After Action Report:

Chelan-Douglas Health District's COVID-19 response

January 2020-December 2022

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Acknowledgments

CDHD acknowledges that meeting the various demands of the COVID-19 pandemic could not have been possible without the support and collaboration of community organizations, local government, and health care partners. Public health appreciates and thanks all local, regional, and state partners for working together in response to the COVID-19 pandemic. CDHD is honored to continue to build upon the various relationships established throughout the pandemic and continue to collaborate with each and every partner and community stakeholder moving forward. Thank you for always working together towards a safer and healthier community.

Key Partners*

Aging and Adult Care
Action Health Partners
Ballard Ambulance
CAFE
Cascade Medical Center
Chambers of Commerce
Chelan County Community Action Council
Chelan County Emergency Management
Chelan County Public Utility District
Chelan County Fire Districts
Columbia Valley Community Health
Columbia Safety
Confluence Health
Douglas County Emergency Management
Douglas County Fire Districts
Express Employment Professionals
Fairfield Inn & Suites
Grant County Health District
Kittitas County Public Health Department
Latinx advisory group
Lake Chelan Health
Lifeline Ambulance
Medical Teams International
Motel 6
National Guard
North Central Accountable Community of Health/Thriving Together
North Central Educational Service District
North Central Washington Fire Chiefs Association
North Central Washington Incident Management Team

North Central Washington Libraries
Northwest Incident Management Team
Okanogan County Public Health
Our Valley Our Future
Parque Padrinos
Serve Wenatchee
Tacoma-Pierce Incident Management Team
Town Toyota Center
VillageReach
Washington State Department of Corrections Incident Management Team
Washington State Department of Health
Wenatchee Police Department
Wenatchee Valley College

*We recognize that many partners came together in the COVID-19 response and we are not able to name them all. Thank you to all individuals and groups throughout the region who contributed to the response efforts.

This after-action report (AAR) was made possible through the participation of Chelan-Douglas Health District (CDHD) former and current staff, as well as community and regional partners who played integral roles in the COVID-19 response. Staff and partners contributed time and careful thought to the process, providing insights into the strengths, gaps, and opportunities related to CDHD's response to the COVID-19 pandemic. We appreciate the time they dedicated to complete surveys and/or participate in interviews. This AAR was designed and produced by VillageReach, a 501(c)(3) whose mission is to transform health care delivery to reach everyone. CDHD staff, who served on the Incident Management Team and were part of COVID-19 response operations, offered invaluable context and support as VillageReach planned and conducted the AAR.

Chelan-Douglas Health District Contact

Communications Team
E-mail: communications@cdhd.wa.gov

VillageReach Contact

WA State Health Equity Team
E-mail: info@villagereach.org

Acronyms

AAR	After-Action Review
CDC	Centers for Disease Control and Prevention
CDHD	Chelan-Douglas Health District
CVCH	Columbia Valley Community Health
EMS	Emergency Medical Services
ICS	Incident Command System
IMT	Incident Management Team
I&Q	Isolation and Quarantine
LCCH	Lake Chelan Community Health
LHJ	Local Health Jurisdiction
LTCF	Long-Term Care Facility
MAC	Multi-Agency Coordinated Policy Group
NCW	North Central Washington
PIO	Public Information Officer
PHEPR	Public Health Emergency Preparedness and Response
PPE	Personal Protective Equipment
TTC	Town Toyota Center
DOH	Washington State Department of Health

Executive Summary

Purpose

The purpose of this after-action report is to document lessons learned and identify areas of improvement from Chelan-Douglas Health District's (CDHD) COVID-19 response. The results will be used to identify specific actions to strengthen CDHD's ability to effectively respond to future emergencies.

Background

On January 20, 2020, the first confirmed case of COVID-19 was identified in Washington State. Within a few days, confirmed and suspected cases appeared in North Central Washington. CDHD Administrator, Barry Kling, quickly announced CDHD would be launching an emergency response team.[1] On March 23, 2020 Governor Inslee issued "Stay Home, Stay Healthy" orders, in which Washingtonians were required to stay home unless pursuing an essential activity. The same day, the two-county area had its first confirmed death from COVID-19.[2]

In 2020, the health district's response was focused on contact tracing, providing testing services, setting up an isolation and quarantine facility, providing accurate and up-to-date information to the public, and advising businesses, schools, and other organizations on guidelines intended to reduce the spread. The early days of the response were difficult due to lack of funds and significant staff and leadership turnover. In April 2020, the long-time Health Officer, Dr. Collins, was replaced by new Health Officer Dr. Butler, and in July 2020, CDHD's health administrator and nursing director retired. By August of 2020, CDHD lost additional key staff members and was struggling so significantly that both local health care providers and the Board of Health requested help from the Washington State Department of Health (DOH). In response, DOH set up a new incident command structure for CDHD, appointed a new interim administrator and brought in additional funding.

In January of 2021, a new health administrator was hired and CDHD started using a long-term internal incident management team. The month prior, the Pfizer and Moderna vaccines against COVID-19 received emergency authorization. Thus, much of 2021 and 2022 focused on vaccination, through a mass vaccination site in Wenatchee, mobile vaccination units and health care providers. During 2021 and early 2022, there were two new peaks in cases and hospitalizations due to the Delta variant which peaked in November 2021 and the Omicron variant which peaked in January of 2022. During those times, the response focused on communication with the public, access to testing services, and vaccination. There was also a focus on supporting the health care system's response,

[1] The Wenatchee World, March 2020, "COVID-19 likely to be a 'community-wide outbreak' but most cases won't be deadly"
[2] The Wenatchee World, March 2020, "Resident of Wenatchee senior facility dies of COVID-19"

with an increase in cases spiking demand for health services and the need for hospitalizations. Washington State's COVID-19 state-of-emergency officially ended in October of 2022, and CDHD ended incident command in November 2022. The federal declaration of emergency ended in May of 2023, as did CDHD's declaration of emergency.

Methods

We collected data through surveys, interviews, focus group discussions, and a "hotwash" debrief. Participants were drawn from current and former CDHD staff, community-based organizations, faith-based leaders, education/school representatives, first responders (fire, law enforcement, emergency medical services), long-term care facility staff, health care clinics and hospitals, incident management team members, state agencies (e.g. DOH), leadership from surrounding LHJs, the coroners from both counties, local county/city leadership, businesses, and transportation, and utilities representatives.

CDHD's response was assessed across five main topic areas: internal operations, external operations, partnerships, communications and outreach, and responder health and safety.

Key Findings

We received survey responses from 158 people, interviewed 33 people, conducted five focus groups and conducted one "hotwash" session. The themes from respondents were categorized into the following strengths and areas for improvement:

Strengths

Internal Operations

1. Staff worked well as a supportive team throughout the pandemic
2. CDHD ultimately established an effective IMT with clear roles and responsibilities

External Operations

1. CDHD played a key role in providing access to testing
2. CDHD's work on the mass vaccination site and other vaccination pathways provided communities with consistent access to vaccination
3. CDHD successfully provided PPE to partners
4. CDHD was able to stand up an isolation and quarantine facility

Partnerships

1. CDHD provided strong support to schools
2. CDHD facilitated teamwork and resource sharing across health providers
3. CDHD built and leveraged relationships that helped CDHD serve the community
4. With time, CDHD became a valued and trusted partner in the response

Communications & Outreach

1. CDHD used a variety of methods to reach communities with information

2. CDHD's convening of health providers enabled agencies to put out aligned messages to the community quickly and effectively

Responder Health & Safety

1. CDHD consistently prioritized staff physical safety in terms of COVID exposure

Areas for Improvement

Internal Operations

1. CDHD was understaffed throughout the pandemic and saw high rates of leadership and staff turnover
2. CDHD was unable to successfully develop a consistent cadre of volunteers to support the response efforts
3. Underutilization of preparedness plans and inadequate training of staff contributed to an underperforming IMT and hindered the overall response
4. Fiscal staff turnover and the complexity of COVID funding sources impacted the first phase of the response
5. Decisions and policies were often set at the state level, without enough local decision-making or resources to implement

External Operations

1. CDHD had a difficult time maintaining essential public health services
2. CDHD's approach to contact tracing was inefficient and unsustainable
3. Vaccination appointment scheduling systems were difficult for the public to navigate

Partnerships

1. CDHD was slow to offer leadership, guidance, and organization to partners and the overall response
2. Partners and staff felt attitudes and actions from the Board of Health undermined CDHD's ability to partner and respond effectively early on in the response
3. CDHD had early missteps in partnership opportunities with first responders that impacted effectiveness of the response

Communications & Outreach

1. CDHD was slow to get information to the public
2. There was room to improve communication and outreach to several specific communities, such as elderly, homeless, and people living in rural areas
3. Early on, the needs of the Latinx community were not fully addressed

Responder Health & Safety

1. Staff were overworked, leading to physical and emotional fatigue and burnout
2. Unclear and inconsistently enforced norms and policies regarding uneven workloads across teams had negative impacts on morale
3. Staff felt their morale and well-being concerns were largely overlooked

Conclusion

Overall, CDHD staff and external partners said that CDHD was under-resourced and unprepared to respond to the COVID-19 pandemic and thus their early response was disorganized and ineffective. However, the resounding feedback was that over time, staff and community partners alike were impressed by CDHD's growth and resilience. In 2021 and 2022, CDHD strengthened their response and took an active leadership role in coordinating community-wide efforts, including a strong vaccination effort. CDHD – along with invited external partners – will use the findings to design plans for maintaining the strengths they displayed and addressing the identified areas for improvement.

Background

Purpose

The purpose of this after-action report is to document lessons learned and identify areas of improvement from Chelan-Douglas Health District's (CDHD) COVID-19 response. The results will be used to identify specific actions to strengthen CDHD's ability to effectively respond to future public health emergencies.

Introduction

CDHD, established in 1961, is a multi-county special purpose district governed by the Chelan-Douglas Board of Health. It provides public health services to the residents of Chelan and Douglas Counties. In addition, CDHD receives federal and state funding to provide Public Health Emergency Preparedness and Response (PHEPR) and Epidemiology for the region, including Chelan, Douglas, Okanogan, Grant, and Kittitas Counties.

As a special purpose district, CDHD receives funding for public health activities primarily from Chelan and Douglas counties and the Washington State Department of Health (DOH). While the scope of CDHD's responsibilities are regional, each local health jurisdiction is conducting their own after-action report. This report focuses primarily on the response in Chelan and Douglas Counties during the timeframe of January 25th, 2020 to December 2022.

Historical Context for CDHD's Pandemic Response Capacity

The state and counties made significant investments in local health jurisdictions (LHJ) in the 1980s and 1990s. These investments enabled LHJ's to provide childhood vaccines, communicable disease response, environmental health, public health prevention, education to local communities and other essential public health services. In 2000, Chelan-Douglas Health District had a budget of $3 million, with a workforce of 72 employees. Cuts to public health funding for local public health services over the subsequent 20 years resulted in a stagnant budget and reduction in workforce. In 2020, CDHD had a budget of $3.45 million, that had not kept up with inflation, and only 39 staff.

Starting in 2001, with the reduction of state revenue from the drastic decrease in car tab tax collections, state and local public health saw a sustained reduction in funding for local public health activities. Specifically, in 2008-2012, due to the financial crisis and the recession, reductions were made to environmental health and overall agency funding. This led to a reduction in workforce. Additional key programs in health education, communication, and communicable diseases were cut as a result of the inability to secure local, state, or federal funding.

Decisions were made by Washington State Legislature, with the advent of the Affordable Care Act, for Washington State to divest direct funding to LHJs for immunizations in favor of funding a "Healthy Home" through Washington State Health Care Authority in partnership with Medicare and Medicaid. Moving childhood immunizations into private provider settings and pharmacies reduced many small to medium sized LHJs to a very limited role in vaccinations. This overall reduction in capacity made it challenging to maintain staff with experience in large-scale vaccination activities.

After September 11th, 2001, federal funding was made available to strengthen public health emergency preparedness and response for events like bio-terrorism and pandemic. This helped establish the Region 7 Health Care Coalition and developed capacity to respond to local emergencies, including analyzing health care equipment needs, exercise all-hazards preparedness and increase memorandums of understanding between providers that could be utilized in a coordinated emergency response. Funding was cut for this program around 2018, and the Spokane Regional Health Department, with the DOH, started the Regional Emergency and Disaster (REDi) Health Care Coalition to provide regional guidance to all of Eastern Washington, including Chelan and Douglas counties, during a disaster.

The United States has a decentralized public health system in which the Centers for Disease Control and Prevention (CDC) sets federal guidelines, the DOH and State Board of Health set state guidelines, and CDHD sets local guidelines. The vast majority of the time this communication is unidirectional, flowing from the federal government down to the local level, with little input from local entities to the state or federal level. This disconnect can create serious issues in times of emergency and delays in information and guidance.

The reduction in capacity for localized regional planning and response preparation reduced capacity for responding to any global crises that impact all jurisdictions at once. While many of the federal and state decisions were made to streamline processes or create efficiencies for programs, there was little investment in expanding local capacity or dealing with the unintended consequences of shifting public health activities to health care.

With CDHD's workforce halved from 2000 to 2020, and with the loss of key programs in immunizations and multi-agency emergency coordination, the district's pre-pandemic response capacity was severely limited. CDHD had gone years without updating policies, investing in staff training, or filling key positions. Positions were consolidated and many employees were managing several jobs at one time. In addition, many of the individuals in senior management and key positions were in the process of retiring in 2020, with limited succession planning. This left gaps in institutional knowledge and overall capacity at CDHD.

Overview of the COVID-19 Pandemic

In December 2019, cases of "viral pneumonia" were discovered in Wuhan, China. By January 2020 it was determined that the outbreak was caused by a novel coronavirus, later

to be classified as SARS-CoV-2, with common symptoms including fever, dry cough, and trouble breathing. The World Health Organization's investigation into the matter detected cases in other countries, and on January 30th, 2020, the World Health Organization declared a public health emergency of international concern, the highest level of alarm.[3]

Despite countries implementing stay-at-home orders, travel restrictions, and risk mitigation measures, the virus spread throughout the world, causing what is known as Coronavirus Disease – 2019 (COVID-19). At the time of this report, globally there have been over 770 million confirmed cases of COVID-19, and nearly 7 million deaths.[4] Washington State has seen nearly 2 million cases and almost 16,000 deaths over the course of the pandemic.[5]

COVID-19 in Washington State and Chelan and Douglas Counties

Early Response

On January 20, 2020, the first confirmed case of COVID-19 was identified in Washington State. This led the CDC to activate their emergency operations center and the Washington State Emergency Management Division to activate the State Emergency Operations Center.[6] Governor Jay Inslee declared a state of emergency for Washington State on February 29th, 2020. Within a few days, confirmed and suspected cases started appearing in North Central Washington. Several area health providers quickly initiated testing triage areas outside their facilities, and the CDHD Administrator, Barry Kling, announced that CDHD would launch an emergency response team.[7] Over the next two weeks, some local organizations voluntarily cancelled events, asked people to work remotely, and/or closed in-person operations.

Throughout March, Governor Inslee started putting limits on large events, restaurants and bars, and other restrictions aimed at slowing the spread of COVID-19. During the week of March 15, 2020, Chelan and Douglas counties both saw over 1,000% increases in unemployment claims, with 1,473 claims filed in Chelan County and 539 claims filed in Douglas County.[8] On March 16, 2020, CDHD Board of Health passed a local Declaration of Emergency for COVID-19 for Chelan and Douglas counties, Resolution 2020-001. The increased restrictions on businesses and events culminated with the "Stay Home, Stay Healthy" order issued by Governor Inslee on March 23rd, in which Washingtonians were required to stay home unless pursuing an essential activity. All social, spiritual, and recreational gatherings were suspended and all businesses except those deemed "essential" were closed.[9] CDHD closed its offices to the public and staff worked from home during this time with limited information technology (IT) infrastructure to support work activities. Staff involved in the response worked extremely long hours while other staff were

[3] WHO, accessed September 2023, Timeline: WHO's COVID-19 Response
[4] WHO, accessed September 2023, WHO COVID-19 Dashboard
[5] Washington State Department of Health, accessed September 2023, Respiratory Illness Data Dashboard
[6] CDC, accessed 2023, CDC Museum COVID-19 Timeline
[7] The Wenatchee World, March 2020, "COVID-19 likely to be a 'community-wide outbreak' but most cases won't be deadly"
[8] The Wenatchee World, March 2020, "Unemployment claims take a big jump in Chelan and Douglas counties after business shutdowns"
[9] Jay Inslee News & Media Page, accessed September 2023, "Inslee announces 'Stay Home, Stay Healthy' order"

unable to adequately access their work from home, leading to an imbalance in workload. On March 23, 2020, the two-county area had its first confirmed death from COVID-19, when a 91-year old resident died due to complications of the disease.[10]

In response to the economic impacts of the pandemic, local organizations and government entities came together to respond. As an example, Town Toyota Center, Serve Wenatchee Valley, Chelan-Douglas Community Action Council, and Link Transit came together to distribute food for families, with an additional bus route added specifically to help those who needed to pick up food boxes at the arena.[11] State and Federal funding sources started providing grants to local health care organizations and businesses in attempts to relieve some of the strain.

During the April Board of Health meeting, long-time Health Officer, Dr. Francis Collins, was replaced by Board of Health-appointed Health Officer Dr. Malcolm Butler. At the time there were limited local funds and CDHD did not have sufficient emergency funding to implement a robust response; communication to staff was that no additional funds were available for the response. Local fire district leadership and law enforcement reached out to the health administrator to offer incident management support and additional non-monetary resources to support coordination and response to the pandemic. The administrator accepted limited support but there was a clear lack of centralized coordination and capacity from CDHD. A limited FEMA grant was awarded to support advertising and communication activities, but this did not provide for necessary financial support for staffing.[12]

At the same time, local organizations and government had to figure out how to implement and enforce new policies and regulations. For example, just a month into the pandemic, harvest season started. Chelan and Douglas counties host thousands of migrant workers each harvest. Changes to the amount of housing space required per person to meet social distance requirements meant that twice as much housing was needed as usual. CDHD had to work with growers to find solutions, including tents and trailers, to house workers.[13] During this time, COVID-19 tests were still in limited supply and not universally available to those who wanted them. CDHD saw a significant number of cases amongst those living in agriculture housing facilities, and CDHD and local health care providers changed their approach to include more widespread testing among agriculture workers.[14]

Throughout April, personal protective equipment (PPE) was in short supply and reserved for health workers. COVID-19 tests were still in limited supply and laboratories struggled to keep up, leading to a long turnaround time on test results. Confluence Health ran a drive-through testing site when supplies allowed. Confluence Health also expanded its intensive care unit to treat more seriously ill COVID-19 patients. Chelan County utilized CARES funding to set up an isolation and quarantine facility to help house and feed those with

[10] The Wenatchee World, March 2020, "Resident of Wenatchee senior facility dies of COVID-19"
[11] The Wenatchee World, March 2020, "Drive-through food service open for those in need at the Toyota Town Center"
[12] Chelan-Douglas Board of Health meeting minutes, April 2020
[13] The Wenatchee World, April 2020, "COVID-19 forces changes in ag housing"
[14] The Wenatchee World, April 2020, "Expanded testing planned after 'remarkable' rate of cases in agriculture housing"

COVID-19 who did not have a safe place to isolate; the first facility opened in April managed by Serve Wenatchee.[15] CDHD started tracking and releasing data to the public on the number of cases and demographics of those who tested positive. This showed notable ethnic and racial disparities, especially among the Latinx community which bore a disproportionate number of positive cases.[16]

Around this time, an attempt was made to bring volunteers into the response. There was limited capacity for CDHD to onboard or supervise volunteers and the volunteer program was terminated. Volunteers were used at other points of the response but were managed and coordinated by other partners rather than CDHD.

In early May, Governor Inslee announced a "Safe Start" phased re-opening plan in which counties could apply to move to phases with looser restrictions on activities and business, depending on how they performed on metrics such as infection and hospitalization rates. At the same time, the Wenatchee Valley Chamber of Commerce released a survey that reported more than two-thirds of businesses were worried they would not be able to sustain themselves for another six months, and over half were worried they would not make it another three months.[17] Lawsuits were filed in Douglas and Chelan counties seeking to overturn restrictions on commerce and construction imposed by Governor Inslee. Three members of the Board of Health were initially a part of this lawsuit (as individuals; not in their official capacity), though they later withdrew.[18] Before the lawsuit was ruled upon, the Board of Health passed a resolution that would institute a phased re-opening in both counties, if the state regulations were overturned. The request to overturn Governor Inslee's state of emergency declaration was denied in June 2020 by a Chelan County Superior Judge.[19]

In May of 2020, CDHD struggled to keep up with the increasing demands of contact tracing and contracted it out to the DOH. With limited information technology (IT) capacity and no additional funding for these activities, CDHD could not fulfill this responsibility. Chelan County contracted with Our Valley Our Future, utilizing CARES funding, to establish the Latino Communications Network to amplify COVID-19 messaging from CDHD and WA DOH.

In June of 2020 the Board of Health approved hiring staff to focus on the COVID-19 response, including three nurses and two support staff. The first support staff person started in August 2020 and the first COVID-19 program lead started in October of 2020.

In July of 2020, the long-time health administrator retired and the Board of Health appointed an interim administrator. Within the same month, the longtime nursing director also retired. This left a significant gap in leadership and institutional knowledge at CDHD. At

[15] The Wenatchee World, April 2020, "The Wenatchee Valley's first COVID-19 isolation shelter opened in Tuesday"
[16] The Wenatchee World, May 2020, "Chelan-Douglas Health District resumes reporting ethnicity data"
[17] The Wenatchee World, May 2020, "Wenatchee Valley Chamber business survey prompts 'Recovery Council'"
[18] The Wenatchee World, May 2020, "Coalition sues Inslee to end the state of emergency"
[19] NCW Life Channel, June 202, "Lawsuit fails to overturn Inslee's COVID-19 executive orders"

the same time, hospitalizations reached a new high locally, and the two counties had some of the highest infection rates in the state.[20]

By August of 2020, CDHD lost additional key staff members and struggled so significantly that local health care providers and the Board of Health both requested help from the DOH, separately from each other. In response, the state set up a new incident command structure for CDHD, appointed a new interim administrator, and deployed the national guard to help increase testing capacity. DOH also brought the first infusion of Coronavirus Response and Consolidated Appropriations (CARES) Act dollars for CDHD to resource its activities appropriately. For the rest of the year, CDHD had groups of external incident management teams rotate through to support CDHD and the response. In addition to responding to the pandemic, DOH's interim administrator started addressing the staffing challenges, outdated policies, and aging infrastructure at CDHD. All staff were brought back to work in-person and temporary staff were hired to help fill in COVID-19 gaps so other public health functions could occur.

In the fall, CDHD, with help from the National Guard, provided free testing services at several locations in Wenatchee and contracted with Medical Teams International to provide mobile testing, with an emphasis on reaching agriculture workers. CDHD and school districts worked on plans to partially re-open schools and supported widespread testing as an important part of the plan. These plans helped pioneer re-opening plans for school districts across the rest of the state. CDHD – along with Confluence Health, Columbia Valley Community Health and Cascade Medical – took back the responsibility of contact tracing. While some of the youngest and most vulnerable kids did start attending school in-person, there were notable setbacks and challenges to re-opening plans, including COVID cases within schools.

By November, COVID-19 rates reached new highs and hospitalizations increased. As a result, Confluence Health started delaying some non-emergency care and surgeries to free up space and staff to care for patients requiring immediate treatment.[21] CDHD added drive-through testing sites to help respond to demand. At this time, CDHD's finance director left, leaving a new payroll coordinator and fiscal assistant to continue the day-to-day financial operations. This left the district unable to receive reimbursements for funding allocations until the new administrator arrived. Douglas County provided CARES Act dollars to support the district's activities during this time.

At this point, CDHD had lost all managers and key operations personnel present at the beginning of 2020. The district was down to 30 core public health employees, with several of them having been promoted into their positions with little to no training. While DOH brought funding and made limited improvements to infrastructure, the district was reliant on

[20] The Wenatchee World, July 2020 "Number of local COVID-19 hospitalizations reach new high"
[21] The Wenatchee World, November 2020, "Hospitalization spikes over the weekend as officials begin to 'ramp down' some non-emergency care."

outside incident management teams for its essential functions. During December, the DOH interim administrator had to return to their normal duties.

Following a national candidate search, Luke Davies was hired and started as health administrator on January 11th, 2021. The selection process included a 12-member panel with representatives from CDHD staff, healthcare agencies, community-based organizations, the business community, the faith-based community, and the Latinx community. During the same month, external incident management teams became increasingly harder to recruit for two-week deployments. Work was initiated to contract with longer-term incident commanders to run an internal incident management team, which allowed CDHD to stop reliance on a rotating group of external incident management teams. In addition, during January and February, the health administrator hired contractors in accounting, communications, and human resources to help stabilize the agency. Additional funding for COVID-19 response was made available through the federal government and the state.

Vaccination

In December 2020, the Pfizer vaccine received emergency authorization and the Moderna vaccine received the same authorization shortly after. The first shipment of 1,000 doses of Pfizer vaccine arrived in Chelan and Douglas counties on December 15, 2020.[22] These doses were managed and distributed by Confluence Health. The DOH guidelines prioritized health care personnel and first responders for vaccination. High risk individuals living in congregate settings, such as adult family homes or nursing homes, quickly followed. Many of these individuals were vaccinated through a federal public-private partnership with pharmacies such as Walgreens.

On Monday, January 18, 2021, Governor Inslee announced that the Town Toyota Center in Wenatchee would be used as one of the four mass vaccination centers set up by the State, to be opened on January 25th, 2021.[23] The announcement was shared with the health administrator the night before the governor's announcement, with very little detail. In less than a week, CDHD coordinated with the DOH, Confluence Health, the National Guard, Law Enforcement, the Public Utility District (PUD), Chelan and Douglas departments of Emergency Management, and others to open the mass vaccination site to appointments. With an intentional "soft" open to test operations, 100 people were vaccinated on the first day. Supply was the main factor that limited the number of people who could be served per day.[24] The mass vaccination site was the only site of the state-run sites to have local support and coordination from the LHJ and local health care.

Even though only those who were 65 and older and those 50 and older living in multigenerational households were eligible for vaccination in the early days, demand for the

[22] The Wenatchee World, December 2020, "'Sheer excitement' as the first vaccine shipment arrives in Wenatchee"
[23] Washington State Department of Health, January 2021, "Four mass vaccination sites opening statewide this week"
[24] The Wenatchee World, January 2020, "Vaccinations begin at Town Toyota Center"

vaccine far outpaced supply. Vaccination appointments were put online for sign-up when they became available and filled up immediately. Those who lacked access to the internet, or had trouble navigating an online system, struggled to get the limited appointments. Local health care providers and CDHD received an overwhelming number of calls per day from people asking about vaccinations and appointments.

In addition to the mass vaccination sites, there were limited amounts of vaccine made available directly to LHJs for distribution. In early February 2021, CDHD contracted with Lake Chelan Community Health to provide equity-based services and coordinated shipments of limited vaccine supply to Confluence, Cascade Medical, Columbia Valley Community Health, and cross-jurisdictional partners to ensure wider vaccine access to vulnerable groups. These efforts made COVID-19 vaccines available to homebound individuals, people who had a hard time traveling out of their communities, and people who were hesitant to use the mass vaccination site. Mobile vaccinations accounted for over 10% of the vaccinations given in the counties, and these efforts were key to achieving high vaccination rates. CDHD also successfully advocated for a clinic that did not require advance appointments, helped elderly residents schedule their appointments by phone, and purchased a mobile unit to allow for more mobile vaccination services.

In March of 2021, Medical Teams International was contracted by the DOH to provide mobile vaccination clinics to agriculture workers. At the time of this report, a slightly higher percentage of individuals who identify as Hispanic have completed their COVID-19 primary vaccination series compared to those who identify as white: 61% of Hispanic individuals have completed their primary series compared to 56% of white individuals in Douglas county; 64% of Hispanic individuals have completed their primary series compared to 63% of white individuals in Chelan County.[25]

Vaccinations surged during the first four months they were available: 12,000 people from the two counties were vaccinated in January 2021, over 30,000 were vaccinated in February, nearly 35,000 were vaccinated in March, and nearly 30,000 were vaccinated in April. It was not until May 2021 that supply finally outpaced demand.[26]

By summer of 2021, there was a significant drop in demand for vaccination. Only about 4,600 doses of vaccine were administered in the two counties in July – the lowest month of vaccination in 2021.[27] In August, Governor Inslee announced several vaccine mandates requiring employees to be vaccinated against COVID-19, including health care workers, all state employees including all school employees (K-12), and many childcare and early-learning workers. Most employees complied with the mandate but some resigned, including health care staff. Some of the Confluence staff who were let go for not complying with the

[25] Washington State Department of Health, accessed September 2023, COVID-19 Vaccination Data
[26] Washington State Department of Health, accessed September 2023, COVID-19 Vaccination Data
[27] Washington State Department of Health, accessed September 2023, COVID-19 Vaccination Data

mandate later filed a lawsuit for wrongful termination. The lawsuit was dismissed by a judge in November 2022, but there may still be ongoing litigation.[28]

In May 2021, the one staff member holding the roles of both Regional Emergency Response Coordinator and epidemiologist left CDHD, as did several additional staff members. In June, the last contracted incident commander, Kent Sisson, became the new Regional Emergency Response Coordinator, and a former fiscal director, Diane Forhan, returned to CDHD as an operations director. These key positions, along with a new nursing director, communications director, and an internal promotion for the environmental health director, helped to fully staff CDHD's management team and get back to conducting day-to-day public health operations.

Food distribution through the Town Toyota Center with coordination from Serve Wenatchee started to wind down toward the end of May 2021 as the CARES funding was depleted. Planning started during this time to continue food distributions and wellness checks through different funding sources. Implementation of those plans started in 2022 through Action Health Partners and Lake Chelan Community Health.

In anticipation of vaccination soon being approved for children, CDHD, local health care providers, and the Wenatchee Valley College's nursing program started planning a strategy for pediatric vaccination, looking to ensure that vaccinations were widely available in every community across the two counties, at easily accessible places like schools. Some vaccination clinics did take place in schools, but barriers such as the inability to host clinics during school hours, schools' concerns about community pushback from vaccine-hesitant community members, and competing priorities amongst busy school staff led the group to look for additional locations, such as fire departments, community centers and government buildings.

In August 2021, the Delta-variant wave started to impact the region and COVID-19 rates started rapidly rising. Cases surged and hospitals were strained. In August, COVID-19 rates in the area reached near all-time highs.[29] Death rates also increased, and the two counties had their highest 7-day death rate in early November 2021, surpassing 100 total deaths for the two counties.[30] Phone calls to CDHD far surpassed what they could respond to. Contact tracing had to be contracted back to DOH due to the volume of cases with CDHD's focus on vaccinations and testing.

The Omicron variant was detected in Washington in December of 2021. By mid-January, local demand for COVID-19 testing outpaced supply. The Town Toyota Center averaged 600 tests per day, but still had to limit testing to only symptomatic individuals for a period of time when demand was the highest. By late January, the Central Washington Hospital's emergency room was overwhelmed and its ICU was operating beyond capacity.

[28] The Wenatchee World, November 2021, "Douglas County judge to dismiss Confluence Health lawsuit"
[29] The Wenatchee World, August 2021, "'We are completely on the defensive,' | COVID rates hit highest number this year"
[30] The Wenatchee World, September 2021, "COVID-19 deaths top 100 in Chelan and Douglas Counties"

Forecasting and early trends in urban areas prompted the health administrator and the regional emergency response coordinator to push for an Emergency Operation Center. The Emergency Operation Center was set up at Wenatchee Valley College and was supported by Chelan County Fire Marshall and Emergency Management. The emergency operations center was able to close by mid-February. By the end of March, hospitalizations and overall cases significantly decreased and returned to the lows experienced during the summer of 2021, before the Delta variant began impacting the area.

In March of 2022, five new members were selected to serve on the Board of Health[31] in response to Washington House Bill 1152, which requires at least half of every Board of Health to be made up of non-elected officials. The law requires new board members to be made up of health care providers, public health professionals, consumers of public health and community stakeholders such as community-based organizations.[32] The Board of Health went through a detailed process to carefully select the new numbers and created six alternate positions for greater representation.

In April of 2022, cases declined to near all-time lows.[33] CDHD started reducing testing and vaccination hours of operation at the Town Toyota Center due to lack of demand. The Town Toyota Center ceased testing and vaccinations at the end of October 2022. The State's COVID-19 state-of-emergency officially ended the same month. CDHD was able to stop incident command in November 2022. However, surveillance activities and COVID-19 care coordination continued through local partners. The federal declaration of emergency ended in May of 2023, as did the Chelan-Douglas Health District's declaration of emergency.

[31]The Wenatchee World, March 2022, "Five named to Chelan-Douglas Health District board"
[32] House Committee on Health Care and Wellness, accessed September 2023, "House Bill Report: HB 1152"
[33]The Wenatchee World, April 2022, "COVID-19 rates near all-time low in Chelan, Douglas counties"

Timeline of Significant Events

March 2020

- First local case of COVID-19
- Chelan Douglas Health District Incident Management Team (IMT) established and led by Health Administrator, Barry Kling
- Governor issues "Stay Home, Stay Healthy Orders" which included the suspension of social, spiritual and recreational gatherings and closing of non "essential" businesses
- Serve Wenatchee Valley, Chelan-Douglas Community Action Council and Link Transit start food distribution out of the Town Toyota Center

April 2020

- In-person school is closed for the rest of the school year
- Limited supplies of personal protective equipment (PPE) arrive and are managed by Chelan and Douglas County Emergency Management
- First isolation and quarantine opened, managed by Serve Wenatchee
- First local outbreak identified among agriculture workers
- Health Officer, Dr. Francis Collins, is replaced by Dr. Malcolm Butler

May 2020

- Contact Investigation and Contract Tracing contracted to WA DOH
- Latinx Advisory Group formed
- Governor Inslee's "Safe Start" re-opening plan is introduced, allowing for phased re-opening of the economy in counties that meet certain metrics
- Lawsuits were filed in Douglas and Chelan counties seeking to overturn COVID-19 restrictions on commerce and construction imposed by Governor Inslee

June 2020

- Statewide mask mandate issued by the governor
- Board of Health approves funds to hire staff to focus on COVID-19 response

July 2020

- Health Administrator Barry Kling retires
- Bruce Buckles starts as interim Administrator, appointed by the Board of Health
- New incident command structure formed within CDHD

August 2020

- First outside IMT supports CDHD on 2-4 week rotations (WA Dept. of Corrections)
- Mobile community-based PCR testing introduced through a contractor (Medical Teams International)
- Hired COVID-19 clinical staff
- Established Coordinated Policy Group, a multiagency body including Board of Health Members, the Health Officer, Confluence Health and Columbia Valley Community Health (CVCH), responsible for providing strategic direction to the IMT

September 2020

- In response to local provider and Board of Health requests for help, a new interim health administrator from Washington State Department of Health is appointed
- National Guard establishes testing site at Wenatchee High School
- Case investigation and contract tracing resumed locally, contracted out to local health providers
- Tacoma-Pierce County Type 3 All-Hazards IMT does a ~2 week rotation

October 2020
- Three local Fire Districts begin IMT rotations at CDHD that will last into February 2021

December 2020
- Pfizer and Moderna vaccines approved by FDA/CDC for emergency use
- High rates of hospitalizations cause Confluence health to start limiting non-emergent care

January 2021
- Luke Davies is hired as new CDHD administrator
- CDHD contracts with a new incident commander
- Phased vaccinations begin starting with essential health care workers and first responders
- WA DOH opens a mass vaccination site opens at Town Toyota Center in collaboration with numerous local partners including CDHD, Confluence Health, Chelan County Emergency Management, and volunteers

February 2021
- J&J vaccine approved by FDA/CDC for emergency use
- CDHD begins vaccine breakthrough testing; breakthrough cases of B.1.1.7 (Alpha variant) emerge

March 2021
- Medical Teams International contracted by DOH to conduct vaccine clinics for agriculture workers

April 2021
- Delta variant first detected in WA State

May 2021
- CDHD takes over mass vaccination site from Washington DOH
- Pfizer vaccine approved for adolescents 12+

June 2021
- CDHD purchased mobile command vehicle for mobile vaccine clinics
- COVID-19 Division created within CDHD

July 2021
- Work group formed to plan pediatric vaccinations including representatives from CDHD, local health care providers, and Educational Service Districts (ESD)

August 2021
- Delta wave begins to have significant local impact on cases, hospitalizations and deaths
- Governor Inslee announces vaccine mandates requiring employees to be vaccinated against COVID-19 including health care workers, all state employees, all school employees (K to 12), many childcare and early learning workers

September 2021
- Pfizer booster authorized for high-risk individuals. Followed by Moderna and J&J booster approval
- Dr. Butler leaves as health officer and replaced by interim health officer Dr. Wallace

November 2021:
- Pfizer vaccine approved for children 5+
- Pfizer boosters approved for anyone 18+

December 2021
- Omicron variant first detected in WA State

January 2022
- Cases surge, testing services are overwhelmed and hospitalizations are high
- CDHD sets up an emergency operations center at Wenatchee Valley College

February 2022
- The emergency operations center and the triage center close

March 2022:
- Five new members are selected to serve on the Board of Health in response to Washington House Bill 1152 which requires that at least half of every Board of Health are non-elected officials

October 2022
- Testing and vaccination operations ceased at the Town Toyota Center
- Governor Inslee ends the COVID-19 emergency declaration

November 2022
- CDHD ends its COVID-19 incident management team

May 2023
- Federal declaration of emergency for COVID-19 ends
- CDHD's declaration of emergency for COVID-19 ends

Methods

The purpose of this after-action report is to determine lessons learned that could inform future responses, including successes and areas for improvement. To determine these lessons learned, a mixed-methods approach was utilized, collecting both qualitative and quantitative insights through surveys, interviews, focus group discussions, and a "hotwash" debrief with CDHD staff. It predominantly covers the time period from January 2020, when COVID-19 was first detected in Washington State, through December of 2022.

Topic areas and specific sub-questions of focus were decided in consultation with CDHD staff and other LHJs in the state. VillageReach and CDHD also drew from the CDC's "Public Health Emergency Preparedness and Response Capabilities."[34] The team made an intentional choice to use preparedness areas that are critical to an effective response, and to phrase and discuss them in a way that they would be understood by both emergency preparedness staff and community members.

Through this consultation process we established five topic areas to assess CDHD's response against:

1. Internal Operations (including staffing, finance, decision-making, and management)
2. External Operations (including testing, vaccination, and contact tracing)
3. Partnerships
4. Communications & Outreach
5. Responder Health & Safety

Data Collection Methods

Survey

VillageReach and CDHD designed a survey to distribute to current CDHD staff, former CDHD staff, and external partners. We built the surveys to address the five key topic areas, pulling from similar surveys used by other LHJs and adding new questions where needed to fully assess CDHD's specific response.

Respondents were asked to give their perspectives on different dimensions of CDHD's response by using a 1-4 Likert scale with answer options of "very dissatisfied," "dissatisfied," "satisfied," and "very satisfied." Optional free response boxes were included after each Likert response so that respondents could expand on, clarify, or give examples related to their rating.

[34] CDC, updated January 2019, "Public Health Emergency Preparedness and Response Capabilities"

CDHD staff and former CDHD staff were sent the same survey, with former staff receiving an additional question related to what degree the COVID-19 response impacted their decision to leave CDHD.

External partners were sent a much shorter version of the survey since many of the questions did not apply to them—for example, we did not ask them to comment on CDHD's internal processes and procedures. We also removed non-critical questions to reduce the overall length, in an effort to increase the survey's response and completion rate.

External partners were recruited to complete the survey from a list generated by CDHD staff that included community-based organizations, faith-based leaders, education/school representatives, first responders (fire, law enforcement, emergency medical services), long-term care facility staff, health care clinics and hospitals, incident management team members, state agencies (e.g. DOH), leadership from surrounding LHJs, the coroners from both counties, local county/city leadership, businesses, and transportation, and utilities representatives. Partners were encouraged to complete the anonymous survey and circulate to colleagues who may be interested in sharing their perspective.

Survey data were collected and managed using Research Electronic Data Capture (REDCap). REDCap is a secure, web-based software platform designed to support data capture.

Survey responses were compiled and analyzed using Excel to examine the average score and percentage breakdown of responses for each Likert question, and qualitative comments were reviewed for themes.

Interviews and Focus Group Discussions

A subset of staff, former staff, and community partners were identified to participate in an interview or focus group with a VillageReach staff person. CDHD staff identified potential participants based on the degree to which they were involved in the response, and whether they might have insights into the array of strengths and weaknesses that CDHD exhibited. VillageReach then reached out to each potential participant and invited them to partake in a 30-60 minute discussion.

The majority of interviews and focus groups were conducted through virtual meeting platforms (Microsoft Teams and Zoom) and by phone, per the interviewee's preference. With permission from interviewees, the interviews conducted on virtual platforms were recorded so that verbatim quotes could be extracted later. Three interviews and three focus group discussions were conducted in-person.

The discussion questions largely mirrored qualitative questions posed throughout the surveys, and offered respondents a chance to go deeper and provided the opportunity for the interviewer to ask follow-up questions.

The interviewer took notes in Microsoft Word and during analysis phase reviewed interview notes and transcripts to extract themes and quotes from across the interviews.

Hotwash

VillageReach planned and facilitated a two-hour "hotwash" debrief of the COVID-19 response with CDHD staff and one former staff. Participants were asked to first reflect on their own on:

1. What went well? Where/how did we shine?
2. What was challenging? Where/how did we stumble?
3. What would/will have made you/your team more successful in any of these areas?

Participants were asked to consider this both generally, and in regards to the five specific content areas that form the basis of this report. After individual reflection, participants discussed in small groups before engaging in a full group discussion. Discussion notes were taken by the facilitator, and sticky notes with individual and group comments across the five areas were collected and summarized.

Summary Statistics

Participants

We received survey responses from 158 people and conducted 33 interviews, five focus groups, and one hotwash.

Surveys

Forty-nine staff members were given the survey and 40 staff participated in the survey, for an 82% response rate. Of those that responded, 35 of them completed the entire survey. Staff were asked to choose all departments and teams they served on during the response and many chose more than one. Operations and community outreach made up the largest proportion of respondents. Staff were also asked how long they have worked at CDHD with the majority having worked for CDHD for two years or less. Ten former staff answered at least some of the survey but only three completed it (30%).

Figure 1: Breakdown of current CDHD staff who responded to the survey

	Number	Percent
Number of current staff surveyed		
Number of current staff asked to complete the survey	49	100%
Number of current staff that completed at least part of the survey	40	82%
Number of staff that completed entire survey	35	71%
Departments represented (respondents could choose more than one)		
Operations	11	19%
Community Outreach	10	18%

Logistics	7	12%
Planning	6	11%
Safety	5	9%
Incident Command	5	9%
Health Administration/Policy	4	7%
Finance/Contracting (including procurement)	4	7%
Communications	4	7%
Do not want to answer	1	2%
Time worked at CDHD		
3 to 6 months	2	6%
7 to 11 months	9	27%
1 to 2 years	11	33%
3 to 5 years	3	9%
6 to 10 years	5	15%
More than 10 years	3	9%

In addition to the staff surveys, 108 key stakeholders responded to a shorter version of the survey. A breakdown of the type of organization they work for is shown in Figure 2. Those that did not specify their sector made up the largest group (28) followed by health care provider or agency (n=16), faith-based representatives (12), and those from education/schools (12). People could choose more than one option to describe their organization so the total below adds to more than 100%.

Figure 2: Breakdown of organizations of external respondents who responded to CDHD survey

	Number	**Percent**
Organization Type		
Did Not Specify	28	26%
Health care Provider or Agency	16	15%
Faith-based Group	12	11%
Education/Schools	12	11%
First responder	11	10%
Community-Based Organization or Non-profit	9	8%
Long-term Care Facility	6	6%
Local County or City Government	6	6%
State or Federal Agency	5	5%
Private Sector/Business	3	3%
Sports & Entertainment Facility	1	1%
Transportation or Utilities	1	1%
Corrections	1	1%
Incident Management Team	1	1%
Another Local Health Jurisdiction	1	1%
Governmental Corporation	1	1%

Interviews and Focus Group Discussions

We conducted a total of 33 interviews with stakeholders. A breakdown of the organizational affiliation of each interviewee is shown in Figure 3.

Figure 3: Breakdown of organizations for interviewees

	Number	Percent
Organization Type		
CDHD Current Staff	11	33%
Local County/City Government	6	18%
CDHD Former Staff	5	15%
Outside IMT Representatives	4	12%
Health Care Provider Agency Representatives	3	9%
State or Federal Representatives	2	6%
Total	33	100%

Five focus groups were conducted: one focus group with outside IMT members and four focus groups with health care provider agencies in the region.

Hotwash

One two-hour hotwash was conducted, in which 10 current CDHD staff and one former CDHD staff member participated.

Key Findings

Findings are presented by the five overarching themes of internal operations, external operations, partnerships, communications and outreach, and responder health and safety.

Each section includes:

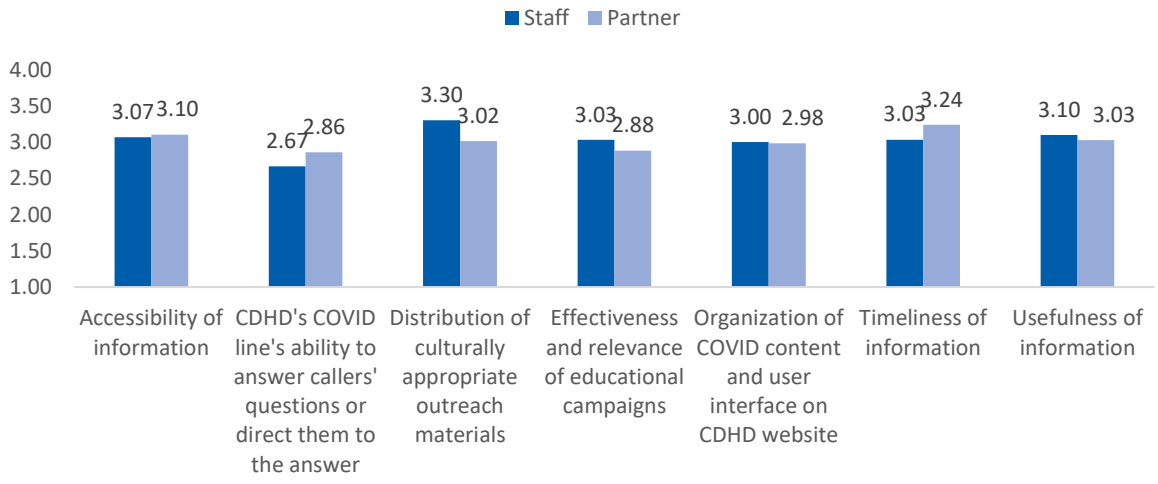
1. **Background:** A description of what occurred in that specific area of the response
2. **Overview of survey results**
3. **Key learnings** which are the major strengths and areas for improvement, determined by reviewing both quantitative and qualitative data

There are two main ways that data are presented: 1. Average scores, and 2. Percentage breakdowns of responses.

The first view is the **overall average** of all the responses for each question. These are broken out by CDHD staff versus external partner responses. CDHD responses will be represented by the dark blue bars and the external partner responses will be represented by light blue bars. Note that quantitative survey responses from former staff are not presented given the small sample size but were considered in determining major strengths and areas for improvement.

For each question, participants were able to choose from the responses "very dissatisfied" (1), "dissatisfied" (2), "satisfied" (3), and "very satisfied" (4). The average response is the mean response of all respondents. If a graph only features dark blue bars, that means that those questions were only asked of CDHD staff. Likewise, if a question only includes light blue bars, it means that staff were not asked that particular question.

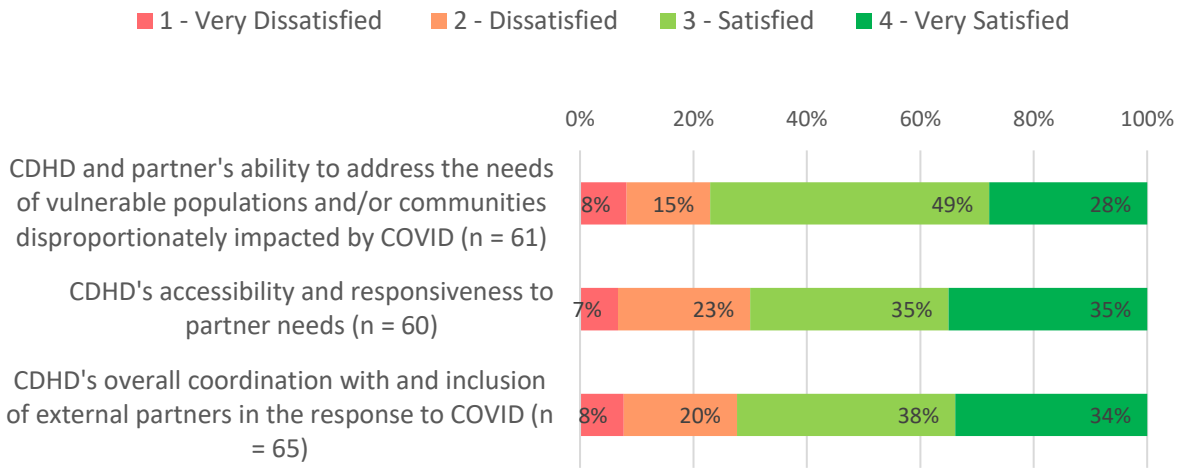
Figure 4: Example of how averages will be presented



The second type of graph is the **percentage breakdown**. This type of graph shows the percentage breakdown across each category ("very dissatisfied," "dissatisfied," "satisfied," and "very satisfied"). Additionally, next to the question there is a number in parentheses, and this is the number of people who responded to this particular question. The figure titles indicate whether the breakdown refers to internal staff responses or external partner responses.

For the sake of report flow and length, if a percentage breakdown distribution visual did not seem to significantly enhance or alter interpretation beyond what the averages visual presented, it appears in the appendix instead of the body of the report. Therefore, you will see that some sections include distributions of responses for staff and/or partners, while others do not. If there is a percentage breakdown visual you would like to see that does not appear in the body of the report, please consult the appendix.

Figure 5: Example of how distribution will be presented; title will indicate staff or external partners



Internal Operations

Background

The following dimensions were considered part of internal operations:

- Staffing and Human Resources: The size of CDHD shrunk over the last 20 years, from 72 full-time staff in 2000 to 39 staff in 2020 when the pandemic started. The number of staff changed and grew throughout the pandemic. As of fall 2023, there are 55 staff. There was significant staff turnover during the pandemic with staff attrition, re-organization, and other internal movement leading to change in staffing for 98% of CDHD positions. Leadership also saw significant turnover. The health administrator of 18 years retired in July 2020. After that, the Board of Health installed an interim administrator who was in place from July 2020 until September 2020, until the DOH provided a new administrator "on loan" from September 2020 to December 2020. Finally, in January 2021, the current CDHD administrator was hired. Early in the pandemic, the organization also lost its longtime nursing director (July 2020) and the finance director (November 2020). The health officer also changed twice in the pandemic – in April of 2020 when Dr. Butler started and in September of 2021 when Dr. Wallace started.
- Fiscal Processes: Only $167,000 for emergency funding was in CDHD's reserve budget at the beginning of 2020. Expenses for 2020 exceeded $970,000 dollars. External funding for the COVID-19 response was not immediately available and ultimately came through multiple sources. Some sources (such as the Federal Emergency Management Agency (FEMA) required LHJs to pay costs out of pocket and then apply for reimbursement. Some funds flowed to the county and state (such as funding from the Coronavirus Aid, Relief, and Economic Security Act (CARES Act)), so the county decided how much to allocate to the LHJ and counties across the state distributed very different percentages to their health districts. External funds for the COVID-19 response were not made available to CDHD until the DOH stepped in during August of 2020. CDHD was designated high-risk because of the turnover in administration and fiscal staff, but there were no financial audit findings from 2020 - 2022 due to staff efforts and strong internal fiscal policies and procedures. In general, the different funding sources, different timelines, and different rules/regulations made it difficult for CDHD to know how much funding was available and how it could best be used.
- Data, Decision-Making and Planning: Information changed frequently and quickly during the pandemic. CDHD generally only had access to information at the same time as the public on key topics such as how to prevent, treat and mitigate COVID-19 as well as changes to state or federal policies and mandates. CDHD had access to the number of people in the two counties testing positive for COVID-19 through the Washington Disease Reporting System (WDRS) and the number of people vaccinated through the Washington State Immunization Information System (WA-

IIS). However, if CDHD staff and/or other health care providers were behind on data entry (as was often the case) then the data was not available.

- Incident Management Team (IMT): An IMT was established in March of 2020. However, health district leadership and staff did not have the incident management training and experience required to make the IMT effective. In August 2020, CDHD started bringing in rotating groups of outside IMT from entities such as Fire Districts, Department of Corrections, and the Tacoma-Pierce County Type 3 All-Hazards IMT, that had incident command experience. In January 2021, CDHD contracted an incident commander who could run the IMT internally. The IMT was in operation until November 2022. At that time, many staff moved back to their original duties, while some core COVID-19 logistics staffing has been maintained while funding allows. Those staff will be part of PHEPR until funding is no longer available.
- Multi-Agency Coordinated Policy Group (MAC): This group was formed at the recommendation of the DOH. This was a multiagency body including Board of Health Members, the Health Officer, law enforcement, emergency managers, Confluence Health and Columbia Valley Community Health. The group was originally larger, including community groups, and was known as the "coordinated policy group." Membership was reduced to streamline decision-making and its name was changed. The group was responsible for engaging with community stakeholders and provided strategic direction and priorities to the IMT.

Current and former CDHD staff were asked survey questions about internal operations across categories of staffing and human resources, fiscal processes, data/decision-making/planning, and team management. External partners were only asked to comment on relevant "Staffing and Human Resources" components.

Overview of Survey Responses

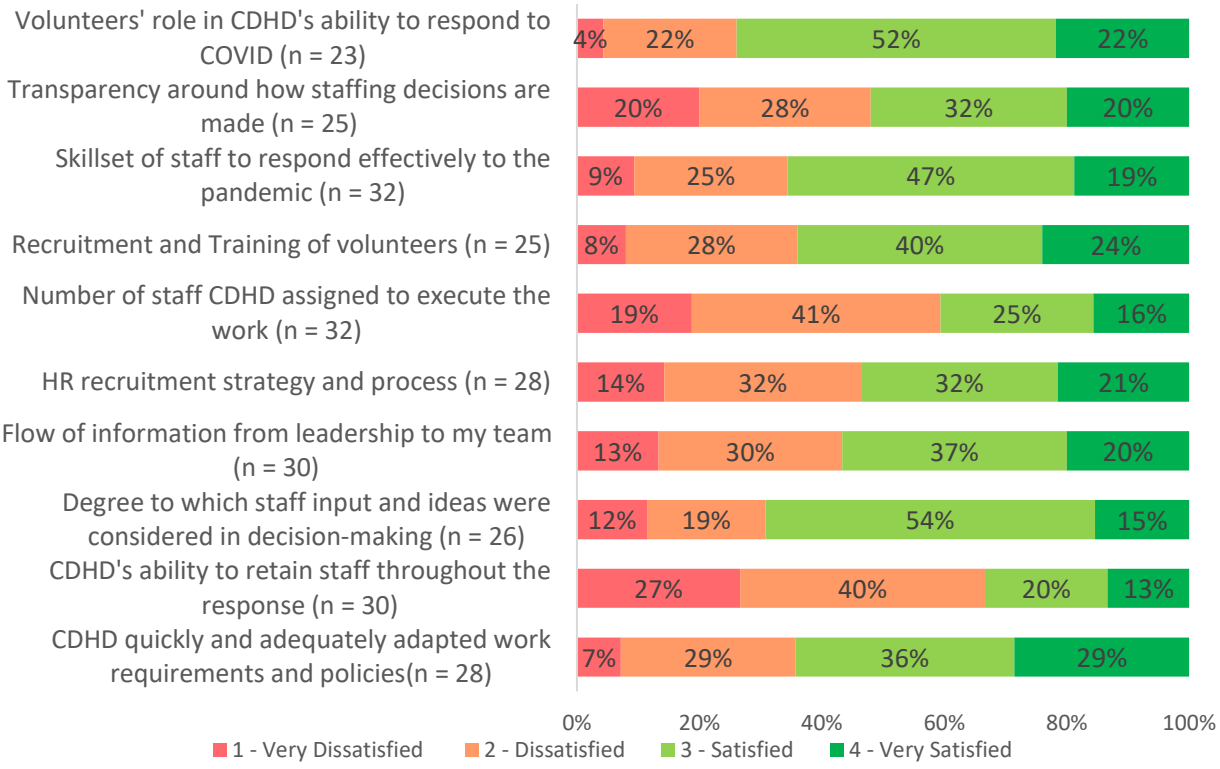
Staffing and Human Resources

When staff were asked to rate their satisfaction with staffing/human resources components through the pandemic, all averages were below the 3.0 or "satisfied" level. The areas that saw the lowest scores were "CDHD's ability to retain staff throughout the pandemic" and "Number of staff CDHD assigned to execute the work." This came across clearly in qualitative responses, too, as detailed in the areas for improvement section below.

External partners were also asked a subset of these questions that they may have insight into, regarding aspects like CDHD's number of staff, ability to retain staff, etc. Data gathered from external partners are included below, and missing data indicates partners were not asked those questions.

Figure 6: Average responses across staffing and human resources (staff and partner)

Figure 7: % breakdown of how staff rated aspects of staffing and human resources (staff)



Fiscal Processes

The staff's satisfaction scores across fiscal dimensions were also consistently low, with only one category (clarity and efficiency of procurement processes) scoring above 3.0 which indicates "satisfied." Context on the low scores is also shared in the areas for improvement below.

Figure 8: Average responses across fiscal processes (staff)

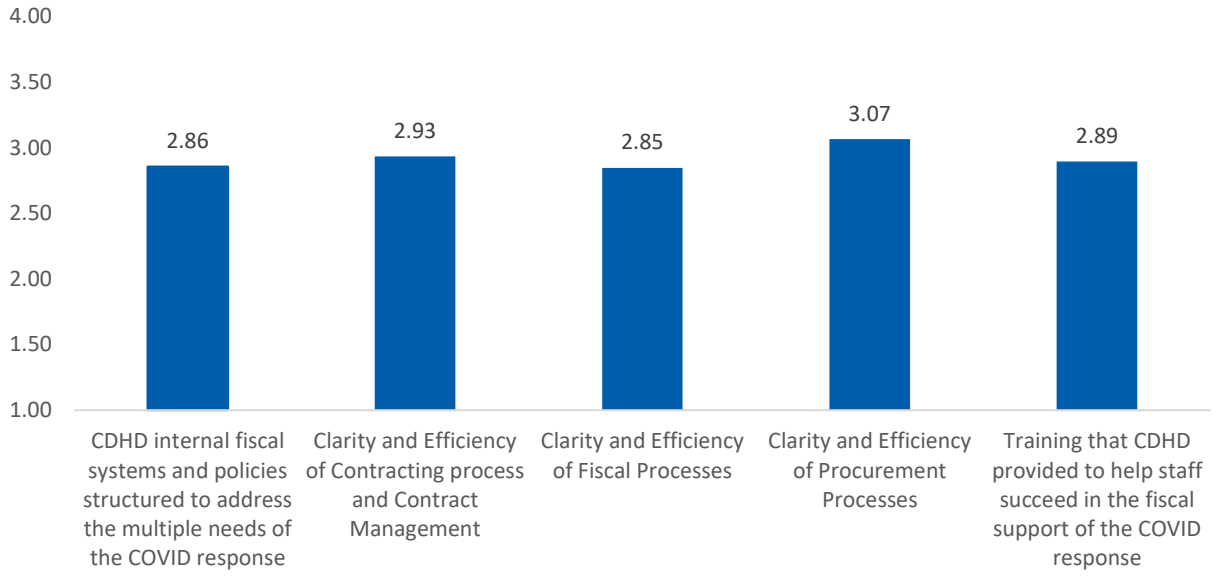
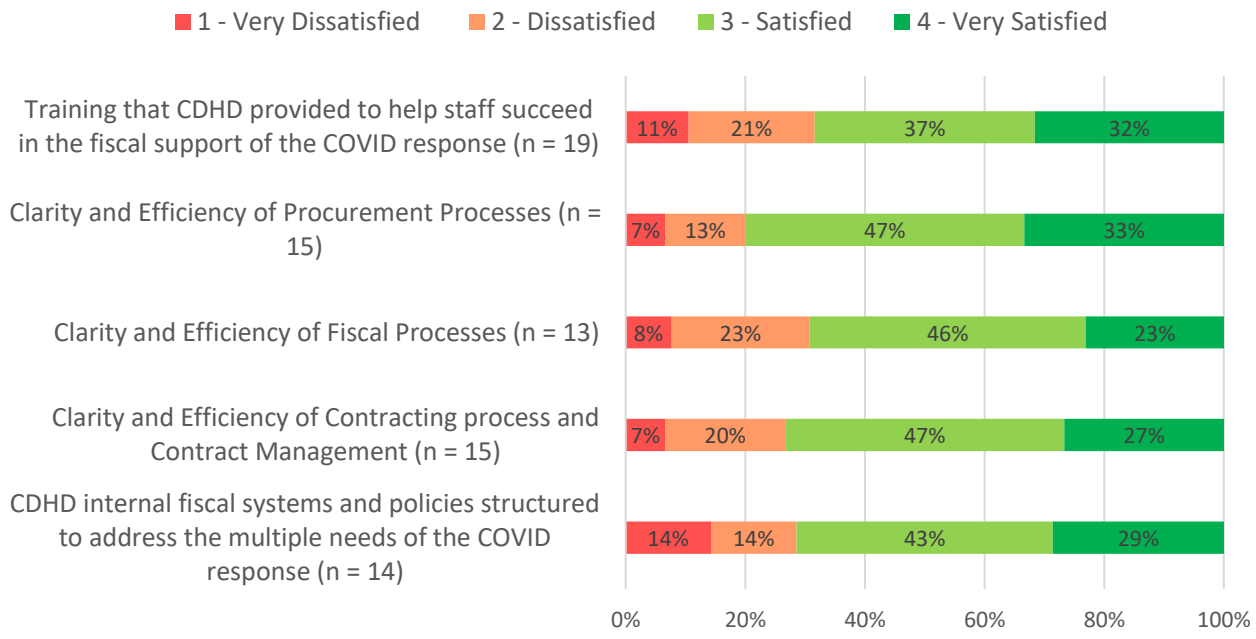


Figure 9: % breakdown of how staff rated aspects of fiscal processes (staff)



Data, Decision-Making, Planning

CDHD staff were asked to evaluate their satisfaction with data usage, decision-making, documentation, and availability of standard operating procedures (SOPs) during the pandemic. Again, averages hovered around and below 3.0, with the lowest rating for "data shared with CDHD staff on a timely basis." "Established an effective organizational structure/chain of command" scored highest at 3.09.

Figure 10: Average responses across aspects of data, decision-making, and planning (staff)

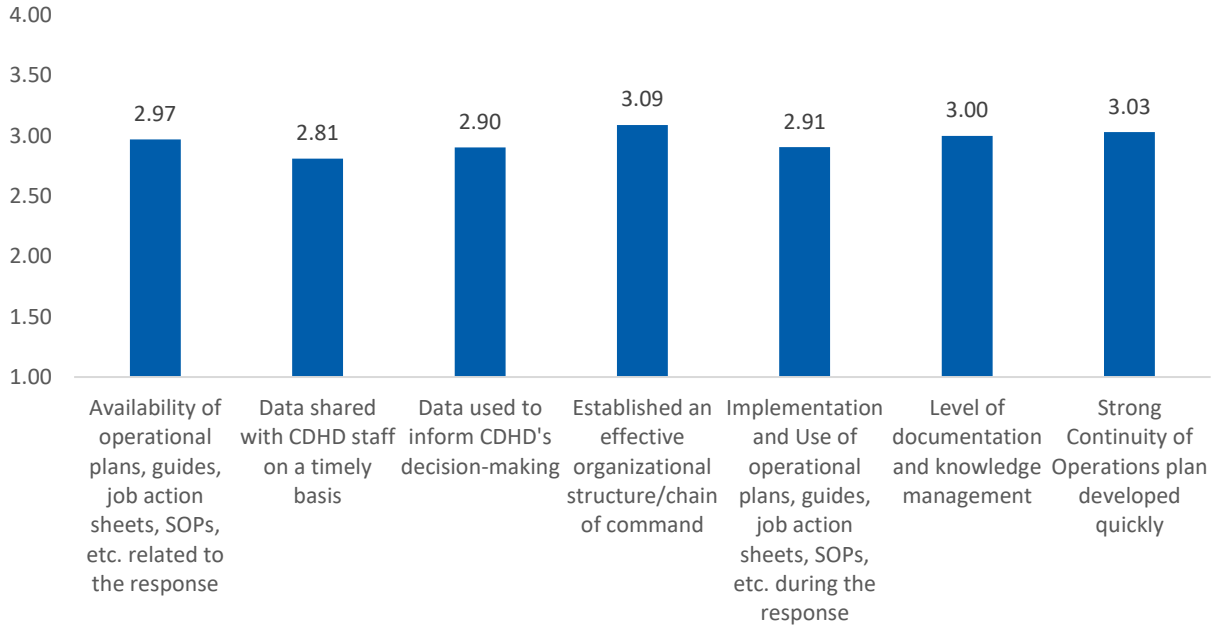
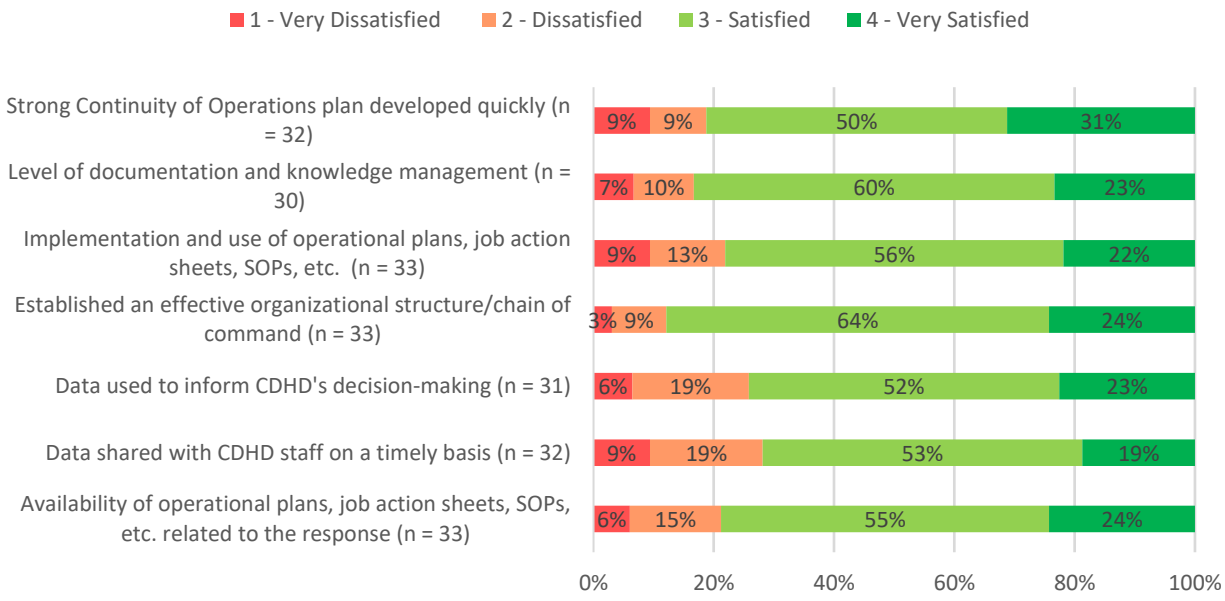


Figure 11: % breakdown of how staff rated aspects of data, decision-making, and planning (staff)



Team Management

Team dynamics were also evaluated, including distribution of workload, number of team members, supervisor support, and training provided to staff. At 3.27, the highest average of all internal operations categories was "supervisor's willingness and availability to support if we faced challenges." Training provided, number of team members to conduct the work, distribution of workload, and clarity of roles all averaged just at or below 3.0.

Figure 12: Average responses across aspects of team management (staff)

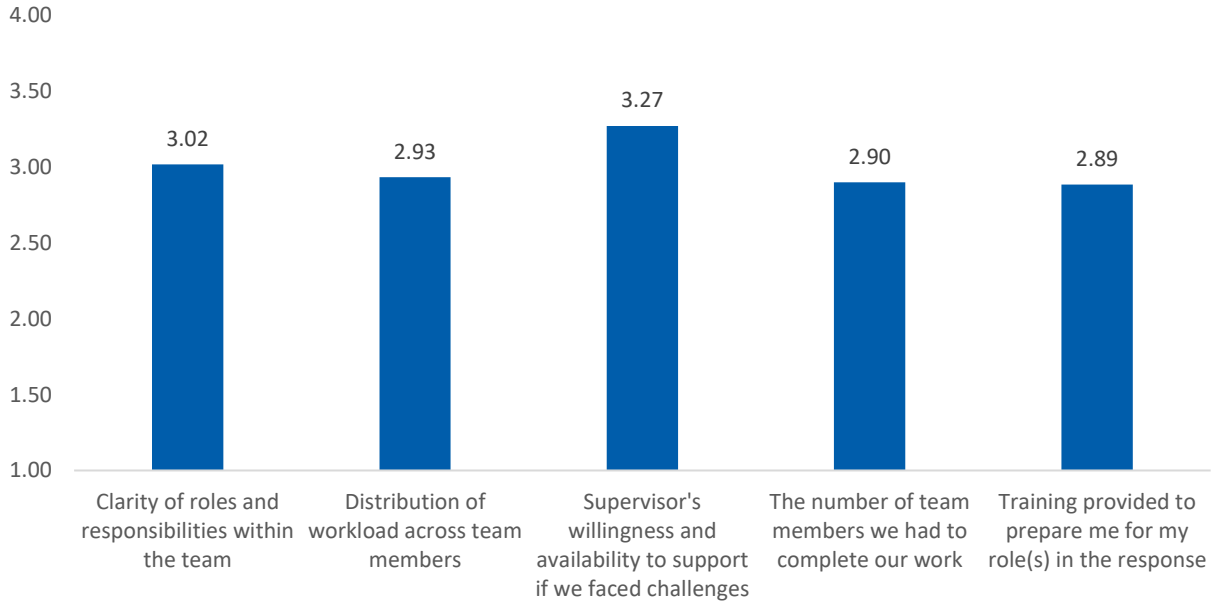
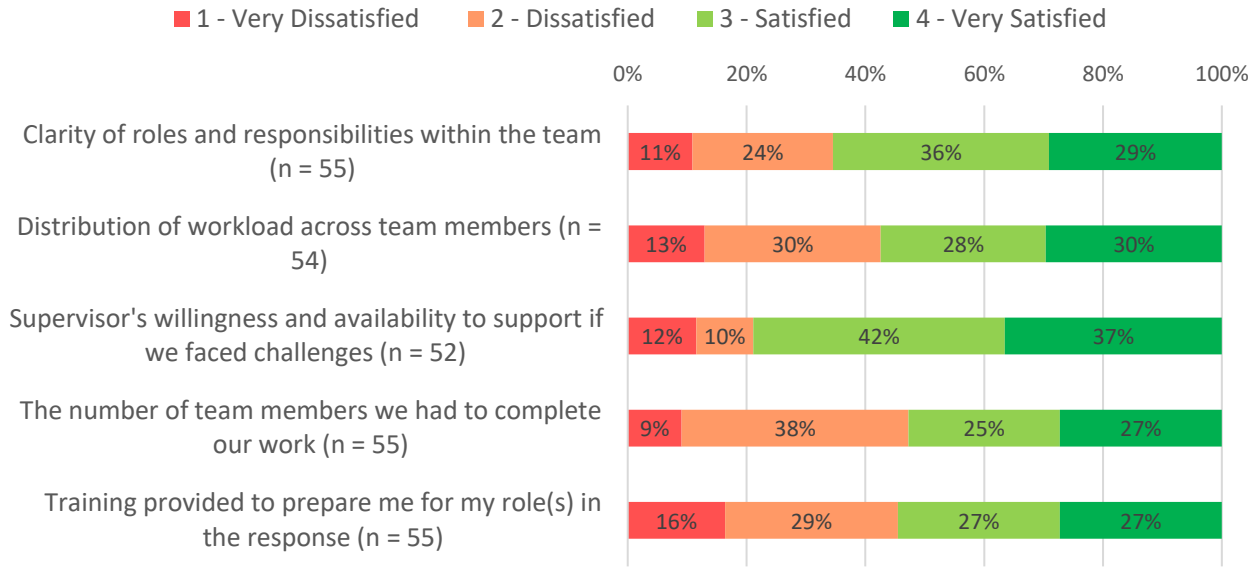


Figure 13: % breakdown of how staff rated aspects of team management (staff)



Key Learnings

Strengths	Areas for Improvement
1. Staff worked well as a supportive team throughout the pandemic 2. CDHD ultimately established an effective IMT with clear roles and responsibilities	1. CDHD was understaffed throughout the pandemic and saw high rates of leadership and staff turnover 2. CDHD was unable to successfully develop a consistent cadre of volunteers to support the response efforts 3. Underutilization of preparedness plans and inadequate training of staff contributed to an underperforming IMT and hindered the overall response 4. Fiscal staff turnover and the complexity of COVID funding sources impacted the first phase of the response 5. Decisions and policies were often set at the state level, without enough local decision-making or resources to implement

Strengths

Strength 1:

Staff worked well as a supportive team throughout the pandemic

In spite of the many organizational operational challenges CDHD faced, the fierce teamwork and dedication to each other came up many times in surveys and interviews with current and former CDHD staff. Many credited the teamwork and support they felt from each other, and how well they worked as a unit, as why they stayed even when things were overwhelming, stressful, or frustrating.

Although some people felt their manager did not have time and/or willingness to support them, surveys and interviews indicated that many did feel supported by their manager.

It was common for current and former staff interviewees to talk highly about their colleagues both generally and specifically, and point to the supportive team dynamics as

what helped them through obstacles and ultimately allowed CDHD to mount a strong response to COVID-19.

Illustrative Quotes:

> "[CDHD team] are the most creative and scrappy group of public health professionals I've ever worked with. They were creative, gritty, scrappy and made things work. The folks still there when I arrived were going to make it happen and had a 'we can do this' attitude."
>
> –Interview, External Partner, State or Federal Agency

> "The team that I worked with was amazing in conquering workload and supporting each other. When one staff member felt overrun with tasks/workload, others would step in to support them."
>
> –Survey, CDHD Staff

> "...those of us that were [on CDHD team] and are still there continued to show up for each other. And then I can extend that for our community...we knew we were all in it together."
>
> –Interview, CDHD Staff

Strength 2:

CDHD ultimately established an effective IMT with clear roles and responsibilities

As discussed throughout this report and in the Internal Operations "areas for improvement" below, CDHD was slow to establish an organized and effective incident management team. However, over time CDHD built this capability and ultimately had an IMT that was effectively and confidently managing the COVID-19 response. Respondents noted that once the IMT was effective, it became a strength.

One of the ways CDHD made the IMT more effective was bringing in outside IMTs and learning from their approach. They later hired an experienced emergency management coordinator to ensure in-house expertise in implementing an effective IMT. Team members on the IMT, as well as those observing from afar, applauded the strides that CDHD staff made in going from unfamiliar with incident command structure and pandemic response at the onset, to a well-oiled machine that worked together effectively and with clear understanding of their roles.

Illustrative Quotes:

> "Initially, there was not clarity of roles for CDHD staff directed to take on the pandemic response. This changed as outside IMTs were brought in to assist. Using an ICS

structure from the beginning would have defined roles and responsibilities. It is an excellent team currently."

–Survey, CDHD Staff

"The people within the operations team worked very well together. There was good information sharing, good cross-training and people were willing to jump in and help with different tasks."

–Survey, CDHD Staff

"After [leadership transitions] you could see the improvement of CDHD and their interaction with this epidemic and managing it. It definitely did improve over time."

–Interview, External Partner, First Responders (Law Enforcement, Fire, EMS)

Areas for Improvement

Area for Improvement 1:

CDHD was understaffed throughout the pandemic and saw high rates of leadership and staff turnover

Staffing issues, in regards to both the low number of staff, as well as high turnover of staff and leadership, significantly impacted staff morale, efficiency, and effectiveness to respond to the COVID-19 pandemic.

CDHD only had 39 staff in 2020 when the pandemic started, significantly less than they had 20 years ago. This understaffing meant that there were not enough people to mount a response. Staff reported working seven days a week and taking no vacation for months on end (which is described further in the "Responder Health and Safety" section). Individuals also had to serve in IMT positions for months before rotating out, which is much longer than recommended.

Interviewed staff, board members, and partners shared that the stress of the pandemic revealed CDHD's many gaps in staffing, institutional knowledge, and training. These issues were exacerbated by the fact that there was heavy turnover across all levels of the organization—the health administrator of 18 years retired in June 2020 which left a large gap in institutional knowledge. After that, the board installed an interim administrator who was in place from July 2020 until August 2020, when DOH supplied another interim administrator, who then served from September 2020 to December 2020. Finally, in January 2021, the current CDHD administrator was hired. Both staff and community partners felt the turmoil of the many leadership changes, and noted that it made it difficult to align and make progress quickly.

Over time, as funds were secured, staffing was expanded and a COVID-19 division was formed in June 2021. This alleviated the workload that the limited number of CDHD staff had been shouldering. After a series of interim placements, additional stability was brought by hiring the current administrator.

Illustrative Quotes

"Our staff was far too small to meet the normal public health needs of our community, much less to respond to a massive pandemic."

–Survey, Former CDHD Staff

"I think CDHD did what they could do...I have seen CDHD have their budgets whittled away...I started [partnering with CDHD years ago] I think I watched [them] lose about 50% of their budget. And then you can't take 50% of someone's budget and then expect them [CDHD] to handle an International Crisis."

–Interview, External Partner, Health Care Provider or Agency

"Staffing levels and staffing decisions got worse. CDHD lost knowledgeable and dedicated employees at a time when we needed their expertise most. There was limited hiring to bring up staffing levels and the staff who were brought in did not have the proper experience for the position."

–Survey, Former CDHD Staff

"...without an administrator and a lot of missing people, it was hard. We had people walk out, quit, leave, couldn't take it no more because they could never see their kids...we had a very scant amount of workers"

–Interview, CDHD Staff

"We were all working beyond capacity—mentally, emotionally, physically. And doing our best that we could with what we had to give in the moment. There were times where it felt like we weren't doing what we could or needed to be doing in terms of individual work, in terms of having five roles....So I felt like I was just doing the bare minimum to slap band aids on what needed to be done...I know we are not the only health district who went into the pandemic as a cracked pressure cooker, who was then put under pressure. Because the department had been underfunded, understaffed we weren't prepared...there weren't enough people to do the amount of work that needed to be done."

-Interview, CDHD Staff

"CDHD is funded when there is a problem and forgotten when there is not...we had an incredible staff shortage, even prior to COVID. It really stressed the staff that existed. Some people left because they couldn't deal with it—I get it and respect it. And some really strong, dedicated people stayed with us."

–Interview, External Partner, Local County or City Government

Area for Improvement 2:

CDHD was unable to successfully develop a consistent cadre of volunteers to support the response efforts

There was potential to have volunteers fill clinical and non-clinical staffing gaps to provide testing, contact tracing, vaccination, and more. However, when the pandemic hit there was no ready-made group of volunteers, and CDHD was unable to invest the necessary time and resources to develop, launch, and maintain a cadre of volunteers in the midst of the response.

At times CDHD did enlist support from volunteers. For example, volunteers played an important role in the implementation of the mass vaccination site at Town Toyota Center. But overall, essential roles and long-term needs needed to be filled by paid staff. Volunteer coordination was time intensive and needed to be streamlined in order to be effective. One challenge with volunteers was the time needed to train them, which was daunting to already overworked CDHD staff. Thus, staff often opted to continue working excessive hours themselves, rather than invest time training volunteers who may or may not be able to fulfill the role and/or stay involved. Another issue was that volunteers who were supposed to staff shifts at testing and vaccination clinics were not as reliable as paid staff, creating logistical challenges for CDHD and the other partners when volunteers arrived late, left early, or did not show up.

As a result, CDHD staff largely felt that working with volunteers was more distracting than it was helpful. The majority of CDHD staff who cited issues with volunteers seemed to think volunteers were not a good fit for this type of response. Others, however, did encourage CDHD to think about how they might have better cultivated a group of volunteers for the COVID-19 response and/or future responses. So, while it was clear that CDHD staff felt that they did not use volunteers well during the COVID-19 response, the opinions differed on whether volunteers could be used better and more efficiently in future responses.

Illustrative Quotes

> "Using volunteers? That's a flat no for me...[people] kept saying 'Oh, there's community members that would love to volunteer because they're not working and they want to volunteer to help. Let me tell you what the volunteers did to me. I had this shift where I had drive thru cars [for vaccination] for blocks and blocks and blocks...I would say I need you here at 8. They would show up at 10:30. And then they'd ask me for a tour of the facility...after that they'd assist with registration or wherever I place them for about an hour, and then they'd be looking at their clock and say 'oh, I have a medical appointment. I need to leave now.' And they'd leave like that too. Leaving me hanging."
>
> –Interview, Former CDHD Staff

"It was easier to work 24/7 hours a day than to build up a volunteer cadre. Had we paused and taken time to invest in a volunteer cadre that would have helped us. We need to think about how to do that differently in the future."

–Interview, External Partner, Local County or City Government

"Contact tracing was very slow to really get going....partially because we were so understaffed, partially because we tried volunteers at first and that really didn't succeed at all." –Interview, Former CDHD staff

Area for Improvement 3:

Underutilization of preparedness plans and inadequate training of staff contributed to an underperforming IMT and hindered the overall response

As discussed above, CDHD brought in strong external IMTs and eventually developed a strong internal IMT. However, the early days of the response featured CDHD staff in IMT roles who did not understand incident command structure, their key duties, and how to fulfill them. This lack of training and effectiveness early on was cited by both CDHD staff and external partners.

This led to issues such as the IMT not leveraging the proper procedures and resources, the chain of command not being followed, and confusion over roles and responsibilities. When CDHD preparedness plans existed, they were not well disseminated or used. When CDHD tried to create new plans, state level plans would supersede local plans, and the plans were no longer useful.

One example of IMT underperformance was the initial IMT formed by CDHD was unaware of the State's resource procurement tool (WebEOC) to source support staff and key supplies – outside of PPE – to support the response. Instead, individuals across the IMT sometimes spent hours researching and tracking down supplies. The lack of ICS training for staff and the Board of Health also led to some misalignment on how to approach operations and decision-making. Outside IMTs were brought in to support the response starting in August 2020, but challenges persisted. One outside IMT shared that sometimes the Board of Health would insert themselves into the weeds. For example, the Board of Health would direct where to specifically conduct testing, rather than setting the big picture vision and letting the IMT operationalize it.

Even with bringing in outside IMTs, the fast pace and the rotating nature of the IMTs (who each had different styles) made it difficult for staff to be trained. After three external IMTs rotated through, the local fire service and emergency management were asked to support CDHD's IMT. Fire and emergency management agreed, and filled several positions on IMT and worked closely with CDHD staff from October 2020 to February 2021 as CDHD became more and more familiar with ICS and procedures. As discussed in the

"Partnerships" section, the local fire departments had offered their IMT support at the onset of the pandemic, but CDHD did not take fire departments up on this offer until fall of 2020. CDHD has since made it a priority to discuss ICS and provide training opportunities so that the staff on IMT are comfortable with their positions and know what they are supposed to be doing.

Illustrative Quotes:

"There was no training provided when I started COVID work I did my own research on CDC, DOH, learned as things came up."

–Survey, CDHD Staff

"There were often times when people would go "out of their lane". I was guilty of this as well yet it was difficult to know where your lane is without much training."

-Survey, CDHD Staff

"Even though teams had been in to assist CDHD, there was no time to stop the merry go round to train people on what they were supposed to do. They were just doing it...people were hungry for training."

-Interview, External Partner, First Responder (Law Enforcement, Fire, EMS)

"One of the biggest barriers for all of the outside teams was [Multi Agency] Coordinated Policy Group [MAC]. The [MAC] wanted to be in charge of operationalizing our response, rather than letting the teams do their jobs, which led to time wasted for the teams. The [MAC] would frequently change the focus of our response, which frustrated the IMTs."

–Survey, CDHD Staff

Area for Improvement 4:

Fiscal staff turnover and the complexity of COVID funding sources impacted the first phase of the response

It came up repeatedly throughout surveys and interviews that CDHD was ill-prepared to understand and manage the fiscal side of the response, and unclear on how to access available resources to fund the response.

Current and former staff, as well as representatives from outside IMTs, shared that CDHD did not have the proper financial systems in place to be able to track their spending and understand what funds were available to them. IMTs struggled to get clear answers from CDHD and DOH on who was responsible for paying for what, and acknowledged that they would often order supplies not knowing if they had the authority to request the supplies and not knowing who would assume financial responsibility for them.

One outside IMT member cited finances as one of the biggest challenges they encountered in supporting the response—there was no clarity on what amount of money had been spent and if it had been spent properly, and so the IMT helped set up tracking systems to start to understand expenditures and total spend.

Additionally, the entire finance department that existed when the response started had left CDHD by the fall of 2020. Finances were then handled by an outside third-party contractor and IMT "finance officers" who rotated every couple of weeks, which was confusing and insufficient for managing the various funding streams with different reporting requirements.

The interim administrator (brought in from the DOH) and the current administrator invested time and effort into understanding the financial landscape at CDHD, as well as exploring how to leverage various funding streams to support the response. During the initial phase of the response CDHD was more passive in terms of identifying and securing financial support. CDHD staff and external partners expressed confusion over the reason that out of the millions of CARES Act dollars received by Chelan and Douglas counties, funding did not reach CDHD sooner and at a higher level of support. As these funds did start to trickle in and stronger financial systems were established, CDHD began to play a larger and more vocal role in the collective response when they knew what they could commit to supporting.

Illustrative Quotes:

"...[I] was expected to manage a lot of the finance issues as related to fed/state reimbursement for COVID response expenses. Having very limited fiscal staff at CDHD made this difficult. I was not prepared to be placed in a position of overseeing much of the IMT fiscal dilemmas."

–Survey, CDHD Staff

"We only had one finance person attached to the IMT at any given time until the summer of 2021. There were too many expenses, procurements and funding streams for one person to manage. There are currently 3 people assigned to fiscal and the need for one additional accountant."

–Survey, CDHD Staff

"Chelan counties accounting system was very antiquated and created an incredible amount of inefficiencies. This made it challenging to set up systems to capture all of the info for the many different funding streams."

–Survey, CDHD Staff

"We had conducted...activities that we could not get reimbursed because our fiscal system had become defunct and we were running on fumes."

–Interview, CDHD Staff

Area for Improvement 5:

Decisions and policies were often set at the state level, without enough local decision-making, advance warning or resources to implement

Interviewees noted that policies and decisions were often made at the state level, leading to numerous challenges at the local level including: lack of advance warning of new policies, lack of resources to implement decisions or policies, and inability to set policies or design solutions that leaders felt would work best in their specific context.

Part of the challenge was the lack of advance warning – such as the example of the Governor announcing the start of a mass vaccination site in Wenatchee during a public press conference with little advance warning to CDHD. In other cases, the challenge was having to implement or enforce a statewide policy that had different ramifications and different levels of public support in different geographic areas. For example, guidance on how much space was needed to allow for social distancing in congregate settings had very specific – and challenging – implications for the two counties that host thousands of migrant agriculture workers. The policy meant they suddenly needed twice as much housing as they had. Several local elected officials called the state response a "one size fits all" approach that rolled out the same policies and mandates across the state without the leeway for local leaders to modify the approach to fit the local context.

Illustrative Quotes:

"Legislation is passed by whichever party passes it, but the rubber meets the road at the local jurisdiction. None of the people that pass legislation have to enforce it, and it's a luxury. But the mayors, law enforcement, local health and the commissioners are the ones that actually have to implement all of those policies. And sometimes a policy would be pushed out and then it would say 'and we will follow up with the information in six weeks. So we would be given a directive, but there was no substance to it."

–Interview, External Partner, Local County or City Government

"I'll use this one as an example…the mass vax center at the Town Toyota Center. The manager of the Town Toyota Center heard [that the Town Toyota Center would be used as a vaccine site] at the same time we heard it when the governor was doing his press conference. [CDHD] didn't know he was standing up the mass vax center. [The person] who runs the Toyota Center as a manager was never called saying his facility was going to be used as a vax center."

–Interview, External Partner, Local County or City Government

"Probably what I heard most from my citizens and my constituents is that we are being asked do things that are being required in King and Snohomish and Spokane and Yakima counties when we're differently situated. So there is just this tension and it felt often like we were not being heard by the Governor's office and so it was frustrating. I think if there is anything to take of this, hindsight being 20/20, is that a "one size fits all" [approach] is really a slippery slope because there are so many different conditions, so many different nuances and so many different needs."

–Interview, External Partner, Local County or City Government

"What was frustrating is we would often times get the new guidance from the state as it was coming out. And so we were just learning about it as the public was learning about it. So to try and go through all the new guidance in a short amount of time was challenging. The public looked to us for that information and we're like 'well, we're getting it at the same time as you so let's look at the guidance together.' That was kind of frustrating, it's like we were never given a heads up from DOH or on whatever mandates that were coming out of the governor's office."

– Interview, CDHD Staff

"One day we walked into work and they said, 'Can you take calls? The Governor put out a mandate that any businesses with two or more positive people need to call their local health jurisdiction.' Nobody told us. Nobody. Calls were coming in like crazy, left and right, from everywhere. Business. Childcare. [Agriculture] facilities. Restaurants. And so the phones were just ringing off the hook. And we were answering calls and putting out fires all day long trying to send them all the updated mandates and requirements… it went like that for months."

– Interview, CDHD Staff

External Operations

Background

The major external operations activities during the pandemic are as follows:

- Disease outbreak and investigation: CDHD started the pandemic with one epidemiologist. At the beginning of the pandemic, COVID-19 tests were extremely limited so only people with severe symptoms were being tested, meaning that most people with COVID-19 were unknown to CDHD. Health care providers would manually (via fax) send positive COVID-19 test results to CDHD. A contact tracing effort was started to try and reach out to everyone who tested positive and their contacts. However, CDHD was quickly overwhelmed with the number of cases and contracted contact tracing out to the DOH. In August 2020, CDHD – along with Confluence Health, Columbia Valley Community Health and Cascade Medical – took back the responsibility of contact tracing. Contract tracing was continued until partway through the Delta Wave in September 2021. It was given back to the DOH due to the incredible volume of cases. CDHD kept its focus on tracing outbreaks in long term care facilities, schools, and businesses through May 2023, when contact tracing ended.
- Isolation and Quarantine (I&Q): In April 2020, Chelan County started work to set up a safe place to quarantine and isolate for those who could not safely do so otherwise. This included people who are unhoused or those living in congregate settings, such as agriculture workers and university students living dormitories. The first location was opened in April 2020 and isolation and quarantine services were available through May 2023. Chelan County led this work through 2020 and the I&Q was transferred to CDHD in 2021. CDHD also supported people isolating and quarantining at home through providing grocery delivery. The first round of this program was supported by Town Toyota Center and Serve Wenatchee through June 2021 and funded with CARES Act funding from the counties. This care coordination program was funded again by the DOH, managed by Action Health Partners, and provided locally by Lake Chelan Community Health and active through May 2023.
- Testing: In the beginning, most COVID-19 testing happened through health care providers. CDHD had an arrangement with some of those providers to reimburse them for the testing services they provided. When tests became more widely available in the fall of 2020, CDHD received test kits from the DOH which they would distribute to health care partners and schools as needed. In August 2020, the Board of Health requested support from the DOH and the National Guard to set up a mass testing site. In addition, starting in 2021, CDHD formed Critical Response Incident Teams (CRIT) that would provide testing services to organizations experiencing or at high risk for outbreaks such as schools, long-term care facilities, adult family homes and shelters.

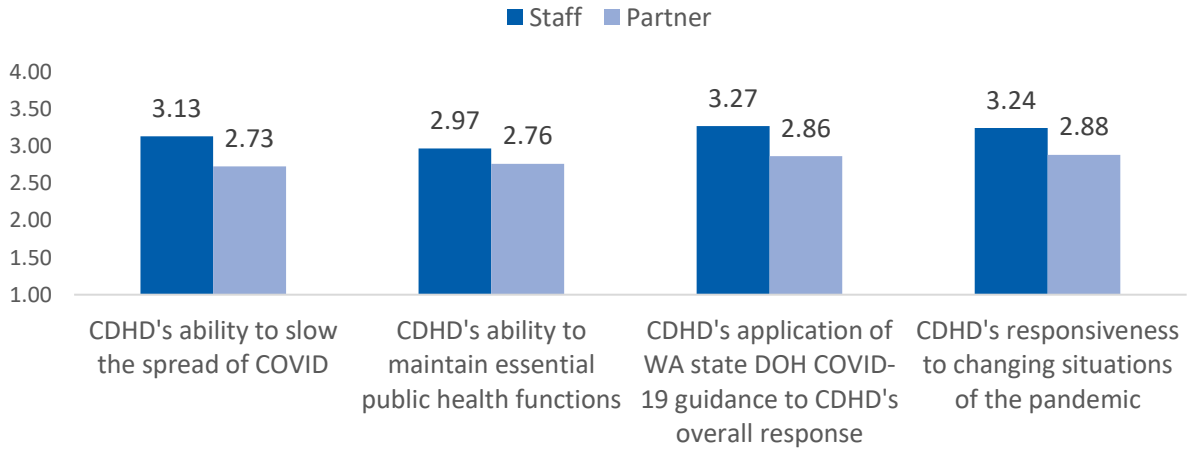
- **Vaccination:** Vaccinations first became available in December 2020 and were rolled out in a phased manner, with health care workers and first responders the highest priority. It is worth noting that in the beginning most locations required online sign-up for vaccine appointments, the ramifications of which are discussed in the following sections.
    - **Mass Vaccination:** In partnership with the DOH, Confluence, Law Enforcement, the Public Utility District, and others, CDHD supported a mass vaccination site at the Town Toyota Center Parking lot.
    - **Mobile Vaccinations:** In partnership with health care providers and contractors, CDHD, Columbia Valley Community Health, Medical Teams International, and Lake Chelan Community Health provided mobile vaccination services to individuals in their homes, at agriculture work sites, and at community and faith-based organization locations. Lake Chelan Community Health also traveled to remote communities only accessible by boat or plane to provide vaccines.
    - **Pediatric Vaccinations:** When pediatric vaccines were approved, there was significant effort to make vaccines widely available including after hours at schools willing to participate, at fire stations (in some areas), and at the mass vaccination site.

Overview of Survey Responses

Both staff and partners were asked to rate their satisfaction with CDHD's ability to slow the spread of COVID-19, to maintain essential services, apply the DOH's guidance, and respond to changing situations of the pandemic.

As shown in Figure 14, external partners consistently rated CDHD lower than staff did across the four measures.

Figure 14: Average responses across external operations overall (staff and partners)



External Partner Responses

Appendix 4 highlights the distribution of partner responses across the satisfaction scale, and demonstrates that 30% of respondents were either "dissatisfied" or "very dissatisfied" with CDHD's ability to maintain other essential public health functions during the pandemic response. Similarly, 29% were "dissatisfied" or "very dissatisfied" with CDHD's ability to slow the spread of COVID-19.

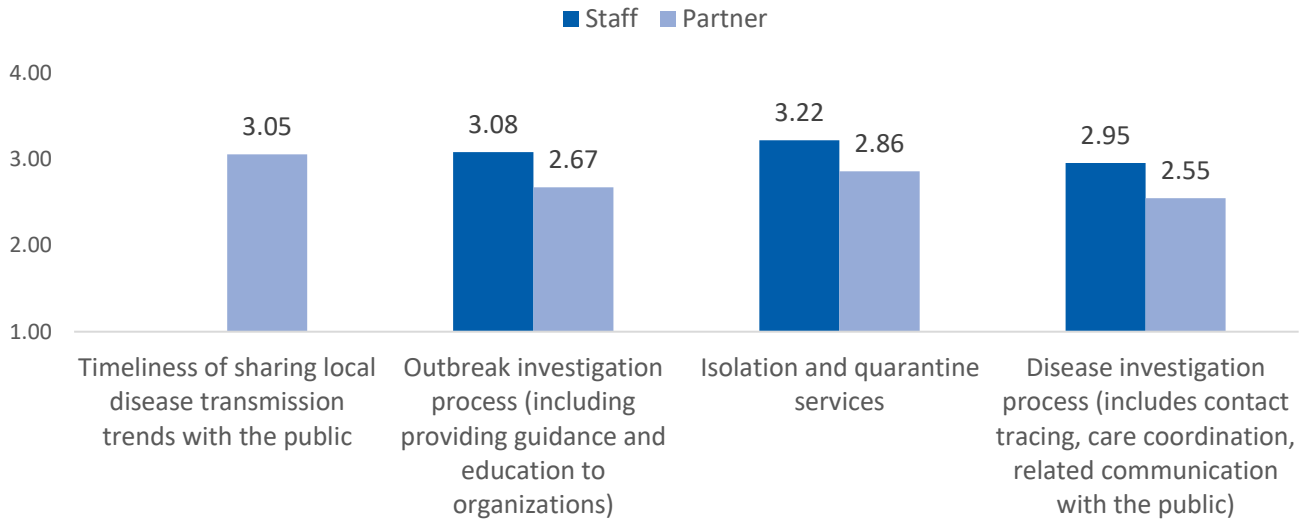
Staff Responses

Similar to external participants, a group of CDHD staff were also dissatisfied with CDHD's ability to maintain essential functions, with 25% of staff indicating they were "dissatisfied" or "very dissatisfied" in this area. When it came to the ability to slow the spread of COVID-19, there was higher satisfaction than expressed among partners, with only 16% of staff "dissatisfied" and none who were "very dissatisfied."

Disease Outbreak and Investigation, Isolation, and Quarantine

Again, partners tended to be less satisfied across all measures compared to CDHD staff. The disease investigation process received the lowest average score from both partners and staff, at 2.55 and 2.95, respectively.

Figure 15: Average responses across disease outbreak and investigation, isolation, and quarantine (staff and partners)



External Partner Responses

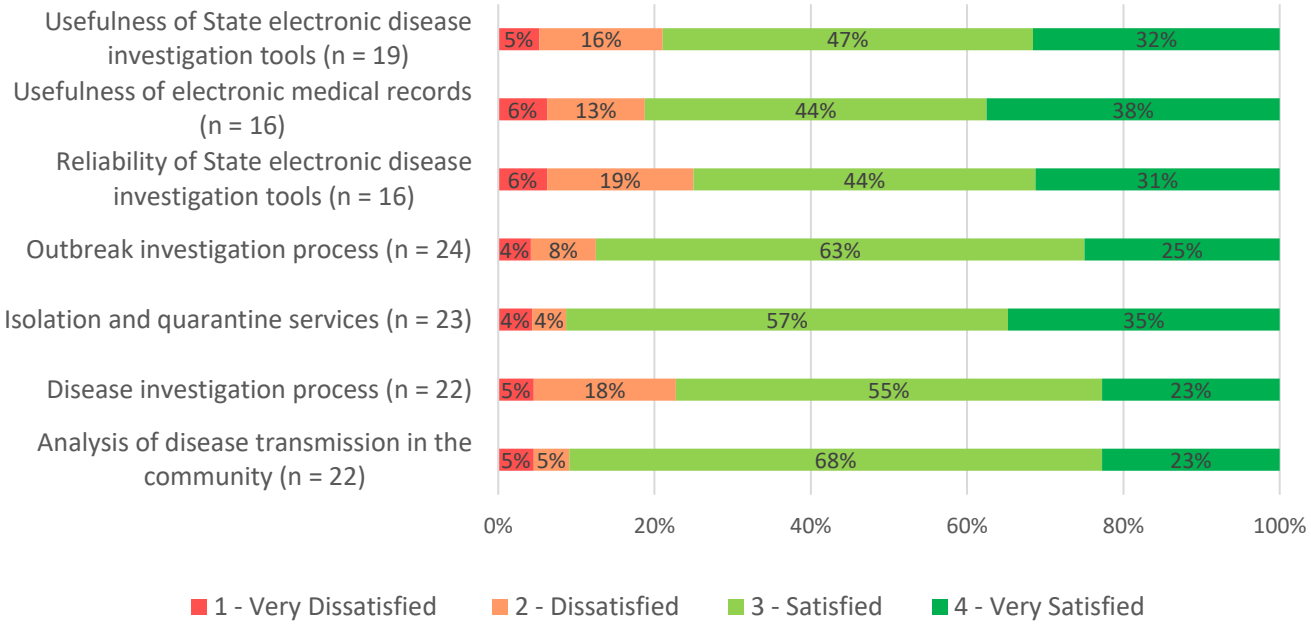
Appendix 6 conveys that partners were fairly satisfied with CDHD's timely sharing of disease transmission trends, with 25% who were "very satisfied" and another 60% "satisfied" in this area. Consistent with the average scores above, we see a large percentage of respondents were "dissatisfied" (35%) and "very dissatisfied" (10%) with the

disease investigation process.

Staff Responses

Staff were asked to rate some additional components, such as usefulness and reliability of disease investigation tools, as well as analysis of disease transmission in the community. The figure below reveals that a sizeable number of staff were unhappy with the usefulness and reliability of state disease investigation tools, with 21% and 25% "dissatisfied" or "very dissatisfied," respectively. On the other hand, there was high satisfaction when it came to isolation and quarantine services, as well as analysis of disease transmission.

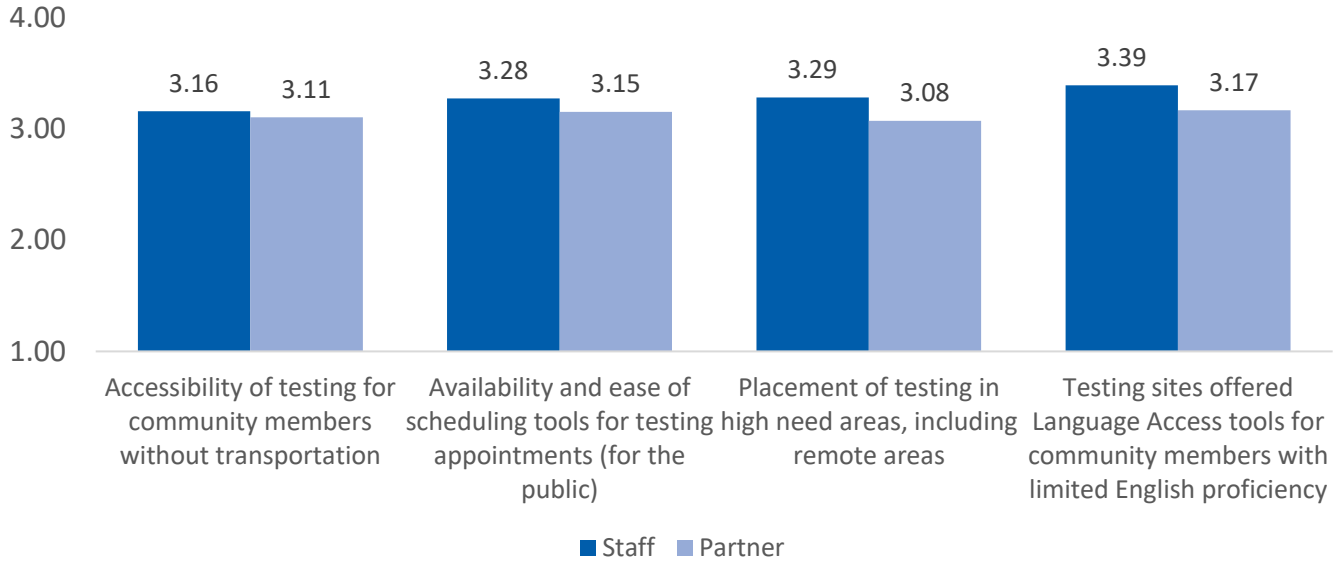
Figure 16: % breakdown of how staff rated aspects of disease outbreak and investigation, isolation, and quarantine



Testing

When it came to testing, both partners and staff were generally satisfied with CDHD's performance, with each aspect scoring above 3.0, or "satisfied." The responses indicated that staff and partners felt CDHD did a good job promoting accessibility and ease of testing.

Figure 17: Average responses across aspects of testing (staff and partners)



External Partner Responses

Per Appendix 7, partners were largely satisfied with the language access tools provided for community members with limited English proficiency, with 90% "satisfied" or "very satisfied." The highest percentage of dissatisfied responses was for "placement of testing in high need areas, including remote areas" and "accessibility of testing for community members without transportation," but even in these cases, 83% and 85% were still "satisfied" or "very satisfied," respectively.

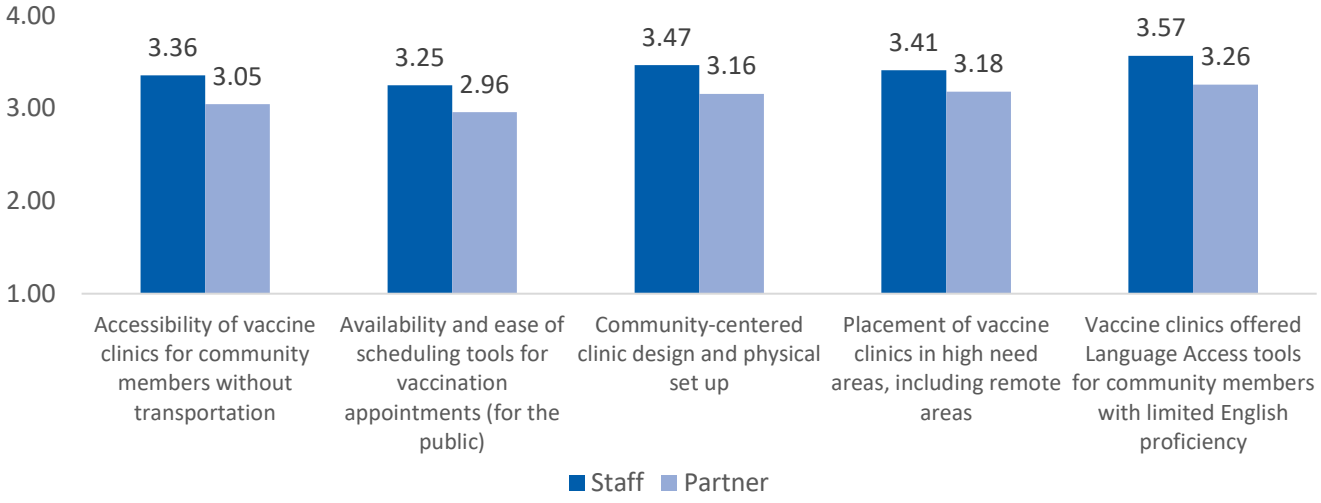
Staff Responses

Similar trends emerged in staff responses, with 93% "satisfied" or "very satisfied" with the language access tools offered, and the highest percentage of dissatisfied responses falling under accessibility of testing for those without transportation. Again, even though it received the highest percentage of unfavorable scores, there were still 84% of staff respondents who were "satisfied" or "very satisfied" with this area.

Vaccination

Both staff and partners alike relayed high satisfaction with CDHD's vaccination efforts, with all averages surpassing 3.0 or "satisfied," The only exception was that partners averaged 2.96 in terms of availability and ease of vaccination appointment scheduling tools.

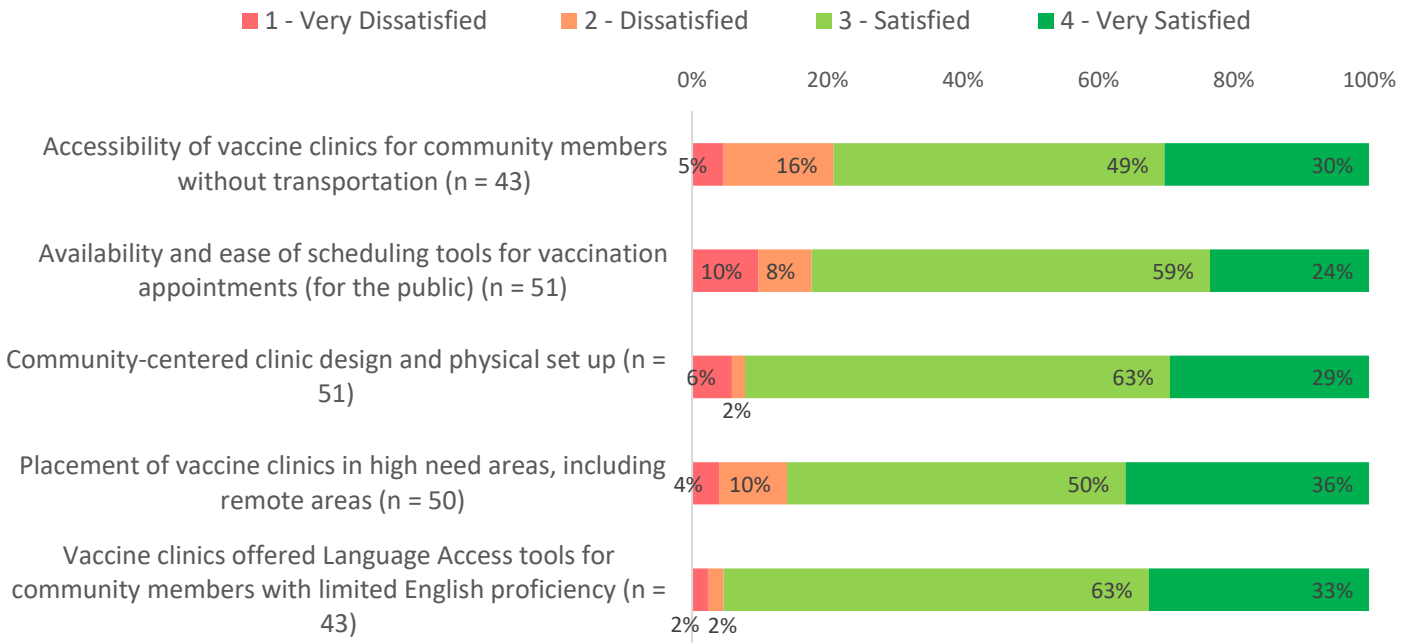
Figure 18: Average responses across aspects of vaccination (staff and partners)



External Partner Responses

Similar to sentiments around testing, the area that had the highest proportion of dissatisfied respondents was accessibility of vaccination clinics for those without transportation, with 21% "dissatisfied" or "very dissatisfied." Again, partners were satisfied with language accessibility tools when it came to vaccination sites, with 96% reporting being "satisfied" or "very satisfied." As implied by the averages reported above, there was a sizeable contingency of partners, 18%, who were "dissatisfied" or "very dissatisfied" with the availability and ease of scheduling tools.

Figure 19: % breakdown of how external respondents rated aspects of vaccination



Staff Responses

Appendix 9 indicates how satisfied CDHD staff were with the placement and accessibility of vaccination sites. Only one staff person was "very dissatisfied" with placement of clinics in high needs areas and "community-centered clinic design." Otherwise, there was strong satisfaction consensus across all measures. For instance, 97% were "satisfied" or "very satisfied" with language accessibility, and 96% were "satisfied" or "very satisfied" when it came to community-centered clinic set up.

Key Learnings

Strengths	Areas for Improvement
1. CDHD played a key role in providing access to testing 2. CDHD's work on the mass vaccination site and other vaccination pathways provided communities with consistent access to vaccination 3. CDHD successfully provided PPE to partners 4. CDHD was able to stand up an isolation and quarantine option for community members	1. CDHD had a difficult time maintaining essential public health services 2. CDHD's approach to contact tracing was inefficient and unsustainable 3. The vaccination appointment scheduling systems were difficult for the public to navigate

Strengths

Strength 1:

CDHD played a key role in providing access to testing

Survey and interview responses indicated appreciation for CDHD's role in making sure testing was available in the region. Some external partners and former CDHD staff flagged that testing was a critical gap that CDHD did not initially address and that health care providers had to fill—however, they acknowledged that over time CDHD entered the space and was helpful in organizing testing efforts.

By partnering with EMS, CDHD supported testing at the Town Toyota Center, and staff and partners alike were impressed with the efforts and the resulting availability of testing. Others appreciated CDHD's role in ensuring that farmworkers had access to testing.

Illustrative Quotes

"Worked hard to be inclusive in every community in the counties. Even when a community only had three people show up but more wanting it, more were scheduled to ensure everyone had local chance of getting tested."

–Survey, External Partner, First Responder (Fire, Law Enforcement, EMS)

"The other thing that I would really applaud our health district for was the setup of our vaccine clinics and testing...they were just top notch, and you could tell if you went out of our area as I did as was what was happening in [other regions in the state]...I mean, we were trying to get [our relatives] over here...just drive over and get service because our service was really fabulous. The other thing that they did was pulling in groups like our EMS teams to set up some of these clinics throughout the region, pulling in the National Guard to provide support. All of those things I think were outstanding."

–Interview, External Partner, Education/Schools

"Testing capabilities for farmworkers was great."

–Survey, External Partner, Community-Based Organization or Non-Profit

Strength 2:

CDHD's work on the mass vaccination site and other vaccination pathways provided communities with consistent access to vaccination

Another area consistently applauded by both internal and external stakeholders was CDHD's role in standing up the mass vaccination site at the Town Toyota Center and establishing additional pathways to vaccination.

There was general consensus that CDHD did a great job partnering with EMS, health care providers, the National Guard, Link Transit, and many more to ensure that community members who wanted vaccination could access it. Particularly impressive was that CDHD and partners were able to support the DOH and National Guard starting a mass vaccination site with very little warning. In mid-January, CDHD learned that a mass vaccination site was being established by the DOH and the National Guard and needed to open on the following week. Thanks to existing relationships, hard work, and quick planning, they were able to pull partners together and be ready by Monday. Staff and partners noted that the Town Toyota Center drew Washingtonians from across the state who wanted to access vaccination from a reliable, consistent location.

In addition to supporting the mass vaccination site, CDHD implemented approaches and partnerships to reach specific groups, such as those who are homebound, agricultural workers, and those living in long-term care facilities and adult family homes. Specifically, CDHD advocated for a walk-in clinic that did not require advance appointments, helped elderly residents schedule their appointments by phone, and organized mobile units to visit

long-term care facilities, adult family homes, remote parts of the region, and those who were homebound.

CDHD was intentional about making sure Spanish-speaking community members could access and navigate testing and vaccination processes. In partnering with community-based organizations like CAFÉ, Spanish-speaking community members could register for appointments by phone, and there were bilingual members on-site for testing and vaccination clinics. Staff and partners shared in their survey responses that vaccination clinics were staffed with multiple individuals who were bilingual and that any printed materials were readily available in both English and Spanish. Efforts to reach the Latinx community are also discussed in the "Communications and Outreach" section of the report.

A few external stakeholders, which included representatives from health care providers and long-term care facilities, did share that while they felt CDHD did a nice job promoting access to vaccinations in Wenatchee and East Wenatchee, they felt that other parts of the region (specifically the Upper Valley), did not receive the same level of attention or access.

Ultimately, CDHD and partners' efforts are reflected in the vaccination rates achieved in the area—at one point in 2021, Chelan County was 5th in the state for counties with the highest percentage of residents initiating their primary series or first dose. At the time of this report, of the state's 39 counties, Chelan County has the 8th highest percentage initiating vaccination (with 73% initiating primary series).[35]

Illustrative Quotes:

> "CDHD, along with other community partners, went above and beyond to reach high need & remote areas with vaccine clinics. We visited all the LTCFs in Chelan and Douglas counties, had regular visits to Chelan County Regional Jail, did home visits to give vaccine to homebound, worked with homeless shelters to offer vaccine, partnered with schools in more remote areas to offer vaccine when desired, did mobile clinics to remote orchards and H2A housing, etc."
>
> –Survey, CDHD Staff

> "The [Town Toyota Center] vaccine clinic is probably what CDHD should be most proud of. CDHD really did an incredible job with the vaccine roll out. Our community should be proud."
>
> -Survey, External Partner, Community-Based Organization or Non-Profit

[35]Washington State Department of Health. Accessed September 2023. COVID-19 Vaccination Data.

"CDHD and CAFÉ supported getting migrant workers bussed to the [the vaccine site] through private busses (churches etc.). CDHD worked with local transportation to make sure that they had a designated day and time to bring people for free to the vaccination site especially those without transportation."

–Survey, External Partner, State or Federal Agency

"...having a number of partners that we were working with...was very beneficial to having the community trust us, and running what I would say categorically was probably the best mass vaccination site in the state in terms of length of duration, continuity. It may not have hit the total numbers others did, but in terms of saturation for our community. Chelan County had 70% primary dose vaccination...we hit 70% primary dose vaccination in 2021, which put us at fifth in the state, number one in Eastern Washington...I think that is a huge feather to the cap of not only [CDHD] staff, but our community partners...you know, we have people drive from all across the state to come and get vaccinated at our site because it was the most consistent."

–Interview, CDHD Staff

Strength 3:

CDHD successfully provided PPE to partners

CDHD staff mentioned that one of their strengths was equipping partners with personal protective equipment (PPE), and partners echoed this. Representatives from health care, schools, and churches specifically noted that CDHD's assistance securing and distributing PPE was incredibly helpful, especially when there were shortages.

Illustrative Quotes:

"I appreciated [CDHD's] ability and willingness to spearhead and organize warehousing efforts for PPE resources."

–Interview, External Partner, Health care Provider or Agency

"The Emergency Management department and CDHD were great helping with masks, and making sure donations coming our way from the feds could be deployed quickly."

-Interview, External Partner, Education/Schools

"On the logistical side of things, we handled it pretty quickly when our partners needed PPE/testing kits."

–Survey, CDHD Staff

Strength 4:

CDHD was able to stand up an isolation and quarantine option for community members

When asked about general or external operations strengths, several staff and board members highlighted CDHD's ability to stand up an isolation and quarantine (I&Q) option for community members who were unable to safely isolate or quarantine where they resided, such as people who are unhoused or live in congregate settings.

CDHD staff shared that there was not much information or precedent on how to set up an I&Q facility, and so staff members responsible reached out to other counties to understand how they were approaching it. They then worked to stand up a facility where community members who needed to isolate could go. The initial hotel chosen for the I&Q site was fairly costly, but later in the response the team adjusted to a site with a more reasonable cost.

Establishing an I&Q facility for community members in-need was generally viewed as a strength, as it provided an option for those who needed it. That said, several external survey respondents and one interviewee noted that the expense and time invested into the I&Q, especially given that only a small number of people ended up using it, made it more of a weakness than a success. Specifically, these respondents noted that the resource was not well publicized and getting access was confusing, and that it took a large amount of CDHD staff time to coordinate. Interviews with staff confirmed that a lot of time went into managing meal logistics, handling calls from the hotel about challenges, etc.

Illustrative Quotes:

"One of the things that I was particularly proud of...is that we...worked really diligently to stand up an IQ facility and that was...in a very short period of time and along with being able to provide for food and necessities...I think that was at a time where there was so much going on...I was thankful that we were able to do that with some amount of success. So that kind of stands out as a bright spot."

–Interview, External Partner, Local County or City Government

"Chelan-Douglas was proactive in establishing an I&Q facility early in the pandemic. The original hotel site was very expensive but was covered by CARES Act funding from both counties. The site was moved in early 2021 to more reasonably price facility. I&Q processes and staffing were well thought out and organized. This was not the case in other parts of the NCW region."

–Survey, CDHD Staff

"Great collaborative effort with other agencies to provide food and lodging solution for quarantines."

–Survey, External Partner, Education/Schools

Areas for Improvement

Area for Improvement 1:

CDHD had a difficult time maintaining essential public health services

Both staff and partners averaged below 3.0 for satisfaction around CDHD's ability to provide essential public health services in the midst of the COVID-19 response. Many interview and survey respondents acknowledged that this was tied to the understaffing and lack of human resources to adequately keep up with existing essential public health services, in addition to the effort that was being poured into the COVID-19 response. An already undersized workforce was further reduced when staff continued to leave due to burnout, and job positions were left unfilled.

Staff relayed that team members had to be pulled from across the organization to respond to COVID-19, and inevitably other work had to be put on hold, including following up on other reportable conditions.

Additionally, internal and external stakeholders noted that the CDHD office being closed to the public was a significant factor in feeling like CDHD was not able to meet other public health needs in the midst of the pandemic. The CDHD building closed to the public on March 19, 2020 and did not reopen to the public until January 2022.

Illustrative Quotes:

"When CDHD office was closed in the spring of 2020 and certain staff were randomly assigned to IMT roles, many of the other essential functions of CDHD were not covered. Staff began resigning and many gaps were created in overall public health services. Public access to CDHD office was not re-established until late 2021. It should have happened much earlier."

–Survey, CDHD Staff

"We had to pull in all of our nurses and other Personal Health staff early on in our response, which meant all routine program work was put on hold for many months. The leads of these programs were heavily involved in our response, which affected how our programs functioned. As a result, many of our high-risk clients went without support during this time. The COVID workload was not equitable, leading to burnout for many staff."

–Survey, CDHD Staff

"COVID-19 seemed to be the primary focus and purpose of CDHD for about 2 years, which is understandable and valid. But in doing so, other public health functions were severely neglected at times. It is understandable that priorities would shift for a short period of time, but it seemed that the redirection of resources to COVID-19 was prolonged/repeated and not enough efforts were made to enable employees to do their other public health work."

–Survey, CDHD Staff

"It was hard to keep up the other core parts of CDHD. [Responding to] the pandemic is just one slice of our mission and it was taking over."

–Interview, External Partner, Local County or City Government

Area for Improvement 2:

CDHD's approach to contact tracing was inefficient and unsustainable

Feedback on CDHD's ability to conduct disease and outbreak investigation revealed frustration with the contact tracing process and effectiveness. Many interviewees, when asked about general operational challenges, specifically raised contact tracing as a pain point.

Stakeholders acknowledged that a key factor was lack of personnel to effectively carry out the contact tracing. One staff member shared that contact tracing team members worked seven days a week for weeks straight, attempting to stay on top of the workload. Others shared that there was a lot of confusion at the onset, the process itself was flawed, and that communication between the IMT and case investigation and contact tracing team could have been stronger earlier.

With the volume of exposures outmatching the ability of personnel available to make calls, the notifications were often delayed and not helpful in stopping the spread of COVID-19. While CDHD attempted to enlist support from schools, health care providers, and DOH, none of these paths worked very well. CDHD would try contracting out to another group or asking the DOH for help, and when that proved unsuccessful, CDHD would take it back on, and the cycle would repeat. Both CDHD staff as well as representatives from schools, health care, and DOH mentioned this shifting responsibility.

Illustrative Quotes

"I felt this became a scare tactic and issue and people were afraid to tell they had [COVID-19]. Also, phone calls would come days to a week after the last contact."

–Survey, External Partner, Education/Schools

"I felt like most of this was left up to the schools, who were also taxed for lack of staffing."
–Survey, External Partner, Education/Schools

"I was a part of the conversations setting up contact tracing protocols - it was a web of insanity and no one knew what they were doing. It was inefficient and ineffective."
–Survey, External Partner, Community-Based Organization or Non-Profit

"It took us way too long to really get functional case investigations and contact tracing established. This was partially due to staffing and partially due to a lack of connection between IMT and the [Case investigation and contact tracing team].
–Survey, Former CDHD Staff

"...we did not have the staffing capacity to complete case investigations and contact tracing throughout the entire pandemic. We could not keep up with the volume of cases. We used school nurse volunteers which was not successful. We contracted with our health partners and that was not successful. We turned over our [Case investigation and contact tracing] to DOH several times because we couldn't keep up."
–Survey, CDHD Staff

Area for Improvement 3:

The vaccination appointment scheduling systems were difficult for the public to navigate

It is important to note that scheduling systems used by other entities such local health care providers and the Washington Department of Health were outside of CDHD's control. Ultimately, however, real and perceived barriers to scheduling and a confusing scheduling process has implications for communities being able to access and receive vaccination.

One fundamental issue was that the vaccine appointment scheduling system used by the DOH at the mass vaccination site relied on online scheduling which often presented a barrier for the elderly, those living in areas with poor internet connection, those who were not tech savvy, and those without mobile smart phones. CDHD received many calls from members of the public who had trouble figuring out how to schedule an appointment. A couple respondents shared that the various vaccine administration sites had different systems and there was not consistent and clear messaging around what platforms to use.

That said, CDHD and partners did provide on-site registration assistance and some walk-in options to mitigate these challenges.

Illustrative Quotes:

"Scheduling tools assumed internet and computer skills and equipment were available to members of the public. For those without, scheduling was very difficult. I later fell away from involvement in this, so I do not know how things went later."

--Survey, CDHD Staff

"The scheduling system for the mass vax site was incredibly difficult for the public to navigate. CDHD received an enormous number of phone calls about scheduling vaccination appointments while the mass vax site was operational."

--Survey, CDHD Staff

"At the very beginning of the vaccination phase, it was incredibly difficult to make an appointment for the seniors of the community and the site from DOH was not very user friendly."

–Survey, Former CDHD Staff

"Early on, this was a disaster. Too many different directions to access the scheduling site. It did not work well. Often people did not know if you needed an appointment or if you could just drive-in. The phone system set up for assistance did not work well. This is the area that was the most problematic."

--Survey, External Partner, Other

"Every clinic had different protocol which made the process difficult to navigate."

--Survey, External Partner, Local County or City Government

Partnerships

Background

When the pandemic started, there were insufficient existing mechanisms for CDHD to coordinate with entities such as health care providers, first responders, schools, community organizations, faith-based organizations, and others to the extent and with the frequency that the pandemic required. Partnership and coordination were lacking for the first six months of the pandemic. By the end of the pandemic, however, new partnerships and coordination mechanisms were established and routinized, demonstrating a significant change over time.

Below are summaries of the partnerships that were identified most frequently by respondents:

- Health care providers: In 2020, health care providers and CDHD operated mostly independently. Many health care providers formed their own incident management teams. CDHD would do their best to answer questions coming from health care providers but the various entities were not regularly sharing multidirectional information. Around December 2020, when vaccines became available, CDHD invited health care providers to join a vaccine planning coalition that met weekly. The coalition continued to meet regularly to share information, ask and answer questions, and jointly problem solve challenges.
- Emergency Responders: There was an initial meeting between the fire districts and CDHD around May/June 2020 where the fire districts agreed to put together an Incident Management Team (IMT) plan for CDHD to follow. The fire districts spent a couple weeks building out the plan and CDHD decided not to implement it. Starting in August and September 2020, CDHD started partnering with emergency responders through testing and outbreak response. Lake Chelan Community Health Emergency Medical Services was contracted in February 2021 to provide vaccines to migrant workers, homebound individuals, isolated communities, and any other vulnerable group identified. They helped achieve vaccinations rates above 70% by providing services to those who had the most significant access issues.
- Schools: The health officer and other CDHD representatives regularly (often weekly) met with school superintendents and school nurses to answer questions that were specific to the school context, such as how to reopen schools (how to improve air circulation and socially distance in the classroom) and how to enact quarantine and isolation guidelines with children showing symptoms or testing positive for COVID-19. The health officer could also clarify public health guidelines since schools sometimes received conflicting information or guidelines from different sources including the DOH, Office of Superintendent of Public Instruction (OSPI), and Educational Service Districts (ESD).

- Faith-based organizations: CDHD shared information with faith-based organizations. This included sharing and explaining information about restrictions implemented by the Governor's office. CDHD also engaged pastors across the Spanish-speaking community to be able to talk to their congregations about COVID-19. CDHD also formed a group of pastors, initially Spanish-speaking and later expanded to include English-speaking pastors as well, through which they could disseminate information and answer questions. The group met regularly so CDHD could give updates on the pandemic and find out what resources churches needed (masks, sanitizer, etc.). CDHD attempted to open up more communication and discussion through a "town-hall style" forum for faith-based organizations, but not enough organizations were interested.
- Multi-Agency Coordinated Policy Group (MAC): This group was formed to help keep the counties, law enforcement, Confluence Health, CVCH, and a few other participants in the loop during the COVID-19 response. The meetings were hosted by Aging and Adult Care and continued through 2022. They provided feedback from community partners in running the IMT.

In addition to how and when CDHD coordinated and engaged partners, actions of members of the Board of Health impacted partner perceptions of CDHD. In May 2020, lawsuits were filed in Douglas and Chelan counties seeking to overturn restrictions on commerce and construction imposed by Governor Inslee during the pandemic. Three members of the Board of Health were initially a part of this lawsuit (as individuals; not in their official capacity) though they later withdrew. The request to overturn Governor Inslee's state of emergency declaration was denied in June 2020 by a Chelan County Superior Judge. The litigation was covered widely in local media and it was mentioned by a number of interview respondents.

Overview of Survey Responses

Both CDHD staff and community partners were asked to rank how well CDHD collaborated with various sectors in the pandemic response, both overall and also when it came to each sector specifically.

Generally, CDHD staff were slightly more satisfied than external partners when it came to CDHD's overall efforts to partner with other groups, although external responses did average out to nearly "3.0" or "satisfied" across the various measures.

Figure 20: Average responses across partnership overall questions (staff and partners)

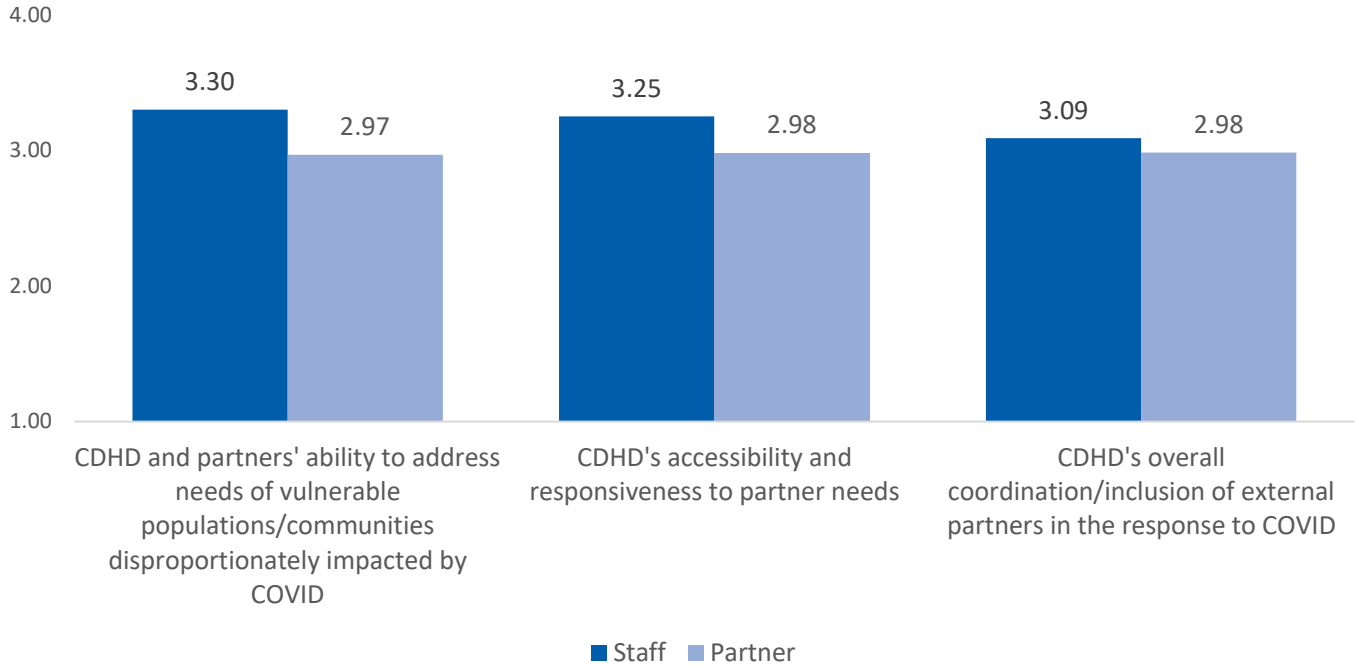
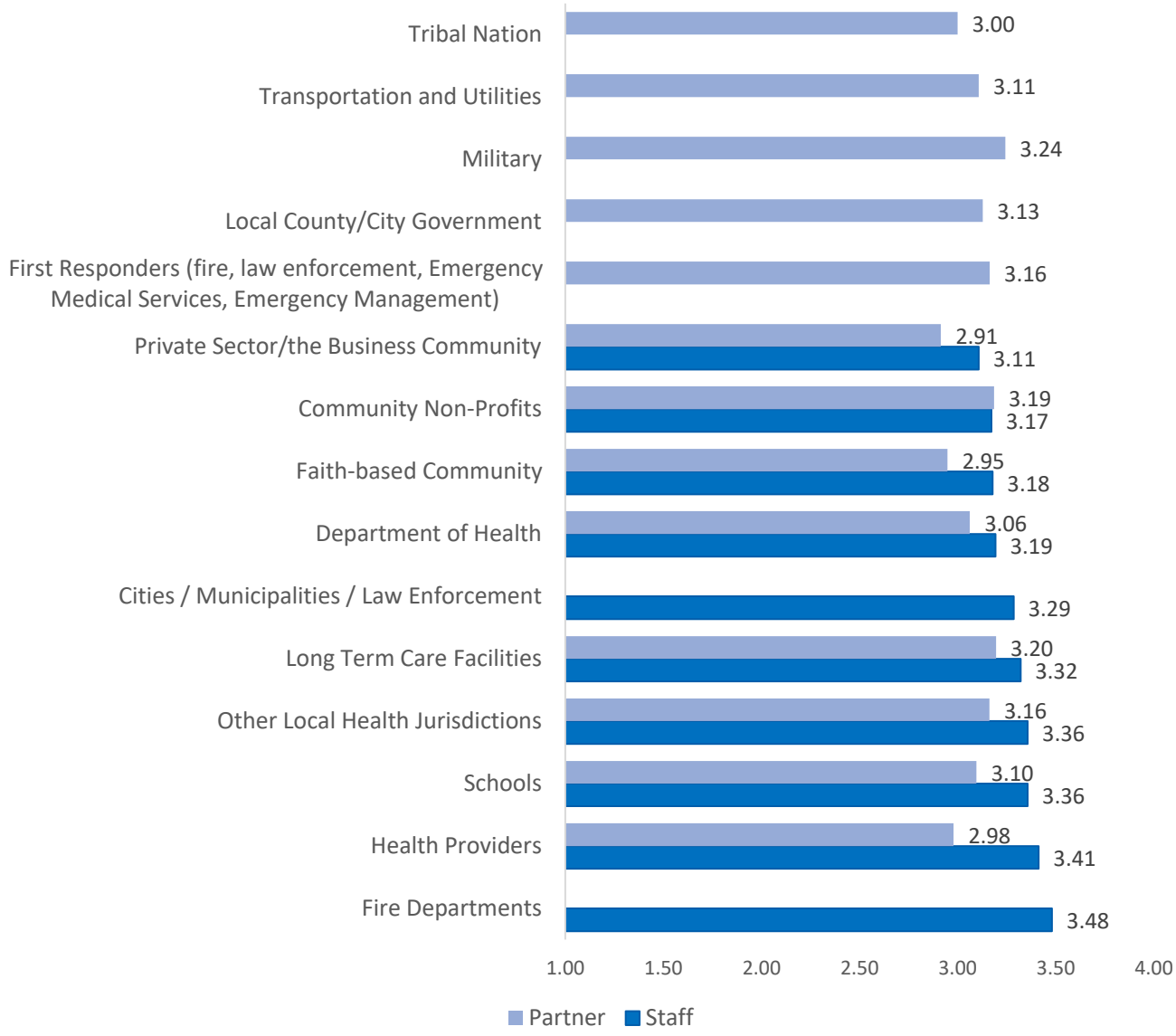


Figure 21 shows staff and partner assessments of how CDHD partnered with particular sectors throughout the pandemic. Note that there are several sectors where staff average or partner average does not appear—this is because after the staff survey was disseminated, several important sectors were added and/or recategorized.

Overall staff ratings were higher than partners', but partners' ratings in almost all sectors scored above an average 3.0 of "satisfied." The exceptions were "Private Sector/the Business Community," "Faith-based Community," and "Health Providers" which averaged out to 2.91, 2.95, and 2.98 respectively.

Figure 21: Average responses for CDHD's partnership across specific sectors (staff and partners)

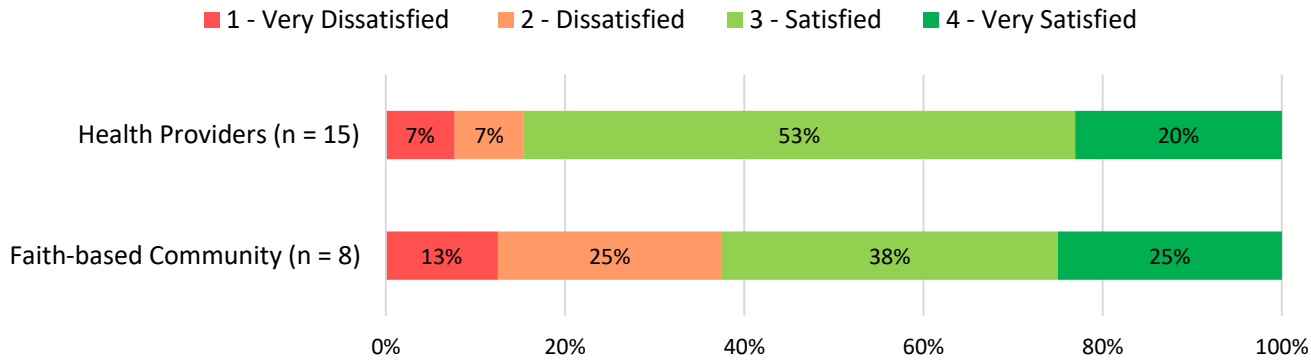


Because averages and distributions for each group are based on rankings from respondents across all sectors—in other words, representatives from Long Term Care Facilities (LTCFs) may be ranking CDHD's partnership with the Faith-based community, for example—we took a closer look at what members of the private sector, the faith-based community, and health providers community themselves thought of CDHD's partnership with them.

We isolated responses from each of these groups and found that the health providers themselves had a satisfaction of 3.27, much higher than the 2.98 average resulting from considering respondents from all sectors. In the case of faith-based community, however, they yielded an average rating of 2.75, or below the 2.95 averaged across all respondents.

There was only one respondent identifying as from the private sector/business community who answered this question, and they were "very dissatisfied" with CDHD's partnership.

Figure 22: distribution of responses for CDHD's partnership in health providers and faith-based community



External Partner Responses

The breakdown of how external respondents felt about CDHD's general coordination and partnership indicate that the majority were "satisfied" or "very satisfied." However, a sizeable number of respondents were not as pleased with CDHD's partnership efforts. For example, 30% of respondents were "dissatisfied" (23%) or "very dissatisfied" (7%) with "CDHD's accessibility and responsiveness to partner needs."

Figure 23: % breakdown of how external respondents rated aspects of CDHD's partnership

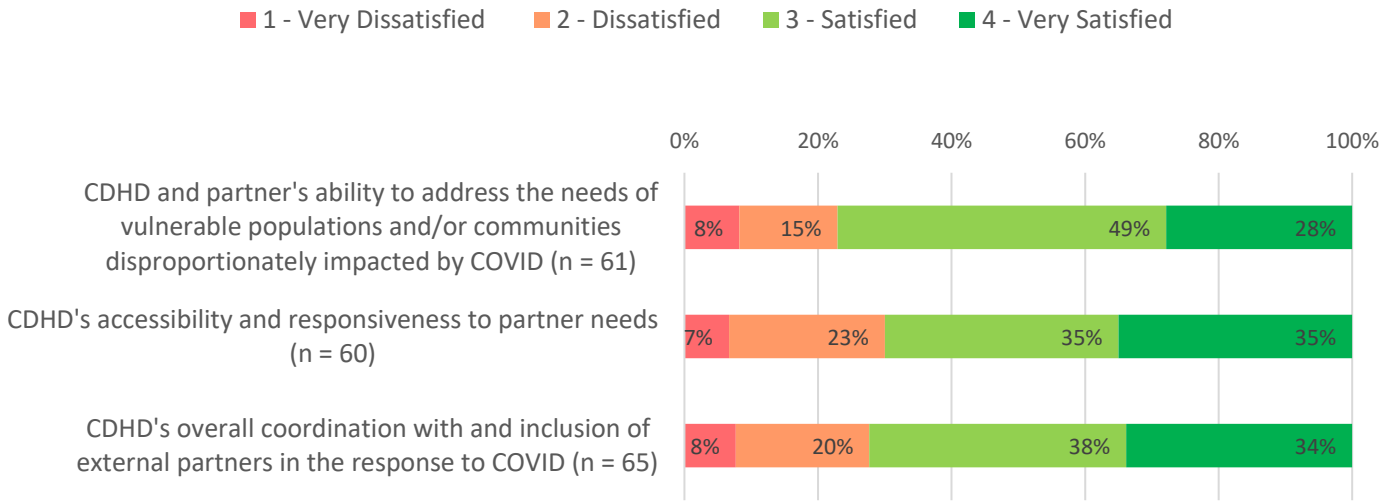
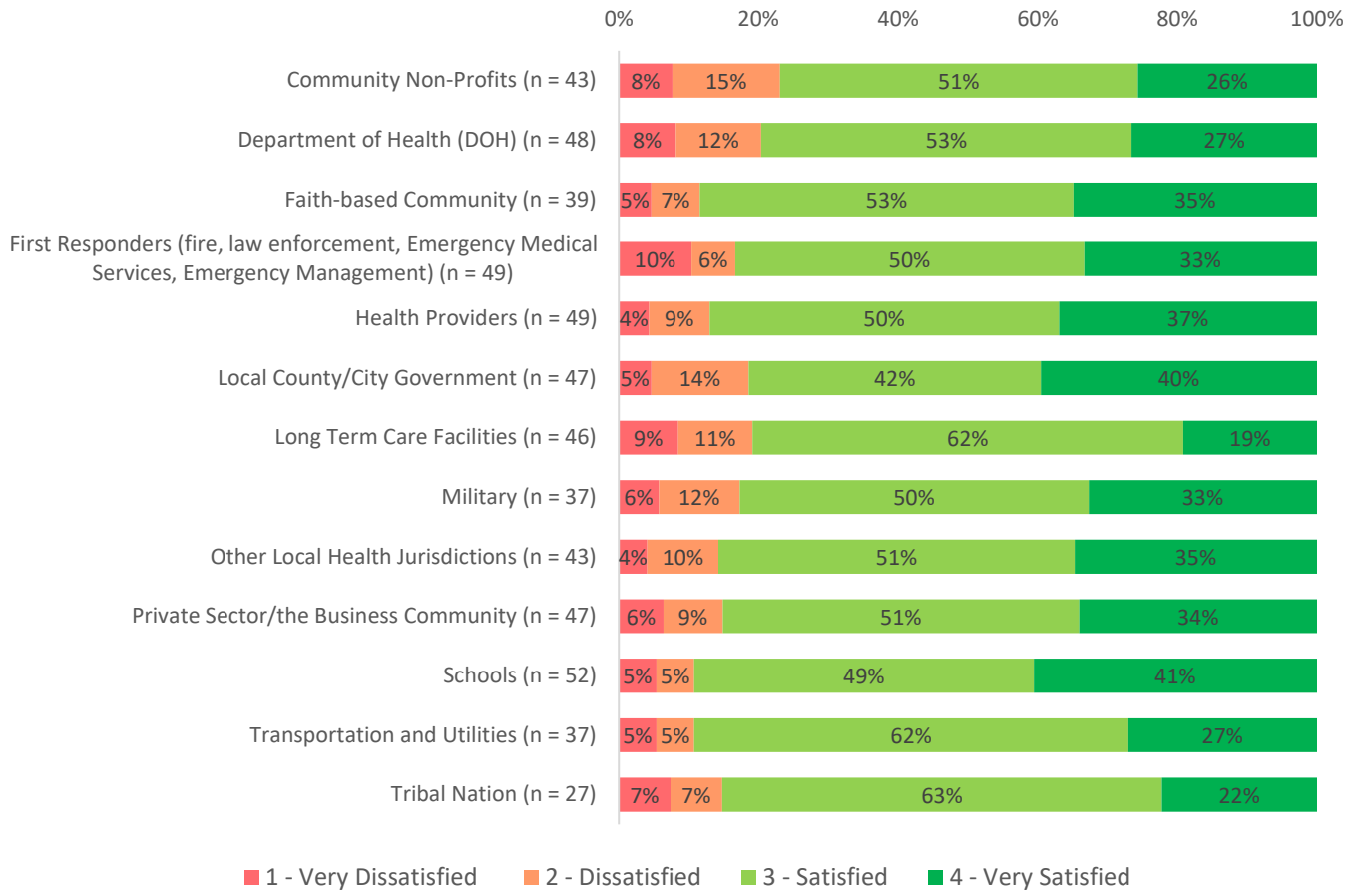


Figure 24 drills down into the breakdown of responses that resulted in the average ratings per sector that are displayed above.

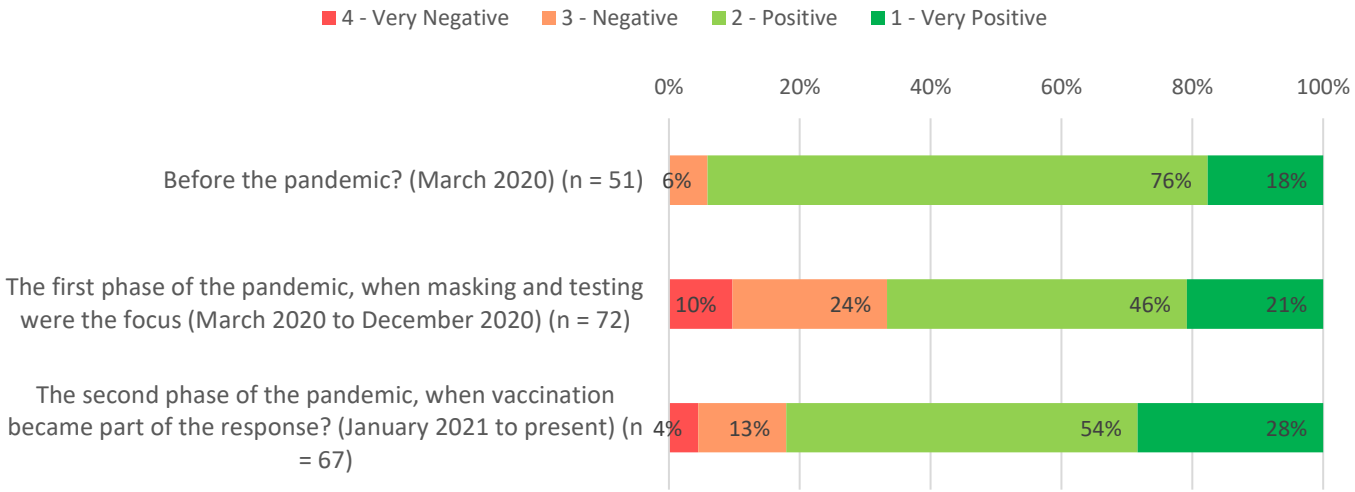
Figure 24: Percent breakdown of how external respondents rated CDHD's partnership with each partner type



External respondents were also asked to rate their relationships with CDHD before the pandemic, during the first phase of the pandemic, and during the later phase of the pandemic. Figure 25 highlights that overall, the majority of respondents considered themselves to have "positive" or "very positive" relationships with CDHD across all time periods. The figure also highlights that while 10% of respondents had a "very negative" relationship with CDHD in the first phase of the pandemic, this shrunk to 4% in the second phase of the pandemic. This indicates that CDHD was able to improve relationships as the response progressed. Another illustration of the improved relationships is that the 67% who were "satisfied" or "very satisfied" in the first phase of the response increased to 82% in the second phase of the pandemic.

Thirty-one respondents stated they did not have a relationship before 2020, compared to only 14 respondents who reported no relationship during the second phase, indicating that CDHD's network grew over the course of the pandemic.

Figure 25: Percent breakdown of how external respondents classified their relationship with CDHD over time



Staff Responses

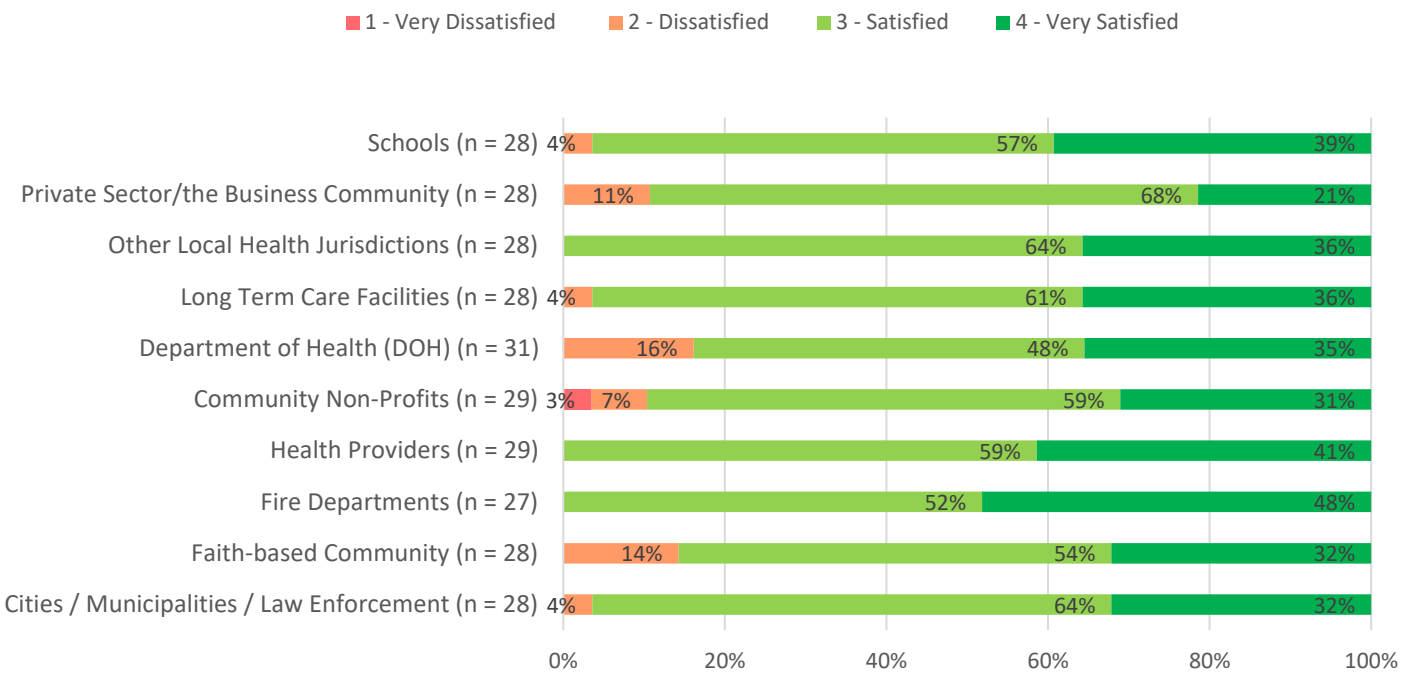
As shown below, staff were generally "very satisfied" with how CDHD coordinated with partners, responded to partner needs, and worked with partners to address needs of vulnerable communities. However, 15% of staff respondents were either "dissatisfied" or "very dissatisfied" with how CDHD coordinated with and included partners in their COVID-19 response.

When staff were asked to rate CDHD's partnership with specific groups, the ratings exceeded how external partners responded—for example, the only "very dissatisfied" response across all groups was a single respondent who was specifically very dissatisfied with how CDHD partnered with community non-profits.

There were 11% "dissatisfied" with the private sector/business community partnership and 14% who were "dissatisfied" with the partnership with the Faith-based community, indicating some convergence with how external partners responded on these areas. The only measure that received a higher percentage of "dissatisfied" responses was on how CDHD partnered with the Department of Health (16%).

"Health providers" is the group for which staff and external responses diverged most—while 13% of external respondents were "dissatisfied" or "very dissatisfied" with how CDHD supported and partnered with them, no staff chose these options, and instead were exclusively "satisfied" or "very satisfied" with CDHD's partnership with health providers.

Figure 26: Percent breakdown of how staff rated CDHD's partnership with specific groups



Key Learnings

Strengths	Areas for Improvement
1. CDHD provided strong support to schools 2. CDHD facilitated teamwork and resource sharing across health providers 3. CDHD built and leveraged relationships that helped CDHD serve the community 4. With time, CDHD became a valued and trusted partner in the response	1. CDHD was slow to offer leadership, guidance, and organization to partners and the overall response 2. Partners and staff felt attitudes and actions from the Board of Health undermined CDHD's ability to partner and respond effectively early on in the response 3. CDHD had early missteps in partnership opportunities with first responders that impacted effectiveness of the response

Strengths:

Strength 1:

CDHD provided strong support to schools

Note: because the predominant feedback was that CDHD did a great job supporting schools, we have categorized this as a strength. That said, there were several representatives from schools whose survey responses indicated they were not happy with the support provided, and we mention this below.

Interviews and survey comments indicated that overall, schools appreciated the support they received from CDHD. CDHD representatives, including the Health Officer, met with superintendents and school nurses on a weekly basis to offer support and guidance as schools navigated the pandemic. Survey responses indicated that most representatives from schools felt that CDHD listened and responded to school concerns and feedback. Likewise, CDHD staff reported being satisfied with the relationships they built with school nurses and administrators.

One interviewee appreciated CDHD's efforts to coordinate with surrounding Local Health Jurisdictions (LHJs) on things like messaging and materials. This increased alignment across LHJs and subsequent guidance to schools mitigated divergence and confusion among schools in the region.

Some interviews and survey comments indicated schools did not always get the support they needed from CDHD. One survey respondent from Education/Schools shared, "At first the response was fine, but after Delta hit, we couldn't even contact CDHD so we started making decisions on our own because we simply couldn't get ahold of anyone." Another respondent lamented the inefficient reporting they were required to do for positive cases and that personnel changes at CDHD made it difficult to know who their point of contact should be for what.

Illustrative Quotes:

> "What was very positive was the weekly meetings with CDHD. We met weekly and included superintendents and school nurses. That was a positive experience for the school nurses. Good opportunity to talk to superintendents and they had backup by public health experts."
>
> –Interview, External Partner, Education/Schools

"CDHD was above par—they were amazing. I have nothing but great things to say. They committed time to meeting with our superintendents weekly…sometimes multiple times a week. I had regular check-ins with [the health administrator] …he presented himself as a learner, listener, and problem solver…CDHD was so responsive to emails and helped us understand guidance from the state. And we knew who our contacts were."

–Interview, External Partner, Education/Schools

"[The health officer] called us directly regarding a safety concern with an upcoming event. He listened to us and partnered with us to find the solution."

–Survey, External Partner, Education/Schools

Strength 2:

CDHD facilitated teamwork and resource sharing across health providers

Interviews and surveys from health care organizations and providers indicated that over time, CDHD's intentionality around convening area providers was incredibly helpful and made for a stronger collaborative response to COVID-19. Respondents were especially appreciative of CDHD's leadership in bringing health care organizations together once a week, at minimum, to discuss challenges, updated guidance from DOH, alignment on messaging, resource sharing, etc. Interviewees credited CDHD with keeping the group of providers in the area working together throughout the response.

Both staff and health provider interviewees mentioned that CDHD's stance of humility and willingness to admit when they did not know something, and CDHD's genuine desire to continue getting better as a partner, stood out and fostered teamwork among the group of health care providers in the region.

CDHD's leadership in this area, however, did not start until some time into the response (around October 2020), and health providers were frustrated with CDHD in the early days ("areas for improvement" will expand on this). Also, two health care provider agencies did mention that although they appreciated CDHD's coordination among health providers, they sometimes felt overlooked due to their size and/or location as compared to other providers in the region.

Illustrative Quotes:

"…it was very helpful when [CDHD] served as the conveners of different organizations in the community because we all had a piece to play and as much as we tried to communicate together, sometimes it was useful to have CDHD bring us together and help us figure it out. They convened infection preventionists to share struggles and successes; that was really helpful for all of us to have an idea what the other was doing during that time. The other helpful thing is [the health administrator] would try to give us transparent ideas of the conversations happening at the state level to give us heads up and context on what was going on. And at the same time, I think he was articulating our problems back up to [the state level]."

–Focus Group, Health care Agency

"CDHD convened "weekly communications meetings [across health care organizations] that were part strategy, part therapy, part informational, and making sure our calls to action were consistent with each other. And that was helpful. If not coordinated exactly, we were at least all rowing the same direction."

–Focus Group, Health care Agency

Strength 3:

CDHD built and leveraged relationships that helped CDHD serve the community

Note: The faith-based community had mixed levels of satisfaction in terms of CDHD's partnership with them. Of the eight faith-based representatives who answered questions in this section, two were "dissatisfied," one was "very dissatisfied," three were "satisfied," and two were "very satisfied" with how CDHD partnered with them. Overall, CDHD made a strong attempt to engage the faith-based community and this was recognized by several pastors who responded to the survey. We are therefore highlighting their relationship as a strength, while recognizing that staff and some faith-based representatives see room for improvement.

CDHD staff worked creatively and with intention to engage a broad coalition of partners that allowed CDHD to better serve the community. As examples, they worked with the Chamber of Commerce throughout the pandemic, including co-designing a safe reopening plan, and CDHD worked with non-profits such as CAFÉ to reach the agricultural worker community with information and access to vaccinations and testing. They also partnered with the nursing program at the college to be able to hold flu clinics at a Parque Padrinos event as they worked to maintain other services beyond COVID-19.

Additionally, CDHD sought to be a helpful partner to the faith-based community during the COVID-19 response, in hopes to reach more community members. For instance, CDHD engaged pastors across the Spanish speaking community, calling to introduce themselves and talk about what was happening with COVID-19 in the region, and equipping pastors to

be able to talk to their congregations about it. CDHD formed a group of pastors, initially Spanish-speaking and expanding to English-speaking as well, to meet regularly so CDHD could give updates on the pandemic and find out what resources churches needed (masks, sanitizer, etc.).

Despite these efforts, some CDHD staff and some representatives from churches felt that CDHD's efforts fell short, or were too overreaching. In many cases, the complaints were more about COVID-19 restrictions imposed by the state rather than actions by CDHD. One person summed it up by saying: "We just wanted to be left alone." Another person elaborated by saying: "Most of our challenges were not in working with CDHD, but in working with the Governor's Orders. We are a Christian congregation that likes to sing. Most people thought it was stupid and unnecessary for Inslee to order us to "hum" underneath our masks, rather than sing! Similarly, the state was also a little heavy handed with its regulations for preachers to preach behind a three-sided plexiglass panel. To be honest, I never did that. I was more than 20 feet from anyone when I preached."

Illustrative Quotes:

"I liked the emails which I received from CDHD, which were tailored to churches like ours. I also thought it was great when CDHD dropped off four cloth masks at our facility. I wore one! Plus, the frequent and informative updates by the health officer, Dr. Malcolm Butler, were very well received by many people. Bravo!"

–Survey, External Partner, Faith-Based Group

"My feeling is that CDHD was viewed by almost everyone in the community as both authoritative, and a genuine partner. They worked with people, and businesses, and churches such as ours, to address the COVID pandemic."

–Survey, External Partner, Faith-Based Group

"I am thankful that CDHD, to be the best of my knowledge, took the approach of education, rather than punitive enforcement. I doubt our church would have taken kindly to CDHD officials coming to "police" worship on Sunday mornings."

–Survey, External Partner, Faith-Based Group

"We amplified the message of CDHD and got information to our membership. We distributed masks for CDHD and counties. We hosted briefing calls weekly where Dr. Butler and the administrator would brief business owners on the state of COVID and answer any questions business owners had about changing regulations and what we knew at that moment about the disease."

–Survey, External Partner, Community-Based Organization or Non-Profit

Strength 4:

With time, CDHD became a valued and trusted partner in the response

Although it took time for CDHD to be seen as a strong player in the response to COVID-19, many survey respondents and interviewees acknowledged that CDHD was able to build this credibility and trust as the pandemic wore on. Specifically, health care organizations, schools, and first responders mentioned the transformation that CDHD underwent and their ability to make real contributions and build back credibility.

Respondents credited this marked improvement to dedicated line staff who did not give up, as well as new leadership that brought improved communication, collaboration, and leadership.

Illustrative Quotes:

Health care organizations and schools saw CDHD's contributions to the response improve dramatically:

"CDHD was very helpful with the vaccine, and bringing in the testing. They began to be public health. Once we got thru [the pandemic] a bit they stepped up. My sense is that new leadership contributed to that."

–Focus Group, Health care Agency

"CDHD was very slow out of the gate, but ultimately became good partners and collaborators over the second half of the pandemic."

– Focus Group, Health care Agency

"CDHD was nonexistent at the beginning but in the end was very strong, and were a key component in our response."

– Focus Group, Health care Agency

"[Eventually] they became a central hub for information, with health providers and leading community response. Side meetings ended. We were meeting with [many other health care organizations] and it was a lot of trying to move things forward—once CDHD was able to take the helm it was more streamlined."

– Focus Group, Health care Agency

"After time, the clarity improved. Weekly regional meetings with the Health Officers were extremely helpful. Being able to contact CDHD staff to get answers was very helpful." – Survey, External Partner, Education/Schools

"Initially when trying to work with [first responders] they felt like CDHD hadn't treated them well, valued them, engaged with them in a meaningful way. As we all got to know each other and work together that really transformed. Some of the fire chiefs became staunch supporters, and some sheriffs started to be strong partners. They came to the table to discuss and were present, involved, and trying to figure things out."

–Interview, External Partner, State or Federal Agency

Areas for Improvement

Area for Improvement 1:

CDHD was slow to offer leadership, guidance, and organization to partners and the overall response

The resounding feedback from health provider survey responses and interviews was that CDHD was largely absent in the first phase of the pandemic, which left a void that health care providers attempted to fill.

All but one of the health care organizations interviewed shared that they felt like they had to take on responsibilities that should have been the role of public health, even though they were already incredibly strained trying to serve patient needs. As one example, health care organizations set up incident command structures in February and March 2020. However, the ineffective IMT that CDHD set up was not in regular communication with IMTs that health care organizations implemented. It was not until August 2020 that CDHD initiated effective incident management of the pandemic by bringing in trained outside management teams to assist the staff.

Both health care organizations and CDHD staff acknowledged that a lot of the difficulty stemmed from CDHD being understaffed, underfunded, and having significant turnover at the leadership level. Nevertheless, partners were frustrated that the majority of coordination fell to them.

Staff also noted that the fact they were receiving information and guidance at the same time as partners and the general public made it difficult for CDHD to be at the forefront leading stakeholders.

Illustrative Quotes:

Health providers and community based organizations throughout the region expressed frustration with CDHD's lack of leadership at the beginning of the pandemic and the resulting void:

"In their failure to lead, CDHD saddled health providers with public health duties well into the pandemic, despite desperate pressures on health providers."

–Survey, External Partner, Health care Provider or Agency

"As a health care organization in the region we felt like we had to be the community response…with CDHD there was a lot of transition in leadership during COVID. And we felt that. We really felt like we needed to be the face of education, the point of testing for the entire community, and ultimately later on the vaccination. We picked up the mantel in a way we wish CDHD could have but we understand that they were significantly under resourced after years of underinvestment."

–Focus Group, Health care Agency

"[CDHD], particularly the leadership, was very ill prepared to manage a crisis of this nature and didn't have the skillset to manage it. Early on a lot of the leadership and decisions were being driven by hospitals and EMS."

–Focus Group, Health care Agency

"Even though they exist it felt like we had to do everything that falls under public health. This was a public health emergency and the hospital should have been a component [and not the driving force]."

–Focus Group, Health care Agency

"The lack of CDHD resources (especially early in the pandemic) placed our organization in a position to be the leaders of the community response (testing, vaccination). Early, it was easier to 'just do it ourselves.' As CDHD leadership changed and resources increased, we became much better collaborators and coordinators of our response efforts."

--Survey, External Partner, Health care Provider or Agency

"I think there was a lot of reliance on partners to do things CDHD should have done, but without the coordination. Other agencies had to pick up the slack of CDHD administrator in the beginning because things weren't getting done. It wasn't until summer 2020 when the incident command structure was put in place that there was real collaboration with external partners. Until then, it was partners doing work because it needed to get done and telling CDHD about it. Partners needed a lot of help from CDHD we just didn't get - rather it was us helping CDHD. In no way did CDHD coordinate the pandemic response in the early days."

—Survey, External Partner, Community-Based Organization or Non-Profit

Staff also acknowledged CDHD's slow start to coordination and partnership:

"In the beginning, CDHD did not do a decent job of partnering with some local health care providers to share info, collaborate or implement a unified system to manage the pandemic. Some the responsibility is that of the local HC providers unwillingness to be "team players" with CDHD or others in 2020. This improved during 2021 to present as regular meetings were established to include all the key HC providers in the region. Should have happened in March of 2020."

—Survey, CDHD Staff

From March through October of 2020, CDHD did a poor job of coordinating and working well with partners. It's taken a lot of failure in the last two years to get to the point of feeling like CDHD plays well with others."

—Survey, CDHD Staff

"Early on, we struggled with working with outside agencies. I think this improved over time, but was again very difficult (and often ignored) by the time I left. I wish we had continued to participate in community and agency meetings."

–Survey, Former CDHD Staff

"At first things were very difficult, we had very little staff to take on something like this. Things were not smooth, nor did everyone work together. We had had poor management, kept losing our administrator, it was chaotic. When DOH would put out a mandate for WA State, no one informed our Local Health District…it was some time before things started to get a little organized…some days is was chaos, everyone had their own ideas, so nothing went smoothly with others. It took a long time before things improved."

–Survey, CDHD Staff

"[Health care organizations and partners] really stepped up in promoting vaccine access and sites. We had community partners who could make up for our slow pace."

–Interview, Former CDHD Staff

Area for Improvement 2:

Partners and staff felt attitudes and actions from the Board of Health undermined CDHD's ability to partner and respond effectively early on in the response

Many partner survey and interview respondents took the opportunity to express dismay at the Board of Health's early response, which many felt actually interfered with CDHD and the community's ability to respond. This was a sentiment expressed by representatives from health care organizations, transportation and utilities, community-based organizations,

local city/county government, Fire/Law Enforcement/EMS, and CDHD staff. Several former staff cited difficulties with the board as driving reasons for why they left CDHD.

Respondents highlighted concerns around the fact that although there were some helpful and well-intentioned board members, a vocal minority severely undermined CDHD's ability to have a strong and cohesive approach to supporting the community through the pandemic. Partners perceived board members to be making decisions according to their personal interests and for re-election, as opposed to what would save lives. Respondents felt that the board politicized the response and this created drama and distraction that hindered stakeholders' ability to come together and respond collaboratively.

Staff and external partners felt that having board of health members initially part of the lawsuit against the governor over COVID-19 restrictions undermined their ability to communicate COVID-19 risks to the community. Interviewed board members relayed that the lawsuit was not about COVID-19, but rather about how to avoid the region's economy coming to a halt and how to help small businesses stay afloat. Ultimately, however, it eroded staff and partners' trust and confidence in the board. Similarly, some board members noted that they felt the lack of trust from others and it impacted their ability to have their suggestions taken seriously.

Several survey respondents and interviewees relayed another concern with board actions that hindered partnership and the response. When the longtime health administrator departed the agency, staff and partners perceived there to be a hurried decision by the board to insert an interim administrator. From their perspective, the appointment seemed to be made without allowing staff input or general insight into the needs of agency at the time and whether the appointee's skillset was right for the role.

While tension and confusion surrounded the board's actions in the early phases of the response, several interviewees made a point of mentioning that over time, the board (particularly leadership) clearly demonstrated their commitment to CDHD and the community in regards to the COVID-19 response. One external partner said that despite actions early on, "[the board members] were very responsive and they changed and they adapted and that was their strength. Their resiliency as a board is what helped keep the ship afloat." A staff member said, "While the board of health had struggled in 2020, not having solid advice and expertise to guide them, they quickly came to understand that they needed to shift how they were operating...that shift was very positive for the agency and they became very supportive...and they deserve credit for turning it around and really making sure CDHD had what it needed to move forward."

Illustrative Quotes:

External partners felt the Board of Health inhibited CDHD's ablity to lead an effective response:

"In the beginning months CDHD had a complete failure to lead in the face of a public health emergency. CDHD board was more interested in fighting health measures than supporting hard choices to keep the community safe and health care resources available for all and the staff seemed unwilling to stand up to the uneducated board."

–Survey, External Partner, Health Care Provider or Agency

"It was most difficult to work with some members of the board who put economic interests above the health of marginalized and underserved communities,"

–Survey, External Partner, Community-Based Organization or Non-Profit

"I was disappointed in how members of the Douglas County Commission and the Wenatchee City Council approached their litigation with the Governor's Office. They did not communicate with the other board members and the public in general. I was also disappointed in the antagonistic approach some board members showed in working with both the Department of Health and the local health officials."

–Survey, External Partner, Local County or City Government

"[What improved over time was CDHD's] ability to react to a changing environment regardless of the politics. I think the staff accepted the board's direction even though they disagreed with it. Once the IMT came on board and said 'No, we need to do it this way to save lives", staff started looking from a different perspective and agreed there is a better way for all and took the lead to make local changes. Empowering your people to grow and do the right thing happened because of the IMT structure where there was a plan in place and not simply listening to the minority board members who were most vocal in the meetings and in the media to undercut the organization they were supposed to champion and represent, not tear down"

-Survey, External Partner, First Responder (Law Enforcement, Fire, EMS)

Former and current staff expressed concerns around how the Board of Health's actions impacted their abiltiy to effectively partner with others:

"Board of health made [coordinating with external partners] very difficult."

–Survey, CDHD Staff

"Actions of the Board of Health and some individual members made it impossible for CDHD staff and its Health Officer to effectively implement a science-based COVID response." –Survey, Former CDHD Staff

"CDHD did not slow the spread even with much effort on the part of staff. The initial response was stunted by internal turmoil between staff and board and by poor decisions by the board."

–Survey, Former CDHD Staff

"The board prevented coordination with certain external partners early on but CDHD staff forged ahead despite this obstacle."

–Survey, Former CDHD Staff

Area for Improvement 3:

CDHD had early missteps in partnership opportunities with first responders that impacted effectiveness of the response

Several interviewees relayed that CDHD administration was quite slow to accept assistance that fire districts and emergency management offered at the onset of the response. There was an initial meeting between the fire districts and CDHD around May/June 2020, and although the fire districts sensed hesitancy around CDHD's willingness, it was agreed that the fire districts would put together a plan for bringing together an IMT and CDHD would follow it. The fire districts spent a couple weeks building out the plan and CDHD administration ended up deciding not to implement the plans that fire districts had drafted. This was frustrating to both the fire districts who devoted time to building a plan and saw the critical need, as well as CDHD staff who would have appreciated more structure, guidance, and experience guiding their efforts.

Some CDHD leadership felt that implementing an incident command structure in the form of an IMT would be more work than was necessary. There was a belief that ICS paperwork and processes would slow down the team's efficiency on important matters. Additionally, there was a concern that following a system originally designed for fires would not be applicable to the public health emergency the region was facing. The fire districts, however, felt that using the incident command structure, which was developed for all hazard events, was crucial because of the enduring nature of the pandemic and that without a solid IMT in place, people would burn out and the response would be uncoordinated.

Despite this faulty start, new CDHD leadership was able to mend relationships with the fire districts later in the response, and ultimately their expertise was leveraged in the response to COVID-19. One staff member surveyed specifically recognized the helpful partnership with the fire departments, stating, "The fire district staff that came in to serve roles on our IMT were extremely helpful in leading our response at the end of 2020."

Finally, at least one law enforcement representative who was surveyed did not appreciate CDHD's initial approach because they perceived CDHD was trying to issue orders to law

enforcement and that CDHD had no legal authority to do that. The survey respondent noted, "This was not well received. As the pandemic response continued and moved towards mass vaccination, initial planning did not include considerations of local Law Enforcement. This was corrected and coordination improved, but changes in command team for mass vaccination were not communicated with local [law enforcement] and caused further confusion." While the Health Officer does have legal authority to respond to public health emergencies under RCW 70.28.031 and the health district is the primary agency in charge for communicable diseases, more education needs to be done with partners and the community so that people understand what public health's role is in a pandemic.

Overall, there was room for improvement in how CDHD partnered with first responder agencies in the early days of the pandemic. A more collaborative and swifter partnership could have positioned CDHD for a stronger response to COVID-19.

Illustrative Quotes:

"The communications between CDHD and other organizations was lacking desperately. And that improved greatly after the IMTs came in…holding collaborator meetings, tying different organizations in together, etc. Even though they came from out of the public health area they're trained in that. I remember we were throwing up our hands…because we knew things weren't going well and there was no desire at the highest level [to engage an IMT]."

–Interview, CDHD Staff

"We should have been more prepared but had very minimal training in incident command, and had poor communication altogether. The administrator wouldn't reach out and get people to come and help us, because I suggested several times, 'Can't we get an [Incident Command] IC team to come in?' and [administrator at the time] wouldn't have anything to do with it so we were just falling apart. Working every single day for months and months."

–Interview, Former CDHD Staff

"CDHD was inclusive in its willingness to partner and accept help. The downfall was the initial structure for the first six months of the response led to CDHD staff burnout and ultimately departures. This impacted CDHD's ability to respond to the crisis, and required more resource/help from outside agencies."

—Survey, External Partner, Community-Based Organization or Non-Profit

"It was very difficult early as an external partner, to get any inclusion with CDHD. Once a true ICS system and teams were set up the process became much better."

– Survey, External Partner, First Responder (Fire, Law Enforcement, EMS)

Communications & Outreach

Background

Prior to the pandemic (January 2020), CDHD had one communications coordinator and one part-time outreach coordinator (who was also the facilities manager). After the pandemic started, there were efforts to grow the team, including adding an outreach component. Some of these activities, in early 2020, tried to utilize volunteers and community members, but CDHD had trouble coordinating these efforts. Information changed frequently and CDHD did not receive information before the public, making it challenging to get information to the public quickly. In the beginning, CDHD also lacked adequate mechanisms to get information to their Spanish-speaking communities quickly.

The size of the team oscillated throughout the pandemic but by January 2021, the team was consistently about three people. This team was later expanded to five people: a communications director, a liaison, an outreach coordinator, and two outreach workers.

Activities that fall under the communications and outreach category included:

- Keeping CDHD website up-to-date with the most relevant COVID-19 information in Spanish and English, sometimes updating the website multiple times per day.
- Providing information about COVID-19 and events through social media.
- Creating and updating an online COVID-19 dashboard that shared information such as number of positive cases and hospitalizations.
- Creating educational materials for the public that needed to be changed or updated as information changed and translating these materials into Spanish.
- Supporting the health officer in creating weekly educational videos in English and Spanish.
- Holding in-person outreach events such as handing out fliers door-to-door, advertising vaccination events, or conducting in-person outreach with agriculture workers living in congregate settings who were high risk for contracting COVID-19.
- In January 2021, CDHD started weekly press conferences that were in English and a live interpreter would translate to Spanish. These were later reduced to monthly and then ended in June 2021 as vaccinations dwindled. They continued ad hoc for information regarding new variants or vaccine activities.
- CDHD received thousands of calls during the pandemic. In an attempt to answer these calls, several tactics were used to try and keep up with call volumes. However, no tactic enabled CDHD to respond to all calls during peak times (such as the Delta Wave in Spring of 2021). Those calling for topics not related to COVID-19 sometimes found that they were unable to reach anyone. The tactics used included:

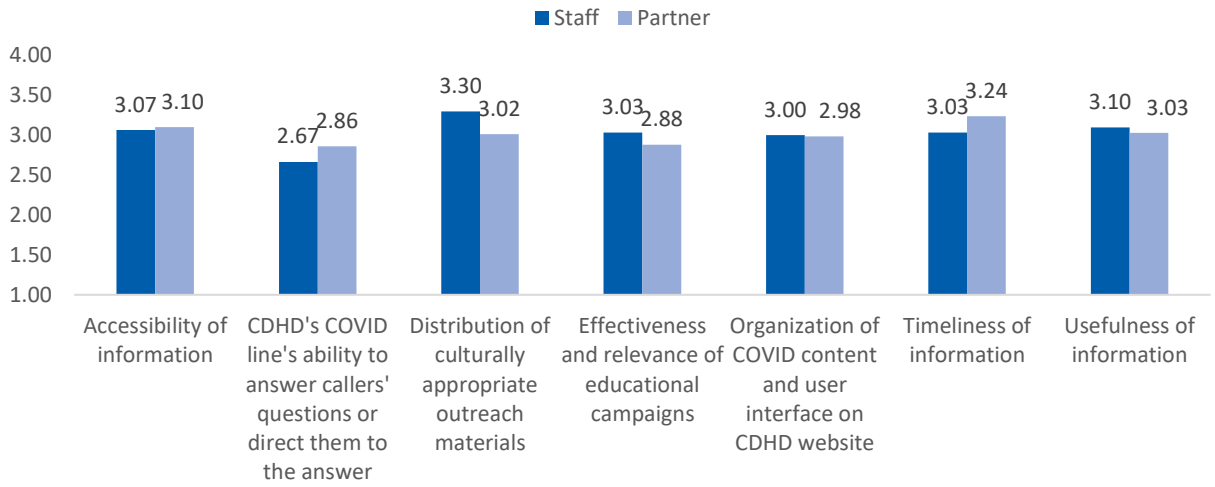
  - Created an automated phone tree to allow people to select the specific person or department they wanted to speak to in attempts to streamline calls to the correct person.
  - Utilized an answering service to help field calls and direct them to the correct person.
  - Forwarded calls to various staff who took turns answering the phone. However, this turned into a full-time (and more) job for those attempting to answer calls. When people in interviews referred to the "COVID-19 line" that is what they are referencing.
- Washington DOH also set up a call line that worked intermittently. Sometimes CDHD would transfer people to that line, only to have them transferred back to CDHD with instructions to talk to their local health jurisdiction.

Overview of Survey Responses

Both staff and partners were asked to rate their satisfaction with CDHD's communications and outreach efforts across areas such as accessibility of information, distribution of culturally relevant information, and timeliness of information.

As shown in Figure 27, in some categories staff rated performance lower than external partners did, and for other areas it was the reverse. For instance, CDHD staff were less satisfied than external partners when it came to the "COVID-19 line's ability to answer callers' questions." On the other hand, staff gave a higher satisfaction rating regarding "Distribution of culturally appropriate materials" than external partners did. Overall, average ratings were fairly similar and generally a 3.0 ("satisfied") or higher, with the exception of the COVID-19 line.

Figure 27: Average responses across communciations and outreach questions (staff and partners)



External Partner Responses

In reviewing external partners' distribution of responses, we found that the area with the highest percentage of dissatisfied partners focused on CDHD's inability to answer questions using the COVID-19 line. Twenty six percent of respondents were either "very dissatisfied" or "dissatisfied." This is explored further in the qualitative responses below.

Staff Responses

In reviewing the staff's distribution of responses, we see that 40% of staff were "very dissatisfied" or "dissatisfied" with the COVID-19 line. Only 10% of staff were "very dissatisfied" with the organization of COVID-19 content on the website. On the other hand, respondents expressed fairly high satisfaction rates when it came to the timeliness of information provided, and the distribution of culturally appropriate materials.

Key Learnings

Strengths	Areas for Improvement
1. CDHD used a variety of methods to reach communities with information 2. CDHD's convening of health providers enabled agencies to put out aligned messages to the community quickly and effectively	1. CDHD was slow to get information to the public 2. There was room to improve communication and outreach to several specific communities, such as elderly, homeless, and people living in rural areas 3. Early on, the needs of the Latinx community were not fully addressed

Strengths

Strength 1:

CDHD used a variety of methods to reach the communities with information

Survey responses and interviews revealed an overall appreciation for CDHD's willingness to use a variety of methods and mediums to reach the community with information and resources.

Staff cited the dedication of the small communications and outreach team as key to a strong communications' response. CDHD employed methods ranging from CDHD staff going door-to-door informing residents about upcoming testing or vaccination events, to using Facebook live, to billboards, to press releases, to Twitter, and more. The outreach team made a concerted effort to be present and accessible in the community—staffing

events in the extreme cold and heat—to ensure that people had access to CDHD and information.

Several internal and external respondents credited CDHD communications and outreach efforts for increasing vaccination rates throughout the region.

A couple survey respondents shared that even though they were not personally interested in the information that CDHD was putting out, they did know right where to find it if they had been interested.

Illustrative Quotes:

"I have so much respect for the outreach and communication teams. It was an absolute victory. The vaccination numbers started going up."

–Interview, External Partner, Incident Management Team

"The information to the public was provided over multiple resources from [Facebook] live, to [Instagram] live, radio, local media and word of mouth connections throughout the community and community groups."

–Survey, External Partner, State or Federal Agency

"You heard it on the radio, you saw the advertisements in the newspaper for...where to go to get tested, where to go to get a vaccine. Articles by [the Health Officer] as a spokesperson, articles by [the Health Administrator]...you know those were really valuable…you have limited resources, so it's challenging to try to come up with media plans that hit everybody equally…but I do think that they put forth the effort of doing that."

–Interview, External Partner, Education/Schools respondent

Strength 2:

CDHD's convening of health providers enabled agencies to put out aligned messages to communities quickly and effectively

CDHD facilitated teamwork across health providers (described in more detail in the "Partnerships" section), which included facilitating weekly virtual gatherings of the Public Information Officers (PIOs) from the various organizations coordinate on messaging.

The health care organizations interviewed shared their appreciation for CDHD's leadership in convening partners, which streamlined efforts and led to clearer, more consistent messaging reaching the public. By joining forces and working together, CDHD and partners were able to deliver more timely, accurate messages to the public.

Illustrative Quotes:

"On the communication level, [CDHD] did a good job of getting PIOs [Public Information Officers] together to do common messaging. Because everyone was receiving different information, and the thing that helped us was unity in messaging, like having the same logos on the same message…we had weekly meetings and talked about the messaging together and then feed it into the messaging [each of our organizations] had."

–Interview, External Partner, Health care Provider or Agency

"CDHD started hosting a weekly call that helped with interagency collaboration, and we knew where everyone was at…if not coordinated exactly, at least we were all rowing the same direction."

–Focus Group, Health care Provider or Agency

"There were not a lot of media outlets so that limited what impact we could have. [CDHD staff person] did a great job working with other PIOs to really leverage the limited capacity pretty effectively and doubled down on social media and alternative media in the community."

–Interview, External Partner, State or Federal Agency

Areas for Improvement

Areas for Improvement 1:

CDHD was slow to get information to the public

There was consistent feedback, internally and externally, that CDHD faced challenges getting timely information to partners and the public. One key challenge was that CDHD would not receive communication from the state in advance of when information was publicly available. Several CDHD staff shared that sometimes they would learn something new from a community member who they were trying to guide and assist, that they themselves had not yet heard.

Both staff and external partners relayed that the COVID-19 line that was established fell short in serving the public with timely and accurate information. Respondents understood this was largely due to the limited number of staff able to be designated to respond to calls, but nevertheless resulted in delays and confusion for those seeking answers. Many staff indicated that the system was not well organized. Often it was difficult to determine appropriate call routing. Also, the process sometimes changed without staff being notified. Staffing the COVID-19 line was incredibly time consuming for the few assigned staff that did it, and despite their extreme efforts (including working well into the evening), the line was not a consistent, timely, and reliable source of information.

Illustrative Quotes:

"The communication was hit and miss. I would call and get a timely response from one contact and then that person was no longer in that position and I didn't know who I was supposed to contact. I would call and leave a message and nobody would call me back."

The same respondent also noted:

"I felt there was not a clear contact for communication and sometimes we couldn't even get through to anyone. It wasn't even clear who we were supposed to talk to. We had a lot of questions and didn't know how to get them answered. We also feel there was less services and communication provided at our facility in comparison to those facilities closer to CDHD building."

–Survey, External Partner, Long-Term Care Facility

"Though it has improved substantially since 2022, too many calls have gone unanswered for days at a time, or the person(s) were 'in a meeting' for several days from sunup to sundown. We always got what we needed but, in a timely manner no, I would say overall I was very disappointed with the delayed responses and requests for testing kits, etc.

–Survey, External Partner, Long-Term Care Facility

"The COVID line at CDHD was not well implemented or organized. There was not enough staff assigned to handle the calls and not enough factual info was shared with the staff handling the call. Many calls went to [voicemail] and went unreturned to the caller. Not well received by the public. This needs to be greatly improved during future emergency responses."

–Survey, CDHD Staff

"I was working with incident command in the early days and the call lines never knew the right answers for people and would have different answers depending on who answered the calls. I saw from the back end how disorganized this process was and how untrained people were."

–Survey, External Partner, Community-Based Organization or Non-Profit

CDHD not getting advance warning about changes in information or policies was noted by multiple interviewees as a communication challenge. It is also mentioned in the "Internal Operations" section of this report because it impacted CDHD's ability to operationalize policies and mandates. These quotes provide insight into how not receiving information in advance impacted communications:

"There was a lot of confusion about messaging because the state would pivot on something and we were trying to catch up, or other groups would be out there throwing out information, and that created mistrust, distrust, and confusion in the community."

–Interview, External Partner, Local County or City government

"The information at the State and Federal levels were changing constantly and there was little to no "heads up" for local government, so it was difficult to tackle questions when we were finding out about nation/statewide changes at the same time as the public."

-Survey, CDHD Staff

Areas for Improvement 2:

There was room to improve communication and outreach to several specific communities

Answers were mixed to the question on the staff and partner surveys that asked "Do you feel any particular groups of people were left out in CDHD's response to COVID-19?" Many said that CDHD did a thorough job across the board and applauded their intentionality around equity. Others, however, gave feedback on groups that could have been served better. Namely, respondents relayed that the needs of rural, homeless, homebound, elderly, and community members who did not speak English or Spanish could have been more fully addressed. Additionally, there was feedback that communication efforts could have been more responsive to community members who did not want to be vaccinated. Staff and partners acknowledged that although more could have been done for these groups, there were some concerted efforts made—for example, CDHD worked with partners to distribute food boxes to those isolating at home.

There was a sizeable contingency who felt that the Latinx group was underserved in the response, while others cited this as an area where CDHD excelled. Because challenges meeting the needs of the Latinx community came out so strongly, this will be discussed in the next "Area for Improvement."

Illustrative Quotes

"Elderly persons with limited information access (smartphones, internet, and similar resources) were disproportionately impacted by the initial public vaccination efforts. The process did not work well and attempts to explain it seemed to add problems rather than fix them."

–Survey, External Partner, First Responder (Fire, Law Enforcement, EMS)

"We focused mainly on reaching our English and Spanish populations, which we did so very effectively. Unfortunately, we had limited resources to even consider other languages or even [American Sign Language] when conducting press conferences or even day-to-day social media/website updates."

–Survey, CDHD Staff

"I think we could have done a better job at trying to reach the homeless population for education, testing, and vaccination. We did reach out to homeless shelter directors about offering vaccines, but some did not respond. We could have gone to known congregation locations to offer education and vaccines."

–Survey, CDHD Staff

"Information still could reach deeper to all sectors of the population including more rural areas."

–Survey, External Partner, Health care Provider or Agency

"Absolutely [there were groups left out in the response]. You did not consider the non-vaxed community with respect and hear their perspective to the result of objectivity in a community plan."

–Survey, External Partner, Other

Areas for Improvement 3:

Early on, the needs of the Latinx community were not fully addressed

Note: There are differing opinions regarding CDHD's response to the Latinx community during the response to COVID-19. Ultimately, surveys and interviews indicate the Latinx community may have been underserved in the earlier phases of the response, mainly due to lack of dedicated resources. Based on the gaps discussed during the initial response, we are classifying this as an area for improvement that appeared in the early response, and have also included context on how this strengthened over time.

Towards the beginning of the response, several Latinx community groups expressed their frustration with the slowness of the CDHD response to Latinx community. CDHD attempted to satisfy the requests and needs, and met with a Latinx advisory group regularly, but challenges persisted. One complaint was that Spanish translation for press conferences and interviews would occasionally lag a day or two behind the English communication due to issues like capacity, availability of interpreters, technological logistics, etc. Some school representatives also mentioned that at times, the Spanish translation of a flier would be provided slightly after the English version.

Despite differing opinions on how well CDHD met these needs early on, respondents across the board seemed to agree that over time, CDHD's response more fully considered

and reached the Latinx community in a timely manner. Over time, more resources were allocated to Communications and Outreach, and CDHD built a three-person outreach team who were all bilingual in English/Spanish.

Quotes below highlight the mixed sentiment around whether CDHD met the needs of the Latinx community.

Illustrative Quotes:

Quotes demonstrating the sentiment that CDHD did not adequately support the Latinx community:

> "We were getting calls wanting resources in Spanish for ag[riculture] workers because it wasn't getting out there. The staff we did have were working really hard to get the message out but they didn't have the money or staffing to do what they needed to do."
>
> –Interview, CDHD Staff

> "[Distributing culturally appropriate outreach materials] was a struggle for CDHD due to the lack of staffing. It wasn't for a lack of desire, or in many cases effort, there just wasn't enough support to assist CDHD in creation of this material state down. This is something the entire public health system in WA could improve upon."
>
> –Survey, External Partner, Community-Based Organization or Non-Profit

> "The Latinx community was left out of decision-making tables and left without prompt information as press conferences and other educational materials were not conducted in Spanish."
>
> –Survey, External Partner, Community-Based Organization or Non-Profit

> "We were roundly criticized by the advocacy groups in town for not having enough Hispanic perspective represented on the Board of Health or in the leadership of the agency."
>
> –Interview, Former CDHD Staff

Quotes that demonstrate the perspectives of those who appreciated CDHD's efforts to engage and reach the Latinx community:

> "This was one of the biggest things they excelled in, in my opinion. CDHD connecting me to their partners in CAFÉ allowed for public messages to be put out to the Hispanic community, it allowed for us to get information and outreach materials translated so that we were delivering the same message to those community members."
>
> –Survey, External Partner, State or Federal Agency

"CDHD focused on creating and distributing culturally-appropriate notifications, alerts and printed materials, particularly for the Spanish-speaking, Hispanic population."
–Survey, External Partner, Education/Schools

"I have never seen an agency work so hard to hit all cultural markets as CDHD."
–Survey, External Partner, First Responder (Fire, Law Enforcement, EMS)

Responder Health & Safety

Background

Health and safety includes physical health and safety, as well as psychological/emotional support and mental health. Prior to 2020, CDHD did not have a full or part-time human resources employee. The role was done as part of payroll and operations with resources provided to staff through CDHD's insurance carrier and Employee Assistance Programs. Contracting for human resources, in addition to a part-time human resources specialist, started in February 2021. CDHD had a safety committee with policies and procedures outlined for staff as well as an employee health and vaccination policy prior to the pandemic.

Staff who had not been tasked with COVID-19 duties worked from home in the beginning of the pandemic. During this time, some routine public health activities like food inspections had been suspended, so there was little for them to do. There were also issues with information technology (IT) infrastructure that limited staff's ability to connect with the district's system and led to many staff not being able to adequately access their work. This led to an imbalance of expectations for staff during the initial response, with those responding to COVID-19 having unmanageable workloads, while other staff had smaller workloads than they did prior to the pandemic.

Efforts to protect physical health and prevent COVID-19 among staff: Most staff worked from home from March 2020 through fall 2020. When staff did need to work in-person, masks were mandated and staff were provided with the appropriate personal protective equipment (PPE) needed. When work resumed in-person at the office, staff did daily attestations about symptoms and exposure, daily temperature checks, and weekly COVID-19 tests in an effort to reduce the chance of interoffice COVID-19 transmission. CDHD did not experience any workplace outbreaks.

In 2021, CDHD utilized CARES Act dollars to provide additional paid sick leave while staff were out with confirmed cases of COVID-19. This was meant to ensure that staff did not run out of sick leave. It was also intended as a benefit to help with staff retention and burnout.

Efforts to support staff mental health and psychological/emotional needs: Staff dedicated to COVID-19 work described working extensive hours during the first few months of the pandemic, including routinely working 10 to 15 hours each day, and often 7 days a week. It was not uncommon for staff to work 60 hours a week, and then remain reachable by phone and email into the evening. Others shared that they did not get breaks or lunches. At one point, there was a moratorium placed on taking vacation days. Interviewees and survey

respondents relayed that people experienced physical and mental ailments from job-related stress and demands.

Later in the response, CDHD brought in resources to support staff with mental health on limited occasions, including a local group specializing in critical incident stress management that provided onsite free sessions for staff on two occasions. A counselor came to provide optional counseling sessions on-site on at least two occasions. Human resources also made staff aware of counseling and other free resources offered through the Washington State Employee Assistance Program.

Overview of Survey Responses

CDHD staff were asked to rank how they felt about their safety across a variety of dimensions, including availability of PPE, safety measures, how safe they felt while doing their job, staff morale, and psychological/emotional support.

Questions around physical health and prevention of COVID-19 among staff (availability of PPE material, safety measures put in place, and how safe staff felt at their jobs) all received an average score above 3 points ("satisfied"). When it came to issues of staff morale, work-life balance, and psychological and emotional support, the averages were significantly lower, with averages ranging from 2.33 to 2.58. Despite the mental and emotional toll the response took on staff, 76% of the respondents were "satisfied" or "very satisfied" when it came to their job satisfaction in their role, averaging out to 3.16.

Figure 28: Average responses across responder health and safety

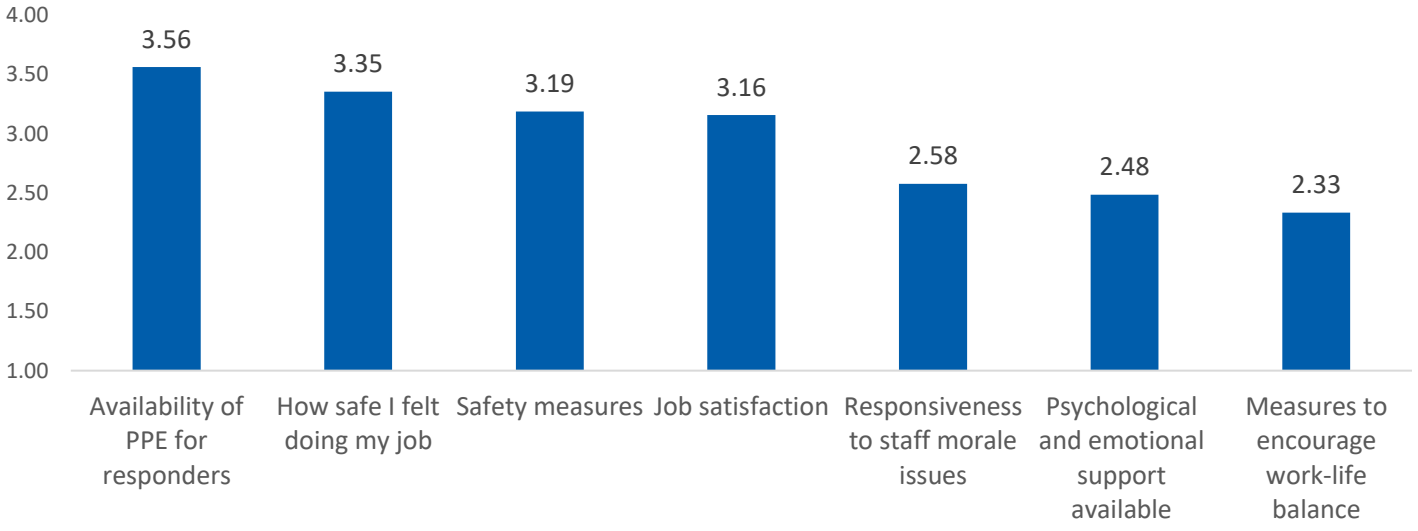
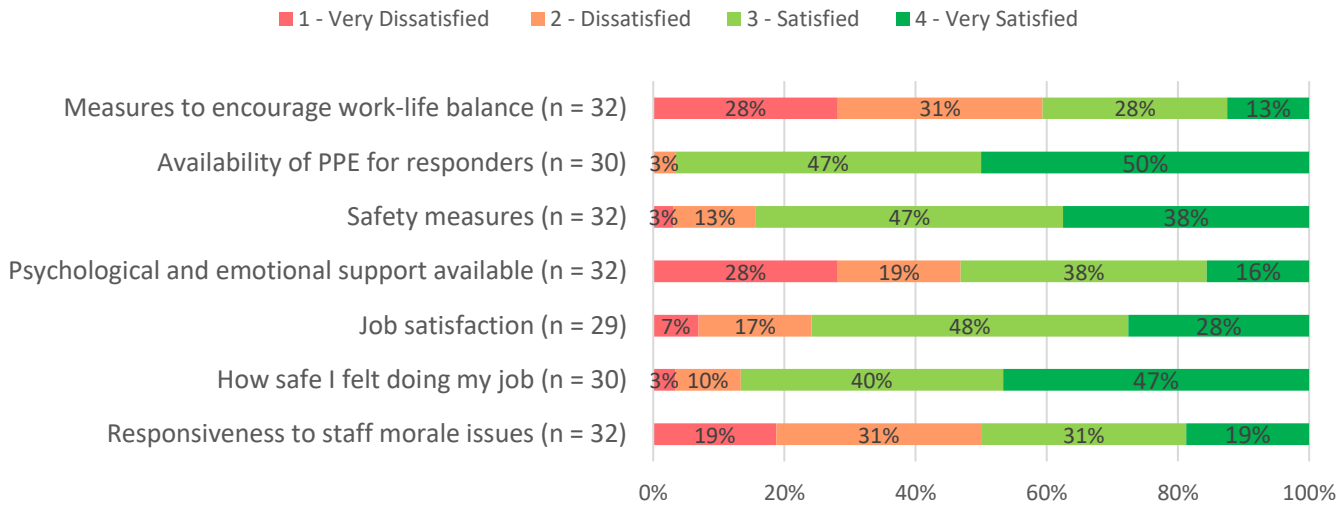


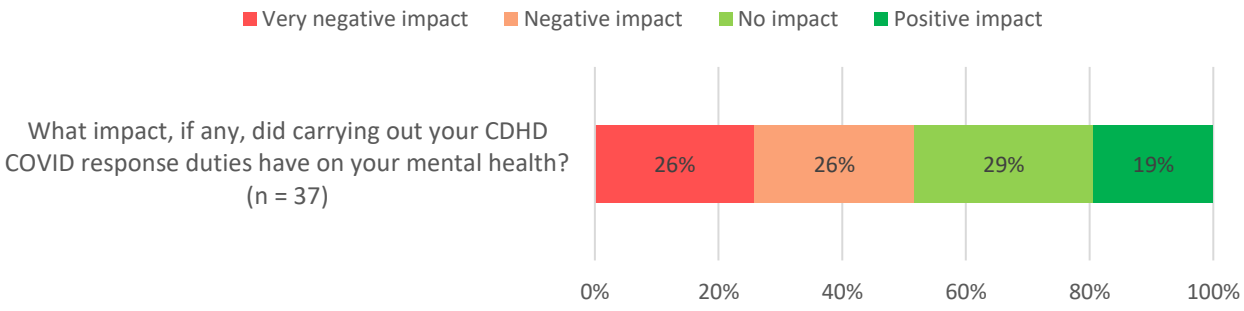
Figure 29 below displays the distribution responses across each category. While the average responses for organizational measures put in place to encourage work-life balance, psychological and emotional support available, and CDHD's responsiveness to morale issues were all relatively low, the distribution indicates that some staff did feel satisfied with these areas. That said, the prevailing sentiment through survey qualitative comments and from interviews with staff were that things were severely lacking across these areas.

Figure 29: Distribution of responses across responder health and safety



Survey respondents were also asked to share what impact, if any, carrying out their response duties had on their mental health. Figure 30 indicates that some saw a positive impact on their mental health, others saw no impact, while the majority experienced a "negative" or "very negative" impact to their mental health.

Figure 30: Impact that carrying out COVID-19 duties had on staff respondents' mental health



Key Learnings

Strengths	Areas for Improvement
1. CDHD consistently prioritized staff physical safety in terms of COVID exposure	1. Staff were overworked, leading to physical and emotional fatigue and burnout 2. Unclear and inconsistently enforced norms and policies regarding uneven workloads across teams had negative impacts on morale 3. Staff felt their morale and well-being concerns were largely overlooked

Strengths

Strength 1:

CDHD consistently prioritized staff physical safety in terms of COVID exposure

A clear theme was appreciation for CDHD's efforts to uphold staff's physical safety when it came to protecting staff from COVID-19, and mitigating potential spread in the workplace and as staff went out into the community. Specifically, CDHD ensured PPE was consistently available to their staff and assigned safety officers for all key events. The logistics team kept a close eye on the amount of PPE available and as supply started to decrease, they made sure to order replenishments from the state to not have any gap in availability.

CDHD also implemented systems (e.g. symptom checking, masking, testing) to safeguard against exposures in the workplace. If any safety risks were identified, CDHD dealt with them swiftly.

Illustrative Quotes:

> "Safety has always been paramount since my involvement with CDHD and during the response. Safety officers were assigned at active testing/vaccination sites. PPE and other safety equipment were supplied to staff without question. Recognized safety issues were dealt with immediately."
>
> -Survey, CDHD Staff

"CDHD took the physical safety of staff seriously. We implemented daily symptom checks, masking immediately, social distancing/physical barriers, working remotely. We eventually implemented weekly staff testing when supplies were readily available."

-Survey, CDHD Staff

"Throughout the pandemic, CDHD did a great job keeping their staff safe - working remotely when possible, mask availability, weekly and as needed testing for staff. Additionally, the IMT safety officers all did a great job at vaccination."

-Survey, CDHD Staff

Areas for Improvement

Area for Improvement 1:

Staff were overworked, leading to physical and emotional fatigue and burnout

As noted in the background section, staff described the extensive hours they worked during the first few months of the pandemic as being routinely 10 to 15 hours each day, and often 7 days a week. It was not uncommon for staff to work 60 hours a week, and they often had to be reachable by phone and email into the evening.

Another former staff member shared the physical toll from long hours in extreme weather conditions, including working in the 100-degree heat and in the freezing snow in order to staff tables, where they could engage with community members who were worried or had questions about COVID-19 and related testing and vaccination services.

Current and former staff relayed that people were not allowed to take leave until around spring 2021, and some even had to cancel pre-planned vacations. Others referenced the fact that they remained in high-stress, fast-paced IMT roles (without others rotating in) for much longer than advisable—14 to 21 days is the recommended maximum for IMTs to serve, while several CDHD staff stayed in their roles for months. This had implications for their well-being, as well as hampered the effectiveness of the response by having exhausted people remaining in roles that are intended to be held for only short stints. Although CDHD did bring in outside IMTs in hopes that it would alleviate strain on CDHD staff and give them a break, this did not happen as intended. Instead, CDHD staff continued serving on the IMT, onboarding and guiding outside IMTs that rotated in.

A couple staff acknowledged that they understand LHJs throughout the country struggled with similar issues, but that colleagues in other LHJs were usually getting a couple days of rest a week—CDHD seemed to be hit particularly hard given their inability to implement policies and systems to mitigate the stress and burnout.

Ultimately, many pointed to the above dynamics and their impact on people's mental health as the key driver of significant turnover of CDHD staff during the pandemic. As the IMT became more established and CDHD started contracting temporary staff to fill various gaps, the extreme workload staff carried lessened and things did improve over time, but this was after a heavy toll on staff and attrition.

Illustrative Quotes:

"The workload and expectation to be available 7 days/week for the first 5 months of the response was overwhelming. I did not sleep well, I did not eat well, and the stress affected my health and relationships outside of work."

-Survey, CDHD Staff

"…the prolonged, heightened stress level caused insomnia, thoughts and worries about work even when away from the office. Finally, it felt there was no 'off the clock' time during the COVID response. I received calls literally every weekend and often in the evenings throughout the entire pandemic, until about March 2022 when things slowed down."

-Survey, CDHD Staff

"People were melting. Crying every day. So exhausted. So stressed out. People were falling apart. Literally."

-Interview, Former CDHD Staff

There were no organizational measures put in place to encourage work-life balance."

-Survey, CDHD Staff

"I was working all the time. I felt like my family life was kind of crumbling."

-Interview, Former CDHD Staff

Area for Improvement 2

Unclear and inconsistently enforced norms and policies regarding uneven workloads across teams had negative impacts on morale

Several staff members raised the fact that there was a sense of inequity around how work was distributed amongst CDHD staff when the pandemic hit. It was unclear why certain people were allowed to work from home, while others were expected to be in the office. There was a perception that those who worked from home could have short days and still get paid their full salary, while those more directly involved in the response were working around the clock to try to get everything done. Staff with these concerns did not understand how or why leadership made these choices, and felt it was an unfair arrangement with the bulk of the work concentrated under a small of a group of people.

Several current and former staff who were interviewed expressed some confusion over why more people were not trained up in the ICS. Having only a small number of staff holding key positions meant that they went weeks or months without anyone rotating in for them.

Aside from issues caused by uneven workloads internally, it further stressed CDHD staff members when outside IMT counterparts were paid more and were permitted to take time off and demobilize after 14 or 21 days. Meanwhile, CDHD staff served on the IMT without taking service breaks and without receiving extra pay.

Illustrative Quotes

"Only some parts of CDHD were allowed to work from home, like environmental health. This was a huge frustration for those of us who had to show up in person and at command post."

-Interview, CDHD Staff

"Some people were at home and not working and still getting paid. I'm here 7 days a week but so-and-so is scared and home working even though they could be here helping. That was frustrating."

-Interview, CDHD Staff

"[Work-life balance was] terrible. The bulk of the responsibilities for the COVID response fell onto the shoulders of a select few people. There was no work-life balance, especially the period from when vaccines rolled out, through the delta variant, through schools opening and then the omicron variant."

-Survey, CDHD Staff

"You rotate staff in and out every 2 weeks and then you take a break. Well who's rotating me? You all are coming in and getting big bucks but the rest of us are here all the time with no vacations and no time off."

-Interview, CDHD Staff

"It was 'all hands-on deck,' but it wasn't really 'all hands-on deck'."

-Interview, CDHD Staff

Area for Improvement 3:

Staff felt their morale and well-being concerns were largely overlooked

Quantitative ratings from the survey were split on CDHD's responsiveness to morale, with 16 staff respondents who were either "very dissatisfied" or "dissatisfied" and 16 respondents who were "satisfied" or "very satisfied" with CDHD's responsiveness to morale. However, the interviews with staff most directly involved in the response revealed that there were significant concerns around CDHD's handling of morale. Staff referenced a

lack of support resources and dismissive responses from Human Resources and leadership when they did express concerns that they were struggling.

Several staff did say that it was incredibly helpful when, in May 2021, CDHD provided the opportunity for staff to meet with an outside agency that counsels those in emergency response (the Local Critical Incident Stress Management team). Being able to share what they were going through in a safe space was much appreciated, and this felt missing in the early parts of the response.

Illustrative Quotes:

"Constantly closed doors of administrators makes it easy to be unaware of staff morale."
-Survey, CDHD Staff

"Any kind of burnout was seen as a personal failing, rather than a normal response. So, that was hard. I definitely think we should have done better as an organization there... Different administrators had different styles…the more successful ones in this area couldn't do much to lessen the stress, but even just acknowledging it and saying 'thanks for what you're doing, and I know it's hard'…with the less successful it was more like, 'why can't you handle this? You should be able to.' Instead of making it a team effort it was much more isolating."
-Interview, Former CDHD Staff

"We were not given the opportunity to meet with trained facilitators to address and talk about our stress/mental health until approx. 12 months into the response. A 2nd opportunity was provided another 12 months later. When I addressed my burnout with administrators, I was repeatedly told that 'everyone is in the same boat.'"
-Survey, CDHD Staff

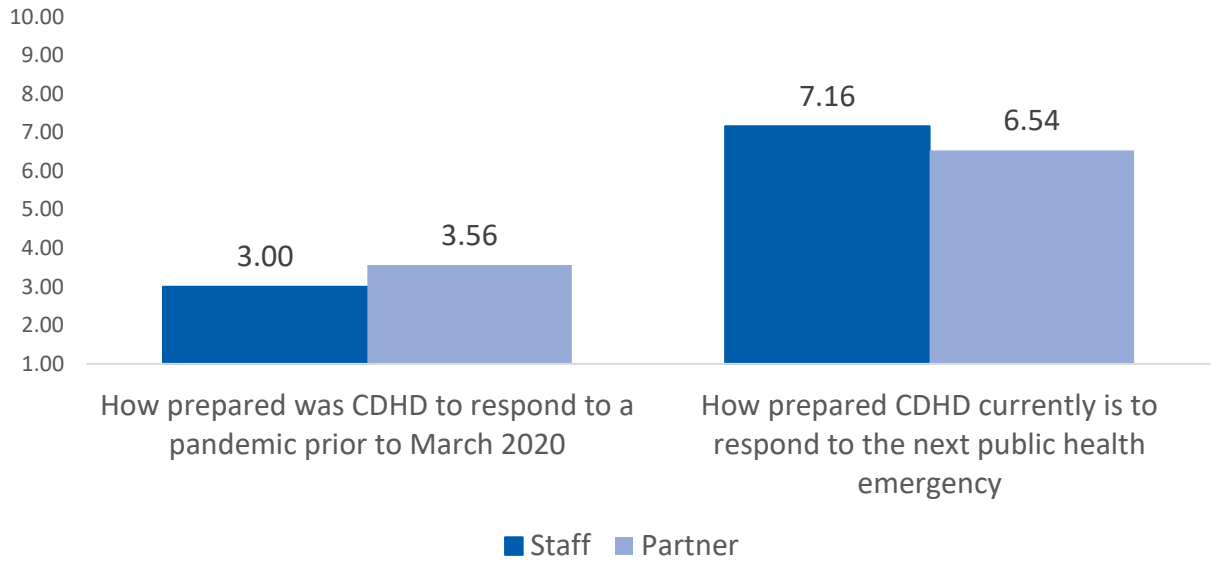
"There was [no psychological and emotional support available]. Even when people expressed distress, nothing was done. There was no time off until people completely burned out. There was no counseling offered. There was no regular check-in for how people were coping."
-Survey, CDHD Staff

"HR response to complaints about management with fears of retaliation is to 'Just go talk to them, what have you got to lose if you're already thinking of leaving?'"
-Survey, CDHD Staff

Overall Response

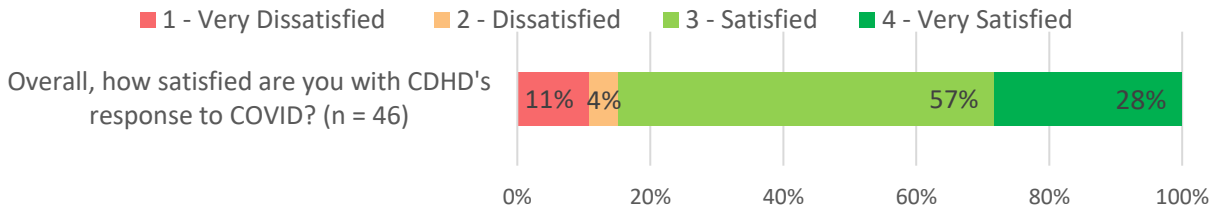
Staff and external partners were asked to rate CDHD's ability to respond to the pandemic, on a scale of 1 to 10. They were asked how prepared CDHD was when the pandemic started and how prepared they are to respond to a future public health emergency. External partners and CDHD staff had similarly low assessments of CDHD's ability at the start of the pandemic, although partners rated CDHD's preparedness somewhat higher than CDHD staff themselves did. Staff and partners both rated CDHD as much more prepared to respond to the next public health emergency. There were many lessons learned and strengths gained during this time period, and participants agreed that CDHD's response improved throughout the course of the pandemic.

Figure 31: Average score for CDHD's ability to respond to the pandemic in March 2020 versus now



External survey respondents were also asked to say how satisfied they were with CDHD's response to COVID-19 overall, with answer options ranging from "very dissatisfied" to "very satisfied." There were 46 external partners who completed this question at the end of the survey, and the average satisfaction rating was 3.02, or "satisfied."

Figure 32: Distribution of responses for partner's satisfaction to CDHD's COVID response



Respondent Recommendations

Survey and interview participants were also asked for their recommendations on the highest priority actions for CDHD to implement in order to be more prepared for future emergencies. Not surprisingly, many of the recommendations are ways to address issues that came up in "areas for improvement" or, in some cases, ways to ensure that strengths continue.

The following is a list of all recommendations offered, grouped by response area. The "Proposed By" column indicates whether staff, external partners, or both made each recommendation.

Internal Operations

Recommendation	Proposed By
Improve internal communication so that all CDHD staff are in the loop, and not just the ones directly involved in the COVID-19 response	Staff
Continue investing in infrastructure, including technology, to be better prepared for future incidents	Staff
Train staff in core areas of budgeting, management and supervision, etc. so the team is strong in all areas and ready to encounter a disruption such as a pandemic	Staff
Staff and board members should have the expertise to respond to public health emergencies, including experienced epidemiologists on staff	Both
Ensure staff are trained in emergency response, including ICS training for specific roles and cross-training for multiple roles (using scenario-based training). Ensure that plans are regularly practiced	Both
Make sure the Board of Health is properly trained in public health and responding to public health emergencies (including IMT training), and have science and health care professionals included in the response	External partner
Develop a volunteer cadre that can be called upon in times of need	Both
Identify a more suitable place to run an ICS (original site was too expensive and the on-site room was too small)	External partner

Consider how to advocate for more local control around messaging, closures, etc. (as opposed to state-level decisions)	Both
Use the results of this after-action report to identify gaps and make improvements for the next emergency response	Both

External Operations

Recommendation	Proposed By
Design a plan so that essential operations, unrelated to the emergency response, are maintained. Ensure staffing levels are adequate to respond to the public's needs, specifically time-sensitive requests from Long-term Care Facilities, and requests from people who would have typically visited CDHD office if it had not been closed	Staff
Invest in supply chain planning and strengthening, and systems to easily share information around supply needs and available resources across health provider groups	External partner
Work with regional Local Health Jurisdictions to identify standardized, meaningful data for schools to collect, as well as design the tools and processes for data collection and reporting. Package data into understandable and actionable findings that school administrators	External partner

Partnerships

Recommendation	Proposed By
Engage community partners more intentionally from the start, including those working with the Latinx community	Staff
Develop and maintain relationships with the faith-based community	Staff
Strengthen existing relationships with agricultural growers and long-term care facilities	Both
Proactively build and maintain relationships with external partners, fostering trust and ensuring stakeholders know their strengths and roles, so that plans can be quickly operationalized in the face of another pandemic	Both

Keep the Region 7 Health Care Coalition strong and functioning so relationships and trust are in place when a response is needed	Both
Do not delay accepting help from outside agencies trained in ICS, especially to address any identified gaps in staff emergency preparedness knowledge	Both
Create at interorganizational agreement between CDHD and health care providers to use one centralized incident management team during future public health emergencies	External Partner

Communications & Outreach

Recommendation	Proposed By
Continue building a presence on social media to offer ongoing education and tips to the community	External partners
Address needs of all community members, such as those who did not think businesses should have been shut down, and who did not see COVID-19 as a serious risk	External partners
Continue to educate community and partners on the role and importance of public health	External partners
Develop plans so that the elderly have a safe place to go when isolating if they are not able to be in shared senior living spaces	External partners

Responder Health & Safety

Recommendation	Proposed By
Have proper staffing levels so staff do not get burned out, vacation days can be allowed, and there are enough IMT staff to rotate through positions (and do not scale down staffing prematurely in the face of unpredictable pandemics)	Staff
Resource CDHD properly—have the right number of staff, with the right expertise, and put measures in place to have high staff retention (including a plan and ability to pay staff more in times that call for staff working	Both

overtime for extended periods, making sure annual performance reviews are happening, etc.)	

Conclusion

This AAR documents the successes and challenges that CDHD experienced in responding to COVID-19, in an effort to pull out the key strengths and areas for improvement. Overall, CDHD staff and external partners said that CDHD was under-resourced and unprepared to respond to the COVID-19 pandemic and thus their early response was disorganized and ineffective. However, the resounding feedback was that over time, staff and community partners alike were impressed by CDHD's growth and resilience. In 2021 and 2022, CDHD strengthened their response and took an active leadership role in coordinating community-wide efforts.

Corrective Action Planning

The Board of Health formed an After-Action Report (AAR) Working Group that reviewed the AAR results presented above, and then held two working sessions in (October and November 2023) ideating on recommendations and actions that CDHD could take to ensure a strong response to future public health emergencies.

Ten major themes emerged during the AAR Working Group discussions that were used to formulate the following recommendations. Some of the recommendations echo recommendations that came from staff and partners, while others are new recommendations generated from discussing the findings.

When CDHD embarks on its strategic planning process in 2024, these recommendations will serve as key inputs into the strategic plan.

1. Training on incident command system (ICS) for all staff. Ensuring that all staff receive an appropriate level of ICS training (from introductory to advanced, depending on position) would prepare staff to respond to an emergency and allow all staff to rotate in and out of an incident management team, creating a more equitable distribution of workload during a response.
2. Hire an equity position. Hiring an equity position would enable all public health programs – routine and emergency – to understand who in the community is under reached and devise strategies to ensure more inclusive programs. Working with community-based organizations proved to be an effective way to reach community members during the pandemic so this position may include building and sustaining those relationships.
3. Invest in communications resources and standards to ensure that all information provided by CDHD is evidence-based and presented in a way that the public can understand it. Efforts may include hiring a senior communications position, training on communications to subject matter experts so they can provide better source material for communications staff, and building expertise on combatting

misinformation. These efforts build a communications foundation needed to be able to ramp up communications efforts during an emergency.

4. Create a continuity of operations plan (COOP). This plan will outline which public health services are "essential" and outline a plan to ensure those services will be prioritized in an emergency situation.
5. Create "ready-to-go" preparedness plans. This means creating plans for key potential incidents. Elements that make these plans "ready-to-go" include elements such as agreements with other organizations on roles and responsibilities each organization would play during an emergency and easy-to-understand instructions and checklists on what needs to be done for each type of incident.
6. Create a reserve fund that can be used by CDHD to respond to a public health emergency. Navigating various funding streams, including some that provide no funds up front, was a challenge during the pandemic. A large reserve fund would allow CDHD to act more quickly and to focus on locally identified needs rather than relying solely on State and Federal funds.
7. Build and sustain strong relationships with schools, healthcare providers, faith-based organizations, businesses, and community organizations. Working together with other agencies and organizations was essential during the COVID-19 response and the AAR showed this coordination improved with time. Building strong relationships and trust with organizations, outside an emergency, allows a coordinated response to be launched more quickly. Reflections from the AAR could be used to guide which relationships may need most strengthening such as relationships with faith-based organizations and agriculture industry.
8. Invest in professional development for leaders and managers, including training in management and supervision, 360s reviews, and succession planning. Staff turnover was a significant challenge during the pandemic. Strong leadership and management can help prevent turnover as well make it easier to orient and onboard new staff when necessary. Succession planning for management and leaders is necessary to manage turnover at the more senior levels.
9. Put in place the relationships and agreements needed for a "unified command". During a public health emergency, the health district, first responders and healthcare providers should agree to a unified incident management team, with leaders from all entities represented. This would lead to a more coordinated and efficient response. In order for a unified command to work, the structure and interagency agreements should be put in place before the next emergency happens and the unified incident management team and its preparedness plans should be regularly practiced.
10. Build a strong relationship between the Board of Health and CDHD leadership and staff. This may include Board Rules and Procedures, education for new board members on their roles and responsibilities, increased mechanisms for engagement between staff such as regular meetings of the executive team, regular presentations from staff to the board, etc.

In addition to the ten themes above, the AAR Working Group also identified some operational actions that could be taken to improve future responses. These are:

a) Identify policies and procedures for staff in emergencies such as how often staff should rotate in and out of emergency response positions, maximum number of days in a row that can be worked, access to psychological and mental health support, address issues with compensation in a crisis, etc.
b) Strengthen human resources policies and procedures so that staff and volunteers can be onboarded and oriented efficiently. This includes looking at how to protect volunteers and contractors from liability and/or cover them under CDHD's insurance.
c) Ensure that the information technology (IT) infrastructure and required policies and procedures are in place to allow staff to work offsite during an emergency if needed.
d) Build up CDHD supply chain capabilities (procurement, storage and distribution) so that they can manage emergency response supplies (such as personal protective equipment or vaccines) during an emergency; these capabilities can be built and strengthened through regular public health activities (e.g. the distribution of air filters).
e) Explore mechanisms for local advocacy with state and federal stakeholders to allow for stronger mechanisms to ensure that the local context is heard by state and federal decision-makers and mechanisms for more local decision-making during an emergency are in place.
f) Regularly monitor and evaluate CDHD capabilities to further identify strengths and areas of improvement and allow the Board of Health to understand CDHD's capacity.

Looking Forward

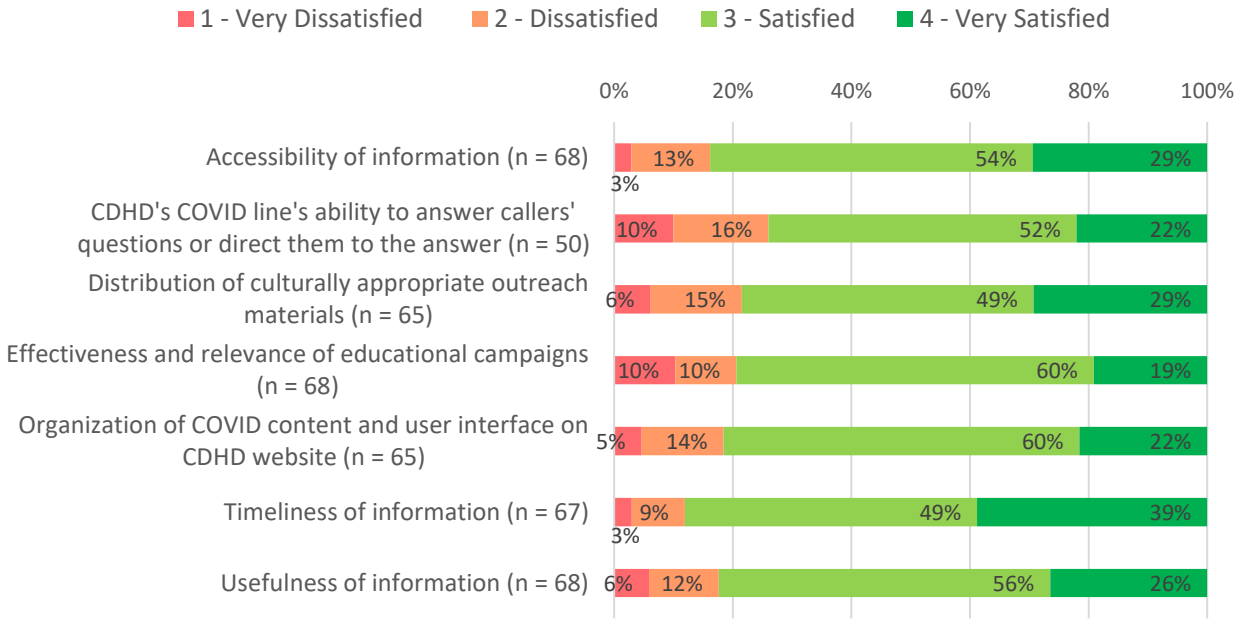
In order to learn from the COVID-19 pandemic and response, CDHD will consider the recommendations generated from the BOH AAR Working Group and continue the reflection process with invited external partners to design plans for maintaining the strengths CDHD displayed and addressing the identified areas for improvement. The resulting recommendations will shape a portion of CDHD's strategic plan to address identified areas for improvement. These findings will also lead to improved Public Health Emergency Preparedness and Response (PHEPR) plans for pandemic response and other similar all-hazard activities. Deeper dives will take place to improve plans for Isolation and Quarantine, Mass Vaccinations, and Testing.

While CDHD has already made significant improvements in several areas, referencing the full list of potential areas for improvement will allow CDHD to continue to prioritize important areas and to see where work remains to be done. Equity in communication and service delivery were a core part of CDHD's work during the pandemic and will continue to inform how plans are made in the future. CDHD's corrective action plan will be part of the 2024 strategic planning process.

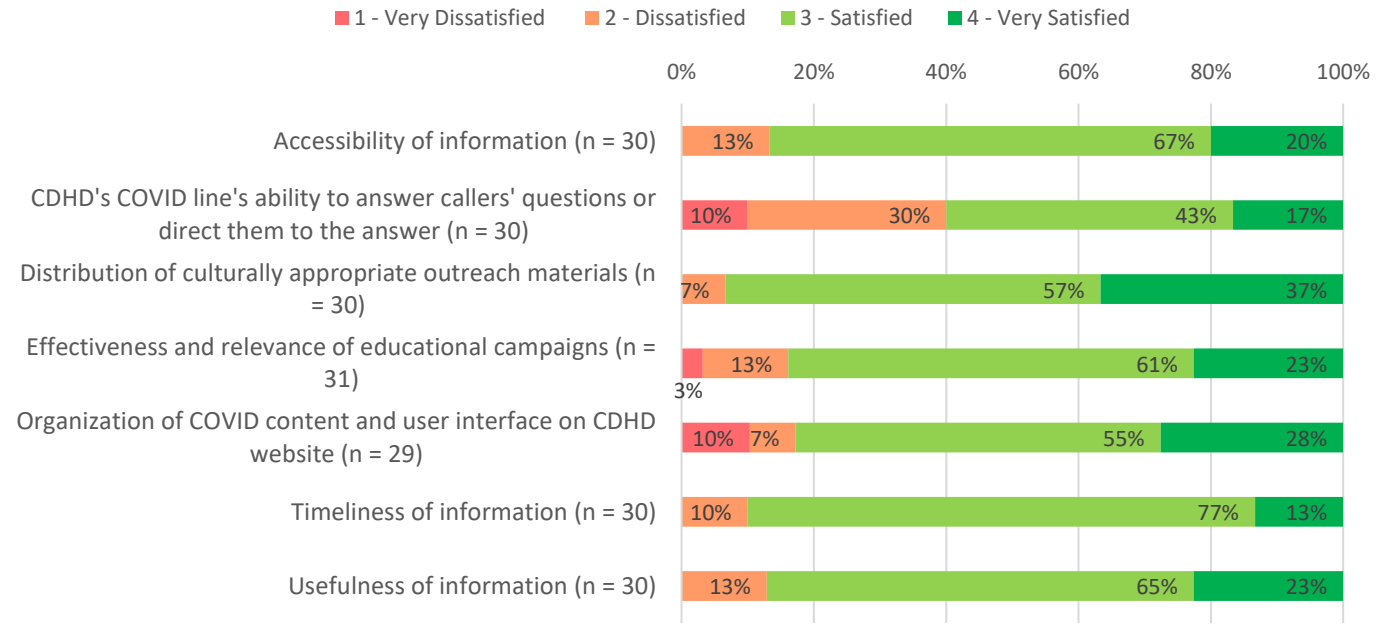
Additionally, at the time of this report there are discussions between CDHD leadership and the Washington DOH to look at statewide data to understand how different interventions for COVID-19 worked across communities. While this after action did not dive into the data on vaccinations, testing, masking, social distancing, and other community interventions, there will be opportunities to analyze COVID-19 interventions as data becomes more available. The hope is to use that data to improve interventions and recommendations to better respond to future pandemics.

Appendix

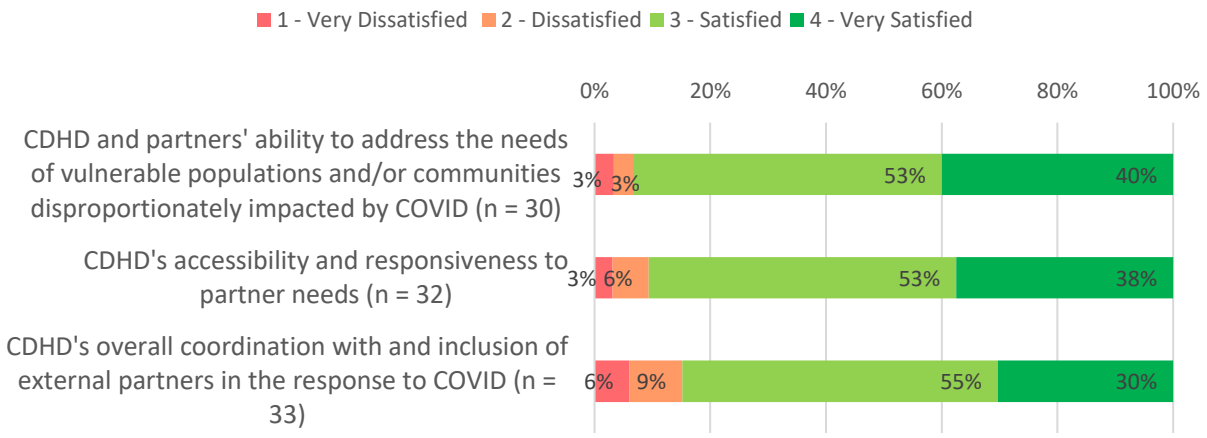
Appendix 1: % breakdown of how external respondents rated aspects of CDHD's communications and outreach efforts



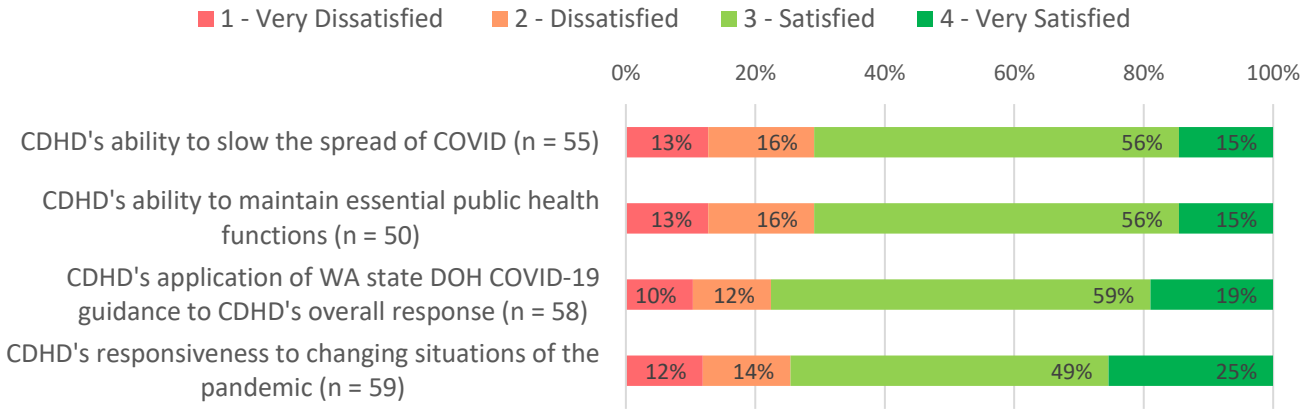
Appendix 2: % breakdown of how staff rated aspects of CDHD's communications and outreach efforts



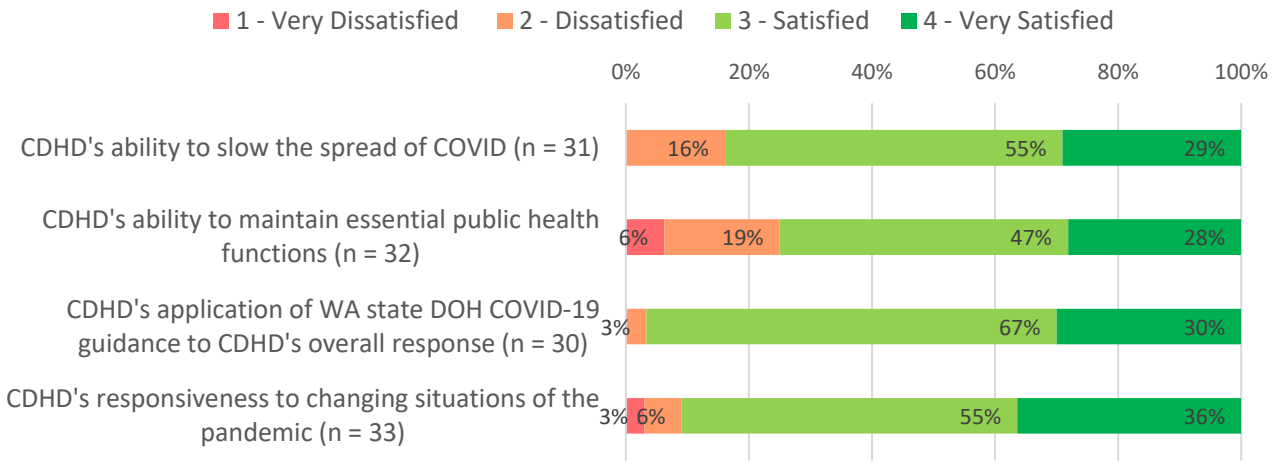
Appendix 3: % breakdown of how staff rated aspects of CDHD's partnership



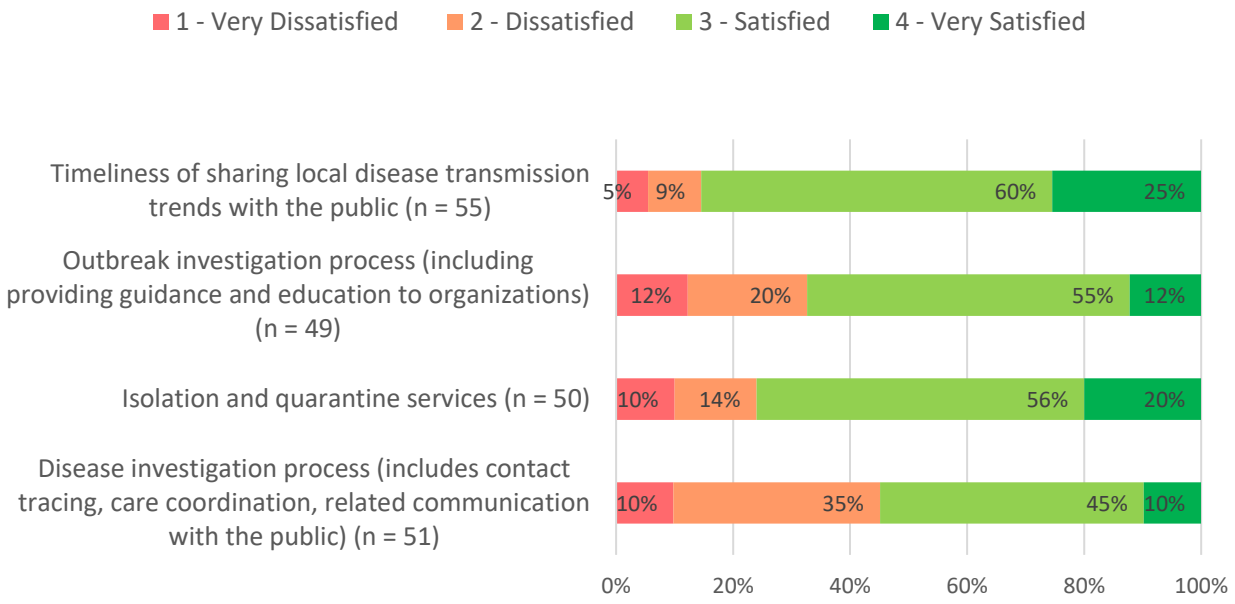
Appendix 4: % breakdown of how external respondents rated aspects of CDHD's external operations



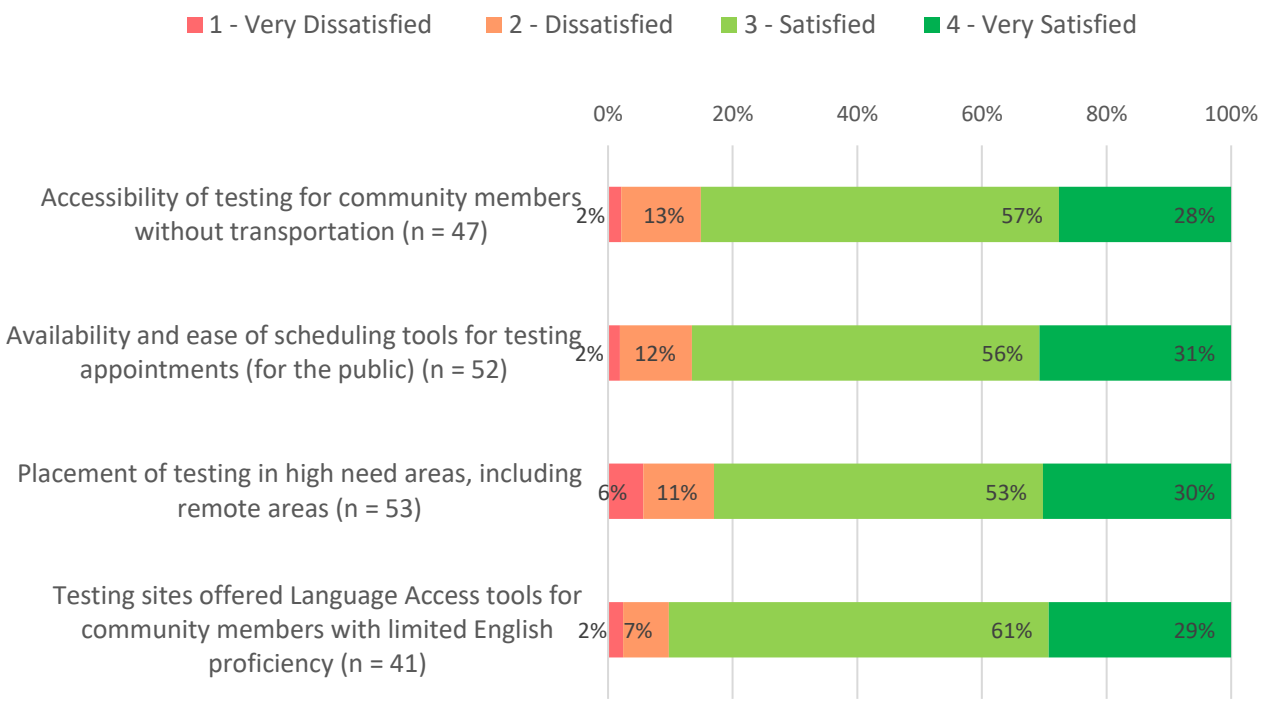
Appendix 5: % breakdown of how staff rated aspects of CDHD's external operations



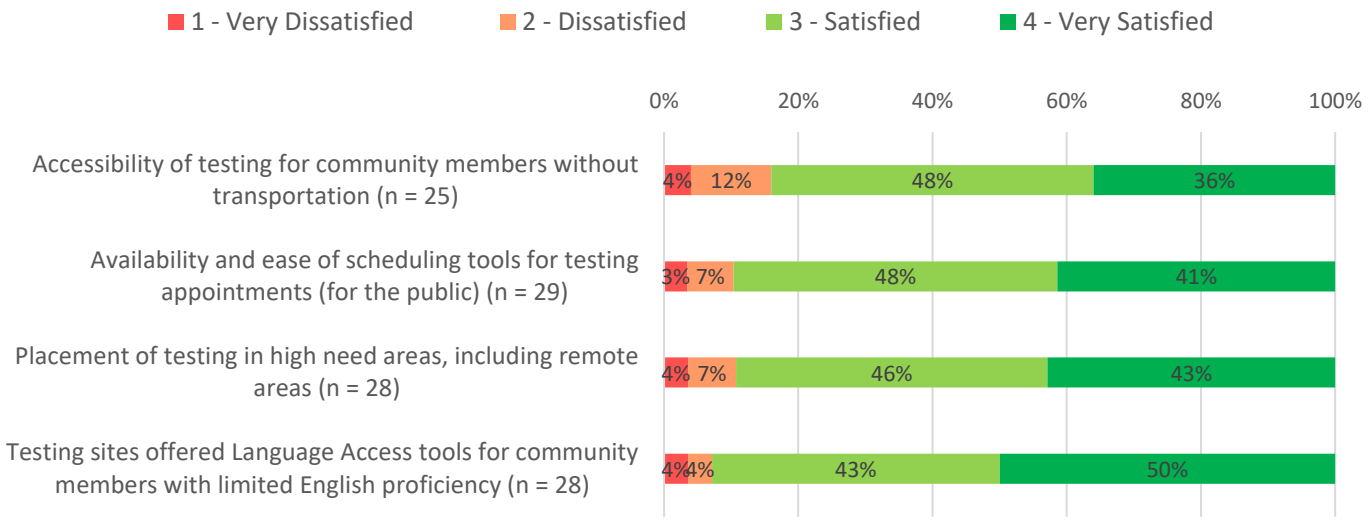
Appendix 6: % breakdown of how external respondents rated aspects of disease outbreak and investigation, isolation, and quarantine



Appendix 7: % breakdown of how external respondents rated aspects of testing



Appendix 8: % breakdown of how CDHD staff rated aspects of testing



Appendix 9: % breakdown of how staff rated aspects of vaccination