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ORGANIZATION: Glenn County HHSA - Public [+](#)

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With the issuance of the statewide Stay-At-Home Order on March 16, 2020, Glenn County proclaimed a local emergency, activated the Emergency Operations Center (EOC), and activated the following response plans: Operational Area Emergency Operations Plan (OA EOP), Public Health & Medical EOP, Pandemic Response Plan, Special Pathogens Infectious Disease Response (SPIDER) Plan, Crisis Emergency Risk Communications (CERC) Plan, and the Healthcare Surge Plan. The EOC was staffed and coordinated emergency response operations from March 16, 2020, through April 8, 2021, when it was demobilized and COVID operations were transitioned to public health staff permanently assigned to COVID program management. During the yearlong activation, the EOC coordinated operational activities including public health and medical response, law enforcement/coroner activities, and care and shelter related to the pandemic. The EOC collected, analyzed, and provided situational information to core emergency partners and executives. EOC Command staff worked with the policy group to establish, interpret, and convey policy related to the COVID incident. EOC staff setup a Joint Information System (JIS) to establish unified local messaging for the public. The EOC provided much needed resources and logistical support to local jurisdictions, first responders agencies, healthcare organizations, and the schools. Throughout this extensive activation, Command staff continually evaluated and adapted response operations to navigate the ever-changing environment of the pandemic and to improve operations.

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- Local OES and Public Health activated and operated the EOC under Unified Command. This provided an efficient use of limited resources. OES provided operational coordination for the response, allowing Public Health to focus on the health requirements of the incident.
- Well established partnerships provided the base for effective communication and coordination.
- EOC staff, first responders, Healthcare Coalition members and schools were equipped to respond to a pandemic due to preparedness activities including plans, trainings, and exercises.

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Pre-established POD Sites, plans, and trained staff were used for the delivery of mass vaccination. Additional agency staff were provided with just in time training and were instrumental in our mass vaccination clinics. Partnership with Northern Valley Indian Health strengthened our vaccine rollout and we continue to partner with NVIH.

Glenn County Community Action Department assisted persons placed in isolation and quarantine with supportive services. CAD continues to work with other community partners to distribute testing supplies to under-served populations.

Statewide: The rollout and use of Sales Force provided a stream-lined process for requesting resources from the state. It continues to be a useful platform. *The State should consider adding Sit Rep reporting functionality into Sales Force so that a sit rep can easily accompany the resource request.*

KEY LESSONS LEARNED

In the box, tells us what knowledge, process or plan was gained from your response, include positive and negative outcomes and recommendations for future responses.

- Communications & Coordination – State to Local. The SEMS/NIMS structure and principles were not followed. The response was not locally derived, negating locally developed emergency response plans and procedures. State directed programs and procedures were not coordinated with the locals and were often announced to the public first without details being provided to the locals, often resulting in chaotic and reactionary response operations.

Public Information - Mixed messages were relayed during initial activation due to public officials communicating information outside the EOC organization. Development of the Joint Information System (JIS) aided in resolving most of the mixed messaging and unvetted information from the local level, however, mixed messaging continued from the State derived response structure that dictated the overall response. Additionally, as public health information continually evolved, new information was not consistently disseminated to front office Public Health staff who were frontline contact for the public. The result was i

- Staffing resources for critical response roles are limited and did not have redundancy of trained backups for an extended response. The pandemic resulted in an activation of the Emergency Operations Center for a period of more than one year. During this time, the EOC was often activated at a moderate level, requiring full staffing daily. With people often filling more than one critical position in the response operations, staff worked long hours; breaks were extremely limited, leading to an exhausted workforce.

- Vaccine platforms – Local public health struggled with inadequate vaccine appointment platform for the mass vaccinations. Web-based appointment system should be employed and maintained. Additionally, State vaccine platforms suffered from many rapid changes. The ever-changing systems resulted in logistical issues including delayed delivery of the vaccine during the first five months of vaccine operations.

CORRECTIVE ACTIONS

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Continue to be an advocate for maintaining the Standardized Emergency Management System (SEMS) organization including the concept of all incidents are local.

Additional County staff should be identified and trained to permit redundancy for critical positions in the EOC and Public Health response for extended operations.

Transition to, and utilize, available state IT platforms earlier (Cal Connect, myCAvax, MyTurn, etc.)

QUESTIONS: This section contains four questions on specific successes and challenges you may have encountered working with partners during your COVID-19 response operations. Please take time to complete a thoughtful response that captures the issue(s) and possible solution(s).

1) What were the successes and challenges when working with your Health Care Coalition (HCC) members? If there were challenges, include possible solutions.

- Well established partnerships and contact lists allowed for the efficient delivery of situational updates, critical information, and effective communication.
 - EOC staff were easily accessible to partner agencies and provided prompt resolution for requests for resources and information.
 - EOC situation reports provided relevant and timely information for key partners.
- Challenge: As the response lengthened in duration, healthcare facility situation reports were inconsistent and facilities struggled to respond when requested - need to continue to work with healthcare partners so they understand the MHOAC process and submit their reports accordingly.

2) What were the successes and challenges when working with your laboratory? If there were challenges include possible solutions.

Glenn OA does not have a lab - Optum Serve filled an urgent resource gap for both testing and vaccinations.

3) What were the successes and challenges when working with your Medical Health Operational Area Coordinator (MHOAC) / Regional Disaster Medical Health Specialist (RDMHS)? If there were challenges include possible solutions.

- MHOAC and RDMHS program communicated effectively and provided for efficient request and delivery of resources.
- EOC situation reports provided relevant and timely information for key partners.
- Well established MHOAC and Healthcare Coalition (HCC) provided the base for effective coordination of public health and healthcare partners.
- Utilization of the OES and MHOAC for point of contact for first responder vaccine clinics worked well.

4) What were the successes and challenges when working with the CDPH? If there were challenges include possible solutions.

- Challenge: State directed response with limited communications with locals prior to releasing direction and intended actions. The State would announce to the public program, services, and restrictions of movement with no advance notice to local OES or Public Health. Additionally, detailed information on these topics were not quickly forthcoming. This led to extremely chaotic and reactionary response operations leading to disorganization, confusion, and distrust for staff and residents throughout the duration of the incident.
- Challenge: Platforms used to allocate and distribute state vaccine supply were modified or re-created, were difficult to access, and were not user-friendly - several providers struggled with the application process and others opted out due to all the requirements and use of multiple systems.
- Success: All of the conference calls were beneficial and appreciated by local staff. Resource requests were filled in a timely manner.

ADDITIONAL COMMENTS

Please use this section to provide any additional suggestions and/or insight not captured in the previous sections.

SUBMIT

TOPIC: In response to the worldwide pandemic due to COVID-19, CDPH and all local health jurisdictions (LHJ) are completing an After-Action Report (AAR) to highlight key successes, identify lessons learned and develop an Improvement Plan to prepare for the next event.

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TEMPLATE: This Abbreviated AAR template is intended to simplify the reporting and data collection process from Public Health Emergency Preparedness (**PHEP**), Hospital Preparedness Program (**HPP**) and Pandemic Influenza (**Pan Flu**) grantees, inform CDPH's statewide report, and allow organizations more time to complete their AAR. This template consists of six main components: an Executive Summary; Key Successes; Advances; Key Lessons Learned; Corrective Actions; and a brief Questions section. When drafting your responses in this template, reflect on your overall performance related to **PHEP**, **HPP** and **Pan Flu** associated capabilities.

COMPLETE & SUBMIT: This Abbreviated AAR by no later than May 1, 2023 to lhtprog@cdph.ca.gov.

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Abbreviated After-Action Report (AAR) Template on PHEP, HPP & Pan Flu Capabilities

ORGANIZATION:

EXECUTIVE SUMMARY

In the box below, provide a summary of your organization's AAR and highlight any major outcomes, successes, challenges, lessons learned, corrective actions and conclusions.

KEY SUCCESSES

In the box, highlight key successes and favorable outcomes and how you achieved the goal(s). Include key elements that determined the success.

ADVANCES

In the box, tell us what initiatives or goals were rapidly pushed forward because of your response needs, include what the need was and why. Include efforts to maintain advances or key challenges in doing so.

KEY LESSONS LEARNED

In the box, tells us what knowledge, process or plan was gained from your response, include positive and negative outcomes and recommendations for future responses.

CORRECTIVE ACTIONS

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- 1) What were the successes and challenges when working with your Health Care Coalition (HCC) members? If there were challenges, include possible solutions.

- 2) What were the successes and challenges when working with your laboratory? If there were challenges include possible solutions.

- 3) What were the successes and challenges when working with your Medical Health Operational Area Coordinator (MHOAC) / Regional Disaster Medical Health Specialist (RDMHS)? If there were challenges include possible solutions.

- 4) What were the successes and challenges when working with the CDPH? If there were challenges include possible solutions.

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- 2) What were the successes and challenges when working with your laboratory? If there were challenges include possible solutions.

- 3) What were the successes and challenges when working with your Medical Health Operational Area Coordinator (MHOAC) / Regional Disaster Medical Health Specialist (RDMHS)? If there were challenges include possible solutions.

- 4) What were the successes and challenges when working with the CDPH? If there were challenges include possible solutions.

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Abbreviated After-Action Report (AAR) Template on PHEP, HPP & Pan Flu Capabilities

ORGANIZATION: Inyo County HHS

EXECUTIVE SUMMARY

In the box below, provide a summary of your organization's AAR and highlight any major outcomes, successes, challenges, lessons learned, corrective actions and conclusions.

On March 4, 2020, California declared a state of emergency in response to the worldwide spread of the Novel Corona Virus (COVID-19). In response to the Public Health Emergency, Inyo County developed a Mass Vaccination Clinic model to test Inyo County Public Health's ability to ensure adequate staffing levels for anticipated prophylaxis while identifying appropriate treatment based on medical history and exposure. Through distribution of pre-printed clinic location flyers and drug information sheets, our goal was to ultimately measure and evaluate Inyo County's ability reach remote, rural, high-risk and priority target groups located throughout our county. The planning team was composed of numerous and diverse agencies that discussed the logistics of setting-up a mass vaccination clinic at each of the designated site locations, coordinated and secured the dates that the clinic exercises would occur throughout the county, and identification of pre-exercise needs from all partners involved. This model was designed to coincide with a Pandemic Influenza Work Plan, Objective 7 (previously Objective 6), to conduct at least one mass vaccination clinic exercise and maximize attendance to test and evaluate Inyo County's mass vaccination capability and capacity.

Major strengths: promoted optimal client flow, development and implementation of a training plan, and ensured accurate/timely vaccination documentation data entry.

Areas of improvement: technologic issues in remote locations, limited outreach strategies for rural communities, and lack of county-wide vaccination database.

Conclusion: Future exercises should focus on the development of a system that would hasten the paperwork process and facilitate the engagement of the community partners. Additionally, we will need to identify new types of avenues in which we can communicate with our communities located across the county and ultimately continue to update outdated protocols with lessons learned.

KEY SUCCESSES

In the box, highlight key successes and favorable outcomes and how you achieved the goal(s). Include key elements that determined the success.

EOC and DOC established early, which helped with response coordination; EOC assigned liaisons to support business community, places of worship, & other government agencies which freed up Public Health to focus on coordination with hospitals/medical providers, schools & the general public; ELC funding allowed our very small Public Health program to hire limited term staff and contractors to expand capacity for contact tracing, public messaging, coordination and staffing of mass vaccination clinics, & epidemiology; multiple successful mass vaccination clinics were coordinated & staffed by Inyo County HHS, hospitals/RHCs, IHS, FQHCs, pharmacies, & local volunteers; at times, large vaccine events were also supported by CDPH contractors. Countywide there was a very collaborative approach to roll out vaccines. Because of the early push and frequent communication/collaboration between HCPs, 70% of the residents have been vaccinated & we saw a significant decrease in deaths month-over-month. Our county had successful mass vaccination clinics with the collaboration & teamwork of the community & its partners; resulting in over 4,000 Inyo County residents vaccinated against COVID-19.

Early coordination with all available resources in the county was important to ensure clear, coordinated public information; communication & continuously changing emergency plans, practical changes within the hospital, & responding to CDPH guidelines. Public Health staff worked tirelessly to identify, contact, and isolate cases. Importantly, County leadership and EOC partners supported Health Officer orders and recommendations to help control the spread of COVID-19. Additional funding allowed the county to hire additional staff to support contact tracing. HCP collaboration to stand-up mass vaccination clinics/on-going vaccine support after the initial push to vaccinate residents. This was an effective method to quickly vaccinate people in a location that could handle the volume vs. smaller clinics.

ADVANCES

In the box, tell us what initiatives or goals were rapidly pushed forward because of your response needs, include what the need was and why. Include efforts to maintain advances or key challenges in doing so.

We identified a need to improve comms during a disaster and COVID pushed us to expand social media messaging, mass email communication, and public communication via PIO to local media resources. COVID also expedited a contractual relationship with an epidemiology team, which helped us to push out detailed local statistics via a weekly newsletter and report to the Board of Supervisors. A contract with a graphic designer also helped PH develop a brand and produce well-formatted, consistent media content. Rapidly pushed forward was the use of an online appointment system via myTurn. Prior to myTurn, Inyo PH used PrepMod, which had limited functionality and poor user experience. myTurn was built as part of the rapid COVID response, the system was built-out while being used; Inyo County was the first County to beta-test the live system and was actively involved in the dev adjustments following the first few mass vaccination clinics. The system was so new our older population did encounter issues (mostly user errors); it became very user friendly with fewer and fewer glitches. NIHID was able to maintain PPE, I believe that county was a big part of that. The ED started a home oxygen concentrator program to get patients home that only needed O2 and no other nursing/hospital care. The hospital first rented oxygen concentrators and then was able to buy some. Ultimately, BOS and County Administrative leadership support facilitated rapid advances in areas that had previously been constrained (such as social media outreach). ELC funding was a major driver in increasing access to resources such as staff and contractors to assist with the ongoing response. Sanitizing was made easier with the help of City staff in providing the necessary cleaners. Though traditional cleaners were difficult to find, we found ways to find our own solutions for sanitizing. The state offering a no-cost clinic/appointment management system helped Inyo PH offer an online option we did not have prior.

KEY LESSONS LEARNED

In the box, tells us what knowledge, process or plan was gained from your response, include positive and negative outcomes and recommendations for future responses.

Public Health improved planning & implementation of vaccination clinics. Regular virtual EOC meetings during COVID helped multiple county departments and partner agencies to practice coordinated response and we have seen coordination and communication improve in other disaster scenarios in recent years. We also learned that some people are skeptical on getting a new vaccine; however, there were those who did want them. Being accessible to individuals throughout the whole county through clinics helped mitigate the spread of COVID. We had the advantage of seeing how the pandemic played out in other areas before we were overwhelmed in the beginning. We prepared early for supply chain issues and kept supplies relatively sufficient. Continuous communication was likely unprecedented and was helpful. Weekly meetings by CDPH provided good information.

The care centers were a highly vulnerable population & it spread through them very quickly. It also spread through the consolidated building; we were notified by the several "someone has COVID" notices plastered on the restroom doors with painter's tape. The county could have had a 'disinfect/sanitation crew' for much longer than they did, especially during the winter months when covid was prevalent in our community. There was some time spent on ethics and how best to decide to allocate scarce resources (like ventilators). The continuously changing requirements from governmental organizations were very difficult to comply/keep up with. We understand the reason it kept changing as more information came out, but a more consistent message would have been ideal. Inventory management continues to be challenging in a small county that does not have the infrastructure to support long term, temperature-controlled storage of medical equipment and supplies. Inventory management systems are expensive/complex and difficult to implement in very small counties that typically do not require warehouse space during times of normal operations.

CORRECTIVE ACTIONS

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The challenge of a forced rearrangement of working conditions for many healthcare professionals, schools, retailers. The loss of staff, high rate of burnout, and extreme cost of travel nurses during the pandemic led to increased strain financially and otherwise on the district and the other employees/contractors. Lack of training and education for health care workers and lack of supplies need to implement safety in health care settings. Limitations of direct contact with people and/or medical personnel. Update and manage inventory information across programs more often; cross-train people so there is more than one person who understands the inventory and process. Lack of precedence; exacerbation of existing healthcare disparities; knowledge deficit; lack of health literacy among rural residents; political divisiveness; geographic location relative to population hubs.

A better (maybe digital) inventory management system is needed. Years of excel files saved and resaved in various places was confusing and incomplete when needing to find XYZ. It would be great if the State could identify an inventory system that can function and sync with other systems in place like the CalOES/MHOAC request portal. Finding ways to support the staff that we have instead of bringing in travelers and locums would be nice. Continue ongoing collaboration between LHJ and County healthcare providers to avoid gaps in cooperation and communication.

QUESTIONS: This section contains four questions on specific successes and challenges you may have encountered working with partners during your COVID-19 response operations. Please take time to complete a thoughtful response that captures the issue(s) and possible solution(s).

- 1) What were the successes and challenges when working with your Health Care Coalition (HCC) members? If there were challenges, include possible solutions.

The MIHCC was very supportive in working together without partners. Requirements put in place at our local partner's facilities were not always readily obtainable, especially in the hospital work environment. Though the organization tried to follow all guidelines and requirements put in place, this was not possible. Many requirements were blanket orders and did not allow for variation due to the type of work performed as first responders. The amount of turnover and schedule conflicts was challenging. At times, organizations outside of PH did not attend by choice or because they were not aware of a meeting. Open communication to all for changes to adapt to the working environment of the organization.

- 2) What were the successes and challenges when working with your laboratory? If there were challenges include possible solutions.

Inyo HCPs are located very far from laboratories. Having couriers on set days of the week was necessary, but delayed result turnarounds times significantly. Even with all the new labs that came online, there was only 1-2 that Inyo tests were sent to due to location. During every surge of COVID, the times for test results (especially at our outside testing agency LabCorp) would balloon from 2 days to 10 days or more. Maintaining ongoing communication between NIH laboratory and NIHD Infection Prevention team to ensure that workflows are aligned with state and federal guidelines for reporting and tracking.

- 3) What were the successes and challenges when working with your Medical Health Operational Area Coordinator (MHOAC) / Regional Disaster Medical Health Specialist (RDMHS)? If there were challenges include possible solutions.

Similar to HCC, at times the MHOAC encountered major conflicts and/or turnover that impacted abilities. There were also so many new people joining teams with limited prior knowledge of a MHOAC, it was a steep learning curve to understand the system setup and flow. Overall the RDMHS (R6) was fantastic. Very supporting in assisting with issues or unknowns to ensure the best solution possible.

- 4) What were the successes and challenges when working with the CDPH? If there were challenges include possible solutions.

CDPH worked very hard to support and relay information, guidance, approaches during an ever-evolving incident and continues to be an incredibly valuable resource. We have implemented training for and monitoring of infection prevention for our two SNFs and will be continuing this work into our jail, senior centers, residential center, and schools. CDPH provided monitoring and oversight of our COVID-19 Vaccine Provider Program and has assisted our clinic with identifying areas for improvement. CDPH provided staff and vaccine for a mass vaccination event on two occasions in Inyo County. The biggest challenge was that the Governor's office or CDPH would release information/updates/plans to the public with little or no heads up to the LHCs, causing a domino effect of working to prepare for whatever change was happening at the local level. Also, there were many requirements that were well meaning but practically difficult, impossible, or prohibitively expensive to execute.

ADDITIONAL COMMENTS

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Continuing to update and maintain systems that can be used across needs; CalREDIE, CalConnect, MyCAVax/MyTurn, CalOES, Snowflake, Federal Vax database, etc. If funding is withdrawn for systems and informatics, we will encounter similar delays in response in the future. We are only as good as the tools available to assist with response--paper processes and outdated analytic approaches will not help--and the level of training available (directing everyone to YouTube to learn how to use something is not always great). There is also a HUGE need for a better communications department within Inyo County that includes PIOs, public relations, social media management, graphic and web design; the way it is setup know pulls staff from active response to work on building communication pieces--which is very time consuming. Additionally, continue to work with first responders to adapt policies to allow for modifications that would allow employees to better serve the community. With the rules at the time, many responses and investigations were not completed due to the staffing levels created during the pandemic.

SUBMIT

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Abbreviated After-Action Report (AAR) Template on PHEP, HPP & Pan Flu Capabilities

ORGANIZATION: Kern County Public Health

EXECUTIVE SUMMARY

In the box below, provide a summary of your organization's AAR and highlight any major outcomes, successes, challenges, lessons learned, corrective actions and conclusions.

On March 4th, 2022, California declared a state of emergency in response to the worldwide spread of the novel Corona Virus (Covid-19). In response to the public health emergency, Kern County immediately sent all employees home for what we thought would be a short period of time. We began to expand our remote communication tools and implemented them department wide. These tools continued to evolve over time and now are the backbone of our department operations. Essential employees were identified, DOC was modified, and goals were created with collaboration from our team and our state and local partners. Frustrations and gaps became apparent with state guidance and communication with Kern County residents. This was challenging to overcome but with the perseverance and devotion of our staff in keeping healthcare workers, county staff and the public safe we ultimately were successful in meeting our goals. The result is we now have a stronger department that has changed over the last few years. We have expanded multiple departments and have even created a Health Equity Team to ensure all Kern County residents receive fair and equitable access to treatment and healthcare. The event also helps show the importance of our LEMSA, RDMHS program, and an Emergency Preparedness Department. The constant communication they had with the state in expanding HCFs, obtaining staff, test kits and PPE really shows how invaluable they are. This event has shown that no matter the incident size, duration, or severity we can come together to create a safer and healthier environment for Kern County residents and our healthcare providers and staff.

KEY SUCCESSES

In the box, highlight key successes and favorable outcomes and how you achieved the goal(s). Include key elements that determined the success.

Key staff was identified and trained. We then quickly developed a communication process that could be used remotely to stay up to date with the states guidance that seemed to be changing frequently in the early days. This greatly assisted in the management of the first cases in Kern County. We learned quickly and constantly to adapt to new information.
Liaison and industry specific groups identified to guide the industry through what was needed. Businesses, schools, camps, golf courses, salons, etc.
SNF representatives were gathered in one room to provide training and information sharing. Identified a SNF Liaison and Infection Preventionist to visit facilities, provide trainings, and ensure compliance of CDPH standards.
PIO held regular press conferences, blog updates, videos, and dashboard for the county to access key information.
County mass vaccination clinic, drive through clinic, information booths, distribution of PPE, testing (through National Guard) and homebound vaccines all built to expand as needed and dependent on resource availability. Contract staff onboarded to assist with mass vaccination efforts in a time of a nurse shortage. All count public health staff involved to operate the mass vaccination site. All partners we eagerly involved and willing to collaborate. Created an infrastructure before MyTurn that was successful and allowed us to provide vaccines quickly before the adoption of the MyTurn system. Our staff were willing to drive 2 hours or more, one way, just to help in the home bound vaccinations. Vaccination distribution was pushed to vaccine providers. Ultimately over 100 providers were offering vaccinations to the public. Weekly office hours provided to the public to maximize vaccination efforts.
BioFire implementation to test hospital staff and patients.

ADVANCES

In the box, tell us what initiatives or goals were rapidly pushed forward because of your response needs, include what the need was and why. Include efforts to maintain advances or key challenges in doing so.

Strengthened relationships and relied on our emergency preparedness to quickly respond to nuances.
Ad HOC committee with different business industries to talk about guidance. Consisted of two members from The Board of Supervisors and weekly meetings with city managers ensured frequent communication.
Schools, Daycares, Hospitals, Jails, Prisons, EMS stakeholders CEOs were regularly communicated of all changes and of information.
Latino Taskforce equitably assisted in testing, treatment and information sharing
The Public Health website had interactive testing, treatments, and vaccination maps

KEY LESSONS LEARNED

In the box, tells us what knowledge, process or plan was gained from your response, include positive and negative outcomes and recommendations for future responses.

SNFs needed close monitoring, direction, and support to ensure follow through of protocols and state guidance regarding PPE, handwashing and proper quarantining (with staff and patients).

Collaboration was minimal prior to covid.

Lack of communication with partners prior to COVID and staff.

Importance of non-traditional communication was apparent after using mailers, social media, fact sheet cards, movie theatres, etc.

Lack of Health Equity Infrastructure.

Lack of regular planning for a worldwide event.

Lack of supplies and rotation of supplies.

Unprepared for staff turn over and appropriate compensation for staff.

DOC was not properly structured.

Emergency plans were not utilized at all.

Public requested information based on patient locations and specific death data.

Media was getting information before us and stories were very reactive.

Kern MRC volunteers were not willing to help.

We missed getting MRC staff prior and being proactive to get those staff back and organize them into the teams. Could have been more proactive with MRC staff.

FQHC had no capacity or infrastructure for testing, vaccination, and therapeutics which we learned to streamline through Kern Medical.

Health equity gaps have existed and became more prominent

Lack of familiarity with accepting vaccines and correct storage processes.

State restrictions for EMS to work in static environments.

CORRECTIVE ACTIONS

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Collaboration, when increased, was the biggest area we strengthened to streamline all process.

We addressed partner communication through daily meetings of change in processes, guidelines, and new information sharing.

Expanded public communication through multiple non traditional means.

We now have a Health Equity Program dedicated to identifying community concerns, gaps in services, and mobilizing services.

We addressed warehouse supplies through thoughtful ordering, warehouse storing and tracking. CSUB assisted with printing face shields when the supply chain could not provide them.

We have now implemented hybrid and alternate work schedule program. Through expansion of technology we are able to work from home and staff could be mobilized in different areas.

After DOC redesign it brought different perspectives and the need for the expertise to create new process.

Plans need to be adjusted to be flexible and more of a job action sheet that can be scaled dependent on the duration and the constant changes of a long term, worldwide pandemic.

Adjusted how much data we provided and how to maintain consistencies statewide to protect patients. Community wanted to know where the cases were from, all details of death data.

Learned to be proactive and pivot media requests firmly.

MRC members were polled for hiring efforts for GACHs.

FQHC had no capacity or infrastructure for testing, vaccination, and therapeutics which we learned to streamline through Kern Medical.

We acknowledged and the gap and now are ready to incorporate equity-based processes into our planning of sites, supply distribution, therapeutics, so that it is meaningful and tactful to prevent further inequities.

Quickly trained staff and adapted equipment to meet those requirements.

We had EMTs, paramedics, and nurses that were able to have more liberty to help and complete our goals quickly.

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See above. It quickly became apparent that the staff attending HCC meetings was not the decision makers. Prior to Covid HCC attendance was high, Teams meeting reduced attendance and willingness to participate substantially. HCC meeting are now back in person and the correct people are now attending. Staff are willing to attend in person and attendance numbers and participation are improving.

- 2) What were the successes and challenges when working with your laboratory? If there were challenges include possible solutions.

Our lab was not capable of being involved. We accepted abbott testing supplies and sent to Kern Medical because we did not have the staffing capacity nor infrastructure to run it. Supply chain issues plagued our lab. In times of surge, commercial labs were overwhelmed. Reporting was an issue and there were delays in processing results.

- 3) What were the successes and challenges when working with your Medical Health Operational Area Coordinator (MHOAC) / Regional Disaster Medical Health Specialist (RDMHS)? If there were challenges include possible solutions.

RR through MHOAC was too slow and requests were unreasonable. Addition of the Salesforce helped to move a lot of requests smoothly because we could see who had supplies and fulfill it quickly. Adding a second RDMHS also assisted this process. Pre-COVID no one knew what MHOAC program was and stakeholder awareness was low.

- 4) What were the successes and challenges when working with the CDPH? If there were challenges include possible solutions.

Poor communication from state. Delay of guidance updates. Meetings didn't have clear action items and lack of follow through after meeting. Communication up and down didn't follow SIMS, NIMS and EOM. Slow responses and lack of involvement from CDPH in guidance making decisions. Guidance was often contradictory. Lack of follow through for guidance pertaining to GACHs and SNFs. No enforcement teams from CDPH even though they said they would include OSHA and other groups. Pushed enforcement onto counties and created gaps. Our solution was to strengthen monitoring of those industries and enhanced staffing capacity to allow more involvement of Public Health. Lack of information sharing with LHJs and CDPH prior to announcements from the governors office being made public. Recommendations vs requirements were not clearly defined. CDPH often released documents that contradicted each other and we would seek clarification that was slow to come. Optum Serve was a burden to the county.

ADDITIONAL COMMENTS

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Successes: Streamlined communication as event progressed.

Additional positions added.

Safe Schools for All Hub relieved us from getting yelled at for a guidance document that was not ours. And community could ask the state directly.

Communication toolkits.

DVR digital vaccination record, CA Vax to MyCAvax was a success. Allowed input from counties in developing of this.

Entering contracts with staffing agencies and would only provide staffing to state and not county. We would get out priced.

State funded staffing agencies greatly assisted when staffing couldn't be found.

SUBMIT

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- January 24, 2020: First RDMHS call/meeting about the COVID 19
- January 27, 2020: The first statewide medical/health call/meeting about the Coronavirus;
- January 31, 2020: CA Governor declared a state of emergency
- February 2020: Calls/meeting about the Cruise Ship
- February 12, 2020: First Returning Traveler call/meeting
- February 20, 2020: First LHD call/meeting
- March 2, 2020: Opened Disaster Operations Center (DOC)
- March 16, 2020: Opened up JIC and link to TRI-HCC
- March 18, 2020: Opened Emergency Operations Center in collaboration with County/City departments and partnership with Lassen College
- March 19, 2020: Opened Lassen County COVID 19 Call center
- March 20, 2020: CA Governor issues the nation's first "lockdown orders". Lassen Health Officer declared public health emergency – Health Officer issued recommendations that all transportation of Federal and state inmates (**Incomplete**)
- March 23, 2020: Lassen County went into a unified command – multi agencies collaboration
- April 1, 2020: Staging of a triage center outside Lassen Banner Hospital to help with a surge/ staging POD at the fairgrounds for mass testing when it comes available
- April 18, 2020: Lassen entered contract with Verily for covid testing by Lassen employees

- May 12, 2020: UCSF provided laboratory services for Lassen County testing for COVID
- May 18 & 19, 2020: Community Covid testing drive through at Lassen College in partnership of Verily
- June 6, 2020: Testing CDCR employees because the state can't
- June 8, 2020: CDCR transferred inmates from San Quentin State Prison to California Correctional Center without testing or quarantining them once they arrived. Bringing first covid positive case to Lassen
- July 18, 2020: Hog fire start – 9,564 acres
- July 18, 2020: Shelter open for Hog Fire
- July 20, 2020: Gold Fire start – 22,614 acres
- July 24, 2020: Shelter open for Gold fire
- August 22, 2020: Sheep Fire start 29,570 acres
- August 22, 2020: Shelter open for Sheep Fire
- September 28, 2020: Migrant Worker COVID Testing
- September 29, 2020: Migrant Worker COVID Testing
- November 30, 2020 SNF first outbreak in facility. Closed admissions, visiting, and dining
- October 4, 2020: First responder drive through Flu clinic
- October 10, 2020: Lassen County first covid related death
- December 14, 2020: Verily Testing Team exited with less than a week notice taking over by Optumserve
- December 28, 2020: Transported 20 Pfizer doses under refrigeration from in Redding to Lassen
- December 28, 2020: Started vaccination clinics at public health
- January 20, 2021: Optumserve set up test sight

- March 1, 2021: Lassen had to cancel Optum Serve due to lack of service
- March 3, 2021: Mass vaccination planning meeting
- March 17, 2021: First public COVID Vaccination drive through at Lassen Community College
- April 14, 2021: Second public COVID Vaccination drive through at the college
- July 4, 2021: Beckwourth Complex Fire start - 105,670 acres
- July 5, 2021: Shelter open for Beckwourth Fire
- July 13, 2021: Dixie Fire started July 2021 – 963,309 acres
- July 15, 2021: Dixie Fire Shelter open mutual aiding with Plumas County at the College
- July 18, 2021: Lassen County lost power – SNF can't power HVAC or laundry services, can't maintain food temps / Hospital is on backup power/ residents running out of oxygen / opening up Oxygen center in Public Health
- July 20, 2021: Installed generator into the SNF to power building
- October 24, 2021: Dixie Fire Contained
- December 2, 2021: Limited supplies of Therapeutics allocated via MHOAC/RDMHS and/or State Team
- December 27, 2021: Winter storm – Hospital cannot transfer patients do to road closers

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2023 Modoc County Public Health COVID-19 After- Action Report

April 2023

ADMINISTRATIVE HANDLING INSTRUCTIONS

The title of this document is: 2023 Modoc County Public Health COVID-19 After Action Report

The information gathered in this After-Action Report (AAR) is classified ***For Internal Use Only***. This draft AAR contains observations that have yet to be validated and will not be final until reviewed by relevant incident subject matter experts for accuracy. This document should be safeguarded, handled, transmitted, and stored in accordance with appropriate security directives.

Points of Contact:

Name: Chris Swasey

Title: Emergency Preparedness Coordinator

Agency: Modoc County Public Health

Street Address: 441 N. Main St.

City, State ZIP: Alturas, Ca 96101

530-233-6311 (office)

e-mail: chrisswasey@co.modoc.ca.us

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EXECUTIVE SUMMARY

The Modoc County COVID-19 response was composed of numerous county and private entities, including primarily, but not limited to, Modoc County Public Health, Modoc County HCC Partners, Modoc County Office of Emergency Services, Modoc County Sheriff's Office, City of Alturas, USFS, CAL FIRE, Alturas Police Department, Modoc County Social Services, Modoc County Office of Education, Modoc Joint Unified School District, Surprise Valley Joint Unified, and Tulelake Joint Unified.

This After-Action Report will primarily focus on Modoc County Public Health's response to the pandemic and our findings of both successes and challenges. It will be important to remember, due to Modoc County's remote locations and small geographic population, response efforts were adapted to better fulfill our communities needs.

STRATEGIC GOALS – OBJECTIVES

Modoc County Public Health, in conjunction with our E.O.C Partners, identified the following Strategic Goals at the beginning of the Pandemic Response.

1. Keep the Public Educated and Informed on current COVID-19 trends and guidance.
2. Provide Resources to mitigate the impact and spread of COVID-19.
3. Support Healthcare response efforts and med-surge sustainability.

As the Pandemic Response continued, and vaccination became available with other post-exposure treatment options, the following Strategic Goals were adjusted.

4. Provide community-wide ease of access to vaccination, with special consideration for vulnerable populations.
5. Continue supporting Healthcare response efforts via supply chain access to new and emerging COVID-19 Therapeutics.

ANALYSIS OF CORE CAPABILITIES

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

Table 1: Summary of Core Capability Performance

Observations	Primary Core Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
Observation 1	Communications		X		
Observation 2 & 3	Operational Response		X		
Key Success 1 & 2	Operational Response	X			
Key Success 3 & 4	Communications		X		

Performed without Challenges (P): The targets and critical tasks associated with the core capability were completed and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

Performed with Some Challenges (S): The targets and critical tasks associated with the core capability were completed and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.

Performed with Major Challenges (M): The targets and critical tasks associated with the core capability were completed but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

Unable to be Performed (U): The targets and critical tasks associated with the core capability were not performed.

SCOPE AND METHODOLOGY

This AAR includes information collected primarily from Modoc County Public Health and Modoc County Healthcare Coalition partners. Observations were developed and based on data collected from both large- and small-scale discussion groups as well as reflection on statistics obtained mid-response.

OBSERVATIONS

During the course of Modoc County Public Health's response to the pandemic, multiple factors were found to be critical to success, as well as multiple factors leading to challenges for response continuity. Below are outlined Key lessons learned that hindered response efforts.

- 1) Inconsistent messaging and guidance from CDPH vs CDC made LHJ information flow appear to be inconsistent and unreliable. This caused a loss of trust from the public.
- 2) Prolonged requirement for contact tracing was cumbersome and ineffective due to COVID-19 communicability. This also caused community 'backlash' and loss of trust/relationship building between MCPH and the public.
- 3) Third Party Administrator for COVID Vaccine created a middle-man that was unnecessarily redundant.
- 4) Mutual Aid and Resource Pathways via RDMHS Systems were vital in success and longevity of responses. Without Area of Operation relationship building and resource sharing, smaller counties would not have been able to stabilize.

Key Successes

- 1) Standing Emergency Supply Caches were well supplied and maintained through HPP/PHEP/PANFLU Funding prior to the event. These caches were critical in Modoc County response efforts until Regional/State allocation cycles commenced.
- 2) LHJ Vaccine Clinics were conducted twice per week and were successful due to good communication with our local population and 'eligible population'. This communication flow was achieved via consistent, and near constant, website updating to reflect current information and improve our public information functionality.
- 3) Modoc County's EOC, as well as Modoc County Public Health's DOC established a 'warmline' to provide information and answer resource-based questions to help guide the public. Modoc County's communication with HCC partners and stakeholders was continuous and effective. This is likely due to the HCC's participation included nearly 100% of all medical providers/facilities within the county.
- 4) Education/awareness provided to the first responder system, including 911 centers and first responder teams also aided in our communication successes. Lastly, the Public Health DOC opening was swift and effective, as was the transition to a County-wide EOC. PHEP/HPP Annual Exercise Drill requirements better prepared the county for this event and were major contributors to the DOC/EOC functionality.

Discussion

Due to the everchanging nature of the event, just in time training was established for CI/CT and was effective/expedited well. Local Staff were able to facilitate trainings effectively and in a timely manner.

Good Communication Pathways established from the State to the LHJs, however information transmitted was sometimes contradictory with near constant change in guidelines.

Supply Chain issues became prevalent very early on in the pandemic response. Modoc County was fortunate enough to have a well supplied and well maintained emergency supply cache system, however supplies were often dispensed 'in a rush' and tracking of post-dispensed resources was sporadic. In order to better manage this in future events, Modoc County Public Health has adopted a new management software specifically designed for medical caches and is in the process of cross training multiple staff members on its use and functionality. Modoc County Public Health is optimistic that, with utilization of HPP/PHEP funding, these caches can be replenished and diversified for future wide-spread emergency response.

Testing Sites supplied by the State were a good idea in theory, but were over supplied with materials that could not be housed locally. Sites were often inconsistently staffed and locations often changed without notice. These problems were resolved when testing sites utilized local agencies/partners.

Local Surge buildouts and ACS were established quickly but not utilized due to low Covid case rates in Modoc County for a long period of time. When Covid cases did emerge and created a burden on the local HCF bed numbers, Region III COVID Surge-Buildouts via Shasta Regional Hospital were vital in maintaining local hospital functionality.

With regard to staffing within Modoc County's HCFs; Modoc County was fortunate enough to not have been put in the situation many larger HCFs found themselves in with regard to extreme staff shortages. Staff shortages were experienced, but primarily cause due to positive COVID tests among staff resulting in their inability to work and were quickly remedied via staff shift changes and the occasional short-term travel-employee.

CONCLUSION

Modoc County, as a whole identified the following hurdles and will be working to attempt and correct course to better prepare for our next emergency.

Adhering to communications 'chains of command' and eliminating direct contact from hospital administration directly to higher level state entities. MHOAC/RDMHS programs were often bypassed or intentionally subverted which created logistical issues. In order to correct this, MCPH hosted a number of ICS related trainings through RDMHS in order to educate our key-players and stakeholders of how the MHOAC system operates and how to properly utilize it to full effect.

Being a very small county, utilization of Regional Plans was incredibly effective. Possibly developing Regional specific guidelines may be a benefit rather than the State-wide guidelines considering population densities and demographics.

Modoc County Public Health also hired a Health Program Manager specifically to focus on public information and communication. In addition, our local HCC really came together to support one another in this event. Modoc County will be working to continue those relationships and building future exercises/drills that require county-wide med-health cooperation.

ACRONYM LIST

AAR	After-Action Review
AFI	Area for Improvement
CIP	Continuous Improvement Program
E.O.C	Emergency Operations Center
D.O.C	Department Operations Center
MHOAC	Medical Health Operational Area Coordinator
RDMHS	Regional Disaster Medical Health Specialist
MCPH	Modoc County Public Health
CDPH	California Department of Public Health
HCF	Healthcare Facility

APPENDIX A: PARTICIPATING ORGANIZATIONS

[List all participating organizations of the event in **Table 2**.]

Table 2: Participating Organizations

Federal
None Directly
State
California Department of Public Health
California Governor's Office of Emergency Services
County / Local
Modoc County Health Services
Modoc County Healthcare Coalition and Allied Partners
Modoc County Office of Emergency Services
Modoc County Sheriff's Office
City of Alturas
USFS
CAL FIRE
Alturas Police Department
Modoc County Social Services
Modoc County Office of Education
Modoc Joint Unified School District
Surprise Valley Joint Unified School District
Tulelake Joint Unified School District
Private Sector / Non-Governmental Organizations
None Directly

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ORGANIZATION: San Luis Obispo County Public Health

EXECUTIVE SUMMARY

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In December of 2019, reports that an outbreak of a respiratory illness caused by a Novel Coronavirus (2019-nCoV) was first identified in Wuhan, Hubei Province, China. The 2019-nCoV strain of coronavirus presented with pneumonia-like symptoms, including fever, cough, or difficulty breathing. The first confirmed death occurred on December 27, 2019 in Wuhan. In January of 2020, the County of San Luis Obispo Public Health Department (SLOPHD) began its response to a pandemic of the novel Coronavirus later named COVID-19.

On March 14, 2020 San Luis Obispo (SLO) County confirmed its first case. In early April 2020, the first COVID-19 death was recorded in the County. The County Health Agency Department Operations Center (CHADOC) activated in January 2020. The County Emergency Operations Center (EOC) activated in March 2020. The County, along with most of the State, experienced school closures in March 2020. The State's Stay Home order took effect March 19, 2020. In an effort to prepare for the initial surge, the County built a 900 bed Alternate Care Site (ACS) inside the recreation center at California Polytechnic University San Luis Obispo.

Over the course of the next two years, new variants emerged, causing five separate surges of COVID-19. Within a period of two years, SLO County experienced over 50,000 cases and more than 500 deaths attributed to COVID-19. The County received millions of dollars in grant funding to support the ongoing response.

Vaccines became available in SLO County on December 15, 2020 and mass vaccination efforts began immediately. Between December 2020 and March 2022, more than 67% of SLO County residents aged five and older were fully vaccinated and more than 73% received at least one dose. In the early phase of the pandemic, limited monoclonal treatments were available. Since then, treatments expanded to oral antivirals and additional monoclonal treatments available through multiple types of providers.

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- SLOPHD partnered with healthcare entities in the community to enhance information sharing capabilities.
 - The SLOPHD PIO team conducted daily and then weekly press conferences to keep the public engaged in the pandemic status and response efforts.
 - The SLOPHD PIO team consistently provided information in English, Spanish, Mixteco, and ASL.
 - SLO PHD quickly operationalized the Phone Assistance Center to meet the increasing needs of the community.
 - SLOPHD provided technical assistance, supplies, and PPE to a broad array of community partners.
 - SLOPHD established a resource request process that streamlined the tracking and distribution of supplies to CHADOC and the community.
 - SLOPHD proactively managed Care and Shelter operations by supporting unhoused individuals under isolation in trailers and hotel rooms.
 - SLOPHD provided outbreak testing to healthcare partners, congregate care settings, and others experiencing major outbreaks.
 - SLOPHD partnered with Central Coast Home Health to provide home-based vaccinations to homebound and vulnerable populations.
 - SLO PHD prioritized response staff allowing them to receive vaccine in an earlier tier along with other healthcare workers.
 - The County of San Luis Obispo MRC volunteers successfully filled staffing gaps and embraced critical leadership roles during the mass vaccine PODs.
 - SLOPHD, in partnership with Public Works, swiftly operationalized mass vaccination PODs, earlier than neighboring counties.
 - SLOPHD proactively established a well-represented COVID-19 Vaccine Task Force.
 - SLOPHD developed the Farm Worker Task Force and successfully utilized it to represent migrant farmworkers and provide advocacy for vaccinations.
 - SLOPHD offered walk-in appointments to essential workers and other individuals unable to plan their work schedules.
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- Our Public Health laboratory was innovative and proactive in getting new equipment and assays. See Laboratory question for additional information.
- We began response testing for congregate care facilities early in the pandemic to identify and isolate cases quickly. Next day testing could be arranged if needed. This helped prevent the spread of COVID-19 in these facilities full of residents at risk of severe disease. To keep up with the demands of surges, the testing team automated many of the processes to decrease the potential of paperwork errors. Errors would still happen when the lists had incorrect information, so the testing team worked more closely with the lab for the testing lists. This slowed down the testing preparation slightly but sped up the laboratory process.
- We pushed the importance of health equity and created a Health Equity branch in our department EOC. The health equity team created many initiatives including:
 - A vaccine task force that represented many different groups and interests in the community. This task force decided the initial eligibility for vaccines within the eligibility guidelines of the State.
 - Farmworker Fridays that helped farmworkers gain easier access to the vaccine. This also helped encourage them to get the vaccine with free food and music.
 - Vaccine Canvassing that helped inform neighborhoods of vaccination events happening near them.
 - Partnered with mobile vaccination team to provide vaccination to areas that had less access to the vaccine.
 - We quickly stood up COVID-19 vaccination PODs. Medical Reserve Corps Volunteers filled the majority of the staffing roles with IMT and public health staff filling leadership roles. Staffing was challenging because it was difficult to know the exact numbers of people needed especially with the addition of more partners sending staff to help. A more centralized staffing process or relying only on MRC volunteers would have streamlined this process further.

KEY LESSONS LEARNED

In the box, tells us what knowledge, process or plan was gained from your response, include positive and negative outcomes and recommendations for future responses.

- SLOPHD experienced delayed service delivery due to the conflicting security policies between HAIT and County ITD.
- The existing network infrastructure at the PG&E EOC Facility could not support the needs of SLOPHD.
- CHADOC staff experienced difficulties with ICS Chain-of-Command reporting.
- SLOPHD continued routine PH services during the response, adding to further confusion and inability to follow ICS Chain-of-Command.
- SLOPHD lacked staffing depth to sustain a long-term event.
- Integrating CHADOC into the EOC structure created confusion of roles and responsibilities.
- HA/PH leadership struggled to strongly advocate for the expertise of public health as a lead agency during a PH event.
- CHADOC staff relocated several times disrupting workflow and impacting staff morale.
- CHADOC staff did not consistently work within the management objectives outlined in Incident Action Plans (IAPs), often taking on more work.
- SLOPHD struggled to address staffing shortage challenges due to barriers in HR's administrative and hiring processes.
- EOC leadership neglected to provide adequate staffing depth to the CHADOC response team resulting in staff burnout.
- The County partnered with the County Incident Management Team (IMT) to operationalize mass vaccination sites resulting in discordance between SLOPHD's response structure and the IMT's operational expectations.
- SLOPHD allowed the County Emergency Operations Center to assume management of the Medical Reserve Corps resulting in disjointed processes.
- SLOPHD struggled to provide adequate mental health support and nutritious food to Care and Shelter clients during their isolation/quarantine period.
- SLOPHD allowed partners to rely heavily on PH instead of empowering them to establish their own programs and utilize available resources.

Continued on Next Page

CORRECTIVE ACTIONS

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- Develop a system for identifying core functions and priority of tasks regularly to ensure staff are working within those boundaries to promote a balanced workload and preserve mental health.
- Develop a plan to ensure use of the Mental Health Branch and the Safety Officer in the CHADOC org structure to monitor staff well-being (breaks, adequate food, hydration, coffee, schedules, etc.). Practice this updated discipline in all future exercises/real events to achieve competency.
- Develop a long-term plan for CHADOC facilities which includes expanded technical (IT) capacity of current facility or work to secure a new facility. If possible, secure appropriate MOUs for facilities that are identified in advance.
- Ensure use of CHADOC SOP (e.g. Org Chart) to include an appropriately modified Org Chart to best suit a Public Health response. Practice this in all future exercises to achieve competency.
- Identify and use a vaccine tracking/inventory management system.
- Incorporate identified changes into the CHADOC SOP, Pan Flu Plan, CERC Plan and the Communicable Disease Response Plan. Include additional messaging templates in the CERC for first case, first death, etc.
- Incorporate Plan training as appropriate.

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See attached page

- 2) What were the successes and challenges when working with your laboratory? If there were challenges include possible solutions.

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- 3) What were the successes and challenges when working with your Medical Health Operational Area Coordinator (MHOAC) / Regional Disaster Medical Health Specialist (RDMHS)? If there were challenges include possible solutions.

Nothing specific to note. The process worked relatively well for us.

- 4) What were the successes and challenges when working with the CDPH? If there were challenges include possible solutions.

See attached page

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SUBMIT

Executive Summary Continued:

SLOPHD staff filled the overwhelming majority of the key roles throughout the med/health response resulting in many other Public Health (PH) services operating in a limited capacity, if at all. Disaster Service Workers (DSWs) from all County departments were assigned to the response, however most were only available in short rotations. Hundreds of Medical Reserve Corps (MRC) volunteers were onboarded along with dozens of Temporary Help and Limited-Term staff to supplement the PH workforce.

Throughout the response, the SLOPHD used the Incident Command System (ICS) to manage the response in a proactive manner. SLOPHD collected and disseminated information—both to the public and to healthcare providers—tested specimens at the Public Health Laboratory (PH Lab), conducted contact tracing and case investigations, provided community and outbreak response testing, coordinated care and shelter for unhoused populations, supplied community partners with personal protective equipment (PPE) and testing supplies, vaccinated many members of the community, and conducted active surveillance and epidemiological investigations. SLOPHD tested all emergency response capabilities throughout the course of the response to the pandemic.

The County Health Agency Department Operations Center (CHADOC) was established at four (4) locations during the first 2-year period of the pandemic response:

- CHADOC 2191 Johnson Ave (January & February 2020)
- Co-located within the County EOC, PG&E Facility (March – June 2020)
- Co-located with the County EOC, New Government Center (June 2020 – July 2021)
- Acacia Creek Business Park, alternate/expanded CHADOC location (July 2021 – Spring 2022)

The purpose of this report is to analyze event outcomes, identify strengths to be maintained and built upon, identify potential areas for further improvement, and support the development of corrective actions.

Key Successes Continued:

- The partnership between SLOPHD and the County Real Property Services (RPS) team greatly aided in identifying and evaluating facilities for the COVID response team, managing property lease agreements and liaising with property management.
- The PH Lab quickly expanded capacity and new testing capabilities for COVID-19.
- The PH Lab closely monitored supplies and altered operations to maximize existing supply when supply chain issues were problematic.
- The PH Lab adopted new assays as soon as test kits, reagents and equipment became available.
- The PH Lab's adherence to good laboratory practices and staff's willingness to extend work hours resulted in an effective and efficient lab response.
- The PH Lab implemented sequencing using the *Clear Dx* instrument which allowed the onboarding of SARS-Co-V-2 sequencing to detect circulating variants.

Key Lessons Learned Continued:

- The EOC and CHADOC Safety Officers focused their efforts primarily on the physical safety of staff and overlooked the impact of mental wellbeing on responder health and safety.
- The Mental Health Unit in the Operations Section of CHADOC focused on community needs and failed to address the needs of staff.

1. Healthcare Coalition

Successes:

- Having already established relationships made communication easier
- Supported coalition with PPE

Challenges:

- Difficult to keep up meeting schedule when every partner and the LHD were busy with the response
- Lost a lot of established partners because things were being handled at upper management level
- Staff turnover at the facilities made it difficult to maintain a current contact list

2. Laboratory

Successes:

- The PH Lab quickly expanded capacity and new testing capabilities for COVID-19.
- The PH Lab maintained frequent and effective communication with the State and with other local labs.
- Staff resolve, initiative, and expertise to initiate (and some cases abandon) eight different amplification assays allowed the Lab to keep pace with demand.
- The PH Lab adopted new assays as soon as test kits, reagents and equipment became available.
- The PH Lab quickly stood up COVID whole genome sequencing in May 2021.
- The PH Lab maintained excellent communication with CHADOC, the State, and with other local labs.
- The PH Lab's adherence to good laboratory practices and staff's willingness to extend work hours resulted in an effective and efficient lab response.

Challenges:

- For a period, the PH Lab experienced delays in result reporting due to medical insurance billing requirements.
- The PH Lab experienced delays and additional staff workload from data entry errors.
- The PH Lab lacked an adjunct system to Apollo Lim.
- The PH Lab lacked scalable procedures for requesting tests and relaying results.

The PH Lab continuously sought effective ways to expand testing capacity while reducing turn-around-time for results. Through the PH Lab staff's determination, initiative, and expertise, the lab initiated 8 different amplification assays and 2 sequencing technologies from March 2020 to April 2022: 1) the CDC singleplex PCR test on the ABI 7500 FastDx instrument, 2) the Aptima SARS-CoV-2 test on the Hologic Panther instrument, 3) the Xpert Xpress SARS-CoV-2 test on the GeneXpert system, 4) the Respiratory Pathogen 2.1 Panel on the Biofire film array, 5) the New Coronavirus Nucleic Acid Detection Kit on the Perkin Elmer system, 6) the CDC Flu/SC2 multiplex PCR test on the ABI 7500 FastDx instrument, 7) the Xpert Xpress CoV-2/Flu/RSV test on the GeneXpert system, 8) the cobas SARS-CoV-2 test on the Roche cobas system, 9) SARS-CoV-2 whole-genome sequencing on the Illumina MiniSeq instrument, and 10) SARS-CoV-2 whole-genome sequencing on the ClearDx instrument.

The laboratory participated in weekly teleconferences to gain information on testing technology and its limitations, recommended testing algorithms, the availability of testing supplies and grant support, and the evolution of the SARS-CoV-2 virus. In turn, the laboratory communicated about testing capacity, supply and staffing constraints, and technical problems with tests and instrumentation. This

communication enabled the laboratory to obtain funding, access, and technical support for equipment and supplies.

In the beginning of the pandemic, the limited number of tests also prompted prioritization of testing based on exposure and risk. The PH Lab maintained excellent communications about the progress of testing, results, and supply inventory despite its physical separation from CHADOC. The laboratory shared preliminary positive test results even before laboratory reports were issued.

Staff willingly adjusted their daily schedules, extended their hours, and worked on weekends. Dedication and flexibility of laboratory staff, including microbiologists, laboratory technicians, and data entry/billing staff greatly contributed to the major success of the PH Lab.

The magnitude of testing created unanticipated data errors by staff. Incorrect information on requisitions (e.g., incorrect submitter location, patient names, etc.), the system required lab staff to document corrections on individual requisitions per laboratory process. Available staff could not keep pace with the number of corrections; consequently, this delayed laboratory reporting until the staff made corrections and completed data entry. The data entry process in Apollo LIMS did not allow for updates to patient accounts, which necessitated the time-consuming creation of new patient accounts with any change to demographic information. Billing testing fees to patient insurance also increased data entry time since additional fields had to be manually entered into Apollo LIMS and insurance eligibility had to be verified.

Duplicative phone calls and queries regarding test results negatively impacted laboratory effectiveness. Laboratory staff reported results as soon as they became available, and such calls applied pressure while taking away time from testing and reporting. Without a defined procedure in place, these requests impeded other lab operations reducing overall efficiency.

Recommendations:

- The PH Lab should identify triggers for outsourcing data entry and/or altering the insurance billing requirements.
- The PH Lab should research a more streamlined and digital system to help with the data entry error challenge.
- The PH Lab should develop an adjunct system to the Laboratory Information System for the rapid receipt and application of patient lists. This will allow the provision of accurate testing lab orders for use at institutional sites.
- The PH Lab should create a streamlined communication strategy for requesting tests and relaying results. This process should be practiced in drills and exercises.
- The ApolloLims system should provide the creation of AdHoc data fields to accommodate automatic result notification to patients.

3. MHOAC & RDMHS

Successes:

- The Operations Section Chief also functioned as the Medical Health Operational Area Coordinator (MHOAC). This allowed the MHOAC to have full situational awareness and represent the MHOAC program and the 17 MHOAC functions successfully in a large-scale public health event.
- Challenges:

4. CDPH

Successes:

- Regular meetings with CDPH were helpful in disseminating information and providing a planned forum for any non-urgent questions.
- The free testing sites organized and sponsored by CDPH greatly aided in providing fast and affordable testing to our county. It would not have been possible for our LHD to provide this volume of testing to the community without this assistance.

Challenges:

- Guidances were often released late. This caused us to have to create our own guidances. Then when the CDPH version came out, those following the guidance would be confused and angry at the differences. It would be helpful to share information on upcoming guidances even before they are confirmed. Even if things did end up changing, many of the discrepancies could be avoided.
- It was extremely difficult when SNAP nurses showed up at our mass vaccination PODs without warning. This caused major frustration with our MRC volunteers to have extravagantly paid staff push them out. We most likely lost volunteers over this issue. Eventually, the volunteers worked in harmony with the SNAP staff, but the initial shock and confusion caused a lot of drama. The SNAP staff were incredibly helpful, but we needed to know the date of their arrival beforehand to make sure we did not waste the time of our volunteers.

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QUESTIONS: This section contains four questions on specific successes and challenges you may have encountered working with partners during your COVID-19 response operations. Please take time to complete a thoughtful response that captures the issue(s) and possible solution(s).

- 1) What were the successes and challenges when working with your Health Care Coalition (HCC) members? If there were challenges, include possible solutions.

- 2) What were the successes and challenges when working with your laboratory? If there were challenges include possible solutions.

- 3) What were the successes and challenges when working with your Medical Health Operational Area Coordinator (MHOAC) / Regional Disaster Medical Health Specialist (RDMHS)? If there were challenges include possible solutions.

- 4) What were the successes and challenges when working with the CDPH? If there were challenges include possible solutions.

ADDITIONAL COMMENTS

Please use this section to provide any additional suggestions and/or insight not captured in the previous sections.

TOPIC: In response to the worldwide pandemic due to COVID-19, CDPH and all local health jurisdictions (LHJ) are completing an After-Action Report (AAR) to highlight key successes, identify lessons learned and develop an Improvement Plan to prepare for the next event.

REQUEST: For CDPH to assess strengths and weaknesses statewide, we are requesting each organization to complete an Abbreviated AAR of their COVID-19 response.

TEMPLATE: This Abbreviated AAR template is intended to simplify the reporting and data collection process from Public Health Emergency Preparedness (**PHEP**), Hospital Preparedness Program (**HPP**) and Pandemic Influenza (**Pan Flu**) grantees, inform CDPH's statewide report, and allow organizations more time to complete their AAR. This template consists of six main components: an Executive Summary; Key Successes; Advances; Key Lessons Learned; Corrective Actions; and a brief Questions section. When drafting your responses in this template, reflect on your overall performance related to **PHEP**, **HPP** and **Pan Flu** associated capabilities.

COMPLETE & SUBMIT: This Abbreviated AAR by no later than May 1, 2023 to lhtprog@cdph.ca.gov.

This does not replace the full AAR requirement, which should be available for review/collection upon request to fulfill audit, site visit, and/or administrative desk review deliverables or AAR requirements for any other organization or funding source.

Abbreviated After-Action Report (AAR) Template on PHEP, HPP & Pan Flu Capabilities

ORGANIZATION:

EXECUTIVE SUMMARY

In the box below, provide a summary of your organization's AAR and highlight any major outcomes, successes, challenges, lessons learned, corrective actions and conclusions.

KEY SUCCESSES

In the box, highlight key successes and favorable outcomes and how you achieved the goal(s). Include key elements that determined the success.

ADVANCES

In the box, tell us what initiatives or goals were rapidly pushed forward because of your response needs, include what the need was and why. Include efforts to maintain advances or key challenges in doing so.

KEY LESSONS LEARNED

In the box, tells us what knowledge, process or plan was gained from your response, include positive and negative outcomes and recommendations for future responses.

CORRECTIVE ACTIONS

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