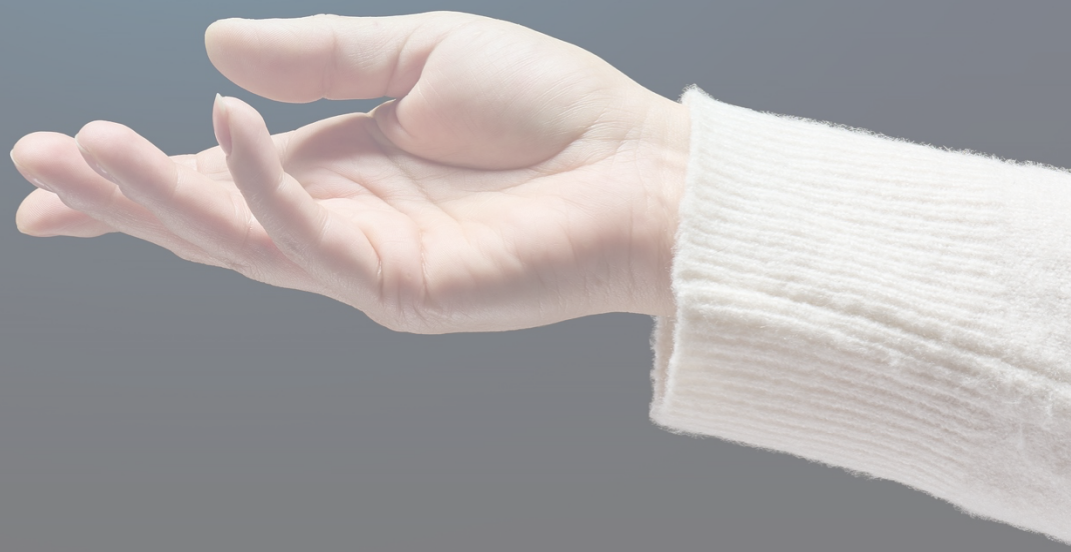
Chapter 4
County Monitoring and Local Coordination



Version History

Version #	Date	Notes
0.1	8/24/2023	First draft submitted to CPR Team for review
0.2	9/6/2023	Final Draft submitted incorporating CPR team edits
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Public Health Emergency Preparedness and Response Capabilities: Community Preparedness; Community Recovery; Emergency Operations Coordination.

Related CDPH AAR Chapters: Vaccines; Policy Development and Guidance; Data and Reporting.

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

Chapter Summary

Overview

This section provides a high-level overview of milestones and activities related to this chapter.

As California sought to manage the spread of COVID-19 and minimize death and severe illness from the disease, leaders needed a better understanding of disease transmission and how the emergency response was being handled at the local level. To address this need, the State established specific metrics to assess counties' case rates, test positivity rates, and hospitalizations, and, over time, added additional metrics as more became known about COVID-19.

Due to its existing relationships with the State's 61 local health jurisdictions (LHJs), CDPH monitored the county metrics, obtained input from LHJs on the data, and provided daily reports on case and test positivity trends to the State's leadership. In March 2020, CDPH stood up a small team, known as the County Data Monitoring (CDM) team, to coordinate with the LHJs on data tracking and reporting. The CDM team worked with individual LHJs to review the State's data, interpret its meaningfulness, and provide valuable insights about the actual situation in their communities. Due to this direct engagement, the CDM team rapidly evolved into the first line of communications between CDPH and the LHJs.

Just as CDPH was launching the CDM Program, the State allowed counties to reopen lower-risk workplaces and other spaces in early summer 2020. The CDM team then monitored the counties' metrics and reviewed the counties'

attestations for their capabilities and capacity to reopen. The team utilized the County Data Monitoring List (CDM List) to inform the public which counties remained closed due to their reported metrics.

When the CDM program ended in August 2020, CDPH reorganized the CDM team into the Local Coordination Team (LCT). This name change and reorganization better reflected the nature and evolution of the team's role. The LCT's effectiveness was based on robust two-way communications with the LHJs. By providing updates, addressing questions, and seeking LHJ feedback, the team fostered a reciprocal relationship. This enhanced understanding allowed the LCT to become a central hub of information, connecting LHJs with relevant COVID-19 task forces, CDPH programs, and State leadership, so that local perspectives helped shaped State policy.

The LCT's collaboration with the LHJs fortified the relationship between CDPH and LHJs, paving the way for a continued partnership on non-emergency public health endeavors. In response to the evident need from LHJs for sustained local support, CDPH established the Regional Public Health Office (RPHO) in July 2022. This new entity encapsulated the collaborative features pioneered by the LCT during the pandemic.

Timeline and Key Milestones

2020	
Spring 2020	• **March 19:** Governor issued statewide Stay-at-Home Order • **April:** CDPH County Variance project took place • **April 14:** Pandemic Resilience Roadmap presented for modifying the State-at-Home Order • **May:** CDPH County Data Monitoring webpage created • **December 5:** Regional Stay-at-Home Orders began
Summer 2020	• **August 30:** County Data Monitoring Program ended • **August 31:** Blueprint for a Safer Economy launched • **August 31:** County Data Monitoring team reorganized into the Local Coordination Team
Fall 2020	• **October 6:** Health Equity Metric established • **November 16:** Emergency Brake instituted
2021	
Winter 2020/2021	• **January 25:** Regional Stay-at-Home Orders ended
Spring 2021	• **March 12:** Vaccine Equity Goal #1 reached • **April 5:** Vaccine Equity Goal #2 reached
Summer 2021	• **June 15:** Blueprint for a Safer Economy ended • **August:** Equity-Focused Outreach (EFO) Campaign began
2022	
Winter 2021/2022	• **January:** Workgroup formed to plan for the new Regional Public Health Office (RPHO)
Spring 2022	• **March – June:** RPHO Workgroup conducted stakeholder engagement
Summer 2022	• **July:** RPHO established
Fall 2022	• **August – December:** RPHO established organizational structure and secured positions
2023	
Winter 2022/2023	• **January:** Local Coordination Team demobilized • **February 28:** California's State of Emergency for COVID-19 ended
Summer 2023	• **July:** RPHO began Regional Discussion Forum

Main Strengths and Successes

This section describes the Main Strengths and Successes, including findings and corrective actions, related to this chapter. Further elaboration and a more detailed discussion of these strengths and successes can be found in the Analysis of Activities section.

1. CDPH built a successful model of local coordination that demonstrated the need for ongoing collaboration between CDPH and local health jurisdictions in ongoing public health efforts.

Prior to the pandemic, CDPH had well-established relationships with LHJs through its existing public health preparedness and immunization programs. However, it quickly became clear that more robust coordination was necessary. To address this need, in March 2020, CDPH established the County Variance team (later became the County Data Monitoring Team) to engage with individual LHJs on their COVID-19 cases, test positivity rates, and emergency response efforts. After County Variance ended, CDPH launched the County Data Monitoring initiative to monitor county COVID-19 data and emerging local trends. It soon became one of the primary COVID-19 communication links between CDPH and the individual LHJs. LHJs continued to work with their RDMHS, with the County Data Monitoring Team and RDMHS coordinating, where possible. By August 2020, with the launch of the Blueprint for a Safer Economy, the team evolved into the Local Coordination Team (LCT), broadening its duties to guide and support the LHJs to implement the State's COVID-19 policies and initiatives. The team's engagement with the LHJs during the pandemic strengthened the bond between CDPH and LHJs, as they navigated challenges together, laying a foundation for future collaboration.

Finding/Corrective Action: For future pandemics, CDPH has the opportunity to continue this enhanced local coordination. *(ID: County Monitoring 1)*

2. The Local Coordination Team served as a conduit of information, promoting communications between the local health jurisdictions and CDPH. This positively influenced the

successful implementation of the State's COVID-19 policies and initiatives.

Initially, some LHJs were resistant to CDPH's involvement at the local level. To remedy this the LCT adopted a two-way communications approach to engage with LHJs. The team offered LHJs the opportunity to receive updates from the coordinators, ask questions, and provide specific LHJ input. This improved communications with LHJs by offering a two-way "feedback loop" between a single focal point within CDPH and the local agencies. Consequently, as conversations became more reciprocal, LHJs recognized the value in their engagement with the LCT.

Over time, the team became instrumental in discerning and addressing the emergency response needs of specific LHJs, linking them to relevant COVID-19 task forces, CDPH programs, and State leadership. The team developed a deep understanding of the goals and functions of the various COVID-19 task forces and response teams, emerging as the primary channel of information for LHJs and within CDPH. Recognized as the central information hub, they not only disseminated vital information to the LHJs but also synthesized feedback from across the State, to swiftly connect LHJs with the appropriate State decision-makers. Because the team understood the locals' needs and concerns, team members were often brought into different COVID-19 initiatives (such as outbreak response, vaccines, and testing efforts), to provide the locals' perspective. Consequently, the feedback loop allowed the team to bring vital information up to CDPH leadership's attention so that locals' perspectives were considered in State policy development and decision-making. As a result, according to one SME, when the LHJs saw their input reflected in guidance and communications, "they realized the benefits of the relationship" with CDPH "in getting their needs met."

Finding/Corrective Action: In the future, CDPH can leverage lessons learned in local coordination to promote robust coordination and collaboration that maintains and strengthens the relationship with LHJs. *(ID: County Monitoring 2)*

Main Challenges and Lessons Learned

This section describes the Main Challenges and Lessons Learned, including findings and corrective actions, related to this chapter. Further elaboration and a more detailed discussion of these challenges and lessons learned can be found in the Analysis of Activities section.

3. The County Data Monitoring List, initially set up to track county metrics, was also used as a decision tool for public health order restrictions. This created implementation challenges and was eventually discontinued.

CDPH initially established the County Data Monitoring List (CDM List) to track daily county metrics and to highlight which counties raised the most concern for disease transmission or that needed additional resources. However, the CDM List quickly evolved into a decision tool for public health order restrictions, such as shutting down specific activities or business sectors based on a county's metrics. A SME observed that this deviated from the CDM List's original intent. The dynamic nature of the CDM List meant counties could frequently switch between being open or closed on a day-by-day basis.Moreover, media representation of the list as a "state watch list" heightened its economic implications, leading to local apprehensions every time a county made the list.

Amid this scrutiny, some LHJs grew skeptical of how their data was aggregated and used as they could not replicate the State's COVID-19 metrics. This prompted intense dialogues between the CDM team and LHJs, leading CDPH to involve its epidemiologists to clarify data-related concerns. As the CDM program progressed, some LHJs started sending their data sets to CDPH, pointing out discrepancies in the State reported data and petitioning CDPH to be taken off the CDM List. With increasing data inconsistencies emerging, the CDM team proposed a reassessment, causing CDPH to halt its daily updates to the list. Subsequently, the CDM Program ended when the Blueprint for a Safer Economy launched in late August 2020.

Finding/Corrective Action: In the future, prior to the launch of an initiative, CDPH should identify processes to share data beforehand and include LHJs in training and information sharing on how data analysis is conducted *(ID: County Monitoring 3)*

4. The Local Coordination Team spent significant time resolving data discrepancies and adjudicating LHJ requests to reassess their tier placement.

In August 2020, the State launched the Blueprint for a Safer Economy, classifying counties into four risk tiers—minimal, moderate, substantial, and severe—based on several metrics. Monitoring these metrics required close coordination with the LHJs, which broadened the scope of the LCT's work. As the COVID-19 pandemic continued to evolve with new evidence and understanding emerging about transmission, the State continually reassessed the metrics and target thresholds for reopening activities and sectors. Consequently, during the Blueprint's implementation, the methods for calculating and adjusting the metrics underwent numerous iterations, prompting the LHJs to seek clarity on the evolving complexities. Counties continued to express concerns about data discrepancies. To address this, CDPH provided LHJs access to its internal dashboard and software algorithms. With this transparency, LHJs could more readily identify discrepancies and facilitate resolution if needed.

In mid-November 2020, with a statewide surge in COVID-19 cases, the Governor pulled "the emergency brake," placing 55 of 58 counties in the most severe tier status. This required closing indoor operations for many businesses in affected counties. With the vast majority of counties in the severe tier status, the LHJs scrutinized their county data very carefully to confirm they had been assessed correctly. LHJs often consulted with the LCT, which often entailed in-depth discussions about qualitative, contextual aspects of the counties' unique circumstances that were not revealed in the quantitative metrics. To streamline these appeals, CDPH had previously (in October 2020) introduced a tier adjudication process, so that LHJs could question data discrepancies and request tier reassignments. After the emergency brakes were applied on November 16, 2023, CDPH communicated with LHJ leadership on how tier adjudication requests would be addressed/reviewed during this period. Each adjudication was unique, requiring detailed analysis by the LCT, with subsequent legal reviews. Of all the tier adjudications handled by the LCT, a significant number were not approved, underscoring the rigor of the process. By June 15, 2021,

the State ended the Blueprint for a Safer Economy, eliminating both tier placement and the need for adjudication.

Finding/Corrective Action: For future pandemics, CDPH should establish an adjudication process that considers both quantitative and qualitative information if an LHJ challenges decisions based on county-level metrics. *(ID: County Monitoring 4)*

5. The rotation of redirected staff, most of whom did not have emergency response training or experience, proved challenging throughout the duration of the County Data Monitoring Program and Local Coordination Team.

When the County Data Monitoring Program launched in May 2020, CDPH redirected staff from within CDPH to establish the CDM team of regional coordinators. Subsequently, when the CDM team evolved into the Local Coordination Team and expanded to include epidemiologists and project management support, the team continued to be comprised of redirected staff and contractors. With the redirected staff on rotation for limited durations, one SME noted that the redirected staff "would come and go," which caused the team to continually redistribute the workload and train incoming team members. The team members were very skilled and experienced, but most lacked a background in emergency response. Consequently, often team members "relied on each other to learn" and to navigate the learning curve inherent in their roles.

Finding/Corrective Action: For future pandemics, when utilizing redirected staff, consider the duration of rotations to minimize the turnover among team members. Also, ensure redirected staff receive the appropriate emergency response training, including a clear understanding of the Standardized Emergency Management System and Incident Command Structure. *(ID: County Monitoring 5)*

Analysis of Activities

This section elaborates and provides more detail on the findings, corrective actions, and lessons learned that are presented in the Main Strengths and Successes and the Main Challenges and Lessons Learned sections.

County Data Monitoring

County Variance Program Implemented to Monitor Case Rates and Test Positivity at the Local Level

- Prior to the pandemic, CDPH had a well-established relationship with the LHJs through its existing public health preparedness and immunization programs. The CDPH centers and programs engaged with LHJs at the local leadership level in "an organized group process with set times and meetings," according to one SME. The pandemic, however, prompted the transformation of CDPH's interactions with the LHJs and its approach to monitoring county-level data.
- With the spread of COVID-19, there was an urgent need for current and accurate county-level data on COVID-19 case rates and test positivity. In March 2020, CDPH initiated discussions with LHJs to better understand the extent of transmission and spread of the virus at the local level. Around the same time the Governor issued the statewide Stay at Home Order, CDPH implemented the County Variance Program to engage with individual LHJs on their COVID-19 cases, test positivity rates, and emergency response efforts.
- The County Variance Program was only in place for about 3 weeks, but it was the beginning of the collaborative relationship that eventually developed between CDPH and LHJ leadership and staff. It involved a small CDPH team, comprised of one lead and two staff, working with each LHJ individually to guide them in preparing attestations to the accuracy of their reported numbers and the actions they were implementing to curb the spread of the virus. LHJs attested to their surge plans with hospitals, testing capacity, availability of personal protective equipment (PPE), staffing levels, and contact tracing capabilities, all aimed at mitigating the spread of the virus. The CDPH team reviewed these attestations, ensuring clarity and accuracy in calculations. Once the attestations were deemed satisfactory, they were formally submitted and sent to the Governor's Office for review and approval

for the county to open. If approved the attestation was posted to the State's COVID-19 website.

County Data Monitoring Program Launched to Better Understand Locals' COVID-19 Response Efforts

- As the number of COVID-19 cases exploded exponentially across the State, CDPH needed a more robust process to better understand what was happening on the ground in each of the LHJs. Consequently, CDPH leadership tasked the County Variance Program team lead to establish a dedicated team to work with individual LHJs and build a new program to monitor the counties' response efforts. This new County Data Monitoring (CDM) Program launched in May 2020.
- To get ready for the CDM Program's launch, in April 2020, CDPH began redirecting staff from within CDPH to establish the CDM team, comprised of 5-6 members. Each team member, called a CDM regional coordinator, was assigned to designated LHJs within a region to serve as the first line of communications. With the redirected staff on rotation for limited durations, the frequent turnover caused the team to continually redistribute the workload.
- The CDM team developed the elements of the new program at the same time as they were implementing it. According to one SME, the CDM team was "literally building the plane as we were flying it." Initially, the team focused their efforts on obtaining county-level qualitative and quantitative data. Since the CDM team served as the single point of contact, they used their relationship with the LHJs to obtain useful qualitative information about each county's situation, in terms of the county's unique geographical, cultural, demographic, and economic environment.
- The CDM team also needed to develop methods to obtain and report on county-level quantitative data that would meet both the State's and LHJs' information needs. As one SME described it, "we put in a lot of manual development at the beginning on how we generated data, used data, and shared it." This transparency proved beneficial as it enabled the LHJs' epidemiologists to review the quantitative data. Upon doing so, they provided valuable insights about the situation in their communities and verified whether the data provided by the State was meaningful.
- Initially, some LHJs resisted the CDM team's involvement at the local level. As one SME commented, the "LHJs were forced to engage with us because of

the emergency," and at first "they didn't understand our role." Some felt that sharing data and their emergency response plans "was taking time away from the response work that they were trying to do."

- To promote a better understanding of their local coordination role, the CDM team members persisted in their engagement with the LHJs. Instead of sending information to the local public health officers and expecting them to disseminate the information down to their LHJ staff, the coordinators interacted with all levels of the staff within their designated LHJs. Using a "bi-directional" communications approach, LHJ staff had the opportunity to receive updates from the coordinators, ask questions, and provide individual input, according to one SME. This improved communications with LHJs in part by developing this two-way "feedback loop" between a single focal point within CDPH and the local agencies. Consequently, as conversations around data became more reciprocal, LHJs were able to see the value in their engagement with the CDM team.
- Another important aspect of the CDM team's responsibilities was understanding and triaging the LHJs' needs for emergency response support and connecting the LHJs with the appropriate COVID-19 Task Force, CDPH program, or State leadership for resources. The CDM team became knowledgeable about the functions and points-of-contact for the various task forces and response teams across the COVID-19 response. This was helpful to the emergency response as a whole, since, according to one CDPH leader, the CDM team became "the hub of information" and could share information back to the LHJs. In addition, the leader pointed out that the CDM team became "the mechanism for local leadership to connect with State leadership."
- The relationship that developed between the CDM team and the LHJs allowed the CDM team to obtain visibility into the LHJs' concerns. According to one SME, if the team "got feedback on a need or a problem, then we would work within our team and we could summarize needs that were coming up across the state." Consequently, the CDM team was able to elevate information on behalf of the LHJs and function as a "bridge" that could "cut through the noise" and connect LHJs to the appropriate entity.
- The CDM team members were very skilled and experienced, but most lacked a background in emergency response. Because each member of the team was always learning something new, one SME commented that it was important to have "people that could synthesize information" and

communicate effectively, both with LHJ leadership and with State leadership. Over time, team members reported that they leaned on their colleagues to learn from each other in order to perform their role in the emergency response.

- The CDM team also supported LHJs to submit their monthly reporting required to fulfill state budget and local allocation requirements (CARES funding). The CDM team developed a system to obtain the information from each LHJ for submission to CDPH leadership and the California Health and Human Services Agency (CalHHS). For further information about federal grant funding to LHJs, refer to the Fiscal Administration chapter in this AAR.

Data Used to Track COVID-19 Transmission and to Determine Restrictions at the Local Level

- On April 14, 2020, the State issued the Pandemic Resilience Roadmap (Roadmap), which laid out a four-stage framework for lifting the stay-at-home restrictions gradually based on specific metrics. Many SMEs referred to the Roadmap as the "dimmer framework," because it required counties to reintroduce activities and sectors in a gradual, phased manner, similar to a dimmer light switch, rather than reopening up activities and sectors all at once. At that time all counties were operating in Stage 1 of the Roadmap, which focused on safety and preparedness. Their emergency response efforts involved building out testing, contact tracing, PPE, and hospital surge capacity, as well as developing policies and guidance to keep the local essential workforce as safe as possible.
- Just as CDPH was launching the CDM Program, in early May 2020, the State allowed counties, under certain conditions, to transition to Stage 2 of the Roadmap to reopen lower-risk workplaces and other spaces. The counties' data reporting over the previous few months had revealed that due to differences in COVID-19 case rates and counties' emergency response capabilities, counties would not be able to progress through the Roadmap stages at the same rate. Therefore, the State issued a public health order which allowed a county to move through Stage 2 reopening more quickly than other counties or continue more restrictive public health measures than the State as a whole, should a county choose to do so.
- In order to open up certain activities and industries, counties had to meet specific thresholds for case rates, test positivity, and several new metrics. These additional metrics included average COVID-19 tests per day,

percentage change in COVID-19-related hospitalizations, percentage of available ICU beds, and percentage of available ventilators. If the county's metrics met the thresholds, the county then had to submit an attestation to CDPH of its capabilities, capacity, and plan to accelerate the pace through Stage 2. The attestation also had to identify the triggers and plan to modify the pace if conditions worsened, including reinstituting restrictions, in advance of any State action. While not required, CDPH recommended as a best practice that LHJs develop a county COVID-19 containment plan in conjunction with hospitals and health systems, a broad range of county stakeholders, and the County Board of Supervisors.

- With this transition to Stage 2, CDPH's county data monitoring responsibilities expanded. Since the CDM Program had been set up to provide additional visibility into what was happening on the ground and the counties' response, it became the CDM team's responsibility to monitor the counties' metrics, review the attestations, and provide guidance on the containment plans, as the counties navigated through Stage 2 of the Roadmap.
- The CDM team created the County Data Monitoring List (CDM List) to monitor each county's metrics daily. Initially, the CDM List was a mechanism to track the counties' data and communicate the information to the Unified Command Group (UCG), the daily leadership meeting with State departments involved in the emergency response, and the Governor's Office. The CDM team leader produced daily reports for the UCG to highlight which counties raised the most concern for disease transmission or that needed additional resources. However, the CDM List quickly evolved into a tool to monitor when to impose restrictions specified in State public health orders to shut down certain sectors in a county, such as bars and restaurants, based on the metrics.
- In May 2020, CDPH began publishing daily updates to the CDM List on the CDPH website to inform the public about closures by county. The CDM List flagged which counties did not meet the State's thresholds for opening certain sectors. A county would have to be "on the metric" for three days before it would be flagged on the list, explained a SME, and it would remain on the list until the county's metrics met the State's specified target for opening. If a county did not meet the target, it would be subject to closure for some or all of the sectors allowed to be open under the State's public health order. A flagged county remained on the list until its metrics improved

and once it met the target for three consecutive days, it was removed from the list.

- Placing counties on the CDM List was very dynamic, as LHJ and CDPH data team constantly updating their analyses based on daily data updates. The fluidity of the information meant that a county's status could change overnight - one day it could be on the closed list and the next day it could be off. Also, there were consequences to putting a county on the CDM List. Being added to the CDM List often prompted local news coverage of possible county closures. The news media began framing the CDM List as a "state watch list," alerting the public that tightened restrictions were looming for those counties that were placed on the list.
- Given this intense scrutiny of the metrics, LHJs became concerned about how their county data were being compiled and used to impose restrictions. LHJs could not replicate the State's COVID-19 metrics, because in the first 6 months of the response CDPH lacked methods to distribute its processed data back to the LHJs. Local agencies questioned how their data was being calculated, which according to one SME, led the CDM team to have extensive discussions about the data with the LHJs. That prompted CDPH, in summer 2020, to include CDPH epidemiologists in the discussions to assist in examining, interpreting, and explaining the data to the LHJs.
- During July and early August 2020, several LHJs sent data sets to the CDM team showing that slices of data the State was reporting were discrepant. Some LHJs challenged the data and petitioned to be taken off the CDM list. As more data discrepancies were identified, CDPH paused the CDM List and temporarily stopped publishing the daily updates to the CDM List until the data discrepancies were resolved.

Local Coordination

Local Coordination Team Established as the State Launched the Blueprint for a Safer Economy

- While the County Data Monitoring program was paused to allow for an investigation into the data discrepancies, State leadership was concurrently at work on a framework that would replace the Roadmap. The new framework still included phased reopening to avoid creating a new surge of COVID-19 cases. However, State leadership also wanted to build equity

considerations into the new framework to assist disadvantaged communities in most need of resources.

- The new framework, called the Blueprint for a Safer Economy (Blueprint), launched on August 31, 2020. The Blueprint designated new criteria for tightening and loosening restrictions on activities, replacing the CDM List. According to the Blueprint, counties were assigned one of four color-coded risk levels—minimal (yellow), moderate (orange), substantial (red) or widespread (purple)—based on the number of daily new cases adjusted for testing volume and test positivity rate. Counties at widespread or substantial risk had to close more categories of non-essential indoor businesses, while those whose data indicated moderate or minimal risk levels could open more sectors of their economy. CDPH published county data and tier assignments each Tuesday on what became to be known by the counties as "Tier Tuesdays," according to one SME. For further discussion of the development of the Blueprint and the associated metrics, refer to the Policy Development and Guidance chapter of this AAR.
- Implementing the new Blueprint framework and monitoring the associated metrics required close coordination with the LHJs, which broadened the scope of the LCT's work. With the introduction of the Blueprint framework, the CDM team changed its name to the COVID-19 Local Coordination Team (LCT) to better reflect the team's responsibilities and better align the coordinators with the Blueprint's designated regions. In addition to its focus on monitoring county data, the LCT actively engaged with LHJs to provide guidance and support on not only the Blueprint, but on other COVID-19 related initiatives, making around 400 county calls per month. As one CDPH leader noted, the LCT became "the source and pulse" of information for the LHJs and the conduit to connect LHJ leadership with State leadership.
- Many LHJs carefully monitored their data to discern patterns of COVID-19 transmission within their communities. This vigilance provided county health officials with the ability to anticipate case trajectories, and they used this information to proactively collaborate with the LCT and the RDMHS assigned to their operational area to secure resources. Often LCT staff and RDMHS communicated to ensure resource requests were going through the appropriate channels per the SEMS process. To illustrate, within one specific county, the local public health officer projected a surge of 2,000 cases at the State prison within the forthcoming week. Recognizing the gravity of this

situation, this LHJ coordinated with the LCT and RDMHS to secure essential resources and devise strategies to tackle the impending challenge.

- Based on their experience with the CDM List, counties remained concerned about how the State's data for their LHJ was being processed, calculated and utilized in tier assessment. To address this concern, when the Blueprint launched CDPH provided the LHJs access to CDPH's data aggregator tool called Snapshot. The Snapshot tool displayed county data in a dashboard so that "LHJs saw the data the same way CDPH saw it," according to one SME. The LCT also conducted weekly webinars with the LHJs to provide beneficial information about Blueprint implementation and communicate how the data was used in tier assignments.
- As the COVID-19 pandemic continued to evolve with new understanding emerging about transmission, CDPH reassessed the metrics and target thresholds for reopening activities and sectors. Consequently, during the Blueprint's implementation, the methods for calculating and adjusting the metrics underwent numerous iterations. The LHJs questioned "why this is so complicated" and discussions to help LHJ public health experts understand the Blueprint metrics "came up constantly," according to a SME. LHJs needed guidance to understand the changing calculations. To promote transparency, CDPH provided the formulas to the LHJs' epidemiologists so that they could review the results first hand.

Local Coordination Team Provided Guidance on the Blueprint's Health Equity and Vaccine Equity Metrics

- To help counties manage disease transmission in their neighborhoods and communities equitably, in October 2020 the State added a health equity metric to the Blueprint framework. To advance to the next less restrictive tier, counties with larger populations had to meet the health equity metric. Additionally, all counties had to demonstrate the targeted investments they intended to make to eliminate disparities in levels of COVID-19 transmission.
- To move to a less-restrictive tier, counties with populations greater than 106,000 had to demonstrate that the test positivity rates in their most disadvantaged communities (monitored at the census tract level) did not significantly lag behind the overall county test positivity rate. Of California's 58 counties, the 23 counties with populations of less than 106,000 were exempted from the metric because test positivity could not be reliably calculated at the census tract level due to the small number of cases.

- The LCT and redirected staff from the CDPH Office of Health Equity played an important role in helping LHJs understand and apply the health equity metric, and perhaps most importantly, provided guidance on its articulation to both their Boards of Supervisors and the public. One SME recalled that the Governor's Office started fielding calls from county elected officials regarding the equity metric, which indicated that some LHJs needed guidance on how to frame their public messaging. It was "definitely new to explain" the health equity metric to LHJs and decision makers, said one SME. To facilitate messaging, the LCT generated helpful talking points that LHJ staff could use in future conversations about health equity.
- In addition to the health equity metric, the Blueprint required all 58 counties to submit an Equity Investment Plan (EIP) in order to move to the next less-restrictive tier. The 3 city LHJs were included within their respective county's plans. This EIP was not a novel requirement as counties already needed to submit an EIP to receive emergency response grant funding through the CDC's Epidemiology and Laboratory Capacity (ELC) program. The State leveraged the ELC process by adding the submission of the EIP as a condition to move to a less restrictive tier. The LCT worked closely with LHJs to formulate EIPs that demonstrated the counties' capabilities and targeted investments that would benefit people living in areas most heavily impacted by the virus.
- In March 2021, the State added two vaccine equity goals to the Blueprint to reflect vaccination efforts in California. Similar to the health equity metric, the LCT provided guidance to LHJs on the vaccine metric goals and how they would be applied. The LCT also facilitated the submission of the LHJs' vaccine equity plans. Throughout the remainder of the response, the LCT and the LHJs partnered on many different vaccine equity initiatives. For further discussion of the vaccine equity metric goals and the LCT's role in coordination with LHJs on vaccine administration, refer to the Vaccines chapter in this AAR.
- In April 2021, the State added recent hospitalization rates as an additional consideration along with Blueprint metrics before moving a county to a more restrictive tier. If a county's case rates and/or test positivity had fallen within a more restrictive tier for two consecutive weeks, CDPH reviewed the county's most recent 10 days of data, including the newly added hospitalization metric, to determine if the county could remain in the less restrictive tier.

Counties Contested Their Tier Placement Through an Adjudication Process

- In mid-November 2020, California started to experience a statewide surge in COVID-19 cases. The Governor accelerated the Blueprint tiering process, likening it to "pulling the emergency brake." At the time, 27 counties were operating in the most restrictive purple tier. With this acceleration, 28 more counties were moved from less-restrictive tiers into the purple tier. As a result, 55 counties, comprising over 90% of the State's population, were now under the most restrictive conditions. Simultaneously, the Governor issued a limited stay-at-home order that applied only to purple-tiered counties. Jurisdictions were provided two days' notice to implement, purple-tiered counties closed all indoor operations for restaurants, churches, and gyms.
- With the vast majority of LHJs in purple-tiered status, the LHJs scrutinized their local data very carefully to confirm they were placed in the correct tier status. The LHJs' epidemiologists compared the data the LHJ collected with what CDPH reported on the Snapshot dashboard. When an LHJ discovered a discrepancy in the their local data, LHJ staff reached out to its LCT regional coordinator to better understand the calculations and resolve data issues. Very quickly, the LCT recognized there needed to be a formal process for LHJs to raise questions about their tier assignment and for CDPH to adjudicate tier placement. Consequently, CDPH established a county tier adjudication process for LHJs to raise questions concerning data discrepancies or other types of errors.
- To initiate the adjudication process, a county submitted an Intent to Submit COVID-19 County Tier Adjudication Request Form by each Monday. Then, by the end of Wednesday, the county submitted a COVID-19 County Tier Adjudication Request Form and the supporting documentation. Once a county entered into tier adjudication with CDPH, the county's tier assignment at the time of the request would not change until adjudication was complete.
- Local Health Jurisdictions supplied the reason for their adjudication request, whether it was due to data discrepancies and/or other contextual reasons. If it was due to a data discrepancy, the LHJ specified how the discrepancy was significant enough to affect the tier status and provide supporting documentation. If the reason was contextual in nature, the LHJ described the conditions that affected their tier status. For example, one rural LHJ reported

that an outbreak occurred on a U.S. Army Base in its jurisdiction during a training exercise from soldiers brought in from out-of-state. Since the soldiers were restricted to base and not allowed into the community, the county argued these case numbers should not be included in the LHJ's weekly data release. As another example, an LHJ discovered a local laboratory reported an abnormally high number of false positive cases. The LHJ asked to not be placed in a more restrictive tier temporarily in order to have time to investigate the situation.

- Each tier adjudication request was unique to the LHJ's particular geographical, cultural, demographic, or economic situation. This required CDPH to conduct a unique review and analysis of each request in order to make a determination. It took a considerable amount of effort, within a short period of time, for the LCT to conduct the background review, recalculate data as necessary, seek clarifications, summarize the findings, and issue a recommendation (e.g., whether the request should be granted or denied).
- The LCT drafted the recommendation and submitted the decision to CDPH's legal counsel, which worked with CalHHS legal counsel and the Governor's Office to quickly announce the decision. Highlighting the meticulous nature of the process, one SME remarked that "adjudication was very well documented." This final determination was then relayed back to the LHJ and subsequently made public via CDPH's official website. Over the span in which the Blueprint was active, a total of 33 tier adjudications were conducted by the LCT. Notably, a significant proportion of the adjudications were not approved.
- On June 15, 2021, the State ended the Blueprint for a Safer Economy, which consequently ended tier assessments and the need for adjudications.
- Based on lessons learned from the pandemic, CDPH leadership saw the value in continued local coordination outside of the COVID-19 emergency response. Ongoing and future regional emergency preparedness work will be supported by 6 new positions in the Center for Preparedness and Response called "Regional Disaster Public Health Representatives."
- Though the Blueprint for a Safer Economy ended in June 2021, CDPH leadership saw the value in continued local coordination outside of the COVID-19 emergency response.

Equity

This section describes equity considerations specific to this chapter.

- The Local Coordination Team provided guidance and helped the LHJs understand the health equity metrics and the vaccine metric goals in the Blueprint for a Safer Economy. In addition to the equity metrics, the Blueprint required all counties, regardless of size, to submit an Equity Investment Plan (EIP) in order to move to less-restrictive tiers. The LCT worked closely with LHJs to formulate EIPs that demonstrated the counties' capabilities and targeted investments that would benefit people living in census tracts most heavily impacted by the virus. These comprehensive plans encompassed a range of strategies, from bolstering testing capacities and disease surveillance to enhancing contact tracing, support for isolation and quarantine, and extending educational outreach.
- As CDPH launched numerous equity initiatives, especially in vaccine administration, the Local Coordination Team served as the connector among the various workstreams to support LHJs with implementation.
- For further discussion of the health equity metric and its use, refer to the Policy Development and Guidance chapter in this AAR.
- For further discussion of the vaccine metric goals and local coordination of vaccine equity initiatives, refer to the Vaccines chapter in this AAR.

Data and Technology

This section describes data and technology specific to this chapter.

- In the late spring and early summer of 2020, CDPH developed an internal data aggregator tool called Snapshot. It allowed users from the State's County Data Monitoring program to examine case rates, test positivity rates, and hospitalization data together and track trends. CDPH provided LHJs access to Snapshot about the same time the Blueprint for a Safer Economy was launched. The Snapshot tool gave LHJs insights on their data so they could make data-guided policy decisions.
- With access to the Snapshot tool, the LHJs began to discover discrepancies between the data they collected and the State's data. These discrepancies were very important to resolve because a county's Blueprint tier assessment depended on reliable calculation of the metrics using the State's data. In addition, the LHJ epidemiologists wanted to confirm the integrity of the calculations, which were based on software coding. To provide transparency in the calculations, CDPH worked with the California Department of Technology (CDT) to give LHJ epidemiologists access to the calculation codes via Github, a cloud-based repository hosting service that allows sharing of software source code, so that LHJs staff could walk through the Blueprint's metric calculations themselves.
- For further discussion about the Snapshot tool and its utilization, refer to the Data and Reporting chapter in this AAR.
- For further discussion of how data was used for monitoring counties and tier adjudication, refer to the Analysis of Activities section in this chapter.

Communications

This section describes communications specific to this chapter.

External

Communicating with LHJs

- CDPH developed and maintained robust communication channels to keep LHJs continuously informed and answer their questions on all aspects of the emergency response through weekly webinars, weekly office hours, weekly leadership meetings with local public health leadership members who were also members of the California Council of Local Health Officers (CCHLO) and County Health Executives of California (CHEAC), and listserve/email communications. These many forums enabled robust two-way communication and provided a space for the State to share updates, answer questions, and obtain local input. According to one SME, it was very important to have these channels available for LHJs to share their concerns and frustrations. In addition, early on in the pandemic response CDPH's Local Coordination Team designated a coordinator for each LHJ, "to give the LHJ someone to go to, which was a helpful conduit." CDPH also established a password-protected SharePoint site for LHJs to post data, files, presentations, and resources.
- However, with so many different workstreams and stakeholders in the COVID-19 response, some communication siloes inevitably developed. Multiple different State teams communicated with different levels of the LHJs (e.g., the local health officers vs. the LHJ staff), which made it difficult to keep communications consistent and aligned.

Internal

- The Local Coordination Team was able to work across response teams within CDPH, bringing local health leaders' varied concerns to the right person in each response team or task force. One SME commented that it was "helpful to hear from the LHJs" and said that as the team "shared up" what they learned, the LHJs were influencing "policy decisions at the state level." Another SME added that it was helpful that the Local Coordination Team leader worked with the State Operations Center (SOC), coordinating with different State-level leaders and becoming a "hub" that "tied response

teams together." Because of this, the LCT connected LHJs' concerns with State leadership in implementing the Blueprint.

Workplan

This section is designed to be used as a workplan for future pandemics.

Definitions:

- **Phase**: The phase of the response in which the major tasks should be conducted (Planning; Initial start-up, Ongoing operations, or Close-out).
- **Major Tasks:** The tasks and activities that have to be conducted as part of the public health emergency response to a respiratory pandemic.
- **Success Criteria:** Criteria used to assess whether a task has been achieved successfully.
- **Considerations Based on COVID-19 Response:** Things to consider, including pitfalls, risks, and lessons learned, based on the COVID-19 response.
- **Finding ID:** The ID(s) from the related Finding/Corrective Action (where applicable).
- **Lead:** The lead person(s) responsible for task completion.

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
Planning; Initial start-up; Ongoing operations	• Establish roles and responsibilities for local coordination	• CDPH receives and incorporates LHJ input in policy decisions. • LHJs participate as a partner in the response.	• Designate CDPH points of contact for LHJs. • Establish regular communication channels and cadences with LHJs. • If using redirected staff, follow regular Standardized Emergency	• County Monitoring 1, 2, 5	

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
			Management (SEMS) process, per Emergency Manual Guidelines. • Provide emergency response training to redirected staff. • Determine appropriate duration of rotations to prevent team churn.		
Planning; Initial start-up; Ongoing operations	• Develop a data monitoring process that meets both the State's and LHJ needs	• State has accurate information for making statewide policy decisions. • LHJs have accurate information for making local policy decisions.	• Include LHJ representatives in development of the process. • Make data and metric calculations accessible to LHJs.	• County Monitoring 3	
Planning; Initial start-up; Ongoing operations	• Implement an adjudication process for LHJs to challenge decisions	• CDPH has comprehensive information to reassess its initial decision. • LHJs are confident that their concerns have been reviewed and	• Develop processes, tools, and timelines for LHJ submissions and CDPH decisions. • Allow LHJs to provide quantitative and qualitative information in their adjudication request.	• County Monitoring 4	

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
		equitably addressed.			