



California Department of Public Health

It Could Do More to Ensure Federal Funds for
Expanding the State's COVID-19 Testing and
Contact Tracing Programs Are Used Effectively

April 2021





CALIFORNIA STATE AUDITOR

621 Capitol Mall, Suite 1200 | Sacramento | CA | 95814



916.445.0255 | TTY 916.445.0033



For complaints of state employee misconduct,
contact us through the **Whistleblower Hotline:**

1.800.952.5665

Don't want to miss any of our reports? Subscribe to our email list at auditor.ca.gov 



April 1, 2021
2020-612

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

This audit report on a high-risk issue provides an update on our assessment of the State's management of a portion of the federal funds it received to respond to the COVID-19 pandemic. In August 2020, we designated the State's management of federal COVID-19 funds as a high-risk issue and determined that the likelihood of mismanagement of these funds is great enough to create substantial risk of serious detriment to the State and its residents.

We assessed the State's use of approximately \$467 million in federal COVID-19 funding with which the California Department of Public Health (Public Health) is supporting statewide and local efforts to address COVID-19. These funds were earmarked for the State's implementation and enhancement of programs related to the U.S. Centers for Disease Control and Prevention's (CDC) Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) Cooperative Agreement. The CDC has outlined several critical purposes for grant funds it distributed to the State through this agreement, including expanding COVID-19 testing and contact tracing as well as improving California's long-term abilities to fight infectious diseases.

We found that the State has met or exceeded targets for testing individuals for COVID-19, but contact tracing throughout the State has lagged behind case surges that have far exceeded Public Health's initial planning. We additionally found that Public Health has been slow to collect and review required work plans, spending plans, and quarterly update reports from the local entities to which it provided ELC funds, leaving gaps in its knowledge of how those entities are using this new federal funding. Finally, Public Health delayed procuring required independent oversight for the development of an information technology project designed to track COVID-19 data, for which it is using ELC funds, increasing the risk of system errors going undetected.

Although the number of vaccinations is increasing and the number of new COVID-19 cases is decreasing, Public Health must remain focused on the pandemic and on learning ways to better address future public health emergencies.

Respectfully submitted,

A handwritten signature in black ink that reads 'Elaine M. Howle'. The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CalREDIE	Public Health's system that collects laboratory results
CCRS	California COVID-19 Reporting System
CDC	U.S. Centers for Disease Control and Prevention
CDT	California Department of Technology
ELC	Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases
IV&V	Independent verification and validation
Public Health	California Department of Public Health

Contents

Summary	1
Introduction	5
Audit Results	
Public Health Is Exceeding Its Testing Targets, but Contact Tracing Efforts Statewide Are Lagging	9
Public Health Has Been Slow to Approve Grant Work Plans and Collect Quarterly Updates From Local Health Jurisdictions	14
Public Health Was Lax in Performing and Securing Required IT Project Oversight for Its COVID-19 Test Results System	17
Public Health Is Using ELC COVID-19 Funds for Subcontracts and Staffing	19
Recommendations	21
Appendix	
Scope and Methodology	23
Response to the Audit	
California Department of Public Health	25

Blank page inserted for reproduction purposes only.

Summary

Results in Brief

This report provides an update on our assessment of the State's management of a portion of the federal funds it received to respond to the COVID-19 pandemic. In August 2020, we designated the State's management of federal funds related to COVID-19 as a high-risk issue and indicated that the likelihood of mismanagement of these funds was great enough to create substantial risk of serious detriment to the State and its residents. This audit focuses specifically on the California Department of Public Health (Public Health) and \$467 million in federal funding it received for the State's efforts to address COVID-19.

In spring 2020, the federal government committed significant funding to combat the spread of COVID-19. To quickly distribute this funding, the U.S. Centers for Disease Control and Prevention used an existing agreement—the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) Cooperative Agreement—through which it regularly provides funding in the form of grants to support states' public health efforts. Through the ELC grants currently in place, the federal government provided \$555 million to California from March 2020 through mid-December 2020 for state-level efforts related to COVID-19 (ELC COVID-19 funds). Of this amount, \$88 million is under the direct management of a nonprofit partner with which Public Health works, Heluna Health. Public Health is responsible for using the remaining \$467 million to expand the State's ability to test individuals for COVID-19 and to conduct contact tracing to track individuals' exposure to the disease, among other objectives.

We found that although the State's testing of individuals for COVID-19 has met or exceeded Public Health's initial targets, contact tracing statewide has lagged well behind original plans. Public Health estimated in early 2020 that contact tracing would require more than 31,000 staff from local health jurisdictions—county agencies and some city health departments—to perform a variety of tasks. Public Health planned to help local health jurisdictions reach that number through the temporary reassignment of 10,000 state employees from different agencies. However, in January 2021, nine months after developing its initial staffing estimates, Public Health calculated that only about 12,100 tracing staff were employed statewide, including both staff hired or redirected by local health jurisdictions and staff reassigned by state agencies. Data show that this total workforce was inadequate to meet the sharp, year-end increase in COVID-19 cases. Public Health is now focusing on increasing the efficiency

Audit Highlights . . .

Our assessment of the State's use of nearly \$470 million in ELC COVID-19 funding, highlighted the following:

- » *Although the State's testing of individuals for COVID-19 has met or exceeded Public Health's initial targets, contact tracing statewide has lagged.*
 - *By January 2021, only about 12,100 tracing staff were employed statewide rather than the 31,000 that Public Health estimated would be needed.*
 - *This total workforce was inadequate to meet the sharp year-end increase in COVID-19 cases.*
- » *Although Public Health allocated \$286 million of its ELC COVID-19 funds to 58 local health jurisdictions, its oversight has been insufficient.*
 - *As of mid-February, it still had not approved all of the local health jurisdictions' required work and spending plans.*
 - *It did not finalize procedures for quarterly reports until recently and as of mid-February had received required reports from only 16 jurisdictions.*
- » *After IT system issues caused the State to undercount new COVID-19 cases, Public Health developed a new COVID-19 reporting system but delayed procuring independent oversight until after the new system's critical development period.*

of the existing workforce's efforts through case prioritization and through technological improvements that allow tracing staff to more quickly reach and notify people who may have been exposed to COVID-19.

To achieve its objectives, Public Health allocated \$286 million of its \$467 million ELC COVID-19 funds to 58 local health jurisdictions. However, it has not provided sufficient oversight of the funds it has distributed to these jurisdictions to date. In exchange for an advance of 25 percent of their allocations, the jurisdictions agreed to provide to Public Health work plans and spending plans by August 31, 2020. Although Public Health received all the work and spending plans, it had not approved them all as of mid-February 2021. Further, Public Health set November 2020 as the initial due date for the local health jurisdictions' quarterly updates to their work plans and spending plans. These quarterly updates are a primary way Public Health can monitor the jurisdictions' performance, but Public Health did not finalize procedures for its staff to review them until February 2021. Moreover, as of this date, it had received both types of quarterly update reports from only 16 of the 58 local health jurisdictions to which it advanced ELC COVID-19 funds. Overall, the gaps in reporting and review of the necessary update reports have left untracked more than \$40 million in ELC COVID-19 funds that Public Health advanced to the jurisdictions.

Finally, Public Health was slow to procure required independent oversight for the development of a new information technology (IT) system to track COVID-19 data, for which it budgeted \$15 million in ELC COVID-19 funds. Accurate and timely laboratory results are critical components of the State's efforts to document the spread of COVID-19 and assess the effectiveness of preventive measures. However, in summer 2020, the California Health and Human Services Agency reported that two IT system issues resulted in the State undercounting new COVID-19 cases. This hastened an existing plan for Public Health to develop a new, stand-alone COVID-19 reporting system, which it completed in February 2021. However, Public Health did not retain an independent verification and validation (IV&V) consultant in time to perform key, early error identification during this urgent project's most critical development period. This failure was in spite of requirements for IV&V in both state IT policies and in the development contract for the system.

Although Public Health has now entered into an IV&V contract, it did not dedicate the IT consultant to a thorough review of the COVID-19 reporting system. Rather, the contract includes both work on the new COVID-19 reporting system and work on several other systems, allowing Public Health to prioritize which systems the IT consultant reviews. Consequently, we question whether the

contract has provided the COVID-19 reporting system with all of the necessary safeguards. Through the development phase, Public Health did not prioritize oversight of the system. As a result, Public Health may have failed to detect potential errors, which creates a risk to future system functionality and the State's plan for addressing the COVID-19 pandemic.

Selected Recommendations

To better leverage contact tracing as a tool to limit the spread of COVID-19, Public Health should do the following:

- By May 15, 2021, reevaluate its contact tracing plan and update it to incorporate efficiencies it has instituted in order to redefine how many tracing staff it believes California needs and for how long it will need them.
- By June 15, 2021, create and implement a plan, in partnership with local health jurisdictions, to hire, train, and retain the number of tracing staff it determines is necessary to limit the spread of COVID-19, including expanding the pool of reassigned state employees functioning as tracing staff.

To ensure that it has all the necessary planning information in place related to the allocations it has made to the local health jurisdictions, Public Health should, by April 15, 2021, review and approve all initial work plans that it has received.

To ensure that it is performing necessary oversight and can provide local health jurisdictions with guidance on improving their activities using the ELC COVID-19 funding, Public Health should, by April 15, 2021, put into place procedures to ensure that it receives all required quarterly updates from the local health jurisdictions to which it made grants.

To ensure that the State has accurate COVID-19 data and to help mitigate the risks it caused by not having IV&V during the development phase of the COVID-19 reporting system, Public Health should direct its IT consultant to monitor system performance and Public Health's data validation efforts and to provide regular reports on the system's reliability until the IV&V contract expires in December 2021.

Agency Comments

Public Health agreed with our recommendations and noted ways it planned to implement them.

Introduction

Background

The California Department of Public Health (Public Health) is responsible for implementing programs that protect and improve the health of people and their communities by detecting, preventing, and responding to infectious diseases; researching disease and injury prevention; and promoting healthy lifestyles. The COVID-19 pandemic has highlighted the importance of this work: Public Health is a key entity responsible for the state-level coordinated response to COVID-19.

Federal Funding for COVID-19 Public Health Activities

To enhance states' public health efforts, the U.S. Centers for Disease Control and Prevention (CDC) awards grants through its Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) Cooperative Agreement. Recipients of ELC grants include state, local, and territorial governments. Through a series of bills Congress passed in spring 2020, the federal government committed significant funding to combat the spread of COVID-19. To quickly distribute this funding, the CDC used its existing grant applications for the ELC Cooperative Agreement. From March 2020 through mid-December 2020, the federal government provided \$555 million in ELC funds to California for state-level efforts related to COVID-19 (ELC COVID-19 funds).

Public Health's Contract With Heluna Health for ELC Grant Funds

CDC guidance states that health departments can use an administrative partner or bona fide agent—an organization that a state has identified as eligible to apply for and manage grants in its stead—to expedite the federal grant process and increase their competitiveness in applying for federal funding, processing grants, hiring staff, implementing grant activities, and assuring compliance with grant requirements. Several years ago, Public Health designated a nonprofit entity, Heluna Health (Heluna), to be its bona fide agent to receive ELC funds. The text box summarizes Heluna's responsibilities under its legal agreement with Public Health. In general, Heluna manages

Heluna's Responsibilities as Public Health's Bona Fide Agent

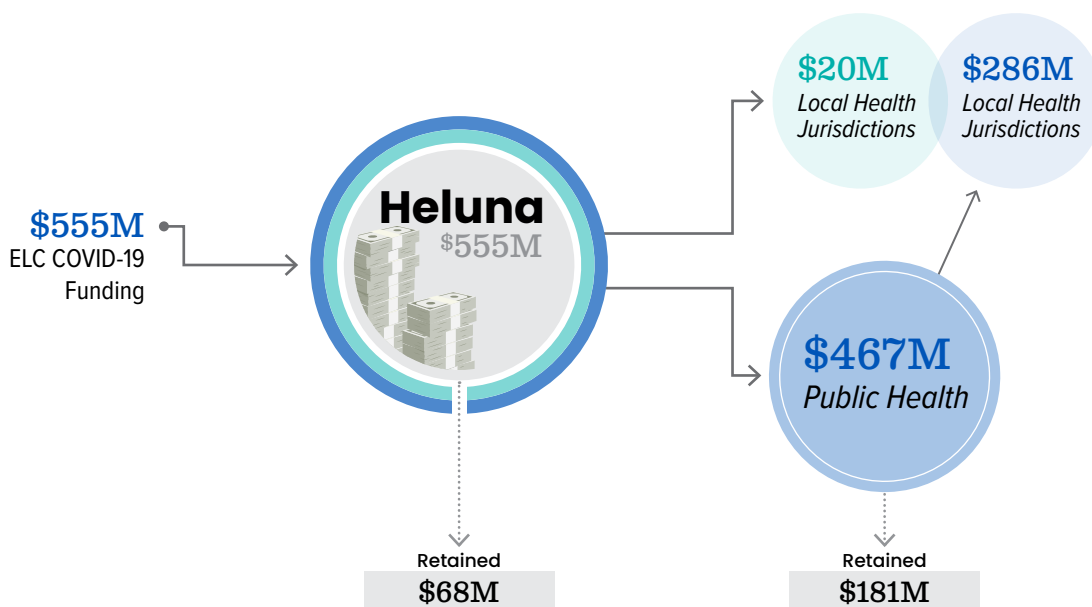
1. Submit a grant application in lieu of a state application for ELC funding.
2. Take sole responsibility for the ELC agreement and assure compliance with its requirements.
3. Perform the administrative tasks needed to obtain funding and implement the ELC agreement, including the following:
 - a. Provide overall coordination of ELC grant implementation.
 - b. Provide general administrative functions and support.
 - c. Recruit, hire, and supervise ELC program staff.
 - d. Prepare and submit reports to the CDC.
 - e. Assist Public Health in preparing legislative and data summary reports.
4. Collaborate with Public Health.

Source: 2017 Bona Fide Agent Designation agreement between Heluna and Public Health.

the administrative aspects of the State’s ELC grant, such as accounting, reporting, and hiring personnel. According to the chief of Public Health’s Division of Communicable Disease Control (division chief), Public Health is responsible for the strategic direction of the ELC grant by participating in making decisions about the activities that ELC grant funds are used to support.

Because Heluna is Public Health’s bona fide agent for regular ELC grants, the CDC officially awarded the State’s ELC COVID-19 funds to Heluna. According to the division chief, Public Health wanted to participate more directly in managing the ELC COVID-19 funds because the department had identified benefits to doing so. Specifically, Public Health wanted to leverage existing relationships formed through other grant work with local health jurisdictions, including county agencies and some city health departments, and to oversee an IT contract to modernize existing COVID-19 case reporting. Public Health and Heluna therefore entered into a contract—distinct from the bona fide agreement for regular ELC grants—that allowed Public Health to control \$467 million of the ELC COVID-19 funds, as Figure 1 shows. Heluna submitted to the CDC a budget and work plan reflecting Public Health’s involvement, which the CDC approved.

Figure 1
Sources and Recipients of California’s Federal ELC COVID-19 Funds as of Mid-December 2020



Source: Notices of Award for COVID-19-related ELC grants, Heluna budgets, and the Heluna–Public Health contract.

Figure 1 also shows that Heluna retained \$68 million of the ELC COVID-19 funds. It used these funds for grant management and to hire and manage scientific and support staff needed to perform ELC program work. For example, Heluna intends to hire several epidemiologists for Public Health's Center for Infectious Diseases. We discuss the status of Heluna's hiring efforts in the Audit Results. Heluna is also responsible for directly distributing \$20 million to local health jurisdictions to use in their efforts to combat COVID-19.

Objectives of ELC COVID-19 Funds

The CDC awarded the State's ELC COVID-19 funds for specific purposes. Of the \$555 million California received, \$499 million is for expanding its capacity to deliver and process COVID-19 tests of individuals and to use testing data to understand disease frequency and spread, among other uses. In addition, these funds are to support contact tracing—a process that determines when, where, and by whom an infected person may have been exposed to a disease and those with whom the individual has had subsequent contact. The text box lists the six goals the CDC set for the State's ELC COVID-19 funds. Heluna and Public Health must use these funds by November 2022.

Public Health has developed a plan for using its ELC COVID-19 funding. Its contract with Heluna lists six objectives for the funding, which align with the six goals the CDC established. For example, one of these objectives focuses on improving disease data reporting, case investigation efforts, and surveillance strategies to help identify where COVID-19 outbreaks occur and where COVID-19 is spreading, as well as the populations affected. This Public Health objective ties into the CDC's goals 3, 4, and 5, which the text box describes. Another Public Health objective focuses on contact tracing and infection control.

CDC's Goals for ELC COVID-19 Funds

1. Enhance laboratory, monitoring, and other workforce capacity.
2. Strengthen laboratory testing.
3. Advance electronic data exchange at public health labs.
4. Improve monitoring and reporting of electronic health data.
5. Use laboratory data to enhance investigation, response, and prevention.
6. Coordinate and engage with partners.

Source: CDC guidance titled *ELC Enhancing Detection Emerging Issues (E) Project: Funding for the Enhanced Detection, Response, Surveillance, and Prevention of COVID-19 Supported through the Paycheck Protection Program and Health Care Enhancement Act of 2020*.

ELC Funding for Local Health Jurisdictions

Much of what Public Health intends to accomplish with its ELC COVID-19 funds involves coordination with local health jurisdictions. As Figure 1 shows, Public Health allocated \$286 million to local entities, which is more than half of the \$467 million it received. For each of the six objectives Public Health outlined in its contract, it calculated an allocation of ELC funding to

local health jurisdictions. We reviewed the basis for the allocations that Public Health made to local health jurisdictions, and they seem reasonable. There are 61 local health jurisdictions statewide—which include counties and some cities—and Public Health made allocations to 58 of them.¹

In summer 2020, Public Health advanced to each of the jurisdictions 25 percent of their total allocation. In exchange for receiving this initial allocation, Public Health required each jurisdiction to submit a spending plan and a work plan showing how it would use the ELC COVID-19 funds to achieve Public Health's objectives in relation to local needs. Public Health made the remaining 75 percent of the funds available to each local health jurisdiction to claim on a reimbursement basis. Public Health requires the local health jurisdictions to submit update reports each quarter to share the status of their spending and progress in meeting its objectives. In the Audit Results, we discuss Public Health's progress in reviewing and approving the two required plan types and the update reports.

The State's Additional COVID-19 Funds

The \$555 million in ELC COVID-19 funding that Figure 1 outlines is not the only federal money the State will receive for its COVID-19 public health efforts. In January 2021, the CDC awarded California an additional \$1.7 billion in ELC COVID-19 funds as part of the Coronavirus Response and Relief Supplemental Appropriations Act of 2021. This report does not address these additional ELC funds. According to the assistant deputy director of Public Health's Emergency Preparedness Office, Public Health is still determining whether it will use its existing contract with Heluna to manage these funds or whether it will develop a separate contract.

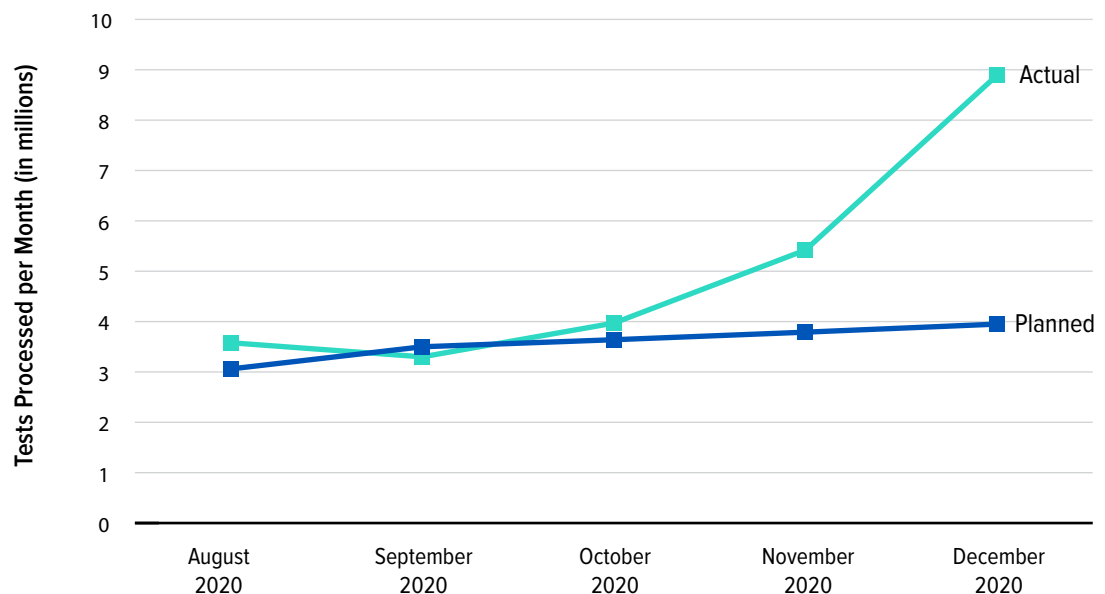
¹ Los Angeles County received ELC funds directly from the CDC and made sub-awards to the cities of Long Beach and Pasadena.

Audit Results

Public Health Is Exceeding Its Testing Targets, but Contact Tracing Efforts Statewide Are Lagging

In May 2020, Public Health created a plan for laboratories in the State to test an increasing number of individuals for COVID-19 each month. The plan projected testing 1.4 million individuals in May and a total of almost 4 million in December. As Figure 2 illustrates, collectively, entities statewide generally exceeded planned testing levels from August through December 2020. The significant month-over-month growth started in October. Entities statewide processed 1.5 million more tests in November than the plan had anticipated and exceeded December's projections by more than 4.9 million tests. Moreover, since August 2020, the laboratories have maintained an average time from administering tests to reporting the results (turnaround time) of fewer than two days, even when cases significantly increased in December. Consistently fast turnaround times are important to ensuring that the State and COVID-19 patients can take timely actions, such as contact tracing or self-isolating, that help reduce the spread of the disease. Taken together, the data about tests processed and test turnaround times support that the State has expanded its laboratory capacity, meeting one goal of the ELC COVID-19 funding.

Figure 2
In November and December 2020, COVID-19 Testing in California Significantly Exceeded Public Health's Targets



Source: Analysis of Public Health's ELC COVID-19 testing plan and online daily testing information.

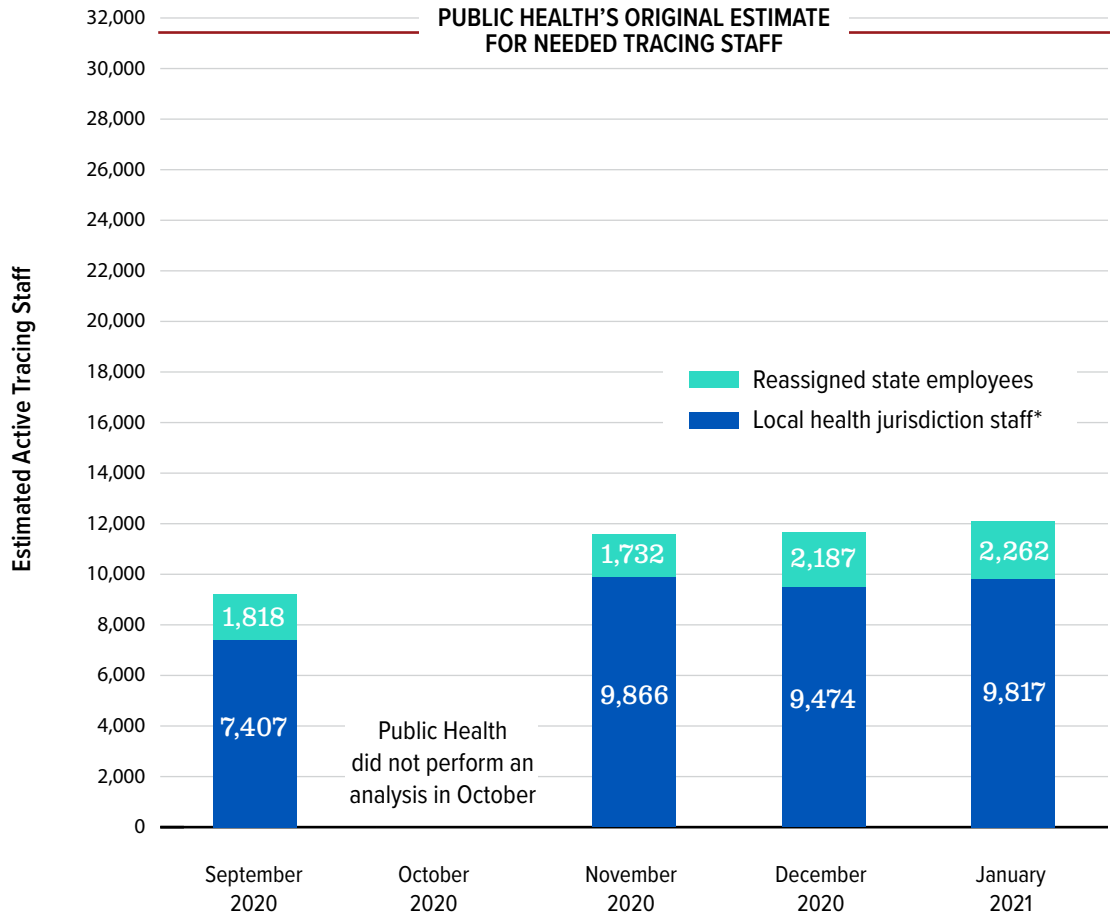
In contrast, Public Health and local health jurisdictions have struggled to meet their goals related to contact tracing. In April 2020, Public Health prepared a contact tracing program report that estimated a need for 31,400 contact tracers, case investigators, and supervisory and administrative staff (tracing staff) statewide. Public Health based its estimate on a survey in which the jurisdictions reported their existing staff levels and projected the number of staff they needed. This projection was predicated on an eventual surge in case levels to three times the April 2020 levels in each jurisdiction and on each case producing a total of 10 contacts requiring follow-up. To supplement the jurisdictions' staffing numbers, the State launched a plan in May 2020 to create a pool of 10,000 state employees who would be reassigned from various state agencies. The local health jurisdictions could draw from this pool for help when needed.

Public Health has continued to survey local health jurisdictions' tracing staff levels, and as of January 2021, its contact tracing data and survey results highlight persistent struggles to expand tracing staff capacity to meet the initial plan's estimated levels. As Figure 3 shows, in its January 2021 report, Public Health calculated that the statewide tracing staff totaled nearly 12,100, including local health jurisdictions' staff and more than 2,200 reassigned state employees. This number is far below the original goal of 31,400. Moreover, Public Health has not reached its goal of 10,000 for the pool of reassigned state employees.

Fewer-than-expected numbers of tracing staff and the influx of new cases have resulted in only a small fraction of COVID-19 cases undergoing the full contact tracing process.

Fewer-than-expected numbers of tracing staff and the influx of new cases have resulted in only a small fraction of COVID-19 cases undergoing the full contact tracing process. Local health jurisdictions reported that they attempted to contact about 85 percent of the roughly 834,000 COVID-19 cases included in the January 2021 report, but they had successful interviews for only 40 percent of the total cases. Moreover, the tracing staff were able to identify an additional person to contact and notify of potential exposure in only 16 percent of the total cases, as Figure 4 illustrates. Public Health's report does not specify the reasons for the low numbers of successful interviews and contacts with people possibly exposed to COVID-19, although Public Health's CA COVID-19 Contact Tracing Program director (contact tracing director) explained to us that many individuals did not report contacts because they did not remember them or had limited exposure to others because of stay-at-home orders. However, these factors do not account for the low number of successful interviews with individuals who had tested positive for COVID-19.

Figure 3
Public Health and Local Jurisdictions Have Not Hired or Reassigned Sufficient Tracing Staff to Meet the State’s Estimated Need



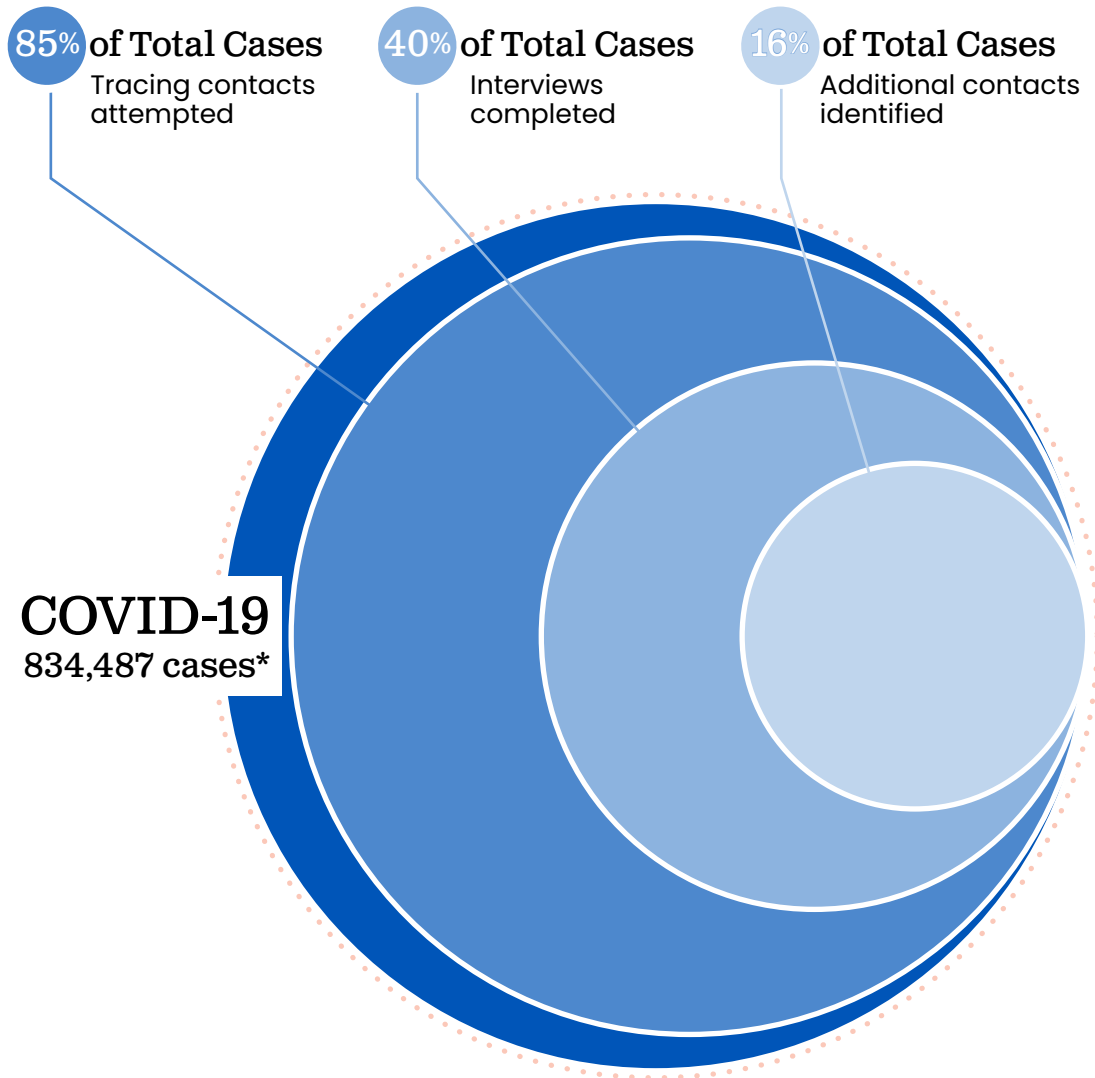
Source: Public Health’s California Local Health Jurisdiction COVID-19 Contact Tracing Program Workforce, Systems, & Training Needs for April 2020 and the California Local Health Jurisdiction Contact Tracing Performance Metrics & Program Assessment (January 2021, Revised).

* Includes reassigned and newly hired staff.

State and local entities have encountered a variety of obstacles to assembling an adequate number of tracing staff. According to the contact tracing director, coordinating remote work was difficult; the initial training was overly abbreviated, resulting in staff needing additional on-the-job training; and staff had to continually adapt to constantly evolving protocols and technology, such as a new database in which to record contact tracing efforts. Local health jurisdictions’ December and January surveys also show that they often redirected their existing staff from their assigned duties to perform the contact tracing duties rather than expanding their overall staff numbers through hiring. Some jurisdictions have also experienced turnover in tracing staff positions.

Figure 4

In December 2020, Contact Tracing Successfully Identified Additional People to Contact in Only a Small Fraction of Cases



Source: Public Health's California Local Health Jurisdiction Contact Tracing Performance Metrics & Program Assessment (January 2021, Revised), COVID-19 Case Interview Cascade.

* According to Public Health, the total number of cases includes cases from the State's contact tracing database and locally reported data from November 25 through December 24, 2020. It excludes certain categories of cases, such as those in which more than 10 days had passed since test specimen collection.

Moreover, the sheer number of cases has overwhelmed local health jurisdictions' contact tracing efforts. Public Health based its estimate of needing 31,400 tracing staff on an average daily new case count of just under 5,000. The statewide daily average total number of newly reported cases at the end of April 2020 was about 1,600. However, from late November through late

December 2020, the cases Public Health tracked for contact tracing averaged more than 25,000 per day.² In the January survey, 15 local health jurisdictions reported that they could not investigate every new case because of the influx of new cases; this number had increased from 11 jurisdictions in the December survey. Public Health determined that caseloads at the majority of local health jurisdictions were at or exceeding their contact tracing capacity.

Public Health is taking steps to support the local health jurisdictions' contact tracing efforts. The contact tracing director explained that because the goal of contact tracing is to notify individuals that they may have been exposed to the virus so that they can self-quarantine, Public Health has focused on improving the efficiency of the existing workforce's efforts to reach and notify people as a way to improve the tracing program's outcomes. For example, Public Health has recognized that it is not possible to trace every COVID-19-positive case while there is widespread transmission, and it is working with the jurisdictions as they determine how to prioritize high-risk cases and outbreaks. Public Health is also working to improve the technology tracing staff use. For example, it released a tool for schools and businesses to upload information directly to the State's contact tracing database, and as such, Public Health can reduce the time it takes for tracing staff to enter information to initiate a case. The contact tracing director also noted that the additional ELC funds the State received in January may provide opportunities for Public Health to further improve tracing technology and to hire support staff, as well as for local health jurisdictions to hire tracing staff.

Although new funding may help improve the State's contact tracing capacity, Public Health has also identified gaps in the assumptions that informed its April 2020 plan's estimates of the number of staff needed. For example, the plan's predicted number of daily cases was too low, while the assumption that tracers would identify 10 contacts per case was too high. The plan also did not account for efficiencies gained from using technology—such as cell phone tools and computer databases—to assist in contacting COVID-19-positive individuals and those whom they had possibly exposed. Nonetheless, the contact tracing director acknowledged that Public Health has not yet updated its original plan to reflect new information and assumptions. We believe that by doing so, Public Health could better track the effect of its efforts to increase contact tracing capacity and more accurately assess the extent of the shortfall in the State's tracing staff.

Although new funding may help improve the State's contact tracing capacity, Public Health has also identified gaps in the assumptions that informed its April 2020 plan's estimates of the number of staff needed.

² According to Public Health's California Local Health Jurisdiction Contact Tracing Performance Metrics & Program Assessment (January 2021, Revised), not every case is appropriate for contact tracing. For example, case counts do not include those in which no community, meaning the general public, exposure was anticipated.

Local health jurisdictions have indicated that they are preparing action plans to rectify the shortfalls in their individual contact tracing efforts. In response to Public Health's December survey, almost all of the local health jurisdictions reported that if cases continued to surge, they would modify outreach protocols by focusing on outbreaks in specific settings, focusing on the newest reported cases, or reducing the number of outreach attempts per case, among other options. In response to the January survey, a majority reported that they had begun using such strategies to prioritize cases by, for example, tracing cases with the most recent testing dates. Further, the majority of local health jurisdictions reported to Public Health in both December and January that they planned to expand their workforce immediately, either through hiring, requesting support from the pool of reassigned state employees, or reactivating local staff.

CDC guidelines highlight the ongoing need for contact tracing to identify exposure to COVID-19 and to encourage self-quarantine, even as the number of people receiving vaccinations increases and the number of cases decreases. Therefore, it remains important that Public Health and local health jurisdictions work together to implement action plans that build contact tracing capacity so that the State may further limit COVID-19's spread during the remainder of the pandemic.

Public Health Has Been Slow to Approve Grant Work Plans and Collect Quarterly Updates From Local Health Jurisdictions

When allocating ELC COVID-19 funds to local health jurisdictions, Public Health has required them to provide work plans and spending plans, as well as two quarterly update reports (quarterly updates) about implementing these two plans. However, Public Health has been slow to approve the jurisdictions' work plans. Public Health required the 58 jurisdictions to which it had made advance allocations to submit their draft work plans by August 31, 2020—a deadline which 32 jurisdictions met. The remaining 26 jurisdictions had submitted their plans by October 2, 2020. Public Health has been using subject-matter experts to review and comment on each element of each work plan. According to the assistant chief of the Division of Communicable Disease Control at Public Health (assistant chief), its process for approving the work plans is slow. By December 2020, Public Health had reviewed substantial portions of many of the work plans and provided feedback to the jurisdictions about how to modify their plans. As of mid-February 2021—more than five months after they were first due—Public Health had approved 48 work plans, and it had reviewed the remaining 10 plans, which were still awaiting its approval.

As of mid-February 2021—more than five months after they were first due—10 plans were still awaiting Public Health's approval.

According to the assistant chief, Public Health is approaching its work plan review as a “continual, iterative process.” She commented that as part of the work plan review and approval process, Public Health is working with local health jurisdictions to adapt their plans to reflect additional guidance Public Health and CDC have issued since Public Health made its advance allocations in August 2020. Nonetheless, pending Public Health’s plan approval, local health jurisdictions may have hesitated to take planned steps that could help in their fight against COVID-19. For example, in fall 2020, one local health jurisdiction reported to Public Health that the county would need plan approval before hiring positions that its ELC COVID-19 funds supported; this jurisdiction did not receive plan approval from Public Health until February 2021. The jurisdiction’s comments indicate that Public Health’s delay may have impacted its ability to meet its plan and goals in the early months after receiving ELC COVID-19 funds.

In contrast, Public Health proactively approved almost all of the spending plans that the local health jurisdictions submitted. As a condition of accepting the 25 percent advance in ELC COVID-19 funds, Public Health required the jurisdictions to prepare spending plans to accompany their work plans and to group their intended expenditures by program goal and cost category, such as salary or equipment. By October 2020, Public Health had approved 54 of the spending plans; it approved three more by February 2021; and it is currently working with the one remaining local health jurisdiction to complete and approve its spending plan. Because Public Health approved these spending plans and issued advance payments, local health jurisdictions were able to begin using the funds to support critical activities, even though their work plans were still under review. The assistant chief told us that Public Health’s priority was to ensure that the jurisdictions’ budgets included only allowable expenses. The chief of the ELC unit at Public Health’s Emergency Preparedness Office (ELC chief) noted that the four local health jurisdictions it did not approve by October required extensions because COVID-19 case surges occupied their staff time.

That said, Public Health has been slow to establish processes to monitor local health jurisdictions’ spending and activities linked to the ELC COVID-19 funding allocations. Public Health set a reporting schedule for each jurisdiction that received this funding to prepare and submit quarterly updates, the first describing the jurisdiction’s progress and challenges related to implementing its work plan and the second summarizing the types and amounts of reimbursable expenses it has incurred. The first set of quarterly updates was due to Public Health in November 2020. However, as of February 2021, Public Health had received both quarterly updates from only 16 of the 58 local health jurisdictions to which it made ELC COVID-19 funding advances. The 42 jurisdictions that did not

Public Health has been slow to establish processes to monitor local health jurisdictions’ spending and activities linked to the ELC COVID-19 funding allocations.

Public Health did not communicate clear expectations to the local health jurisdictions about the quarterly update reports it expected them to prepare and submit.

submit one or both quarterly updates include several of the State's most populous jurisdictions, such as Sacramento and San Mateo counties. Overall, the gaps in reporting leave more than \$40 million in ELC COVID-19 funding untracked. Because Public Health has not received all quarterly updates, it has had limited ability to assess local health jurisdictions' use of COVID-19 funds and determine their progress in meeting program goals and fighting the spread of COVID-19.

Public Health did not communicate clear expectations to the local health jurisdictions about the quarterly update reports it expected them to prepare and submit. Though Public Health staff explained to us that the department expected all local health jurisdictions that received advances to submit quarterly updates in November 2020 regardless of work plan approval status, its original allocation letters to the jurisdictions indicated that only those with approved work plans needed to submit quarterly updates. Therefore, some of the local health jurisdictions may have believed that they did not have to prepare or send these update reports. To get the local health jurisdictions to submit the needed reports, Public Health created notices to remind the jurisdictions about reporting requirements and deadlines, which it began sending out in early February 2021.

The assistant deputy director of the Emergency Preparedness Office explained that Public Health's original wording of its reporting instructions was an administrative oversight and that Public Health would revise future allocation letters to clarify that it requires quarterly updates even from local health jurisdictions whose work plans are still pending approval. It is important that Public Health continue to improve response rates—the number of jurisdictions submitting quarterly updates—because without these updates, Public Health lacks an important means of verifying that the jurisdictions are using their ELC COVID-19 funding effectively and appropriately.

Public Health also lacked a process by which to review the quarterly updates it did receive until nearly six months after it made advance allocations in August 2020. In early February 2021, Public Health finalized procedures for its staff to review the quarterly updates upon receiving them and to contact the local health jurisdictions to ask questions or provide guidance as necessary. The ELC chief explained that Public Health had waited until January 2021 to assign staff to set up a review process for the quarterly updates and that Public Health did not consider review of the expenditure reports to be an urgent issue because local health jurisdictions were not yet reporting costs that exceeded their initial 25 percent advances. Nonetheless, because Public Health delayed creating this process and reviewing the quarterly updates, it may have missed an opportunity to make course corrections that could improve

the appropriateness and effectiveness of the jurisdictions' future spending. However, we are encouraged by Public Health's work to remedy this deficiency and its plans to perform reviews in the future.

Public Health's progress in improving its collection and use of local health jurisdictions' quarterly updates is important to support both current COVID-19-related efforts and long-term activities to prepare for future infectious disease emergencies. As we discuss in the Introduction, one of the ELC COVID-19 funding's key goals is to build capacity, or the long-term ability for recipients to perform necessary testing and information gathering related to infectious diseases. Their increased capacity will help jurisdictions be better prepared to respond to future infectious disease emergencies in ways they were not prepared to respond to COVID-19. Public Health has set a deadline of November 2022 for jurisdictions to use the ELC COVID-19 funds, more than a year after experts predict the COVID-19 pandemic to peak.³ Therefore, it is important for Public Health to continue working to improve the timeliness of jurisdictions' submission of quarterly updates and its own review of those reports.

More robust collaboration between Public Health and local health jurisdictions for long-term planning may also become easier in the later months of the pandemic if local and state government workloads related to COVID-19-specific issues decrease. Thus, Public Health must ensure that it is establishing productive lines of communication and that it is prepared to provide the jurisdictions with constructive feedback and guidance as the funding program continues.

Public Health Was Lax in Performing and Securing Required IT Project Oversight for Its COVID-19 Test Results System

Of the approximately \$181 million in ELC COVID-19 funds Public Health initially retained, it budgeted \$49 million over three years to replace its system that collects laboratory results—CalREDIE. Accurate and timely laboratory results are a critical component of the State's efforts to document the spread of COVID-19 and assess the effectiveness of its preventive measures. However, in August 2020, the California Health and Human Services Agency reported that two information system issues affecting CalREDIE

In August 2020, the California Health and Human Services Agency reported that two information system issues in the prior weeks resulted in the State undercounting new COVID-19 cases.

³ We based this estimate on modeling by the Institute for Health Metrics and Evaluation, University of Washington, updated on February 12, 2021.

in the prior weeks resulted in the State undercounting new COVID-19 cases. As a result, Public Health had to hasten its plans for both long- and short-term solutions to replacing CalREDIE.

As a significant first step in this effort, Public Health initiated a \$15 million information technology (IT) contract in August 2020 for the California COVID Reporting System (CCRS), a new system for securely and accurately collecting, storing, analyzing, and publishing COVID-19 laboratory and case data. This IT project reflects the CDC's guidance to use ELC COVID-19 funds to obtain systems that enable relevant entities to exchange laboratory data and to monitor and analyze measures to fight COVID-19. Public Health's contractor (IT vendor) conducted the project in two phases. The first phase, which Public Health declared complete in December 2020, focused on system development and migrating historical laboratory data from CalREDIE to CCRS. The second phase, which Public Health declared complete in late February 2021, focused on connecting entities so they can upload laboratory results data directly. According to the chief of the Division of Communicable Disease Control, the new CCRS system was key to stabilizing laboratory reporting to Public Health by the end of 2020—one of Public Health's critical goals for the system.

Public Health's oversight of the IT vendor was initially deficient.

Because of the critical nature of new system development, both the State's IT policies and Public Health's contract with the IT vendor require multiple forms of oversight. However, Public Health's oversight of the IT vendor was initially deficient. Specifically, the project contract required the IT vendor to provide Public Health with weekly and monthly status reports containing information such as lists of tasks completed and in progress. Despite this requirement, Public Health did not collect either of these reports from the IT vendor until mid-October 2020, two months after it initiated the contract. The chief of the project management branch at Public Health (project management chief) explained that before October 2020, Public Health received daily project updates from the IT vendor. However, the sample daily update that she provided to us was missing elements the contract requires in the monthly and weekly status reports. Although Public Health demonstrated that it rectified this issue, it did not do so until a significant portion of the first project phase—system development—was complete. Thus, we are concerned that for the initial development process, Public Health did not ensure that it received complete updates, potentially affecting its ability to assess the status of work performed at that time.

In addition, the State's most critical IT projects have two primary forms of oversight: independent verification and validation services (IV&V) and reports the California Department of Technology (CDT) prepares regarding issue areas including

schedule management, cost management, scope management, and risks. Typically performed by an independent contractor, IV&V is an important step to identify system deficiencies and verify that development incorporates industry standards and best practices. For this reason, the *State Administrative Manual* requires agencies to have an independent technical evaluator in place by the start date of a project. However, Public Health did not secure an outside oversight entity to perform IV&V until January 2021—months after the project began and weeks after Public Health had formally determined that the CCRS project was ready to move to the final project phase. The project management chief explained that the delay was caused by the unusual speed with which the project progressed. Although she stated that Public Health kept CDT informally apprised of the delay, Public Health could not demonstrate that it received CDT's approval to depart from the *State Administrative Manual* requirement.

In addition, Public Health's IV&V contract bundles the IV&V for the CCRS project with several other ongoing IT projects, which leads us to question whether the contract has provided the CCRS project with all of the necessary safeguards. The *State Administrative Manual* describes IV&V as a function that continues from project initiation through completion. Nonetheless, with the bundled contract structure, Public Health had significant leeway to determine the amount of CCRS-specific work it assigned to the IV&V consultant. According to the project management chief, IT projects get the most value from technical oversight earlier in the development process, so Public Health structured the bundled IV&V contract so that the IV&V consultant would focus primarily on other projects that were still in early development. Although the project management chief asserted that Public Health plans to continue working with the IV&V consultant to continue to reevaluate the system and address risks, the contract's structure does not guarantee that these important efforts will continue. By the time of the IV&V contract's start, the CCRS project was in its final phase, and it concluded less than two months later. As a result, Public Health may have failed to detect potential system development errors, which creates a risk to future system functionality and the State's plan for managing the COVID-19 pandemic.

Public Health may have failed to detect potential system development errors, which creates a risk to future system functionality and the State's plan for managing the COVID-19 pandemic.

Public Health Is Using ELC COVID-19 Funds for Subcontracts and Staffing

In addition to securing a new IT system, Public Health has budgeted funding to use for contracts and staffing for various COVID-19-related activities. Public Health has until November 2022 to spend the COVID-19 funds and has begun doing so. For example, it budgeted \$97 million for contracts for mobile

laboratory testing capacity, which includes specimen transportation and testing site operations. The assistant deputy director of Public Health's Emergency Preparedness Office (assistant deputy director) explained that the department has used these funds for a contract with a diagnostics company. The contract requires the company to provide testing through a number of means, including a mobile bus, at-home testing kits, and a traveling team that can be deployed to locations such as skilled nursing facilities. The goal of this contract is to ensure that individuals who are disproportionately affected by or are more susceptible to the virus can easily access testing services.

Public Health also budgeted \$10 million for contracts that focus on COVID-19 testing disparities and vulnerable populations. It has allocated about \$4 million to support the California Health Interview Survey for 2021 and 2022. The University of California, Los Angeles, administers the survey, which covers a wide range of health topics and gives a detailed picture of the health and health care needs of California's population. The university has administered the survey since 2001. According to the assistant deputy director, Public Health will use the remaining \$6 million for projects focusing on populations that may be particularly vulnerable to COVID-19 and have less access to testing. However, it has not yet allocated these funds.

In addition, Public Health is using ELC COVID-19 funds to hire a small number of staff for COVID-19-related assignments. As of the end of January 2021, it had used the state hiring process to fill six of nine total positions. The chief of the ELC unit at Public Health's Emergency Preparedness Office (ELC chief) explained that because many of these positions are limited-term, Public Health has had difficulty attracting enough qualified applicants. It will be reposting the open positions to try to get additional applicants.

Heluna is also using a large portion of the \$68 million in ELC COVID-19 funding it retained for hiring. It is filling 133 positions for the COVID-19-related programs it and Public Health have established. The two entities have developed lists of positions needed to staff these programs. Many of these positions will work for specific terms linked to the availability of ELC COVID-19 funds. An attorney for Public Health explained how Heluna and Public Health cooperate during the hiring process. Specifically, Heluna first conducts initial screenings, then Public Health conducts interviews and makes final hiring decisions, and finally Heluna makes the job offers to the candidates. Although Heluna will employ these individuals, they will be working on statewide public health efforts. For example, Heluna is hiring several epidemiologists for Public Health's Center for Infectious Diseases and infection preventionists for Public Health's Healthcare-Associated Infections Program.

Because many of the new positions for COVID-19-related assignments are limited-term, Public Health has had difficulty attracting enough qualified applicants.

As of February 2021, Heluna had filled 88 of the 133 positions (66 percent). The chief of the business operations support section at Public Health's Center for Infectious Diseases (support section chief) noted that hiring had initially been slow as Heluna dealt with various administrative difficulties that receiving the additional COVID-19 funds raised, such as developing new budgets and filling needed positions quickly. However, Public Health established weekly meetings with Heluna to provide assistance, and by September 2020, the process had become smoother. The support section chief stated that Public Health continues to hold regular meetings with Heluna to discuss staffing.

Recommendations

To better leverage contact tracing as a tool to limit the spread of COVID-19, Public Health should do the following:

- By May 15, 2021, reevaluate its contact tracing plan and update it to incorporate technological and medical advances in order to redefine how many tracing staff California needs and for how long it will need them.
- By June 15, 2021, create and implement an updated plan, in partnership with local health jurisdictions, to hire, train, and retain the number of tracing staff it determines is necessary to limit the spread of COVID-19, including expanding the pool of reassigned state employees functioning as tracing staff.
- By June 15, 2021, and in collaboration with local health jurisdictions, determine what barriers exist to contact tracers successfully identifying and contacting people who may have been exposed to COVID-19. After studying those barriers, it should share best practices with the jurisdictions and encourage them to implement those practices that will be successful at overcoming the barriers.

To ensure that it has all the necessary planning information in place related to the allocations it has made to the local health jurisdictions, Public Health should, by April 15, 2021, review and approve all initial work plans that it has received.

To ensure that it is performing necessary oversight and can provide local health jurisdictions with guidance to improve their activities using the ELC COVID-19 funding, Public Health should, by April 15, 2021, put in place procedures to ensure that it receives all required quarterly work plans and expenditure updates from local health jurisdictions to which it made grants.

To ensure that the State has accurate COVID-19 data and to help mitigate the risks it caused by not having IV&V during the development phase of the CCRS project, Public Health should direct its IV&V consultant to monitor system performance and Public Health's data validation efforts and to provide regular reports on the system's reliability until the IV&V contract expires in December 2021.

We conducted this performance audit in accordance with generally accepted government auditing standards and under the authority vested in the California State Auditor by Government Code sections 8543 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA
California State Auditor

April 1, 2021

Appendix

Scope and Methodology

State law authorizes the California State Auditor to establish a program to audit and issue reports with recommendations to improve any state agency or statewide issue that our office identifies as being at high risk for the potential of waste, fraud, abuse, and mismanagement or as having major challenges associated with its economy, efficiency, or effectiveness. In January 2020, we issued our latest assessment of high risk issues that the State and selected agencies face. In August 2020, we added the State's management of federal COVID-19-related funding to that assessment as a high-risk issue because of the significant amount of money the State has received, the rapid nature of the allocation, and the urgent need for the funding. Public Health is responsible for managing a portion of the federal COVID-19-related funds. The table lists the objectives we developed for our review and the methods we used to address them.

Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
<p>1 Assess whether the CDC has approved Public Health's ELC grant work plan and budget and evaluate Public Health's controls for monitoring its own performance and that of various counties.</p>	<ul style="list-style-type: none"> • Interviewed key Public Health officials. • Reviewed federal law and CDC grant guidance. • Reviewed CDC and Public Health grant documents for stated requirements and goals. These documents included Notice of Awards, Notice of Funding Opportunities, grant work plans, grant budgets, and county allocation letters. • Reviewed Public Health's metrics for its grant performance and periodic performance reports, in addition to its internal reports and analysis on testing and contact tracing.
<p>2 Evaluate Public Health's relationship with Heluna and determine whether there is sufficient oversight to ensure that Heluna performs its required duties.</p>	<ul style="list-style-type: none"> • Interviewed key Public Health officials. • Reviewed state law and the agreement between Public Health and Heluna that makes Heluna its bona fide agent. • Determined that the CDC advises that using an administrative partner or bona fide agent is one way to expedite the federal grant process and increase a health department's competitiveness in applying for and accepting federal funding.
<p>3 Determine whether Public Health is distributing its share of grant funds within federally required timelines and in a manner that allows recipients to deploy the funds immediately in response to COVID-19.</p>	<ul style="list-style-type: none"> • Interviewed key Public Health officials. • Reviewed federal law and CDC grant guidance. • Reviewed CDC and Public Health grant documents, including Notice of Awards, grant guidance documents, grant work plans, grant spending plans, and county allocation letters. • Identified no concerns with Public Health's allocations.

continued on next page...

AUDIT OBJECTIVE	METHOD
<p>4 Determine whether Public Health's contract for CCRS requires monitoring to help ensure that the new data system meets timelines and operating expectations.</p>	<ul style="list-style-type: none"> • Interviewed key Public Health officials. • Reviewed the contract between Public Health and OptumInsight, Inc., to design, develop, configure, implement, and support CCRS. • Reviewed project oversight guidelines for state IT projects. • Reviewed relevant project documents, including status reports, checklists, deliverable expectation documents, and project plans.

Source: *State High Risk Update: The California State Auditor Has Designated the State's Management of Federal COVID-19 Funding as a High-Risk Issue*, Report 2020-602, August 2020, and information and documentation identified in the column titled Method.

Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily obligated to follow, requires us to assess the sufficiency and appropriateness of computer-processed information we use to support our findings, conclusions, or recommendations. In performing this audit, we relied on electronic data files that we obtained from Public Health. We verified that we received the information we requested. We also reviewed the data for logic and completeness. We found the data to be sufficiently reliable for our purposes.

April 2021



Tomás J. Aragón, MD, DrPH
Director and State Public Health Officer

State of California—Health and Human Services Agency
California Department of Public Health



GAVIN NEWSOM
Governor

March 15, 2021

Elaine Howle
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Public Health (Public Health) has reviewed the California State Auditor's draft audit report titled "California Department of Public Health: It Could Do More to Ensure Effective Use of Federal Funds for Expanding the State's COVID-19 Testing and Contact Tracing Programs." Public Health appreciates the opportunity to respond to the report and provide our assessment of the recommendations contained therein.

Below we reiterate the audit findings and our response to the auditor's specific recommendations.

Finding: "Public Health Is Exceeding Its Testing Targets, but Contact Tracing Efforts Statewide Are Lagging."

Recommendation to Public Health:

To better leverage contact tracing as a tool to limit the spread of COVID-19, Public Health should do the following:

By May 15, 2021, reevaluate its contact tracing plan and update it to incorporate technological and medical advances in order to redefine how many tracing staff it believes California needs and for how long it will need them.

Management Response:

Public Health agrees with this recommendation. The California Connected Contact Tracing (CT) Program is working with Public Health and academic partners to develop a new contact tracing staffing model based on current scientific knowledge, actual data from the first ten months of California's contact tracing response, and the State's projected COVID-19 case numbers for 2021. This revised staffing model will also consider technology innovations that save staff time and expand local workforce



Elaine Howle
March 15, 2021
Page 2

capacity, including automated case and contact surveys and data portals that enable external partners such as schools and businesses to share core data for cases and exposed contacts with their local health jurisdictions. This model will include the estimated workforce needed within the variety of staffing roles that together implement contact tracing activities, for example: case investigators, contact tracers, contact tracing team leads and supervisors, clinical advisors, isolation and quarantine resource coordinators, and data entry and triage staff. Of note, this new model will not include projected cases and staffing needs in prisons, long-term care and skilled-nursing facilities, and other congregate settings that are not supported by Public Health's community CT Program and its related contact tracing workforce. The new model and subsequent revised California contact tracing staff plan will be complete by May 15, 2021.

Recommendation to Public Health:

By June 15, 2021, create and implement an updated plan, in partnership with local health jurisdictions, to hire, train, and retain the number of tracing staff it determines is necessary to limit the spread of COVID-19, including expanding the pool of reassigned state employees functioning as tracing staff.

Management Response:

Public Health agrees with this recommendation. By June 15, 2021, local health jurisdictions and the CT Program will partner to expand local workforce capacity as needed to meet the current and projected needs of the COVID-19 response, according to the revised staffing plan developed by the CT Program. If necessary and the projected need cannot be met by local- and state-hired contact tracing staffing, the CT Program will continue to use the state redirected staffing pool to supplement the local health jurisdiction contact tracing workforce. In partnership with the UCSF/UCLA Virtual Training Academy and local health jurisdiction partners, the CT Program will ensure that the workforce is sufficiently trained to effectively perform its contact tracing duties.

Recommendation to Public Health:

By June 15, 2021, and in collaboration with local health jurisdictions, determine what barriers exist to contact tracers successfully identifying and contacting additional people who may have been exposed to COVID-19. It should then study those barriers and share best practices with the jurisdictions and encourage them to implement those practices that will be successful at overcoming the barriers.

Management Response:

Public Health agrees with this recommendation. By June 15, 2021, the CT Program will utilize data and information collected via the State's contact tracing data management system (CalCONNECT) and reported by local health jurisdictions through monthly ELC reporting to determine the existing key barriers that hinder successful contact tracing efforts. The CT Program will gather information shared by local health jurisdictions via facilitated learning collaboratives, town halls, and/or CalCONNECT LHJ Council

Elaine Howle
March 15, 2021
Page 3

meetings, as well as information shared by other states, the Centers for Disease Control and Prevention (CDC), and other national partners to identify best practices for mitigating these barriers. The CT Program will share these best practices with California local health jurisdictions and will work with them to create mechanisms to facilitate implementation of these best practices using CalCONNECT system enhancements, workforce training and development opportunities, community engagement strategies, health promotion efforts, or other methods identified as important to implementation.

Finding: “Public Health Has Been Slow to Approve Grant Work Plans and Collect Quarterly Updates From Local Health Jurisdictions.”

Recommendation to Public Health:

To ensure that Public Health has all the necessary planning information in place related to the allocations it has made to the local health jurisdictions, by April 15, 2021, Public Health should review and approve all initial work plans that it has received.

Management Response:

Public Health agrees with this recommendation. There were 58 work plans submitted to Public Health for the ELC Enhancing Detection application. As of March 9, 2021, Public Health has approved 56 work plans, or 97%. Public Health will have the remaining two work plans approved by the recommended date of April 15, 2021.

Public Health has a team in place to collect and review future ELC applications. Public Health will be developing a timeline to follow for its internal review process ensuring timely approval of applications in an effort to maximize the local health jurisdictions planned activities.

Recommendation to Public Health:

To ensure that it is performing necessary oversight and can provide local health jurisdictions with guidance to improve their activities using the ELC COVID-19 funding, by April 15, 2021, Public Health should put in place procedures to ensure that it receives all required quarterly work plans and expenditure updates from local health jurisdictions to which it made grants.

Management Response:

Public Health agrees with this recommendation. Internal procedures for collecting progress reports and expenditure reports were in place on February 3, 2021. These procedures include a detailed process for reviewing the reports once received. Aside from what Public Health had included in the Direct Allocation letters issued on August 11, 2020, Public Health communicated a reminder for submission of such reports February 5, 2021 via email. These reminders will be issued on a regular basis moving forward to ensure submission of progress and expenditure reports.

Elaine Howle
March 15, 2021
Page 4

Finding: “Public Health Was Lax in Performing and Securing Required IT Project Oversight for Its COVID-19 Test Results System.”

Recommendation to Public Health:

To ensure that the State has accurate COVID-19 data, and to help mitigate the risks it caused by not having IV&V conducted during the development phase of CCRS, Public Health should direct its IV&V consultant to monitor system performance and Public Health’s data validation efforts and provide regular reports on the system’s reliability until the IV&V contract expires in December 2021.

Management Response:

Public Health agrees with the recommendation and concurs regarding the importance of the Independent Verification and Validation (IV&V) process. While starting IV&V at project inception would have been ideal, Public Health agrees there is value in onboarding IV&V during any project phase. The IV&V consultants have been directed to monitor system performance and Public Health’s data validation efforts and provide regular reports on the system’s reliability until the IV&V contract expires in December 2021.

We appreciate the opportunity to respond to the audit. If you have any questions, please contact Mónica Vázquez, Chief, Office of Compliance, at (916) 306-2251.

Sincerely,



Tomás J. Aragón, MD, DrPH
Director and State Public Health Officer