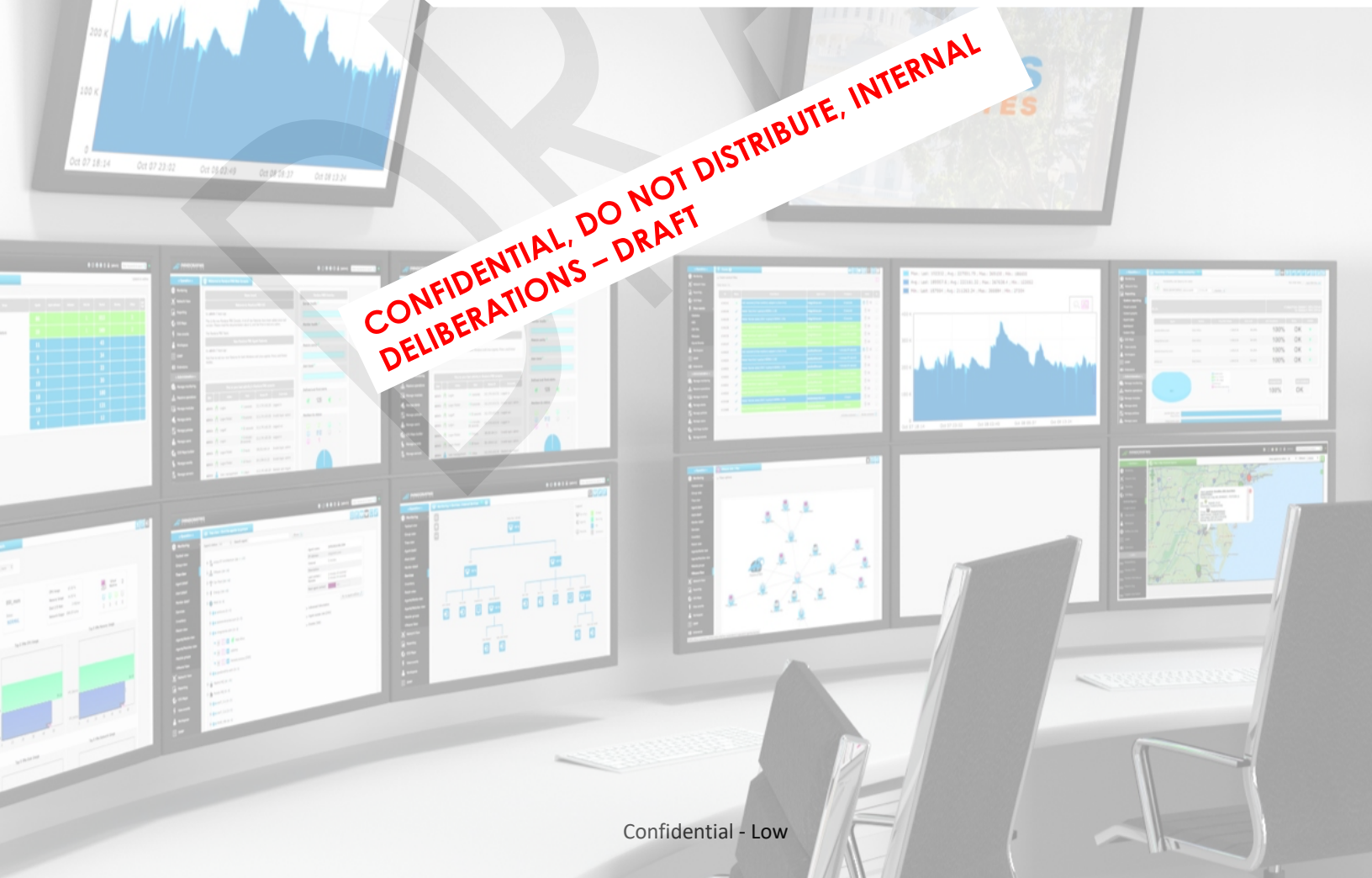
CONFIDENTIAL, DO NOT DISTRIBUTE, INTERNAL DELIBERATIONS – DRAFT

Chapter 1
Operational Organization



CONFIDENTIAL, DO NOT DISTRIBUTE, INTERNAL DELIBERATIONS – DRAFT

Version History

Version #	Date	Notes
0.1	3/13/2024	First Draft to combine Incident Command System, Inter-ESF 8 Communication, and MHCC and Continuity of Operations chapters. First draft submitted to CPR Team.
0.2	4/30/2024	Final Draft revised per CPR Leadership review
0.3		

DRAFT

Table of Contents

DRAFT

1. Operational Organization

Related Public Health Emergency Preparedness and Response Capabilities: Community Preparedness; Community Recovery; Emergency Operations Coordination; Information Sharing.

Related CDPH AAR chapters: Resource Requesting and the Public Health Ordering System; Policy Development and Guidance; Data and Reporting; Testing; Vaccines, Medical Surge; MAC Group and Scarce Resource Allocation; Logistics, Distribution, and Warehousing.

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.

In 2009, the California Governor's Office of Emergency Services (Cal OES) revised the State Emergency Plan (SEP), which established the California Emergency Support Functions (CA-ESFs), including CA-ESF 8: Public Health and Medical. The CA-ESF 8 framework was designed to strengthen collaboration among public health and medical stakeholders during emergencies. CA-ESF 8 partners include the Departments and Offices under the California Health and Human Services Agency (CalHHS) with the exception of the Department of Social Services, which oversees CA-ESF 6 (Mass Care and Shelter). The CA-ESF 8 partners coordinate to implement California's public health and medical emergency response activities.

In addition to the CA-ESF 8 framework, the California Public Health and Medical Emergency Operations Manual (EOM) provides guidance on the basic roles and responsibilities with the public health and medical system and the coordination with the emergency management structure at all levels of California Standardized Emergency Management System (SEMS). The EOM supports California's ability to provide assistance to local governments when disasters overwhelm available resources.

Within CDPH, the Center for Preparedness and Response (CPR) coordinates overall emergency planning and preparedness efforts for CA-ESF 8. One of CPR's key responsibilities is to manage and run the Medical Health and

Confidential - Low

Coordination Center (MHCC) during public health and medical emergencies. When activated, the MHCC supports and coordinates the public health and medical emergency response between its CA-ESF 8 partners, and also responds to the needs of local public health and medical partners.

Historically, the MHCC has played significant roles in leading and managing California's prior public health responses, including the 2015 Ebola response and the 2009 H1N1 response. However, during COVID-19, the MHCC's role evolved and its scope expanded significantly to meet the unprecedented needs of the pandemic. As the State's response progressed through several distinct phases, CDPH's responsibilities increased, which required substantially more resources with a commensurate level of management and oversight activities.

On January 24, 2020, CDPH activated the MHCC in response to COVID-19, and coordinated with other state and federal department partners, including the Cal OES and the California Emergency Medical Services Agency (EMSA), GovOps, and multiple federal entities, on the repatriation, quarantine, and returning traveler monitoring of citizens returning from overseas. Due to significant amount of resources being deployed, EMSA activated its own DOC to coordinate logistics. The two departments coordinated with Cal OES and multiple federal entities on the repatriation, quarantine, and returning traveler monitoring of citizens returning from overseas. (For additional discussion, see the Repatriation, Quarantine, and Returning Traveler Monitoring chapter in this AAR.)

In spring 2020, community transmission of COVID-19 began and the State's response dynamically shifted into its second phase. In March 2020, with over 800 COVID-19 cases, the Governor declared a State of Emergency, elevating the response to the second-highest level (and, later, the highest level) at the State Operations Center (SOC). The pandemic's unprecedented size and scope necessitated the leadership from the Governor's Office (GO), CalHHS, CDPH, EMSA, and Cal OES to engage and set priorities and provide critical decision-making. Consequently, California's initial response shifted to a "whole-of-government" approach. Cal OES requested the physical relocation of selected MHCC and EMSA personnel to the SOC to conduct joint efforts, which diminished CDPH's ability to coordinate its response actions as effectively as they would through the established ESF 8 and MHCC structure. Communication challenges surfaced as decision-makers and operational groups operated separately at the SOC.

Confidential - Low

California's response evolved and, in addition to the traditional roles and responsibilities through the SOC, it established 19 task forces, each with a lead agency and some with co-leads. This contributed to divergent and sometimes discordant communication and decision-making pathways. Many task forces, including the Central Valley Task Force, were highly successful and effective, However, some taskforces involved leadership and staff from multiple agencies and consistent information sharing with CDPH was challenged.

The MHCC also navigated several new challenges, including the shift to remote operations and rapidly expanding the number of staff. It implemented a health and safety program, provided just-in-time training, and developed protocols to track and manage almost 2,000 COVID-19 responders over the course of the response, which included redirected CDPH staff and external consultants. Additionally, the MHCC had to adapt to multiple activations. In addition to COVID-19, it mobilized for other significant incidents over the next three years, including some of the worst wildfires in California's history, heat waves, the national infant formula shortage, and Mpox.

In mid-2021, CDPH leadership began planning for the launch of "ICS 2.0," which marked the third phase. By this time, the size, scope, and duration of the COVID-19 pandemic response began to have a significant impact on CDPH's day-to-day business operations. This prompted an internal reevaluation of CDPH's response structure. CPR and the MHCC led a significant effort to bring all COVID-19 response teams, many of which were operating in siloes, under the MHCC umbrella. "ICS 2.0" was successfully implemented in December 2021/January 2022, which established a more streamlined reporting and response structure, improving coordination and communication.

Following the rollout of ICS 2.0, CDPH's response leadership transitioned from the SOC and many State departments scaled back their involvement in the pandemic response. The restructuring allowed CDPH to bring most response activities in-house. Improved nimbleness and better visibility into response activities marked the success of ICS 2.0. The joint CDPH/Cal OES Situation Report concluded with the end of California's state of emergency on February 28, 2023. On June 30, 2023, CDPH and the MHCC formally deactivated from the COVID-19 response.

Confidential - Low

Timeline and Key Milestones (through June 2023)

	2020
Winter 2019/2020	▶ **December**: MHCC began receiving notifications of a novel coronavirus in China ▶ **January 24**: CDPH activated the MHCC for COVID-19 ▶ **January 26**: First two confirmed COVID-19 cases in CA ▶ **February 26**: First COVID-19 case through community transmission identified in California
Spring 2020	▶ **March and April**: First Surge (Skilled Nursing Facility [SNF] Surge) ▶ **March 4**: Governor declared a state of emergency for COVID-19 ▶ **March**: Some MHCC sections physically relocated to the State Operations Center (SOC) ▶ **March – May**: Governor's COVID-19 task forces created
Summer 2020	▶ **June – August**: Second Surge (Hospital Surge) ▶ **August**: MHCC activated in response to wildfires
Fall 2020	▶ **November**: Beginning of Winter Surge
	2021
Winter 2020/2021	▶ **December – February**: Third Surge (Winter Surge)
Spring 2021	▶ **April – May**: CDPH initiated an internal operational readiness review
Summer 2021	▶ **June**: MHCC Plans section initiated internal conversations around ICS reorganization ▶ **August**: MHCC activated in response to wildfires ▶ **End August**: Beginning of Delta Variant Surge
Fall 2021	▶ **September – November**: Fourth Surge (Delta Variant)
	2022
Winter 2021/2022	▶ **December – January**: New ICS structure ("ICS 2.0") implemented ▶ **December – February**: Fifth Surge (Omicron Surge)
Spring 2022	▶ **February**: CDPH releases the SMARTER Plan (the next phase of California's COVID-19 response)
Summer 2022	▶ **May**: MHCC activated in response to national infant formula shortage ▶ **May**: MHCC activated in response to Mpox ▶ **July**: MHCC deactivated from the infant formula shortage response
Fall 2022	▶ **September**: MHCC activated in response to wildfires ▶ **September**: MHCC conducted second responder rostering survey

DRAFT

	2023
Winter 2022/2023	▶ **February**: Mpox state of emergency ended ▶ **February 28**: California's state of emergency for COVID-19 ended
Spring 2023	▶ **May 11:** Federal state of emergency for COVID-19 ended
Summer 2023	▶ **June 30:** MHCC deactivated from the COVID-19 pandemic response

DRAFT

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. The MHCC evolved to meet unique and changing pandemic needs (including expanding, restructuring, and demobilizing), while responding to multiple emergency activations and leading the unprecedented public health response to COVID-19.

For over three years, CDPH's MHCC was activated in response to the COVID-19 pandemic. During this prolonged activation, it continuously evolved to meet changing pandemic needs and challenges. Early in the response, the MHCC focused on increasing staffing through redirections of CDPH staff and contractors, while some sections relocated to the SOC and others transitioned to remote work. In 2021, as California's response shifted, the MHCC was reorganized and took on a more significant leadership role on the COVID-19 response teams. The following year, it conducted extensive planning and organizational change management to prepare for demobilization and transition of ongoing activities into CDPH programs. Over this entire time, MHCC staff responded to multiple emergency activations and incidents in addition to COVID-19. These included wildfires, the national infant formula shortage, heat wave events, and Mpox. Staff relied upon its multiple incident planning guide to help navigate the challenges of multiple activations. Throughout the COVID-19 response, the MHCC successfully evolved to meet changing expectations and stakeholder needs to respond to the unique scope, duration, and severity of COVID-19.

Finding/Corrective Action: The MHCC should continue to monitor and reassess its emergency response leadership role, as needed, in order to meet stakeholder expectations. *(ID: Operational Organization – 1)*

Finding/Corrective Action: The MHCC should maintain and update its multiple incident planning guide. *(ID: Operational Organization – 2)*

2. The MHCC quickly transitioned to remote operations for the first time in its history.

When some sections of the MHCC were physically relocated to the SOC in early 2020, the MHCC location at CDPH headquarters was left thinly staffed, and the decision was made to let remaining teams work remotely. This was due in part to concerns about COVID-19 transmission, which at the time was unknown. Conversations about the MHCC transitioning to remote operations had been underway for months, but doubts had been raised about how an emergency operations center would be able to function in a fully virtual environment. After numerous deliberations and after having developed remote operations plans, the MHCC was granted permission to shift to a remote operation. Despite the absence of precedent or established procedures for a fully remote workspace, the MHCC's transition to virtual operations was swift and effective, due in part to its robust technology team. The majority of MHCC staff successfully worked remotely from January 2021 until the COVID-19 response deactivation in June 2023. While future activations will likely be in-person, the MHCC now has procedures and structures in place should it need to go remote in the future.

Finding/Corrective Action: The MHCC should implement the structures it developed for the COVID-19 response if it needs to transition to a remote environment in the future. *(ID: Operational Organization – 3)*

3. CDPH successfully reorganized its COVID-19 response within the MHCC, improving information flow, eliminating siloes, and elevating equity.

Beginning mid-2021, CDPH began working on how to restructure its response with the MHCC to better respond to the unique needs posed by the COVID-19 pandemic. The process, spearheaded by the MHCC Plans section, aimed to merge a conventional ICS structure with a hybrid approach, addressing the blurred lines between pandemic response and standard operations. It had become increasingly difficult to separate, distinguish, and prioritize CDPH's continuity of operations from its COVID-19 response work. After analyzing and re-assessing its response structure, CDPH began integrating all CDPH programs involved in the response, eliminating inefficient siloes, and enhancing overall response

Confidential - Low

efficiency. Confronting initial staff hesitation over these impending changes, the MHCC Plans embarked on a culture change initiative, which involved speaking with staff about the importance of following emergency response protocols in addition to their routine work responsibilities. By late 2021 and early 2022, the newly implemented "ICS 2.0" system, which focused on the role of individual teams within a larger, integrated response structure, began to take shape. CDPH reorganized response teams within the MHCC, and elevated equity to a management-level position. The revised structure also incorporated a results-based accountability framework and improved the flow of information and reports from response teams to the MHCC. Many factors contributed to the successful ICS 2.0 transition, including a motivated and communicative leadership team, extensive planning and preparation, and many preparatory conversations.

Finding/Corrective Action: In future responses, CDPH can leverage the hybrid ICS model that it developed for COVID-19. *(ID: Operational Organization – 4)*

Finding/Corrective Action: In future responses, CDPH should establish a management-level health equity function within the MHCC from the start. *(ID: Operational Organization – 5)*

Finding/Corrective Action: In future responses, CDPH should consider creating a management-level continuity of operations position to help non-responders maintain situational awareness of the emergency response, participate in discussions about policies that might impact non-responders, and assist in reprioritizing workloads to meet urgent response ends. *(ID: Operational Organization – 6)*

4. CDPH participated in the Unified Command Group, which provided statewide strategic direction and situational awareness.

CDPH leadership participated in the Unified Command Group (UCG), which was a meeting of State executives and leadership attended by Cabinet Secretaries and the Governor, when necessary, on an established cadence (often daily). These meetings facilitated cross-departmental collaboration, priority setting, and whole- of-government situational awareness in the pandemic response. CDPH received

Confidential - Low

strategic direction from this group, and also supplied crucial data and reports to UCG stakeholders. The focus of CDPH's reports evolved based on response priorities, such as hospitalization surveillance during surges or emphasis on testing, contact tracing, and vaccinations at different phases. The daily meeting cadence and need for detailed data required extensive preparation by CDPH staff. However, the UCG meetings were helpful as they provided direction to CDPH and guided the State's overall response priorities. CDPH leadership regarded UCG positively for its role in maintaining situational awareness, and emphasized the importance of having these high-level coordination meetings and efficient communication channels with the UCG.

Finding/Corrective Action: In future emergency responses CDPH can leverage the successful processes it developed for the UCG to maintain situational awareness, receive strategic direction, and communicate with other response partners. *(ID: Operational Organization – 7)*

5. As part of the Central Valley Task Force, CDPH successfully collaborated to deploy multi-disciplinary teams to hard-hit counties.

When case numbers began to rise in the Central Valley in the summer of 2020, CDPH and its State partners formed the Central Valley Task Force Unified Support Teams (USTs). Led by Cal OES, these teams successfully implemented a comprehensive whole-of-government approach, bringing together government partners and departments. Cal OES coordinated federal, local, and State resources, organizing three support teams focused on seven critical response strategies. The teams, composed of State and local representatives, worked on-site in the Central Valley for three days, tackling region-specific challenges with local partners. Described as a success by many CDPH SMEs and leaders, the teams facilitated unprecedented collaboration among various departments and stakeholders, effectively addressing barriers and community-specific issues. Ultimately this State intervention helped reduce community transmission in the region. The Central Valley USTs represent a model of successful whole-of-government collaboration, connecting experts and stakeholders to address complex challenges.

Finding/Corrective Action: The Central Valley Task Force's Unified Support Teams provide a successful model of multi-disciplinary

Confidential - Low

collaboration that can be leveraged in future emergency responses. *(ID: Operational Organization – 8)*

DRAFT

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.

6. The non-traditional COVID-19 response structure highlighted the need to revisit and update the CA-ESF 8 framework.

Traditionally, in public health and medical emergencies the CA-ESF 8 departments (CDPH, EMSA, and DHCS) may be activated together under the MHCC. During the lengthy COVID-19 activation, in addition to the independent response work within CDPH's and EMSA'S DOCs, other public health emergencies occurred, and consequently the MHCC was activated for various other emergencies, such as Mpox and wildfires. Additionally, because the COVID-19 Pandemic affected all Californians and disproportionately impacted certain populations (e.g. older, aging adults, persons experiencing homelessness, jails and prisons, etc.) many of the other CalHHS departments needed to respond and provide resources and assistance to the populations they serve. And due to whole-of-government approach and non-traditional COVID-19 response structure, many CalHHS departments were reporting directly to Cal OES, which confused the role of the MHCC. CDPH did not have a protocol to determine departmental activation criteria, and what roles different departments should play when activated. The ambiguity over who should be included in emergency activations was exacerbated by the sheer size and scope of the COVID-19 response, which included many new and unconventional response partners and reporting relationships. A key lesson learned, according to SMEs and leaders, is the need for CalHHS to reassess and reevaluate the CA-ESF 8 structure and framework to determine if it should be updated to clarify roles and responsibilities.

Finding/Corrective Action: CalHHS and CA-ESF 8 partners should determine if they want to update the ESF 8 structure and framework to better integrate the unique capabilities of CDPH, EMSA, DHCS and the other CalHHS departments. *(ID: Operational Organization – 9)*

7. The physical relocation of some MHCC sections to the State Operations Center led to miscommunication, siloes, and confusion.

In March 2020, as the size and scope of the COVID-19 response escalated, Cal OES requested key MHCC sections be relocated to the SOC, which was functioning at the central hub of California's response. The Plans and Operations sections (comprised of approximately 50 staff), physically relocated to the SOC. This separation created many challenges, and at one point resulted in having three MHCC directors overseeing different sections. The MHCC staff at the SOC were in an unfamiliar setting with makeshift facilities and working irregular hours. Separated from CDPH leadership and colleagues, the MHCC sections located at the SOC began taking more direction from Cal OES. The structure disrupted communications, created siloes, and led to confusion. While some MHCC staff remained at the SOC for the entirety of the response, operations eventually improved after a single director took over all of the MHCC sections.

Finding/Corrective Action: If possible, in future responses the MHCC should remain at its CDPH headquarters and not be relocated to the SOC or elsewhere. *(ID: Operational Organization – 10)*

Finding/Corrective Action: In future responses, CDPH should immediately appoint a single director to oversee all MHCC sections. *(ID: Operational Organization – 11*

See the related finding, *Resource Requesting – 6,* in the Resource Requesting and Public Health Ordering System (PHOS) chapter in this AAR.

8. The Governor's multiple COVID-19 task forces operated outside of CDPH, and consequently it was challenging for the MHCC to maintain situational awareness of all relevant task force activities.

During the early phase of the pandemic response, Cal OES established multiple Governor's task forces, marking an unprecedented shift in the structure of California's response operations. The creation of core public health and medical functions outside of CDPH was challenging for the MHCC, which typically coordinates all public health and medical emergency responses. The unique configuration of each task force led to operational silos and uneven information sharing, limiting the visibility of the MHCC into vital response areas. Unlike previous activations, the

Confidential - Low

MHCC was unable to maintain situational awareness of all the task forces' activities. In some areas (for instance, resource requesting), the MHCC fielded questions about decisions that it had not been involved in. The proliferation of task forces also precipitated new communication patterns for the MHCC. Instead of communicating up and down the chain with its traditional local and regional partners, the MHCC adapted to communicate laterally with task forces and other State response partners, who were not always familiar with emergency management principles. Often, task forces would communicate to CDPH and State leadership, but this information would not make it to the MHCC. In future responses, MHCC SMEs expressed the need to be included on task force reporting and distribution lists earlier and to better integrate ICS into taskforce reporting and communications. Lastly, given Cal OES's central role in California's emergency response framework, SMEs emphasized the need to conduct ongoing communication and collaboration with Cal OES, and foster this relationship in the MHCC's plans and exercises.

Finding/Corrective Action: CDPH and its State partners should explore and exercise ways to adapt an ICS structure to large, complex emergency responses that require a whole-of-government approach. *(ID: Operational Organization - 12)*

Finding/Corrective Action: In future responses, the MHCC should be included on task force reporting and distribution lists from the start, and these should be regularly maintained and updated. *(ID: Operational Organization – 13)*

Finding/Corrective Action: Going forward, the MHCC should include Cal OES in its communications planning and exercises given Cal OES's central role in any California emergency response. *(ID: Operational Organization – 14)*

9. State departments assumed different roles and responsibilities on the task forces, leading to confusion.

California's 19 task forces faced significant challenges, including the non-standardized roles and responsibilities assigned to various departments. Cal OES, CDPH and the California Emergency Medical Services Authority (EMSA) had different roles and responsibilities on each task force, causing confusion. Co-led task forces proved particularly

Confidential - Low

difficult to navigate, leading to confusion about which department was responsible to conduct specific task force activities. According to CDPH leaders, Cal OES's efforts to apply a traditional emergency management approach to core public health functions led to frustration and misalignment. CDPH response leadership and SMEs recommended that if task forces are created for future emergencies, roles and responsibilities should be clearly defined and communicated for each department. This would include deciding lead agencies and departments, as well as defining each participant's specific activities and responsibilities.

Finding/Corrective Action: For future task forces, CDPH and its partners should establish consistent, clear roles and responsibilities for each participating department or agency. *(ID: Operational Organization – 15)*

10. It was challenging for the MHCC to redirect, roster, and track thousands of COVID-19 responders, including CDPH staff and contractors.

During typical emergency activations, the MHCC is primarily staffed by CPR staff, with temporary assistance from redirected staff from other CDPH centers and programs. However, due to the unprecedented size and scope of the COVID-19 pandemic response, more staff was needed. CDPH began recruiting more departmental volunteers and redirected them for longer periods of time, and, later, began mandatorily redirecting less experienced staff. As the response continued, the MHCC struggled with numerous staffing-related challenges, including finding replacements for staff returning to their home programs and negotiating staff extensions. Once the redirection pool was exhausted, the MHCC turned to contractors (which it had not done before) to fill staffing gaps with specialized skills such as project management. Ultimately, the rapid expansion of the MHCC and related COVID-19 response teams led to difficulties with tracking, rostering, and monitoring all response staff. In 2021 the MHCC initiated a rostering project to help identify and track all staff working on the response and identified almost 2,000 individuals. Although the number of COVID-19 responders had expanded rapidly, the MHCC infrastructure teams who supported the responders with tracking, rostering, and timekeeping services did not.

Confidential - Low

Finding/Corrective Action: In future pandemic responses, the MHCC should begin rostering efforts early in order to track all responders and leverage CDPH's Human Resources Division to help. *(ID: Operational Organization – 16)*

Finding/Corrective Action: In future pandemic responses, the MHCC should expand its infrastructure teams (Plans, Logistics, and Finance) to support the increased administrative workload, and maintain a trained bench of CDPH staff to provide back-up. *(ID: Operational Organization – 17)*

Finding/Corrective Action: CDPH should continue its work to identify and implement a new technology solution for MHCC responder rostering, including accelerating the existing project. *(ID: Operational Organization – 18)*

11. A lack of ownership and investment in the COVID-19 SharePoint sites made it difficult to keep the sites, response rosters, and distribution lists accurate and up to date.

During the COVID-19 response, CDPH and the MHCC heavily relied on MS SharePoint as a collaboration tool and created two sites, one for CDPH and State responders and one for LHJs. However, challenges soon arose with ongoing site management and maintenance. Initially, a contractor created and maintained both sites, but when they left, there was no plan in place for ongoing management of the sites. Temporary management was handled by another contractor until the MHCC Logistics section took over in 2021 and conducted extensive cleanup, removing outdated members. During this time, it was discovered that other response teams had created their own isolated SharePoint sites. Proactive maintenance of the sites lapsed due to a lack of IT infrastructure support and capacity within the Logistics section. Overall, SMEs recognized the need for accurate COVID-19 response rosters, email distribution lists, and online collaboration sites, but the opportunity to align these efforts was missed due to unclear expectations and a lack of technical support. Moving forward, establishing a centralized CDPH SharePoint site with role-based access and increased IT support would help streamline processes, maintain accurate rosters and distribution lists, and avoid technology siloes.

Confidential - Low

Finding/Corrective Action: CDPH should create a SharePoint framework for a large response effort and implement when needed, with a plan to establish clear site ownership and assigning dedicated SharePoint support resources. *(ID: Operational Organization – 19)*

DRAFT

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.

CA-ESF 8 Framework Not Utilized in the COVID-19 Response

- In 2009, in conjunction with the revision of the State Emergency Plan, Cal OES created the CA-ESFs to bring together discipline-specific stakeholders in 18 primary response activities. One of the 18 response activities is CA-ESF 8: Public Health and Medical, dedicated to strengthening collaboration and coordination among public health and medical stakeholders to support state departments and local jurisdictions during emergencies. During an emergency response, State departments and agencies coordinate within the CA-ESF 8 structure to deploy medical teams, operate medical shelters, distribute pharmaceuticals and medical equipment, and perform other response activities.
- CalHHS leads CA-ESF 8 with its 12 Departments and five Offices designated as "core members." CDPH and EMSA are designated as the primary departments responsible for developing the operational framework and the processes associated with CA-ESF 8. CDPH's main responsibilities include public health program administration, infectious disease surveillance, statewide public health policy creation, and healthcare facility emergency preparedness. EMSA leads and coordinates the planning, development, and implementation of local EMS systems. Another important partner is DHCS, which administers California's Medicaid program, Medi-Cal, a public health insurance program which provides health care services for eligible individuals.
- On January 24, 2020, CDPH activated the MHCC in response to COVID-19, and coordinated with other state and federal department partners, including the California Governor's Office of Emergency Services (Cal OES) and the California Emergency Medical Services Agency (EMSA), GovOps, and multiple federal entities, on the repatriation, quarantine, and returning traveler monitoring of citizens returning from overseas. Due to the significant amount of resources being deployed, EMSA activated its own DOC. The two agencies coordinated with Cal OES and multiple federal entities on the repatriation, quarantine, and returning traveler monitoring of U.S. citizens

Confidential - Low

returning from overseas, which is further discussed in the Repatriation, Quarantine, and Returning Traveler Monitoring chapter of this AAR.

- Since CDPH and EMSA were operating their own DOCs, the CA-ESF 8 framework was not utilized. Several SMEs noted that not utilizing the CA-ESF 8 framework contributed to missed opportunities to leverage existing resources. For example, early in the pandemic CDPH and EMSA established Alternative Care Sites (ACSs) to expand California's hospital bed capacity during surges. DHCS was not involved in creating these sites, which led to a missed opportunity to access Medi-Cal funding by associating the sites with existing hospitals. Once the sites had already been built, DHCS was engaged to develop Medi-Cal billing solutions, which was challenging. Additionally, in 2020, the State launched the Acute Hospital Care at Home (AHCAH) Program to address hospital staffing shortages through in-home care options. While successful, the program was terminated in May 2023 due to misalignment between State and federal regulations and a lack of statutory authority to continue beyond the expiration of the State's public health emergency declaration. According to SMEs, these experiences highlight the need for CA-ESF 8 partners to better understand each other's expertise, as well as the importance of collaboration in policy development and program implementation.

MHCC Activated in January 2020 as the CDPH Department Operations Center

- Within CDPH, CPR coordinates overall emergency planning and preparedness efforts. Known as the Emergency Preparedness Office (EPO) until early 2023, CPR has many responsibilities, including overseeing Statewide public health disaster planning, distributing funding to LHJs for disaster planning, operating the California Health Alert Network (CAHAN), and maintaining a real-time 24/7 Duty Officer Program, which receives contacts regarding public health and environmental health concerns from the private, local, state, and federal sources. Additionally, CPR manages and maintains the MHCC, which is located at CDPH headquarters in Sacramento.
- CDPH delegates CPR as the emergency function lead, which operates the MHCC. During emergencies, the MHCC may function as a coordination center for the response activities of CA-ESF 8 stakeholders and has delegated authority from CalHHS for the overall coordination of CalHHS departments responding to the emergency.

Confidential - Low

- The MHCC has four levels of activation, from Level 4 (duty officer status or low-level incidents) to Level 1 (catastrophic). When activated, the MHCC provides support and coordination for the emergency response activities of CDPH, EMSA, and DHCS and to meet the needs of local jurisdictions when public health and medical assistance is requested. The MHCC's other primary duties include developing incident action plans, gathering and integrating information into a consolidated Situation Report (SitRep), and receiving, coordinating, and fulfilling resource requests for public health medical resources and supplies. The MHCC is divided into five main sections: Management, Operations, Finance, Plans, and Logistics. It also includes a Receiving, Staging, and Storage (RSS) Warehouse located in West Sacramento, California. See the Logistics, Distribution, and Warehousing chapter in this AAR for discussion of the RSS.
- The MHCC follows the ICS protocols. ICS is a standardized, documented approach to the command, control, and coordination of emergency responses. ICS enables a coordinated response among various jurisdictions and agencies and establishes common processes for incident-level planning and resource management.
- Beginning in December 2019, the MHCC began receiving notifications of a novel coronavirus in China as part of its duty officer program. On January 24, 2020, CDPH activated the MHCC which was staffed initially by the approximately 45 CPR employees. During January and February 2020, CPR led the coordination of the statewide response to the pandemic.
- In January and February 2020, CDPH coordinated with other state and federal entities departments on the repatriation, quarantine, and returning traveler monitoring of citizens returning from overseas. During this phase, the MHCC also answered phone calls and emails from the public and LHJs prior to establishing the COVID-19 public call center in March 2020. CDPH epidemiologists and researchers in the Coronavirus Science Branch, whose staff was drawn mainly from CDPH's Center for Infectious Diseases (CID), tracked cases and reported into the MHCC.
- However, as community transmission began, the response dynamic—and the MHCC's role—shifted in March 2020 due to the pandemic's unprecedented size and scope. On March 4, 2020, the Governor declared a State of Emergency in California when there were over 800 cases of COVID-19. That same week, the Governor activated the SOC in Mather, California to its

Confidential - Low

second-highest level to support federal, state, and local emergency managers, public health officials, and first responders. With these changes, California's response shifted from being mainly CDPH-led to a "whole-of-government response," and higher-level governmental agencies and entities (including CalHHS, the Governor's Office, and Cal OES) assumed greater involvement and oversight over response activities.

Some MHCC Sections Deployed to Cal OES State Operations Center

- In March 2020, as Cal OES became more involved in the response, CDPH was asked to physically relocate the MHCC from its headquarters to the SOC. CDPH initially resisted this request for various reasons, including staff reluctance to be in such close quarters with others at the SOC during a time when much was unknown about COVID-19. However, in spring 2020 the Plans section and Operations section of the MHCC relocated to the SOC. These two teams totaled approximately 50 staff. The remaining MHCC sections remained at CDPH headquarters. The physical relocation of part of the MHCC was unprecedented.
- This separation proved to be challenging and disruptive for many reasons, as it created silos and made information-sharing difficult. At one point, the MHCC had three different directors instead of a single director. One director remained at the original MHCC offices to oversee the Logistics section and the Finance section, while two directors went to the SOC, one devoted to the Plans section and the other to the Operations section. According to one SME it "didn't make any logistical sense. Everyone was just doing a separate set of objectives." At the SOC, the MHCC staff were separated from their other team members, CDPH leadership, and from their usual technology and support. They were set up in a room that was not on the SOC floor. While CDPH leadership was at the SOC, they were in different rooms. Often, the Governor and his team were at the SOC, creating a unique operating environment.
- Within the SOC, executive decision-makers met "upstairs" while the teams who were implementing the decisions were located "downstairs." Decisions and information did not always flow downstairs to the operation groups, revealing how challenging it was to connect executive-level policy decisions with the teams responsible for executing them. According to one leader, while this disconnect is common in emergencies, it was even more pronounced during the COVID-19 response. As the leader noted, one of the

Confidential - Low

ongoing challenges and lessons learned was that "you can't have a whole unified response if everyone's not operating under the same information."

- Eventually, a single director began supporting all MHCC sections and staff, including those working at the SOC, at the MHCC, and remotely. In the future, CDPH SMEs stressed the importance of maintaining a single director and maintaining the MHCC at its original location.

Size and Complexity of the COVID-19 Emergency Response Triggered Creation of an Unprecedented Number of Task Forces

- In Spring 2020, the Governor's Office and Cal OES established multiple task forces each with their own staffing, reporting, and leadership structures. Ultimately, 19 different task forces were created (which are discussed in further detail below). It was nearly impossible for an overarching leadership unit to manage and coordinate all 19 task forces. In normal emergency responses, Cal OES would act as the coordinating body to manage all Statewide ESFs, and the MHCC would report on the public health and medical function to Cal OES. But due to the sheer size of the COVID-response, "it would have been impossible to manage" in this traditional way, one SME noted. Consequently, the response was no longer following a traditional ICS structure. The individual response teams and task forces were doing their own planning. As one leader noted, "it wasn't in one cohesive ICS structure—we had leaders of subject matter areas reporting to other leaders."
- The task forces lacked standardized roles and responsibilities, according to CDPH SMEs. While all task forces were formed by Cal OES, the roles and responsibilities held by Cal OES, CDPH, EMSA, and other departments varied on each task force. As one leader noted, "sometimes they (Cal OES) were in the front seat, sometimes we were side by side – it was not a standard approach and not always clear who was leading what." For instance, Cal OES led the Logistics and Commodities, Enforcement, and Central Valley task forces, which were effective, according to SMEs. (The Central Valley Task Force is discussed in greater detail below.) CDPH led the Vaccine Task Force. However, it was difficult to navigate the jointly-led task forces, such as the Medical Surge and Testing task forces, as it was not clear which state organization would specifically lead and conduct the numerous task force functions, resulting in confusion.

Confidential - Low

- According to CDPH leaders and SMEs, in co-leadership situations Cal OES "wanted to institute 'command and control' processes for a more traditional emergency," but these processes did not always align with the unique public health needs posed by COVID-19. In future emergencies that require a whole-of-government response and/or the establishment of multiple task forces, CDPH leaders and SMEs recommended that clear roles and responsibilities for each task force and department be instituted. This would include identifying who was the lead department or agency and the activities this entailed. As one leader noted, this would include answering the question "what does it really mean to be the lead?"
- CDPH was a member on all task forces, but its role varied depending on the functional area. For instance, Cal OES led the Logistics and Commodities Task Force, whereas CDPH assumed greater roles in the Testing Task Force, the Vaccine Task Force, and the Medical Surge Task Force. EMSA and CDPH played significant roles in the Medical Surge Task Force. "Everything was an urgent need and every sector had a problem to solve," one SME explained, "so they tried chunking the response into different task forces to solve problems within the functional groups." As a result, core public health functions were conducted outside of CDPH, with no relationship to the MHCC.
- Consequently, the MHCC lost visibility into the work being done by the various task forces, which did not report to the MHCC or to CDPH. This created operational and communication challenges for the MHCC and CDPH leadership. For example, in early 2020, Cal OES and the Logistics and Commodities Task Force took the lead to ordering PPE and testing supplies. Consequently, CDPH was "mostly blind" on this specific task force, according to one SME. This was challenging because one of the MHCC's key functions was to manage resource requests from local and regional jurisdictions. When the MHCC received questions about the status of resources, it often could not answer them because it lacked visibility into ordering decisions. Ultimately, "it would have been really useful for the MHCC to have access to what the task forces were working on," one SME noted. CDPH assumed a leadership role on the Vaccine Task Force, and consequently information-sharing with the MHCC was much better for vaccination activities.
- Cal OES was the centralized entity responsible for monitoring all task force activity. However, while task force leaders would share information with

CDPH leadership, it was not sent to a standardized, centralized process within CDPH (e.g., the MHCC). Consequently, the information did not reach other response partners, since CDPH leadership did not have the bandwidth to filter and share information coming in from various task forces. According to one SME, "information that would be going directly to leadership would get lost." Ultimately, CDPH was often the one interacting directly with LHJs and other local stakeholders, who were receiving different, conflicting, and sometimes outdated information from other task forces and response partners. As the response continued, communication pathways improved to give CDPH and the MHCC better insight into the activities of each task force.

- With the introduction of so many new response partners, the MHCC's role shifted. Instead of working primarily with its historical stakeholders—LHJs, MHOACs, and RDMHSs— the MHCC adjusted to work laterally with other state departments, programs, and task forces to coordinate resources and information. The proliferation of task forces stood up outside of CDPH "put us on a totally different course," according to one SME. Eventually, in late 2021 and early 2022, some functions and response areas that had been led by CalHHS and Cal OES were transitioned back to CDPH.
- For further discussion of the Testing Task Force, see the Testing chapter in this AAR. For further discussion of the Vaccine Task Force, see the Vaccines chapter in this AAR. For further discussion of the Logistics and Commodities Task Force, see the Medical Surge chapter and the Logistics, Distribution, and Warehousing chapter in this AAR.
- For a discussion of coordination with other State departments, see the Policy Development and Guidance chapter in this AAR.
- For further discussion of resource requesting, see the Resource Requesting and Public Health Ordering System chapter in this AAR.

CDPH Leadership Participated in the Unified Command Group

- At the SOC, CDPH response leadership participated in the Unified Command Group (UCG), which was a high-level meeting of executives and leadership from all State agencies and departments participating in the pandemic response. This daily meeting was run by Cal OES and attended by Cabinet Secretaries and sometimes the Governor. During these meetings, agency and department leaders reported out on progress, next steps, issues, and challenges, with the goal of maintaining situational awareness for all

partners. As one leader noted, "sharing was critical because we had to work across lines." For example, CDPH would report on the public health and medical response, while the California Department of Industrial Relations, Division of Occupational Safety and Health (Cal/OSHA) and the California Employment Development Department (EDD) provided information on issues affecting the private sector and California's businesses.

- CDPH reported key data used to inform many UCG decisions. CDPH devoted significant time preparing for these daily meetings to obtain and provide data at the right level of detail so it could be meaningful to UCG stakeholders. Staff worked nights and weekends to compile the daily reports. CDPH and CalHHS held early morning pre-meetings to review the data and prepare concise talking points on objectives, outcomes, and trends. CDPH leadership emphasized the effort and importance of preparing for these meetings. As one leader noted, "it was a lot of work to get ready and be prepared."
- During the early phase of the response, CDPH provided very detailed data on disease rates. However, CDPH's reports to the UCG evolved over time depending on response priorities. For instance, during surges the focus was on hospitalization surveillance. At other times in the response, testing, contact tracing, and/or vaccinations were reported on. When priorities shifted, different stakeholders joined the UCG meetings to coordinate. As one leader noted, "the agenda morphed, and there were so many programs and initiatives." Another noted that "the cadence changed throughout," with the UCG sometimes meeting twice daily.
- CDPH leadership also received strategic direction from the UCG to share with the CDPH response teams. Confidential or sensitive information could not be readily disseminated, requiring the CDPH UCG team to develop separate communication channels. However, leadership described this as generally successful and emphasized the importance of having efficient and timely communications pathways, as well as the ability for CDPH to respond quickly to requests for information and reports.
- Ultimately, CDPH leadership noted that "UCG was extremely positive" and it was helpful to have a routine meeting so that all State stakeholders could stay up-to-date on the breadth of California's response. At a certain point, the UCG's in-person meetings transitioned smoothly to virtual meetings. When

Confidential - Low

the State of California scaled down its response in 2021, CDPH absorbed many response functions and the UCG meetings were discontinued.

Central Valley Task Force Provided Unified Support Teams

- In the summer of 2020, many of the counties in the Central Valley (including Madera, Stanislaus, San Joaquin, Fresno, Kings, Kern, Tulare, and Merced County) were experiencing high case rates and hospitalizations. In response, the State formed the Central Valley Task Force Unified Support Teams (USTs), led by Cal OES, to identify strategies for this region using an "all of government" approach. Cal OES developed a Regional Action Plan with an organizational chart that outlined team members, team leads, and contact information.
- Cal OES led the coordination of federal partners and organized diverse State departments into three support teams structured around seven response strategies: agricultural workers; public health resources; wrap-around services including behavioral health and social services; disease investigation and contact tracing; public education, risk communication, and adherence to public health guidelines; schools; and compliance and enforcement. Each response strategy included targets, action items, and objectives. The multi-disciplinary support teams then traveled in August to the Central Valley for three days to work with local agencies to address their region-specific problems. As one SME described it, "It was concerted effort to really get information on what the barriers were and what was happening on the ground."
- Many SMEs described the Central Valley USTs as "a huge success," as they "brought everyone together that wouldn't normally work together." One leader noted the problems faced by Central Valley "were bigger than CDPH" and involved other departments that CDPH does not normally work with, such as the California Department of Food and Agriculture (CDFA) and the California Department of Aging (CDA). Another leader credited Cal OES with bringing together these departments, noting that "OES brought everyone to the table" in a way "that only OES can."
- The support teams included State representatives from CDPH, Cal OES, EMSA, Cal/OSHA, CDFA, CDA, the California Department of Health Care Access and Information (HCAI), the California Department of Health Care Services (DHCS), the California Department of Social Services (CDSS), and the

Confidential - Low

Agricultural Labor Relations Board. The teams also included local and regional representatives. Cal OES also coordinated federal resources, especially testing resources deployed to the Central Valley. In this coordinating role, Cal OES helped prevent the duplication of efforts and elevated local concerns to the federal level.

- Ultimately, the Central Valley USTs "really made a difference in community transmission," according to one leader. Another noted that the initiative was a successful example of "how we've been able to connect all of the experts and the players" under a whole-of-government approach.
- For a discussion of specific task forces, see the relevant chapters in this AAR (e.g., see the Testing chapter for discussion of the Testing Task Force, the Vaccines chapter for discussion of the Vaccine Task Force, etc.).

MHCC Transitioned from In-Person to Remote Work

- When the MHCC's Plans and Operations section deployed to the SOC, very few staff remained in the MHCC at CDPH headquarters. At this point in the pandemic, very little was known about how COVID-19 spread and there was concern about staff safety. Cal HR quickly allowed each department to establish its own telework policy. At CDPH, discussions were already underway about the possibility of teleworking. However, there was uncertainty about whether an emergency operations center could function successfully in an entirely remote environment. When it came to operating a virtual MHCC, "we didn't see that coming and we didn't plan for it," according to one leader.
- Eventually, the MHCC received approval to transition to a remote operation. It was a "challenge to get to that point, as no one could envision an emergency operations center running remotely," according to one leader. However, even though this scenario had never been practiced before and there were no procedures for fully remote work, transitioning the MHCC to virtual operations quickly became a major success. The operations center swiftly transitioned into remote mode, enabled in part by its responsive technology team.
- When MHCC staff transitioned from the SOC and worked remotely, one member of each section was always present at CDPH. CDPH rotated on-site staff to avoid overburdening the same individuals. Some MHCC staff, including those who worked at the SOC and at the State warehouses, were

Confidential - Low

in-person throughout the entire pandemic response. However, the majority of MHCC staff worked remotely until the MHCC's demobilization for COVID-19 on June 30, 2023.

- In future activations, the MHCC will be in person, unless the circumstances necessitate a remote environment. Should the MHCC need to transition to remote operations in the future, it can draw on the successful structures, plans, and procedures that it implemented during the COVID-19 response.

Redirected CDPH Staff and Contractors Helped Staff the MHCC and COVID-19 Response Teams

- Prior to the COVID-19 response, during typical emergency activations the entire MHCC response staff would be drawn primarily from CPR and a handful of other CDPH volunteers. However, it quickly became clear that more staff would be needed, so CPR began recruiting volunteers from across CDPH to staff the MHCC and some of the COVID-19 task forces. This was the first of many staffing pools that the MHCC would draw on. The voluntary "redirects" needed approval from their home programs but generally had applicable experience, since some of them had served on incident response teams in the past. As the response continued beyond six months, their prolonged redirection began to negatively impact their home CDPH centers and programs, who requested that staff return. At a certain point, given the shortage of voluntarily redirected CDPH staff, it was necessary to mandatorily redirect staff from across CDPH who had no prior experience and needed just-in-time training. Other challenges included continually negotiating extensions, finding replacements for ill-suited staff, and identifying redirects who could work in-person. As one leader noted, "it's been a significant battle to get the right staff at the right time."
- Once the MHCC had exhausted the redirect staffing pool, it began using contractors. According to one leader, this was a "new concept" for CDPH that enabled it to fill staffing gaps and augment its teams with specialized skillsets, such as project managers. CDPH established a multi-pronged approach. This included engaging contractors from the private sector, using existing contracts to address longer-term needs, hiring retired annuitants, and conducting a significant amount of "emergency hires." While these contractor pools helped augment the MHCC and other response teams, they also had varying levels of emergency management expertise, and some were working multiple activations. Many also received just-in-time

Confidential - Low

training but not full orientation, according to SMEs. Eventually, dedicated contractors were hired to support the MHCC, which offered a longer-term solution.

- During this early phase, the MHCC experienced significant growing pains due to its rapid expansion. Initially, there were no rostering and tracking mechanisms. "We were just so focused on growing, we lost track of everyone working in the response," one SME noted. There were teams of people working on important response activities that the MHCC Management Section was not aware of. CDPH managed almost 2,000 COVID-19 responders over the course of the response, which included redirected CDPH staff and external consultants. As discuss further below, it was not until 2021 that CDPH embarked on a concerted rostering effort to help identify and track all staff working on the response. In the future, SMEs noted that it will be important to remain cognizant of the need to track and roster all responders, while recognizing this will not occur immediately. "There will be chaos at the beginning, but we can anticipate the chaos and get methodologies in place as soon as possible," one leader noted.
- While the number of COVID-19 responders managed by the MHCC quickly swelled to over 1,000, the MHCC Plans, Logistics, and Finance sections were not staffed up appropriately to handle this volume. From an administrative standpoint, the initial rapid expansion of the response—as well as the ICS 2.0 effort to integrate response teams within the MHCC, which is discussed below—was overseen by the same small MHCC teams. It was challenging for the Plans, Logistics, and Finance sections to absorb the increased rostering and tracking work. In the words of one SME, "it's still very small teams who are managing to spin a lot of plates at once for thousands of people." Many redirected CDPH staff who initially contributed were further redirected to other response roles, which required MHCC teams to continually re-train new staff as their rotated in and out.
- In the future, it will be important to conduct advance planning around the MHCC's infrastructure teams, which may include increasing their staffing, training, and resources. For instance, maintaining a trained bench of CDPH staff would help alleviate the burden on CPR staff and enable redirected staff to fill some of the support roles in the Plans, Logistics, and Finance sections.

Confidential - Low

CDPH Reorganized the MHCC and COVID-19 Response Teams into a New ICS Structure

- The fact that thousands of CDPH staff were activated for the COVID-19 response at any given time started to interfere with continuity of operations and day-to-day, non-emergency business activities that needed to be continued. In mid-2021, new CDPH leadership worked on a new ICS structure that would accommodate both COVID-19 response work and normal business operations, which use different reporting structures. It was a significant challenge to distinguish regular roles from emergency response roles, especially with the pervasive influence of COVID-19 response activities. "Those lines are blurry, since COVID is touching everybody's work all the time now," one SME noted. However, it was still critical to identify those engaged solely in continuity of operations for a more organized and structured approach between regular operations and emergency response. For teams who worked in continuity of operations there was a need to have more situational awareness of CDPH's response work, including how changing policies might impact them and how to reprioritize workloads to meet urgent response needs.
- This reorganization would bring all of the various COVID-19 response teams under the MHCC organizational umbrella as part of a large, comprehensive ICS structure. CDPH began to reevaluate the role and focus of the MHCC and one of the first steps was to develop an accurate roster of COVID-19 responders. MHCC Plans staff designed a survey and identified the information needed including the definition of what constituted a COVID-19 "responder." All CDPH employees and contractors who spent more than 10% of their efforts on the COVID-19 response needed to be identified and included on the roster. This helped the MHCC better measure the level of involvement and also capture valuable information on potential cost reimbursement. While the MHCC initially planned to use MS Dynamics for the roster database (which the contact tracing team used successfully for this purpose), this proved too difficult to implement and instead MHCC rosters were managed in Excel.
- During data collection for the rostering surveys, MHCC Plans staff were surprised to find the growing numbers of COVID-19 responders. Initial counts quickly grew from 800 to 1,600, as the team kept identifying "entire response teams of people that we didn't know existed," according to one SME. The

Confidential - Low

MHCC conducted two surveys approximately one year apart and continued to further clean and analyze the data. The rostering surveys were critical to establish a baseline to help guide decisions on how to restructure and reorganize the MHCC and CDPH's COVID-19 response. The MHCC Plans section also created a comprehensive programmatic review, which documented the response's impact on all CDPH programs and centers. This analysis was also an important input into discussions around workload priorities.

- CDPH then hired a consulting firm to conduct an internal operational assessment to help inform the new organizational structure. With limited insight into other response teams, some inefficient siloes emerged with people doing the same work in different sectors. The MHCC Plans section formulated a hybrid organization, which would adapt the traditional ICS structure to the unique needs of the COVID-19 pandemic. Due to its unprecedented size and complexity, the pandemic response had required a "whole-of-program" response that included nearly all CDPH programs and centers.
- In summer and fall 2021, the MHCC Plans section engaged in many internal conversations with stakeholders as part of working through the "murkiness" of consolidation, according to one SME. Culture change was a significant component of this project as there was hesitation amongst staff who were being asked to work in a new way. The biggest challenges related to communications, reporting, and educating staff who were not familiar with emergency management principles. This entailed training staff on why it was critical to follow emergency response reporting structures in addition to their normal, day-to-day reporting channels, and bridging some fundamental "philosophical differences," according to one SME.
- CDPH implemented "ICS 2.0" in December 2021 and January 2022. Within CDPH, the revised ICS structure emphasized the role of individual teams within a larger, integrated response structure and also incorporated a Results-Based Accountability (RBA) framework. To accomplish this, the MHCC Plans team helped COVID-19 Response teams to design their own plans, activities, and metrics, which were organized into standardized ICS forms. Streamlining the information-gathering and reporting process from response teams to the MHCC Plans section helped expedite the MHCC's subsequent reports, which include the joint SitRep that is produced in collaboration with Cal OES.

Confidential - Low

According to SMEs, CDPH's successful ICS 2.0 reorganization was due in large part to a highly motivated, connected, and communicative leadership team, which depended on and supported each other throughout the transition.

- Following the roll-out of ICS 2.0, CDPH response leadership transitioned out of the SOC. However, CDPH maintained staff at the SOC because it was still activated for the COVID-19 response. CDPH staff who continued working in the SOC represented the department, answered questions, and reported key information to the department.
- As other departments such as the California Department of Technology (CDT), the California Government Operations Agency (GovOps), and non-profit entities scaled back their involvement, CDPH navigated changes associated with bringing many of the State's response activities "in-house." This included determining how to absorb different response teams, including the Testing Task Force (TTF), a particularly large team. Unlike other task forces, the TTF had been a public-private partnership co-led by CDPH and Blue Shield of California. However, once CDPH assumed full leadership of the TTF, it needed to integrate many TTF consultants and contractors.
- It was an "interesting transition" to merge the TTF infrastructure into CDPH's organization, according to one leader. Unlike the Vaccine Task Force, which had been closely tied to CDPH's Immunization Branch (IZB), the TTF had been stood up outside of CDPH and had not been integrated with CDPH's laboratory directors and other laboratory leadership. As the TTF transitioned to CDPH, leadership focused on bridging these gaps by integrating TTF infrastructure with CDPH's laboratory work. While one leader acknowledged that "testing and lab work go hand in hand," it was not easy to "roll back" the TTF and determine how its work should be led and coordinated going forward. For further discussion of the TTF, see the Testing chapter in this AAR.
- As a result of implementing ICS 2.0, CDPH's response became more streamlined, organized, and easier to manage. "We have a better view of things and can be more nimble," one leader noted. Another emphasizing that "for ICS in particular, we're at the best we've been for the whole COVID response." Some challenges remained, including the expectation for CDPH to continue providing the same level of response work with fewer resources. Another challenge included the need to reiterate and communicate the new ICS structure. "It's an ongoing challenge to make sure everyone is super

Confidential - Low

clear on what the roles are," one leader noted. Lastly, leaders noted the need to establish a "feedback loop" to help analyze and synthesize feedback from response partners. Different entities, including CDPH, the Governor's Office, and the Vaccine All 58 campaign, conducted surveys and focus groups throughout the pandemic response, but there was no entity or team responsible for synthesizing the information to summarize successes and lessons learned. "There's a lot of great information, but we don't really have an entity whose role it is to do that synthesis and feedback loop," one leader noted."

- The joint CDPH/Cal OES SitRep was discontinued following the end of California's state of emergency for COVID-19 on February 28, 2023. On June 30, 2023, CDPH and the MHCC formally deactivated from the COVID-19 response.

During COVID-19 the MHCC Responded to Simultaneous Emergency Activations, Including Wildfires, Public Safety Power Shut-offs, Mpox, and Infant Formula Shortage

- During the summer of 2020 California was also confronted by a substantial wildfire season. "All of a sudden we had a gigantic wildfire season upon us," one SME noted, and the State had to pivot and respond to this new emergency while still maintaining its COVID-19 response as the State headed into the Delta surge. Multiple activations put constraints on the MHCC that can lead to delays in response efforts due to competing priorities. Fortunately, in June 2020 the MHCC developed a Multiple Incident Planning document to provide guidance for expanding MHCC operations in response to a new incident, such as wildfires or a public safety power shut-off (PSPS). This plan outlined staffing scenarios for each section and highlighted considerations for incorporating a non-COVID-19 response into the overall MHCC activation.
- This guide helped the MHCC respond to the 2020 and 2021 wildfire seasons by identifying the additional staff and resources needed to support expanded operations. Moreover, wildfires were not the only emergency activation that the MHCC responded to while concurrently responding to COVID-19. Over the three-year period that it was activated in response to COVID-19, in May 2022 the MHCC also responded to the infant formula shortage and Mpox outbreak as well as the heat wave in September 2022, in addition to other minor incidents. As one leader noted, what made these

Confidential - Low

multiple activations so unique was that they occurred against the backdrop of California's ongoing COVID-19 response, which was "all-hands, all-department, and all-State." Despite these challenges, the MHCC successfully navigated these additional emergency activations while continuing to respond to COVID-19 until June 2023.

- For further discussion of these incidents, see the Mpox AAR, the Infant Formula Shortage AAR, and the Heat Event AAR.

CDPH Established COVID-19 Health and Safety Protocols to Protect MHCC and Response Staff

- Prior to March 2020 CDPH and the MHCC lacked robust employee COVID-19 safety protocols. Early in the pandemic response, the MHCC director enlisted National Guard representatives to take temperatures and conduct health screenings for staff working in person at the MHCC. Eventually, CDPH installed plexiglass dividers in the MHCC to support physical distancing. According to one leader, implementing MHCC employee safety protocols was ultimately successful, but it took significant time for them to be embraced and accepted. "It took time to wrap everyone's brain around it, since it was just nothing we've ever dealt with before," one leader noted.
- Beginning March 2020, CDPH implemented the Emergency Responder Health Monitoring and Surveillance (ERHMS), CDC's gold standard framework to protect the health and safety of responders. Using this framework, CDPH expanded the scope and staffing of the MHCC Safety Officer position, including additional positions in the Safety Unit.
- For further discussion of the ERHMS program, MHCC responder health and safety program, CDPH health and safety protocols established for all CDPH employees, and the health and safety guidance that CDPH developed for other State departments, see the Human Resources Administration chapter in this AAR.

MHCC Demobilization Initiated in 2023

- With the end of California's COVID-19 state of emergency on February 28, 2023 and the end of the federal state of emergency on May 11, 2023, CDPH began the process of demobilizing many of its response activities. This involved reassessing the response teams embedded within the MHCC, as well as the broader role and future vision for the MHCC. Prior to COVID-19,

Confidential - Low

the MHCC was seen as a coordination body for emergency response, but this changed with the pandemic as the MHCC became a leadership body. In the word of one SME, previously "it was just a cog in the wheel, now it's a central nervous system needed to keep everything going."

- Historically, the MHCC activated for limited periods of time during emergencies. During the pandemic response, however, a variety of factors (including the MHCC's rapid expansion, its prolonged activation, and its assumption of a leadership role) contributed to the expectation that it is continually operating. "There's an expectation that the MHCC is leaning in, doing more, and always operating," one SME noted. Another SME welcomed the opportunity to rethink the MHCC's traditional role, pointing out that there will always be public health and medical emergencies that the State will need to respond to.
- As part of this effort, CDPH and CPR leadership considered how to transition from the current state, in which COVID-19 response activities were organized within the MHCC, to a future state, in which response activities would be either discontinued, transitioned to CDPH programs, or transferred to other partner organizations. These conversations took place over several months and included many stakeholders and teams. There were many factors to consider, including that some teams would be ready to transition from the MHCC to CDPH programs earlier than others. For instance, staff that that had been redirected from the Immunization Branch (IZB) to work on the COVID-19 Vaccine Task Force were able to transfer back before those staff who were working on more enterprise MHCC functions, such as communications. Planning for demobilization required a shift in thinking, since the MHCC had devoted considerable energy the previous year to integrating and unifying all CDPH COVID-19 response teams and responders under its organizational umbrella.
- Part of the MHCC demobilization required rethinking its activation levels. Historically, there were three levels of activation (low, medium, and high). In 2023, these levels were redefined and a fourth level of activation was added. This new level four, represents the lowest level of activation and defined "duty officer status" as an integral part of the activation hierarchy. This new activation level was designed to make it easier for the MHCC to rapidly scale up to higher levels of activation in future emergencies. In addition, plans are also underway for the creation of a 24/7 "intelligence center" in the Center

Confidential - Low

for Preparedness and Response, which would be connected to the duty officer program and would be tasked to monitor, research, and report on emerging public health issues across the globe that could potentially affect California.

- On June 30, 2023, the MHCC formally deactivated for the COVID-19 response. Its core sections transitioned back to CPR, while components of its Management and Operations sections transitioned to other CDPH programs (both existing and new) and other response partners. Other MHCC functions were slated to continue for a predetermined length.

DRAFT

Equity

This section describes equity considerations specific to this chapter.

- In mid-2021, when CDPH leadership began working on a new ICS structure to reorganize all COVID-19 response teams underneath the MHCC umbrella, many discussions were held about where equity would fit in. Up to that point, different response teams had addressed equity in different ways, depending on their individual workstreams. For instance, equity was a major component of the Vaccine Task Force and the Testing Task Force. However, during the discussions about ICS reorganization, CDPH determined that a higher-level equity function should be added to MHCC's Management Section (also known as the "command level"). Previously, this type of equity role had not been included in the MHCC's organization chart.
- The management-level equity position reflected the importance of incorporating equity throughout all COVID-19 response functions. CDPH formally elevated equity to the management level in the new MHCC structure. The new MHCC equity function was led by CDPH's Office of Health Equity and was tasked with supporting the MHCC director and CDPH leadership in developing equity metrics, targets for reaching vulnerable populations, and ensuring that all response operations considered equity.
- At the same time, CDPH maintained the expectation that all COVID-19 response teams and units were incorporating equity and are reporting their equity activities and metrics to the MHCC. Every group had an equity component that was incorporated within its objectives, although the applicability varied by response team. According to one SME, there are ongoing discussions about whether to focus on equity at the enterprise level and coordinate equity efforts across the entire response or to embed equity into individual response teams. "I think we're doing it both ways now," another SME noted, and added that it was needed to stay focused on equity.

DRAFT

Confidential - Low

Data and Technology

This section describes data and technology specific to this chapter.

- Prior to the pandemic, CalHHS and CDPH had started to create the CalHHS All-Hazards Dashboard, which combined several data pipelines into a single visual dashboard. The dashboard was expanded and completed during the pandemic. The dashboard provided CalHHS departments with the ability to identify facilities that could be impacted by various disasters and emergency events. Using GIS technology, the dashboard displays a Statewide map that is populated with various emergency events (e.g., fires, earthquakes, heat/cold events) and allows users to filter and visualize facilities that may potentially be impacted. The All-Hazards dashboard is populated with data supplied by all CalHHS departments and includes data on thousands of State-licensed and State-managed facilities.
- While the dashboard was a successful step towards more sophisticated real time data visualization, SMEs felt that the dashboard is underutilized. "It feels like we built this tool that nobody knows about or uses," one leader said. Departments continue to submit data to the dashboard, but also continue to receive questions about the same data via email. SMEs identified an opportunity for continued training, education, and communications to improve the dashboard's utilization.
- CDPH and the MHCC relied heavily on SharePoint as a collaboration tool for the COVID-19 response. In 2020, CDPH created two main COVID-19 response SharePoint sites: one for State staff and one for LHJs. Initially, a single contractor created and maintained these two sites, but when this contractor left it exposed the fact that there was no plan in place for ongoing site management and maintenance. Another contractor temporarily took over SharePoint management, until the MHCC Logistics section inherited the SharePoint sites in 2021 as part of the broader reorganization and rostering efforts. The MHCC Logistics section conducted extensive site clean-up, including editing access rights and removing those who were no longer on the response. During this process, it was discovered that other COVID-19 response teams, including the contact tracing team, had established their own SharePoint sites without knowledge of the main COVID-19 response site.
- Following this clean-up, maintenance of the SharePoint sites lapsed again. This was partially due to the Logistics section' lack of IT infrastructure support,

Confidential - Low

as well as a lack of capacity. As State and LHJ COVID-19 responders transitioned off and on the response, they would be added to the appropriate SharePoint, but not to the email distribution list of all COVID-19 responders. According to SMEs, the need to have an accurate roster, accurate email distribution lists, and accurate SharePoint sites are related and these efforts could have been aligned. There was a missed opportunity to centralize these functions and take advantage of automatic update functionality (so that changes made to a central distribution list would be populated to the roster and to SharePoint).

- In the future, SMEs spoke of the need for CDPH to establish a centralized, overarching SharePoint (or similar) site that could be broken down into tiers or teams using role-based access, rather than re-establishing new sites for new emergency activations or workstreams. This would require more active, ongoing involvement of technical experts from CDPH's Information Technology Services Division (ITSD) as well as program staff.
- Additionally, while SharePoint made it easier to collect and store information from a large number of people, granting access permissions to each individual became a full-time job for one person. Managing access rights to CDPH's SharePoint was further complicated by the fact that SharePoint does not easily facilitate collaboration outside of CDPH. When external partners request access to CDPH SharePoint sites, information security and privacy was considered before granting them access. Information security policies vary across organizations, and sometimes granting access to external response partners "put us in a gray area" when it came to information technology policies, according to one SME.
- An additional technology challenge related to CDPH's need to track COVID-19 responders over the course of an extraordinarily long response. During prior emergency responses, the MHCC was primarily responsible for tracking staff assigned to the MHCC itself as response personnel. However, during the COVID-19 pandemic, thousands of CDPH staff were directed to various response teams outside of the MHCC. The MHCC was tasked with tracking these CDPH staff and contractors working on anything COVID-19-related, yet it lacked the necessary tools or process flows to accommodate this significant increase in workload.
- The MHCC explored ways to leverage the MS Dynamics-based rostering system used successfully by the contact tracing team. After attempts to

Confidential - Low

standardize data and modify the system, it proved too difficult and costly to incorporate two different datasets into the same system. Consequently, the MHCC relied on more manual tools (Excel and SharePoint) to manage the roster of COVID-19 responders.

- In the future, SMEs expressed the need for a technology solution that would enable the MHCC to track response staff based on availability and skillset. Other desired functionalities include scheduling and timekeeping and approval. In fact, CDPH's Human Resources Division (HRD) has existing processes and systems for most of these functions. For any future large-scale emergency response involving thousands of responders, SMEs felt that HRD should be heavily involved in responder rostering and tracking, since the MHCC is best equipped to track a smaller number of responders (e.g., less than 100) currently.

DRAFT

Communications

This section describes communications specific to this chapter.

Internal

- During the first year of the COVID-19 response, MHCC SMEs indicated that information-sharing and communication was challenging. This was due to many factors, including the sheer size and scope of the response, which introduced many new response partners, task forces, and teams as part of the whole-of-government response. Not all of these new partners, task forces, and response teams had experience with emergency management or ICS principles, which made information-sharing and communication difficult. The whole-of-government response structure made it difficult to share information across teams and was not resolved until CDPH's ICS reorganization in late 2021 and early 2022.
- The MHCC also struggled to obtain information from CDPH programs about staff deployments. Initially, there was a lack of accurate reporting, rostering, and tracking of CDPH redirected staff. Only after the MHCC initiated its significant rostering surveys in 2021 did CDPH obtain a more comprehensive status of all its COVID-19 responders.
- In June 2021, CDPH held a COVID-19 Recognition Event to highlight and recognize the contributions of CDPH response teams. From then on, CDPH initiated more regular "All-Hands" meetings, which were designed to share information with and appreciation for all CDPH COVID-19 responders. These meetings, which were supported by the MHCC, occurred approximately every six to nine months until the deactivation of the MHCC for COVID-19 in June 2023.

COVID-19 Task Forces

- Historically, during emergency activations the MHCC usually communicates up and down its established chain with its local and regional partners—LHJs, MHOACs, and RDMHSs. However, the unique size and scope of the COVID-19 pandemic drastically changed these communication channels. As discussed earlier in the Analysis of Activities, the Governor's task forces outside of CDPH changed the MHCC's communications and information-sharing patterns in new, challenging ways. Some decisions between State leadership, the Governor's Office, and Cal OES did not trickle down to the MHCC. The

Confidential - Low

MHCC had to develop new communication channels to obtain information from these task forces and other State agencies and departments working on the COVID-19 response. Information siloes still developed across task forces and "we just didn't get a lot of the information," one SME noted.

- According to SMEs, information sharing would have improved if the MHCC had been included in distribution lists for the various task forces and response teams earlier in the response. In the future, SMEs recommended the MHCC be added to these lists as early as possible.
- Overall, MHCC staff indicated a need for ongoing coordination and communication with Cal OES. CDPH wants to better incorporate Cal OES into its plans and exercises to increase bi-directional communications.

CA-ESF 8 Partners

- SMEs noted that communication between CDPH, EMSA, and DHCS was generally successful. According to one CDPH SME, "the close relationship between CDPH and EMSA" went well and made it easy to know the correct individuals to contact. Similarly, an EMSA SME noted that "in general, we worked great with our CDPH partners." A DHCS SME indicated that they "really liked how much communication was provided to DHCS," especially as the department established its own internal emergency team. SMEs emphasized that all three departments are growing and that it would be beneficial after the pandemic response to regroup and learn more about each other's scopes and capabilities.
- CA-ESF 8 partners reported a lack of standardized reporting processes, leading to time-consuming and duplicative processes. A recurring issue noted by SMEs was the ad-hoc requests for reports by various executive teams, leading to significant time spent tailoring reports. According to one leader, teams were "spinning trying to pull all these reports together." This approach not only consumed significant staff resources but also resulted in multiple report versions generated by different teams. The main goal of these reports was to deliver actionable insights; however, this became challenging as each report had to be customized to specific stakeholders. This could have been alleviated if the MHCC Planning Section had been overseeing the publication of all written reports. For future activations, SMEs emphasized the need for a unified, standardized reporting process, overseen by the MHCC Planning Section, to enhance overall effectiveness.

Confidential - Low

DRAFT

Situation Reports

- CDPH produced various situation reports throughout the response. These included the joint CDPH-Cal OES Situation Report (SitRep). Cal OES was the official owner of this Statewide report and determined its format. Within CDPH, the MHCC Plans section collected, compiled, and submitted information for inclusion in the report every week. The MHCC Plans section would email Requests for Information (RFIs) to CDPH response teams or pull information from other weekly reports that teams were producing. Once the Plans section had consolidated all of the updated information and sent it to Cal OES, who then incorporated it into the Statewide SitRep. In the beginning of the response, the joint SitRep was published nightly, seven days per week.
- To accommodate this schedule, MHCC staff responsible for the joint SitRep adjusted their schedules to work evenings and overnights (when necessary) to meet the needs of this unique reporting situation. As reporting cadences were adjusted, fewer late nights were required, but overall, the production of the SitRep required flexibility and a wiliness to adjust to the unpredictable schedule. Over time, the reporting cadence was reduced to five days per week, twice per week, and then once weekly until it was discontinued in June 2023.
- CDPH also created additional SitReps for its leadership, LHJs, response teams, and other partners. As opposed to the stable format of the Cal OES SitRep, these additional SitReps were constantly evolving in format, level of detail, audience, and cadence. At a certain point, the CID was producing a nightly epidemiology report, which was turned into a SitRep and distributed to CDPH, CalHHS, and the Governor's Office daily. Over time, this report was reduced to three and then one time per week. As the MHCC was activated for different emergencies, such as Mpox, there were attempts to consolidate SitReps for different emergencies into a single report. In general, the SitReps that CDPH produced for non-Cal OES entities were constantly evolving and changing.
- For discussion of COVID-19 reporting, see the Data and Reporting chapter in this AAR.

Major MHCC Calls

- The MHCC director, sections, and staff participated in many COVID-19 standing coordination calls and meetings. While the specific calls evolved

Confidential - Low

over the course of the pandemic, the MHCC generally participated in at least five to six regularly scheduled meetings every weekday, in addition to ad hoc meetings. For a majority of the response, MHCC sections met daily. On a weekly basis, MHCC leadership and the Plans section participated in an advanced planning coordination call with the Richmond Campus Coordination Center (RCCC). Other weekly calls included a weekly internal cost summary meeting, weekly briefings for CDPH response leadership and the Director's Office, and weekly meetings with RDMHSs. MHCC staff also attended weekly All-Facilities meetings, LHJ COVID-19 Vaccine Planning meetings, and LHJ general calls. When the MHCC was activated for other emergencies (such as Mpox or wildfires), additional calls and communications were added.

- Once a month, the MHCC participated in Tribal coordination calls. The MHCC also coordinated and met with various COVID-19 task forces as needs arose, including the Vaccine Task Force, Therapeutics Task Force, Medical Surge Task Force, Logistics and Commodities Task Force, and the Border Response Task Force.
- MHCC staff also presented as needed to various groups about the CDPH response, its COVID-19 responsibilities, and MHCC functions. These groups included other CDPH programs, other State departments, academic institutions, and professional associations and organizations. The MHCC also participated in federal regional calls twice per week, which included representatives from U.S. Health and Human Services Agency (HHS), CDC, FEMA, and other partner states.
- For a discussion of how the MHCC Operations Section communicated with LHJs, MHOACs, and RDMHSs, see the Resource Requesting and Public Health Ordering System chapter in this AAR.

DRAFT

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	Activate MHCC and scale up staffing resources	• All MHCC sections are adequately staffed to support response operations. • Emergency responders are accurately rostered and tracked.	• Remain cognizant of challenges associated with redirections. • Invest in MHCC infrastructure teams and technology to support expanded operations.	• Operational Organization 1, 12, 13, 14, 16, 17, 18	

DRAFT

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
			• Initiate and maintain rostering efforts early. • Involve HRD in rostering work, especially for large-scale responses.		
Planning, Initial Start-Up, Ongoing Operations	Coordinate and communicate with different response partners	• The MHCC maintains visibility into all public health and medical response work. • The MHCC can navigate its changing role within a larger whole-of-government response.	• Advocate for the MHCC to be included in task force distribution lists as soon as possible. • Acknowledge and anticipate Cal OES' central role in any Statewide emergency. • Adapt to the unique situation reporting conditions, which may require late hours.	• Operational Organization 12, 13, 14	
Planning, Initial Start-up, Ongoing Operations	Revisit ESF 8 Annex and develop a new version to socialize with all	• State public health stakeholders operate within a structure tailored to their	• Include CalHHS in the socialization and training of the updated ESF 8 Annex.	• Operational Organization 9	

Confidential - Low

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
	stakeholders and train on	operational capabilities. • The State's public health and medical emergency response is coordinated and aligned. • ESF 8 leverages existing department capabilities and knowledge. • ESF 8 partners are aware of intersections in scopes of work.	• Ensure that all relevant departments and stakeholders are involved in decision-making. • Determine the roles that departments should play during activations. • Implement standardized activation criteria and procedures. • Create process to share information regarding each departments' scopes. • Consider offering training to other response partners on ESF 8.		
Planning, Initial Start-Up, Ongoing Operations	Maintain updated procedures on transitioning to remote work	• The MHCC can successfully continue is operations as needed during	• The MHCC's general work environment is in person. • Be prepared for changing work	• Operational Organization 3, 10	

DRAFT

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
		different work environments	conditions (e.g., relocation to SOC, telework) that separate MHCC sections and teams from each other and leadership.		
Planning, Initial Start-Up, Ongoing Operations	Prepare for multiple emergency activations	• The MHCC can respond to multiple emergency incidents simultaneously.	• Maintain the multiple incident planning guide.	• Operational Organization 2	
Planning, Initial Start-Up, Ongoing Operations	Maintain an integrated, flexible ICS response structure	• The State can apply a whole-of-government response while maintaining coordination and an adapted ICS structure. • CDPH's response is appropriately structured to meet response work and reporting needs. • The ICS structure can change based on evolving needs.	• Plan for and exercise ways to adapt ICS to large, whole-of-government responses. • Clearly articulate the relationship between emergency response work and continuity of operations work. • Maintain a single MHCC director. • Incorporate equity at the MHCC	• Operational Organization 1, 4, 5, 6, 11	

Confidential - Low

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
			management (command) level. • Communicate any impending changes to affected staff. • Create an MHCC management-level continuity of operations position.		
Planning, Initial Start-up, Ongoing Operations	Establish Unified Command Group (or equivalent) meetings	• Daily executive-level meeting cadence promotes situational awareness and strategic direction for all response partners.	• For a public health emergency, CDPH will play a pivotal role and may be asked to provide significant, detailed data reports. • Anticipate that extensive preparation is necessary for UCG-type meetings. • Develop communication pathways to disseminate information	• Operational Organization 7	

DRAFT

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
			to/from the meeting.		
Planning, Initial Start-Up, Ongoing Operations	Establish and communicate roles and responsibilities for task forces	• Task force participants understand roles and responsibilities, fostering task force success.	• Define each task force participant's specific activities and responsibilities. • For jointly-led task force, it is especially important to clearly establish roles and responsibilities for each of the co-leads.	• Operational Organization 8	
Planning, Initial Start-Up, Ongoing Operations, Demobilization	Establish and maintain collaboration technology tools (e.g., SharePoint)	• State and LHJs responders can access information needed for their response work. • Tools are centralized, supported, and kept accurate and up to date.	• Invest in a centralized CDPH SharePoint or other alternative collaboration tool. • Dedicate IT resources to help manage SharePoint response needs. • Establish ownership and clear expectations regarding	• Organizational Operation 19	

DRAFT

Confidential - Low

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
			management of sites, rosters, and e-mail distribution lists. • Consider changing the MHCC email naming conventions to be based off positions instead of numbers (e.g., MHCCDirector, MHCCPlanning, etc.).		
Demobilization	Plan and conduct for demobilization	• The MHCC successfully continues or transitions its response activities.	• Conduct demobilization planning to determine which activities should be continued or transitioned to other programs, centers, or stakeholders.	• Operational Organization 1	

DRAFT