributed a survey to Medical Health Operational Area Coordinators (MHOACs) and Regional Disaster Medical Health Specialists (RDMHSs). The survey was distributed to RDMHSs, who collected responses from their respective MHOACs and provided responses back to CDPH. CDPH received survey responses from four of the six regions (Regions 1, 2, 3, and 5). In addition, CDPH facilitated an in-person meeting with RDMHS representatives from all six regions in April 2023 to obtain their input. The contents of this chapter are derived from qualitative analysis from the survey responses and the meeting outcomes. For more details on this chapter’s methodology, refer to the appendix in this chapter.

In the survey and the facilitated meeting, MHOACs and RDMHSs shared their thoughts on their COVID-19 successes and challenges, their communications with CDPH, and their lessons learned for improvement. This chapter summarizes the input provided by MHOACs and RDMHSs as self-reported in the survey and the meeting. **It does not reflect responses or comments from CDPH on the MHOACs’ and RDMHSs’ observations.**

California maintains a robust public health and medical mutual aid system during disasters and emergencies. The system relies upon specific coordination programs—the MHOAC program and the RDMHS program—support public health and medical activities while integrating into existing emergency

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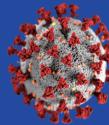
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management structures. The roles of the MHOAC and the RDMHS are defined in statute in the California Health and Safety Code (CA HSC [§1797.153](#) and [§1797.152](#), respectively). The primary responsibility of the MHOAC is to help the county (Operational Area [OA]) manage the medical and health aspects of a disaster or emergency. The MHOAC is a program, not an individual. The 17 specific functions of the MHOAC [as defined in statute](#) are displayed in **Figure 1**:

Figure 1 – Mandated MHOAC Functions

| Function No. | Function Description |
|--------------|---|
| 1 | Assessment of immediate medical needs |
| 2 | Coordination of disaster medical and health resources |
| 3 | Coordination of patient distribution and medical evaluations |
| 4 | Coordination with inpatient and emergency care providers |
| 5 | Coordination of out-of-hospital medical care providers |
| 6 | Coordination and integration with fire agencies personnel, resources, and emergency fire prehospital medical services |
| 7 | Coordination of providers of nonfire based prehospital emergency medical services |
| 8 | Coordination of the establishment of temporary field treatment sites |
| 9 | Health surveillance and epidemiological analyses of community health status |
| 10 | Assurance of food safety |
| 11 | Management of exposure to hazardous agents |
| 12 | Provision or coordination of mental health services |
| 13 | Provision of medical and health public information protective action recommendations |
| 14 | Provision or coordination of vector control services |
| 15 | Assurance of drinking water safety |
| 16 | Assurance of the safe management of liquid, solid, and hazardous wastes |
| 17 | Investigation and control of communicable disease |



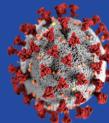
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During the COVID-19 pandemic, MHOACs performed many of these functions, and played an especially significant role in patient movement and transfers. One Another key role played by MHOACs during the COVID-19 pandemic response involved resource requesting. CDPH maintains a defined, standardized resource requesting process for California entities or jurisdictions that need State assistance in obtaining medical and health resources, which can include personal protection equipment (PPE), testing supplies, durable medical equipment, and staffing. Medical and health resources requests submitted to the State are managed by CDPH's Medical and Health Coordination Center (MHCC) and they can be submitted at any time (e.g., they are not limited to times of emergency).

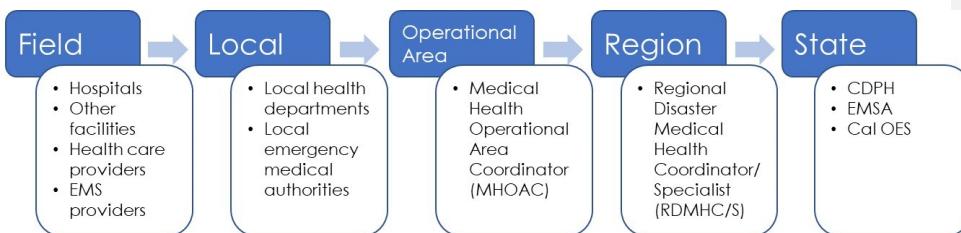
During emergencies, resource requesting follows a specific process as defined by the Standardized Emergency Management System (SEMS) and outlined in the [Public Health and Medical Emergency Operation Manual](#) (EOM). SEMS consists of five consecutive organizational levels (Field, Local, Operational Area, Region, State), and it unifies all elements of California's emergency management community into a single integrated system. Resource requests start at the field level (e.g. hospital or other health care facilities), and move to the MHOAC (operational area level). If the MHOAC is unable to locate resources locally, the request will elevate to the RDMHS (regional level), which first attempts to locate resources regionally before turning to the State. The MHCC is responsible for receiving requests and then routing them to either CDPH, the Emergency Medical Services Authority (EMSA), or the California Governor's Office of Emergency Services (Cal OES) for fulfillment. In some cases, resource requests may elevate to the federal level. This process is depicted in **Figure 2**. Resource requesting activities during the COVID-19 pandemic response included the ordering, distribution, inventory management, and reporting of medical and health resources.

Figure 2 – SEMS Resource Requesting Process



CDPH COVID-19 After Action Report Chapter 8 – MHOAC and RDMHS

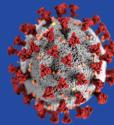
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The need for many different types of resources during the COVID-19 pandemic was unprecedented in scale and volume and unlike any other previous emergency or disaster. The California public health and medical mutual aid system is based the ability to identify and source resources locally (and regionally) before obtaining them from the State level. During previous emergencies and disasters, this system functioned well. However, during the pandemic, the overwhelming demand for resources (coupled with their low supply) presented a unique challenge that the system was not designed to handle. Since many jurisdictions were unable to obtain resources at the local or regional level, the State stepped in to either purchase scarce resources on the open market or obtain them from the federal government.

The successes and challenges associated with resource requesting during the pandemic response was a key theme in the MHOAC/RDMHS responses. Additional key themes in the responses included the successes and challenges of communications and coordination, as well as the success and challenges associated with data and information technology. In general, MHOAC/RDMHS respondents had a wide range of opinions about these key themes—for instance, some respondents felt that CDPH's approach to resource requesting was very helpful, while others felt that it was confusing and inconsistent. Similarly, most respondents appreciated the State's new technology systems that resulted from the pandemic and found them successful, while some felt that the systems were delayed, disparate, and lacked needed functionality. The nuances of these differences in opinion are discussed in greater detail in this chapter.

Respondents agreed on several overarching topics. One was the critical importance of following SEMS processes and procedures, and the challenges that were created when SEMS was not followed. Respondents also agreed that the State's initial use of a Third-Party Administrator (TPA) in the COVID-19 vaccination program was disruptive and not helpful to local response efforts.



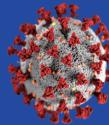
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Additionally, respondents also agreed that CDPH's therapeutics program was lacking on many fronts, including initial communication, public awareness, and distribution. While most MHOAC/RDMHS respondents felt that their vaccination and testing campaigns were successful, no one mentioned therapeutics as entirely successful.

Lastly, despite the communication and coordination challenges that took place throughout the pandemic response, MHOAC/RDMHS respondents agreed on the criticality of the State/local/regional relationship and emphasized that it should be maintained, fostered, and reinforced through future training.

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Main Strengths and Successes

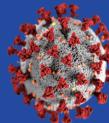
This section describes the main strengths and successes identified by MHOAC/RDMHS respondents. Further elaboration and a more detailed discussion of these strengths and successes can be found in the Analysis of Responses section.

1. Over the course of the pandemic CDPH communications with the MHOACs and RDMHSs improved.

During the pandemic response, communication between CDPH and MHOAC/RDMHS representatives markedly improved, and many respondents noted that information sharing between the State and local/regional entities was a key success. Initially, CDPH depended on emails and documents, but later transitioned to more effective virtual meetings, webinars, and calls. Having a cadence of regularly scheduled meetings allowed MHOAC/RDMHS representatives to better engage with CDPH on different response topics. Respondents highlighted the MHCC meetings, LHJ meetings, and Local Coordination Team meetings as especially beneficial for clarity and coordination. Additionally, respondents noted that CDPH offered many other communications channels, including direct access to individual subject matter experts. Many MHOAC/RDMHS representatives developed valuable ties with CDPH personnel, ensuring swift and accurate information dissemination. One respondent described how, if their CDPH contact "didn't know something, they knew exactly who to ask and made those connections to ensure timely responses and information was relayed back." This sentiment was echoed by other respondents who described individual CDPH staff communication efforts as "responsive and helpful," "always great," and "timely."

2. MHOAC and RDMHS respondents reported that effective coordination with CDPH and other key stakeholders was a key success factor for their COVID-19 response.

Numerous MHOAC/RDMHS respondents reported that effective coordination with CDPH, other State agencies, the federal government, healthcare providers and hospitals, and nongovernmental organizations factored into their successful pandemic response. Intergovernmental coordination was most successful when all parties followed SEMS, were



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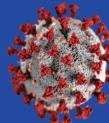
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willing to modify regulations to address specific response needs and were innovative in leveraging State and Federal resources. A number of MHOAC/RDMHS respondents mentioned coordination and cooperation with their local and regional healthcare partners as a critical success factor. A few respondents reported that they successfully coordinated with providers to collect and analyze data, which yielded insights into individual facility needs and utilization patterns. The MHOAC/RDMHS respondents implemented frequent information gathering and exchange methods with providers to develop resource requests. Lastly, several MHOAC/RDMHS respondents reported that they successfully worked with community organizations, large employers, and volunteers to obtain critically needed staff and supplies. These groups were mobilized to respond for case investigation, contact tracing, public messaging, local COVID-19 hotlines, resource distribution, and other activities. Some jurisdictions were able to source PPE from local businesses when other supply channels were low.

3. MHOACs and RDMHSs attributed some of their successful COVID-19 resource requesting efforts to CDPH's timely and critical support, standardized processes, and a new technology solution.

The majority of MHOAC/RDMHS respondents successfully handled a high volume of resource requests and efficiently distributed supplies within their jurisdictions. They reported that adherence to the State's established SEMS resource requesting process played a pivotal role. Additionally, respondents attributed many of their achievements to CDPH, which promptly fulfilled critical and urgent supply needs, offering clear processes for supply requests even across different categories. CDPH's ability to follow up on orders and clarify requests was highly appreciated by the MHOACs/RDMHSs.

Another significant success factor reported by most respondents was the implementation of the Public Health Ordering System (PHOS) in spring 2020. PHOS replaced manual and paper-based processes, streamlining resource requesting by allowing direct shipments to receiving facilities. This innovative system marked a substantial improvement over the prior challenges and delays in the resource requesting process. The implementation of PHOS, combined with the crucial role of CDPH and



adherence to SEMS, optimized the efficiency of many MHOAC/RDMHS resource requesting operations.

4. CDPH's new vaccine and contact tracing technology solutions streamlined local COVID-19 response work.

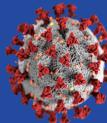
Many MHOAC/RDMHS respondents highlighted the success of CDPH's new technology solutions in different program areas. Some credited CDPH's vaccine technology solutions (myCAvax and My Turn) with bolstering COVID-19 response efforts. These platforms, along with their help desk support, played pivotal roles in streamlining vaccination activities. MyCAvax enhanced the accuracy and transparency of resource requests, while My Turn boosted the efficiency of vaccination clinics. Furthermore, integrating vaccination checks into CalCONNECT greatly expedited isolation and quarantine procedures. In addition, the new systems established by California Connected, the State's contact tracing program, were also helpful. MHOACs and RDMHSs noted that both CalCONNECT and the Virtual Training Academy (VTA) had a positive impact on contact tracing and local responses.

5. MHOACs and RDMHSs successfully requested and received PPE from CDPH.

Despite the global shortage of PPE that characterized the early pandemic response, many MHOAC/RDMHS respondents reported that they were able to successfully obtain PPE through the resource requesting process. Respondents also indicated that they were able to mitigate PPE shortages through local planning and collaboration with CDPH. Partnerships with hospitals and healthcare facilities allowed for early development of PPE conservation strategies, maximizing cached inventory until additional supplies became available. Respondents emphasized CDPH's vital role in providing the needed PPE during critical times and mentioned that even small jurisdictions were able to have their needs met.

6. CDPH successfully supported MHOACs and RDMHSs to implement the COVID-19 vaccination program.

A number of MHOAC/RDMHS respondents reported that mass vaccination was a key success during the pandemic. These MHOAC/RDMHS respondents attributed their success in part to vaccine



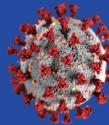
resource requesting and CDPH's innovations during the pandemic. Several respondents felt CDPH significantly improved its vaccine resource requesting process over the pandemic as well as provided advance information on vaccine pre-orders and clear delivery timelines. The ability to request vaccines from various manufacturers proved invaluable during supply shortages. CDPH's innovations in vaccine redistribution were lauded, with the use of third-party redistributors and the creation of the Vaccine Marketplace facilitating the redistribution of vaccines, particularly for smaller providers. Lastly, several respondents credited CDPH's support of temporary licensing waivers with helping jurisdictions hold and staff vaccination events.

In addition to CDPH support, MHOAC/RDMHS respondents noted that successful local vaccination activities were bolstered by community-based organizations and local volunteers. Coordination with these stakeholders was instrumental in streamlining provider communications and building strong collaborative relationships to efficiently scale vaccination efforts. Community collaboration allowed for widespread vaccination events, enhancing accessibility and adaptability based on community needs.

7. CDPH successfully provided different types of staffing support that accelerated local response efforts.

Many respondents reported success in collaborating with CDPH to request and obtain staffing, particularly for mass vaccination events. CDPH supplied various medical staff and supported turnkey vaccination events, significantly contributing to mass vaccination clinic success. After the need for mass vaccination events, CDPH mobile vaccination teams greatly expanded vaccination capabilities in underserved communities. CDPH's staffing support extended to other response operations, including local hospitals, and was regarded as invaluable when local sources were insufficient. Respondents also mentioned the availability of State-contracted staffing, hospital strike teams, and other staffing teams as successful approaches to increasing staff.

Several MHOAC/RDMHS respondents successfully obtained additional staff by securing grant funds, mobilizing disaster service workers from county departments, and enlisting volunteers. Some respondents reported that the pandemic drove innovations in public health staffing,

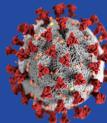


leading to the creation of new permanent positions in various domains, new professional relationships, and new staffing and care approaches.

8. CDPH's Testing Task Force successfully provided testing supplies, vendors, and innovative testing programs, including mass testing and mobile testing.

Numerous respondents highlighted their ability to conduct COVID-19 testing at mass testing centers, mobile testing sites, and testing pop-ups as key successes, with many highlighting CDPH's crucial role in these efforts. These sites were instrumental in controlling outbreaks in communities, and the transition to State-sponsored vendors was generally seen as seamless. Some MHOACs and RDMHSs commended the State testing vendors for their innovative contributions.

Additionally, CDPH's process to request COVID-19 tests was lauded for its flexibility and accessibility. Direct delivery streamlined the process and enabled a broader range of facilities to access test supplies, with the Testing Task Force (TTF) distributing tests directly to enrolled organizations. These efforts were appreciated for expanding testing equity and alleviating the burden on MHOAC program staff, an instance where resource requesting was improved by not being confined to SEMS protocols.



Main Challenges and Lessons Learned

This section summarizes the main challenges and lessons learned identified by MHOAC/RDMHS respondents. Further elaboration and a more detailed discussion of these challenges and lessons learned can be found in the Analysis of Responses section.

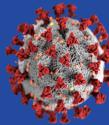
9. The State's approach to releasing COVID-19 policy and guidance frustrated many MHOACs/RDMHSs.

The MHOACs/RDMHSs cited communication challenges that arose in the COVID-19 pandemic when the State released policy and guidance without advance notification to the Local Health Jurisdictions (LHJs) and the MHOACs/RDMHSs. This led to miscommunication, confusion, and erosion of trust. The delayed synchronization between CDPH and CDC guidance, and the occasional misalignment with guidance being released by other California agencies and departments, further compounded the confusion. Additionally, many respondents stressed the benefits of using SEMS to communicate policy updates and felt that SEMS was not followed. The MHOACs/RDMHSs indicated that a departure from SEMS and the introduction of new response partners who were unfamiliar with emergency management and SEMS led to communication silos, often causing information delays. Respondents recommended that in future responses, SEMS should be followed by all response partners to ensure better information sharing and communication.

10. In the early stages of COVID-19 MHOAC/RDMHS respondents reported challenges with CDPH's resource requesting processes.

As discussed earlier in this chapter there were many successes in resource requesting. However, the MHOAC/RDMHS respondents also noted several resource requesting challenges. Respondents found it frustrating that different resource types (e.g., PPE, vaccines, therapeutics, and staffing) each had separate systems and processes that needed to be learned and followed, which contributed to additional logistical workload and confusion for local jurisdictions. Additionally, confusion arose regarding the evolving nature of the resource allocation process, which they noted changed frequently and

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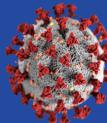
was not always well communicated. Data compilation and reporting was also a source of challenge and delay for several MHOAC/RDMHS when it came to resource requesting, regardless of resource type.

Additionally, respondents also mentioned that minimum ordering quantities were sometimes too large, which led to storage challenges as well as the need to continuously stay up to date on resource quantities, packaging, sizes, and burn rates. Having new, non-traditional response partners into the resource requesting process—not all of whom were familiar with SEMS or the resource requesting process—was also challenging for MHOACs and RDMHSs. Finally, while the implementation of the PHOS was generally seen as a vast improvement, respondents noted that this system lacked robust inventory, warehousing, tracking, and reporting functionality. Respondents recommended that this functionality be added to PHOS.

11. According to some MHOACs/RDMHSs, CDPH's recurring data requests and periodic system failures disrupted local COVID-19 response efforts.

The State's data demands and information technology challenges hindered local COVID-19 response efforts, according to MHOAC/RDMHS respondents. During the pandemic's onset, local jurisdictions grappled with pressing data requests from CDPH, often detracting from their primary duties.

System issues, particularly with the State's CalREDIE disease surveillance system, resulted in data failures and hampered local interventions. The delays in vital CalREDIE processes consumed substantial local resources, and delays in implementing the State's new contact tracing system (CalCONNECT) was challenging for local case investigation and contact tracing. For improved readiness ahead of future pandemics, respondents emphasized the urgency of overhauling outdated systems like CalREDIE and underscored the need for real-time data interoperability, better incident management, and more coherent data dashboards. They advocated for proactive system development, with CDPH seeking ample feedback from local and regional jurisdictions to ensure efficiency and effectiveness. Additionally, many respondents noted that CDPH should continue investing in technology to inform



data-driven decision-making, and limit data gathering to pertinent, actionable items to reduce local reporting burdens.

12. Some MHOACs and RDMHSs reported PPE quality issues and logistical challenges for supplies provided by CDPH.

While PPE requesting was generally successful, there were several challenges reported by some MHOAC/RDMHS respondents regarding the requesting and management of PPE. Sometimes, the PPE provided by the State was of inconsistent quality, and respondents reporting receiving poor quality items that could not be used. When items were not usable, MHOAC/RDMHS respondents were left with unusable products and no way to return them to CDPH. MHOAC/RDMHS respondents had to visually inspect PPE upon arrival to determine usability. Additionally, some respondents reported logistical challenges in understanding the appropriate quantities of PPE they should request, as well as storage issues caused by delivery of large amounts of PPE that exceeded available space.

13. MHOACs and RDMHSs felt that the Third-Party Administrator (TPA) disrupted and delayed local vaccine efforts.

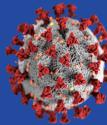
The most significant challenge reported by respondents was the State's introduction of the TPA to manage ordering and allocating COVID-19 vaccine. Most respondents indicated that the TPA disrupted and delayed local vaccination efforts. They reported that the TPA's lack of public health expertise and SEMS knowledge created barriers to ordering and interrupted local vaccine distribution and equity initiatives.

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14. MHOACs and RDMHSs experienced challenges with COVID-19 ultra-cold vaccine storage and handling requirements.

The complex requirements for ultra-cold storage and handling were difficult for MHOACs and RDMHSs to navigate, and jurisdictions struggled with unclear instructions, unpredictable and inconvenient vaccine delivery times, and how to avoid vaccine wastage.

15. Many MHOACs and RDMHSs felt that CDPH's COVID-19 therapeutics program suffered from early communication, allocation, and technology issues, which led to low local



demand for therapeutics, as well as storage and redistribution problems.

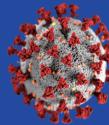
Many MHOAC/RDMHS respondents faced challenges related to COVID-19 therapeutics, the most significant of which involved communication, low public awareness and demand, allocation issues, and information technology access. Several respondents felt that the initial communication from CDPH regarding therapeutics was not robust or effective, especially compared with CDPH's vaccine communications. This was a challenge until CDPH launched its therapeutics webinar series.

Additionally, respondents felt that communications to the public about COVID-19 therapeutics were also insufficient and contributed to a lack of public understanding and awareness. This translated into low public demand for therapeutics, and challenges with recruiting local providers to offer therapeutics. In rural regions, low demand—coupled with minimum order allocations—contributed to storage and redistribution problems, when regions received more therapeutics than they could use. In addition to these challenges, MHOACs/RDMHSs reported several technology-related therapeutics challenges as it was difficult for some to access and use the federal system to order and track therapeutics.

16. MHOACs and RDMHSs experienced some challenges to request and deploy contract staff from CDPH.

Several MHOAC/RDMHS respondents encountered challenges when requesting staffing from CDPH, including confusion in the requesting process, variability in staff quality and experience, and delays in obtaining staff. During the requesting process, some were confused about different staff types, who would pay for staff, and how long deployments would last. There was also uncertainty about the requesting process for staff. In addition, a wide degree of variability in the qualifications and experience of State-provided staff sometimes led to a disconnect between staff's capabilities and their responsibilities. CDPH sometimes deployed Staff without enough advance notice to the MHOACs/RDMHSs. Lastly, a few respondents reported significant delays or non-fulfillment of staff requests, with requests going unmet for months.

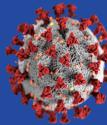
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17. Some MHOACs and RDMHSs felt that CDPH added to the confusion when communicating date extensions for antigen test kits.

MHOAC/RDMHS respondents indicated that the most significant testing challenges occurred early in the pandemic, when testing capacity was limited and testing turnaround times were lengthy. After antigen test kits became available, the main challenge reported by respondents involved the kits' expiration dates. Many test kits initially had short expiration dates, but they were frequently extended, which caused confusion. Communications from CDPH regarding extended expiration dates came through various channels, changed frequently, and was challenging for local jurisdictions to track.

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Analysis of Responses

This section elaborates and provides more detail on the information presented in the Main Strengths and Successes and Main Challenges and Lessons Learned sections.

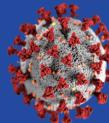
Resource Requesting Overall

Most Respondents Agreed that Resource Requesting During COVID-19 was Successful, Especially the Implementation of the Public Health Ordering System

Most MHOAC/RDMHS respondents reported that CDPH effectively fulfilled its resource requesting role, supplying PPE, staff, COVID-19 tests, therapeutics, and vaccinations. Respondents described CDPH as a crucial partner in obtaining and distributing millions of items to hospitals, facilities, and community-based organizations. MHOACs and RDMHSs benefited from receiving supplies from existing CDPH stockpiles; additional staff resources via CDPH's coordination of State staffing and contracted medical personnel; mass testing and vaccination services from CDPH contractors; and COVID-19 therapeutics.

The majority of MHOAC/RDMHS respondents characterized their resource requesting and management activities as successful during the COVID-19 pandemic response. As one noted, CDPH processed a "huge number of requests" and supplied "vast amounts of items for distribution to our partners." Another respondent noted that "requests were responded to and processed rapidly, mostly successfully."

Several MHOAC/RDMHS respondents also cited CDPH's role in fulfilling resource requests as a critical success factor. One wrote that when supply needs were "critical and urgent," CDPH "responded urgently and didn't require as much justification, which allowed for efficient resource requesting/receiving." Another described CDPH as being "very good about filling resource requests in a timely manner." One respondent noted that CDPH successfully defined clear processes for requesting supplies, "even if they [the CDPH request processes] were different for each major category that we managed." When needed, the MHCC would "follow up to confirm orders and get clarification on orders," which was appreciated by the MHOACs and RDMHSs.



Several MHOAC/RDMHS respondents attributed their success in resource requesting to effective adherence to SEMS. One respondent wrote that its “resource requesting process was well structured” because it had many years of experience in running requests “through our MHOAC program up through the RDMHS during past disasters.” These respondents reported that staff who were trained in SEMS were able to properly direct the flow of requests through the MHOAC and RDMHS for health and medical supplies and use other processes to request non-medical and health items. Respondents with past SEMS emergency response experience reported their staff were “trained and ready to respond” and they also had systems and warehouse space already available.

Finally, most MHOAC/RDMHS respondents agreed that the State’s implementation of PHOS for resource requesting was “a huge success.” The implementation of this automated system in Spring 2020 replaced manual and paper-based processes, which had historically contributed to challenges and delays. (For a discussion of PHOS from a State perspective, see chapter on Resource Requesting and the Public Health Ordering System in this AAR.) As one respondent wrote, “the system really streamlined our ability to submit resource requests; it was helpful when we could direct where the shipment needed to go.” Another respondent concurred, emphasizing that the system increased efficiency by enabling LHJs to send resources directly to receiving facilities, rather than to a centralized location for redistribution.

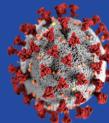
While all agreed that PHOS represented a significant improvement, some expressed frustration that the system was launched during the midst of a pandemic and wished that it had been in place earlier. One respondent wrote that “dropping a new system in the midst of a fast-paced event was difficult.”

The Introduction of New Response Partners Led to Resource Requesting Challenges

MHOAC/RDMHS respondents identified several resource requesting challenges:

1. Not following the SEMS resource requesting process;
2. confusion regarding allocations and ordering.

As the size and scope of COVID-19 response grew rapidly to include staff and contractors from multiple State departments, programs, task forces, and agencies, it became clear that many involved were not familiar with SEMS or the standard resource requesting process. Traditionally, only those working within emergency management functions knew the process and its intricacies well



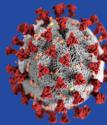
due to either training and/or experience in prior disasters. As a result, SEMS was not always followed, which created challenges for the MHOAC/RDMHS. Several respondents wrote that resource requesting was challenging because some entities were unclear about the SEMS process and incorrectly attempted to obtain supplies through MHOAC/RDMHS, which resulted in the program having to spend time and effort to resolve.

One respondent described how all entities in their area were directed to the MHOAC for supplies, “yet the CDPH did not communicate with the MHOAC program to ensure the entities being directed were appropriate or provide direction on how to handle these [incorrect] requests.” Another described how, in their area, response partners lacked clarity on whether they should submit resource requests through the MHOAC/RDMHS system or through Cal OES: “partners like fire and law were requesting resources and because those resources were med/health resources, it was going through the MHOAC, but that is not the established process.” This respondent described the challenge of redirecting law enforcement partners’ requests through Cal OES, which “caused some confusion.”

Respondents learned that the SEMS resource requesting process worked (when followed) and recommended that all parties continue to receive training on the SEMS resource requesting process. Several felt that ongoing communication, training events, and exercises would increase the future adherence to these protocols. Several highlighted the need in SEMS training to clarify distinctions between which organizations may submit requests to the MHOAC and which organizations should submit through other entities. This would involve distinguishing the public health and medical system from other systems (e.g., law enforcement and fire). As one respondent noted, healthcare partners need to stay up to date on resource requesting and the use of PHOS by establishing exercises, “so that when the need arises, we have the muscle memory to request emergency resources quickly and efficiently.”

Each Resource Type Had a Different Process and System, Which Was Challenging

Though CDPH's resource requesting processes and systems were generally described as successful, a few respondents expressed frustration that each category of resource (e.g., PPE, staffing, vaccines, testing, and therapeutics) used different processes and systems. Several respondents noted that it was difficult to learn and keep track of these different processes and systems. This



reality was “a huge logistical load” for many regions. One overarching recommendation was to develop a standardized process or consolidated platform for requesting all public health and medical resources managed by CDPH.

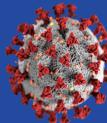
Some Challenges Arose with Order Allocations and Delivery

Even when resource requests followed SEMS correctly, figuring out allocations and ordering the proper amounts and types of items was challenging. As one respondent wrote, “the allocation process was cumbersome, changed frequently, was not well communicated, and had short turnaround times.” For example, MHOACs responsible for the three city LHJs (Berkeley, Long Beach, and Pasadena) did not know whether the city LHJ would receive a separate allocation for items or be “lumped in” with their counties.

Another respondent wrote that resource requesting was challenging because the minimum order quantity for some resources was too large for a small operational area (OA). Several respondents described the challenge of having to learn and revise quantities, packaging, sizes, and burn rates for items in order to properly manage their resource requests during the course of the pandemic. One respondent wrote that this effort was complicated by CDPH’s tendency to ship large amounts of materials with short expirations, which were difficult to use (even with extensions) and caused challenges with storage.

Several MHOAC/RDMHS representatives wrote that the resource requesting process would benefit from tailoring the allocation amounts to the OA or region, and having clear allocations for the city LHJs. They recommended that allocations and ordering thresholds be carefully reviewed to align with the needs of different areas and regions. One respondent recommended that shipments could contain “items with various expiration dates so counties/facilities can prioritize earlier expirations first” to further reduce wastage.

Respondents recommended developing a standardized inventory list, attempting to standardize products used within the OA, and establishing one standardized inventory system. Some respondents recommended that CDPH develop standard specifications for all items available for resource requesting, or allow the MHOAC/RDMHS to review available items in advance to determine whether or not the item should be ordered.



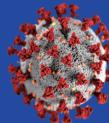
MHOACs and RDMHSs Were Challenged by CDPH Technology Limitations Related to Resource Requesting, including Data Reporting, Inventory Management, and Tracking

Data compilation and reporting was a source of challenge and delay for several MHOAC/RDMHS when it came to resource requesting, regardless of resource type. Several respondents described CDPH's required reports as time-consuming, especially since some requirements were communicated belatedly. As one respondent noted, "if there are going to be distribution reporting requirements, they should be specified when the resources are provided."

Furthermore, some regions did not have automated systems in order to generate CDPH's required reports. One respondent described the State's reporting requirement for PPE distribution as "redundant and unnecessary," since the items were shipped directly to the healthcare provider, not to the county. The State often requested "burdensome" reports on how PPE was distributed, in specific formats that were not easily extracted from the counties' inventory systems. As a result, counties were forced to modify or bypass their existing inventory tracking systems and procedures. Another respondent noted that the test kit distribution reporting in PHOS was a "pain in the neck" for operational areas, and recommended that "for any such reporting, there should be a simple electronic data interface format."

CDPH's inventory and warehousing systems were also mentioned as challenging by several MHOAC/RDMHS respondents. There were times when CDPH would send out a list of items available. However, sometimes after submitting requests based on this list, LHJs would find out that the product was no longer available, because the quantity CDPH originally released was incorrect or was over-allocated. Respondents recommended that CDPH improve its warehouse management system to reflect real-time, accurate inventory levels. One respondent noted that ReddiNet (an emergency medical communications system) needs to be fully integrated with PHOS. Lastly, some respondents indicated that resource tracking was a challenge, as the State "relied too heavily on local tracking instead of having its [own] tracking mechanism."

Numerous respondents had recommendations to enhance the PHOS system. One recommended adding Situation Report functionality to PHOS to enhance reporting efficiency. A number of respondents recommended establishing a standardized list of products that can be ordered and adding shipment tracking numbers to facilitate ordering status updates. One recommended developing



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functionality that would enable MHOACs to upload spreadsheets into PHOS for distribution reporting, which would streamline reporting from operational areas that have their own inventory systems.

In addition to making system improvements, a few respondents recommended working with healthcare partners to ensure they stay up-to-date on how to use PHOS for resource requesting. Additionally, several MHOAC/RDMHS respondents recommended that more public health staff be trained in the use of PHOS and practice using this system regularly.

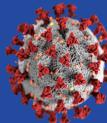
Requesting PPE

PPE Requesting Was Largely Successful, Despite Some Initial Difficulties with Quality and Logistics

Despite the initial worldwide shortage of PPE, a number of MHOAC/RDMHS reported success in requesting PPE from the State and consequently providing PPE to the facilities within their jurisdiction. As one respondent noted, “large amounts of PPE were distributed, and shortages were significantly mitigated.” These successes were largely attributed to local planning and to partnering with CDPH. For instance, one respondent described working with their hospital and healthcare partners to develop PPE conservation strategies early in the pandemic when these supplies were scarce. This local planning enabled them to maximize their cached inventory of PPE to meet their needs until additional supplies were available. Another respondent reported that it worked with its local partners to coordinate local PPE supplies which, with good planning, “never ran out.”

For most regions, good planning was combined with collaboration with CDPH to obtain PPE. Because most regions faced PPE shortages, the MHOAC/RDMHS worked with CDPH to request, obtain, and distribute PPE. As one respondent wrote, CDPH’s PPE provisioning was successful and enabled the MHOAC/RDMHS to “receive the resources we needed when we needed it most.” Another MHOAC/RDMHS wrote that it “did well with PPE” thanks to CDPH. As one noted, “even a small county like ours was able to receive the resources we needed when we needed it most.”

A few MHOAC/RDMHS reported challenges associated with PPE resource requesting, including the unpredictable quality of some items. Several respondents described the delivery of items that were unsuitable or poor quality:



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respirators with exhalation valves, gowns made of material that was too thick to wear, and materials that would expire before they could be used. Respondents described how they would have to “vet” received items to determine whether it was usable by providers; if not, the MHOAC “would be stuck with the product with no way to return it back to CDPH.” Due to a lack of standardized inventory and items, this vetting had to be done in person at the warehouse each time a new item arrived.

Other MHOAC/RDMHS respondents experienced challenges with managing and storing PPE. One respondent described that its biggest challenge in PPE resource requesting was “learning quantities, packaging, size” and figuring out burn rates in order to submit requests in a timely manner. Another respondent found it challenging not having enough space for PPE in “geographically accessible caches/depots” across its region.

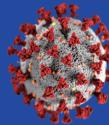
COVID-19 Vaccines

Note: When asked about the successes and challenges associated with requesting vaccines, most MHOAC/RDMHS respondents provided feedback on many different aspects of the State's overall vaccination program (e.g., responses were not limited to vaccine requesting).

Vaccine Technology Solutions, Ordering, and Distribution

Many MHOAC/RDMHS respondents reported the new vaccine technology solutions helped their COVID-19 response initiatives. Respondents felt the myCAvax and My Turn platforms, along with their email and phone help desks, were critical success factors for local vaccination activities. According to one respondent, the creation and continued investment in both platforms helped accelerate and assist with critical COVID-19 initiatives. Several MHOAC/RDMHS respondents felt that the creation of myCAvax as a centralized provider ordering platform streamlined and increased accuracy of resource requesting significantly. A number of MHOACs/RDMHSs also stated that My Turn made mass vaccination clinics more efficient. One MHOAC/RDMHS wrote that the inclusion of the vaccination check in CalCONNECT was extremely helpful with isolation and quarantining efforts and cut down on the time needed to verify vaccination.

In the initial roll-out of the State's vaccination program, some MHOAC/RDMHS respondents felt that the program was too complex, had too many changing



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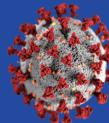
requirements, and had “too many different systems and setups,” which dissuaded providers from signing up. In addition to having “too many complicated websites,” as one respondent wrote, the various technology platforms were not user-friendly and did not appear to have been thoroughly tested by end users before they were rolled out. The State went through multiple iterations of vaccination management systems (e.g., COVIDReadi, CalVax, and myCAvax), and also introduced a new vaccine clinic scheduling system, My Turn.

When it came to ordering vaccines, initially “vaccine ordering was confusing and not simple,” one respondent noted. Ordering the correct quantities was also challenging as vaccine eligibility and availability changed. A few respondents reported challenges regarding vaccine policy and guidance. One MHOAC/RDMHS felt that the prioritization process should have been based on public health criteria and vaccinated the most vulnerable (elderly and those with health issues) first, rather than healthcare workers who were able to protect themselves with appropriate PPE. Another respondent felt that releasing guidance that a “dose is a dose” too soon before vaccine supply stabilized resulted in all supply being used as a first dose and then encountering supply shortages for second doses in a two-dose vaccination series.

CDPH was credited for improving its vaccine resource requesting process over the course of the pandemic. Providing information about vaccine “pre-orders” and a clear timeline for delivery as new vaccines were rolling out gave one MHOAC/RDMHS time to prepare its requests. Respondents appreciated how they were able to request all vaccine products, which was “extremely helpful” when one manufacturer’s vaccine became scarce and the MHOAC/RDMHS could utilize alternative manufacturers.

Lastly, CDPH’s innovations in vaccine redistribution were also mentioned by several MHOAC/RDMHS respondents as successful and helpful initiatives. CDPH contracted with third-party redistributor and also created the Vaccine Marketplace, both of which were helpful to providers (especially smaller ones) that needed to redistribute vaccines. “Early on, the ability to transfer doses about to expire from one LHD to another was critical to avoid wasting vaccine,” one MHOAC/RDMHS noted.

Challenges with the TPA and Vaccine Storage & Handling Caused Delays



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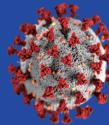
MHOACs/RDMHSs felt there were several challenges associated with their vaccine resource requesting activities. However, the most frequently cited challenge was working with the TPA for vaccine ordering. In February 2021, in order to try to accelerate and equitably allocate the administration of doses, State leadership engaged a TPA to manage and determine gaps in the vaccine provider network. The TPA was responsible to enroll additional providers, support the State's vaccine allocation efforts, and improve the quality of vaccination data.

Several MHOACs/RDMHSs noted that using a TPA was inconsistent with SEMS. Respondents pointed out that the TPA lacked in-depth public health expertise, knowledge of SEMS, and insight into the needs of the LHJs. Many indicated that the TPA's insertion into the vaccine ordering process created unnecessary barriers and complexity, and that extra time was spent on explaining nuances to the TPA, who was not familiar with public health. Other respondents reported that the State's decision to contract with the TPA disrupted existing local vaccine distribution measures and undermined efforts to promote vaccine equity. Jurisdictions were frustrated by disorganized ordering standards that changed on a weekly basis. Multiple MHOAC/RDMHS respondents noted that when the TPA took over vaccine allocations, it created delays to local COVID-19 initiatives and the vaccine roll-out.

A number of respondents stated that it would be important in future events for CDPH to oversee the SEMS resource requesting process without having a TPA as an intermediary. As one wrote, "for future responses that involve an MCM [medical countermeasure], it would be beneficial to allow CDPH to oversee the process without interference of a TPA." Were a TPA to be used in a future pandemic response, one respondent recommended that the TPA have experience and background in SEMS.

The second most frequently mentioned vaccine challenge involved the complex receipt, storage, and handling requirements for vaccines, especially the requirement for ultra-cold storage. For one MHOAC/RDMHS, storage and handling challenges included unclear instructions, the fact that vaccine shipments could arrive at times that complicated proper storage processes (e.g., during lunch hours and at close of business), and difficulty preventing vaccine wastage. Another MHOAC/RDMHS described that it was challenging to "rebalance" thawed vaccine from one local jurisdiction to another to avoid wastage. Respondents also referred to the need to monitor vaccine inventory

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for expiration dates as another significant challenge. As one MHOAC/RDMHS wrote, its pre-COVID-19 vaccination plans did not include ultra-cold storage and recommended that these considerations should be incorporated in future plans and playbooks.

Local Vaccination Clinics Benefited from Temporary Waivers, as well as Local Partnerships

In addition to provide staffing for mass vaccination events (which is discussed below in the Requesting Staff section), the State also enabled locals to permit emergency medical technicians (EMTs) and paramedics to administer vaccines, which helped more Californians get vaccinated.

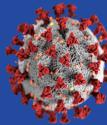
In addition to receiving support from CDPH, local vaccination activities were also successful thanks to utilization of community-based organizations. A number of MHOAC/RDMHS respondents described using local volunteers to intake supplies and run mass vaccination clinics. Coordination with community stakeholders for vaccination activities took many forms. For example, one rural MHOAC/RDMHS described a close partnership with the Indian Health organization to conduct widespread vaccinations in the county. Another described how the entire “community came together” to “stand up mass vaccination events for our first responders, and then down through the tiers of eligibility.” Leveraging community volunteers enabled this area to “scale up and down” vaccination efforts “depending on the need.” An urban MHOAC/RDMHS area described building an “infrastructure” focused on “streamlined provider communications” and “strong collaborator relationships” to ensure the success of its vaccine efforts.

COVID-19 Therapeutics

Therapeutics Allocations Were Ultimately Successful, though Initial Communications and Technology Hampered the Rollout

The State managed the therapeutics allocation for each MHOAC, and most respondents felt that allocation was done successfully. Respondents described being able to obtain adequate levels of therapeutics for their healthcare systems. MHOAC/RDMHS respondents also felt that the ability to expand therapeutics providers “upon request” was helpful to increase access. One respondent appreciated having an allocation of all available therapeutics, instead of being limited to just one. Another appreciated that CDPH guidance

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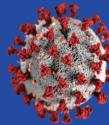
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and technical support were available to manage requesting process for therapeutics.

However, the majority of MHOAC/RDMHS respondents also reported numerous challenges, including issues with initial communications, allocation and distribution, and information technology. Respondents described how CDPH's communications for COVID-19 therapeutics lacked compared to COVID-19 vaccine communications. One respondent contrasted CDPH's "centralized" CDPH vaccine response, which boasted well-coordinated and timely communication, with the delayed communication from CDPH about therapeutics. Initially, CDPH did not update MHOAC/RDMHS with enough lead time for local agencies to submit orders. As one wrote, "we would get updates about therapeutics through our MHOAC and RDMHS as soon as they could" but it would be too late to coordinate with major hospitals and healthcare systems and place a therapeutics order before the deadline. As a result, the MHOACs/RDMHSs looked for federal therapeutics meetings (e.g., hosted by ASPR) to receive more advance notification. However, respondents noted that communications significantly improved after CDPH launched its weekly COVID-19 therapeutics webinars.

Several MHOAC/RDMHS felt that CDPH was unsuccessful in communicating to the public about the availability of COVID-19 therapeutics. As one respondent noted, therapeutics were "not well explained to the public." This resulted in COVID-19 therapeutics being generally unknown to the public, with even less awareness about where and how to receive therapeutic treatment. This translated into lower demand for therapeutics, and several MHOACs/RDMHSs described challenges getting their local providers to order therapeutics. New providers were not interested in becoming approved to deliver therapeutics, and approved providers were not interested in ordering more inventory because "there was no demand for product." One respondent felt that the required prescription also reduced demand for therapeutics.

Because demand for therapeutics was generally low and allocations were set by CDPH, several smaller regions reported challenges in receiving too much supply. This especially posed challenges in storing and then redistributing therapeutics across facilities in rural areas. As one respondent wrote, "the process for redistributing allocations from one facility to another facility was unclear and poses many logistical challenges." Even after receiving therapeutics, rural areas had challenges utilizing the drugs. One rural



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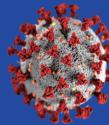
respondent described challenges integrating certain therapeutics into skilled nursing facilities in the region because the facilities “didn’t have the staffing or capabilities to manage the therapeutics.”

The information technology available to order and dispense COVID-19 therapeutics was another area of challenge. MHOAC/RDMHS respondents reported that therapeutics ordering process, which relied on the federal Health Partner Ordering Portal (HPoP), was “confusing” and they could not assist providers with their orders because they did not have access to the system. Instead of ordering directly through HPoP, providers were asked to use Excel spreadsheets. The lack of a centralized platform also made it difficult to track order and shipping status. Since MHOAC/RDMHS did not have visibility into provider systems or accounts, it was difficult to respond to providers who reached out regarding delayed or missing therapeutics orders. In addition, unlike vaccines, there was no system to track therapeutics dispensing, so MHOACs/RDMHSs developed their own processes to collect data on therapeutics utilization and inventory. MHOACs/RDMHSs used this data to determine allocations for providers based on utilization history and projected need, but having to develop their own therapeutics data tracking system was a challenge. As one respondent noted, “since CDPH had such a huge success with myCAvax with vaccine, we would recommend that CDPH look into something similar for therapeutics.”

Requesting Staff

CDPH Successfully Provided Different Types of Staffing Support

Numerous MHOAC/RDMHS respondents reported success in working with CDPH to identify personnel needs and obtain staff, especially staffing for mass vaccination events and clinics. One wrote that CDPH-provided mobile vaccination teams “greatly increased” the area’s ability to vaccinate a much larger community and to prioritize underserved populations, which was “something we would not have been able to accomplish with our limited staff.” CDPH provided nurses, supplemental medical staff, and turnkey vaccination events, which was critical to several MHOACs/RDMHSs and helped accelerate and support local COVID-19 response activities. As one respondent noted, “CDPH’s resources contributed greatly to the success of mass vaccination clinics and events.” Another wrote that “we were immediately allotted personnel to



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assist with our response, [and] we had support when otherwise our healthcare system would have been overwhelmed."

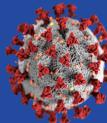
Many MHOACs/RDMHSs described CDPH's success in providing a variety of staff to support local response operations. As one noted, "providing State-contracted staffing to local hospitals was critical in our response." One respondent said that this program was "invaluable" because the region had no other source of additional nurses. Respondents also noted that they successfully requested and obtained other staffing from the State, including a hospital strike team, a CalGUARD rapid response team for a local hospital, a California Medical Assistance Team (Cal-MAT) for mass vaccine clinics, and State disaster service workers to support remote contact tracing efforts. Several mentioned that CDPH's temporary waivers of licensing and certification requirements for out-of-state personnel as an important success factor.

A few respondents described being able to obtain staff from non-CDPH sources to meet the demands of the pandemic. One respondent successfully applied for grant funds from the Centers for Disease Control (CDC) and private foundations in order to hire additional staff. Other respondents pulled in disaster service workers from other county departments and volunteers to perform case investigations, contact tracing, manage COVID-19 incident data, conduct tests, and staff mass vaccination events.

In general, MHOAC/RDMHS respondents stated that the pandemic prompted innovations in public health staffing. One respondent said it successfully used COVID-19 funds to create permanent positions in data science, technology, health communications, disease investigation, and equity and belonging. Another respondent said that the pandemic eliminated preexisting organizational siloes, as staff had to work across different departments and fields of knowledge, which built new professional relationships and networks. Yet another respondent said that the pandemic facilitated many crucial improvements around staffing and care delivery by pre-hospital (EMS) providers, which would not have otherwise been possible.

Several Challenges with Staffing Requests, Communications, and Deployments

While appreciative of the resources, MHOAC/RDMHS respondents reported challenges to request staffing from CDPH. These challenges included a



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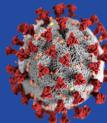
challenging process to request staff, variability in the quality of staff, and delays in obtaining staff.

A number of respondents found the CDPH process to request staff initially confusing and expressed a desire for a streamlined process with better communications. MHOAC/RDMHS respondents reported that CDPH would sometimes be unclear about the types of staff available, who would pay for the staff, how long the staff would be able to work in the region, and what forms to fill out. As one respondent noted, "not having a clear process was an issue." One reported that it did not know that the CalCONNECT system needed to be used to receive state staff. Additionally, respondents noted that locals would receive notification about upcoming staff deployments very late, which left the LHJs very little time to prepare trainings for the staff. Additionally, since LHJs could only request staff for six weeks, this created uncertainty about how long staff would be assigned and whether replacements would be available. Over time, communications from CDPH improved and "there was more communications from the State about which types of requests could be filled," which helped locals submit more "realistic" requests, one respondent noted.

Once State-contracted staff were deployed to facilities, not all were able to perform their assignments, and there was a general "disconnect between staff sent and their responsibilities," one respondent noted. The deployed staff had a wide range of experience, licenses, and qualifications, which presented logistical challenges. For example, one respondent described how mass vaccination teams deployed to their jurisdiction included State-provided staff who were not adequately trained in vaccine storage and handling. Several MHOAC/RDMHS respondents recommended that more information provided about staffs' skills and experience in advance would have helped LHJs better prepare, plan, and develop training.

A few MHOAC/RDMHS reported that their requests for staff were fulfilled too late, or not at all. One respondent stated that it submitted staffing support requests for its contact tracing, mass testing, and mass vaccination clinics but there were delays with filling each of these requests. Another respondent said that they were never able to obtain State-provided staff for its crucial events, writing "the request forms stated we would hear back within 7-10 business days and we often wouldn't hear back for months – long after our event date passed." Lastly, one MHOAC/RDMHS noted that tracking deployed staff was tedious due to the "data points" that were required to deploy them.

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Requesting Tests and Testing

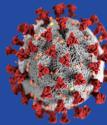
State-Run Mass Testing Sites and Testing Task Force Programs Were Generally Successful and Helped Expand Testing Capacity

Most MHOAC/RDMHS respondents successfully requested testing supplies and resources for mass testing sites from CDPH. Respondents cited numerous success factors, including CDPH's mass testing sites, expanded test ordering processes, use of testing contractors, and resources provided to regional public health laboratories.

According to one respondent, the "State-run mega-test sites were a success." The ability to operate mass COVID-19 testing was frequently mentioned by many MHOAC/RDMHS respondents, and that CDPH's resources were essential to standing up mass testing sites early in the pandemic. Several felt that these sites were instrumental in managing and containing outbreaks in their communities. One respondent wrote that, after the "baseline" mass testing capability was created by CDPH, the transition to a State-sponsored vendor (Optum Serve) to continue mass testing went smoothly. Another observed that it would have been helpful to initiate Optum Serve (or a similar system) sooner.

Additionally, many respondents appreciated that the process to request COVID-19 testing was broadly accessible and not restricted to SEMS protocols. One wrote that "direct delivery was excellent as it streamlined the process for us" and enabled an expanded number of facilities to request test supplies from "robust" allocations. Several respondents mentioned the Testing Task Force programs, which distributed tests directly to organizations enrolled in its programs. One respondent wrote that it appreciated CDPH's efforts to expand access to test kits for Community Based Organizations (CBOs) and underserved communities in its region, which helped promote testing equity. Another noted that because CBOs and schools could request and receive tests directly from the TTF, this alleviated the burden on its MHOAC program staff, which was helpful to the region's overall response work. As one respondent noted, the "State TTF was successful, and I wish it had been established earlier in the response."

While direct delivery of test kits to facilities and organizations was an "excellent" process it did lead to some miscommunications, according to some MHOAC/RDMHS respondents. Occasionally, facilities were told by CDPH to request testing supplies from the MHOAC, which the MHOAC did not have. A



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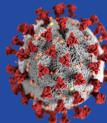
respondent described the need to have clearer communication from CDPH regarding the direct ordering program, with greater specificity regarding criteria for distribution and supply availability.

Several MHOAC/RDMHS respondents highlighted the successes of the testing vendors, including Color, Curative, and Optum Serve, who supported testing in their communities. One wrote that “Optum Serve served our community well for testing,” and another mentioned that Optum Serve’s mobile testing van was a critical resource for its region, serving as the only site for the community to receive free PCR and rapid testing for a long period of time. A different MHOAC/RDMHS praised the contracted pop-up and mobile testing initiatives as “innovative initiatives”.

However, a rural region reported challenges in working with the TTF’s testing vendors. According to one rural MHOAC/RDMHS, “it was hard for us to host a site for Optum Serve, and the initial testing platform was hard for a low-tech community to use.”

A MHOAC/RDMHS representing a different rural region described numerous challenges it encountered using the State-provided testing contractors, which were geared more towards larger counties. Originally, Verily and Team Rubicon provided testing services in the region, but they ended abruptly six months later, and services were hastily transitioned to Optum Serve. The MHOAC/RDMHS reported that the new vendor’s minimum deployment package of 500 vaccinations/tests per day was a number the county “couldn’t hit in 6 months, let alone a day.” For this MHOAC/RDMHS, the transition resulted in a large cache of unused materials that had to be disposed, stored, or returned. For this respondent, the episode represented the challenge of CDPH’s “one size fits all big counties” solutions, which did not work for its region. Eventually, it established its own small local testing and vaccination teams instead of using State-provided resources.

A few MHOAC/RDMHS mentioned success in testing at public health laboratories. One wrote that its public health lab was able to bring on new assays, instrumentation, and staffing to achieve high throughput testing capacity within months of tests becoming available. A second wrote that being able to pull a number of staff from other areas to work full-time in the public health lab was a critical success factor. Another respondent commended the State Public Health Lab for its “excellent communication” with local labs, both



organizing weekly update meetings and contracts for sequencing and related bioinformatic pipelines and supplies.

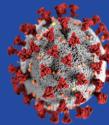
Extending Expiration Dates for Antigen Testing Caused Challenges and Confusion for Some MHOAC/RDMHS Respondents

For the majority of MHOAC/RDMHS respondents, the process to request and obtain testing resources from CDPH presented no issues. Many noted that early in the pandemic, before the widespread availability of antigen tests, testing capacity was low and it took too long to receive test results, but acknowledged that this was not in the State's purview. As one respondent noted, "the greatest problem was the early lack of access to testing, and [we are] not sure how much CDPH could have done given the federal oversight and system."

Some MHOAC/RDMHS respondents reported that many antigen tests provided by CDPH initially had short expiration dates that were frequently extended, which became a source of confusion. According to one respondent, communication around expiration extension dates was confusing because it "was sent through various channels, changed often, and was hard to track." Additionally, this respondent added that State and local personnel within the resource requesting and distribution process often lacked technical knowledge of the supplies. For instance, the respondent noted that test kits from a specific manufacturer required training to distribute properly and even though State and local personnel informed facilities that the test expiration dates had been extended, the testing devices would not run the test past the original expiration date.

CDPH-MHOAC/RDMHS Relationship

In the MHOAC/RDMHS survey, respondents were asked how they communicated with CDPH, and if CDPH provided assistance or caused any delays to local COVID-19 response efforts. Responses have been organized into the following three categories:

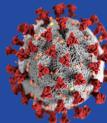


- Communications
- CDPH Assistance
- CDPH Delays

Communications: CDPH Communications Improved Over Time and Was Largely Successful. MHOAC/RDMHS Respondents Reported Multiple Ways to Get Answers and Information from CDPH

Respondents felt that communication between CDPH and the MHOACs/RDMHSs improved during the pandemic response. Describing this evolution, respondents noted that CDPH initially disseminated emails and documents to communicate, and later established more robust regularly scheduled virtual meetings and webinars. Respondents felt this was a significant improvement and that the meetings, webinars, and calls (on different response areas and initiatives) provided an opportunity for MHOAC/RDMHS partners to ask questions and receive CDPH input/guidance. Several respondents stated that CDPH's webinars and calls reduced confusion and saved time, and that being able to hear information directly from CDPH was critical to promote a more consistent and coordinated response. Respondents mentioned CDPH's MHCC, LHJ, Local Coordination Team, and RDMHS virtual meetings as particularly beneficial. As one noted, "the weekly CDPH-led webinars for LHJs were extremely helpful" and assisted with local response activities. Another felt that the Wednesday afternoon California Conference of Local Health Officers (CCHLO)/County Health Executives Association of California (CHEAC) calls were the most helpful and was the chance to "hear things first" that would be repeated in later meetings. In addition, some respondents noted that they participated in regular coordination calls hosted by EMSA for the local EMSA medical directors, which CDPH representatives also attended.

For the RDMHS respondents who participated in an in-person hotwash, many felt communications with the MHCC were helpful and successful. "Our direct content communication with MHCC was great," one respondent noted, and others echoes that MHCC communications were quick, streamlined, and accurate. The MHCC was a "critical piece in the communication pathway," one noted. RDMHS respondents appreciated having access to CDPH leadership during daily MHCC calls, which was helpful since decisions were being made quickly. The calls also provided a venue for RDMHSs to elevate concerns from their LHJs and provide local perspectives to inform decision-making and policy



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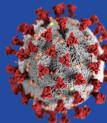
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implementation (e.g., the development of staffing waivers). According to one RDMHS respondent, “CDPH was always very open to listening to our concerns about things,” including how to adjust policies to each operational area’s unique considerations. Many RDMHS respondents emphasized that CDPH should continue to maintain and foster the communications pathways and relationships enabled by the MHCC. As one RDMHS respondent noted, the pandemic “reinforced to me how important it is to maintain the State/regional/local relationship.”

In addition to communicating with the MHCC, many MHOAC/RDMHS respondents continued to communicate with CDPH in other ways, including through the traditional SEMS channels, email, regular process reports, Situations Reports, surveys, and via the Chatter messaging feature in various systems (PHOS and myCAvax). As one respondent mentioned, “there were many different avenues to communicate with CDPH and more existed at different levels as the pandemic continued.”

Many respondents also mentioned communicating with various CDPH subject matter experts, who were described as very responsive in answering questions outside of regularly scheduled meetings and calls. Several MHOAC/RDMHS representatives described how they developed close working relationships with individual CDPH staff. These relationships became a valuable channel for MHOAC/RDMHS respondents to receive information and answers. One respondent described how, if their CDPH contact “didn’t know something, they knew exactly who to ask and made those connections to ensure timely responses and information were relayed.” This sentiment was echoed by other respondents who described individual CDPH staffs’ communication efforts as “responsive and helpful”, “always great”, and “timely”.

The importance of strong relationships was a lesson learned for most MHOAC/RDMHS respondents. Respondents felt the MHOAC program and RDMHS relationship was fostered and reinforced during the pandemic, with all participants appreciating the teamwork, trust, and shared knowledge that developed. Respondents also developed close working relationships with specific CDPH staff and teams during the pandemic. These ties were often essential in facilitating MHOAC/RDMHS resource requests. However, even if a MHOAC/RDMHS representative did not have a preexisting relationship with CDPH staff, they were able to obtain assistance.



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A few MHOACs and RDMHSs felt the CDPH's SharePoint site was a useful communication channel that was under-utilized. CDPH placed some LHJ documents and files in SharePoint folders, but these respondents thought this platform could have been utilized more heavily to serve as a single, shared repository of disease reporting, onboarding materials, training and webinar recordings, and other tools. As one respondent wrote, having a single online destination for CDPH-provided information "would have improved communication and efficiency between programs and with CDPH."

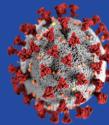
Communications: Challenges Arose When SEMS was Not Followed

Many MHOAC/RDMHS respondents felt that communication with CDPH worked best when it followed established SEMS channels. According to these respondents, the emergence of new communications channels, and the introduction of new response partners who were not familiar with SEMS, made communications challenging. According to one RDMHS respondent, "not following SEMS started early on, [and was] exacerbated as [the] event grew." Another wrote that "rather than a typical bottom-up approach to incident management, the top-down approach from CDPH created confusion and often time delays in information."

Some respondents faulted CDPH for these communication challenges, while others indicated that other factors outside of CDPH's control (such as the establishment of some task forces) played a role. According to one respondent, task force leadership often did not follow SEMS or the Emergency Operations Manual (EOM) and would reach out directly to the healthcare facility level. Sometimes this caused delays, confusion, and required the RDMHS to step in and help clarify.

Other respondents mentioned that CDPH's other response teams created silos and communication delays. One RDMHS noted that CDPH's creation of the Local Coordination Team "added another silo of someone who is communicating with the public health department that wasn't following the SEMS process," which was problematic. One MHOAC/RDMHS respondent noted that "communication from CDPH to LHJs was often siloed and not all programs [such as directors of nursing] were getting information directly from the State."

Another RDMHS respondent noted that in order to expand its response, CDPH had to quickly hire contractors, who were generally not familiar with emergency management principles. As a result, "folks didn't know their place in ICS



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[Incident Command System] and SEMS," and consequently one RDMHS found itself having to provide education on SEMS "so they could understand what you were asking."

Communication breakdowns also occurred when the MHOAC/RDMHS received conflicting information from different CDPH representatives. One respondent described inconsistent information it received from two different CDPH branches.

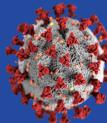
Respondents acknowledged that everyone was "charting unfathomed waters" early in the pandemic and that confusion and inconsistency in CDPH's communication was less of an issue as the emergency wore on. However, many emphasized that "SEMS always works when it is followed on every level," and that in future responses, the State should adhere to SEMS, which provides a useful, "system-based" approach. Another RDMHS suggested including a local or regional representative on all future CDPH response task forces. According to this respondent, having a local or regional representative would promote more transparency and trust in State decision-making, and better communication.

CDPH Assistance: Successes Included the State's Contact Tracing Program and the State's Emphasis on Equity

In addition to CDPH's successful fulfillment of resource requests including staffing, PPE, testing supplies, therapeutics, and vaccines (discussed earlier), MHOAC/RDMHS respondents also indicated that the State's contact tracing program (California Connected) helped accelerate and assist their local COVID-19 initiatives. The program was managed by CDPH, and respondents mentioned that the State's redirected contact tracing and case investigation (CI/CT) workers helped LHJs conduct ongoing contact tracing and case investigation when they otherwise would not have had capacity to do so. As one respondent noted, "the reallocation of State staff into contact investigations for LHJs was brilliant and absolutely essential to the success of investigations in smaller LHJs." These staff sometimes took on lead roles within local teams, up to and including providing support to the local health officer. The redirected State staff also enabled one MHOAC/RDMHS to establish a specialized school outbreak response team.

Several respondents also mention the new contact tracing technology systems, CalCONNECT and the Virtual Training Academy (VTA), as effective and helpful to local responses. One respondent appreciated how the State included LHJs in

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the CalCONNECT system design and ongoing improvement initiatives. Another indicated that CDPH staff assisted in training and writing businesses practices for CalCONNECT, which helped streamline local processes and enabled the local jurisdiction to train others.

Another success factor, according to respondents, was CDPH's emphasis on equity. Respondents mentioned the efforts to incorporate equity in the State's vaccination and testing campaigns. As one noted, CDPH took the lead on implementing "the State's transparent grounding in equity and science for most decisions," which helped local response activities.

Additional MHOAC/RDMHS respondents noted other areas in which CDPH's efforts assisted local responses. For instance, several mentioned that CDPH's temporary waivers of licensing and pharmacy requirements enabled local jurisdictions to mobilize clinics and field hospitals rapidly.

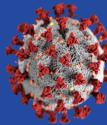
Lastly, respondents mentioned the following initiatives as beneficial to local response efforts: CDPH grant funding, the speed of response from the Western States Scientific Safety Review Workgroup, and the State's various legal frameworks (including the Blueprint for a Safer Economy, masking orders, and the expansion of Medi-Cal and CalFresh).

CDPH Delays: CDPH's Bed Polling and Patient Distribution Approach Needs Improvement

When asked if CDPH caused delays to local COVID-19 response initiatives, MHOAC/RDMHS respondents mentioned a diverse range of topics. Many of these are discussed in earlier sections of this chapter, including delays related to resource requesting and reporting, the use of the TPA, CDPH's release of guidance, and the use of communication channels that bypassed SEMS.

In addition, a few MHOAC/RDMHS respondents attributed challenges and delays related to hospital bed polling and patient distribution. During the pandemic response LHJs were required to provide CDPH with hospital bed polling data for their region. This was often a time-consuming, mostly manual process because not all regions had bed tracking systems for the facilities in their region.

Respondents expressed a desire for improvements to CDPH's bed polling processes. One recommended the implementation of a Statewide or region-wide hospital bed tracking system (such as Reddinet, Image Trend, or EMSystems). According to this respondent, "this would improve future responses



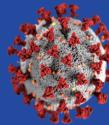
during urgent scenarios such as wildland fires where facility evacuations may occur, and rapid placement is needed."

State Delays: Confusion on Policy and Guidance Caused Delays to Local COVID-19 Responses

Several respondents were frustrated by the State's release of policy and guidance, especially when it made policy announcements to the public without providing advance notice to LHJs or the MHOAC/RDMHS system. When decisions and guidance were changing quickly, one RDMHS noted that it was "really hard on some of the smaller Operational Areas" and contributed to an erosion of trust. As another MHOAC/RDMHS respondent wrote, when updates were released to the public and LHJs at the same time, "LHJs were caught off guard by inquiries from the public and gave incorrect guidance or had no infrastructure to support new policies." Another noted that unclear guidance or late messaging related to guidance made it difficult to answer partner questions. In general, one MHOAC/RDMHS respondent summarized that "COVID-19 was very much a state directed response with limited communications with locals prior to releasing direction and intended actions." When this occurred it led to disorganization, confusion, and distrust.

Respondents also found it challenging when the State released guidance significantly after the CDC. As one respondent noted, the State often waited too long after CDC released its guidance to create and release guidance specific to California. Other respondents noted that CDPH's guidance sometimes was not aligned with guidance put out by other State departments, such as Cal/OSHA and CDSS. According to one MHOAC/RDMHS respondent, "delayed cohesive regulatory action and orders" contributed to local response delays. Another mentioned that CDPH's All-Facilities Letters (AFLs) were confusing and caused delays.

Many MHOAC/RDMHS respondents offered recommendations for future responses. Several respondents recommended that in future public health emergencies CDPH and the State follow SEMS protocols when issuing guidance. One wrote that the CDPH and the State could create a "forum for policy-level agencies to compare guidance before release," which would help "ensure a unified message around disease control and prevention." This MHOAC/RDMHS felt such a forum was necessary because COVID-19 guidance was not always consistent across the CDC, the Centers for Medicare and Medicaid Services (CMS), CDPH, and the California Division of Occupational Health and Safety



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(Cal/OSHA), resulting in confusion for local jurisdictions and the public. Other respondents also recommended that public health guidance needed to be made consistent, and needed to be released to LHJs, MHOACs, and RDMHS prior to being released to the public. Lastly, one respondent suggested that CDPH maintain a Public Information Officer who is solely devoted to publishing approved information, to mitigate the release of incorrect communications from CDPH.

For a discussion of vaccine-related delays, see the section on Requesting Vaccines in this chapter.

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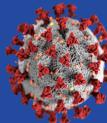
MHOAC/RDMHS Key Lessons Learned and Recommendations for Future CDPH Responses

In the MHOAC/RDMHS survey, respondents were asked to provide key lessons learned and recommendations for CDPH for future emergency responses. This section summarizes the main themes of the survey responses: interagency relationships, emergency plans and training, data and information technology, and rural regions.

Interagency Relationships

Most MHOAC/RDMHS respondents felt that their partnerships with hospitals, providers, LHJs, and CDPH (and its subsidiary groups like the MHCC and various task forces) were successful. Many respondents recommended that CDPH maintain and build these working relationships by scheduling regular meetings with public health emergency response organizations. According to respondents, CDPH could compile and maintain contact lists of names, phone numbers, and email addresses for all intragovernmental partners and provide this list on its SharePoint site. Having a consolidated contact list would identify gaps in staff resources and make communication more efficient in future emergencies.

A few respondents also recommended that CDPH help MHOACs and RDMHSs develop relationships with other stakeholders that were instrumental during the pandemic response. These would include volunteer organizations, tribal authorities, and large community-based organizations. One recommended that the CDPH consider convening semi-annual meetings with such groups to “ensure relationships are maintained and ongoing public health concerns relevant to these partner agencies continue to be addressed.” Regularly



convening these parties would help all remain “ready for CDPH engagement” in advance of a future emergency.

Additionally, one respondent noted that it would be helpful for MHOACs and RDMHSs to “better understand what CDPH, Cal OES, and EMSA do individually and collectively.” While these departments were all “indispensable” on the response, individuals were often confused about the correct points of contact and would appreciate clarification on this topic.

Emergency Plans and Conducting Training

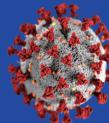
MHOAC/RDMHS respondents recommended that CDPH work to ensure that all jurisdictions update their public health emergency operations manuals and provide robust training on SEMS protocols. Respondents pointed out that the COVID-19 response led to many innovations and that rendered portions of these manuals obsolete. Specific examples include the new PHOS solution, as well as ultra-cold vaccine storage and handling protocols, which both emerged during the pandemic.

With these plans updated, CDPH could also ensure that jurisdictions, as well as CDPH itself, are training staff and regularly holding drills and exercises to practice emergency response procedures. As one respondent noted, a key lesson learned is to practice and exercise operational coordination through “annual PHEP activities, and statewide planning and resource coordination for large scale events with CDPH support and guidance.” Several respondents echoed the recommendation that CDPH coordinate large-scale exercises and drills, specifically around volunteer staffing deployments and medical countermeasure dispensation and administration.

Data and Information Technology

Several MHOAC/RDMHS respondents mentioned that the State’s need for data, coupled with challenges related to the State’s information technology systems, delayed local COVID-19 response efforts. During the initial stages of the pandemic, MHOACs and RDMHSs diverted resources to address urgent data requests from CDPH. Local jurisdictions completed “cumbersome” surveys and requests for data and reports that required immediate attention.

One respondent mentioned issues with several Statewide systems, which caused delays. The launch of CalCONNECT and CA Notify “came about 3-5 months later than needed,” given the rapid scaling of contact tracing and case investigation. Data failures in the State’s disease surveillance system, CalREDIE,



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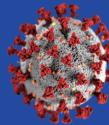
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limited local situational awareness and case-level interventions. The time it took to automate key CalREDIE processes (such as incident creation and de-duplication) "led to significant resource waste at the local level," this respondent noted.

Respondents recommended that CDPH solicit local input when it develops new systems for the next pandemic. Several respondents recommended developing a new system to replace the "archaic" CalREDIE, a system that produced "data failures" that "caused significant limitations to situational awareness" during the pandemic. Respondents wanted a new case management system replacing CalREDIE to improve incident creation, de-duplication, real-time data interoperability with other systems, and data dashboards.

MHOAC/RDMHS respondents had many data and information technology lessons learned and recommendations. Many noted that CDPH should continue investing in technology to inform data-driven decision-making, and limit data gathering to pertinent, actionable items to reduce local reporting burdens. One respondent wrote that "automation, standardization, and interoperability of data management" should be a high priority for any new systems. Others emphasized the importance of continuing to invest in technology infrastructure and capacity, especially for systems that would benefit from Statewide standardization and consolidation, such as disease surveillance. One MHOAC/RDMHS respondent recommended that CDPH "continue investing in well-researched, centralized platforms." Another noted that CDPH should plan ahead in this area, since starting new projects and initiatives in the middle of a pandemic is "ill-advised."

Several MHOAC/RDMHS respondents provided lessons learned related to being more strategic when it came to local versus State reporting, data, and technology use. According to another respondent, local jurisdictions dedicated significant time and staff resources to tracking and analyzing case data, which in retrospect "was unnecessary and a duplication of effort as the State's data was used for all reporting purposes." That is, it would have been better to use data from CalREDIE instead of maintaining separate case data. Another respondent indicated that a key lesson was that it is in the "best interest" of local jurisdictions to adopt and utilize CDPH-developed platforms as soon as possible. Finally, another MHOAC/RDMHS wrote that it learned that the State will build centralized Statewide technology platforms, but these solutions may take awhile to arrive. Planning for the delayed arrival of Statewide technology platforms can



help local jurisdictions decide how much to invest in building local systems, since the benefits of using State systems may outweigh the benefits of locally tailored ones.

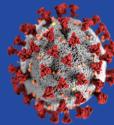
Information technology, data, and reporting lessons learned and recommendations specific to resource requesting and PHOS are discussed earlier in this chapter.

Rural Regions

Several MHOAC/RDMHS respondents representing rural regions recommended that CDPH invest more time to better understand the unique public health challenges of smaller, rural counties. One respondent wrote that its region “has issues and strengths that don’t exist in larger counties” and CDPH needs to better understand and accommodate the area’s “limitations or how we approach a problem differently than other counties.” Rural jurisdictions face “extreme geographic isolation and lack of access to internet and cell service,” which limited COVID-19 pandemic response efforts such as mass testing and vaccination. Case investigation and contact tracing activities are also complicated in rural areas because, as one MHOAC/RDMHS reported, rural residents are “skeptical” of any call originating from outside the area and will not answer it.

When it came to resource requesting, minimum order allocations for various resource types were often too large for small jurisdictions. One rural MHOAC/RDMHS noted how early in the pandemic, a small county had to rely on a larger county to order and redistribute its supplies. Some MHOAC/RDMHS respondents who represented smaller communities felt the CDPH did not consider their needs when determining allocation amounts. One MHOAC/RDMHS believed that CDPH’s public communications and policy guidance was directed primarily to urban areas and did not “consider the needs of small counties.” Another described that mass vaccination events held by CDPH and its contractors could not be held in the region because it could not offer a large enough site. This respondent’s lesson learned was that the jurisdiction would need to be self-reliant, as CDPH would not adjust its requirements to meet its needs.

In general, those respondents who mentioned the needs of rural regions emphasized that CDPH should “consider the needs of small counties differently,”

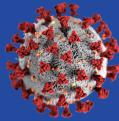


and develop better, more meaningful messaging that will resonate with citizens of these counties.

Matrix of MHOAC/RDMHS Lessons Learned and Recommendations

This section provides a summary matrix of the MHOAC/RDMHS key lessons learned and recommendations as reported by respondents.

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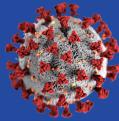
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Matrix of MHOAC/RDMHS Lessons Learned and Recommendations

| Topic | CDPH | MHOAC/RDMHS |
|----------------------|--|--|
| Allocations | <ul style="list-style-type: none">Clearly communicate whether MHOACs responsible for the three city LHJs will receive a separate allocation for items on behalf of these jurisdictionsEnsure that minimum order quantity is low enough for smaller and more rural operational areasStreamline the process for redistributing allocations from one facility to another | <ul style="list-style-type: none">Develop plans with local/regional partners to obtain needed supplies and equipment, and conservation strategies if needed, to mitigate shortages in future pandemics |
| Communication | <ul style="list-style-type: none">Follow SEMS communication protocolsCoordinate with federal and State partners to align guidance and ensure consistencyRelease policy and guidance to LHJs and MHOAC/RDMHS prior to the publicTask a Public Information Officer who is solely devoted to publishing approved information and releasing guidance more quicklyUse webinars from the start with time set aside for MHOACs/RDMHSs to submit questions and obtain answers from CDPHLeverage CDPH's LHJ SharePoint site to serve as a single repository for materials, training documents, recordings, and | <ul style="list-style-type: none">Maintain and foster the communications pathways and relationships enabled by the Health Care Coalitions |

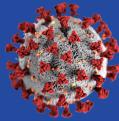


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| Topic | CDPH | MHOAC/RDMHS |
|----------------------------|---|-------------|
| | <ul style="list-style-type: none">other tools for MHOAC/RDMHS emergency responseProvide clear and comprehensive communications, in advance, about staffing requesting and deployment processes, and the skills and experience of deployed staff to each regionInclude a local or regional representative(s) on all response task forces to promote transparencyEnsure CDPH divisions and branches do not communicate conflicting information | |
| Emergency Contracts | <ul style="list-style-type: none">Specify details about State-provided emergency response staff:<ul style="list-style-type: none">Staff classificationsStaff qualifications and licensesWho will pay for staffLength of staff deploymentsAvailability of staff replacementsWhen staff are available for deploymentEnsure that contracts for materials and supplies specify low enough minimum amounts so inventory can be managed by smaller and more rural operational areas | |

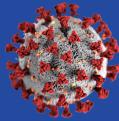


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| Topic | CDPH | MHOAC/RDMHS |
|---|--|---|
| Information Technology – General Resource Requesting | <ul style="list-style-type: none">• Consolidate the various CDPH resource requesting systems into a single system or fewer systems• Invest in public health IT infrastructure and involve end users in the development of the consolidated resource requesting system• Re-examine the types of required reports (including bed polling and distribution reports) from MHOACs/RDMHSs to determine how data can be obtained through automation rather than manual data compilation | <ul style="list-style-type: none">• Utilize CDPH-developed resource requesting systems and train staff on them• Leverage CDPH systems that track and report on public health data, rather than developing local/regional stand-alone tools |
| Information Technology – CalREDIE | <ul style="list-style-type: none">• Develop a new case management system replacing CalREDIE to improve on incident creation, de-duplication, real-time data interoperability with other systems, and the generation of data dashboards | |
| Information Technology – Patient Tracking System | <ul style="list-style-type: none">• Develop a hospital bed polling system that could also be used to inform patient transfer activities | |
| Information Technology – CalCONNECT | <ul style="list-style-type: none">• Have the caller ID appear as a local number, so residents will be more inclined to answer the call | |
| Information Technology – Public Health Ordering System | <ul style="list-style-type: none">• Provide shipper/shipment tracking numbers• Add a Situation Report functionality to generate required reports | <ul style="list-style-type: none">• Work with providers to develop a standardized list of products that can be ordered |

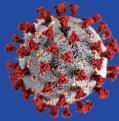


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| Topic | CDPH | MHOAC/RDMHS |
|--|--|---|
| | <ul style="list-style-type: none">• Work with MHOAC/RDMHS to develop a standardized inventory list of products that can be ordered• Enable users to upload spreadsheets containing distribution reporting data from external inventory systems | <ul style="list-style-type: none">• Train more public health staff in the use of PHOS and practice using this system regularly |
| Information Technology - Therapeutics | <ul style="list-style-type: none">• Enable MHOAC/RDMHS and LHJ access to HPoP for therapeutics ordering• Provide system functionality to track therapeutics dispensing, inventory, utilization, and reporting through a centralized database• Calibrate therapeutics shipment sizes based on local/regional demand | <ul style="list-style-type: none">• Work with CDPH to obtain access to HPoP for therapeutics ordering• Train LHJs on how the HPoP site works• Work with CDPH to develop a centralized database for therapeutics dispensing, inventory, utilization, and reporting |
| Information Technology – Warehousing | <ul style="list-style-type: none">• Develop a warehouse/inventory management system that can be used statewide to automate all warehouse, inventory, and related reporting requirements related to supply receiving, distribution, item counts and item expiration dates, and reporting of all products in real time | <ul style="list-style-type: none">• |
| Interagency Relationships | <ul style="list-style-type: none">• Maintain and build relationships established by the pandemic across public health sectors by scheduling regular meetings with emergency response organizations, providers, community organizations, and businesses | <ul style="list-style-type: none">• Maintain ongoing relationships with stakeholders that were instrumental during the pandemic response. These include CDPH representatives, providers, facilities, volunteer organizations, tribal authorities, and large community-based organizations |

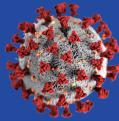


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| Topic | CDPH | MHOAC/RDMHS |
|------------------------------------|---|--|
| | <ul style="list-style-type: none">• Compile and maintain contact lists of names, phone numbers, and email addresses for all intragovernmental, private sector, and nonprofit partners and provide this list on its SharePoint site• Strengthen relationships with smaller rural regions• Maintain public health stakeholder networks developed during the pandemic | |
| SEMS | <ul style="list-style-type: none">• Oversee and ensure federal, state, regional, and local parties follow SEMS resource requesting process and communication protocols• Ensure that all jurisdictions update their public health emergency operations manuals and provide robust training on SEMS protocols• Foster the updating of EOMs and conduct trainings/drills/exercises (Statewide and region-wide)• Monitor jurisdictions' progress in updating and training their EOMs | <ul style="list-style-type: none">• Continue to train on the SEMS resource requesting process through ongoing communication, training events, and exercises• Emphasize the different flow of information and requests through the MHOAC/RDMHS for those in public health vs. emergency management for non-health and medical organizations• Update EOMs, plans, and playbooks based on lessons learned from COVID-19 |
| Testing, Therapeutics, Vaccination | <ul style="list-style-type: none">• Create mass testing and vaccination event requirements for rural regions• Calibrate minimum order quantities for vaccine and therapeutics to reflect the smaller populations in certain operational areas | <ul style="list-style-type: none">• Update emergency plans to incorporate ultracold storage of vaccines |

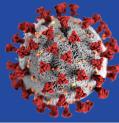


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| Topic | CDPH | MHOAC/RDMHS |
|----------------|---|-------------|
| | <ul style="list-style-type: none">• Strengthen relationships across hospitals, universities, communicable disease programs, public health labs, and epidemiology programs to create a network that can scale up testing and vaccination responses in a future pandemic• Continue to use direct delivery of testing supplies• Provide greater clarity regarding test expiration date extensions• Ensure guidance and criteria on who should be prioritized for vaccine are clear and based on public health considerations• If a TPA is used in vaccine allocation and requesting processes, ensure that the TPA uses SEMS protocols• Focus on data-driven decision-making for vaccine order approvals and where to locate mobile vaccination clinics | |
| Waivers | <ul style="list-style-type: none">• Quickly issue temporary waivers of licensing requirements in future public health emergencies so that vaccination clinics can be placed in areas of need and personnel such as out-of-state health care workers, EMTs, and paramedics can administer vaccines and conduct other activities | |

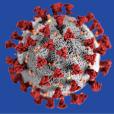


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| Topic | CDPH | MHOAC/RDMHS |
|-------------|------|--|
| Warehousing | • | <ul style="list-style-type: none">• Ensure enough warehouse space in geographically accessible areas throughout the region• Prioritize distribution of items with earlier expirations first to reduce wastage |

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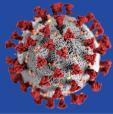
Appendix: Data Gathering Approach and Methodology

CDPH distributed a survey to MHOACs and RDMHSs in early 2023 on their COVID-19 response activities and interactions with CDPH during the pandemic. Surveys were distributed through RDMHSs to their respective MHOACs. CDPH received survey responses from Regions 1, 2, 3, and 5.

In addition to the survey, CDPH facilitated an in-person meeting in April 2023 with RDMHS representatives from all six regions to obtain feedback on the same topics. Both the feedback provided in the surveys and notes from the meeting are incorporated in this chapter.

The survey questions were:

1. What are your top 3 successes in responding to COVID-19 and how did you achieve them?
2. Did CDPH help accelerate or assist with your critical COVID-19 initiatives? If so, how?
3. Did CDPH cause delays to any of your critical COVID-19 initiatives? If so, how?
4. What are your top 3 lessons learned in responding to COVID-19 specific to your relationship with CDPH?
5. How did you communicate with CDPH regarding your COVID-19 response activities and how do you feel this went?
6. Based on your experience with responding to COVID-19, what recommendations do you have for future responses specific to CDPH?
7. What were the successes and challenges of the resource requesting process? For challenges, please include possible solutions.
8. What were the successes and challenges associated with requesting the following resources? For challenges, please include possible solutions.
 - a. PPE
 - b. Vaccines
 - c. Therapeutics
 - d. Staffing
 - e. Testing



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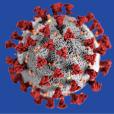
9. What (if any) additional feedback do you have for CDPH that was not captured in the previous questions?

For some regions, multiple respondents submitted surveys; other regions were represented with a single survey. Region 4 and Region 6 did not submit any responses. This completion rate potentially represents a limitation of the survey data, with a single individual's feedback informing this report's understanding of an entire regions' perspective, and no feedback from an entire region.

Because the survey responses are subjective and qualitative, the data used in this chapter represents frequency distributions and not expressions of intensity. Frequency statistics are commonly used to guide analysis of textual data, providing a quantitative dimension to the text. By quantifying the occurrence of specific themes or categories within a set of surveys and interview notes, areas of emphasis can be highlighted. In **Figure 3** below, the frequency of MHOAC/RDMHS pandemic response activities mentioned in surveys and the interview helped identify the areas of commonality as well as outliers and helped guide this chapter's review and analysis.

Figure 3: Frequency of Activity Mentioned by Region

| Activities | Frequency of Activity Mentioned By Region | | | | % overall frequency |
|--|---|----------|----------|----------|---------------------|
| | Region 1 | Region 2 | Region 3 | Region 5 | |
| Resource Requesting | 17 | 50 | 15 | 14 | 19% |
| Communication | 10 | 43 | 7 | 11 | 14% |
| Personnel and training | 7 | 37 | 6 | 5 | 11% |
| Data systems | 8 | 34 | 6 | 6 | 11% |
| Vaccination | 1 | 38 | 7 | 5 | 10% |
| Testing | 4 | 20 | 8 | 2 | 7% |
| Relationship building | 2 | 18 | 3 | 5 | 6% |
| Implement plans | 5 | 12 | 7 | 4 | 6% |
| Guidance | 3 | 12 | 4 | 1 | 4% |
| Reporting | 4 | 3 | 6 | 1 | 3% |
| Case investigation / contact tracing (CI/CT) | | 13 | | | 3% |
| Change requirements | 6 | 8 | 2 | | 3% |
| Decision-making | 1 | 4 | 2 | 1 | 2% |
| Therapeutics | 2 | | 4 | 1 | 1% |
| Infrastructure investment | | 7 | | | 1% |
| Infection prevention | 1 | 2 | | | 1% |



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| | | | | | |
|---------------|---|---|--|--|----|
| Grant funding | 1 | 3 | | | 1% |
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