EMERGENCY PREPAREDNESS

More Needs to Be Done to Improve California's Preparedness for Responding to Infectious Disease Emergencies

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Department of Health Services, Emergency Medical Services Authority, and five local public health department's responses as of November 2005[1]

Audit Highlights . . .

Our review of California's preparedness for responding to an infectious disease emergency revealed the following:

- ☑ *The Emergency Medical Services Authority has not updated two critical plans: the Disaster Medical Response Plan, last issued in 1992, and the Medical Mutual Aid Plan, last issued in 1974.*
- ☑ *The Department of Health Services (Health Services) does not have a tracking process for following up on recommendations identified in postexercise evaluations, known as after-action reports.*
- ☑ *Although Health Services has completed 12 of 14 critical benchmarks it was required to complete by June 2004 for one cooperative agreement, we cannot conclude it completed the other two. In addition, Health Services has been slow in spending the funds for another cooperative agreement.*

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The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits conduct an audit of the State's preparedness to respond to an infectious disease emergency requiring a coordinated response between federal agencies, the Department of Health Services (Health Services), local health agencies, and local infectious disease laboratories. Specifically, the audit committee requested that we (1) evaluate whether Health Services' policies and procedures include clear lines of authority, responsibility, and communication between levels of government for activities such as testing, authorizing vaccinations, and quarantine measures; (2) determine whether Health Services has developed an emergency plan; (3) determine whether California's infectious disease laboratories are integrated appropriately into statewide preparedness planning for infectious disease emergencies; (4) determine if the management practices and resources, including equipment and personnel, at the state health laboratories are sufficient to respond to a public health emergency; and (5) review Health Services' standards for providing oversight to local infectious disease laboratories, and determine whether its oversight practices achieved their intended results.

The audit committee further requested that we evaluate whether a sample of local infectious disease laboratories are operated and managed effectively and efficiently and have the necessary resources to respond to an emergency, including sufficient equipment and personnel with the appropriate level

[1] The five local public health departments are: County of Los Angeles, Department of Health Services (Los Angeles); Sacramento County Department of Health and Human Services, Division of Public Health (Sacramento); County of San Bernardino, Department of Public Health (San Bernardino); Santa Clara County, Public Health Department (Santa Clara); Sutter County, Human Services Department (Sutter).

of experience and training. We also were asked to review the local laboratories' testing procedures for infectious diseases and determine if they meet applicable standards.

☑ *None of the five local public health departments we visited have written procedures for following up on recommendations identified in after-action reports.*

☑ *None of the five local public health departments we visited had fully completed the critical benchmarks for a cooperative agreement by the June 2004 deadline.*

Finding #1: The Emergency Medical Services Authority needs to update two critical plans.

The Emergency Medical Services Authority (Medical Services) has not updated two emergency plans: the *Disaster Medical Response Plan* and the *Medical Mutual Aid Plan*, the latest versions of which are dated 1992 and 1974, respectively. The state emergency plan, issued in 1998, mentions both plans and describes them as "under development." The state emergency plan indicates that state entities would use the two plans to help respond to emergencies caused by factors that include epidemics, infestation, disease, and terrorist acts, therefore, we believe the two plans are critical for California's successful response to infectious disease emergencies. Medical Services agrees that the plans must be updated to ensure that they reflect the State's current policies and account for any changes in roles or responsibilities since they originally were issued. According to the chief of the Medical Services' Disaster Medical Services Division, these plans have not been updated because Medical Services lacks resources and has competing priorities.

We recommended that Medical Services update the *Disaster Medical Response Plan* and the *Medical Mutual Aid Plan* as soon as resources and priorities allow.

Medical Services' Action: Pending.

Medical Services indicated that it is working to update the Disaster Medical Response Plan that will provide a concept of operations for all-hazard response and define the roles and responsibilities of public and private agencies as part of the Standardized Emergency Management System. Medical Services stated that it plans to include a Medical Mutual Aid annex that will address the resource management process to identify, acquire, deploy, and support medical personnel, supplies, equipment, and casualty evacuation systems. According to Medical Services, a draft plan will be available in approximately 90 days and an interim plan will be available by the summer of 2006.

Finding #2: Health Services does not have a tracking method to ensure that it benefits from the lessons it learned.

Health Services could improve its ability to learn from its experiences by developing and implementing a tracking process for following up on the recommendations made in its postexercise evaluations, known as after-action reports. According to guidelines set forth by the U.S. Department of Homeland Security's Office for Domestic Preparedness, after-action reports are tools for providing feedback, and entities should establish a tracking process to ensure that improvements recommended in after-action reports are made. Similarly, the National Fire Protection Association also suggests in its Standard on Disaster/Emergency Management and Business Continuity Programs (2004 edition) that exercise participants establish procedures to ensure that they take corrective action on any deficiency identified in the evaluation process, such as revisions to relevant program plans. An exercise allows the participating entities to become familiar, in a nonemergency setting, with the procedures, facilities, and systems they have for an actual emergency. The resulting after-action reports give these entities an opportunity to identify problems and successes that occurred during the exercise, to take corrective actions, such as revising emergency plans and procedures, and thus benefit from lessons learned from the exercise. Therefore, we believe that tracking the implementation status is a sound practice to ensure that state entities address all relevant recommendations in after-action reports, which can then serve as important tools for increasing overall preparedness levels.

In response to our concerns that Health Services lacked a written policy and procedures for following up on recommendations identified in after-action reports for exercises, the deputy director for public health emergency preparedness provided us on July 14, 2005, with the recently developed policy and procedures. However, our review of the policy found that it does not include a standard format for tracking the implementation of recommendations, such as assigning an individual the responsibility for taking action, the current status of recommendations, and the expected date of completion. Therefore, Health Services still needs to refine its policy further by developing and implementing written tracking procedures to ensure it addresses all relevant recommendations that it identifies in after-action reports. Without a tracking method, Health Services cannot be certain that it takes appropriate and consistent corrective action, such as revising emergency plans, and thus reduces its potential effectiveness to respond to infectious disease emergencies.

We recommended that Health Services develop and implement a tracking method for following up on recommendations identified in after-action reports.

Health Services' Action: Corrective action taken.

Health Services developed and implemented a policy on after-action reporting in response to our draft report in July 2005. This policy and the associated procedures provide a specific tool for tracking recommendations identified in after-action reports.

Finding #3: We cannot conclude that Health Services completed a critical benchmark requiring it to assess its preparedness to respond to infectious disease emergencies.

In the aftermath of the terrorist attacks in September 2001, and the anthrax attacks later that year, two federal agencies—the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA)—offered cooperative agreements to states, local jurisdictions, and hospitals and other health care entities. The cooperative agreements are intended to provide increased funding to improve the nation's preparedness for bioterrorist attacks and other types of emergencies, including those caused by infectious diseases. However, despite making progress toward completing many of the critical benchmarks established in the CDC cooperative agreement with a June 2004 deadline, we cannot conclude as of our review that Health Services completed critical benchmark number 3, which requires the State to assess its emergency preparedness and response capabilities related to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies with a view to facilitating planning and setting implementation priorities. Therefore, California may not be as prepared as it could be to respond to infectious disease emergencies.

According to its deputy director for public health emergency preparedness (Health Services' deputy director), Health Services prepared an assessment as did all local health departments. She also stated that some staff documented parts of their assessment and that Health Services' application for CDC funding in 2004 included references to the assessments. However, she also acknowledged that Health Services did not prepare a single written summary of the assessment it prepared and the assessments prepared by local health departments. Without such a summary and without complete documentation of the assessments, Health Services has not demonstrated to our satisfaction that it has fully completed critical benchmark number 3. Health Services' deputy director also told us that to obtain a more current assessment, Health Services has entered into a contract with the Health Officers' Association of California (HOAC) to be conducted from mid-2005 through December 2006.

We recommended that Health Services should ensure that the contractor performing the current capacity assessment provides a written report that summarizes the results of its data gathering and analyses and contains applicable findings and recommendations.

Health Services' Action: Pending.

Health Services stated that it has contracted with HOAC for an assessment of public health emergency preparedness in 61 local health departments. Health Services indicated that these assessments are to be completed by December 2006 and it is requiring HOAC to provide written reports that summarize the results of the analyses and contain applicable findings and recommendations for improvements.

Finding #4: Local public health departments could do more to address after-action reports.

Local emergency plans, such as the counties' overall emergency operation plans and local public health departments' (local health department) emergency operations and response plans, generally included sufficient guidance for emergency preparedness; however, the plans did not include specific procedures for following up on recommendations identified in after-action reports. When we asked officials of the local health departments, they agreed with our assessment and confirmed that they did not have written procedures for following up on recommendations in after-action reports although Los Angeles County has developed a draft policy.

Moreover, the California Code of Regulations requires state entities to complete after-action reports for declared emergencies within 90 days of the close of the incident. There is no requirement for preparing after-action reports for an exercise or drill as there is for a declared emergency, but we believe that promptly writing after-action reports for exercises is prudent and equally relevant. Waiting longer than 90 days to complete the reports might make it more difficult for the individuals involved in the exercise to recall specific details accurately. Therefore, we expected all participants in the November 2004 exercise hosted by Medical Services to have prepared after-action reports within 90 days to identify any weaknesses in plans and procedures and to take appropriate corrective actions. However, as of July 2005, the after-action report from Los Angeles County's health department was still in draft stage, which is approximately seven months after the exercise. According to the executive director of the county's Bioterrorism Preparedness Program (executive director), the Los Angeles County health department had not yet implemented all the recommendations identified. The executive director stated that it experienced delays in drafting its after-action report because the individuals who participated in the exercise were inexperienced with the formalized after-action report process and completing the surveys and observations needed. She further stated that several drafts were reviewed and resubmitted by its management. However, because the Los Angeles County health department did not complete its after-action report promptly, it did not address all the recommendations as quickly as it could have. Consequently, it is not as prepared as it could be to respond to infectious disease emergencies.

We recommended that local health departments establish written procedures for following up on recommendations identified in after-action reports and that they prepare after-action reports within 90 days of an exercise.

Local Public Health Departments' Actions: Partial corrective action taken.

Generally, four of the five local health departments we visited indicated that they have developed written procedures for following up on recommendations identified in after-action reports and for preparing after-action reports within 90 days of an exercise. Further, in its July 2005 response to our draft report, the fifth public health department—Sutter County—agreed that it did not have a written plan in place to assure the deficiencies reported in after-action reports were mitigated properly and it also indicated that it planned to correct this. However, Sutter County has not provided us with a more recent update indicating whether it has done so.

Finding #5: Not all local public health departments have met the deadline to implement several federal benchmarks.

None of the local health departments we visited had met all 14 of the CDC 2002 critical benchmarks by the required deadline of June 2004. Specifically, Los Angeles and Sacramento counties health departments did not meet the June 2004 deadline, but they report that they have since completed the benchmarks. Further, Sutter and Santa Clara counties did not meet one of the 14 2002 critical benchmarks as of June 2005, and San Bernardino County did not meet three. The purpose of the CDC cooperative agreement is, in part, to upgrade local health departments' preparedness for and response to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. Therefore, by not meeting the critical benchmarks, these jurisdictions may not be as prepared as possible to respond to an infectious disease emergency.

We recommended that local health departments complete the critical benchmarks set by the CDC cooperative agreement as soon as possible.

Local Public Health Departments' Actions: Partial corrective action taken.

As we state above, Los Angeles and Sacramento counties health departments reported that they had completed the critical benchmarks. Additionally, Santa Clara now reports that it has completed its last benchmark while San Bernardino reports completing two of three outstanding benchmarks. Finally, although in its July 2005 response to our draft report, Sutter County indicated that it is working to complete critical benchmarks, it has not provided us with a more recent update.