CALIFORNIA MEDICAL ASSOCIATION

House of Delegates
OCTOBER 24, 2020

FOR INFORMATION

THIS REPORT DOES NOT REFLECT OFFICIAL CMA POLICY

Report to the House of Delegates from the
Council on Science and Public Health
Robert Oldham, MD, Chair

OCTOBER 24, 2020

Pandemic Response and Preparedness

Summary of Recommendations

PUBLIC HEALTH PLANNING AND PREPARATION

RECOMMENDATION 1: That CMA work with the State of California and local jurisdictions to ensure that CMA and practicing physicians are involved in the development and execution of planning and response including but not limited to health care delivery related to the COVID-19 pandemic, and that plans for COVID-19 pandemic response focus on procurement of medical equipment and supplies, strengthening the infectious disease data surveillance system, addressing health disparities, addressing impacts from climate change, supporting the health and social safety net to facilitate infection control policies, ensuring a robust healthcare workforce; and mitigating the pandemic's impact on the erosion of social cohesion in communities.

RECOMMENDATION 2: That CMA, after state and federal governments have declared the end of the state of emergency related to the COVID-19 pandemic, should continue to advocate for and participate in the development of After Action Reports (AAR) and a new pandemic preparedness plan that is regularly updated and informed by the experiences of stakeholders and lessons learned from the COVID-19 pandemic.

RECOMMENDATION 3: CMA shall support that future pandemic planning shall be conducted through a public and transparent process and informed by the experiences of stakeholders and lessons learned from the COVID-19 pandemic, and that the scope of the plan shall include, but not be limited to, procurement of medical equipment and supplies; strengthening the infectious disease data surveillance system; addressing impacts of the plan on and by health disparities and climate change; supporting the health and social safety net to facilitate infection control policies and safeguard communities and social development; supporting transparent communication between government entities and physicians about vaccine development; and ensuring a robust healthcare workforce.

RECOMMENDATION 4: CMA support improving access to federal resources in the current and future pandemics by documenting the impact of the federal governments failures on pandemic response in California, especially with regard to physicians and their patients, and engaging in federal advocacy to reform how the federal government plans for and executes effective pandemic response.

RECOMMENDATION 5: That CMA reaffirm HOD 114-02 that supports preserving and strengthening the public health infrastructure in California at the state and local level, including significant funding increases for infectious disease and disaster preparedness programs.

RECOMMENDATION 6: That CMA support that pandemic planning includes the establishment of the Health Professions Pandemic Advisory Committee comprised of representatives from statewide health professional associations which shall advise the Executive and Legislative branches on pandemic policies and procedures that impact health care delivery and patient care and ensure that input from health providers reflects the wide diversity of health care delivery by geographic region, health specialties and modes of practice.

RECOMMENDATION 7: That CMA support that future planning for pandemic response needs to be done through a lens of health inequities and structural

racism to better evaluate disparate impacts of policies and protocols on minority, incarcerated, detained, and homeless communities and develop solutions before the pandemic occurs.

RECOMMENDATION 8: That CMA support that future pandemic planning will develop solutions that are sustainable for the environment, which may include reusable PPE and disinfection practices that are not harmful to the environment, in order to also address the concerns of climate change.

RESOURCE PROCUREMENT AND ALLOCATION

RECOMMENDATION 9: That CMA support the establishment of a state-operated Group Purchasing Organization (GPO), with voluntary physician participation, that can aggregate demand across health care providers, including through collaborative agreements with other states; buy medical supplies in bulk; and obtain better prices for products than individual health providers can negotiate on through individual purchases.

RECOMMENDATION 10: That CMA support consistent rules regarding paying the costs testing and treatment for diseases related to a pandemic, which should apply to all patients, based on a health care provider's determination of medical necessity, without regard to the specifics of their insurance coverage.

RECOMMENDATION 11: That CMA support a review and revision of the CDPH crisis care guidelines ensuring that health care providers and medical specialty societies have sufficient time to review and provide feedback to develop a more robust set of crisis care guidelines.

RECOMMENDATION 12: That CMA encourage physicians and health care systems to plan for equitable distribution of resources needed to respond to mass vaccination through a review of their practice's immunization procedures and how they might need to be altered to accommodate an influx of patients seeking the COVID-19 vaccine.

WORKFORCE

RECOMMENDATION 13: That CMA support that the safety and wellness of health care providers and essential workers should be a priority in pandemic planning and that policies and protocols supporting public health officer safety, provider wellness program, financial considerations and enhanced protection against infection through sheltering programs and access to personal protective equipment, should be developed to support and preserve the workforce during and after a pandemic.

RECOMMENDATION 14: That CMA support that public health officials should be protected from harassment, assault, and violence and that local and state law enforcement should investigate all credible threats, provide security details as warranted, and prosecute harassment.

RECOMMENDATION 15: That CMA support that the State of California should consolidate the various emergency healthcare volunteer programs that currently exist into fewer programs that use a common application and credentialing process; provide training; provide financial support to facilitate service; offer comprehensive immunity and liability coverage; provide opportunities for medical students and residents to serve; and the option for healthcare providers to serve as an individual or as part of a medical assistance team.

RECOMMENDATION 16: All licensed healthcare providers rendering services in relation to, or failing to perform such services in relation to or as a result of, a pandemic and declared emergency shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability.

RECOMMENDATION 17: That CMA support during a pandemic or other state of emergency (1) that medical schools should not disenroll or interrupt medical education due to inability to pay tuition and fees; (2) an option for medical school education postponement at the discretion of the student; and (3) a reduction in tuition fees when an exclusively virtual learning environment is absolutely necessary.

RECOMMENDATION 18: That CMA support that medical schools develop innovative learning opportunities and offer optional in-person learning experiences with appropriate PPE for content that cannot effectively be replicated virtually during pandemics and other states of emergency, such as clinical exam skill and anatomy sessions.

RECOMMENDATION 19: That CMA recognize medical students as a vulnerable population with potential for volunteer coercion during pandemics and other states of emergency, and support provision with appropriate PPE and occupational health care coverage should medical students decide to volunteer.

RECOMMENDATION 20: That CMA recognize that the primary purpose of postgraduate training programs is to provide clinical training to prepare physicians for future practice and that residency programs should prioritize this purpose during a pandemic by ensuring that residents and fellows, who may be at risk for exploitation and coercion to provide care outside of their usual training activities, should be protected and adequately compensated with appropriate paid sick leave, hazard pay, and/or loan forgiveness commensurate with any increased risk. CMA supports that programs should develop policies that support and protect residents who do not elect to provide high-risk patient care outside of their regular training program during a pandemic.

RECOMMENDATION 21: That CMA supports that postgraduate training programs should, during a pandemic, ensure that resources are provided to allow residents and fellows to remain in their programs with salary and benefits, progress in their training in a manner which ensures that they develop the necessary competencies and can meet requirements for licensure and board certification upon completion of the program.

RECOMMENDATION 22: That CMA support that during a pandemic, fellows who assume attending physician roles should receive pay and benefit

commensurate with those roles and that residents and fellows who are assigned to provide care outside of the regular training program must be appropriately trained and supervised.

ACCESS TO MEDICAL CARE

RECOMMENDATION 23: That CMA support a social marketing campaign coordinated with physicians, public health departments and health systems on the importance of preventive care and regular visits to prevent illness and reduce strain on the healthcare system during the pandemic.

RECOMMENDATION 24: That CMA encourage physicians to communicate with their patients about the importance of medication adherence and how to access medications if the prescriber is unavailable during a pandemic or other emergency.

COMMUNICATION

RECOMMENDATION 25: That CMA support improved collaboration between physicians and public health systems in their community and at the state level and that CMA encourage and promote physician participation in the California Health Alert Network (CAHAN) which is accessible for emergency planning and response communication with public health partners and facilitates alerting and collaboration between Federal, State, Local County Health Departments, Clinics, Hospitals, and other public health emergency partners. CMA also supports that CAHAN work with the Medical Board of California and the Osteopathic Medical Board of California to develop procedures for promoting CAHAN and regularly updating the CAHAN database with physician contact information from the state's licensing data.

RECOMMENDATION 26: That CMA support, champion and participate as an active partner in the development of a statewide social marketing campaign that supports practices such as hand hygiene practices, masking, and social distancing as effective methods of infection control; that quickly combats the spread of inaccurate and misleading public health and scientific information; that supports the validity and

non-partisan nature of medical science and public health directives and that recognizes local public health officers as trusted leaders who are sources of accurate information during a pandemic.

RECOMMENDATION 27: That CMA support that physicians, health systems, public health officials collaborate with organizations that serve marginalized communities and communities of color to promote awareness and understanding of vaccination.

RECOMMENDATION 28: That CMA should include specialty-specific information on its pandemic information platform, with links to specialty organizations for additional guidance.

COLLABORATION

RECOMMENDATION 29: That CMA support that physicians should be prepared and supported to lead and serve on local and state committees and policymaking bodies to ensure that the physician and healthcare perspective is included in public policy development.

CMA GOVERNANCE AND PLANNING

RECOMMENDATION 30: That CMA establish a technical advisory committee to assess and make recommendations to improve CMA's readiness to respond to pandemics and other disasters.

FISCAL IMPACT: No cost to adopt as policy. If legislation is required, the potential cost is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $110,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost. If federal legislation is contemplated, the cost of CMA sponsoring or opposing a federal bill could be $150,000 or more and is dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the

proposal, communications, and commitment of resources by opponents and proponents.

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The CMA Board of Trustees adopted the recommendation of the CMA Committee of Delegation Chairs (CDC) to designate pandemic response and preparedness as a major issue for discussion for the 2020 CMA House of Delegates meeting.

This report presents CMA's existing policy and advocacy efforts, provides background information, and proposes recommendations for action that address gaps in existing CMA policy. The Board of Trustees referred the topic to the CMA Council on Science and Public Health (CSPH).

CMA POLICY

CMA has existing policy on disaster and pandemic response that highlights the need for a strong public health infrastructure, a trained health care workforce that can be deployed quickly in an emergency and planned coordination between stakeholders.

CMA supports collecting information about, and addressing, coordination issues among existing medical disaster response teams and plans, including those of component medical societies, hospitals, the medical reserve, and federal and state-sponsored disaster medical assistance teams. CMA supported defining the roles of CMA and component medical societies roles in response to a disaster; preparing recommendations for improved coordination among the various teams and plans that involve physician participation and investigating liability coverage issues for participating physicians; and addressing the separate issue of physicians volunteering to fill unmet medical needs of indigent persons, including liability coverage for physician volunteers (HOD 101a-11). CMA has also supported standardized training for disaster preparedness for health professionals (HOD 103a-11).

CMA endorses the concept of the national disaster medical system and urges increased medical leadership in the planning process. CMA urges early implementation of the national disaster medical system in California (BOT 6-28-85:18).

CMA supports working cooperatively with state agencies and the California Association of Hospitals and Health Systems to develop a uniform method of identifying physicians and other medical personnel, in the event of a disaster (HOD 111a-88). CMA supports immunity from liability for medical and nonmedical care rendered and triage decisions made during a major disaster or state of emergency anywhere within any jurisdiction covered by such emergency for the extent of time that a state of emergency may exist (HOD 513-09).

CMA supports that the Department of Managed Health Care, the Department of Insurance, pharmacy benefits managers and health plans to develop policies that would allow patients to stockpile up to a one month supply of all appropriate medications for chronic medical conditions in the event of a flu pandemic or other local or national disaster (HOD 106a-06).

CMA supports preserving and strengthening the public health infrastructure in California at the state and local level, including funding increases for infectious disease and disaster preparedness programs including supporting the appointment of qualified physicians to fill leadership positions in public health within state and local government (HOD 114-02). In 2005, CMA joined the California Medicine and Public Health Initiative (CMPHI), a coalition of leaders in medicine, public health and related disciplines, in warning about increased risk of health decline and disaster in our state, and urge that the threat to California's health be recognized by a broad coalition of leaders in business, government, the media and the public. CMA supported the CMPHI in urging the Governor of California, the California Chamber of Commerce, the State Department of Health and Human Services and other relevant state leaders to join leaders in medicine and public health in a prompt and concerted effort to reverse the decline of the public health infrastructure in our state (HOD 720-05).

CMA ADVOCACY

In March 2020, as the number of COVID-19 infections and deaths began to increase in California and globally, CMA actively engaged with the Governor Gavin Newsom, Legislature, state and federal agencies, and local governments to contain and respond to the many pandemic-related public health and health care delivery issues impacting the state. The speed with which the pandemic grew and the scale of resources needed to effectively respond to issues that impacted all aspects of society, made it clear that California’s existing public health infrastructure and emergency planning system was not adequately equipped to respond to the COVID-19 pandemic.

The issues impacting the practice of medicine and public health that needed to be addressed quickly through new funding or changes in state or federal law were extensive and CMA advocacy ranged from requesting administrative guidance and action, executive orders and legislation to waive or change state and federal laws. Policy areas that required CMA advocacy included addressing:

- Access to personal protective equipment (PPE) and COVID-19 testing supplies;
- Removing barriers to care provided via telehealth;
- Difficulties in complying with licensing and renewal requirements during the pandemic;
- Liability issues related to providing care during an emergency;
- Protecting patient privacy; and
- Securing resources to support necessary quarantine and wellness services for health care providers.

Strong Public Health Approach to COVID-19 Response. CMA has been at the forefront of seeking to ensure that the state takes a strong public health approach to COVID-19. Early on, CMA urged the Governor to declare a public health emergency to allow flexibility for the state and locals to respond appropriately to the quickly unfolding crisis. CMA also sought the establishment of a statewide face covering order when it became clear that some local jurisdictions were allowing politics to eclipse science.

CMA also sponsored Senate Bill 483 (Pan) to keep the personal information of health officers confidential, in the wake of threats and attacks against California's public health officers at their homes. The bill extends current law, which states that the home addresses of members of the legislature, city councils, board of supervisors and other officials are prohibited from appearing in Department of Motor Vehicle records that can be accessed by the public, to public health officers.

Keeping Physicians Up to Date on New Information. The response to COVID-19 from multiple local, state and federal agencies resulted in a flood of clinical, regulatory, legal, financial and practice management guidance for physician practices. CMA has closely monitored new information and consolidated resources on the CMA website and shared this information with physicians through regular email blasts and webinars. Constant evaluation of new information has also informed CMA's legislative, legal and regulatory advocacy to ensure that new policies and guidance can be implemented and do not have negative impacts on physicians and their patients.

Reducing Regulatory Burdens. As California prepared for a potential COVID-19 surge, physicians needed flexibility to quickly respond to calls to reinforce COVID-19 frontlines. CMA helped streamline regulatory burdens that could have slowed down getting care where it was needed.

PPE Distribution to Physician Practices. Governor Gavin Newsom worked to secure shipments of equipment from Chinese manufacturer BYD, among others, but getting that equipment into the hands of physicians who need it remained a challenge. The administration leaned on CMA and its component medical societies around the state to help get this equipment out of state warehouses and into the hands of frontline workers.

Due to CMA's advocacy, the state made millions of pieces of medical-grade PPE – including N95 masks, surgical masks, shields, gowns, and gloves – available free to physician practices. The California Office of Emergency Services (OES) partnered with CMA to distribute this equipment to qualifying small and medium sized medical practices. PPE Relief kits include up to a two-month supply.

In July and August 2020, dozens of personal protective equipment (PPE) distribution events were held around the state, as the CMA partnered with its component medical societies and the State of California to bring millions of medical-grade masks, gloves and gowns to physicians who need them.

At one of the first drive-through events in Pasadena, CA representatives from more than 600 physician practices descended on the Rose Bowl to receive their free PPE kits.

Practices with 50 or fewer providers were eligible to receive up to a two-month supply of PPE to ensure they can reopen with proper safety precautions in place. This equipment was made available to all qualifying physician practices, whether or not they are CMA members. Nearly 10,000 practices that will be received PPE as part of this initial effort.

In response to the current shortage of personal protective equipment, Senate Bill 275 (Pan) was introduced in 2020 focusing on requiring stockpiles to mitigate such shortages during future emergencies. CMA position on SB 275 was oppose unless amended because requiring physicians to maintain PPE stockpiles would be burdensome on already strained practices and has advocated that PPE solutions should be on improving the supply chain rather than redundant stock piling.

CMA requested amendments to any PPE related legislation that instead requires California to develop a supply chain that is resilient through a risk-hedging supply chain model administered by a state-run group purchasing organization (GPO). A GPO would focus on efficiency largely driven by controlling costs and minimizing excess inventory, when efficiency alone does not result in a resilient supply chain that can deal with disruptions caused by a pandemic or any other disasters. A state run, risk-hedging GPO would allow California to mitigate the risks of supply disruptions through active mitigation measures that manage three important dimensions of the supply chain: (i) supplier sourcing, (ii) inventory levels and (iii) geographic dispersion or distribution system. A state-run GPO would also be able to mitigate the normal cost implications of building a risk hedging supply chain through its immense size as a nation-state and negate the need for stockpiles and such specific requirements that will only further burden already struggling physician practices and health care facilities in the state.

Providing COVID-19 Clinical Information. COVID-19 is likely to be part of the clinical landscape for the foreseeable future, so the California Health and Human Services Agency (CHHS) and the California Medical Association (CMA), in partnership with the California Academy of Physician Assistants (CAPA) and the Osteopathic Physicians and Surgeons of California (OPSC), are hosting a monthly and virtual grand rounds series on the evolution and management of COVID-19 patients.

INTRODUCTION

The 2020 COVID-19 pandemic has had a major impact on society in California, the nation and the world, as morbidity and mortality associated with the disease continues to increase. Since March 2020, when California's initial "stay-at home" orders were ordered, policymakers and public health officials have been struggling to respond to the pandemic by containing the disease and its widespread impact on California's economy, health care delivery system, education, and social services—just a few areas impacted by the pandemic. At the time of this report, the pandemic is ongoing with little indication of when it is likely to be contained.

Even as our state continues to address the ongoing issues brought on by the COVID-19 pandemic—which evolve on a daily basis—policymakers also wrestle with the broader questions of how the crisis unfolded, what we can do to plan and be better prepared to respond to the next pandemic. All industries and institutions are debating these issues. Each disaster and its context are different, yet many share similar health sector vulnerabilities, and often, hospitals and public health workers are the focal points of disaster response. The COVID-19 pandemic has exposed emergency preparedness weaknesses in the California and U.S. healthcare systems.

This report explores these issues from the perspective of California's physicians by examining experiences and lessons learned from the current pandemic and developing a policy agenda for improving California's state of pandemic response and preparedness.

BACKGROUND

Pandemics and large-scale outbreaks can claim millions of lives, disrupt societies and devastate economies.[1] The World Health Organization works with countries to prepare for large-scale outbreaks and pandemics, including building core capacities strengthen disease-specific systems and capacities, including for vaccines, pharmaceuticals and other public health interventions. Countries are also encouraged to engage the whole of society for effective pandemic preparedness and response. During the last decade, especially in the aftermath of the 2009 H1N1 pandemic, the focus has been on planning for pandemics caused by influenza.

In 2005 and 2006, the White House Homeland Security Council outlined the National Strategy for Pandemic Influenza and National Strategy for Pandemic Influenza Implementation Plan to guide the United States' preparedness and response activities in an influenza pandemic. These plans aimed to stop, slow or otherwise limit the spread of a pandemic to the United States; limiting domestic spread, mitigating disease, suffering and death; and sustaining infrastructure and lessening the effects on the economy and society as a whole. At the same time, HHS framed its Pandemic Influenza Plan around a doctrine that laid out guiding principles for pandemic influenza preparedness and response.[2]

Since 2005, the U.S. Department of Health and Human Services has worked with partners in public health, health care, and emergency management to make significant strides in improving the nation's pandemic influenza preparedness. Today, there is a well-established domestic vaccine manufacturing capacity, stockpiles of influenza vaccines and therapeutics, and evidence-based guidance on prevention, mitigation and treatment available for state and local governments, the private sector, individuals, and families.

With the COVID-19 pandemic, the state and the nation faces new challenges — a novel coronavirus, how to sustain the advances made, how to keep up with the changes in how people live and work for example — and these challenges call for new approaches to better protect the nation against pandemics. Federal and state officials intended that the capacity and capabilities developed for pandemic influenza preparedness would enable the nation to respond more

[1] *Preparing for Pandemics*, World Health Organization *website at* https://www.who.int/westernpacific/activities/preparing-for-pandemics.
[2] *National Pandemic Influenza Plans*, Centers for Disease Control website at https://www.cdc.gov/flu/pandemic-resources/planning-preparedness/national-strategy-planning.html.

effectively to other emerging infectious diseases as well. While elements of the influenza pandemic plans could be applied to the COVID-19 pandemic, many solutions were unplanned, developed and implemented in real-time, with expenditures that have led to a staggering budget deficit.

Federal Role in Pandemic Response. While all sectors of society are involved in pandemic preparedness and response, the federal government is the natural leader for overall coordination and communication efforts. In its leadership role, the federal government should:

- Identify, appoint, and lead the coordinating body for pandemic preparedness and response;
- Enact or modify legislation and policies required to sustain and optimize pandemic preparedness, capacity development, and response efforts across all sectors;
- Prioritize and guide the allocation and targeting of resources to achieve the goals as outlined in a country's Pandemic Influenza Preparedness Plan; and
- Provide additional resources for national pandemic preparedness, capacity development, and response measures.[3]

State Authority. California law provides the legal authority for the state to act in the event of a pandemic or other medical emergency. The California Emergency Services Act (ESA) confers emergency powers on the Governor and Chief Executives of the state's political subdivisions to provide for state assistance in organization and maintenance of emergency programs and establishes the California Governor's Office of Emergency Services (OES). OES authority includes the assignment of functions to state agencies to be performed during an emergency and the coordination and direction of emergency actions of those agencies. It also grants authority to suspend statutes and agency rules during an emergency.[4]

The current State of California Emergency Plan (SEP) was adopted in October 2017 by Governor Jerry Brown.[5] The plan addresses California's response to emergency situations associated with natural disasters or human-caused emergencies, including pandemics. In accordance with the ESA, this plan describes the methods for conducting emergency operations,

[3] *3 ROLES AND RESPONSIBILITIES IN PREPAREDNESS AND RESPONSE,* Pandemic Influenza Preparedness and Response: A WHO Guidance Document, WORLD HEALTH ORGANIZATION (2009) *available at* https://www.ncbi.nlm.nih.gov/books/NBK143067/.

[4] Government Code §8571

[5] *State of California Emergency Plan & Emergency Support Functions,* California Governor's Office of Emergency Services website at https://www.caloes.ca.gov/cal-oes-divisions/planning-preparedness/state-of-california-emergency-plan-emergency-support-functions.; Edmund G. Brown and Mark S. Ghilarducci, *State of California Emergency,* California Governor's Office of Emergency Services (October 1, 2017), *available at* https://www.caloes.ca.gov/PlanningPreparednessSite/Documents/California_State_Emergency_Plan_2017.pdf.

the process for rendering mutual aid, the emergency services of governmental agencies, how resources are mobilized, how the public will be informed, and the process to ensure continuity of government during an emergency or disaster.

California's existing disaster preparation and response system for declared emergencies has several statewide agencies tasked with various and sometimes overlapping emergency response functions and requires significant coordination across departments. Lead departments include:

California Department of Public Health. The California Department of Public Health (CDPH) is the lead state department for the state's public health response. In this role, CDPH communicates directly with other state agencies and coordinates activities through Cal OES. The Emergency Preparedness Office (EPO) coordinates overall planning and preparedness efforts for the California Department of Public Health. EPO plans and executes activities to prepare Californians for public health emergencies, coordinates planning for the Strategic National Stockpile, maintains contact names and numbers for crisis response, oversees statewide public health disaster planning, and distributes and oversees funds to local health departments for disaster planning.

California Emergency Medical Services Authority. The California Emergency Medical Services Authority (EMSA) is the lead agency for coordinating California's medical response to disasters by providing medical resources to local governments in support of their disaster response. This may include the identification, acquisition and deployment of medical supplies and personnel from unaffected regions of the state to meet the needs of disaster victims. Response activities may also include arranging for evacuation of injured victims to hospitals in areas/regions not impacted by a disaster.

The medical response to disasters requires the contributions of many agencies. EMSA works closely with the OES, CDPH, the California National Guard, the Department of Health Care Services and other local, state, and federal agencies to improve disaster preparedness and response. EMSA also works closely with the private sector: hospitals, ambulance companies, and medical supply vendors.

Responsibilities for disaster medical services preparedness and response include the following:

- Development and maintenance of disaster medical response plans, policies and procedures;

- Provision of guidance and technical assistance to Local EMSAs, county health departments, and hospitals for the development of local disaster medical plans, policies and procedures;
- Enhancement of state and local disaster medical response capabilities through the development of civilian disaster medical assistance teams (CAL-MATs), Ambulance Strike Teams (ASTs), disaster medical communications systems, and a statewide medical mutual aid system;
- Testing disaster medical response plans through periodic exercises with local, state, and federal agencies and the private sector; and
- Management, support and coordination of California's medical response to a disaster.

Local Authority.[6] Local county health officers have authority to preserve and protect the public health by enforcing county orders, ordinances and statutes pertaining to public health.[7] The local health officer is authorized to take any preventive measure that may be necessary to protect and preserve the public health from any public health hazard during any "state of war emergency," "state of emergency," or "local emergency".[8]

In 2006, the Legislature passed a law allowing county health officers and the local EMS agency administrators to jointly act as the Medical Health Operational Area Coordinator (MHOAC).[9] The MHOAC, in cooperation with the county's office of emergency services, local public health departments, local offices of environmental health, the local Department of Mental Health, the local EMS Agency, the local fire department, the regional Disaster and Medical Health Coordinator and the regional Cal OES is responsible for ensuring the development of a medical and health disaster plan for the provision of medical and health mutual aid within the operational area. The plan must be consistent with federally created standards.[10]

Local county health officers have authority to preserve and protect the public health by enforcing county orders, ordinances and statutes pertaining to public health.[11] The local health officer is authorized to take any preventive measure that may be necessary to protect and preserve the public health from any public health hazard during any "state of war emergency," "state of

[6] Deborah R. Kelch, *Locally Sourced: The Crucial Role of Counties in the Health of Californians*, CALIFORNIA HEALTHCARE FOUNDATION (October 2015), *available at* https://www.chcf.org/wp-content/uploads/2017/12/PDF-LocallySourcedCrucialRoleCounties.pdf.
[7] Health & Safety Code §§101000, 101025, 101030
[8] Government Code §8558
[9] Health & Safety Code §1797.153(a)
[10] Health & Safety Code §1797.153(a)
[11] Health & Safety Code §§101000, 101025, 101030

emergency," or "local emergency," within his or her jurisdiction.[12] Local emergencies include health emergencies in which imminent and proximate threats of the introduction of any communicable disease, chemical agent, non-communicable biologic agent, toxin or radioactive agent. The Director of CDPH may declare a health emergency as well.

Local emergency proclamations are issued by the governing body of a city, county, or city and county, or by an official designated by and adopted by a local ordinance. This official designee is usually a police/fire chief, or the director of emergency services. The ability to designate an individual occurs in case a local emergency needs to be proclaimed before the local governing body can meet. A local emergency proclamation authorizes the undertaking of extraordinary policy power and provides limited immunity for emergency actions of public employees and governing bodies. For example, the proclamation might allow for the establishments of curfews in order to protect life and property. In addition, a local proclamation activates pre-established local emergency procedures.

A local emergency proclamation is also a prerequisite for requesting a Governor's Proclamation of a State of Emergency and/or a Presidential Declaration of an Emergency or Major Disaster. A local emergency proclamation is not a prerequisite for mutual aid assistance.

California's State Public Health Funding.[13] For decades, public health officials and physicians have been warning policymakers about the steady erosion of funding and support to maintain California's vital public health infrastructure, including budget increases for infectious disease and disaster preparedness programs

Funding for California's public health functions is primarily through the California Department of Public Health (CDPH) which was established as a standalone state department in 2006 with a major budget appropriation. However, as California's economy has gone through contractions and expansions, subsequent budget growth and funding allocations have been relatively stagnant such that during the last decade the funding allocated to CDPH has remained the same. In addition, much of the funding allocated to the department has been for specific purposes and diseases reducing flexibility at the state and local levels to move funding as needs and priorities change. The 2019-20 budget provided $775 million and funded 350 positions for infectious diseases, a more-than-$100 million bump from 2018. The financial blueprint also provided $96 million for emergency preparation. While needed and significant, this funding did not fully address the needs that existed at the beginning of the pandemic. Additional state and federal

[12] Government Code §8558; Health & Safety Code §101040
[13] Hannah Wiley, *Before coronavirus, California let its public health funding stall for a decade*, SACRAMENTO BEE (March 20, 2020), *available at* https://www.sacbee.com/news/coronavirus/article241237666.html.

funding have been directed to address the public health issues resulting from the pandemic, but it is too early to know whether funding will continue on an ongoing basis.

State funding also impacts public health funding at the local level. In 1991, the Legislature shifted significant fiscal and programmatic responsibility for many health and human services programs from the state to counties—referred to as 1991 realignment. The 1991 realignment package: (1) transferred several programs and responsibilities from the state to counties, (2) changed the way state and county costs are shared for certain social services programs, (3) transferred health and mental health service responsibilities and costs to the counties, and (4) increased the sales tax and VLF and dedicated these increased revenues to the new financial obligations of counties for realigned programs and responsibilities. The intent was to provide counties with greater flexibility to establish a local program structure and administer these service responsibilities independent of what other counties were doing. Realignment impacted available funding for local public health services because revenues for health services was split between direct health services and public health functions often resulting in funding being redirected away from public health as revenues failed to match increased county health care responsibilities. Much has changed during the ensuing 3 decades. During the last two years, the California Department of Finance and the Legislative Analyst's Office released reports which found that due to changes in county obligations, realignment funding no longer accurately reflected the county's level of control over programs and their increased responsibilities.

DISCUSSION

The COVID-19 pandemic has been unprecedented in modern history in its scope and global scale. Countries, such as New Zealand and Taiwan, that have had relative success compared to California and the United States with regard to reducing the number of COVID-19 positive cases and deaths, engaged in specific strategies early in the pandemic including:

- Extensive testing and contact tracing
- Public engagement and education to actively support and participate in social distancing, masking, self-isolation, and good hygiene practices
- Closing borders and significantly limiting travel into the country
- Imposing strict quarantine and self-isolation requirements for individuals entering the country
- Development of data collection systems to support tracking community transmission, identification of high-risk populations, and to facilitate contact tracing.

Every pandemic will be accompanied by a unique set of challenges, resource requirements and impacts on society. California is still experiencing the impacts of the COVID-19 pandemic and

the state's experience has prompted many to envision a more effective response by federal, state and local governments for future pandemics. The magnitude of the current pandemic has identified major deficiencies in the state's pandemic response system. A close review and analysis of the state's experience with the COVID-19 pandemic can provide useful insights for identifying desirable outcomes in current and future pandemics. [14]

PUBLIC HEALTH PLANNING AND PREPARATION[15]

While California was initially recognized as a model state during the COVID-19 pandemic, compared to many other states, for taking action at the start of the pandemic to implement a mandatory stay-at-home order, including closing schools and non-essential businesses, there have also been multiple setbacks which had a root cause in the absence of strong leadership, decisive action, effective coordination and supply of resources from the federal government. California has taken steps to mitigate the lack of action and resources from the federal government, deficiencies in the state's pandemic planning and public health infrastructure have limited the state's response capacity. There has been a growing recognition that existing plans had not been developed with a focus on quick execution and insufficient resources had been earmarked produce these outcomes. The result has been many challenges to effective pandemic response, including:

- Inadequate stockpile of PPE, ventilators and other medical supplies leading to shortages
- Ineffective distribution procedures for PPE and other medical supplies and equipment;
- Individuals from racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19 due to impacts from racism and systemic health and social inequities;
- Lack of coordination between various healthcare workforce education, licensing and volunteer programs to provide a trained supply of healthcare providers across the state;
- Lack of effective systems for developing and distributing resources to support frequent COVID-19 testing, treatments, and vaccines;
- Inadequate protection, authority and support for public health officers leading to high turnover at the state and local levels;

[14] Christopher Cheney, *How To Improve Emergency Preparedness For Pandemics*, HEALTHLEADERS MEDIA (August 12, 2020), *available at* https://www.healthleadersmedia.com/clinical-care/how-improve-emergency-preparedness-pandemics.
[15] *Essential steps for developing or updating a national pandemic influenza preparedness plan*, WORLD HEALTH ORGANIZATION (2018), *available at* https://apps.who.int/iris/bitstream/handle/10665/272253/WHO-WHE-IHM-GIP-2018.1-eng.pdf.

- Lack of consistent communication to healthcare providers and the public;
- Outdated data collection and reporting system for public health surveillance of infectious diseases; and
- Emergency plans that did not engage, educate and prepare the public, physicians, and other frontline healthcare workers to be full partners in planning, practicing for, and implementing an effective pandemic response;
- Lack of model policies and procedures to implement in healthcare settings during a pandemic (ex. crisis care guidelines, emergency credentialing and privileging policies; policies to implement telehealth services, etc.); and
- Lack of coordinated pandemic response for non-healthcare entities (ex. schools, prisons, sports, etc.)

California needs actionable pandemic plans that result in:

- Coordinated plan implementation between local, state and federal public health authorities;
- Collaboration between public health authorities and health care providers;
- Consistent and effective communication with the public;
- Public health data collection and analysis for disease surveillance and case monitoring;
- Frequent testing and extensive contact tracing to support infection containment and mitigation;
- Equitable access to testing, treatment and vaccines and policies that address the health disparities of populations at risk for greater disease exposure and negative impacts resulting from infection mitigation strategies;
- Reliable supply of PPE, testing materials, ventilators and other necessary equipment and supplies which are easily accessible to healthcare providers;
- Physician workforce capacity to provide care during the pandemic and beyond;
- Safety net health, education, and social service systems that prevent economic decisions from driving public health decisions

While the state's public health resources are appropriately focused on responding to the current pandemic at this time, it is also critical that policymakers and public and private stakeholders document and incorporate lessons learned into public health planning for future pandemics. Prior to the pandemic, many health professions were facing impending retirements and the rate of increased retirements and departures from healthcare professions may be accelerated in the years following the pandemic. There may also be more departures from public health, physician

and state leaders which may increase the potential loss of knowledge and experience in responding to future pandemics. Supporting a rigorous process for capturing valuable information to inform future pandemic planning also provides an opportunity to ensure that physician involvement and input in the process. In the event of an emergency, overly complex and untested plans can be deficient and ineffective, endangering the lives of the public and potentially contributing to an escalating emergency situation.

As the state considers how to plan for future pandemics, there are areas that require greater consideration and emphasis during future planning activities.

Advocate for Strong Federal Leadership in Current and Future Pandemic Response. As of August 28, 2020, the US had 5,845,876 positive cases of COVID-19 and 180,165 deaths from COVID-19, and continues to have more cases and deaths than most countries in the world. The reasons for the unprecedented spread and mortality from the disease in the US has been attributed to a number of initial and ongoing failures from the federal government including:

- Not halting travel from foreign nationals from China to the US in January 2020;
- Lack of health screenings at airports;
- Lack of a robust testing and contact tracing program;
- Slow development of and failure to widely supply testing kits;
- Slow action and leadership in implementing stay-at-home orders early in the pandemic resulting in even more prolonged lockdowns nationwide;
- Not using the federal governments purchasing power to obtain large quantities of personal protective equipment (PPE), medical supplies and equipment.[16]

The result has been almost incalculable losses in lives, access to public education, the nation's economic, physical and mental health, and public trust in the government and the public health system. As California considers how to improve future pandemic response planning and execution, similar failures at the federal level would likely hinder successful pandemic response at the state level regardless of how well California plans and reinforces its public health infrastructure to improve its response. While California and other states now know that an inadequate federal response is a potential risk during a pandemic and can take steps to build in redundancies to its contingency planning, simply assuming that expected resources from the federal government may not be forthcoming and trying to plan around it, is an insufficient plan.

[16] David Schanzer, *Coronavirus: Your government failed you*, THE HILL (April 18, 2020) *available at* https://thehill.com/opinion/white-house/493494-coronavirus-your-government-failed-you.

CMA can support access to federal resources in the current and future pandemics by documenting the impact of the federal governments failures on pandemic response in California, especially with regard to physicians and their patients, and engaging in federal advocacy to reform how the federal government plans for and executes effective pandemic response.

Physicians in Public Health Leadership. While disaster and pandemic planning is an effort that cuts across multiple policy areas, on issues related to public health and health care delivery, it is critical that planning is led by state and local health officers who are physicians with training and experience in public health. During a pandemic, physicians have been called upon to be key players in providing care, being public health ambassadors, developing policies, etc. It is critical that they also be included and lead at the outset of pandemic planning.

For example, the state could convene a Healthcare Pandemic Planning Committee with representatives from the major stakeholder groups including physicians from a range of specialties, other health professions, hospitals and public health officials. The purpose of the committee would be to develop plans for the coordinated response to a mass pandemic and to establish protocols for centralized decision-making and centralized message development, likely at the level of the state department of public health.

Data Collection. One of the most important tools in a pandemic is the use of health data surveillance systems that allows accurate real-time tracking of cases through interoperable data sharing between physicians, public health officials, hospitals, laboratories, etc. When the state's Reportable Disease Information Exchange (CalREDIE) system was overwhelmed with the number of cases being reported and stopped accepting data transfers in some counties, the state was temporarily "blind" with regard to the disease's progression during a two week period. The state is currently in the process of developing a new data system as a solution. The next iteration of pandemic planning will need to consider advances in technology and electronic health records to inform what types of data need to be collected by whom and who will need access to the data. The ability to collect and report accurate data by race and ethnicity is important for tracking the spread of infection, whether there is sufficient access to testing and treatment, and to allow communities to hold the state and the health care system accountable for health disparities.

Planning for Health Equity. The pandemic has revealed starkly the disproportionate impact of the virus on minoritized and marginalized communities. While the data remains incomplete, the data that have emerged on the racial and ethnic patterns of the COVID-19 pandemic show that the virus has clearly disproportionately affected Black and Latinx, American Indian/Alaska

Native—particularly in the Navajo nation—Asian-American, and Pacific Islander communities.[17]

Social determinants of health (SDOH), current and historic inequities in access to health care and other resources, and structural racism contribute to these disparate outcomes.[18] "We all experience conditions that socially determine our health. However, we do not all experience SDOH equally. The SDOH are impacted by larger and powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation. In the U.S., these historic and systemic realities are baked into structures, policies, and practices and produce, exacerbate, and perpetuate inequities among the SDOH, [especially for those in minoritized and marginalized communities] and, therefore, affect health itself."[19] Dr. Zinzi Bailey et al. published a study, "Structural Racism and Health Inequities in the US: Evidence and Interventions," that explains structural racism to be the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."[20] And one key example of structural racism included how "residential segregation systemically shapes health care access, utilization, and quality at the neighborhood level, health-care system, and provider levels."[21] The Institute of Medicine published *Unequal Treatment*, which documented substantial racial and ethnic disparities in access to services, clinical care, and health outcomes.[22]

"The Affordable Care Act (ACA) helped narrow some disparities in health coverage, access, and utilization, but groups of color continue to fare worse compared to Whites across many of these measures as well as across measures of health status."[23] Communities of color have higher rates of certain underlying health conditions compared to Whites, which means they are at increased

[17] *Statement of the American Medical Association to the U.S. House of Representatives Committee on the Budget Re: Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change*, AMERICAN MEDICAL ASSOCIATION (June 23, 2020), *available at* https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-6-22-Written-statement-for-Budget-C-Hearing-final.pdf; *Racial Data Dashboard*, THE COVID TRACKING PROJECT (August 5, 2020), *available at* https://covidtracking.com/race/dashboard.

[18] *Addressing Health Equity During the COVID-19 Pandemic*, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (May 11, 2020), *available at* https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2020/addressing-health-equity-during-the-covid-19-pandemic.

[19] *Supra* note 17.

[20] Zinzi D. Bailey et al., *Structural racism and health inequities in the USA: evidence and interventions*, 389 THE LANCET 1453, (April 8, 2017).

[21] *Id.*

[22] *Unequal Treatment*, INSTITUTE OF MEDICINE (2003), *available at* https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care.

[23] Samantha Artiga et al., *Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19*, KAISER FAMILY FOUNDATION (April 7, 2020), *available at* https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/.

risk for experiencing serious illness if they become infected with coronavirus.[24] In addition, access to preventive strategies, COVID-19 testing, and health care resources may also be limited for these communities. Rural areas, tribal lands, and low-income communities may have limited access to internet and cell service, making it difficult to access care through telehealth services when they are unable to receive in-person services, which results in delays in necessary care.[25] Minoritized communities are also more likely to live in locations and work in industries that put them at increased risk of infection from COVID-19. COVID-19 has exacerbated these underlying, long-term health and economic disparities and inequities experienced by minoritized and marginalized communities, which has led to the disproportionate impact of the virus on these communities.

Future planning for pandemic response needs to be done through a lens of health disparities and structural racism to better evaluate disparate impacts of policies and protocols on minority communities and develop solutions before the pandemic occurs. Preparing for the next pandemic is an ongoing, iterative process. California will need to refine its approach and incorporate lessons learned as it continues to prepare the nation for the next pandemic.

Pandemic in the Time of Climate Change. During a pandemic, the focus will be on infection control and eradication of the disease as society experiences the immediate impacts on morbidity, mortality and the economy. This can obscure the ongoing and growing impacts from societies' continued inaction to slow and reduce the impacts from climate change. The potential combined impacts of a pandemic during a time of climate change can amplify the negative impacts of both events. For example, the mass use of disposable personal protective equipment (PPE) may be necessary to prevent infection, but it also has the effect of increasing waste and pollution that further degrades air and water quality and fills landfills. Similarly, directives for the population to refrain from congregating indoors to prevent infection may not be possible if the climate, due to poor air quality and rising temperatures does not allow it. Poor air quality exacerbated by increased wildfires due to the drier and hotter climate could also worsen respiratory symptoms from an infection. The next iteration of pandemic planning will need to center these types of issues, focus development of solutions such as reusable PPE and strategies for health care delivery in areas that lack clean air and water, and consider the even greater urgency to respond to climate change.

[24] *Id.*
[25] *Supra* note 18.

RESOURCE PROCUREMENT AND ALLOCATION

During the current COVID-19 pandemic, the state has experienced, and in some cases continues to experience shortages in the supply of personal protective equipment (PPE), ventilators, testing supplies, medication, and general medical office supplies.

Personal Protective Equipment (PPE). Lack of personal protective equipment has compounded the hardships for medical practices since the beginning of the COVID-19 outbreak.

In July 2020, CMA conducted a survey of physician practices to assess the need for various types of PPE, the extent to which lack of PPE impacted their ability to provide patient care and whether existing mechanisms for obtaining PPE were effective. The response from small physician practices found that most practices did not have a regular PPE supplier and the majority had less than one month's supply of PPE. The list of needed supplies was extensive with N95 and procedural masks being in the highest demand, followed by hand sanitizer, steriwipes, gloves and gowns.

CMA physicians have provided feedback that they do not support a requirement to maintain individual stockpiles at the practice-level and believe that securing the PPE supply is a state responsibility which could be accomplished through mechanisms such as a GPO or a state-sponsored manufacturing solution.

Testing. Throughout the pandemic, California has experienced an ongoing shortage of testing supplies and laboratory testing capacity which has been a significant barrier to implementing mass testing at a level similar to other countries that has facilitated effective contact tracing and re-opening of the economy. There has been confusion about where to get tested as the state originally opened drive-thru testing sites and then closed the sites; patients have been directed to their providers (who may not have testing supplies); other health care facilities have also offered testing to varying degrees. Patients and providers also report turnaround times for receiving testing results as long as several weeks after testing has occurred rendering the testing ineffective for more that simply confirming diagnoses based on patient symptoms. Furthermore, there continues to be confusion about how testing services would be reimbursed.

The Department of Managed Health Care (DMHC) promulgated emergency regulations seeking to clarify when California health care service plans must cover COVID-19 testing. The emergency regulation went into effect on July 17, 2020. Instead of making diagnostic COVID-19 testing more accessible, however, the DMHC emergency regulations provide guidance on how health plans can impose utilization management restrictions and cost-sharing obligations on enrollees seeking diagnostic testing. That is, instead of broadening access consistent with federal

law that prohibits cost-sharing obligations on enrollees, the emergency regulations provide "clarity" regarding the restrictions that plans can impose on enrollees.

While CMA would support widespread access to testing that is coordinated with laboratories that can support processing the test results and a coordinated mechanism for providing and capturing data on test results, this can only occur with improved access to test supplies that does not require providers to individually determine how to procure materials and perform tests without appropriate reimbursement. Developing a clear testing mechanism that can be applied irrespective of the specific infection is a critical component of any pandemic response plan.

Treatment. California continues to experience a shortage of COVID-19 testing supplies and lab capacity to analyze test samples. The supply of resources to care for the individuals with the most severe symptoms, such as in-patient and intensive care unit beds, ventilators, and other treatments and medications, has varied at different points depending on the surge of cases. The lack of crisis care guidelines when they were most needed early in the pandemic prompted CMA, the California Department of Public Health and other health care facilities to quickly develop guidelines for how health care providers should determine the allocation of limited resources during the pandemic. California's initial draft guidelines published April 19, 2020 adopted a point system that directed scarce resources to younger people, those thought to have longer life expectancies, and individuals without certain pre-existing medical conditions. More than 60 community and advocacy organizations representing millions of Californians opposed the earlier policy because it discriminated against people of color, disabled people, higher weight people, and older adults.[26] A revised version that addressed many of these concerns was released on June 9, 2020. It is unknown how effective crisis care guidelines have been because the number of cases in many parts of the state have been reduced such, while still high overall, do not exceed the current capacity of the local health care system to provide care.

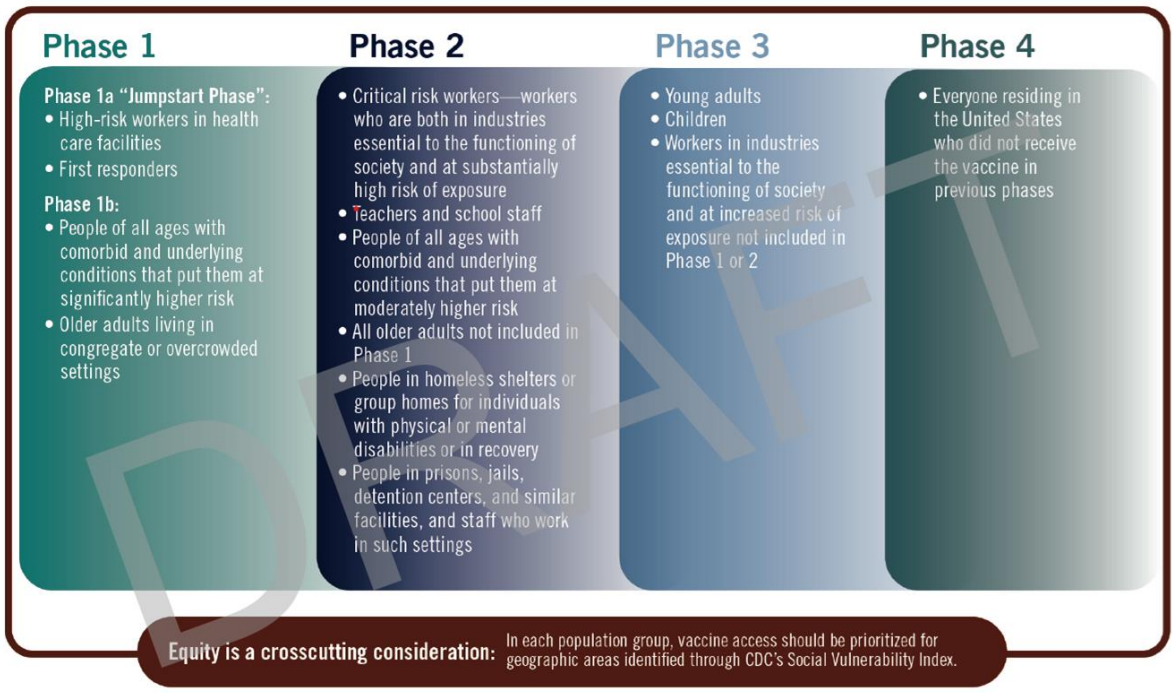
A more thorough review and revision of the current crisis care guidelines—which were developed in a very short period of time without formal input from a broad group of health care stakeholders—would be appropriate. Health care providers and medical specialty societies need time to review and provide feedback to develop a more robust set of crisis care guidelines.

Vaccines. Research on potential COVID-19 vaccines continues and pharmaceutical companies have initiated clinical trials to identify effective vaccines. In addition to uncertainty about when an effective vaccine will be approved, the process for distributing vaccine supply to the states

[26] *Summary of California's Revised Crisis Care Guidelines,* DISABILITY RIGHTS EDUCATION & DEFENSE FUND (June 2020), *available at* https://dredf.org/2020/06/10/summary-of-californias-revised-crisis-care-guidelines/.

and to physicians for administration is also unknown. It is likely that the initial supply will be limited so there will need to be a process for prioritizing who should receive the vaccine.

The CDC and the National Institutes of Health requested the National Academies to produce a framework. The Committee on the Equitable Allocation of Vaccine for Novel Coronavirus drafted the framework and intends for it to be folded into the considerations the CDC's Advisory Committee on Immunization Practices (ACIP) work, which is the entity that will make the final determination about allocation. The Committee sought public comment on their draft plan. The framework laid out lessons learned from prior vaccine rollout efforts and discussed many of the considerations at play in preparing for distribution of a COVID vaccine. The plan proposed a phased roll out for vaccine access, which is included below:



CMA's comments included recommending that physician offices be included in the definition of health care facilities in phase 1, moving children from phase 3 to phase 2 to support safe school reopening, expanding upon how medical societies will be engaged to help in a distribution plan, ensuring that physicians have the information they need to help their patients navigate vaccination, ensuring that costs associated with vaccination are covered, and including physicians from disproportionately impacted communities in planning efforts to ensure that the needs and concerns of those communities are addressed.

Physicians and health care systems can begin planning for equitable distribution of resources needed to respond to mass vaccination or medication through:

- A review of their practice's immunization procedures and how they might need to be altered to accommodate an influx of patients seeking the COVID-19 vaccine. If the practice does not usually offer immunizations, the physician may wish to consider whether it would be appropriate to offer the service specifically for COVID-19. Similarly, the physician may consider whether to offer the influenza vaccine as part of statewide efforts to reduce comorbidities in COVID-19 patients.
- A review of their patient data to identify high risk or target groups, and the desired demographics that may include age, sex, ethnicity, the existence of special health care needs, insurance source (private plan, public program dependence or none) and setting where medical care was usually provided.
- Messaging for patients and how physicians should be discussing and recommending vaccines for their patients.

WORKFORCE

A healthcare workforce led by physicians that is trained and prepared to respond quickly and provide appropriate care is one of the most critical pandemic resources. Ensuring that this resource is not depleted means providing for resources to secure their physical and mental wellbeing and addressing barriers that may prevent them from staying in the healthcare workforce. Pandemic planning and resource deployment should support:

- A robust supply of trained healthcare providers who can provide care to infected patients and well-functioning mechanisms for allocating the workforce to areas of highest need;
- Access and continuity of regular medical care to uninfected patients; and
- Continuity of education and training and system to support provider security and wellness to ensure the preservation post-pandemic workforce.

The COVID-19 pandemic has highlighted gaps and opportunities that exist in California's disaster response system with regard to maintaining and deploying a healthcare workforce. While a wide range of healthcare providers are needed during a pandemic, this discussion will focus specifically on meeting these objectives with respect to physicians.

Expanding the physician workforce. California has several statewide and county-based volunteer opportunities for physicians during times of disaster:

- *Disaster Healthcare Volunteers.* Disaster Healthcare Volunteers is a registry of pre-credentialed medical professionals assigned to a specific Operational Area (OA) who could respond to a disaster if requested by that OA. They are individuals rather than a trained team and rely on supplies, equipment and management of other organizations. EMSA manages the Disaster Healthcare Volunteers database, which is a secure, web-based portal system that registers and credentials health professionals who may wish to volunteer during a disaster. Volunteers' identities, licenses, credentials, accreditations, and hospital privileges are all verified in advance of emergency situations. Also, volunteers who enroll in this program will be registered as Disaster Service Workers (DSW) as set forth by California law and be given limited immunity from liability.[27] The Disaster Healthcare Volunteers database may be accessed by all 58 California counties to support a variety of local needs, including augmenting medical staffs at health care facilities or supporting mass vaccination clinics.
- *Medical Reserve Corps.* Medical Reserve Corps (MRC) are national, community-run networks of volunteers, activated by their Medical Health Operational Area Coordinator (MHOAC) that assist medical and public health efforts in times of special need or disaster. The mission of MRC is to establish teams of local volunteer medical and public health professionals, focusing on the skills of these professionals to be used during times of emergencies or disasters. MRC units may consist of physicians, nurses, pharmacists, therapists, public health officials and other community members. Currently, there are 42 MRC units throughout California. Registered MRC units may receive federal assistance and can take advantage of efforts to coordinate and collaborate with other agencies and organizations, offering training opportunities and resource sharing. They are able to utilize the California volunteer registry and credentialing system by accessing the Disaster Healthcare Volunteer database. MRC units also offer the opportunity to partner with local organizations and county health departments to ensure optimal outreach and integration.
- *California Medical Assistance Team (CAL-MAT).* CAL-MATs are state-coordinated, rapid deployment teams of health care and support professionals modeled after Federal teams (DMATs) for use in catastrophic and other local emergency or potential emergency events. All CAL-MAT members are registered in DHV, train as a Unit and work with pre-staged and maintained medical supplies and equipment caches. Upon activation and arrival at the mobilization center, CAL-MAT members become “Emergency State Hires” and receive a salary equivalent to the State classification to which they are assigned. CAL-MAT Units are not tied to a specific

[27] Civil Code §1714.5(c), (d)

OA. While a state-controlled asset, response and management of emergency and disaster events are a local responsibility. CAL-MAT missions are largely determined by medical response needs as determined by local government. CAL-MAT Units may also be activated at the State-level through the State Medical and Health Coordination Center in conjunction with OES.

- *Volunteer Physician Registry*. The Medical Board of California maintains a Volunteer Physician Registry that allows physicians interested in providing volunteer medical care at no-cost to clinics and other entities, to register and have their information made available to entities who need their services. The registry only provides physician information and does not credential or deploy physicians. The registry does not specify if physicians on the registry are willing to work in declared emergency or non-declared emergency situations.
- *California Health Corps.* During the COVID-19 pandemic, the state established the California Health Corps and requested that a variety of healthcare professionals register as volunteers to provide care if needed. If deployed, volunteers would be paid and provided with malpractice insurance coverage.

During a pandemic, the need for physicians and other healthcare providers in certain areas may exceed the existing supply of available licensed providers. To increase the supply of available physicians, the state should remove legal and financial barriers for physicians who wish to volunteer and expand the pool of eligible providers to include medical students and residents.

- *Recruiting Healthcare Volunteers.* There are several state and local programs for recruiting healthcare volunteers to provide care during an emergency, with different requirements and capacities. It is difficult to determine whether the existing system for recruiting, credentialing, training and deploying volunteer physicians to serve in declared emergencies is functioning appropriately because every event is unique and mission success depends on a variety of factors including the nature of the emergency, effectiveness of state and local coordination, and resource availability and allocation. Even prior to the current pandemic, however, EMSA struggled to recruit and maintain clinician participation in its disaster response programs. During the COVID-19 pandemic, it was clear that many of these programs are not well-known among physicians. This led to the creation of a new program, California Health Corps, in an attempt to streamline registration for statewide healthcare volunteer programs. Due to the decrease in COVID-19 cases, there has not been a significant need for deployment of physicians who have registered for volunteers, so the extent to which implementation of these volunteers in various settings would be effective is unknown.

During the current pandemic, CMA has worked with the state to increase physician participation in current medical volunteer opportunities. CMA could play a more prominent role by developing educational resources and marketing volunteer opportunities to its member physicians to better connect them to existing emergency response programs. If CMA were to take on any of the elements that these state agencies are tasked with in emergency declarations, such as registering and credentialing health professionals, training for response and deployment, and acquisition of medical supplies and materials from unaffected regions of the State to meet the needs of affected counties, it would require a significant investment and could result in duplication of effort and resources. It is also important to note that medical deployments typically happen in multidisciplinary teams and does not solely involve the deployment of physicians.

- *Collaboration with Local Health Systems, Clinics and Medical Groups.* During the COVID-19 pandemic, there was significant interest from physicians in registering to be a healthcare volunteer. There was a lack of clarity regarding the extent to which healthcare employers would allow them to provide care as a volunteer; how they might move between volunteer service and their regular employment; and whether their regular malpractice coverage would cover them for volunteer service. The extent to which local health systems were aware of physician healthcare volunteer commitments and whether there was communication between local public health officers and health systems about deployment and the potential impact on local health care delivery is unknown but may be a barrier to having an agile healthcare workforce during a pandemic.
- *Medical Students and Residents as Providers.* Deploying unlicensed medical students and residents may be an option to temporarily address physician workforce shortages during an emergency. As California has experienced during the COVID-19 pandemic, however, effectively using medical student and residents to treat patients is not simple and requires the development and implementation of policies that address concerns related to provider safety and wellbeing, continuation of medical education and training, and accommodation for activities outside of regular medical training. In addition, unplanned use of medical students and residents can create challenges as health facilities accommodate more providers than usual, resulting in potential shortages of PPE and other supplies and equipment; implementation of new emergency protocols; lack of appropriate training and supervision; and potentially increased risk for unlicensed medical students and residents and their patients.

Medical students and some residents do not meet requirements for full licensure and practice in California and under normal circumstances would not be able to provide independent and unsupervised patient care. The COVID-19 pandemic highlighted that while California had laws and policies and place that allowed other individuals who were not licensed in California (but held a license in another state) could care for patients during an emergency, no mechanism existed to allow students and trainees in health professional programs to be deployed to provide care during a declared emergency.

During the COVID-19 pandemic, there has been significant debate regarding issues such as whether medical students and residents should be allowed to provide direct patient care, and if so how to ensure that medical students and residents have the opportunity but do not feel coerced into volunteering to provide care to COVID-19 patients; whether it would be safer and more efficient to allow medical students and residents to assume duties such as treating non-COVID-19 patients and/or treating patients entirely via telehealth; whether residents and medical students should receive additional financial compensation or hazard pay if performing functions that are outside their regular training program or that increases personal risk to them or their families; and whether time spent providing care in an emergency setting should count toward their regular educational requirements.

The Association of American Medical Colleges (AAMC) developed Guidance on Medical Students' Participation in In-person Direct Patient Contact Activities which highlights issues that medical schools should consider as policies are developed.[28] This guidance document is intended to add to, but not supersede, an academic medical center's independent judgment of the immediate needs of its patients and preparation of its students. The AAMC recognizes that the medical school dean has the authority and responsibility to make such decisions regarding medical students. The Guidance prioritizes medical student safety by directing programs to ensure that medical students' PPE needs are included in supply planning for PPE at each medical school's clinical sites. Responsibility for the provision of PPE to medical students at each clinical site should be determined prior to the start of students' arrival at the site. If availability of PPE is not adequate to fully meet medical student PPE needs, medical students should not be involved in any direct in-person patient care activities for which their roles require PPE, whether in the context of curricular direct patient

[28] *Guidance on Medical Students' Participation in Direct In-person Patient Contact Activities*, ASSOCIATION OF AMERICAN MEDICAL COLLEGES (August 14, 2020), *available at* https://www.aamc.org/system/files/2020-08/meded-August-14-Guidance-on-Medical-Students-on-Clinical-Rotations.pdf.

contact activities or as volunteers to help meet critical health care workforce (HCW) needs. In addition, medical students' participation in direct care of patients in this capacity, outside of the required core curriculum, should be voluntary, not required, and programs should ensure that academic credit or other benefits are not provided to students who volunteer which might put pressure on students to volunteer.

+ *Financial Compensation for Healthcare Volunteers.* Some healthcare volunteer programs compensate volunteers for participation by classifying volunteers as state employees and providing malpractice insurance coverage. Other programs do not provide compensation. In addition, medical students and residents who volunteer may be eligible for different types of compensation depending on whether patient care is already part of their educational program. In the event of a pandemic, lack of compensation may be a significant barrier, particularly if patient care is being provided in a particularly high-risk environment or if volunteering will direct resources away from the physician's regular practice and potentially place the economic survival of their own practice in jeopardy. The state can eliminate financial compensation as a potential barrier by developing standardized policies across healthcare volunteer programs regarding compensation and malpractice insurance coverage and including funding in the budget to fund compensation in these programs.
+ *Expand Liability Protections for Physicians Providing Care During a Pandemic.* Providing patient care always includes risk to the physician that they may be the subject of a future malpractice claim by a patient and this risk may increase during a pandemic as physicians provide care to patients who are at higher risk for morbidity and mortality, often in less than ideal clinical environments. Mitigating or eliminating this risk during emergencies removes a significant barrier to recruiting physicians to provide care during pandemics. Under existing law, physicians have immunity and liability protections when providing service as part of a declared emergency. It is unclear if the same immunity and liability protections that apply to physicians deployed without a declared emergency.

In order to empower all licensed health care providers to respond to the emergent call-to-action issued in the State of California and across the United States in relation to pandemics, the state should amend state law to state that all licensed health care providers render services in relation thereto, and that any licensed health care provider who performs or fails to perform such services in relation to or as a result of a pandemic and declared emergency shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing,

professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability and no cause of action shall exist or be brought against such licensed health care provider in relation thereto. This means that existing State of Emergency Immunity laws would encompass all pandemic related activities by licensed health care providers.[29]

Prioritize Provider Safety and Wellbeing. In addition to expanding the pool of physicians available to provide care during a pandemic, planning needs to consider how to protect physicians who are already providing care and protecting public health during a pandemic.

Public health leaders who are often at the forefront of making unpopular decisions and taking responsibility for enforcing policies that protect the public need to be provided with appropriate authority and support for their personal and professional safety. Health care facilities must have adequate supplies of appropriate personal protective equipment (PPE) to protect health care workers and ensure effective infection control. Organizations need to be able to quickly implement policies and make resources available to support the mental and physical health of health care providers.

- *Support for Public Health Officers.* On June 24, 2020, California Governor Gavin Newsom remarked on a disturbing phenomenon: health officers are "getting attacked, getting death threats, they're being demeaned and demoralized." At least 27 health officers in 13 states (including Nichole Quick of Orange County in southern California) have resigned or been fired since the start of the coronavirus disease 2019 (COVID-19) pandemic. Across the US, health officers have been subject to doxing (publishing private information to facilitate harassment), angry and armed protesters at their personal residences, vandalism, and harassing telephone calls and social media posts, some threatening bodily harm and necessitating private security detail.[30]

  The public health workforce is already facing challenges in retaining staff. A 2019 national study found that a high percentage of staff plan to retire or are considering leaving their organization for other reasons.[31] Approximately 22% of staff were planning to retire by 2023 and 24% were considering leaving their organization for reasons other than retirement in the coming year. Political appointees, especially chief executives and state health officials have a relatively short tenure, an average of only 3 years. Senior deputies and other managers and leaders who are key to the transfer of

[29] Government Code Section 8659; Business & Professions Code Section 900(e).
[30] Michelle M. Mello et al., *Attacks on Public Health Officials During COVID-19*, 324 JAMA 741, (August 5, 2020).
[31] Katie Sellers et al., *The State of the US Governmental Public Health Workforce, 2014–2017*, AMERICAN JOURNAL OF PUBLIC HEALTH (April 10, 2019), *available at* https://doi.org/10.2105/AJPH.2019.305011.

institutional knowledge and smooth transitions between changes in leadership at the highest level are some of the most at risk to retire in relatively large numbers.

While CMA sponsored SB 483 to keep the home addresses of public health officers confidential, more can be done to protect and demonstrate support for public health officers. Elected leaders should provide them with protection from illegal harassment, assault, and violence. States and the federal government should investigate all credible threats, provide security details as warranted, and prosecute those whose harassment crosses legal lines. Without protection and support, the already scarce supply of qualified individuals willing to serve in health officer roles will decline further. In addition, with regard to pandemic planning, widespread ongoing education to the public *before* a pandemic occurs, about public health broadly and how public health officers work with elected officials and community leaders to serve and protect the public against threats is critical to changing a culture that permits harassment of public health officers.

- *Wellness Programs.* The emotional stress of responding to patients during the COVID-19 pandemic puts front line health care workers at exceptional risk. Caregivers are at an elevated threat of contracting the virus while caring for patients, and they risk emotional burnout from the daily grind of responding to the crisis. In response, CMA Wellness has launched the Care 4 Caregivers Now program, which focuses on the mental and emotional well-being of caregivers while they fight COVID-19. Care 4 Caregivers Now connects physicians, physician assistants, nurses, nurse practitioners and respiratory therapists serving on the front lines of the pandemic with a trained peer coach who will provide remote and confidential coaching sessions at no cost. While it is not a substitute for therapy or medical care, coaching has been demonstrated to provide several benefits, including relief from emotional exhaustion and reduced levels of self-reported burnout.
- *Sheltering for Healthcare Workers.* The Non-Congregate Sheltering (NCS) for California Healthcare Workers Program was created to keep California's healthcare workers safe and healthy and reduce the spread of the COVID-19 virus.[32] It provides hotel rooms to healthcare workers who give critical care to COVID-19 patients so they don't bring home the virus to their household. Once they leave their shift, they can stay near their healthcare facility at a participating hotel for free or at a discount.
- *Provider Financial Security.* The COVID-19 pandemic has caused anxiety and uncertainty across all of parts of society. For medical students, residents and

[32] *Hotel rooms for California healthcare workers*, California All website at https://covid19.ca.gov/hotel-rooms-for-california-healthcare-workers/.

physicians, in addition to clinical concerns related to treating their patients and safeguarding their own health, there has been economic insecurity related to the stability of their practices and for many, whether they will be able to continue to pay the significant medical education debts incurred during their training. At the start of the pandemic, it was unclear whether payments on student loans would be suspended, whether and postponement or forgiveness would apply to all loans, and other concerns about how relief would be implemented. This was due in large part to entities not planning for how loan payments would be handled in the event of large-scale emergency for which there was no clear end date.

Continuity of medical education and training. As demonstrated by the state's experience with COVID-19, a pandemic can interrupt virtually all of society's activities, including medical education and training. In 2020, medical schools and postgraduate training programs and the medical education system as a whole struggled to quickly develop new policies, procedures and requirements to respond to the impact of program activities coming to an abrupt stop with only a few months remaining in the academic year and no clear indication regarding when regular activities would resume. Programs implemented different policies on issues such as whether learning would continue in a virtual environment; whether 4th year medical students and residents would be allowed to graduate early without completing all program requirements; how national professional testing would occur and whether delays should impact the educational progress of students and trainees.

Medical schools, graduate medical education programs, national accreditation entities, and licensing bodies should collaborate to develop mutually agreed upon strategies for addressing widespread interruptions in medical education and training as part of pandemic planning to ensure that students and trainees do not experience negative impacts to their multi-year training programs that delay their ability to progress and become licensed physicians.

ACCESS TO MEDICAL CARE

Pre-pandemic, many patients in California already face long wait times or travel distances to see providers, especially specialists. The resulting delays in care can have serious consequences on their health. Declaration of a state of emergency for a pandemic can have a major impact on medical care unrelated to the pandemic disease as medical practices, pharmacies, clinics and other health facilities may be closed in compliance with shelter-in-place order or health care resources are redirected to treating infected patients. Patients will have medical appointments cancelled often with little information about when their care can be rescheduled. During the COVID-19 pandemic, patients have had non-elective procedures postponed and even when

practice have reopened, many are seeing a fraction of their pre-pandemic patient loads due to social distancing restrictions, supply shortages and reduced staffing.

As the use of technology becomes an integral part of the provision of health care, physicians are embracing the use of telemedicine and telehealth in their practices. Telehealth has the potential to improve access to care, reduce costs and facilitate physician communication with their patients. Telehealth overcomes these barriers by using technology to better harness physician time and expertise and connect patients to the care they need more quickly and conveniently. Telehealth has the capacity to improve access to specialty and behavioral health care; increase the efficiency and capacity of the health care workforce; and improve quality and health outcomes. Telehealth cannot, however, fully replace preventive screenings and services that need to be done in-person, such as childhood immunizations, mammograms and colonoscopies.

Preventive Care. During a pandemic, delaying in-person preventive care may be appropriate in the short-term as patients cope with other more acute challenges in their daily lives. Extended delays on a large scale, however, will have major impact on public health as conditions go undetected and untreated. Delayed or avoided medical care might increase morbidity and mortality associated with both chronic and acute health conditions. When California issued shelter-in-place orders in March 2020, many practices closed temporarily even though there was not a specific mandate that medical practices and clinics. Reopening has been challenging and providers are reporting a decrease in patients receiving necessary preventive services, especially pediatric immunizations.

According to a June 2020 CDC survey, about 12 percent of respondents reported avoiding urgent or emergency care, and 31.5 percent reported avoiding routine care because of concerns about COVID-19.[33] Avoidance of urgent or emergency care was more prevalent among unpaid caregivers for adults, persons with underlying medical conditions, Black adults, Hispanic adults, young adults, and persons with disabilities. While health care providers are contacting patients to remind them to keep current with preventive care, a social marketing campaign coordinated with physicians, public health departments and health systems on the importance of preventive care and regular visits to prevent illness and reduce strain on the healthcare system during the pandemic may be helpful.

Medication Access During an Emergency. Effective January 1, 2019, Assembly Bill (A.B.) 2576, Stats. 2018, ch. 716, allows a pharmacist or specified clinic to furnish a dangerous drug or

[33] Mark É. Czeisler et al., *Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020*, 69 MORBIDITY AND MORTAL WEEKLY REPORT (MMWR) 1250, (2020).

dangerous device in reasonable quantities without a prescription during a federal, state, or local emergency, to further the health and safety of the public. A record containing the date, name, and address of the person to whom the drug or device is furnished, and the name, strength, and quantity of the drug or device furnished must be maintained. The pharmacist or clinic must communicate this information to the patient's attending physician as soon as possible (Business & Professions Code §4062).

During a proclaimed state of emergency, a pharmacist, a mobile pharmacy, or specified clinic may refill a prescription if the prescriber is unavailable, or if after a reasonable effort has been made, the pharmacist, clinic, or mobile pharmacy is unable to contact the prescriber (Business & Professions Code §4064(g)). During emergency, the Board of Pharmacy, the Medical Board of California and other regulatory agencies will send reminders about these laws to expand provider flexibility to their licensees and stakeholders. It may be helpful to have this information disseminated more broadly to the general public and encourage health providers to share this information to improve access to care.

COMMUNICATION[34]

During a pandemic, ensuring access to accurate information that can be quickly communicated to those who can act on it, is critical to responding to the many issues that can arise. Everyone, including public agencies, the public, media organizations, schools, businesses, non-profits, depends on accurate information to inform their decisions and respond to the pandemic. The flow of information also needs to be coordinated and appropriately sourced to ensure that various entities are not contributing to confusion by reporting conflicting and possibly inaccurate information.

For example, as the state's approach to COVID-19 continues to evolve, education and communication is critical to ensure that healthcare providers, patients and the general public are operating according to the most current standards. Developing a statewide coordinated education strategy that includes standards for infection control and mitigation and guidelines for treating the disease in an ambulatory setting will help to ensure that consistent and high-quality care is provided regardless of where the disease emerges. In addition, an emphasis needs to be placed on the development of simple, clear, concise and unambiguous message executed at the local level through multiple channels of communication.

[34] Mary Doyle, M.D., *Is California Any Better Prepared? Enhancing Pediatric Partnerships to Promote Pandemic Preparedness,* AMERICAN ACADEMY OF PEDIATRICS, *available at* https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Documents/AAP-California-Chapter-Article.pdf.

Communication between public health authorities and all physicians and health care entities. The primary method that the state has used to communicated with all physicians has been through the state licensing board who can communicate via email to all licensees. While this could be effective, it also requires all information to be funneled through the state's bureaucracy before being approved for communication to all physicians. This makes it difficult to transmit information in a timely manner to physicians. Furthermore, the use of email fails to recognize that many licensees do not use email as their primary method for urgent communications and that it may be more effective to communicate via phone, text, social media or other platforms. The California Health Alert Network (CAHAN) is a secure web-based system accessible anytime and anywhere for emergency planning and response communication with public health partners. The Emergency Preparedness Office administers CAHAN to facilitate alerting and collaboration between Federal, State, Local County Health Departments, Clinics, Hospitals, and other public health emergency partners. CMA can encourage physician participation in CAHAN to strengthen the state's ability to contact physicians effectively during an emergency.

Public Education. During a pandemic, the public health system will rely heavily on the public to engage in basic actions, often with minimal oversight and enforcement. It is critical that resources are developed before the pandemic to encourage the public to be active and well-educated partners during a pandemic by practicing effective handwashing, masking, social distancing, and appropriate use of PPE. These resources could include regular messages in TV, social media, billboards, school-, work-, and community group-based training and practice. It is important that these resources also be developed in multiple languages, at the appropriate comprehension levels, and in accessible formats to ensure broad reach and penetration to California's diverse population.

COLLABORATION WITH PHYSICIANS

During a pandemic, physicians and other health care providers are on the frontlines, providing direct care to their patients, often in an environment of limited and constantly changing information, significant resource constraints and at great personal risk to themselves and their families. In addition, government agencies, researchers and public health experts may be issuing guidelines, standards, and other instructions that practicing physicians are expected to incorporate into their treatment plans and use to advise their patients. Model procedures for distributing equipment and supplies are developed and decisions are made with the assumption that providers will follow the developed protocols.

These actions by policymakers can achieve their desired outcomes—such as infection control and reduced fatalities—only if policies and procedures can be implemented quickly by frontline

healthcare providers. If there are disconnects between policies and actual practice, it is likely to result in mistrust, low adherence and wasted effort and resources. To address this challenge, it is important that practicing physicians be:

- Educated about public health functions in their community and at the state level and how they might interact with the public health system under non-emergency circumstances (ex. submitting confidential morbidity reports, signing up to receive public health communications, participating in social marketing campaigns, contributing to immunization registries, etc.) and during a disaster or pandemic (ex. reporting test results to public health officers, accessing supplies through the local MHOAC, amplifying public health messages, etc.).
- Involved in pandemic preparedness advance planning and embedded in local and state entities that will be making critical decisions during a pandemic.[35]
- Participate in pandemic training exercises so they become familiar with and provide critical feedback from a medical-practice perspective on procedures and protocols.

In addition to involving the physician perspective in pandemic planning, CMA's recent experience with COVID-19 demonstrated that there is no state-sponsored mechanism to funnel information from the frontline physicians. During the pandemic, CMA has served as a mechanism for identifying emerging issues, areas of confusion, provider needs and conveying this information up through appropriate channels in the state administration. While CMA has been effective in this role for its member physicians, other physicians likely tried communicating through local public health officials, their employers, local legislators, etc. The lack of a clear point of contact for physicians to communicate concerns to the state likely resulted in delayed responses and less effective pandemic response.

CMA has long advocated for inclusion of the physician perspective on a broad range of issues and especially on healthcare issues. The current pandemic has highlighted that the physician perspective is also critical on issues that might be considered outside the purview of medicine, including education, social services, climate change, and racial justice. These issues, however, all intersect with health care and it is appropriate for physicians to be engaged advocates on these issues. Training physicians to be advocates on these issues at the local and state level, as well as supporting their inclusion on committees and boards working on these issues will help to ensure that the physician perspective is included as policies are developed.

[35] C. Mackie M.D. and J. Lu, M.D., *Physicians And The Health Authorities: Key Partners In An Influenza Pandemic*, BC MEDICAL JOURNAL (JUNE 2007), *available at* https://bcmj.org/articles/physicians-and-health-authorities-key-partners-influenza-pandemic.

CMA PLANNING AND GOVERNANCE

Much like many other associations, CMA was caught off-guard by the scope and impact of the COVID-19 pandemic. While the Association had emergency plans for events such as natural disasters, facility damage, security incidents, there was no plan in place that anticipated and extended period of teleworking, simultaneous and severe impacts to member practices, and broad changes to state and federal laws.

Due to CMA's excellent leadership and staff, the Association has been nimble in adapting and redirecting resources to respond to constantly changing issues. CMA was able to quickly convene ad hoc committees on issues to develop guidelines and provide feedback on issues such as infection control, reopening a physician practice, development of crisis care guidelines, and improving the state's testing capacity. The governance procedures were adapted to provide for virtual Board of Trustee, Council and Committee, and House of Delegate meetings to continue the work of the Association in its policymaking functions.

While these changes have been generally effective, it may be appropriate for the Association to consider developing a plan to implement, in the event that there are future disasters/pandemics of this scale. The plan could include establishing a committee to advise on pandemic issues and develop consensus medical guidance to disseminate to the public; amending the CMA bylaws to include emergency governance procedures; procedures for sharing information with the membership; and policies and procedures for coordination with local medical societies on disaster and pandemic management.

CONCLUSION

California's progress to date in reducing the spread of COVID-19 among the state's 40 million residents has been mixed because the state has been responding not to a single outbreak but many regional outbreaks that have risen and declined in response to a variety of constantly changing factors. In some regions it appears that the state has made significant progress toward "flattening the curve", leading the way toward safe and gradual reopening of the economy. Overall, however, the pandemic is far from being resolved.

The recommendations in this report highlight the most significant issues that need to be addressed during this and future pandemics. Effective implementation of these recommendations requires supporting a culture of unification, solidarity and hope among California's physicians that the challenges brought on by the pandemic are not insurmountable and that we can achieve success in overcoming the pandemic through hard work, strong advocacy, effective cooperation

with other stakeholders and a focus on educating physicians and the public that we are all in this together and that it will take all of us to truly flatten the curve.

RECOMMENDATIONS

PUBLIC HEALTH PLANNING AND PREPARATION

RECOMMENDATION 1: That CMA work with the State of California and local jurisdictions to ensure that CMA and practicing physicians are involved in the development and execution of planning and response including but not limited to health care delivery related to the COVID-19 pandemic, and that plans for COVID-19 pandemic response focus on procurement of medical equipment and supplies, strengthening the infectious disease data surveillance system, addressing health disparities, addressing impacts from climate change, supporting the health and social safety net to facilitate infection control policies, ensuring a robust healthcare workforce; and mitigating the pandemic's impact on the erosion of social cohesion in communities.

RECOMMENDATION 2: That CMA, after state and federal governments have declared the end of the state of emergency related to the COVID-19 pandemic, should continue to advocate for and participate in the development of After Action Reports (AAR) and a new pandemic preparedness plan that is regularly updated and informed by the experiences of stakeholders and lessons learned from the COVID-19 pandemic.

RECOMMENDATION 3: CMA shall support that future pandemic planning shall be conducted through a public and transparent process and informed by the experiences of stakeholders and lessons learned from the COVID-19 pandemic, and that the scope of the plan shall include, but not be limited to, procurement of medical equipment and supplies; strengthening the infectious disease data surveillance system; addressing impacts of the plan on and by health disparities and climate change; supporting the health and social safety net to facilitate infection control policies and safeguard communities and social development; supporting transparent communication

between government entities and physicians about vaccine development; and ensuring a robust healthcare workforce.

RECOMMENDATION 4: CMA support improving access to federal resources in the current and future pandemics by documenting the impact of the federal governments failures on pandemic response in California, especially with regard to physicians and their patients, and engaging in federal advocacy to reform how the federal government plans for and executes effective pandemic response.

RECOMMENDATION 5: That CMA reaffirm HOD 114-02 that supports preserving and strengthening the public health infrastructure in California at the state and local level, including significant funding increases for infectious disease and disaster preparedness programs.

RECOMMENDATION 6: That CMA support that pandemic planning includes the establishment of the Health Professions Pandemic Advisory Committee comprised of representatives from statewide health professional associations which shall advise the Executive and Legislative branches on pandemic policies and procedures that impact health care delivery and patient care and ensure that input from health providers reflects the wide diversity of health care delivery by geographic region, health specialties and modes of practice.

RECOMMENDATION 7: That CMA support that future planning for pandemic response needs to be done through a lens of health inequities and structural racism to better evaluate disparate impacts of policies and protocols on minority, incarcerated, detained, and homeless communities and develop solutions before the pandemic occurs.

RECOMMENDATION 8: That CMA support that future pandemic planning will develop solutions that are sustainable for the environment, which may include reusable PPE and disinfection practices that are not harmful to the environment, in order to also address the concerns of climate change.

RESOURCE PROCUREMENT AND ALLOCATION

RECOMMENDATION 9: That CMA support the establishment of a state-operated Group Purchasing Organization (GPO), with voluntary physician participation, that can aggregate demand across health care providers, including through collaborative agreements with other states; buy medical supplies in bulk; and obtain better prices for products than individual health providers can negotiate on through individual purchases.

RECOMMENDATION 10: That CMA support consistent rules regarding paying the costs testing and treatment for diseases related to a pandemic, which should apply to all patients, based on a health care provider's determination of medical necessity, without regard to the specifics of their insurance coverage.

RECOMMENDATION 11: That CMA support a review and revision of the CDPH crisis care guidelines ensuring that health care providers and medical specialty societies have sufficient time to review and provide feedback to develop a more robust set of crisis care guidelines.

RECOMMENDATION 12: That CMA encourage physicians and health care systems to plan for equitable distribution of resources needed to respond to mass vaccination through a review of their practice's immunization procedures and how they might need to be altered to accommodate an influx of patients seeking the COVID-19 vaccine.

WORKFORCE

RECOMMENDATION 13: That CMA support that the safety and wellness of health care providers and essential workers should be a priority in pandemic planning and that policies and protocols supporting public health officer safety, provider wellness program, financial considerations and enhanced protection against infection through sheltering programs and access to personal protective equipment, should be developed to support and preserve the workforce during and after a pandemic.

RECOMMENDATION 14: That CMA support that public health officials should be protected from harassment, assault, and violence and that local and state law enforcement should investigate all credible threats, provide security details as warranted, and prosecute harassment.

RECOMMENDATION 15: That CMA support that the State of California should consolidate the various emergency healthcare volunteer programs that currently exist into fewer programs that use a common application and credentialing process; provide training; provide financial support to facilitate service; offer comprehensive immunity and liability coverage; provide opportunities for medical students and residents to serve; and the option for healthcare providers to serve as an individual or as part of a medical assistance team.

RECOMMENDATION 16: All licensed healthcare providers rendering services in relation to, or failing to perform such services in relation to or as a result of, a pandemic and declared emergency shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability.

RECOMMENDATION 17: That CMA support during a pandemic or other state of emergency (1) that medical schools should not disenroll or interrupt medical education due to inability to pay tuition and fees; (2) an option for medical school education postponement at the discretion of the student; and (3) a reduction in tuition fees when an exclusively virtual learning environment is absolutely necessary.

RECOMMENDATION 18: That CMA support that medical schools develop innovative learning opportunities and offer optional in-person learning experiences with appropriate PPE for content that cannot effectively be replicated virtually during pandemics and other states of emergency, such as clinical exam skill and anatomy sessions.

RECOMMENDATION 19: That CMA recognize medical students as a vulnerable population with potential for volunteer coercion during pandemics and other states of emergency, and support provision with appropriate PPE and occupational health care coverage should medical students decide to volunteer.

RECOMMENDATION 20: That CMA recognize that the primary purpose of postgraduate training programs is to provide clinical training to prepare physicians for future practice and that residency programs should prioritize this purpose during a pandemic by ensuring that residents and fellows, who may be at risk for exploitation and coercion to provide care outside of their usual training activities, should be protected and adequately compensated with appropriate paid sick leave, hazard pay, and/or loan forgiveness commensurate with any increased risk. CMA supports that programs should develop policies that support and protect residents who do not elect to provide high-risk patient care outside of their regular training program during a pandemic.

RECOMMENDATION 21: That CMA supports that postgraduate training programs should, during a pandemic, ensure that resources are provided to allow residents and fellows to remain in their programs with salary and benefits, progress in their training in a manner which ensures that they develop the necessary competencies and can meet requirements for licensure and board certification upon completion of the program.

RECOMMENDATION 22: That CMA support that during a pandemic, fellows who assume attending physician roles should receive pay and benefit commensurate with those roles and that residents and fellows who are assigned to provide care outside of the regular training program must be appropriately trained and supervised.

ACCESS TO MEDICAL CARE

RECOMMENDATION 23: That CMA support a social marketing campaign coordinated with physicians, public health departments and health systems on the

importance of preventive care and regular visits to prevent illness and reduce strain on the healthcare system during the pandemic.

RECOMMENDATION 24: That CMA encourage physicians to communicate with their patients about the importance of medication adherence and how to access medications if the prescriber is unavailable during a pandemic or other emergency.

COMMUNICATION

RECOMMENDATION 25: That CMA support improved collaboration between physicians and public health systems in their community and at the state level and that CMA encourage and promote physician participation in the California Health Alert Network (CAHAN) which is accessible for emergency planning and response communication with public health partners and facilitates alerting and collaboration between Federal, State, Local County Health Departments, Clinics, Hospitals, and other public health emergency partners. CMA also supports that CAHAN work with the Medical Board of California and the Osteopathic Medical Board of California to develop procedures for promoting CAHAN and regularly updating the CAHAN database with physician contact information from the state's licensing data.

RECOMMENDATION 26: That CMA support, champion and participate as an active partner in the development of a statewide social marketing campaign that supports practices such as hand hygiene practices, masking, and social distancing as effective methods of infection control; that quickly combats the spread of inaccurate and misleading public health and scientific information; that supports the validity and non-partisan nature of medical science and public health directives and that recognizes local public health officers as trusted leaders who are sources of accurate information during a pandemic.

RECOMMENDATION 27: That CMA support that physicians, health systems, public health officials collaborate with organizations that serve marginalized communities and communities of color to promote awareness and understanding of vaccination.

RECOMMENDATION 28: That CMA should include specialty-specific information on its pandemic information platform, with links to specialty organizations for additional guidance.

COLLABORATION

RECOMMENDATION 29: That CMA support that physicians should be prepared and supported to lead and serve on local and state committees and policymaking bodies to ensure that the physician and healthcare perspective is included in public policy development.

CMA GOVERNANCE AND PLANNING

RECOMMENDATION 30: That CMA establish a technical advisory committee to assess and make recommendations to improve CMA's readiness to respond to pandemics and other disasters.

FISCAL IMPACT: No cost to adopt as policy. If legislation is required, the potential cost is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $110,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost. If federal legislation is contemplated, the cost of CMA sponsoring or opposing a federal bill could be $150,000 or more and is dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents.

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