



Washington State COVID-19 Pandemic Task Force Summary

William D. Ruckelshaus Center
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Acknowledgements

This *Washington State Pandemic Task Force Summary (Task Force Summary)* reflects discussions held by the State Pandemic Task Force (Task Force), February 2022 - June 2023, through a collaborative effort of facilitators, members of the community, community organizations, subject matter experts, and state agency staff.

Disclaimer: *Information contained within this document reflects information discussed by members of the State Pandemic Task Force, participants in focus area workgroups, and information compiled by state agencies. It is intended to reflect the opinions and analysis of the contributors based on discussions, presentations, data gathering efforts including surveys, interviews, and additional engagement opportunities. Information in this document was informed by Task Force members, the After-Action Review (AAR) Steering Committee, William D. Ruckelshaus Center, Division of Governmental Studies and Services at Washington State University, Baker Consulting, Inc, and IEM (Contractor). The information and recommendations in this summary do not represent the views and opinions of the preparers of this document or the institutions that they are associated with.*

The role of IEM was to assist in compiling the information provided by the data gathering activities throughout this process. IEM worked with data and information that was previously collected, developed, and provided to them. In a few circumstances, IEM, added information and recommendations from their previous experience in other jurisdictions, as well as augmented information related to the review of state agency after-action reviews.

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Executive Summary

Why Conduct This COVID-19 After-Action Review Process?

Early in 2020, the United States Department of Health and Human Services and the State of Washington declared COVID-19 a public health emergency. On October 31, 2022, the Washington State Disaster Proclamation was lifted, and on May 11, 2023, which was 1,196 days after the designation of the emergency, the federal Public Health Emergency Declaration expired.

The three-year COVID-19 pandemic response was very different from previous responses. In the global context of the COVID-19 pandemic, our state worked diligently to slow the spread of the disease, save lives, and preserve health in our communities. This work required coordination across state government, integrated solutions between local, tribal, state, and federal organizations, and collaborative participation between community organizations and response partners, dedicating energy to multiple missions.

The pandemic highlighted many preexisting social inequities and gaps in our society. Even before the pandemic, people struggled with housing and food security. Our healthcare system was not designed with a massive public health response in mind, and our educational systems were expected to both educate and provide social service resources. Many businesses and organizations that support our communities lacked critical resources to meet pressing social demands. Systemic racism and structural ableism caused clear inequities in how people could access social and health services.

The Goals of the After-Action Review and the Task Force Process

The immense and all-encompassing scope of the COVID-19 pandemic created unprecedented challenges to local, state, and national officials across the nation - the effects of which have been felt by just about every individual across the globe. To better understand the impacts of the COVID-19 pandemic, including the impacts of public health and safety measures to vulnerable and underserved communities, The Washington State Legislature (via Engrossed Substitute Senate Bill 5092.SL, Section 114) charged the Washington State COVID-19 Pandemic Task Force with conducting a comprehensive after-action review of the state's COVID-19 pandemic response to improve our state's response and recovery systems for future pandemics and other disasters.

The review was to include consideration of the disparate impacts across racial, economic, cultural, and geographical communities. This unique focus provided an opportunity to not only improve traditional emergency management operational response plans, but to also view response and recovery activities through a much broader lens to better understand the needs of different communities and more effective ways to provide resources and information. Ultimately, this review and the recommendations from the Task Force Summary were used to inform the Washington State COVID-19 After-Action [Report](#). The report consolidates and highlights key issues and recommendations brought forward during the Task Force process. The Report link includes the final AAR report as well as other information, meeting notes, and recordings from the Task Force.

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The Task Force embedded core principles of equity to identify disparity and discrimination through lived experiences, with resulting recommendations to improve whole community integration across emergency response and recovery planning efforts. Additional details on the formation and charter of the Task Force are included in **Section 1.2**.

Throughout the Task Force process, participants such as state agency representatives, legislators, tribal representatives, underrepresented community groups disproportionately impacted by COVID-19, county staff, and others collaborated to reflect on the state's response to the COVID-19 pandemic and its devastating effects on many communities. This effort resulted in many recommendations to create stronger partnerships between the state and those hardest-hit communities to build more resilient and better supported communities in future emergencies.

State Pandemic Task Force members devoted one and a half years to understanding what worked well in Washington's response to the pandemic, exploring disparities that disproportionately impacted many of our communities, and exploring lessons learned and identifying recommended improvements for emergency preparedness and future responses. The wide impact caused by the pandemic and the complexity of the response has led to recommendations that generally fit into three categories:

- **Operational** – the systems, processes, or actions that organizations can improve through changing procedures, equipment, information systems, or training.
- **Cultural** – the approaches and values that drive decision-making that can be modified through collective social changes.
- **Relationships** – the connections between leaders, organizations, and structures that can be enhanced through improved pre-emergency coordination and engagement.

The Task Force led learning efforts across several key areas identified by the legislature. These focus areas A-H, shown in **Figure 1**, were prescribed through the Washington State Legislature.

 <p>A Aspects of the COVID-19 response that may inform future pandemic and all-hazard responses.</p>	 <p>B Emergency Response that would benefit the business community and workers during a pandemic.</p>
 <p>C Standards regarding flexible rent and repayment plans for residential and commercial tenants during a pandemic.</p>	 <p>D Whether establishing regional emergency management agencies would benefit Washington state emergency response to future pandemics Strength/Area for Improvement.</p>
 <p>E Gaps and needs for volunteers to support medical professionals in performing their pandemic emergency response functions within Washington state Strength/Area for Improvement.</p>	 <p>F Gaps and needs for tools to measure the scale of an impact caused by a pandemic and tailoring the pandemic response to affected regions based on the scale of the impact in those regions.</p>
 <p>G Gaps and needs in health care system capacity and case tracking, monitoring, control, isolation and quarantine, and deploying medical supplies and personnel.</p>	 <p>H Implementing guidelines for school closures during a pandemic Strength/Area for Improvement.</p>

Figure 1: Key Areas of the COVID-19 Response Identified by the Washington Legislature

Key Lessons Learned

- ✓ **Addressing the disparities that were starkly evident among racial and cultural groups, economic and geographical areas across our society and highlighted by the COVID-19 pandemic must be an integral piece of future emergency planning for response and recovery. This work must be applicable to all hazards for our state to prepare for, identify and respond to the needs of all communities in a more equitable and sensitive manner.**

Emergency management planning to respond to and recover from emergencies, often, does not integrate considerations to adequately support individuals and groups that are part of vulnerable and/or underserved communities. Many people, such as those primarily speaking a language other than English, Black communities, Indigenous communities, other People of Color, low-income households, immigrant communities, and those experiencing homelessness experienced disparities and challenges in accessing healthcare, vital information, and access to available support and financial resources. These challenges existed within these and other underserved communities long before the COVID-19 pandemic. However, the global scale of the pandemic highlighted these disparities and compounded the effects of the pandemic in multiple ways. In addition to barriers to accessing healthcare and information, there were many unintended or

unconsidered consequences to many of the public health measures implemented to preserve general life safety.

Cultural, societal, and geographical considerations such as communities whose cultural ways include maintaining aging family members in the home versus long-term care facilities, trauma triggered by historical experiences within the Black community, and providing service to rural communities versus urban areas need to be woven into planning for emergencies. Across these lessons learned, the common thread is the importance of acknowledging disparities that exist, and the institutional barriers created that harm marginalized and underserved communities. Through authentic community engagement and direct involvement with these communities and culturally responsive organizations that best understand these communities and cultural ways of being, government entities will be able to develop emergency plans that include a more equitable implementation and recovery strategy.

✓ **Integrate response equity strategies that support all communities across all phases of emergency management planning.**

Disasters such as Hurricane Katrina, Hurricane Sandy, and now the COVID-19 pandemic have shown time and time again that the lack of integrated planning with vulnerable and/or underserved populations including people with disabilities, access, and functional needs, those who primarily speak a language other than English, individuals living in poverty or low-income households, and those who are unhoused, among others, lead to a challenging and sometimes impossible recovery following a disaster. Planning with communities to learn how they receive and digest information, who they trust for reliable information, and their anticipated diverse priorities when disaster strikes, is key for government response organizations to be able to effectively support these communities.

The COVID-19 pandemic especially highlighted that public health measures meant to keep the general public safe created different burdens for different communities across Washington. These included challenges faced by low-income families during the school facilities closure, loss of access to vital in-home healthcare in multi-generational households, and individuals in need of support but not eligible for financial and other social services support due to their immigration status. Thoughtful, integrated, and more equitable emergency planning to include considerations for the multitude of diverse communities will provide forward progress toward a stronger, more resilient Washington State.

✓ **Invest in community collaboration opportunities that engage vulnerable and underserved communities to further expand the “Whole of Community” planning philosophy.**

Supporting increased investment for community collaboration opportunities across all phases of emergency management will strengthen the relationship between Washington state and community organizations that support vulnerable and underserved communities. Encouraging and resourcing community organizations to participate in local and state planning, response, and recovery activities will lead to better informed response priorities, greater community cohesion, and increased social capital among the participating organizations and members. This leads to more resilient communities overall.

✓ **Identify sustainable state funding to continue successful initiatives implemented during the COVID-19 pandemic that supported communities in need.**

The state utilized federal Coronavirus Aid, Relief, and Economic Security (CARES) and the American Rescue Plan Act (ARPA) funding to support communities. However, increased collaboration with underserved communities to ensure timely identification of needs and appropriate support would benefit these communities. From 2021 to 2023, Washington State utilized over \$16,000,000,000 to support sectors such as K-12 schools, businesses, broadband access, childcare, food security, transportation, and housing. While funding made available through federal resources allowed the state to support many critical endeavors, the funding is not sustainable. Identifying successful programs and pilot initiatives that helped address challenges to vulnerable and underserved communities that were implemented throughout COVID-19 and supporting long-term, sustainable investments in these programs moving forward will build further resiliency in communities that were hardest hit.

✓ **Continue to build on the relationships created during the COVID-19 pandemic, especially between emergency management and public health.**

Prior to the COVID-19 pandemic, many state and local jurisdictions had not established a strong connection between emergency management agencies and public health agencies. The Federal Emergency Management Agency supports a “Whole of Community” planning approach which includes engagement with all levels of government, communities, and organizations. This approach provides for a better understanding of different community needs and how best to strengthen and utilize community assets and effectively coordinating government resources to support communities in need. Through the COVID-19 pandemic, it became clear that the disconnect between emergency management and public health created a barrier in being able to efficiently coordinate and manage the rapidly changing COVID-19 environment. Washington state will need to capitalize on and continue to grow the relationships forged across many public and private entities throughout this pandemic in order to effect necessary change and implement key lessons learned through this experience, and to ensure that state leadership is in the best position possible to respond to, and recover from, the next emergency.

Suggested Next Steps

There are numerous significant issues to resolve, systems to transform, and opportunities for improvement in future emergency responses. This Task Force Summary informs the Washington State After-Action Review Report by providing insight and recommendations, but additional work is needed to build upon the lessons learned to embed equity into emergency planning, decision-making, and response.

Task Force members suggested that a next step could be to create a collaborative process to engage a diversity of governmental entities, communities, and community-based organizations to define short and long-term strategies, policies, operations, and practices that work to resolve current and historical disparity issues and address equity in future emergencies.

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1. Introduction

The state of Washington, along with the rest of the world, experienced an unprecedented response operation due to Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), referred to as COVID-19, with the first case of COVID-19 in the United States confirmed on January 21, 2020, in the state of Washington. In response to the possibility of emerging cases of COVID-19 across the state, the Washington Military Department (WMD) activated the State Emergency Operations Center (SEOC) on January 22, 2020, with leadership from the Washington State Department of Health (DOH), Governor's Public Affairs Office, the Washington Emergency Management Division (EMD), and other state agencies. In mid-March, officials from DOH, EMD, and the Washington State Department of Social and Health Services (DSHS) implemented a unified command structure to manage the COVID-19 state response.

Governor Jay Inslee declared a State of Emergency to facilitate a statewide coordinated response to the pandemic on February 29, 2020, under Proclamation 20-05. This emergency proclamation was terminated effective October 31, 2022, through Proclamation 20-25, Washington Ready. Governor Inslee also issued over 85 Proclamations in response to the COVID-19 pandemic. They can be found at <https://www.governor.wa.gov/office-governor/official-actions/proclamations>. The U.S. Department of Health and Human Services (HHS) declared a public health emergency on January 31, 2020, and the World Health Organization (WHO) declared COVID-19 a global pandemic on March 11, 2020.

For more than three years, the lives and daily activities of the residents of Washington, as well as the state's economy have been significantly altered by the pandemic. According to information available on the Washington DOH website, from February 29, 2020, through January 25, 2023, the state reported a total of over 1.9 million cases with over 15,000 deaths. According to the US Centers for Disease Control and Prevention (CDC) website https://www.cdc.gov/nchs/pressroom/sosmap/covid19_mortality_final/COVID19.htm, Washington state reported 206 deaths per 100,000 people from COVID-19. This translates to Washington having one of the lowest COVID-19 death rates in the United States and its territories. Only Alaska, the District of Columbia, Puerto Rico, Utah, Vermont, and Hawaii reported lower rates.

While the COVID-19 pandemic impacted everyone around the world in some way, some individuals and communities were disproportionately impacted by the pandemic with more dire consequences. Communities challenged with inequities in healthcare, social and other human services such as seniors, people with disabilities, immigrant farm workers, communities primarily speaking a language other than English, low-income communities, and Black, Indigenous, People of Color (BIPOC) communities, experienced a greater difficulty accessing the supports and care they needed as the pandemic grew. Some jurisdictions found they were not adequately prepared to communicate with communities where outreach has traditionally been a challenge or where there may be a long-standing distrust of government entities. These issues presented barriers to getting critical information and support to these communities. Additionally, rampant disinformation and misinformation spread throughout the pandemic, including by elected officials, exacerbated the communication challenges and outreach efforts.

The COVID-19 pandemic has been an unprecedented emergency for this country but for many individuals and communities, the impacts of the COVID-19 pandemic exposed harsh realities that society in the United States has been grappling with for decades. In the final report of the *Presidential COVID-19 Health Equity Task Force, Final Report and Recommendations*, dated October 2021, a member of the Presidential Health Equity Task Force stated the following:

“COVID-19 has laid bare what has been the reality for so many in our country, who over generations have been minoritized and marginalized and medically underserved, and the pandemic took advantage of the legacy of intentional policies that have structurally disadvantaged communities over time.”

- Presidential Health Equity Task Force Member

Most often when discussing equity, it is important to differentiate equality from equity. **Equality is everyone receiving the same thing.** This view is often taken mistakenly when people intertwine their concept of fairness. **Equity is ensuring that every person receives what they individually need and as cultural and social groups to be successful.** Because of the inequities that have impacted underserved communities, especially, indigenous and Black/African American, “Targeted Universal”, which means setting universal goals and using targeted processes to achieve those goals, is a suggested method to correct deficiencies caused by institutional and systemic racism supported by state, local, and federal government organizations. A discussion of the actions that federal, state, and local government can take to remedy harms caused by racism could be helpful. Additionally, some governmental agencies have declared racism a public health crisis. More detailed information regarding the Targeted Universal method is included in **Section 11.**

Due to the disproportionate impacts of the pandemic, this Task Force process reviewed response and recovery activities applying equity principles to identify critical areas for improvement and recommendations to ensure that integrated planning for these communities is part of the overall emergency management planning system across the state. Using these principles will support a more integrated and effective emergency management process and build resilience for communities across Washington.

In addition to responding early on to the emerging COVID-19 situation, the state of Washington has responded to 30 federally declared emergencies between January 2022 and present, including many destructive and deadly straight-line winds, mudslides, flooding, and severe weather incidents, and numerous devastating wildfires across the state.

The COVID-19 pandemic mobilized the most significant, sustained response and recovery effort for a public health emergency in history. The recommendations and information provided in this Task Force Summary are the result of the combined efforts of state agencies that participated in the COVID-19 response, including DOH, WMD and EMD, as well as the State Pandemic Task Force, to evaluate the successes, strengths, innovations, challenges, areas for improvement, and recommendations to build further resiliency, address inequities, and strengthen the State’s ability to prepare for, respond to, and recover from, future emergencies.

1.1. Purpose

The Task Force’s purpose was to identify strengths, areas for improvement, and recommendations related to the state’s response to and recovery from the COVID-19 pandemic. This Task Force Summary, reflecting Task Force discussions, supports the state in ongoing preparedness activities and informs the state’s planning and response to future emergencies. The Task Force also focused on understanding the experiences of vulnerable and historically underserved communities and highlights how the COVID-19

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pandemic affected them in disproportionate ways. Information and recommendations presented in this Task Force Summary provide context to and recommendations for the Washington State After Action Review to encourage state agencies, state and local emergency management and responders, public health officials, and community organizations, among others, to strengthen collaboration and understanding of communities and their needs.

1.2. Scope

The Washington State Legislature, through Engrossed Substitute Senate Bill (ESSB) 5092.SL (Section 114), established the State Pandemic Task Force. The originating legislation mandated WMD to “facilitate a Task Force to conduct a comprehensive after-action review of the statewide pandemic response and recovery.” The proviso designated the representative Task Force entities. In addition, the Task Force was charged with conducting:

[a] comprehensive after-action review of the COVID-19 pandemic response in accordance with established national standards for emergency or disaster after-action reviews. In order to improve the response to and recovery from future pandemics, the Task Force shall develop lessons learned and make recommendations that include but are not limited to the Focus Area topics A through H.

Focus Areas A–H, as stated in the proviso, are shown in **Table 1**. The proviso also stated that the topics identified were intended “to be illustrative, but not exhaustive.” The Task Force Charter and additional information are available on the Task Force website: <https://mil.wa.gov/pandemic-after-action-report-task-force>.

The Task Force was also asked to consider issues relating to equity, disparities, and discrimination across all the topics researched and in the development of recommendations. Disproportionate impacts of the COVID-19 pandemic were considered throughout the discussions and data reviews. Consideration of the experiences of communities disproportionately impacted was emphasized in Task Force and equity gathering discussions. The Task Force was charged with focusing on designated Focus Areas A–H as stated in the legislation. Other essential topics, such as food insecurity, rural issues, childcare, and senior care emerged throughout the Task Force discussions and are often reflected in the Task Force recommendations that are not associated with Focus Areas B–H.

This Task Force Summary includes data and information from multiple sources to highlight the multiple perspectives of those responding to and affected by the COVID-19 pandemic. Recommendations put forward throughout the Task Force process considered lessons learned from the Task Force members and presenters to the Task Force, information gathered through a series of additional equity gatherings, information and recommendations from a series of Focus Area workgroups and supporting information from a review of state agency AARs. In addition, information in the analyses of Focus Areas A–H was intended to maintain the voices of the contributors in a meaningful way.

1.3. Analysis of the Focus Areas

The analyses of these Focus Areas present strengths, areas for improvement, lessons learned, and recommendations identified throughout the Task Force process. Data that informed the development of each Focus Area was provided by the Task Force, Focus Area Workgroups, and state agency reviews. Also

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included was information based on lessons learned through the Contractor’s experience conducting after action reviews with other states.

The Task Force recommendations in Focus Area A are broader than the legislative specificity of Focus Areas B–H. Lessons learned and recommendations for Focus Area A were developed from multiple sources and are presented in three subsections: 1) Task Force Observations and Recommendations, 2) Equity Gatherings and Engagement Opportunities, and 3) State Agency AAR Reviews. Given the collaborative, multi-source, and multi-topic efforts, these sections appear in varying formats to maintain the voice and intent of the contributors.

The information is presented based on the established Focus Areas A–H as listed below.

- (A) Aspects of the COVID-19 response that may inform future pandemic and all-hazards responses;
 - State Pandemic Task Force Observations and Recommendations
 - Equity Gathering and Engagement Opportunities Lessons Learned and Recommendations
 - State Agency After-Action Reviews
- (B) Emergency responses that would benefit the business community and workers during a pandemic;
- (C) Standards regarding flexible rent and repayment plans for residential and commercial tenants during a pandemic;
- (D) Whether establishing regional emergency management agencies would benefit Washington state emergency response to future pandemics;
- (E) Gaps and needs for volunteers to support medical professionals in performing their pandemic emergency response functions in Washington state;
- (F) Gaps and needs for tools to measure the scale of an impact caused by a pandemic and tailoring the pandemic response to affected regions based on the scale of the impact in those regions;
- (G) Gaps and needs in health care system capacity and case tracking, monitoring, control, isolation, and quarantine, and deploying medical supplies and personnel; and,
- (H) Implementing guidelines for school closures during a pandemic.

Table 1 highlights the relevant sections associated with Focus Areas A–H and the lead entities that compiled and analyzed the information. Additional details on the process for data gathering and the development of recommendations for each of the Focus Areas are presented in each section.

Table 1: Focus Area Leads for Recommendations

Recommendation Section	Relevant Text	Focus Area Lead/Activity
Focus Area A: Aspects of the COVID-19 response that may inform future pandemic and all-hazards responses (contains three data sets)	Section 2	<ul style="list-style-type: none"> • State Pandemic Task Force, facilitated by the William D. Ruckelshaus Center • Facilitation of equity gatherings led by Baker Consulting teamed with the William D. Ruckelshaus Center • Contractor review of individual state agency AARs and additional information available highlighting

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Recommendation Section	Relevant Text	Focus Area Lead/Activity
		items that have relevance across all state agencies.
Focus Area B: Emergency responses that would benefit the business community and workers during a pandemic	Section 3	<ul style="list-style-type: none"> Facilitation led by the Washington State Department of Commerce
Focus Area C: Standards regarding flexible rent and repayment plans for residential and commercial tenants during a pandemic	Section 4	<ul style="list-style-type: none"> Facilitation led by Washington State Department of Commerce
Focus Area D: Whether or not establishing regional emergency management agencies would benefit Washington state emergency response to future pandemics	Section 5	<ul style="list-style-type: none"> Facilitation and data gathering led by the William D. Ruckelshaus Center in collaboration with Berk Consulting, Inc. and the Pacific Northwest Economic Region
Focus Area E: Gaps and needs for volunteers to support medical professionals in performing their pandemic emergency response functions in Washington state	Section 6	<ul style="list-style-type: none"> Facilitation led by DOH.
Focus Area F: Gaps and needs for tools to measure the scale of an impact caused by a pandemic and tailoring the pandemic response to affected regions based on the scale of the impact in those regions	Section 7	<ul style="list-style-type: none"> Contractor review of individual state agency AARs and additional information provided highlighting items that have relevance across all state agencies
Focus Area G: Gaps and needs in health care system capacity and case tracking, monitoring, control, isolation and quarantine, and deploying medical supplies and personnel	Section 8	<ul style="list-style-type: none"> Facilitation led by DOH.
Focus Area H: Implementing guidelines for school closures during a pandemic	Section 9	<ul style="list-style-type: none"> Facilitation led by the Washington State Office of Superintendent of Public Instruction (OSPI)

2. Focus Area A: Aspects of the COVID-19 Response That May Inform Future Pandemic and All-Hazard Responses

This Focus Area includes information and recommendations identified through three (3) data sources and is broken into three (3) sub-sections including: 1) a synthesis of the Task Force observations and recommendations; 2) information gathered through a series of equity gatherings and engagement opportunities; and, 3) state agency AAR reviews as identified through a review of individual state agency COVID-19 pandemic response AARs as well as a review of additional information provided. Information contained within this section, Focus Area A, will focus on strengthening community collaboration, preparedness, planning, response, and recovery capabilities for future pandemic and all-hazard responses.

2.1. Observations and Recommendations of the State Pandemic Task Force

Brief Background

The Task Force participated in monthly meetings between February 2022 and June 2023. These meetings were designed to create open discussions, elicit frank observations, provide opportunities to share lived experiences, and develop recommendations from a wide variety of perspectives related to the state's response to COVID-19 and future pandemics. The Task Force included state agency representatives, legislators, tribal representatives, representatives from demographic groups that were disproportionately impacted by COVID-19, unions, associations, county staff, and community members with diverse experiences and stories related to their experience of the pandemic impacts and response. The Task Force developed a Charter to guide its process. The full Task Force Charter document is available at <https://mil.wa.gov/asset/62475923221f3>.

The monthly meetings were scheduled for three-hours and included a variety of presentations from Task Force members and external presenters. These presentations ranged across sectors, communities, and issues—for example, tribal perspectives, small business experiences, communities of color, communities with disabilities, emergency food providers, and others. The meetings included discussion, both full-group and break-out small groups. Considerations related to equity and inclusion were integrated and openly discussed throughout the course of the Task Force meetings.

The notes, recordings, and presentations from the Task Force meetings were compiled and synthesized to identify foundational issues, general goals, and recommendations. While this process was neither intended nor constructed to reach group consensus, many recommendations were discussed and agreed upon. Issues that arose from these discussions expanded upon the topics specified in the Legislative proviso. The Task Force also provided input to the Focus Area Workgroups, including reviewing the analysis and preliminary recommendations of the Workgroups, as presented during Task Force meetings.

Task Force meeting notes, presentations, and recordings are posted on the Task Force website at: <https://mil.wa.gov/pandemic-after-action-report-task-force>.

Overarching Principles and Values

Equity was the overarching principle maintained throughout the Task Force meetings. The Task Force utilized an equity document that included a series of fundamental principles and questions to assist in framing discussions and maintaining the focus throughout Task Force discussions. This document is included in **Appendix A**. These principles were helpful in keeping the Task Force aligned and focused on integrating equity into observations of the impacts and responses to COVID-19, as well as into the development of recommendations. Discussions brought forth the importance of embedding in decision-making core underlying values that support equity and identifying actions that address historic, institutional, and social issues that contributed to disproportionate impacts.

Foundational Issues and General Goals

The Task Force recommendations coalesced into the nine issue categories listed below with their general goals. These areas are treated in detail in the following sections.

- **Planning**
 - Improve planning and preparation to eliminate disparate response outcomes to vulnerable communities
 - Improve existing processes to inspire community and stakeholder confidence.
 - Make consideration of downstream impacts an integral and transparent part of the emergency order process.
- **Communication**
 - Streamline leadership response and community feedback to eliminate time delays, lost lives, and economic hardship.
- **Collaboration and Partnerships**
 - Create effective and durable partnerships that engender trust, empower shared creative problem-solving, and improve response.
- **Governance, Decision-Making, and Accountability**
 - Adopt a clear, consistent, tested, and trusted decision-making structure in Washington that leads collaboratively through emergencies.
- **Access to Services and Support**
 - Create equitable access to eliminate gaps in support and services to vulnerable communities.
- **Data/Information Access, Use, & Effectiveness**
 - Produce effective, trusted, and shared information that empowers faster response and feedback for decision-making between government, stakeholders, other funders, and communities.
- **Workforce**
 - Respect the value of a trusted community-based workforce (full time, part time and volunteers), that understands the specific cultural needs of their community and provide funding to ensure sustainability.

- **Administrative Systems**
 - Simplify systems to allow communities and partners to respond quickly and provide timely feedback to improve equitable responses.
- **Funding**
 - Create systemic funding capability and capacity for vulnerable communities that does not rely on the good graces of underfunded community-based organizations (CBOs), non-governmental organizations (NGOs), tribes, and other organizations carrying a disproportionate and unfair load during emergencies.

Observations and Recommendations

The following Task Force recommendations are not specific to the proviso language Focus Area A–H topics. Some observations and recommendations apply to several of the issue categories above, so they are not duplicated between sections. Additional context is based on examples from Task Force discussions. The Task Force’s meetings addressed both emergency response and overarching systemic improvements. These improvements are intended to address both the causes and symptoms of challenges, including those facing underserved communities and stakeholders.



PLANNING

- ✓ **Create more deliberative and culturally inclusive upstream planning processes to build collective trust.**
- ✓ **Clearly define authorities and responsibilities affecting underserved community partners and related collaborators.**

- Task Force members representing vulnerable communities often spoke of being engaged only when in “reactive” mode to the pandemic—and often not at all. They also emphasized their need to be an integral part of upstream planning, as opposed to being asked or surveyed only for their input without being an integral part of the planning process.
- Others spoke of being treated with a paternalistic undertone, which degrades trust and prohibits positive collaboration. One example is to rethink food bank paternalism, which resulted in white food culture being pushed on brown and black/African American communities.
- Everyone felt that anti-racism, anti-ableism, and other anti-ism principles should be a fundamental, deliberate, and necessary part of planning processes.
- Many spoke of the need for a change in focus—from government *telling* communities, businesses, and others what they want them to do to *identifying* what they can do.
- Others noted that involving communities in upstream planning would help build social capacity and networks to better coordinate and share resources during emergencies.
- Some mentioned that collaborative planning efforts would help to deepen the connection between needs, resources, and equity, versus the current focus on scarcity that seems to characterize government budget personnel.

- Some community representatives expressed a hierarchy of neglect in governmental planning and ripple effects. For example, while many stories from communities of color noted significant gaps in service and support equity, others (e.g., those with intellectual/developmental disabilities; sight and hearing impaired; seniors) experienced other lack of attention, forcing advocates and CBOs (and even state agency departments) to scramble to address individual's needs without cohesive centralized planning or apparent recognition of vulnerability and impact. In addition, a historical shift away from institutional residential services to home- and community-based services (e.g., for seniors, people with disabilities) highlighted a further lack of planned support for community-based residents, as they lack the potential response advantage of organized congregate living.
- Task Force members felt that an investment in participatory upstream planning that is inclusive and culturally sensitive would result in better outcomes and collective trust, including a more flexible framework that avoids reactive "one size fits all" (and fragmented) solutions during emergencies.
- Others recommended creating a document library of best practices, strategies, and improvements from lessons learned to support future planning.
- Some members noted the need for better planning for those who became marginalized in shelters. County rules changed numerous times, which prevented many from qualifying for isolation centers.
- Others recognized a need to identify and map service barriers in advance as part of the planning process. This could include a lack of personal protective equipment (PPE), vaccination center placement, and concentrated areas of isolated seniors.



COMMUNICATION

- ✓ **Streamline communication between state administration, state agencies, local governments, associations, unions, service providers, and community partners through effective, trusted, and agreed-to frameworks, enabling timely feedback and coordinated response.**
- ✓ **Determine where and why top-down responses were effective or ineffective with diverse communities.**
- ✓ **Evaluate impact of silos (between governments; between governments and CBOs; between CBOs and other community partners), to identify leverage points for communications improvement.**

- Task Force members often spoke of fragmented and uncoordinated communication, lack of effective communication access points, and chaotic responses. Others noted improvements after the initial COVID-19 phase but were still often perceived as inconsistent. Community organizations frequently felt left out and scrambled to search for resources on their own.
- At times, members experienced conflicting messaging from state and local authorities, which created confusion and wasted energy.

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- Some members spoke of siloed government and healthcare delivery structures as a key root cause of fragmented communication and response effectiveness. Evaluate community impacts from silos across government with respect to communication deficits.
 - Focus on underserved and isolated communities, including BIPOC, those with disabilities, and those living in food and healthcare deserts.
 - Identify the communication and cultural gaps that impacted response effectiveness between different levels of government, communities, and providers.
 - Improve public health communication between local public health agencies and DOH to ensure that local voices are valued, and that information flows back up to DOH in a timely manner.
 - Carefully structure and time different feedback loops in a communications framework to identify suffering more quickly at all levels, including disproportionate impacts on underserved communities. Use feedback loops to quickly adapt to inform and implement response.
 - Create templates to help county government and leaders operate during crises and communicate effectively with their constituents.
- Communication and messaging with different community cultures require different approaches.
 - Create communications in non-English languages to keep information current. Need multi-lingual communications from government, NGOs, the faith-based community, and others to properly distribute food and other resources and improve outreach.
 - Avoid military-style efforts (e.g., tents) with BIPOC communities, as they engender lack of trust; instead, conduct weekend/community convenings in a more family-friendly atmosphere. Ensure that events meant to communicate integrate culture (music, food, and other cultural components).
 - Ask diverse communities which methods work best to improve communication (and feedback). Avoid one size fits all. Communities with disabilities require different forms of effective communication to best fit their needs.
- Create consistent communication and messaging about continuity of care in community-based health care providers. For example, more consistent messaging around pharmacy capabilities and timing, including immunizations and educational services could have mitigated much confusion, wait times and lost productivity.
- Improve communications from the Governor's office and state agencies to be authentic, transparent, honest and credible. Create new messaging techniques to reach people at home, senior and other types of congregate housing, shelters, and others more rapidly and effectively. Focus on those who are technically challenged.



COLLABORATION AND PARTNERSHIPS

- ✓ **Develop/grow/sustain effective partnerships experienced throughout the pandemic to avoid losing momentum.**
- ✓ **Improve trusted relationships between sectors and industries; leverage pandemic experimentation between private/public/NGO partnerships to advance equity and quality of life.**

- Task Force members experienced mostly positive impacts from a variety of statewide, regional, and local partnerships. Some were based on different levels of inter-government collaboration to address immediate needs, such as setting up vaccination, isolation, and quarantine centers and “pop-ups.” Others included government partnerships with private industry to manage data more quickly for decision-making, including Microsoft and Amazon. Still others included community-based partnerships, borne of necessity; for example, tribal leaders and communities helping other skeptical communities of color with vaccination progress around operational and cultural barriers.
 - Continue to build tribal public health officer partnerships with local health jurisdictions; include tribes in local health communications as sovereign entities and collaborative partners.
 - Maintain regular meetings between tribes, AIHC, and DOH to avoid losing pandemic lessons learned.
- The stories of collaboration shared in the Task Force meetings were often inspirational. Members repeatedly noted the need to capture this experience, and leverage it to scale, export, and maintain these relationships post-pandemic.
 - For example, the Washington State Department of Agriculture (WSDA) presented a significant experience involving how the pandemic changed their context of working with the hunger relief sector. This experience might have changed the way WSDA operates in the future. There may be lessons learned from this systemic experience that are applicable to other industries and sectors.
 - Create a coordinated hunger response system to help WSDA allocate resources.
- Identify communities who have experienced and continue to experience cultural marginalization, and those who may experience barriers to identifying and accessing trusted information in Washington (based on historical experiences). Focus on identifying trusted community representation to build partnerships and establish open lines of communication and information sharing.
 - For example, improve the relationship between the Pacific Islander Community Association and local health care providers, to consider employing Pacific Islanders who practice traditional medicine. Pacific Islanders were disproportionately and significantly impacted by COVID-19.
- Redefine community ‘partnership’ and ‘collaboration’ models and beliefs within government to consider longer-term need, value, and impact; avoid paternalism and genuinely recognize the value of local decision-making. Create positive options for partnerships with non-English speaking communities.
- The state should have a process in place to collaborate with organized community networks when offered.



GOVERNANCE, DECISION-MAKING, AND ACCOUNTABILITY

- ✓ **Evaluate the distribution of leadership and decision-making authority to determine how centralized and distributed decisions impacted vulnerable communities with positive and negative results.**
- ✓ **Implement systemic change to address future emergencies as well as opportunities to improve equitable quality of life during non-emergent times.**
- ✓ **Implement accountability based on the comparative value of improved decision-making authority between centralized, regional, and local focus and shared decision-making, potentially including public, private, nonprofit, and other community representation.**

- The Task Force engaged in less-detailed discussion around this issue area but communicated the pressing need to carefully review how decisions (at centralized and distributed levels) were made, what conflicts and resulting impacts arose, and what an improved process of decision-making might look like.
 - Task Force members felt the impact of confusing and changing authority structures at the beginning of COVID-19, which created adverse experiences in communities. Organizations and people questioned who was in charge, and who was making decisions. Confusion resulted in decreased credibility and the feeling that communities were on their own to bootstrap solutions.
 - Members recognized the challenges of emergency-based decision-making; many believed that local communities were too frequently the recipients of confusing and sometimes conflicting decisions made at different governmental levels. Local county governments were often caught in between, without an adequate playbook. State government had to make time-sensitive decisions (especially early in the pandemic) without comprehensive information during an unprecedented time.
 - Members felt the importance of understanding which existing structures were used, modified, or ignored to recommend specific improvements. In addition, many believed that understanding who was excluded from those structures would help identify gaps and improve processes moving forward.
- Many Task Force members suggested that communities could match accountability to increased decision-making authority and responsibility. Several noted that the state must go further to recognize the value of local decision-making, change the process to benefit from local understanding of diverse community needs, fund those needs, and then make communities accountable. Metrics to measure accountability could be developed and agreed to between community partners, local governments, and the state.
- County government members suggested that locally informed public health input into centralized state public health decision-making could include other county officials, for example, to help make decisions about vaccine placement.
- Several members recommended developing a pandemic template or checklist for local jurisdiction planning and execution with practical steps to help local governments and

communities plan for and work together more effectively, as well as clarify understanding decision-making authority.



ACCESS TO SERVICES AND SUPPORTS

- ✓ **Evaluate how services, support, and supply chains were triaged and distributed, including impacts on vulnerable communities.**
 - ✓ **Understand how to meet the essential needs of communities, including underserved communities. Determine how to reduce community vulnerabilities by implementing equitable change.**
 - ✓ **Create equity strategies for access to essential services, including education, healthcare, small businesses, transportation, and other publicly and privately supported needs.**
 - ✓ **Create standardized and agreed-to language around equity and access at all leadership levels.**
 - ✓ **Simplify access points and feedback loops for communities to use to improve delivery, messaging, and support.**
- Task Force members noted that barriers to access emerged in many forms, ranging from access to healthcare and PPE delivery and distribution, to data sharing, to appropriate food, to timely capital and cash assistance.
 - Several suggested that BIPOC communities should not have to do more work than others to prove their need for resources.
 - Others recommended placing more trust in those who do direct and solution-based work at the community level. Greater scaling and fewer barriers might create expanded and trusted access points in communities.
 - Small businesses, including minority-owned businesses, experienced significant barriers to accessing loans and grants due to English-centric communication norms, financial institution barriers, and other barriers. Small businesses are substantially cash-flow sensitive—when short-term cash flow and capital dry up, they are at greater risk for insolvency and closure. This creates a vicious cycle, as underserved communities are more dependent on small businesses to provide their residents with goods, services, and support. In addition, small businesses are less structured administratively, which creates further barriers to accessing capital.
 - Specify distinctions between small businesses and micro businesses to help plan for crisis response and differing needs and requirements.
 - Consider the linkages between cultural competencies and improving community access and utilization. For example, tribal elders led forward and demonstrated vaccine acceptance to their communities, who followed their lead.
 - Address access to vulnerable populations who normally have significant access barriers during non-emergent periods. For example, increase access to remote therapies, supports, and technology for people with disabilities, including physical, intellectual/developmental, sight and hearing, as well as their caregivers. The most

vulnerable populations (and caregivers) should be the first to access vaccinations and services.

- Consider changing food resource allocation to incentivize increasing access and reducing hunger rates.
 - Source food locally to mitigate national supply chain issues and invest in local food economies. Provide local access points for local food. Food becomes more than nutrients, especially during emergencies. Culturally insensitive food distribution delivers the wrong food to the wrong people.
 - Use human-centered design to define food distribution points, such as food pantries in schools.
 - Focus on access to fresh produce.
 - Improve food emergency preparedness by expediting state resources, creating rapid supply and demand assessment, and moving to a single distribution model.
 - Create support for a food supply chain to quickly transition from restaurant packaging to food bank distribution packaging.
- Hospitals were used as a safety net when other systems were compromised. Evaluate creating separate and distinct supply chains for hospitals to preserve their safety net status during pandemics/emergencies.
- Create implementation strategies to shift in-state manufacturing capabilities to quickly produce needed emergency products.
- Evaluate the role of federal resources (requested versus delivered), as well as federal funding's impact on delivered goods, supports, and services in Washington.



DATA/INFORMATION USE, ACCESS, AND EFFECTIVENESS

- ✓ **Analyze existing systems from the context of equity and under-served populations. Identify and mitigate important informational gaps by disaggregating data (by detailed race/ethnicity, type of disability, other categories) and improving collection details and techniques. Consider data sharing and coordination processes to address timing lags and the potential use of streamlined data to target the most vulnerable populations.**
- ✓ **Identify data deficiencies related to businesses, including ties to funding access and impacts of setting/assessing/lifting emergency orders.**

- Task Force members relayed a sense of one-way data sharing—up rather than down. Many felt this left communities guessing about status, changes, and trends and yearning for a more collaborative information-sharing approach.
 - Members envisioned useful and practical ways for collaborating organizations to communicate, share, and feed information back, including shared dashboards developed with community input. More effective information can lead to better decision-making and downstream forecasting of ripple effects.
- Some recommended incorporating qualitative data into reporting and measurement, to help weight stories and lived experience. Much real-time information from communities is qualitative.

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- Design metrics with community input for reporting and accountability. One size does not fit all.
- Data-collection and -reporting should be improved to address the needs of the most vulnerable populations, including but not limited to those with disabilities and communities of color.
- Update systems to make data available equitably to all counties. Create data reciprocity between the state and nonprofits to enable faster decision-making and implementation of community solutions.
- Evaluate all data sharing agreements to improve sharing efforts (for example, DOH datasets, umbrella tribal data sharing agreement) to improve tracing and testing and to share the burden with local health jurisdictions.
- Improve the management and communication of quickly emerging/changing information changes and updates. Emergent situations require shared information (with community and business partners) on a nearly real-time basis.
- Improve data collection to assess hunger risk and food bank utilization.
 - Regularly assess data across food assistance programs. Use to improve enrollment in food assistance programs, distribution, and allocation of food resources, and inform opportunities for local food access.
- Improve collection of minority-owned business data to identify where funding goes, where gaps exist and how to support small businesses.
 - Use data to better inform when to lift business restrictions and protect economic interests, as well as more effectively forecast small business risk.
 - Small counties need access to centralized info identifying minority-owned businesses to provide targeted assistance, rather than relying on personal networks.
- Improve housing/caregiver services/workforce data tracking for those with disabilities, including intellectual and developmental disabilities, who frequently live in community-based settings.



WORKFORCE

- ✓ **Everyone is strained during a pandemic – there is a need to break vicious cycle loops during the worst parts of a crisis, which requires trusted advance planning between an expanded set of partners.**
- ✓ **Build consensus understanding around community support inequities. Create value for community-based work and support in an overall system that lacks capacity and continues to lose capacity.**
- ✓ **Understand and address the impact of current operational limitations and workforce burnout, and its impact on vulnerable populations and communities.**

- Task Force members recommended investing in community worker relationships to increase community resilience and improve emergency planning.

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- Develop, train, and scale the medical reserve corps/healthcare reserve/emergency volunteer network to support broad community health work, support work, and the non-volunteer workforce.
 - Create rapid training for citizens to augment emergency response when capacity is limited.
- Put draft contracts in place to be refined and executed quickly in the next emergency.
- Recognize and compensate community workers in housing and homelessness services as part of an emergency response structure/first responder network.
- Create childcare/eldercare options for communities of color and other underserved communities, including rural options. Business owners and teens were especially impacted by diverting their time and resources to care for family members, causing negative ripple effects.
- Continue to support strategies implemented through the COVID-19 pandemic for small businesses to maintain their workforce during emergencies.
 - Washington state created the Small Business Resiliency Network (SBRN), as a hub to create a support administrative structure for small businesses, including applications for loans and grants More details are provided in **Section 3**.
 - Develop a model that requires corporations to pay small business' accounts receivable within 30 to 60 days, to mitigate minority-owned business cash flow impact during emergencies.
- Identify sustainable investment opportunities to continue to support unemployment compensation for undocumented workers. Using Coronavirus Aid, Relief, and Economic Security Act (CARES) and American Rescue Plan Act (ARPA) funding, Washington state provided financial support to immigrant workers who did not qualify to receive federal economic impact payments or unemployment insurance.
- Mitigate crisis burnout with more effective upstream planning, improved funding of support networks, and improving effective and shared responsibilities.
- Prioritize the use of the National Guard, including consideration of cultural sensitivity.



ADMINISTRATIVE SYSTEMS

- ✓ **Simplify the administrative burden on community-based organizations and local governance to allow the full system chain of participants to become more effective with limited resources.**
- ✓ **Current administrative systems are generally too complex for communities and local systems to work with. In their current state, they create forced compliance rather than true partnerships.**

- Task Force members felt there were too many systems to learn. Coupled with a lack of coordinated communication, this created untenable barriers to getting things done at a local level.
- Create solutions to administrative burden that are publicly centric, and not politically centric. Reevaluate and map existing systems to identify where heavy regulatory or other forms of burden create barriers to local implementation of solutions.

- When multiple layers of authority are absolutely required during emergencies, do everything possible to streamline and accelerate approvals.
- Reduce administrative barriers to help food distributors assist communities and individuals. For example, waive documentation requirements when individuals or families are receiving food.
- Evaluate local regulations and restrictions that became a significant burden on small businesses that struggled to remain open.
 - Evaluate and automate administrative systems affecting small businesses that lack resources or experience to navigate through administrative mazes, to help maintain and sustain them during emergencies.
- Recognize and reform burdensome activities that inflame racist history (for example, the history of case investigation, which requires building community trust to be effective).



FUNDING

- ✓ **Community based organizations, other nonprofits and public health are chronically underfunded during non-emergencies. Pushing their resources too hard is not sustainable, especially during a prolonged pandemic.**
- ✓ **Create new, creative trusted funding models that are innovative and where funding is shared in partnership between public, private (including foundations) and other sources. These models should focus on both equity to the most vulnerable populations, as well as downstream ripple effects, including positive virtuous cycles, as well as consideration of unintended consequences.**

- Task Force members shared stories of funding gaps, funding timing deficiencies and how the pandemic made existing gaps more visible.
- Many felt the state should stop telling communities what they need and start listening to what communities need. Some noted that foundations trust community judgement – why not the state? Members felt that funding models should be community-informed, consistent with community input on decision making. Others felt the state should simply write the checks and conduct the oversight.
- Stabilization and predictable cash flows are most important to small business and CBO sustainability. Plan for future mitigation of boom-and-bust cycles.
- The state can leverage relationships with federal entities to advocate for more flexible funding processes related to future federal emergency assistance programs. The state received financial assistance through CARES and ARPA programs to support the needs of communities throughout the COVID-19 pandemic, however that funding comes with prescribed parameters resulting in limited flexibility on the state's part as to eligible activities allowed to be funded and the criteria to determine edibility to receive funds. The following provide some challenges experienced through the pandemic and considerations for funders moving forward to improve the financial assistance process:
 - Provide up-front funding that is transparent and non-paternalistic, to provide access to funds ahead of time. Not all small businesses and non-profits can pay for things in advance.

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- Small organizations cannot comply with burdensome funding criteria.
- Streamline burdensome loan processes such as the Paycheck Protection Program (PPP) for small businesses.
- During emergency proclamations, reasonably protect small businesses from liability (while enforcing the emergency rule).
- Continue to focus on funding small organizations who do direct community work, rather than continually funding the same larger organizations over time.
 - Washington state provided financial support to many local organizations through CARES funding to support continuation of vital services. More details on use of CARES and other available funding streams are included in **Section 2.4**.
- Some members felt that the state should be obligated to buy PPE, after asking businesses to pivot to manufacture PPE (for example, distilleries shifting to manufacture hand sanitizer).
- Minority-owned businesses need quicker access to needed capital. Streamline systems for equity, funding, and accountability.
 - Grants are not the most effective use with small businesses to limit economic damage. Small businesses do not have the money to hire grant writers or legal advisors.
 - Set up prompt payment terms to mitigate minority owned business cash flow risk.
- Direct state appropriations towards the emergency food system.
 - Direct significant investment and infrastructure overhaul to support and incentivize BIPOC-owned organizations providing food access
 - Provide more flexible cash assistance options to people with hunger, streamlined through local points of access.
 - Donated food was replaced with purchased food during the pandemic. Stabilize funding for the food distribution model to avoid funding gaps, lost staff, and volunteers.
 - Provide funding for under resourced food security CBOs and grassroots organizations. Expand partnerships between grassroots organizations and established food distribution agencies.
- Explore tax increment financing for small businesses.
- Improve business insurance relative to event insurance language.
- Continue to support and fund resources such as phone banks and call centers staffed with trusted community leaders and members to provide a resource of vital information such as the multilingual hotline Washington state support to provide information sharing across multiple communities during the COVID-19 pandemic.

As noted, the Task Force members recognized that the proviso language excluded areas of importance that were minimally explored during the Task Force meetings. For example, childcare and issues specific to rural communities were noted, but not discussed to a great extent. The Task Force recommended that these and potentially other important areas should be the focus of further work.

2.2. Equity Gatherings and Engagement Opportunities: Lessons Learned and Recommendations

Information contained in this section was gathered through a series of Equity Gatherings and additional engagement opportunities that were conducted in collaboration with the State Pandemic Task Force and reflects the opinions and experiences of the participants.

Context

Many Americans faced unmet basic needs prior to the COVID-19 pandemic, which was compounded by disparities and marginalization that exists because of structural, systemic, and institutional racism and other 'isms. The impacts of COVID-19 spotlighted underlying social and economic issues. As the COVID-19 crisis developed, it became clear how essential schools were to communities and how much communities depend on schools to meet family needs, such as daycare, meal provisions, and child abuse prevention, in addition to meeting the educational needs of children. This dependency on schools for meals and hunger relief especially highlighted how far-reaching food insecurity is in communities. Additionally, aging communities and persons with disabilities are often underserved and during COVID-19 concern arose that their needs were not fully understood or addressed. The ability to provide equitable services may have been hindered because of different ideas of how to address equity and differing desires to address inequities. "One size fits all" approaches often do not work as they don't account for the unique cultural, geographic, and social aspects of different communities, including differences between rural and urban communities. It will be important to continue to understand the geographic differences in order to appropriately align with the differing needs of urban and rural communities.

It became clear during the response to the pandemic that cultural responsiveness must involve meaningful engagement and outreach across communities. Also, it became clear that community organizations and leaders struggled to provide essential and culturally sensitive services during the pandemic response with minimal additional resources, often depending upon volunteers to fulfill fundamental necessities such as food services. There were many examples of community organizations collaborating and developing partnerships that lowered the barriers and reduced bureaucracy that often hinder services to individuals and families in need.

Pertaining to the work environment, the COVID-19 pandemic ushered in a new way of working. As many workers lost jobs, and work environments were changing, so did workers' attitudes about how they work and what they are and are not willing to accept. This created a staffing crisis in some areas and feelings of freedom and creativity in others. This creativity coupled with the desire to keep as many people working as possible expedited the adaptation to virtual work environments, "working from home". There were many lessons learned while working from a virtual work world. One lesson shared was that level of daily microaggressions towards those in BIPOC communities were greatly reduced by not being in offices. Additionally, people with disabilities shared that new opportunities were opened to them with the expansion of teleworking.

Introduction

From the beginning, the State Pandemic Task Force members, based on experiences navigating the COVID-19 pandemic, requested a greater focus on equity throughout this Task Force process. Inequities in underserved communities rose to the top of that list. The historical and ongoing impacts of institutional

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and systemic racism were exacerbated by the impacts of COVID-19, some of which are expressed through the Equity Gatherings and engagement opportunities. These underlying issues were further highlighted by the public murder of George Floyd and subsequent protests that occurred during the pandemic. An increase in awareness occurred because many people were following stay-at-home orders, which increased their access to news.

In response to the State Pandemic Task Force's request for an increased focus on equity, a series of two-hour Equity Gatherings, one-on-one interviews, and small group engagement opportunities were conducted. These gatherings were open not only to Task Force members. The purpose of these engagement opportunities was to facilitate discussions on specific topics to better understand the challenges faced by communities as well as identifying potential recommendations and considerations for addressing challenges. Early Task Force discussions helped inform the Equity Gathering topics, which included subjects that were not specifically referenced in the legislative proviso language.

The Equity Gatherings and engagement opportunities included:

- "Come one, Come All" Group Facilitated Discussion
- "Disability Community" Group Facilitated Discussion
- "Food Insecurity" Group Facilitated Discussion
- "Washington state agency staff leading equity initiatives" Group Facilitated Discussion
- "Black/African American" Group Facilitated Discussion
- One-on-one and small group engagement activities for the Latino Community

Participants in the Equity Gatherings shared their views from both their personal perspectives and their professional experiences. Participants identified lessons learned, gaps and potential recommendations, while recognizing what went well and the important contributions made by community-based organizations and leaders in response to the challenges they faced. It is important to note that many complexities existed on all levels as individuals, communities, community-based organizations, and state staff worked to respond to the needs of Washington residents.

Through these engagement opportunities, there were several statements made as to why a focus on equity is important. A few examples of these statements include:

- ***I've had experience working with families during the pandemic. It's important to make suggestions for those who haven't had this experience.***
- ***Need to provide an equitable environment for people to thrive. Health is the foundation.***
- ***Everyone deserves to live a healthier life. Our society was unaware of health inequities. We have a responsibility to do something about that.***
- ***COVID-19 provided the evidence: We developed a vaccine, but we couldn't convince people to get vaccinated. This should be investigated as an equity question.***

On June 11, 2020, King County declared Racism as a public health crisis.

Racism is a public health crisis. 1) It threatens communities across the United States by causing health inequity, depriving individuals of vital access to healthcare, and resulting in higher death rates, shorter life expectancy, higher severity of disease, and lack of access to treatment; 2) Structural racism is a root cause of several health disparities, manifesting through laws and policies that create barriers to equitable and high-quality care; and, 3) In addition to individual acts of discrimination, structural racism invades systems of power, informing decision making and furthering health inequity.

These same structures exclude people with disabilities, resulting in health disparities. People with disabilities are more likely to be denied health care than people without, as inequities are fueled by discriminatory and antiquated views of disability. When understanding the impacts racism has on the health of communities, it is vital to use an intersectional lens – racism often does not occur in a vacuum, but intersects with other forms of discrimination, including discrimination on the basis of ability or socioeconomic status. Using a lens capable of recognizing this layering of discrimination is necessary especially in public health and emergency response.”

- Public Health - Seattle and King County COVID-19 After Action Report

There is a strategy called Targeted Universalism. “Targeted universal strategy is one that is inclusive of the needs of both the dominant and the marginal groups but pays particular attention to the situation of the marginal group” (Powell, 2008). Targeted Universalism is a framework that can be used to pursue equity. This strategy to pursue equity goals can work as it recognizes the differences in cultures and communities. The goal of Targeted Universalism is to provide people, groups and communities with what they need– Targeted–to reach Universal goals to be successful. When considering the underserved groups and communities, the responses to and impacts of Covid-19 increased the urgency to address long standing needs that have gone unaddressed; reflected in one participant’s statement: “If not us, who, if not now, when”.

Methodology

To coordinate the Equity Gatherings and engagement opportunities, State Pandemic Task Force members and community members were asked to provide input to help plan the gatherings and conduct outreach.

For each Equity Gathering and engagement opportunity, the following questions were posed to the participants and framed around each specific topic area. The information presented in each section reflects statements, opinions, and experiences expressed by the participants during the gathering.

1. What key lessons have you learned during COVID-19?
2. What themes and gaps have emerged?
3. How did COVID-19 exacerbate the current issues caused by institutional, systemic, and individual racism and ableism?
4. What recommendations would you convey to the State Pandemic Task Force?
5. Consider the equity “why,” meaning why is equity important to consider.

Key Definitions: The following terms are used throughout this section and are defined below for context and clarity.

- **Ableism** - Ableism is a set of beliefs or practices held by people without disabilities, that devalue and discriminate against people with physical, intellectual, developmental, mental health, or other invisible disabilities and often rests on the assumption that people with disabilities must be “fixed” in one form or another. <https://cdrnys.org/blog/uncategorized/ableism/>
- **Equality** – Equality refers to the concept that everyone receives the same thing.
- **Equity** – Equity refers to ensuring that each person receives what they need individually, as well as racial/cultural groups in order to thrive.

“Come One Come All”

This gathering was available to anyone who wanted to share knowledge, learning, and recommendations. There were participants from both CBOs and state agency staff.

Lessons Learned

- Many BIPOC communities have experienced increased racism and disproportionately negative impacts throughout the COVID-19 pandemic.
- Public health measures mandating that individuals remain at home created challenges for many BIPOC communities who live in multigenerational households.
- There is insufficient information on how different cultural communities were impacted by policies, mandates, programs, and response operations during COVID-19. A review is needed to identify opportunities for improvement.
- Misinformation traveled quickly through social media and impacted people’s choices and behavior.
- The politicization of public health was a challenge to some communities.
- The root causes of health disparities must be better understood and researched in order to implement solutions.

Themes and Gaps

- The participants expressed that relationships form between individuals, not necessarily with organizations. Relationships were critical to effective responses. Conscious structures must be put in place so that, when individuals change roles or leave, new relationships and collaborations can be developed.

How did COVID-19 exacerbate the current issues caused by institutional, systemic, and individual racism and ableism?

- Individuals with preexisting conditions were more at risk for health challenges throughout the COVID-19 pandemic.

Recommendations

Participants provided the following recommendations and considerations:

- Create an initiative to determine ways to redesign the current healthcare services system to include long-term strategies to deal with implicit biases caused by systemic and

structural racism that continues to cause harm to BIPOC communities when engaging healthcare services and providers for more equitable services.

- Advocate for culturally appropriate/responsive education efforts to increase the historical understanding of how/why institutional, systemic, and structural racism came to be and the historical and current impacts.

“Disabilities Community”

Several individuals, organizations, and disability advocacy groups participated in this gathering. It is important to state that people with disabilities had a variety of experiences during the COVID-19 pandemic, and those experiences were likely based on the impacts of differing mandates put in place based on federal, state, and local regulations and guidelines. The lifestyles (for example, living in institutional settings versus multi-generational homes), independence, and needs of people with disabilities vary, and these differences are important to consider when developing responses to a crisis.

When discussing underserved targeted groups, we must reflect on how those with privileged identities show up, which is referred to as Ableism, as defined above. Ableism is discrimination and social prejudice against people with disabilities and/or people who perceive themselves as disabled.

The Arc of Washington State and the Disability Empowerment Center provided vital support and coordination in the planning for the Disability Community Equity Gathering, contributing to the success of this gathering.

Lessons Learned

In some cases, people felt as if:

- The standard operating procedures did not include people with disabilities.
- Those with disabilities are viewed by society as devalued and diminished; thus, they feel left out of critical planning activities.
- Generally speaking, the general public does not have a great deal of exposure to or understanding of the needs of people with disabilities, and this created an inclusivity issue.
- People with disabilities felt left out of comprehensive planning for a pandemic—therefore feeling devalued and dispensable. An example includes those who are dependent on in-home care and their providers feeling left out of planning for and distributing PPE to their homes.

Themes and Gaps

- Considerations for those with disabilities are often an afterthought. The COVID-19 pandemic created more of a divide between people with disabilities and those without disabilities. Some believe that the lives of those with disabilities are considered expendable.
- New work opportunities were available to those with disabilities throughout the COVID-19 pandemic when businesses pivoted to remote work environments.
- Increase engagement with community organizations and individuals who support those with disabilities on a daily basis to provide guidance and assistance on services that may be needed. Overwhelming requirements for documentation to justify eligibility for services can present an undue burden on those with disabilities.

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- Many people with disabilities who live in the community by choice (rather than in institutional care facilities) may be reliant on in-home caregivers and were thus unable to isolate. This subjected them to increased risks of exposure and disease transmission. People with disabilities were not prioritized or acknowledged as a group who were disproportionately affected by the virus. It was stated in the gathering that people with developmental disabilities were up to 10 times more likely to die or be hospitalized from COVID-19. They felt largely invisible due to their focus on care for those in “facilities.”
- Some felt that insufficient data was gathered to measure the specific impact on people with developmental disabilities. Data gathered neglected to address specific disabilities. Needs may vary based on one’s disability. Those who are deaf have different needs from people who are blind, as do those with mobility limitations, traumatic brain injury, sensory issues, and intellectual or developmental disabilities.
- Many of the lessons learned and issues identified during the Disability Community gathering were also relevant to older adults who receive in-home care - including those with dementia, who rely on others for their total care.

How did COVID-19 exacerbate the current issues caused by institutional, systemic, and individual racism and ableism?

- A great deal of advocacy was necessary to bring attention to the needs of those with disabilities and the increased risk of illness and death from COVID-19 exposure.
- There seemed to be a lack of infrastructure to provide accessible communication and information to some with disabilities. Websites and other information delivery methods used were often not fully accessible, nor was information provided in a timely manner.
- The pandemic seemed to amplify Ableism through a tendency to view those with disabilities as constitutionally fragile. For some individuals, that may be the case, but the one-size-fits-all model highlighted the patronizing mindset that infantilizes people and puts them into helpless boxes.
- Those in authority positions making the decisions during the response to the COVID-19 pandemic that often negatively impacted those with disabilities might have lacked the understanding necessary to make decisions, resulting in positive effects for those with disabilities.
- Those with English as a second language or who use written communications were often challenged to have access to critical information.
- Participants indicated that chronic healthcare needs for those with disabilities tend to be higher than average.
- Participants expressed that those with disabilities are often viewed as expendable. Access to healthcare, support and services, emergency services, and accessibility are all important equity considerations.
- A lack of provisions and options prevented a safe environment for students with complex medical needs as children returned to school facilities.
- Solutions to address the needs of those with disabilities often were delayed or inadequate, leaving those individuals to find their own alternative solutions.
- Keep in mind that those with disabilities are a diverse group, and when some offer a perspective that does not mean they can “speak” for all.

Recommendations

Participants provided the following recommendations and considerations:

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- When planning for pandemics, those responsible for comprehensive planning should expand planning efforts to include the whole community, including persons with disabilities.
- In-home care providers should be considered a part of the healthcare system and prioritized to receive PPE.
- Use universal design principles to prioritize people with disabilities.
- Continue the effort to increase access to technology, such as broadband.
- Make grassroots community support systems a part of the essential long-term infrastructure by ensuring those representatives of the community are involved in decision making.
- Increase and strengthen partnerships across service silos.
- Increase investment and resources in rebuilding the personal care workforce.
- Identify opportunities to increase education and awareness of accommodations.
- Ensure that standard communication practices include providing information in a variety of languages and formats.
- Responders and crisis decision-makers in local, regional, and state government should coordinate, collaborate, and form relationships with the vast network of care providers who serve people with developmental disabilities and other disabilities in the community (rather than solely in facilities) before the next pandemic.

“Food Insecurity”

Participants in the Food Insecurity Equity Gathering included various members working in the food insecurity field, including government, food banks, food pantries, local farmers, and other CBOs. In this discussion, many noted that issues of equity and bias are not always recognized in hunger relief efforts, such as providing culturally relevant food or who distributes and how the food is distributed.

Lessons Learned

- Based on lived experiences and historical precedents, there is some distrust of government and institutions from many disenfranchised communities (BIPOC communities in particular).
- The requirement to provide documentation of citizenship created a barrier to access to food resources for some undocumented families.
- Mutual aid, peer, and grassroots food distribution led by BIPOC communities fill a critical gap in the “conventional” emergency food system.
- Food insecurity intersects with health disparities.

Themes and Gaps

- Low-income communities of color continued to face the brunt of the issues around accessing food.
- When programs are rapidly deployed, there can be challenges with implementation, and it is difficult to track and learn from these challenges in real time.

How did COVID-19 exacerbate the current issues caused by institutional, systemic, and individual racism and ableism?

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- Some participants expressed that they felt that there was a competition for food resources among demographic groups versus multi-racial, multicultural groups in solidarity to help each other.
- Low income, BIPOC, immigrants and refugees, people with disabilities, older adults, and those experiencing homelessness, among others, were disproportionately impacted.
- BIPOC, immigrant, and refugee communities continue to have many barriers to access funding, resources, power/influence, and program benefits.
- Participants indicated that the use of volunteers at food pantries can present challenges.

Recommendations

Participants provided the following recommendations and considerations:

- Provide culturally relevant foods.
- Recognize food as a human right.
- As part of emergency planning, a deeper understanding of how decisions affect communities that are vulnerable or that have been historically marginalized and underserved is necessary to better anticipate the needs of a community and provide needed resources and support in times of emergency.
- Identify opportunities to increase land ownership for rural farm workers who work the land to provide culturally appropriate food to better sustain themselves, especially during an emergency.
- Capitalize on the innovations developed and operational changes made by emergency food providers during the COVID-19 pandemic and continue investments to strengthen and increase food sovereignty and long-term community-based solutions versus hunger relief programs. Address the causes of food insecurity.
- Allow local communities to determine their needs, versus assuming what they need, then support with available resources and work to limit the restrictions on resources.
- Improve universal access to food support by removing reporting barriers. Develop funding sources with fewer data-reporting requirements.
- Identify opportunities to create more infrastructure to support and incentivize collaboration between food banks, mutual aid, and local farmers.
- Move the distribution and control of resources, funding, and programs to the local level, where appropriate. Allow policy and program decisions to be as flexible as possible and developed in collaboration with BIPOC-led CBOs, food banks, etc.
- Identify opportunities for BIPOC-led organizations, CBOs, and community navigators to administer more food system and hunger relief grant work.
- Identify funding opportunities and resources for improved physical, technology, and distribution infrastructure.
- Develop collaboration between emergency planners and hunger relief organizations to inform future emergency plans and develop joint scenarios for future disasters.
- Identify opportunities and funding to increase access to culturally appropriate foods.
- Provide increased emergency management training and emergency preparedness resources for schools. Work toward providing universal meals for all students across the state.
- Identify and build upon lessons learned during the pandemic regarding the role schools played as centralized distribution points for food, PPE, hand sanitizer, and technology, especially in rural communities.

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- Identify opportunities to systematize hunger relief programs, including identifying opportunities for more formal collaboration among the federal, state, and community-based programs and operations.

“Washington State Agency Staff Leading Equity Initiatives”

Participants in this gathering included agency staff who are currently leading equity initiatives in state government. The initiatives were not necessarily related to the COVID-19 response.

Lessons Learned

- Participants noted that differing definitions, understanding, and commitment to equity are felt in the enthusiasm to consider equity in decision-making. This shows up when tensions arise between speed and equity. Speed is often prioritized over equity.
- Resources created at the state level didn't always resonate in every part of the state. For example, the most common languages spoken in the state may not be the most common languages in some specific counties. Resources created for an urban context may not resonate in a rural one.
- In-home services were not often accessible because of the high risk of COVID-19 exposure.

Themes and Gaps

- The participants indicated that more collaboration and cooperation between state agencies is needed. Many state agencies were conducting townhalls and other community outreach. Information from these events was not always shared with non-participating agencies. More collaboration would increase efficiency and increase a shared understanding of needs and ways to address them.
- Public health systems were strained, even with additional funding from federal sources. The system struggled to ramp up quickly enough to respond. More planning needs to be done to build resilience.

How did COVID-19 exacerbate the current issues caused by institutional, systemic, and individual racism and ableism?

- Participants expressed that the digital divide was exacerbated for those not comfortable with technology, do not have access to the Internet, do not have a home computer, or do not use English when using technology.
- With limited time and resources, it seemed as though it was more convenient and expedient to support communities that were not the most in need of access and services.
- Some participants indicated that systemic racism became more evident in the contracting process. Considerations for expanding contracting to BIPOC communities felt like an afterthought. It often appeared that where people are comfortable receiving services was not considered in contracting, for example, the expectation that people of color would access services in a predominately white area.

Recommendations

Participants provided the following recommendations and considerations:

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- Be proactive instead of reactive when working with underserved communities. Use community input to inform future actions. Report back to communities how their input was used.
- Identify opportunities to expand engagement and build partnerships with CBOs that provide services and support to marginalized and underserved communities. Involve these organizations in emergency planning, training, and exercises to better understand the needs of these communities.
- Identify opportunities to develop institutional leaders at all levels from within the most impacted communities.

“Black/African American”

Understanding that racism is a public health crisis in America, it is important to understand that the impacts of racism—both historical and current—were exacerbated by the pandemic. Health inequities that already existed grew larger, and because of historical issues with Black/African Americans and the medical industry, i.e., Tuskegee experiments and other events, mistrust became more apparent as the call for vaccinations grew. Some African Americans believe that racism is the first Pandemic that has impacted African Americans for 100’s of years in the U.S. and other parts of the world. This is important because the recommendations speak to long-standing issues that were perpetuated and exasperated by COVID-19.

Lessons Learned

- Participants indicated that the effects of isolation at the beginning of the pandemic impacted the mental health of some Black/African American communities due to their relationship-centric culture. Limitations on interactions had serious impacts.
- Some older adults could not access telemedicine due to either a lack of, or unfamiliarity with, smartphones.
- Statements made by participants indicated that when school facilities closed, the gap in digital access became starkly apparent, especially for low-income students and their families. There was a lack of access to both technology and the Internet. Parents were also affected, as many lacked the skills necessary to help their children. This further burdened schools and social service providers who work with these families.
- Families living in multi-generational homes had increased COVID-19 risk and had fewer options for isolation and quarantine.
- Participants stated that co-morbidities and a lack of health insurance increased COVID-19 risk factors for Black/African Americans.
- Participants expressed that systemic issues, such as those in education and the criminal justice system that have plagued the Black/African American community for hundreds of years, were further highlighted by the pandemic. Due to public health measurers requiring people to stay at home, more individuals increased the time that they watched television and news, bringing increased visibility to events such as the murder of Mr. George Floyd and the subsequent nationwide protests.
- Participants shared that financial disparities that impact the Black/African American community left many families unprepared for burial expenses.

Gaps and Themes

- Participants indicated that there were limited services for children with developmental disabilities to address the lack of digital access, which created a barrier to education and other services.

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- Some public health measures meant limited access to services, such as critical therapies for children and adults with developmental disabilities.
- Participants stated that some parents caring for both young and adult children with developmental disabilities lost access to respite care (and school and therapies for young children) and were providing 24/7 care to children with needs, losing all support and breaks in care. This led to crises in many family homes.
- Some participants expressed that multigenerational homes and young adults might not have taken COVID-19 as seriously as they should.
- Equitable digital access was an issue in some Black/African American communities.
- Participants expressed that Black/African Americans experience disenfranchisement through the criminal “injustice” system.
- Participants felt that more data is needed to quantify the number of BIPOC households that provide care for older adults in the home and by family. Isolation presented an additional challenge to these households, and considerations are needed to ensure these households can access the care they need in a future crisis.
- Participants indicated that data are not disaggregated for the Black/African American community to determine the best ways to serve. Services for African immigrants and refugees are different from those for generationally U.S.-born Black/African Americans.

How did COVID-19 exacerbate the current issues caused by institutional, systemic, and individual racism and ableism?

- Participants expressed that resources for the Black/African American community were under-resourced and that the Black/African American community was overly impacted.
- Participants expressed concern about the loss of education for Black/African American students. The recent “Nation’s Report Card” published by the National Assessment for Educational Progress (NAEP) showed that education gaps for Black/African American students have expanded.
- Participants noted an increase in mental health issues due to isolation-increased trauma.
- Participants indicated the challenges associated with the lack of healthcare available to the Black/African American community.
- There may be a lack of trust for the treatment of health conditions.
- Participants also expressed concern regarding low-wage jobs and being essential workers, putting Black/African Americans at greater risk.
- There was expressed concern for the lack of employment for those who were coming out of prison or with a criminal history as a barrier to gaining employment.

Recommendations

Participants provided the following recommendations and considerations:

- Increase understanding of U.S. history and how this history impacts historical and current conditions that have led to the marginalization of the Black/African American communities.
- Improve investment in Black/African American communities and create different funding strategies that move away from community organizations competing with each other for funding. This has further marginalized Black/African American communities by creating a scarcity mindset. Move toward cooperative and collaborative funding models.
- Look to associations of Black psychologist and social workers for solutions for Black/African American mental health.

- Improve funding and culturally responsive mental health resources for Black/African American children and adults.
- Provide more resources for small Black/African American owned businesses and nonprofit organizations.
- Identify opportunities to offer or continue teleworking, as it lessens the microaggressions that Black/African Americans experience in workplace environments.
- Improve the policies of homeownership to increase housing equity.
- Increase education on implicit bias as a way to:
 - Improve healthcare
 - Decrease police brutality so that relationships between police and Black/African American communities can improve.

2.3. Engagement Opportunities with the Latino Community

For these engagement opportunities, Centro Cultural Mexicano, a nonprofit organization represented on the Task Force, suggested an alternative approach to the Equity Gathering model used for the previously described gatherings. They relayed that many community members may be experiencing meeting fatigue related to COVID-19, which appeared as a recurring theme in other gatherings. For this engagement, Centro Cultural Mexicano took the lead by facilitating one-on-one interviews with community members and small group discussions with CBOs who support the Latino Community.

Through the engagements, an important point was made regarding aging adults in the Latino community. Many Latino community members care for elders at home in multigenerational settings including carrying for elders with dementia. Due to this, health issues in the Latino community may be underreported. Those with dementia had a higher rate of COVID-19 vulnerability. Most elder deaths were not in care homes, but rather at private homes. In addition, fears in allowing strangers into private homes had a likely impact on secondary health concerns in the elderly Latino community contributing to additional negative outcomes.

Table 2 presents a summary of the themes that emerged from the engagement opportunities and recommendations. The information presented below reflects statements, opinions and experiences expressed by the participants of these engagement opportunities.

Table 2: Discussion Topics and Recommendations from the Latino Community

Discussion Topic	Recommendation
Communications	<ul style="list-style-type: none"> • Strengthen communication between government entities and the community prior to emergency events <ul style="list-style-type: none"> ▪ Spanish-language information to be shared at the same time as English-language information ▪ Provide targeted language access for smaller communities ▪ Used trusted entities for information sharing ▪ Awareness of anti-Latino messaging ▪ Cultural and linguistic approaches
Community Organizations	<ul style="list-style-type: none"> • Fund direct service community-based organizations and nonprofits • Provide sustainable long-term unrestricted funding

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Discussion Topic	Recommendation
	<ul style="list-style-type: none"> • Eradicate exploitative institutional behaviors • Provide weekend and evening services • Provide access to culturally relevant foods in food assistance programs • Use existing non-governmental networks • Understand how different communities have different needs- (eldercare/childcare)
Business Community	<ul style="list-style-type: none"> • Provide resources for small businesses • Provide mentoring for small businesses to access emergency programs in Spanish • Clarify language around programs like Paycheck Protection Program • Prioritize workforce development for Spanish-speaking professionals in health care and mental health care fields
Essential Workers	<ul style="list-style-type: none"> • Clarify classifications of “essential workers” • Provide adequate protections, information, and resources regardless of workplace environment • Provide equitable allocation of resources • Provide equitable geographic access to resources • Prioritize resource allocation • Phasing plans for vaccinations must prioritize vulnerable jobs! For instance, Latino restaurant workers had one of the highest incidences of outbreak, but never made it into phasing plan until the very end
Youth and Education	<ul style="list-style-type: none"> • Provide access to mental health services • Build up mental health practitioners who speak Spanish prior to need • Provide guidance for parents to access appropriate services in Spanish • Provide technology access, education, and broadband support in advance of need
Coordination and Planning	<ul style="list-style-type: none"> • Create pipelines connecting government entities, institutions, and community organizations in advance of an emergency • Invest time in relationship-building • Pre-map where Latino communities live • Pre-map existing resources to understand geographical access points
Undocumented and Asylum-Seekers	<ul style="list-style-type: none"> • Create relief programs to fill gaps • Develop and implement positive consistent messaging to ensure participation
Program Delivery	<ul style="list-style-type: none"> • Coordinate programs statewide for consistency in implementation • Increase communication to avoid “reinventing the wheel” and duplication of efforts • Create baseline program standards
Data	<ul style="list-style-type: none"> • Share data to allow for more complex analysis • Provide access to real-time data

Discussion Topic	Recommendation
	<ul style="list-style-type: none"> • Reconsider Latino personal identifiers to get better data • Implement qualitative data-gathering mechanisms for accurate assessments

Additional Supporting Equity Information:

Public Health Seattle and King County included an equity focus in their AAR. The following summarizes key points in their report.

Supporting Recommendations from the Public Health Seattle and King County After Action Review

Public Health Seattle and King County conducted a COVID-19 After Action Review and some findings from that endeavor support the data gathered through the equity gatherings and engagement opportunities conducted as part of the State COVID-19 review process. The full report can be accessed here: https://kingcounty.gov/depts/health/COVID-19/data/~/_media/depts/health/communicable-diseases/documents/C19/report-PHSC-COVID-19-AAR-Sep2022.ashx.

The following highlights from the King County AAR support the information presented above.

Themes and Gaps

- There were delays in leadership decisions that compromised work, including an emphasis on urgency over equity, decisions made without community input, occasional difficulties identifying how to influence work in established coordination structures, and a lack of equity training across activated staff.
- There was a noted lack of BIPOC providers in the Public Health Reserve Corps, which raised concerns about the ability of those systems to serve communities disproportionately impacted by the pandemic.

Recommendations

- Capitalize on the collaboration and relationships built with community partners during the COVID-19 response and continue to convene regularly with these organizations to foster a deeper partnership with Public Health – Seattle & King County (PHSKC) and sustain built relationships.
- Formalize relationships forged during COVID-19. Embrace these relationships and develop a program to ensure that valued partnerships are maintained and strengthened. Consider establishing a formal process where stakeholders and partners are officially recognized.
 - Invite stakeholders and partners to become involved in emergency planning meetings.
 - Encourage the participation of these groups in training and exercises.
 - Seek their counsel in areas where they possess unique knowledge of the issue, problem, or question.
 - Continue to pay community members, stakeholders, and partners for their work with PHSKC.
 - When appropriate, formalize relationships with agreements, charters, or memorandums of understanding (MOUs).

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- Develop and document a clear, consistent process for conducting initial equity reviews of proposed policies and programs. Delineate the procedures for doing an initial, internal-only equity review versus a secondary review that involves feedback from external stakeholders.
- Ensure that all plans for continued work with CBOs, community navigators, and other community leaders include compensation.
- Advocate for the adoption of common service delivery and accessibility standards across PHSKC programs to accommodate diverse communities. The standards should be met day-to-day, as well as during disasters. This may include training for staff to review accessibility and health literacy standards of written materials (plain language, considerations for images, etc.), maintaining Americans with Disabilities Act (ADA) accessibility best practices for programs/ services, or creating protocols and training for incorporating ADA standards into operations.
- Review structures to promote greater internal cross-team coordination to help various response teams stay aligned with changing guidance and awareness of activities being led by other teams. Identify ways to support a common operating picture to increase collaboration in efforts. Continue broad information sharing between internal teams by disseminating relevant materials and developing plans on a knowledge management-driven shared portal.
- Perform an in-depth equity analysis of the burden and administrative barriers county business processes present to critical (small) partners, such as navigators, translators, and presenters. Work with the Equity Response Team to review analysis and prioritize barriers for removal.

2.4. State Agency After-Action Reviews

State agencies provided their own AARs as part of the Task Force process. They were asked to share some of their lessons learned with the Task Force. This information was collected and reviewed by the Task Force and some agencies presented their findings at Task Force meetings. During these meetings, Task Force members had the opportunity to ask questions of the agency presenting and provide comments. IEM also reviewed the state agency AARs. This information is provided in the Task Force Summary as the strengths and areas for improvement that were identified that are common across state agencies and were pertinent to improving the overall response and recovery posture for Washington state. Additional information provided in this section was based on IEM's previous experience in other jurisdictions. Each strength or area for improvement includes a primary observation and narrative analysis based on an information review. Where appropriate, the analysis presents recommendations that are specific and actionable. The strengths and areas for improvement are organized by the following topics:

- Operational coordination/communication
- Continuity of operations (COOP) planning
- Logistics/resource management
- Public information

A complete list of state agency AARs included in this review is in **Appendix B**.

Operational Coordination/Communication

Strength A.1: Support Across State Agencies

Observation: Many state agencies provided support staff to other agencies to maintain operations and services.

Analysis: Multiple state agencies mentioned the support provided by staff from other state agencies early in the COVID-19 pandemic response. Some of these agencies indicated that they would like to see more cross-agency coordination outside of an emergency response. Agency staff who would not traditionally coordinate, had the opportunity to develop new working relationships, find new effective ways to deliver services, and learn new skills. For example, the Washington State Fraud Prevention and Labor Standards division and the Division of Occupational Safety and Health (DOSH) worked together in coordination with the State Emergency Operations Center (SEOC) to address complaints related to the COVID-19 response. Many agency staff expressed gratitude for the opportunity to work within the SEOC structure and gain exposure to the emergency management environment. This is experience that they might not have otherwise received.

It was also noted that leadership across several operational groups came together to develop solutions to complex issues. There was a strong partnership between the Safety and Health program at the Department of Labor and Industries (LNI) and the Operations Leadership Team (made up of program managers who collaborate on business needs and impacts of work activities and proposals). This enabled them to work quickly and effectively to create a set of operational safety protocols, specific to the hazards of COVID-19 for various work settings. These protocols supported the safety-first perspective of keeping staff safe while working in the field and in office settings. This coordination allowed the protocols to evolve along with the rapidly changing conditions and requirements coming from the Governor's Office, DOH, and LNI, as well as requirements and guidance coming from CDC.

Strength A.2: Working Relationships with Interstate, Industry, and Federal Partners

Observation: Strong working relationships with various private sector, federal, and community partners and state agencies developed prior to the COVID-19 pandemic enhanced their ability to respond effectively.

Analysis: Throughout the COVID-19 pandemic response, state agencies were able to maintain services and effectively navigate various aspects of pandemic response by using existing relationships with partners, including federal partners. Most state agencies have established coordination with private sector partners and federal agencies based on the services and (SBA) industries they oversee. Coordination with federal partners such as the Small Business Administration and federal housing and mortgage regulators proved vital for the state to effectively implement many federally funded relief programs. The Washington State Department of Financial Institutions (DFI) has strong relationships with financial regulators from other states, which have been fostered through the creation of a multi-state cooperative licensing agreement, including federal counterparts. DFI leveraged these relationships to gain compliance with emergency orders, assist with the distribution of federal relief funds, and negotiate more favorable repayment moratoria agreements with private student loan servicers not subject to federal mandates.

Strength A.3: Development of the Roadmap to Recovery Plan

Observation: The *Healthy Washington – Roadmap to Recovery Plan* provided a regional approach to COVID-19 recovery based on a particular region’s situation at a given time.

Analysis: In January 2021, Governor Inslee’s office announced the *Healthy Washington – Roadmap to Recovery Plan*. This plan, developed through the SafeStart/Roadmap to Recovery Steering Committee, outlined a multi-phased statewide plan based on regional needs to allow for recovery activities to better fit the needs and capacities of the regions across the state. This plan allowed for the coordinated easing of public health restrictions while maintaining critical healthcare capacity, depending on the COVID-19 data in a region. Having a framework such as this provided much-needed information sharing at state leadership levels as well as supporting local jurisdictions in managing local public health needs depending on the COVID-19 case load and hospitalizations in each region versus a one plan for everyone approach. This also allowed local public health, healthcare, and emergency management officials to make decisions based on the needs of the region.

Area for Improvement A.4: Familiarity with Emergency Response/ Management Structure

Observation: State agencies deployed personnel who had not had prior exposure to basic emergency response and management concepts, such as the National Incident Management System (NIMS), Incident Command System (ICS), and Emergency Operation Center (EOC) functions, resulting in confusion and misunderstandings, at times, about how decisions were made, and information was meant to flow.

Analysis: Prior to the COVID-19 pandemic, some state agencies reported not having any sort of internal emergency management mechanism nor had they conducted any emergency management or ICS-related training among the staff. Many personnel working in state agencies had no prior experience or training in basic emergency management concepts. In the early days of the COVID-19 pandemic, it became apparent that this would be an “all hands-on deck” situation for many, if not all, state agencies and staff were assigned roles with little to no understanding of how the emergency management structure operates. Staff had a steep learning curve. For example, the Washington State Department of Children, Youth, and Families (DCYF) did not have designated EOC or support staff trained to fill EOC positions to support coordination with other state agencies. The necessary response to the COVID-19 pandemic presented the need for this type of structure. As a new agency, DCYF staff were largely unfamiliar with NIMS and ICS and had to adjust their roles and responsibilities in rapid coordination. The Department of Corrections provided subject matter expertise, guidance, and support for the establishment and management of a new EOC in DCYF. They worked daily with DCYF EOC staff to provide consultation, guidance, and training. In addition, the DCYF IT department provided critical technical support to ensure the uninterrupted functionality of the new EOC and DCYF as a whole.

Recommendations:

- a) EMD should collaborate with leadership from all state agencies to conduct basic ICS and NIMS training across all levels of staff in each state agency. Use workshops and exercises to provide additional opportunities for agency staff who may be called upon in future emergencies to gain valuable exposure to the EOC environment. Possible trainings include the following:
 - o Federal Emergency Management Agency (FEMA) Independent Study (IS) 100 Introduction to the Incident Command System
 - o FEMA IS 200 Basic Incident Command System for Initial Response
 - o FEMA IS 700 NIMS, an Introduction

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- FEMA IS 800 National Response Framework (NRF), an Introduction
- FEMA IS 2200 Basic Emergency Operations Center Function
- b) EMD should consider developing Emergency Support Function (ESF)-specific training and exercise series that would engage each ESF's primary and support agencies.
- c) Conduct training with state agency staff to provide an overview of the Unified Command Group (UCG) structure, roles, and responsibilities of agencies participating in the UCG, and information flow between UCG, SEOC, and State Agency EOCs. Ensure that everyone has a firm understanding of the role of the UCG and how strategy decisions translate into response actions through the SEOC and other state agency EOCs. Communicate the established chain of command structure to local officials in the affected jurisdictions, as well as to state, local, federal agencies, nonprofits, and private sector partners who may provide resources for the response or recovery.

Area for Improvement A.5: Delineation and Communication of Lines of Authority

Observation: With multiple leadership and coordination groups, it was challenging to fully understand the lines of authority and the decision-making process.

Analysis: At the onset of the COVID-19 pandemic, several leadership and coordination groups were formed to address the growing needs of the situation. In the SEOC structure, there was a multi-agency coordination (MAC) group and the UCG. For some, the roles and responsibilities, as well as the flow of information between these groups and beyond, was unclear. Processes such as planning for non-pharmaceutical interventions and identifying what would constitute an essential worker or program across the state felt rushed and uncoordinated at times, leading to duplication of efforts and confusion for personnel responsible for communicating and implementing these operational guidelines. A particular challenge at the beginning of the COVID-19 response was the lack of a clear communication channel between state agencies and the State Incident Response leadership. At times, this created confusion and misinformation, as agencies had to interpret messaging or create alternate communication channels to receive more specific guidance and direction. There seemed to be competing lines of authority as well between state and federal entities, which added to the confusion.

Early in the COVID-19 pandemic, some agencies established good communications with the SEOC, but they were unclear about who or what agency was leading the response. Having the lines of authority clearly communicated across all state agencies, along with clearly identified points of contact at the leadership level, could alleviate much of this confusion and provide a clearer path of communication for agencies when looking for guidance or clarification.

Recommendation:

- a) EMD and DOH should coordinate a review of the existing emergency response and pandemic-related response and recovery plans to ensure all are updated to reflect an accurate portrayal of command structures and chains of command and control that would be implemented in future emergencies. This should include updating activation and communication protocols to identify authorities to activate and the corresponding actions to expect from state leadership and state agencies.

Area for Improvement A.6: Messaging Across Various Leadership Groups

Observation: There seemed to be conflicting decisions and messages between the different response coordinating groups that presented a challenge to staff responsible for implementation at the operational level.

Analysis: To some, it appeared as though decisions were being made without consulting with agencies that may be either impacted by these decisions or responsible for implementing outcomes from the decision. Broadening the opportunity for input into certain decisions, when it is appropriate, allows for better understanding of the needs and the desired outcomes of the decision. It also would provide a chance for agencies that may be impacted to conduct any necessary preparations to better absorb the decisions and outcomes.

Moreover, inconsistent or conflicting messaging from federal partners, state leadership, and local jurisdictions contributed to an increased politically charged environment that presented some unintended consequences to some agencies. Some agencies, including law enforcement and public health agencies with public enforcement responsibilities, experienced an increase in negative reactions in some cases. More coordinated and consistent messaging from all levels of the response could address some of these challenges.

Recommendations:

- a) Implement a communication mechanism across the various leadership and response coordinating groups involved in a complex response to ensure that all appropriate leadership has an opportunity to review and deconflict information that may be informing decision making.
- b) Upon activation of the SEOC and UCG, implement a routine briefing schedule to allow adequate and timely communications of outcomes and action items from UCG and leadership meetings to the SEOC section leaders and state agency EOC leadership to ensure that those responsible for implementing outcomes are adequately informed. Communicate this meeting schedule to all SEOC staff and ensure that each individual knows to whom they are reporting as well as those for whom they are responsible.

Continuity of Operations (COOP) Planning and Staffing

Strength A.7: Staffing Across the COVID-19 Response Structure

Observation: Integration of agency staff at multiple levels of the COVID-19 response enhanced coordination and communication for some state agencies.

Analysis: Several state agencies were represented at various levels of the COVID-19 response, such as the UCG, the MAC Group, and the SEOC. Having staff present at these various levels allowed for more effective coordination. One state agency implemented an Area Command organizational structure with all its programs and response organizations and used incident management concepts to manage response activities.

Strength A.8: Implementing Continuity of Operations (COOP) Plans and Delineating Essential Functions

Observation: Some state agencies reported having had existing COOP protocols and could quickly assess what functions and operations were essential.

Analysis: Early in the COVID-19 pandemic, state agencies had to evaluate their operations, services, and functions and determine which were essential and what could be suspended or altered. This was especially critical for state agencies who provide direct public-facing support and services on which communities rely. With slight alterations in the way services are delivered, such as providing virtual services where feasible, and implementing PPE standards, DCFY continued vital child welfare operations to maintain uninterrupted care for children and teens across the state.

Prior to the COVID-19 pandemic, the Department of Transportation (DOT) planned a COOP exercise to validate existing COOP plans. The exercise was meant to test the remote working concept by having selected staff perform their duties from home based on the COOP plans. Although the exercise never took place, much of the preparation and planning directly benefited agency staff when transitioning to a remote work environment in March 2020. Once public health measures such as social distancing and mask wearing were implemented, DOT had to evaluate their operations and find alternatives to critical operations that could not be conducted remotely, such as maintaining the state road system. The DOT also recognized the importance of maintaining staff through the halt in certain operations due to public health measures. The DOT provided staff access to trainings that directly support their jobs, as well as training opportunities that supported cross-training in other areas.

Strength A.9: Departmental Virtual EOC

Observation: Unable to operate in a traditional manner, state agencies developed amended emergency management environments to maintain operations.

Analysis: DOT could not come together in a traditional EOC setting due to remote work requirements, so it developed a virtual EOC concept to support agency operations. They incorporated Microsoft Teams to better refine the virtual EOC experience. They have not been able to implement some lessons learned from the virtual EOC to manage other disasters that occurred during the COVID-19 pandemic, such as severe storms and wildfires.

Strength A.10: Development of the Modern Work Environment (MWE) Strategy

Observation: Development and implementation of an MWE strategy supported an effective pivot to a remote working environment.

Analysis: In February 2021, the Department of Ecology created the MWE strategy based on lessons learned during the early phase of the COVID-19 pandemic. The MWE strategy focused on allowing staff more flexibility to work in a way that would maintain the mission of the agency. The foundational assumption of the MWE is based on the premise that activities related to all positions, apart from field-based crews or facility operations staffing, are conducive to a telework environment. Technology was key to making this MWE successful. The addition of technology provided access to routine workday platforms, such as email, electronic documents, phone, and virtual meetings. Procedures were developed for the efficient deployment of technology and necessary supplement equipment, such as office furniture that

staff might have needed in their remote environments. An online request/approval process was implemented for staff that also provided tips for setting up and using IT equipment. Once staff return to their traditional work environments, this same process will be used to return IT and other equipment provided to staff once it is no longer needed. Based on needs, changes will be made to current workspaces to use our spaces more efficiently.

Strength A.11: Development of a Pandemic Rapid Response Group

Observation: Identifying a team that focused on staff needs, such as potential COVID-19 cases, was effective in addressing staff concerns.

Analysis: To address the needs of staff during the COVID-19 pandemic, such as reports of illness, potential COVID-19 cases, guidance on reporting requirements, provision of PPE and other supply needs, and staff concerns, the Washington Department of Labor created the Pandemic Rapid Response Group, which proved to be very effective and efficient for providing for staff needs throughout the pandemic.

Area for Improvement A.12: Updating and Socializing COOP Processes

Observation: Some state agencies implemented existing COOP procedures but discovered that some leadership and staff were not familiar with COOP and the concept of essential functions.

Analysis: Some state agencies reported that the COOP plan was not well known to all members of agency leadership and staff who were designated to support mission essential functions. The COOP plan organizes actions according to an ICS. This system for organizing the response created more confusion than value, as regular lines of authority remained in place and communications remained uninterrupted. Future disasters should consider whether an ICS response structure is relevant for all agency COOP activations. Some agencies indicated that they did not receive clear guidance until many months into the response. Payroll, Communications, and Human Resources (HR) were all left to problem solve at the agency level, often unsure if their actions were meeting the intent of the emergency order without violating other preexisting policies. At times, guidance from CDC, DOH, the Office of Financial Management (OFM), and LNI were not clear or consistent. In addition, policies regarding activation pay were not clearly defined. It was not clear who was eligible, given that many staff were performing both COVID-19-related response/recovery work and "normal day-to-day" non-pandemic work.

Recommendations:

- a) The current agency COOP template organizes actions according to an ICS. This system for organizing the response created more confusion than value, as regular lines of authority remained in place and communications remained uninterrupted. Future disasters should consider whether an ICS response structure is relevant for agency COOP activations.
- b) Consider developing more of a chapter approach to COOP planning for state agencies with multiple programs. Each program would be a chapter in the agency COOP plan, which could allow for more efficient maintenance, implementation, and expansion, when needed. This approach would provide greater flexibility and quick adaptability and use during short, middle, or long-term responses.

Area for Improvement A.13: Mechanisms for Implementing COOP Policies

Observation: Some state agencies did not have adequate policies or procedures to provide supplemental compensation for additional work being performed while supporting the COVID-19 pandemic response.

Analysis: There were reports of staff involved with the COVID-19 pandemic response receiving additional compensation besides overtime pay, for the additional roles and responsibilities expectations. Some state agencies did not have mechanisms in place to compensate staff for the additional workload. In addition, COOP plans seemed to address staffing and ensure that the right staff were in place to ensure continued operations, but they lacked the necessary technological planning to implement a mass teleworking environment without challenges. One agency reported having its IT division use pre-identified working connections to link into WaTech and using third party vendors to obtain additional hardware, software, and licenses to make many employees telework capable for the short term.

Recommendations:

- a) Each state agency should review COOP plans to incorporate and memorialize the considerations and lessons learned related to teleworking procedures identified through the COVID-19 pandemic.
- b) Each state agency should consider development of an agency Emergency Operations Plan (EOP), if one does not exist, to identify roles, responsibilities, and communications that outline the agency's mission and role in emergencies as they align with the State ESFs and tying into the agency COOP plan as well.

Resource Management/Financial Assistance

Strength A.14: Procurement of PPE

Observation: Early in the COVID-19 pandemic, state agencies had to move quickly to procure the necessary PPE to maintain a safe working environment for staff.

Analysis: At the beginning of the COVID-19 pandemic, non-pharmaceutical interventions were the only tools available to mitigate transmission of the COVID-19 virus. State agencies found ways to procure needed PPE, such as hand sanitizer and cleaning supplies, to maintain clean and safe spaces. One state agency reported creating a group to focus on this issue. Eventually, as the enormity of the pandemic situation became apparent, the state began implementing procurement and warehousing processes at the state level through coordination with the state Equal Employment Opportunity Commission (EEOC) office. The EEOC management analysts used existing retail channels to get needed supplies. However, procuring PPE and other infection-control supplies, such as masks and gloves, and later COVID-19 testing supplies, quickly became a challenge because of overwhelming global demand. Due to these limitations of availability, the state implemented a tiered process of priority to ensure that vulnerable communities, such as long-term care facilities, had the protection they need to care for these individuals.

Strength A.15: Effective Use of Coronavirus State Fiscal Recovery Funds (CSFRF) to Support Vulnerable and Underserved Communities

Observation: Washington state used federal CSFRF funds to support the needs of vulnerable and underserved communities, such as those experiencing homelessness, immigrant farmer workers, low-income communities, and those facing food insecurities.

Analysis: At the start of the pandemic, Washington state received \$2.2 billion in Corona Virus Relief funds through the CARES Act. These emergency funds went out quickly to support public health and medical care, and to prevent the economic collapse of state businesses. A year later, the state received additional

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funding through the ARPA and had the ability to focus on vulnerable populations disproportionately impacted by the COVID-19 pandemic.

The CSFRF program is part of ARPA, and it provided \$350 billion to state, local, and tribal governments across the U.S. to support COVID-19 response and recovery efforts. Washington state received a total of \$4.4 billion CSFRF funds, which were used to combat the effects of the COVID-19 pandemic. The state's goal was to use this funding to create a more versatile and equitable economic system. *The State of Washington Recovery Plan Performance Report: Coronavirus State Fiscal Recovery Funds, August 2021* and July 2022, can be viewed here:

https://ofm.wa.gov/sites/default/files/public/publications/WA-CSFRF-Recovery-Plan-Performance-Report_Aug2021.pdf

https://ofm.wa.gov/sites/default/files/public/publications/WA-CSFRF-Recovery-Plan-Performance-Report-July2022_.pdf

Examples of how funds were used to support vulnerable and underserved communities include the following:

- \$31 million for behavioral health treatments for low-income patients.
- \$100 million for stabilizing the community's behavioral health workers by maintaining and expanding staff capacity.
- \$340,000 million for one-time cash grants of \$1,000 for eligible immigrant populations. Another \$128 million of CARES Act funding supported approximately 120,000 immigrant workers who did not qualify for federal economic impact payments or unemployment insurance.
- \$104 million helped vulnerable communities have access to food.
- Over \$10 million for the Food Assistance Program (FAP), which provided food support to 15,000 immigrants with unauthorized status and were therefore not eligible for Supplemental Nutrition Assistance Program (SNAP) benefits.
- \$103 million to support the We Feed WA, Farmers to Families food box program. This program provided fresh produce, milk, and prepared meats to foodbanks and other nonprofits that supported underserved populations.
- \$500 million for unemployment insurance tax relief for small businesses, which prioritized women- and minority-owned businesses.
- \$50 million for the Working Washington Small Business Grant Program, which provided support to underrepresented and underserved small businesses.
- \$45 million to provide permanent housing to those residing in public rights-of-way. Another \$22.5 million was provided for rapid housing acquisition grants to support the expansion of housing, such as emergency shelters, supportive, transitional, and youth housing. This created an additional 803 beds.

Area for Improvement A.16: Coordination and Maximization of Available Funding Streams

Observation: There was a disconnect in coordination between the multiple entities at the state and federal levels who were responsible for managing and implementing funding support coming in through a multitude of sources, including the CARES Act funding, the ARPA funding, and FEMA Public Assistance (PA) funding streams.

Analysis: The CARES Act funding initiative was an unprecedented approach to providing financial relief in response to a nationwide catastrophic disaster. Under the CARES Act, a wide range of grant programs and support mechanisms were implemented, many with unclear guidance. In addition, more traditional

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emergency funding through FEMA PA was available, creating some additional confusion. There could have been more effective consideration for when to use CARES funding versus FEMA PA funds. Initiatives were included in CARES funding that could have been FEMA-funded, and CARES funding could have been designated for FEMA ineligible activities. It was not always clear how funding was being used. The process of funding being passed through to other organizations, such as school districts, was also unclear at times. Additional information sharing regarding funding streams and clear, defined processes for the distribution of funds would have eased the process. Confusion with these various funding streams originated through the funding sources, but it was also exacerbated by a lack of cohesion in the state agencies responsible for administering these funding sources. There needed to be more clarification on the state strategy for these funds and how they were to be prioritized based on the criteria and requirements connected to each funding source.

The Washington Military Department oversaw the management of the FEMA PA funding stream and was successful in providing guidance to funding applicants on the limits of funding and eligible activities under the funding requirements designated by FEMA. However, this was made more of a challenge, with conflicting messaging from multiple funding authorities and state agencies also providing information. Increased coordination between state agencies with responsibilities in receiving and managing federal funding sources, emergency management, and public health authorities (at both the state and local levels) is needed to ensure the effective identification of needs and efficient distribution of available funds.

Recommendations:

- a) Establish a disaster financial relief coordination group that activates in large-scale disasters such as a pandemic, to include state agencies responsible for using and managing disaster funds such as WMD, EMD, OFM, and DOH. Once activated, affected local emergency management, public health officials, and others should be included, as appropriate.
- b) Consider creating a centralized online hub for disaster cost recovery information, grant opportunities, and grant applicant submissions and tracking to increase information sharing and make the most effective use of available funding streams.
- c) Participate in federal training and discussions regarding disaster cost recovery processes specific to COVID-19.
- d) When new funding streams are made available, conduct research to ensure all potential funding sources are known.
- e) Request funding guidance for allowability of purchases from the appropriate federal agency to distribute to appropriate local, tribal, and nongovernmental partners.

Area for Improvement A.17: Coordination with Manufacturing Partners for PPE

Observation: Coordination with manufacturing partners in the state was not as coordinated as it could have been, at times, leading to delays in manufacturing needed items and miscommunications.

Analysis: It is safe to say that states across the country encountered a challenge in not having PPE-type supplies available at the beginning of the COVID-19 pandemic. To that point, in August 2019, the Office of the Assistant Secretary for Preparedness and Response (ASPR) at HHS conducted a functional exercise meant to test the Nation's ability to respond to a large-scale outbreak of a novel avian influenza virus, beginning with an American returning from overseas travels and quickly spreading across the country. The *Crimson Contagion 2019 Functional Exercise After-Action Report*, dated January 2020, identified that the

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U.S. lacked sufficient domestic manufacturing capabilities and access to raw materials to produce almost all the pandemic influenza medical measures needed to address the scenario that was part of the exercise. With the global demand for PPE supplies such as hand sanitizer, gloves, masks, and cleaning supplies, states across the country began looking to local manufacturing partners to pivot to production of these items. The state was supportive in this endeavor and worked to provide local manufactures with the documentation they needed in the form of waivers and such from the Federal Food and Drug Administration (FDA), but these waivers were not always recognized by state authorities, thus delaying the ability for local manufactures to move forward. There were additional challenges in the state procurement processes. They are, at times, slower than industry manufacturing timelines, which delayed the process. It seemed as though state support for the emergency manufacturing of PPE was not coordinated with the state procurement and acquisition process. This led to frustration and further delays with manufacturing partners.

Recommendations:

- a) Review processes developed for the statewide procurement of PPE and other supplies during the COVID-19 pandemic and memorialize newly created processes into procedures and guidelines for emergency procurement.
- b) Conduct emergency procurement awareness training to state agencies to ensure that the process is well socialized.
- c) Consider conducting a forum with local manufacturing partners to further explore partnership opportunities and ways to fine tune the existing relationships.

Area for Improvement A.18: Warehousing and Storage Processes

Observation: As mentioned above, early in the COVID-19 pandemic, state agencies had to quickly acquire PPE to ensure the safety of staff, but with lack of local stockpiles, storage capacity, and global demand, this became a challenge.

Analysis: During the COVID-19 pandemic, DOH relied heavily on the Department of Enterprise Services (DES) to locate and procure PPE, manage incoming inventory, process orders from the SEOC, and distribute the orders throughout the state. Normal surplus operations had to be put on hold. Day-to-day operations at the warehouse to receive, inventory, pick, pack, and ship critically needed PPE items throughout the state required Surplus Operations staff to work long hours and weekends to ensure that supplies were received in a timely manner. DES also pulled in additional staff from the Printing & Imaging program to provide support. To pivot to PPE warehousing and distribution, DES had to implement an inventory management system; a testing process for products (when needed) as products arrived; processes to validate incoming products against purchase orders; warehouse configuration for products; processes to pick, verify, pack, and ship products; and processes and criteria for shipping.

Given the volume of PPE that was required to support the state's pandemic response, the Surplus warehouse had to be re-configured to absorb this new body of work, which meant that items located in the warehouse not been sold had to be disposed of by either recycling methods or landfill. This impacted the revenue generation that would have occurred if these items could be sold. Even with the reconfiguration in the warehouse, the DES team quickly determined that additional space was needed. A second facility was located, and a short-term lease was negotiated, and this helped accommodate some of the overflow. This secondary facility provided a stop gap while DES's Real Estate Services (RES) located a facility that could accommodate the long-term needs for the PPE mission. In July 2020, RES located and secured a 200,000 square foot logistics facility that met the space requirements for the PPE mission. DES

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began receiving PPE at the Polaris facility in July 2020. However, a tremendous amount of work had to be done to prepare this new space.

Once the state was successful in stockpiling PPE, the distribution process was not always clear to all responding agencies. In some cases, there was confusion in messaging around PPE distribution between state agencies, local governments, and business & nonprofits.

Recommendation:

- a. The state should review warehousing and procurement processes developed during the COVID-19 pandemic and memorialize them into updated plans and procedures. Consider further collaboration between DES, DOH, and EMD to implement effective warehousing strategies, including establishing roles and responsibilities across state agencies. This planning should include communicating statewide emergency procurement procedures for future emergencies that require a state-led procurement of equipment and supplies.

Public Information

Strength A.19: Coordination with Community Organizations

Observation: A coalition of organizations serving the Latino community increased public outreach opportunities.

Analysis: Many states experienced challenges in reaching Latino communities during the COVID-19 pandemic. In some Latino communities, there may be a hesitancy to fully trust information coming from government officials, there also may be issues of access to broadband in low-income neighborhoods, and the lack of information provided in Spanish and other languages presented a challenge in making sure that vital public health information and access to financial assistance was widely available to communities that needed it. The Washington State Commission on Hispanic Affairs established a coalition of 40 Latino organizations to develop a plan for nonprofits and providers to share data, resources, and information. The Commission also held weekly community conference calls throughout the COVID-19 pandemic for the Latino community to provide an opportunity to hear updates from Governor Inslee's office, state agencies, other community organizations, and updates from around the state. This use of networks and collaboration with established CBOs that provide services to the Latino community serves as a force multiplier in information sharing and it helps provide more trusted messengers.

Recommendations:

- a. Coordinate with trusted voices in underserved and diverse communities when developing public messaging to ensure messaging is relatable and receivable.
- b. Develop multi-language hazard- and/or incident-specific templates for communicating critical information to diverse communities.
- c. Memorialize the processes of information translation and dissemination for incorporation into future incidents.

3. Focus Area B: Emergency Response That Would Benefit the Business Community and Workers During a Pandemic

This section provides strengths and areas for improvement related to support to the business community and workers related activities during the COVID-19 pandemic.

As part of the State Pandemic Task Force, the Department of Commerce convened a workshop to explore actions taken in response to COVID-19 to support business and workers. Representatives from state agencies and commissions, local governments, economic development organizations, and business/trade associations were invited to participate. The workshop occurred on October 20, 2022. Some information in this section is based on additional research, best practice, lessons learned, and recommendations from the Contractor's previous experience in other jurisdictions

Strength B.1: Establishment of the Small Business Resiliency Network (SBRN)

Observation: The SBRN provided a place for businesses in marginalized communities to access crucial information related to financial assistance available.

Analysis: The SBRN, <https://www.commerce.wa.gov/serving-communities/small-business-resiliency-network/> was established through the Washington State Department of Commerce in response to COVID-19 and is an extremely valuable mechanism for improving access to financial assistance for businesses from historically marginalized communities. The COVID-19 pandemic highlighted the importance of small, local businesses in underserved communities and the positive impact of supporting them through the pandemic. Continuing to support this resource for financial, technical, and program guidance to these businesses builds resiliency in underserved communities and thus provides for a stronger recovery from emergencies such as the COVID-19 pandemic.

Washington state provided \$15 million in Coronavirus State and Local Fiscal Recovery Funds to expand the Small Business Resiliency Network and to establish a small business Credit Repair Pilot Program. Both prioritized services to businesses owned by historically disadvantaged populations.

Moreover, the COVID-19 pandemic highlighted a great need for business support and mentoring to improve financial and digital literacy. Many small "mom and pop" businesses, especially in underserved communities did not use technology such as contactless payments, either due to familiarity or costs. Many of these businesses provided essential services to these communities such as food, household essentials, and medications. Support to keep these small businesses operational through times of emergencies, as well as providing resources to support preparedness and technology implementation provides much needed support and resources to communities that often, struggle to recover.

Recommendations:

- a. Working with the Washington Department of Commerce, the state should identify and allocate ongoing funding to maintain and expand the services offered through the SBRN.
- b. Collaborate with local universities and technology corporations in Washington to develop programs to support teaching small business owners to implement technology into their daily operations and make the hardware and equipment needed to build this capacity.

Area for Improvement B.2: Coordination and Communication with the Business Community

Observation: There was no centralized mechanism for coordination and communication between state responders and the business community to share information on what and where the needs were, resources available to the business community or providing guidance to businesses on how to access resources.

Analysis: Initial COVID-19 emergency response plans were developed under an incredibly short timeline. This necessitated quick decisions that had enormous impacts to businesses. Because these decisions were made under such urgency, a formal method for feedback from the business community was never established. Some businesses were successful in getting feedback to state leadership through lobbying, trade association membership, union memberships, and their state regulators. Others lacked any of these associations and were therefore unable to provide meaningful feedback that might have greatly assisted state leaders in their actions to address COVID-19. Any mechanism to address business feedback to emergency response planning must account for the varying level of access experienced by different business communities across the state.

Recommendations:

- a. Engage and collaborate with the business community through existing networks such as the Washington Small Business Development Center, Washington Chamber of Commerce, and other business associations to develop a mechanism for the state's business community to provide immediate feedback into emergency response planning and operations. This could address disproportional impacts to businesses in rural communities and communities of color by creating a more equitable dissemination of information as well as providing a platform to provide feedback on unmet needs.
- b. Consider using a technology platform within the SEOC such as Microsoft Teams and Forms, or WebEOC to develop surveys to the business community in times on emergency to both gather information on the needs of the business community and also resources available to support response and recovery efforts. Consider utilization of social media tools such as Facebook Live to conduct informational briefings and engagement and connection opportunities.
- c. Consider creating a private sector liaison position in the SEOC to focus on the coordination and communications with the private sector. EMD might also consider creating a section in the State EOC to focus on coordination with the private sector that would include representatives from key sectors such as utilities, grocery, fuel, etc. The *FEMA Emergency Operations Center How-to Quick Reference Guide, October 2022*, contains some guidance on engaging the private sector in EOC operations. https://www.fema.gov/sites/default/files/documents/fema_eoc-quick-reference-guide.pdf

Area for Improvement B.3: Dissemination of Public Health Guidance to Business Community

Observation: Public health guidance being disseminated across multiple state agencies were often conflicting resulting in confusion across business sectors as to the parameters of the guidance and which state agency's information to follow.

Analysis: To curb the spread of COVID-19, the state issued numerous business closures and subsequent re-opening guidance documents that were inconsistent and unclear to the business communities they impacted. Guidance documents at times conflicted between regulatory agencies (DOH, LNI, Liquor and Cannabis Board), or were missing key perspectives from these agencies. Certain industries found vaccination, seating, and masking requirements extremely difficult to enforce when the general population was unaware or in opposition to the requirements. Presumably, these discrepancies were due to the rapid pace with which the state was working to mitigate the spread of COVID-19. But without a clear framework or methodology to explain these inconsistencies, businesses struggled to have confidence in the state's decision-making process.

For example, during the initial PPE shortage, some of the professions licensed by the state were denied access to supplies. This proved taxing on the members of the death management community and their ability to provide services. It would be useful to have pre-developed handouts to provide to licensees that would explain the situation clearly and provide alternative actions that would maintain safe pandemic operations in the absence of adequate supplies. In addition, using or including Agency SAL contacts for special Task Force communications (like death management, professions outreach, etc.) would be extremely helpful for a complete understanding of Agency emergency operations and involvement.

Recommendation:

- a. Develop clear procedures for creating and disseminating public health guidance information including mechanisms for cross-agency collaboration and feedback when appropriate. These procedures should also include a communications component to identify the information sharing channels and engage the business community such the Washington Small Business Development Center, Washington Chamber of Commerce, and other business associations to leverage their existing networks and messaging power.

Area for Improvement B.4: Access to Resources for All Sectors Deemed Essential Operations

Observation: Workers deemed essential but working outside the healthcare and medical sector were not prioritized for PPE and COVID-19 testing resource support, which presented a challenge for these essential businesses to adequately protect front-line workers.

Analysis: Governor Inslee's Emergency Proclamation 20-25, Stay Home, Stay Health dated March 23, 2020, which was an amendment of the previous Emergency Proclamation 20-05, declared that residents of Washington were to remain at home except to participate or conduct essential activities or business services. Permitted essential activities included 1) getting necessary supplies and services such as food, household items, pet supplies, 2) seeking healthcare, emergency services, and medications, 3) providing care for a family member, friend, or pet in another residence. It also declared that all businesses not deemed essential were to cease operations apart from basic minimum operations. Essential businesses could operate provided they implemented social distancing and sanitation measures established through

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the U.S. Department of Labor Guidance on Preparing Workplaces for COVID-19, <https://www.osha.gov/sites/default/files/publications/OSHA3990.pdf>.

In general, operations outside the medical sector and their workers who were included on the “essential workers” list found themselves without adequate access to testing and PPE to adequately meet the U.S. Department of Labor guidelines. Non-healthcare essential businesses and front-line workers such as grocery, food service and others that were necessary to continue to meet the basic needs of society, were not included as a priority in receiving PPE and COVID-19 testing. These essential workers experienced significant number of infections that may have been avoided had they been properly resourced with PPE and access to testing. While it is understandable that the priority for these critical resources was health care, the definition of “essential” should be re-examined and expanded based on lessons learned across the country through the early months of the COVID-19 pandemic. Public health measures and mandates should consider the resource needs for the businesses allowed to operate under the amended proclamation as essential to maintain basic essential services to communities.

An example of the challenges created by the essential workers designation was seen in the critical infrastructure sector. The safety and continuity of energy, water/wastewater, transportation, or communication work is critical toward ensuring continued operation of society, to include frontline healthcare facilities, however, prioritization for the distribution of PPE and early vaccinations did not consider critical infrastructure workers in the highest category. The definition of “essential workers” and how this list determined did not provide a clear process through which businesses could understand which of their workers were determined essential. Absent a process, the Joint Information Center was forced to react to a huge demand for information and problem solving in a short amount of time.

Due to the dramatic and immediate effects the public health safety measures such as the closing of businesses, and the consequential availability of financial assistance, key industries such as the financial sector became vital to supporting small business owners, commercial property owners, landlords and tenants. DFI supported many of these individuals with information about mortgage obligations in the wake of payment moratoria declared by federal housing finance authorities, and access to nongovernmental housing counseling services. They also worked with the governor’s office to issue guidance to regulated industry on how to support state and federal proclamations, directives, and orders. Collaborating across state agencies, including emergency management and public health agencies could strengthen the state’s ability to adequately support important sectors that must continue operating in these types of emergencies.

Recommendations:

- a. State leadership, along with DOH, should ensure that all sectors, especially those outside the healthcare sector, deemed to be essential operations during an emergency have adequate access to necessary resources that may include PPE, testing, and vaccine resources.
- b. The state could benefit from maintaining a list of essential services that must remain in place during an emergency to meet basic needs of society. The state might also benefit from developing a better understanding of commercial property lease agreements to be used when making decisions about potential interventions to support small businesses experiencing sustained losses because of closures.

Area for Improvement B.5: Financial Resources and Information Sharing to Business Community

Observation: While financial support to address impacts from the COVID-19 pandemic were available, the business community and local organizations providing support to business, especially in marginalized communities, were challenged to implement management and distribution processes for funds made available.

Analysis: While the structure evolved for each round of state administered COVID-19 business relief funding, it is not clear if a repeatable, scalable process has been enacted for future use. Institutionalizing such a structure should prioritize access to historically marginalized communities, provide clarity around eligibility requirements, and ensure a timely process that expedites delivery of funds to businesses in need.

COVID-19 economic relief funding efforts provided an extremely large amount of money to the business community compared to previous, non-disaster investments of public resources. The delivery of these resources relied on local economic development entities to case manage applications and distribute the funds to businesses. While this large increase in funding was welcomed by economic development entities, they were faced with a capacity gap to manage and distribute them.

Finally, many businesses experienced a delay in non-English outreach, guidance, and support for applying to new business relief funding. This delay often resulted in missed opportunities for these businesses as they only became aware of the grants after the deadline for submitting an application had passed

Recommendations:

- a. Collaborate with local economic development organizations and appropriate state agencies to memorialize processes implemented to manage and distribute financial support funds during emergencies. These processes should include parameters for eligibility and support to adequately manage an influx of applications.
- b. The state should prioritize sustained funding and technical assistance to these economic development agencies to ensure they have standard, interoperable capabilities to distribute economic relief to businesses in the future.
- c. Working with established organizations providing support to business in non-English speaking communities to develop and implement an institutionalized process to ensure outreach and guidance for communities with English as a second language is provided in the predominant language in relation to funding opportunities and provide timely and clear details on eligibility requirements and application processes.

4. Focus Area C: Standards Regarding Flexible Rent and Repayment Plans for Residential and Commercial Tenants During a Pandemic

This section provides strengths and areas for improvement related to emergency rental assistance related activities during the COVID-19 pandemic.

As part of the State Pandemic Task Force, the Department of Commerce convened a workshop to explore actions taken in response to COVID-19 to address rent assistance. Representatives from state agencies and commissions, local governments, rent assistance grantees, and community-based organizations were invited. The workshop occurred on October 27, 2022. Additionally, some information contained in this section is based on additional research, best practice, lessons learned, and recommendations from the Contractor's previous experience in other jurisdictions.

The following recommendations emerged from group discussion. For a detailed accounting and analysis of the COVID-19 rental assistance funds distributed in Washington, see Washington State Department of Commerce Emergency Rent Assistance Distribution, <https://forwardplatform.com/wa-state-department-of-commerce-emergency-rent-assistance-distribution/>.

Strength C.1: The Eviction Resolution Pilot Program (ERPP)

Observation: The ERPP provided much needed support to both residents and landlords, but the process could be simplified and made clearer.

Analysis: The COVID-19 pandemic highlighted challenges in keeping individuals housed while necessary public health measures resulted in many residents and landlords losing access to income. Many states, including Washington, implemented eviction moratoriums and other programs to support both renters and landlords through a difficult time. The State created the ERPP, and it was successful at establishing a program to help residents and landlords holistically address these interdependent areas.

Additionally, participation in the rental assistance program by landlords was inconsistent. Some counties required rental assistance to go directly to landlords while other counties allowed funding to be distributed to tenants. Some landlords did not live in-state and were unfamiliar with the eviction moratorium and rental assistance. When the eviction moratorium was lifted, many residents experienced rent increases and evictions from landlords who were financially impacted by the moratorium.

Recommendations:

- a. The state should continue its investment in community-based dispute resolution and refine processes and outreach efforts to provide maximum clarity and efficiency in issuing economic assistance and housing stability support to residents and landlords.
- b. State agencies could review, clarify, and simplify efforts to package rental assistance, landlord and tenant rights, and dispute resolution to ensure that both tenants and landlords are supported.

Strength C.2: Support for Renters and Landlords

Observation: Through the experience of the COVID-19 pandemic, Washington state has developed updated and robust state landlord/tenant laws in addition to financial support for both renters and landlords through the COVID-19 pandemic.

Analysis: Early on in the COVID-19 pandemic, when it became necessary to temporarily close business in an effort to limit transmission of the virus, one affect was the challenge of workers, now out of work, being able to continue making rental payments. This also affected business owners' ability to pay commercial rent as well. Through the CARES Act funding, the Washington Department of Commerce was able to distribute approximately \$100 million utilizing the existing network of community-based organizations providing services and advocacy to vulnerable populations such as homeless services, and organizations serving youth experiencing homelessness. Information on the Washington State Commission on Hispanic Affairs website indicated that a survey showed that 17% of renters across the state missed their July rent payments. Specifically, the Commission on Hispanic Affairs was able to provide \$21 million in rental assistance in coordination with the City of Bellevue.

Washington state provided over \$650 million to keep residential landlords financially stable, which in turn resulted in 80,000 low-income renters avoiding accumulating crippling debt by owing back rent during the eviction moratorium.

The Washington State Legislature passed Senate Bill (SB) 5160 in April 2021, which addressed landlord-tenant relations and provided certain tenant protections during and after public health emergencies. This bill also provided guidance for legal representation in eviction cases, and authorized landlord access to state rental assistance programs. This legislation provided a path forward once local, state, and federal moratoriums on eviction began to expire

<https://app.leg.wa.gov/bills/summary?Year=2021&BillNumber=5160>

Area for Improvement C.3: Scalable and Uniform Emergency Rental Assistance Support to Local Jurisdictions and Community-Based Organizations

Observation: Community-based organizations and local jurisdictions struggled to manage the increased need for rental assistance and guidance to residence when rental assistance funding became available due to both complex processed and limited resources such as staffing.

Analysis: Community-based organizations were critical in linking residents to rental assistance. These organizations typically function with limited staff and resources. The COVID-19 pandemic and the effects of closing businesses and loss of income greatly increased the number of individuals in need of rental assistance and support which overtaxed many of these organizations providing assistance to these residents. However, systems designed around homelessness response were the primary conduit for COVID-19 rental assistance. This forced CBOs whose daily operations were centered around providing support to those experiencing homeless to add pandemic rent assistance in addition to their roles supporting isolation/quarantine and vaccine distribution. Because of this, many homelessness response activities lost momentum as providers re-directed their focus on rental assistance.

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The devastating impacts of the COVID-19 pandemic and the release of available emergency funding, resulting in an intense amount of pressure to get financial resources into the community as quickly as possible to avoid evictions. This left local governments and community-based organizations struggling to intake and distribute funds while simultaneously recruiting staff to support the scale up. As mentioned above, many CBOs operate with thin staffs and resources and the pandemic exacerbated these impacts. The rapid scale up and gap in resourcing and guidance to manage the rental assistance process created an environment vulnerable to fraudulent applications. The process combined with the unprecedented number of residents seeking rental assistance presented challenges to CBOs. Having the personnel needed to review and process a large number of applications meant that some organizations were ultimately unable to distribute all their funding in the timeline required. Additionally, some organizations were able to provide payments in advance of the emergency funds while others lacked the capital to provide advanced payments. This contributed to disproportionate outcomes across communities.

Additionally, rental assistance funding guidance was not always available at the time funds were issued. Federal and state requirements left some room for interpretation at the local level. While this added flexibility, it also generated confusion. Local governments reported receiving audit findings based on funding requirements that were not present at the time funds were issued.

State agencies who work with these CBOs have an opportunity to support building stronger networks across these organizations and collaborate to create a more efficient and scalable process to better manage and distribute rental assistance funding in future emergencies. Working with organizations that work in marginalized and underserved communities are critical to address the unique needs of different communities. For example, funding support for organizations proves hard to access due to a lack of an established network and insufficient support for outreach in rural communities.

Recommendations:

- a. In collaboration with local community-based organizations who provide rental assistance and support, the State should identify and implement more formalize support for these organizations through increased state investment, support, and technical assistance. Through this collaboration, a state-wide network of organization can be established to communicate the needs across various communities, share lessons learned and innovative solutions to strengthen the capacity of these organizations to serve their communities.
- a. Develop a repeatable, scalable structure and process for emergency rental assistance funding to provide a standard, understood process across all jurisdictions in Washington.
- b. Ensure future efforts to scale up rental assistance are accomplished without impacting other critical processes such as homelessness response work and other public health activities like isolation/quarantine and vaccine distribution.

Area for Improvement C.4: Simplification of State Rental Assistance Program Support

Observation: Complex state rental assistance programs inadvertently excluded some community-based organizations.

Analysis: While state rental assistance programs are making a concerted effort to improve their processes with local governments and community-based organizations, public requirements for procurement, contracting, and auditing remain burdensome. The complex nature of these requirements reinforces

inequities by excluding valuable grantee organizations who may lack experience with these processes. Additionally, community-based organizations expressed frustration with waiting long periods for a contract only to be given one day to review and sign.

Recommendation:

- a. The State should review and reform state procurement, contracting, and auditing processes to provide a more clear and efficient process. This will serve to alleviate the burden put on local governments and community-based organizations.

Area for Improvement C.5: Distribution of Funding Guidance and Updates

Observation: Guidance pertaining to available rental assistance was often vague and not distributed ahead of issuance of funding.

Analysis: Rental assistance funding guidance was not always available at the time funds were issued. Federal and state requirements left some room for interpretation at the local level. While this added flexibility, it also generated confusion. Local governments reported receiving audit findings based on funding requirements that were not present at the time funds were issued. Also, some residents were unaware of the state's intention to extend the eviction moratorium which led to unnecessary self-evictions.

Also, many federal funding entities had onerous reporting requirements for federal funds. Meeting these requirements consumed many hours and resources at the local level. The intended purpose of some of the requested data was not always clear to state and local governments.

Recommendations:

- a. State agencies responsible for distributing funding into communities should work with CBOs to develop and issue guidance well ahead of funds distribution. Consider offering opportunities to a small group of CBOs to review guidance and ensure clarity.
- b. Ensure that any updates or changes to rental assistance or moratoriums related to evictions and housing are released well ahead of proclamation end dates to provide ample preparation for both tenant and landlords.
- c. State agencies who coordinate with federal housing partners should provide feedback to these federal funding entities on the need to simplify and standardize the reporting requirements for federal funding.

Area for Improvement C.6: Guidelines for the Inclusion of Hotels Under Eviction Moratoriums

Observation: Hotel/Motel owners and management do not operate as landlords and being included under the eviction moratorium placed hotel/motel ownership in uncharted territory.

Analysis: Washington state categorizes hotels as transient accommodation and permits stays up to 29 days. Under the initial Washington state COVID-19 eviction moratorium, hotels were included within the eviction protections and individuals residing in hotels were considered tenants thereby making hotel owners and management essentially landlords and preventing them from performing evictions of stays over 29 days. Hotels are not permitted or resourced to act as landlords.

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Recommendation:

- a. State agencies should review the current regulations for hotel operation including allowable length of stay and consequences for non-payment and consider development of new guidelines to address the unique nature of hotels as accommodations.

5. Focus Area D: Whether Establishing Regional Emergency Management Agencies Would Benefit Washington State Emergency Response to Future Pandemics

As part of the Washington State COVID-19 Task Force Process, Focus Area D explored the concept of developing a regional emergency management structure as part of the Washington State EMD as a way to better support local jurisdictions. This exploration addresses the question of whether regional emergency management agencies would improve the state's response to future emergencies. It does not presuppose a deficiency in the current structure of the state's EMD but considers how regional structures would provide an opportunity to enhance response capabilities throughout the state. The pandemic created a lot of new opportunities to examine how our current structures can be reimagined to better address emergencies of today and the future.

The William D. Ruckelshaus Center, which also facilitated the State Pandemic Task Force, gathered information in the form of one-on-one interviews, a survey, and a forum discussion from individuals with various disciplines and levels of decision making including EMD, DOH, city and county staff, universities, hospitality, and non-profits. This effort focused on identifying potential needs, benefits and challenges related to establishing regionality within the structure of the Washington State's Emergency Management Division. Partners in conducting this research also include the support of BERK Consulting and Pacific Northwest Economic Region (PNWER).

This section will provide an excerpt of the benefits and concerns that were identified through the assessment. The conclusion of this section will present vital core principles to guide decision-making around regional emergency management before outlining potential options and a recommendation for a regional emergency management model. The full report contains more detailed information on the data collection methods, a background of the structure of emergency management, a summary of the perspectives identified through the various participant engagement activities, and more detail about the core principles identified by participants. Additional information on the emergency management models utilized in other states is also included. Information contained within this section was provided to the Contractor by The William D. Ruckelshaus Center and was incorporated into this document in its unedited version. The full report, *A Question of Emergency Response Regionality, Perspectives from Cross Jurisdictional COVID-19 Responders Throughout Washington State*, may be viewed in its entirety here <https://mil.wa.gov/pandemic-after-action-report-task-force>.

Key Findings

These findings include concerns, potential benefits, and perceived challenges that surfaced while discussing regionality as a means of addressing gaps and needs present in Washington State's current emergency response efforts.

One important finding that addressed the overall context of the conversations was participant's connection to the term "regionality." The term triggered a multitude of responses among those interviewees. Some individuals seemed indifferent to the term while others held strong disdain towards

the word itself. This disdain appeared to stem from negative associations of the word to bureaucratic structures, which will be explored further down. This aversion to the word caused us to adapt alternatives during the State Emergency Management Advisory Group (EMAG) facilitation. Taken out of context from the overall discussion, the alternative terms used could be misunderstood so there will not be provided. In summary, the key opportunities that were raised that could benefit from implementing additional regionality within EMD are:

- Strengthen the relationship between the state EMD and local emergency managers including improved communications and understanding the unique needs, assets, and aspects of local communities.
- Increase resource equity for under resourced small and rural communities by providing technical assistance, grant writing, planning, and training resources, where needed.
- Improve regional communication, coordination, and collaboration prior to and during emergencies.
- Support efforts of regions to strengthen local resilience and mitigation planning and implementation.

Potential Benefits

While there were a few voices that were adamantly against regionality, many participants expressed that a strengthened regional approach across that state could benefit the state and their local jurisdictions depending on how it was implemented.

Localized Support

A significant number of participants perceived regionality as a way to bring the state closer to local jurisdictions and increase state recognition of the uniqueness and specific needs of each community throughout Washington state and ensuring that one-size-fits-all models are not implemented. The ability for a state-run regional approach to accomplish this awareness, however, was articulated under the caveat that it could be achieved only if the state approach was focused on building trust and relationships with local jurisdiction during “blue-sky” times—a term used to address emergency management work that is not in active response.

Perspectives also surfaced in which emergency response managers did not see much value in a traditional brick- and- mortar building model. Instead, individuals expressed a desire to have regional state employees that were mobile. This seemed connected to ideas that regional state employees would receive greater understanding of local communities by being present within them rather than having local jurisdictions interacting with them virtually or traveling to them.

Stronger Communication

Some participants described state communications during the COVID-19 pandemic as both fragmented and incomplete or inconsistent. A regional presence was seen by some as an important mechanism for ensuring that information from the state is clearly communicated to local jurisdictions, and that local needs and priorities are communicated upwards to the state.

Equity

There was a strong voice in the conversations, especially the survey, which indicated regionality being a benefit for resource equity goals. Individuals pointed to the fact that many communities along the I-5 Corridor and more urban spaces often receive greater consideration and distribution of resources. This was believed to relate to the I-5 Corridor and urban space's capacity to have multiple agencies advocating their voices rather than their actual need compared to their eastern or more rural counterparts. Views were presented claiming that regionality could in fact provide a more direct line for the voices of less resource rich communities to be heard. This included the idea that, in a regional network, communities could have a greater collective voice when applying for state resources, such as grants. To achieve this, the regional approach should be proactive in connecting local jurisdictions with one another, even across disciplines (e.g., public health, emergency management, and hospitality—who can provide staging space or quarantine rooms).

Efficiency

- **Spending**
Some participants saw regionality as a way to increase efficiency in spending. Currently, there is a sense that many communities must compete with one another, including their immediate neighbors, if they are going to obtain enough resources to sustain their efforts. A prominent voice in this view were the smaller and more rural communities who expressed feelings that the cities and counties along the I-5 corridor and more urban spaces often have greater access to the resources that could benefit the smaller jurisdictions. Local communities within regional networks could increase their collaboration efforts in applying and sharing resources such as FEMA BRIC funding. This may also amplify the possibilities to increase how often various jurisdictions collaborate in their training/exercise and preparedness measures.
- **Response**
It has also been discussed that regionality could assist in a reduced response time to local requests by the state when receiving requests for assistance from local jurisdictions. This would reduce the span of control and increase efficiency of the state's response for all.

Washington State Benefits

During our interviews, there were also comments made that indicated how the state may benefit from implementing increased regionality.

Decision Making

Interviews illustrated a need to reduce the distance between emergency response managers and policy and decision makers. Emergency managers advocate for the specific needs and concerns of local communities while also implementing the decision and policies that have been made. Having open lines of communication with local jurisdictions increases the feedback loop following decision-making. Increasing the relationship between state and local jurisdictions could also reduce resistance when new decisions and policies are made as local jurisdictions are likely to have greater understanding of why decisions were made and ideally feel as though their input was considered.

Efficiency and Duplication

Connected to shortening the network between decision making and implementation is the idea that having a more direct connection to local communities could increase efficiency in resources by decreasing duplicative efforts. Interviewees commented that throughout the COVID-19 Pandemic local communities would set up efforts or access resources only to have the state duplicate them or send unneeded resources.

In connection, a stronger relationship between state and local jurisdictions could help ensure that the state can trust and turn to locals rather than reinventing the wheel. Many participants felt that during pandemic response, the state created its own structures rather than trusting, supporting, and increasing capacity for local emergency response management.

Concerns

As is the case with many complex questions, responses from participants represented a wide range of perspectives. At times, these perspectives aligned with one another (e.g., the desire for the state to be in a supportive role), while other perspectives contradicted each other (e.g., statements that regionality “is not the answer” while others claimed, “regionality would benefit us greatly”).

Bureaucracy

Among the greatest concerns individuals expressed around regionality was that it could create more bureaucracy. Some participants perceived the idea as adding another level of governmental structure between decision and policy makers and the local operations. This was viewed as potentially resulting in the slowdown of the overall emergency management system through inefficiencies and miscommunication, especially during response and recovery. To many participants, these concerns are supported by evidence surfaced during the COVID-19 pandemic. Jurisdictions that experienced closer connection between decision/policy makers and those who operationalized them experienced less confusion, miscommunication, less duplication, and quicker adaptation as the pandemic persisted. On the other hand, those working for jurisdictions that felt distanced connection expressed that messages were often dropped prematurely, efforts were duplicated across disciplines and jurisdictions, and they regularly remained unaware of what decisions were being made and why.

Duplication of Effort

Duplication was a common concern for interviewees in two ways. First, some local emergency response managers stated they already have regional networks and relationships. This view recognized state-run regional approaches could interfere or duplicate relationships that already exist. Some even feared the state would control where and when networks are built and used. Second, some people pointed out that there are already regional structures, such as the nine Homeland Security Regions. Many comments were made that the current regional structures are ineffective and rarely used beyond grant funding. It was clear that these regional structures were not relied upon for other actions such as networking and training.

Reduced Funding and Staffing

Another prominent concern around regionality was the fear of reduced funding and resources, including staffing. People were concerned that a regional approach would strip local jurisdictions of already scarce funding and resources by shifting, rather than expanding, them. Many were adamant that they are against

any form of structuring that would take away the resources they currently have. Instead, their biggest support surrounds efforts that would increase their capacity. This view was largely shared across all levels of emergency response management. It was also clear that there is skepticism by many that the state resources and support for expanding EMD are stable enough to ensure long-term stability for regional expansion. Concerns raised were that legislative funding is not necessarily consistent or dependable over a long period of time, especially given that budgets are biennial. Even though the additional resources and support would be welcomed, the concern was that without a long-term financial commitment, the increased support could wax and wane, creating challenges.

Consistent Support

Along with the sustainability of funding, participants discussed how support from state level decision makers for EMD work has historically come in waves, shifting as new administrations take office and positions turnover. There was commentary indicating that a regional structure would only be effective if, at the higher state levels, support and dedication for EM work was more stable. This view further aligned with concerns about sustainability of networks. Turnover in emergency management results in the continuous need to re-establish necessary relationships and trust. If there were high turnover in the regional structure, then regionality could fail to meet its objectives.

Confusion and Reduced Local Authority

Connected, some participants expressed worry that added layers between local jurisdictions and state EMD could increase community confusion on where to turn for information regarding emergency management during response. The pandemic surfaced that people often felt lost on where they could turn for guidance and information, and the concern is that adding another state layer could amplify such experiences.

Furthermore, interviewees continuously articulated that only local jurisdictions can identify the needs and realities of the local community. However, they hold no authority beyond their relationships and expertise to ensure the community follows the emergency response plan. Increase formalized regionality was perceived by some as having the potential to destabilize this already unstable authority. Through this destabilization, another perspective surfaced recognizing that even if the intent behind state formalized regionality is to support local jurisdictions, there was concern that this opens the door for the state to increase its authority over local emergency response decisions. This concern was somewhat based on some experiences during the pandemic.

Prominent Tensions

Although the Project Team has outlined potential benefits and concerns it is important to draw attention to where views expressed were divergent from one another. Specifically, in the surveys, there were views that contradicted one another.

Understanding Local Communities

Although many individuals expressed a belief that regional approaches could help the state be more in tune with the specific and unique needs of the communities across Washington State, this view was not unanimous. There were contradictory perspectives that focused on the idea that only individuals that live and work in a community daily can understand the holistic realities of that community. Overall, the amount of understanding gained by the state of local communities is likely to vary based on the community and the relationships built between local jurisdictional staff and the potential regional staff.

Providing Resource Equity

Ideas of regionality increasing equity were also a point of tension between survey responses. While some, specifically those in rural and more eastern communities, believed that regionality could increase the consideration they are given by the state when making decisions—such as resource allocation—others expressed that would not be the case. They instead argued that there could be the same inequalities just on a smaller scale. Put differently, they indicated that the larger jurisdictions in each region would continue to receive disproportionate access to resources over their more rural or less populated counterparts.

Considerations and Options

The Project Team collaboratively considered the divergent perspectives represented, looked for commonality, and developed potential options that could benefit local entities and the state. Many of these options may result in a reexamination of the current structure of EMD in Washington State. Recognizing that the current structure was put into place purposefully, the Project Team acknowledge that the landscape of emergency management has shifted since those decisions. Combining such shifts with the lessons that were/are being learned following the COVID-19 pandemic, the contemporary context is perfect for examining what structural changes are necessary to meet the emergency management needs of today.

Core Principles

Throughout the engagement efforts the Project Team identified some core principles, based upon participants' responses, which could guide any decisions associated with regionality in Washington State. These core principles have been identified through direct comments made throughout interviews, surveys, and forum discussions, as well as being extrapolated by our team based on other commentary provided by participants.

Local Control and Support

Likely the dominant core principle was the idea that regionality should only be a means of support for local communities and not strip them of "home rule." This suggests that regionality should not move decision-making away from local entities. This is further supported by models from across the nation. Support includes helping local communities apply for grants, coordinate training exercises, organize meetings, and facilitate networking opportunities. The support role would also include communicating the needs of local communities to the state and keeping local jurisdictions informed about the state inner workings. This support could especially impact communities whose emergency response efforts are an added responsibility to other positions rather than a full-time position.

Relationship and Trust Building

At every point in the engagement process, it was made clear that emergency response is dependent on strong relational ties and trust. This is often achieved through informal ways. If the state chooses to pursue regionality, it must be centered around a principle to actively and diligently build relationships and trust with local community members. This is especially important to do during "blue sky" times. By the time an emergency in any region arises, the relationships and trust must already be built to be effective.

Beyond building relationships from the state to local EMD, it is important for regional staff and efforts to prioritize connecting locals across jurisdictions and disciplines. One important way to do this would be to

approach relationship and trust building through a systems-thinking lens which seeks to critically examine which jurisdictions and disciplines are interdependent and/or could benefit from collaborative efforts. This includes strengthening and maintaining relationships between emergency response managers, public health, hospitality, and any other local community structures that could be beneficial to EMD efforts.

Flexibility

Flexibility is another key aspect of a regional approach that was regularly addressed. Emergencies and disasters rarely remain contained in communities. They usually extend across cities, counties, and state lines. interviewees advocated that they know their surrounding community partners and have the necessary relationships developed to adjust who they coordinate with depending on context. In association with this reality, participants articulated that any regional approach should be flexible and adaptable. Rigid universalized regional efforts could fail to meet the contextual realities of active emergencies.

Ideas of flexibility also appeared in statements that recognized communities do not necessarily share the same needs simply because they are geographical neighbors. Rather, a community may share more similarities, needs, and vulnerabilities with other communities across the state (for example two rural communities with urban neighbors). This leads to the recognition that a regional approach should recognize that within a region, communities are still unique, and a one-size-fits-all model does not work. Furthermore, a regional design may have to explore region layouts designed around other factors besides geography as well as being strategic for which communities a region is designed around (e.g., connecting cross state rural communities together or placing a rural community at the center of a regional effort).

Sustainable Funding and Support

Any move towards regionalization should ensure long-term sustainability. First and foremost, this should be built around efforts to expand emergency response management capacity across Washington State, not centralize it. That includes ensuring long-term increased funding, staffing, and other resources without shifting them from already existing jurisdictions. Moreover, sustainability also needs to be achieved in terms of support from elected officials and state decision-makers. Ultimately, built into a regional effort should be purposeful action to inoculate the emergency management system from shifts in political power.

Connected to this is the principle that any regional approach should hold at its center a commitment to adding value and capacity to local jurisdictions, and Washington State EMD as a whole, not limit or reduce it.

Resource Equity

A regional model should be dedicated to meeting the different needs of large and small urban and rural communities. This means implementing strategic efforts to ensure that smaller and rural communities do not continue to feel overlooked but valued and supported. This would include being flexible based on all communities acute and situational needs.

Regional Role for the State

As reflected in the Guiding Principles above, the state could consider 1) expanding its role in regional emergency management; and 2) to do so in a way that is supportive of, and not threatening to, local control. This could be accomplished by focusing the state's regional role in two primary capacities:

- **Serving as a communications conduit.**

This role could be active in all phases of emergency management and seek to:

- Provide consolidated and cohesive information from the state to local emergency managers.
- Share local concerns, needs, and questions with others at the state.
- Facilitate communication among local emergency managers at the regional level.

- **Serving as a convener and providing technical assistance and resources.**

This role would shift depending on the emergency management phase:

- In prevention, mitigation, and planning, the focus would be supporting grant writing and local planning, training, and exercises, perhaps organizing regional training or exercises.
- In response and recovery, the state's regional focus could include providing subject matter expertise, technical assistance, communications support, or other resources to support the local response.

Potential Models for Regionality in Washington State

Based on participant responses, the project team developed a series of potential models for how EMD might structure additional regionality. These potential models are just a starting point to stimulate thinking and discussion about how regionality could be structured.

Enhance and Expand Existing Regional Structures

Currently, regional structures throughout the state, such as the nine Homeland Security Regions are fairly limited in their scope to grant administration. This approach would call on and fund already existing entities to take a more proactive role and build capacity to support local jurisdictions further. This would mean working to build relationships with and across local communities, assisting in training exercises, and becoming a strong liaison between the state and local jurisdictions.

Community Liaison Team

This option is based around the idea of having a team of EMD employees, based out of EMD's main office that serves as a point of contact for local communities. These employees' jobs would be to get to know the local communities and develop a list, or menu, of services they can provide for local emergency managers. This provides local emergency response managers a point person to seek assistance from while also creating a proactive trust and relationship building entity on the state's behalf.

This model has the potential for various differing structures. First, there could be one liaison for rural communities and another for urban. EMD could also ensure that each of the state liaisons are specialized in different aspects of emergency response management and then "dispatch" the one who is most experienced in the need requested at the time. Or EMD could break the state into different geographic areas with one liaison for each.

Field Offices

This option is to establish one or more field offices in one or more locations around the state. These offices would have local field representatives who would assist with technical assistance, training, planning, communications, grant writing, and regional resilience efforts.

Field Representatives

Another option is the implementation of field representatives. This is similar to the community liaison option; however, these individuals would not be stationed in EMD's main office, but mobile throughout the state. They would be dedicated to traveling and engaging with various community emergency response teams and their community partners. This would also likely take on the latter of the liaison team structures in which the state would be divided into geographic areas, similar to states like Mississippi and Tennessee, and each representative would be assigned to and based in an area.

Adaptive Regionality

This model is enacted only in times of a statewide emergency such as the pandemic. Prior to an event occurring, the state could work within established regions to identify local entities who already have strong relationships and trust throughout their area and assist them in building their capacity to support their neighboring communities. Then only as needed by request or in response, the state could call on these entities to step into a state regional representative role and liaise between the state and affected community and provide assistance where needed.

Initial Recommendation

There appears to be sufficient benefit to increasing regionality in EMD, as long as decisions are guided by the core principles stated earlier in the report. The state could choose to start with piloting some additional regional structures, where it would benefit the state and local jurisdictions, and then modifying these approaches based on experience. Any new structures would have to be supported by additional sustainable financial resources and staffing resources. An initial option might be to establish an Eastern Washington field office that includes a small staff who could provide the technical assistance in training, planning, grant writing, and communication links. In addition, a few regional field representatives who focus on other areas of the state could also be added. These field representatives could be distributed throughout the state. These field representatives could also play a role in mitigation grant writing.

Moving EMD

There were many interviewees who discussed the idea that the state EMD should be moved from under the Washington State Military Department and established as its own department or be established in the Governor's Office. This would mirror other state models, such as Oregon whose EMD reports directly to the Governor since 2022. This idea is supported by the belief if EMD directly reported to the Governor, emergency response professionals would have a stronger presence at the state level and could work even more effectively as part of the Governor's decision-making processes.

Some believe that creating an independent EMD department would elevate the discipline and signal its importance as a state function. Some emergency management professionals at the city and county level have recommended this in their own organizations for these reasons.

The support for such a move, however, was not unanimous. Another perspective presented was that the EMD, the Governor's office, and DOH, at the state level, already have a strong working relationship that would not be improved by EMD moving. Furthermore, concern was raised that the current placement of EMD has created strong relationships between EMD, the federal Homeland Security Advisor, the Federal Grants Administrator, and the Commanding General of the National Guard who are often called upon for

labor and human capital in times of crisis. A move out of the Military Department, over time, could erode the current relationship that is a crucial part of response.

Should this be considered, significant effort should be placed on exploring what unintended consequences may arise from this move. Also, it could be useful for EMD to discuss with local emergency managers what concerns some may have and why they believe that restructuring EMD would be of benefit. This may uncover other issues that could be addressed in the current structure.

Conclusion

As this report has illustrated, perspectives surrounding a move for Washington State to increase regional state-run efforts vary across jurisdictions and communities. Through this report, the Ruckelshaus Center, in partnership with PNWER and BERK Consulting Inc., have described how engagement was completed between July 2022 and February 2023; provided background information about EMD—nationwide and at the state level—while also outlining how regionality is handled in other states; synthesized findings from engagement efforts; and provided core principles and possible avenues to be taken to strengthen regionality, should the state decide to make the shift.

The findings this report provides recognizes perceived benefits, by some, that increasing state-run regionality would provide, concerns others have about such a shift occurring, and foreseen challenges towards establishing regionality in a way that increases Washington State's capacity to respond to crises. While there were points of tension around if regionality would establish the necessary knowledge of local communities and provide equity for Washington State communities, there were many points of shared insight that also surfaced in terms of benefits, concerns, and challenges. Furthermore, through these views, the Ruckelshaus Center and its partners surfaced core principles that could guide any decision around regionality for emergency response management. These core principles were local control with state support, relationship and trust building being a primary focus, contextual flexibility, increased stability through high level support and expanded capacity, and commitments to ensuring resource equity across Washington State communities.

6. Focus Area E: Gaps and Needs for Volunteers to Support Medical Professionals in Performing Their Pandemic Emergency Response Functions in Washington State

This section provides strengths and areas for improvement related to volunteer activities during the COVID-19 pandemic.

As part of the State Pandemic Task Force, the DOH convened a workgroup to explore actions taken in response to COVID-19 to support the use of volunteers. Representatives from local governments, health jurisdictions, emergency management departments, medical reserve corps were invited to participate. State agency participation included representatives from the DOH, DSHS, WMD, OFM, Department of Ecology, Department of Agriculture, and Healthcare Authority. Feedback was solicited by the workgroup using both a survey and interviews. Some information in this section is based on additional research, best practice, lessons learned, and recommendations from the Contractor's previous experience in other jurisdictions.

The workgroup conducted a survey containing 47 questions and sent to representatives from state agencies, tribal partners health districts, medical reserve corps, senior service organizations, city and county emergency management agencies, and CBOs. Over 110 surveys were completed. Group and individual interviews were also conducted. The workgroup facilitated a total of five (5) focus groups:

- Medical Reserve Corps (MRC) representatives;
- State agencies and statewide organizations; and,
- Three (3) geographical-based groups based on a whole-community approach for volunteerism:
 - East of the Cascades
 - Northern I-5 corridor
 - Southern I-5 corridor and Western Washington.

For the purposes of the Task Force process, the workgroup used the definition of volunteer found in Revised Code of Washington (RCW) 51.12.035.

A "volunteer" shall mean a person who performs any assigned or authorized duties for any such unit of local government, or any such organization, except emergency services workers as described by chapter 38.52 RCW, or firefighters covered by chapter 41.24 RCW, brought about by one's own free choice, receives no wages, and is registered and accepted as a volunteer by any such unit of local government, or any such organization which has given such notice, for the purpose of engaging in authorized volunteer services: PROVIDED, That such person shall be deemed to be a volunteer although he or she may be granted maintenance and reimbursement for actual expenses necessarily incurred in performing his or her assigned or authorized duties: PROVIDED FURTHER, That juveniles performing community restitution under chapter 13.40 RCW may not be granted coverage as volunteers under this section.

Area for Improvement E.1: Management and Resource Support for Volunteer Programs

Observation: Staff responsible for recruiting and deploying volunteers during the COVID-19 response often had many additional responsibilities in addition to volunteer management, making it difficult to effectively use a vital resource. Many jurisdictions and organizations managing volunteers across the state were using many different types and formats of tools to manage and track volunteer activities, creating inconsistent accounting of volunteer needs and uses.

Analysis: Many of the staff in emergency management and public health agencies that who were responsible for coordinating volunteers had multiple other roles in addition to volunteer management. They expressed a need for at least one full-time employee to manage their volunteer program during non-emergencies and a need for additional management staff during emergencies. During COVID-19, organizations reported they had difficulties with managing volunteers due to a lack of internal staffing dedicated to managing their volunteers throughout COVID-19. The lack of dedicated volunteer management personnel delayed the recruitment, conduct of background checks, placement, and tracking during their response. Sustainable volunteer management programs are needed to help ease the burden on small agencies and organizations that do not have the capacity to recruit and train volunteer management personnel.

Organizations also reported using many different tools to manage their volunteer program. Examples of the tools they used included WAServ, which is a registry for individuals who are willing and able to help during disasters and significant events, Microsoft Excel spreadsheets, Smartsheet's, Salesforce, Volgistics, and direct email, phone calls, text messages, and social media. Some organizations sent spreadsheets of potential volunteers to facilities requesting assistance and allowed the facility to coordinate directly with the volunteer. Although communications back to the originating organization notifying them which volunteers were being used from the spreadsheet was requested, the receiving facility oftentimes was unable to respond. Therefore, it was challenging to understand whether a volunteer vacancy had been filled or which specific volunteer was being used. This also led to problems with accurate accounting for a volunteer's time. A volunteer management tool available to all jurisdictions that can be used to onboard, deploy, track volunteers is needed to ensure volunteers are deployed quickly

Recommendations:

- a. Collaborate with existing volunteer organizations across Washington such as the Serve Washington program, Medical Reserve Corps, American Red Cross, and others to develop a statewide volunteer program to create a more robust and sustainable volunteer recruitment and management system. Collaborations could begin with development of standardized set of tools and resources for local jurisdictions, state agencies, and organizations using volunteers to use.
- b. Evaluate other state programs/models to support the creation of a Disaster Service Worker program similar to that in California.

Area for Improvement E.2: Develop a Statewide Volunteer Mechanism

Observation: The inconsistent nature of volunteering across the state creates ineffective use of volunteer resources, duplication of efforts across state agencies, and inefficiencies in needed human resource during times of emergency.

Analysis: Across Washington state agencies a number of volunteer programs using different funding, indemnification mechanisms, and mission areas existed pre-pandemic. During the pandemic, with a surge of citizen interest in contributing to the collective response to the emergency, the independent, autonomous programs were unable to meet the needs of people looking to serve. A statewide approach could provide a centralized registration, tracking, deployment, indemnification, reimbursement, training, and demobilization structure that can be scaled up or down to meet the demands of the State enterprise and would ensure that appropriate vetting, verification, and training exist in all places regardless of mission area. Several existing state resources, such as those listed below, could be reviewed and expanded to fit the needs of a statewide volunteer program.

- [Serve Washington, Americorps](#)
- [Secure Access Washington](#)
- [State of Washington Job Opportunities | Work that Matters \(governmentjobs.com\)](#)
- [Careers.wa.gov - Find a job working for Washington state](#)
- [Washington State Learning Center | Department of Enterprise Services \(DES\)](#)

One example of a statewide volunteer program is the Disaster Service Worker program implemented in California in the 1970s, which primarily pertains to public service employees, but also has a volunteer side. This allows California to have a consistent statewide program that manages a cadre of recruited and vetted volunteers for specific tasks at the ready when emergency strikes

Recommendation:

- a. Develop a unified statewide inter-agency approach to volunteer management to support WMD, the Departments of Ecology, Agriculture, Health, Commerce, Children, Youth, and Families, Social and Health Services, Natural Resources, and other agencies.

National best practice for surge staffing
The State of California Disaster Service Worker program includes all public employees impressed into service by a person having authority to command the aid of citizens in the execution of his or her duties during a state of war, a state of emergency, or a local emergency. This program includes both employees and registered volunteers. More information can be found here: <https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/human-resources/disaster-service-worker-volunteer-program/>

Area for Improvement E.3: Mechanisms to Convert Volunteers to Paid Staff

Observation: During long-duration disasters, organizations need mechanisms they can use to convert volunteer staff to paid staff.

Analysis: During the initial months of COVID-19, many organizations reported having adequate medical and non-medical volunteers. However, as the pandemic continued, many volunteers began to experience burnout, needed to return to the workforce, or had other personal matters to return to. Therefore, they chose to end or minimize their volunteer availability. Organizations found it increasingly difficult to use volunteers who had minimal or restricted availability. Many volunteers chose to continue to work,

however, and the organizations they supported oftentimes began to use them full time. Organizations reported feeling guilty at using volunteers for lengthy periods of time while believing their volunteer's work should more appropriately be filled by paid staff. Some organizations found funding and converted positions from volunteer to paid staff. Many organizations could not secure the funding for this.

Recommendations:

- a. Identify funding sources that social services agencies and nonprofits may access to expand or support existing programs and supplement needed surge staffing.
- b. Include social service organizations in planning efforts, trainings, and exercises with state agencies to encourage further collaboration and coordination.

Area for Improvement E.4: Volunteer Opportunities for Vulnerable Individuals

Observation: Potential volunteers with time and skills to offer, often, were amongst the higher-risk of negative consequences from contracting COVID-19, such as those over 65 years old, decreasing a vital pool of volunteers.

Analysis: Many people in the available volunteer pool were those who were most at risk for getting COVID-19. Oftentimes, they are elderly or have conditions that made them more at risk. While they wanted to volunteer, they chose to not risk exposure to COVID-19 while providing volunteer services. On the other hand, there were many people who wanted to volunteer but chose to not get vaccinated, which made them ineligible to assist in person. Some organizations developed opportunities for volunteers to work from home. For example, they used them as part of call centers, contact tracing, or with other administrative tasks. When appropriate, training programs for home-based volunteers could help bolster the availability of volunteers.

Recommendation:

- a. Develop a list of activities and tasks that can be conducted in a remote environment to ensure utilization of volunteer resources.

Area for Improvement E.5: Integration of Equity in Volunteerism

Observation: Often, underserved, marginalized, and diverse immigrant communities were supported by volunteers who might not have been familiar with the local culture, customs, and/or needs of the community, which could possibly contribute to a mistrust of the intended support.

Analysis: Throughout the pandemic, many marginalized or underserved communities were not represented in the volunteer pool who served them. A best practice for gaining trust and access to many communities is through engagement with trusted community members. Some jurisdictions reported success in accessing these communities by using community health workers, also known as Promotoras in Hispanic communities. Other trusted members of the communities provided translating or testing and vaccination assistance. Developing incentives that encourage volunteerism in underrepresented communities can help gain trust and access to those communities during disasters.

Recommendation:

- a. Collaborate with trusted organizations providing services and advocacy to underserved communities to support development of volunteer opportunities to match volunteers familiar with the communities they are working to support.

7. Focus Area F: Gaps and Needs for Tools to Measure the Scale of an Impact Caused by a Pandemic and Tailoring the Pandemic Response to Affected Regions Based on the Scale of the Impact in Those Regions

This section provides strengths and areas for improvement related to tools to measure the scale of impact caused by a pandemic as it relates to activities during the COVID-19 pandemic. Information in this section was developed through IEM's review of individual state agency AARs and additional information provided, highlighting items that have relevance across all state agencies.

Strength F.1: Development of Data Dashboards

Observation: Development of various data dashboards provided an effective way to share vital data and statistics across state agencies as well as throughout local jurisdictions and the public.

Analysis: The Washington Department of Commerce contracted for the development of the COVID 019 Economic Recovery Dashboard to track the state's economic recovery across several different data indicators. This dashboard allows for analysis on a county-by-county basis, and it can inform state programs through COVID-19 recovery and beyond. The Department of Commerce funded and developed the Small Business Resiliency Network to provide technical assistance to small businesses from culturally relevant, trusted community messengers. It was updated monthly and is available to the public. Another dashboard is the DOH COVID-19 Data Dashboard, which provided vital data not only to the public but across state agencies, and local jurisdictions as well. This dashboard included data related to COVID cases, testing, vaccination rates, hospitalizations, and deaths at the state and local levels.

Strength F.2: Development of a Frequently Asked Questions (FAQ) Tool for the Energy Sector

Observation: The FAQ tool developed for the energy sector provided up-to-date and consistent information to the energy sector.

Analysis: The ESF #12 group developed an FAQ tool for the energy sector to ensure energy stakeholders remained aware of the evolving PPE and safety guidelines and requirements released by DOH and the Governor's office. They also implemented a data analysis unit that created re-occurring survey tool to assess energy sector resource requests, safety information, and to track operational capabilities. This tool was very useful to help stay ahead of emerging challenges. There were also regular coordination calls with energy sector stakeholders. The feedback was received from these calls was extremely helpful in getting updated and accurate information. ESF 12 shared the state's situation reports, the COVID-19 data dashboard, and other official links with their energy emergency distribution list. These resources were well received by energy sector stakeholders.

8. Focus Area G: Gaps and Needs in Health Care System Capacity and Case Tracking, Monitoring, Control, Isolation, and Quarantine and Deploying Medical Supplies and Personnel

This section provides details on strengths, areas for improvement, and recommendations identified through the DOH *Washington Statewide Comprehensive After-Action Report Recommendations for Focus Area G*. In addition to the information presented in this section related to the Focus Area G, the full report includes information and recommendations related to topics not included in Focus Area G that include behavioral health impacts and jurisdictional challenges. The *Washington Statewide Comprehensive After-Action Report Recommendations for Focus Area G* dated April 11, 2023, in its entirety is available on the Task Force website: <https://mil.wa.gov/pandemic-after-action-report-task-force>.

For each strength or an area for improvement, there is the primary observation and a narrative analysis based on information review. Where appropriate, the analysis presents recommendations that are specific and actionable. The strengths and areas for improvement are organized by the following topics:

- Healthcare Capacity
 - Healthcare Workforce
 - Long-term Care
 - Social Worker and Healthcare Capacity Challenges
 - Mortuary Services
- Case Monitoring, Disease Surveillance, and Operational Visibility
- Case Tracking and Investigations
- Control and Prevention
- Isolation and Quarantine
- Public Health Supply Chain
- Deploying Personnel
- Deploying Medical Supplies

8.1. Healthcare Capacity

Area for Improvement G.1: Disaster Surge Capacity for Healthcare Infrastructure

Observation: The hospital business model in Washington, and many other states, prioritizes high patient capacity levels for optimal profitability, resulting in a lack of disaster-level surge capacity.

Analysis: This limited hospital surge capacity led to bottlenecks in the system during the pandemic and created cascading impacts on hospitals and other healthcare organizations across the state. The Washington State Hospital Association (WSHA) reported that many healthcare facilities were operating at 120% to 130% capacity in 2022, posing significant challenges for surge-related response efforts. Due to the problems at larger hospitals, rural critical access hospitals, which are generally intended for shorter in-patient visits with lower-level illnesses and prompt transfer of patients to larger systems if required,

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encountered significant delays in patient transfer causing them to retain patients for longer than standard practice. The sudden influx of patients overwhelmed the existing healthcare infrastructure, leading to bed and medical supply shortages, treatment delays, long wait times, and further strain on already overworked healthcare workers. Healthcare facilities encountered further obstacles due to their emergency management plans being insufficient to handle the level of crisis presented by the pandemic. Healthcare facilities (17 provider types) are required, as a Centers for Medicare and Medicaid Services (CMS) conditions of participation to receive reimbursement are required to have emergency management plans in place. The CMS and other regulatory bodies have established guidelines and regulations for these plans, to ensure that healthcare facilities are adequately prepared to handle emergencies. Unfortunately, the assessment of these plans by regulatory officials is a small component of the larger site survey conducted to ensure compliance of safety, quality of care, and infection control protocols in healthcare facilities. The level of scrutiny and prioritization of emergency management plans varies depending on the provider type, the agency conducting the regulatory survey, the background and experience of the surveyor, and the level of preparation of the facility.

By taking a comprehensive and proactive approach to healthcare system resilience, Washington can better prepare for future emergencies and ensure that all members of their communities have access to high-quality healthcare services. This includes building surge capacity into hospital systems and associated payment models, improving emergency management programs, increasing fiscal and training support for healthcare workers, addressing healthcare disparities through access to care, and investing in training programs to increase the number of healthcare professionals. Healthcare resilience involves collecting and analyzing data on healthcare outcomes, utilization, and costs, as well as conducting regular assessments of emergency management programs (including associated plans) and other preparedness measures. Prioritizing equity in healthcare delivery is critical to ensure that vulnerable populations have access to safe and appropriate care in emergencies. Focusing on equity includes addressing healthcare disparities, improving language access and cultural competency, and increasing access to healthcare services in underserved areas and among underserved populations.

Recommendations:

- a. Establish a statewide healthcare resilience collaborative charged with developing inter-agency and inter-jurisdictional strategies for hospitals and key healthcare organizations to build more resilient and flexible models of care and identify new and innovative emergency healthcare workforce strategies that could be implemented in disasters.
- b. Conduct an evaluation of what healthcare facilities and resources that Washington state needs to support our growing population, and what system incentives or approaches are necessary to support the wise creation of additional healthcare capacity in our state.
- c. Develop and enhance systems and policies that sustain and further develop rural healthcare facilities and Critical Access Hospitals to ensure appropriate level of health care for Washington state Residents.
- d. Washington state should develop a mechanism for activating a statewide ambulance strike team that provides both additional Emergency Medical Services (EMS) as well as inter-facility patient transport capacity during emergencies and large events. Additional details related to suggestions for a statewide ambulance strike team are included in the full report located on the Task Force website.
- e. Update state-level Medical Surge Plans at the health care facility, county, and state level to better reflect agreed upon strategies for mitigating surge across our state's healthcare system during

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emergencies. Additional details related to a state-level Medical Surge Plan are included in the full report located on the Task Force website.

- f. ESF 8 agencies should collaborate to develop an annual cycle of healthcare emergency preparedness trainings and exercises that involve healthcare, public health, EMS and first responder agencies, county and city officials, state agencies, and community volunteers including MRC, and that advance pandemic preparedness statewide. Additional details related to suggested trainings are included in the full report located on the Task Force website.
- g. Prioritize equity in healthcare access and delivery. This means addressing disparities in healthcare access and outcomes for marginalized communities, including people of color, low-income individuals, and rural populations. To achieve this, policymakers need to allocate funding for community-based healthcare programs, expansion of Medicaid coverage, and financial incentives for healthcare providers to work in underserved areas.

Area for Improvement G.2: Healthcare Workforce Surge Capacities and Mechanisms

Observation: As a strategy to meet surge capacity, Governor Inslee issued Proclamation 20-24 on February 29, 2020, which restricted all non-urgent medical procedures, thus providing additional bed capacity, medical supply conservation, and reduced risk of exposure to patients and staff. However, the disruption in care delivery had negative unintended impacts on the healthcare system, which continues to be felt across the state today.

Analysis: Patients requiring access to non-COVID related care were unable to receive services in a timely manner due to appointment backlogs, compounded by staffing shortages. The lack of available appointments drove patients to seek treatment at Emergency Departments (ED), resulting in higher patient volumes and increased patient to provider ratios, consequently placing additional strain on the ED's capabilities and capacity. The added loss of healthcare staff during the pandemic was due to multiple factors, including, but not limited to, increased risk to personal physical and mental health, increased patient to provider ratios resulting in higher burden to caregiver, long work shifts, denied time off, denied hazard pay, and burnout. Additional healthcare waivers were implemented to remove administrated barriers, such as expediting licensure requirements for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) across state lines.

Our state's healthcare system must become more resilient in order to handle surges in demand, retain existing workforce, prioritize workforce well-being, and effectively provide care for patients during emergencies. Building surge capacity into hospital systems, expanding access to telehealth services, implementing new staffing models are interventions that can help to alleviate burnout and staff shortages. Improving supply chain management can help ensure that the healthcare system is better equipped with the medical material needed to handle future crises.

Recommendations:

- a. Adopt a mechanism to allow for expedited licensure of RNs and LPNs in the state of Washington. This will assist healthcare facilities with having the appropriate and necessary staffing levels to care for patients. It reduces the burden on healthcare workers and provides the opportunity for high-quality care without staff being overworked and at risk of burnout.
- b. Create statutory requirements that provide hazard pay for staff working in healthcare related fields during a federally declared major disaster that is caused by infectious disease or other

public health related response. Stafford Act Funding should be evaluated to finance this recommendation.

- c. Create policies and reimbursement models that support telehealth, such as increased funding for telehealth services and expanded coverage by insurance companies.
- d. Conduct a study designed to identify the forces and influences that affect healthcare staffing in hospitals in Washington state.

Area for Improvement G.3: Prioritization for Long-Term Care (LTC) Facilities

Observation: Many existing county and state pandemic preparedness plans did not adequately prioritize the LTC sector, and there was limited or no routine follow-up to update existing plans with LTC partners, which hampered adequate and timely reaction to the pandemic.

Analysis: The pandemic has illuminated significant shortcomings in pandemic preparedness and response systems, particularly regarding the LTC sector. Access to testing and PPE in the early stages of the pandemic was a major challenge for the LTC sector, which left many workers and residents vulnerable to infection. Lack of knowledge on screening and limited access to healthcare professionals and testing hindered efforts to identify symptoms among residents and staff.

Long-term care facilities faced additional challenges in complying with regulatory requirements during the pandemic and received fines for non-compliance with COVID-19 regulations, leading to negative impacts on their operations. Although compliance is important for the safety of residents and staff, the unique circumstances of the pandemic should also be taken into consideration. Issuing fines is not the most constructive approach; providing education and training for staff of LTC facilities on compliance during public health emergencies would be more beneficial to the healthcare ecosystem. The DOH's Office of Science and Health Division of Disease Control and Health Statistics Office of Communicable Disease Epidemiology Healthcare Acquired Infections Team, as well as some local health jurisdictions, conducted extensive outreach and provided technical assistance to LTC facilities, however, many facilities stated additional training support would have been helpful. To improve compliance, LTC regulatory officials should collaborate with public health authorities to identify gaps in regulations and guidelines that may hinder compliance during public health emergencies. This collaboration can lead to the development of more effective guidelines and training programs tailored to the specific needs of LTC facilities during public health emergencies.

Many LTC facilities also experienced challenges in transferring residents to hospitals due to capacity constraints or restrictions on hospital admissions. This made it difficult for residents with respiratory problems, such as those with COVID-19, to receive appropriate medical care. To address this issue, some LTC facilities added respiratory therapy services, which helped avoid hospitalizations by providing in-house respiratory care for their residents.

Furthermore, the LTC sector is currently facing staffing shortages and financial limitations, which are hindering their ability to admit patients from hospitals who are no longer in need of hospitalization, even when there are available beds. Additionally, numerous LTC facilities have declined to accept these patients due to the challenges of providing care to individuals with COVID-19 in a long-term care environment. This has caused difficulties for hospitals, as they cannot discharge patients, resulting in bed shortages. Due to the inability of hospitals to transfer patients to LTC facilities, there has been a delay in hospital discharges, which has led to an increased burden on emergency departments, hospital staff, and

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resources. As a result, healthcare costs have escalated, and patients in need of care are experiencing longer wait times.

Recommendations:

- a. Invest in workforce development programs specific to LTC. It's essential to develop a stronger and more resilient system for the future that protects vulnerable populations and treats no one as expendable, not just during the current pandemic but for generations to come and any future emergencies.
- b. Develop structures that enhance coordination between public health emergency preparedness and response, communicable disease subject matter experts, regulatory teams, and the long-term care associations to refine the set of optimal response measures reviewed in regulatory assessments of preparedness at LTC facilities.
- c. Ensure long-term care facilities, including skilled nursing facilities have dedicated and trained staff for infection prevention. Facilities should provide training on infection prevention and control to staff regularly and have up-to-date evidence-based policies in place, including policies and protocols for timely communication between residents and their family and friends.
- d. Strengthen planning partnerships between LTC facilities, local health jurisdictions, public health, and emergency management to lead to a more coordinated and patient-centered care approach. Additional details related to suggested plan development are included in the full report located on the Task Force website.
- e. Implement robust coordination channels between LTC facilities, the broader healthcare system, public health authorities, and the social sector, as well as adequate follow-up mechanisms on the strategies undertaken, with standardized data on infections and characteristics of facilities and residents.
- f. Efforts should be made to increase coordination and collaboration between DSHS, LTC regulatory officials and the DOH, to ensure LTC facilities are prepared to handle public health emergencies and are in compliance with relevant regulations and guidelines. Facility site- visits from local health jurisdictions (LHJ) and DSHS regulatory officials must be well- coordinated to prevent overwhelming facilities and lessening their ability to care for their residents during a public health emergency.

Area for Improvement G.4: Support for Mental Health and Social Services

Observation: The capacity for psychiatric facilities were strained, leading to individuals seeking mental health treatments in emergency rooms, causing further strain to a system that was stressed prior to the COVID-19 pandemic.

Analysis: The COVID-19 pandemic has posed significant challenges for mental health services and social workers in Washington state, impacting both individuals seeking treatment and the professionals providing care. The increase in mental health patients seeking emergency room treatment, with a shortage of psychiatric hospital beds created difficulties for hospitals, as patients with severe psychiatric impairments cannot be discharged due to bed shortages in psychiatric facilities, placing a strain on hospital resources that are not equipped to manage these patients. Additionally, if a patient with severe psychiatric impairments tests positive for COVID-19, hospitals must hold them for ten days before transferring them to a psychiatric facility, causing further capacity issues. This situation is not conducive to

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patients in psychological distress, as they are not receiving adequate psychological therapy while in the emergency room setting.

Furthermore, Washington state government issued a vaccination mandate in 2021 that required all state employees to be vaccinated in order to protect public health and safety. However, this mandate resulted in some social workers choosing to resign rather than comply, while others have faced an increased workload without any additional compensation, financial incentives, or hazard pay. Social workers are currently facing challenges due to understaffing and difficulties in transferring cases, which has resulted in extended caseloads that negatively impact effective case management. Social workers are also dealing with situations where clients have been discharged from the hospital to an adult family home without adequate medication or support. This is particularly problematic for clients who rely on Social Security Income (SSI) benefits, as their benefits may be temporarily suspended due to long behavioral health hospitalizations, resulting in an inability to access the psychological medications they need. These challenges create a dangerous situation for individuals who are already in a fragile psychological state and rely on medication to manage their symptoms. Without access to psychiatric medications, these individuals experience worsening symptoms and often require re-hospitalization.

Social workers are also responsible for ensuring that patients discharged from psychiatric institutions have a discharge plan that includes wrap-around services and home care, based on the patient's functional needs assessment. Unfortunately, social workers are encountering challenges in finding caregivers due to technical issues with the Consumer Direct Care Network Washington (CDWA), a system designed to streamline the recruitment and vetting process of healthcare providers in Washington state. CDWA was launched by DSHS in February 2022, and it requires all providers to create a profile on CDWA in order to receive payment for services rendered, while clients must create a profile to receive a suitable match. However, creating a profile is an online-only process, and disabled clients are expected to identify care providers and conduct provider interviews, which is unrealistic and presents access barriers for them. This has placed an unfair burden on those who lack the functional capacity to navigate the system. Additionally, the CDWA database has numerous software problems that inhibit providers and clients from creating a profile. Many care providers who were in pay status with DSHS at the time CDWA was launched were unable to create a profile and subsequently experienced lost wages. Disabled clients also experienced loss of care due to the inability to create a profile.

According to social workers, there are numerous accessibility issues with the CDWA system. The lengthy wait times for technical assistance, complicated profile creation process, and unrealistic expectations for disabled clients to manage the system and conduct caregiver interviews all contribute to the system's overall inefficiency. The inability of providers to create a profile has added further obstacles that prevent the system from functioning as intended. The CDWA website's technical support only offers one customer service number with wait times that often exceed 2 hours. After waiting, clients may be informed that someone will call them back or send an email. The customer service representatives don't have individual phone numbers, so if they leave a voicemail, clients must call the customer service line and wait in the long queue again. It is important to recognize that these clients have difficulty explaining their needs and often lack the functional capacity to access and use technology, including email and other online tools. They also lack the concentration, pace, and persistence required to call customer service, wait in a long queue, and then explain complex technical problems. Trained social workers with experience are also having difficulty navigating the CDWA system, raising concerns about the system's usability and accessibility, especially for individuals with severe mental health disabilities.

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In situations where social workers are unable to find homecare providers for their patients upon their release from psychiatric institutions, the institutions are unable to discharge them, which causes a cascade of problems for healthcare system capacity. Among them is the inability of psychiatric institutions to admit patients from hospital emergency rooms, as there is a shortage of psychiatric beds available. The situation places pressure on hospital resources, which may not have the capacity to provide care for patients who require involuntary psychological hospitalization and extensive psychiatric treatment. This leads to significant strain on the healthcare system, causing bottlenecks in emergency departments and putting additional pressure on resources. In order to prevent undue burden on the healthcare system, it is crucial for social workers to have adequate support and resources to secure appropriate care for their patients, ensuring safe and timely discharges from psychiatric institutions.

Recommendations:

- a. Enact policies that provide temporary coverage of medication costs for individuals who experience a temporary suspension of benefits or creating partnerships between hospitals and pharmacies to ensure that individuals have access to their medication upon discharge.
- b. Re-evaluate minimum home healthcare training requirements to allow qualified family members to care for loved ones and provide competitive prevailing wages. This would alleviate the continuing home healthcare staffing shortages.
- c. Prioritize resources and support needed by social workers to effectively manage their caseloads and provide the necessary services to their clients. This includes addressing staff shortages, improving the process of transferring cases between social workers, and investing in technology. Implementing these recommendations will improve the quality of social services and promote the well-being of social workers and their clients.
- d. Prioritize hiring more social workers and providing incentives to retain them. This can include increased salaries, benefits, and opportunities for professional growth.
- e. Improve the accessibility and usability of the CDWA system for clients with mental health disabilities and healthcare providers seeking employment. Additional details related to considerations for this policy recommendation are included in the full report located on the Task Force website.

Area for Improvement G.5: Support for Death Services (Coroners, Mortuaries, Crematoriums, Funeral Homes)

Observation: In Washington state, county emergency managers are legally responsible for developing the All-Hazard Response Plan, which includes fatality management. However, many counties did not have emergency management plans in place, which created confusion during the pandemic response as it was unclear who was in charge. Some entities were bypassing their local community systems and calling the DOH directly. Every county was handling processes differently, and lack of coordination and communication resulted in further difficulties during the pandemic.

Analysis: Washington state law assigns county coroners the responsibility of investigating suspicious or unusual deaths and determining the cause of death for criminal or civil liability. However, different counties interpret their authority differently, leading to confusion, delays, inefficiencies, and errors. Coroner offices also have varying operating procedures, some investigating every death on a specific list while others lack the capacity to do so. Smaller coroner offices may not require reporting of all hospital deaths and may not have complete documentation of deaths in their county. These offices also struggled

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to track COVID deaths, as they typically do not track other natural deaths in a hospital setting, such as pneumonia or the flu. Funeral homes have also faced challenges with capacity requests as they receive multiple requests from different entities for the same capacity number, which creates a burden for small funeral homes that do not have the capacity to report these numbers to multiple entities daily. To ensure effective management of death reporting, there needs to be clear and defined roles and responsibilities for each county coroner and medical examiner, along with oversight of all death reporting in every county. There also needs to be a unified reporting system, where all deaths are added by each entity storing the remains.

Additionally, in Washington state, county emergency managers are legally responsible for developing the All-Hazard Response Plan, which includes fatality management. However, many counties did not have emergency management plans in place, which created confusion during the pandemic response as it was unclear who was in charge. Some entities were bypassing their local community systems and calling the DOH directly. Every county was handling processes differently, and lack of coordination and communication resulted in further difficulties during the pandemic.

To tackle the challenges in the mortuary services system in Washington state, a coordinating committee was formed by DOH with representatives from the medical examiner's office, county coroners, the Department of Licensing, and some hospital communities. The committee held weekly calls to discuss capacity issues and problem-solving, with one of the objectives being to educate the different players in the complex system. For example, funeral homes were initially not provided with PPE due to a lack of understanding of their important role in society. While they eventually received the resources needed, the lack of understanding highlighted the need for government officials to fully comprehend the mortuary services system to ensure that everyone is provided with the necessary resources to perform their duties safely during a pandemic.

Washington state mortuary services are composed of three major components: healthcare system and hospitals, funeral homes and crematories, and the medical examiner and county coroner system, all of which have different authority. When a person dies in the hospital, the hospital facility must hold onto the remains until the family determines what type of services they want. This process can take several days, which results in storage capacity issues. The hospital infrastructure in Washington state is old, with an average age of 25 years, and has minimal holding capacity for human remains. Hospitals in Washington state that have an average of 300 beds only have a morgue capacity of three. Due to the surge of COVID-19 deaths, hospitals became overwhelmed, leading to a backlog of remains being held for several days, awaiting pickup by funeral homes. The Funeral Board within the Department of licensing has the authority over transport of human remains, but funeral homes were also facing challenges with storage capacity, staffing shortages, and transportation problems. In addition, hospital morgues were often the last pickup priority for funeral homes because when they arrive, they would regularly have to wait for an extended period outside the hospital morgue or in the hallway before somebody would come to let them in. After a funeral home receives human remains, they must obtain a disposition permit by sending a request to the doctor for signature and then filing it with the DOH. However, in some counties, the permit must be obtained through the County Medical Examiner, and then filed with DOH for the death certificate. County Medical Examiners are required by law to issue death permits within three days of death. However, due to staffing shortages and the increase in deaths caused by COVID-19, the medical examiner's office has been unable to meet this requirement, resulting in delays. This has a direct impact on funeral homes, who cannot proceed with dispositions, and Tribal Nations, who are unable to proceed with customary ceremonies, which usually take place within days of a Tribal member passing.

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Regulatory barriers also prevent transport across county lines without the death permit, causing additional challenges for families. The delay in issuing death permits not only affect the grieving families of the deceased, but they also disrupt traditional cultural practices and customs. Funeral homes are unable to provide timely services to their customers, while Tribal Nations are unable to perform customary ceremonies within the usual timeframe. These regulatory barriers have caused additional distress to grieving families.

Another challenge for funeral homes is unclaimed remains. Washington state law requires funeral homes and medical examiner's offices to hold onto unclaimed human remains for 90 days, which is problematic for funeral homes with limited storage capacity. Funeral homes can use embalming instead of refrigeration for non-refrigerated storage, but they require permission from an authorized family member or next of kin. However, some families do not approve of embalming due to the cost involved and their reluctance to bear the financial responsibility.

Cremation is the most common method of disposition in Western Washington, but environmental regulations limit their operation and capacity. Crematories were already at full capacity before the pandemic, and the surge in COVID-19 deaths added more volume to their workload, causing additional challenges with storage capacity. Some counties were able to obtain portable morgues, temporary storage trailers, and containers for storing fatalities at hospitals, which was particularly beneficial in the eastern and central regions of the state. This allowed for additional space for those who needed to be transferred. However, storage capacity for decedent remains continues to be a statewide challenge across the mortuary services system.

Recommendations:

- a. Request the Regional Clean Air agencies to expand access and regulations for cremation services during fatality surges that permit 24/7 access and mobile crematories to process decedents.
- b. Review and incorporate Medical and Mortuary Services lessons learned into the ESF 8 Medical and Mortuary Services Fatality Management Appendix.
- c. Establish a temporary emergency waiver or contingency plan that provides flexibility to allow for alternative transport options and streamlined permit and approval processes during public health emergencies and mass fatalities. The waiver must also include language to expedite the release of human remains back to Tribal Nations so they can proceed with customary ceremonies.
- d. Increase decedent transportation and geographically accessible storage facilities awaiting interment processing across Washington State.
- e. Create emergency protocols that allow scalability of decedent storage options in disasters. This can help alleviate the strain on funeral homes and other storage facilities and provide a temporary solution for families who may be waiting for transportation or other arrangements.
- f. Provide funding for a unified reporting system, where all deaths are added by each entity storing the remains. The centralized database should have the capability to streamline the permit issuance process and improve communication between funeral homes and County Medical Examiners. The system should also have the capability to allow funeral homes to track the status of permits and receive real-time updates on any delays or issues. This would improve transparency and accountability in the mortuary services system and help ensure that decedents are treated with dignity and respect, even during times of crisis.

- g. Explore legislation that mandates consistent death reporting with regulatory oversight in every county. This legislation should provide the necessary funding to support this requirement, including the hiring of additional staff to oversee death reporting, the development of technology infrastructure to facilitate reporting, and the training of staff and funeral home directors on regulatory requirements and best practices. Having oversight of all death reporting in every county is important for ensuring that deaths are accurately reported and tracked, which will help inform public health responses and interventions. It will also help identify patterns or trends in mortality that may indicate emerging public health threats or issues.
- h. Require counties to have standardized protocols and procedures in place for death reporting and investigation, as well as effective communication channels between different entities involved in the mortuary services system. This will help to minimize confusion and ensure that all deaths are reported and investigated appropriately, regardless of the county size or population. Additional details related to this recommendation are included in the full report located on the Task Force website.
- i. Create a central document that outlines the protocols and standards for coroners and medical examiners to follow and ensure they have access to the necessary information and guidance to carry out their duties effectively, regardless of their level of experience or tenure in the position. The document must provide a consistent set of guidelines that recognizes jurisdictional sovereignty but ensures that basic standards are maintained from county to county. It is important to note that implementing such a document would require careful consideration and collaboration with coroners and medical examiners across the state to ensure that it is comprehensive, practical, and acceptable to all parties involved. Additionally, funding and resources may be necessary to develop and maintain the document over time.
- j. DOH should provide unified guidance on identifying highly infectious disease positive decedents, handling human remains, and environmental guidelines. There should also be clarity on rules and guidelines for dealing with surges in hospitals, funeral homes, and crematories, as well as other available options such as portable storage and crematories. It is important to understand the various authorities and regulatory oversight of each of those areas and how they affect the process. Providing clear guidance and understanding of the system will help with future response efforts

8.2. Case Monitoring, Disease Surveillance, and Operational Visibility

Area for Improvement G.6: Support and Expansion for Disease Surveillance Capabilities and Data Management

Observation: Early supply chain shortages, compounded by a crippling workforce and underfunded public health, created a cascading effect on healthcare system capacity resulting in unreliable and inadequate disease surveillance and medical surge.

Analysis: The lack of testing availability prompted the implementation of a syndromic surveillance strategy as a stop gap measure. Once testing kits became available, public health laboratories were quickly overwhelmed with the number of COVID-19 tests that needed to be processed. Not only was the state Public Health Laboratory not set up for processing large volumes of samples prior to the COVID-19 pandemic, but decades of funding cuts for county public health labs meant there was little public lab

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infrastructure in the state to respond to the demand for processing large numbers of COVID-19 tests. The strain on the system was further compounded by the primary healthcare lab draws. The labs didn't have the instrumentation or the space to meet the demand for COVID-19 testing. It took time for the state PHL to ramp up its testing capabilities, and initially there was a lack of supplies needed to do the testing. As the pandemic progressed, rapid tests became readily available, and the Public Health Lab secured the necessary equipment needed to alleviate the backlog in processing COVID-19 tests.

The need to monitor the spread of COVID-19 throughout the state was evident at the start of the pandemic. Data from various sources needed to be collected, analyzed, and displayed concisely to help policy makers, public health officials, healthcare organizations, and other response workers monitor disease trends, identify outbreaks, and make informed decisions about resource allocation and interventions. Washington state disease surveillance databases, such as the Washington Disease Reporting System (WDRS), were implemented to track virus separately from operational issues & data tracking.

Operational visibility into the healthcare system capacity was also essential in understanding the impact of the virus on availability of healthcare during the pandemic. Hospitals were requested to provide daily census and resource data but lacked clear direction on how to submit the data and what data was pertinent. In addition, the process for monitoring hospital and Intensive Care Unit (ICU) beds to predict potential surge was convoluted and caused confusion and delays in data sharing. For example, hospitals were required to provide DOH with operational information about bed capacity and patient movement. However, confusion between staffed bed-capacity and licensed bed-capacity arose, causing hospitals to provide the wrong information. Hospitals provided licensed bed-capacity when DOH needed staffed bed-capacity. The difference is that hospitals cannot fill licensed beds if they don't have the staff to care for those patients.

Multiple healthcare organizations expressed interest in using a single platform for reporting operational and surveillance data. To improve surveillance and mitigate potential surge events, DOH collaborated with Microsoft to create a database for hospital data collection, providing transparency to medical surge partners. However, these systems rely on self-reported data and some healthcare providers were hesitant to share operational information with DOH due to regulatory scrutiny, which limited DOH's ability to respond effectively. Microsoft and DOH also developed the public-access virtual data portal, a COVID-19 data dashboard that provides comprehensive information beyond just hospital capacity, including disease activity, testing, vaccination, and demographic information. The dashboard improved public health surveillance and response.

Recommendations:

- a. Evaluate the potential need to increase workspace, equipment, and stable funding allocated to the DOH Public Health Laboratory to maintain testing capabilities and agility to increase high throughput testing if needed.
- b. Expand, streamline, and standardize emergency response training for testing operations, laboratory personnel, and local testing partners.
- c. Provide the resources necessary to improve existing lab data systems and implement new ones. Examine funding streams for testing and surveillance operations to develop a new tracking system. This will promote cohesion in data analysis.

- d. Establish hospital requirements for reporting staffed bed capacity to DOH on a regular basis, using the DOH provided guidance on how to calculate and report their staffed bed- capacity. During the pandemic response lack of adherence to DOH guidance on interpretation of staffed bed capacity led to data discrepancies that can be resolved by adherence and mandatory reporting.
- e. To improve collaboration and support for healthcare providers during public health emergencies, DOH should embark on a branding and communications campaign to differentiate the regulatory role from the supportive role of the agency. This will help promote the importance of non-regulatory technical assistance services, such as training, education, coordination, and information sharing, and improve compliance with regulations and guidelines. Additional details related to suggested policy implementation steps are included in the full report located on the Task Force website.
- f. Maintain the public-access virtual data portal so that the public can continue to access disease activity and healthcare capacity data throughout pandemic and other disaster response efforts.
- g. Invest in public health infrastructure by creating a centralized data system that can collect, analyze, share, and report data on epidemiological trends and potential surge. The data system should meet federal cybersecurity protocols and integrate with CMS. To minimize overlapping functions and ensure efficiency, it is recommended to consolidate existing databases such as WATrac, WAHealth, Electronic Health Record (EHR), and Health and Human Services into the centralized system. Additionally, there should be a streamlined process for fast tracking data sharing agreements to enable timely data sharing between healthcare providers and public health officials.

8.3. Case Tracking and Investigations

Area for Improvement G.7: Increased Capacity for Trained Case Tracking and Investigations Activities

Observation: Contact tracing and case investigations were hindered by the need to quickly fill tracing and investigation roles, leading to mass hiring of personnel with little to no training on how to properly track or investigate COVID-19 positive cases.

Analysis: There were a variety of approaches taken by different LHJs in terms of how they handled contact tracing and other public health functions during the pandemic. Some LHJs set up their own contact tracing models, while others contracted with the state or hired third-party providers. Similarly, some LHJs were able to develop good communication and information-sharing relationships with local healthcare providers, while others were not. The effectiveness of these efforts often depended on the relationships between the LHJ's public health officer and local healthcare systems.

School health professionals also struggled to maintain regularly assigned duties with the added responsibility of contact tracing for school staff, students, and students' families. Family Educational Rights and Privacy Act (FERPA) prevented schools from releasing information on students, so some local health contact tracers went to the schools directly to perform tracing services. Many jurisdictions asked schools to take on the responsibility of contact tracing, adding further burden to school health professionals. An additional challenge case investigators and tracers faced was the lack of continuity in the contact tracing process, as cases were often transferred between different counties and agencies, resulting in a

loss of information and potential delays in the tracing process. This was often the case for homeless and transient individuals, making it difficult to keep track of cases and control disease spread.

The lack of standard procedures and training protocols coupled with unmanageable staffing caseloads led to residents not being notified of interaction with a positive case, which resulted in increased disease spread. To assist with contact tracing, the state developed WA Notify, a free tool that residents could activate on their smartphone to alert users of potential COVID-19 exposures.

Recommendations:

- a. Create mutual aid agreements that provide LHJs the option to enter a formal delegation of authority to DOH for services during a declared public health emergency, including but not limited to contact tracing and case investigation for the LHJ. Under this agreement and process, implement a centralized and unified approach to contact tracing and case investigation, where the same tracer/investigator follows a case from start to finish, regardless of where the person is located. This approach would ensure continuity in the contact tracing/case investigation process and a clearly defined component to state public health response activities.
- b. Create a statewide planning workgroup to develop a Washington Office of Superintendent of Public Instruction (OSPI)-maintained plan that supports each individual school district with implementation of case tracking and testing during a public health emergency. In terms of membership, the workgroup should include school administration officials, legal experts, public health officials, social service representatives, Tribal Nations, Urban Indian communities, and any other bodies who may be affected. It is important to have a diverse group of contributors involved to ensure that all perspectives are considered and that everyone's needs are met. Additional details related to suggested goals and objectives of this workgroup are included in the full report located on the Task Force website.

8.4. Control and Prevention

Area for Improvement G.8: Managing Communications and Misinformation

Observation: Overall, the medical and non-medical countermeasures implemented in Washington state have been effective in controlling the spread of COVID-19 and keeping the death rates low. However, these measures also had unintended negative consequences, highlighting the influence of misinformation, institutional distrust, and the impact of social and economic factors on health equity and community well-being.

Analysis: The pandemic challenged policymakers and communities to find innovative solutions to protect public health while attempting to maintain essential services and activities. To address the spread of the virus the state implemented various non-medical countermeasures, including stay-at-home orders, travel restrictions, virtual reporting to work and school, masking mandates, social distancing, limitations on social gatherings, and promotion of healthy habits. The state also implemented medical countermeasures, such as mass testing and mass vaccination sites, mobile testing and mobile vaccination sites, homebound vaccinations, and more. As a result of these measures, Washington had one of the lowest death rates in the country.

The spread of misinformation during the pandemic not only caused confusion and anxiety among residents, but it also led to people making choices that contributed to the spread of the virus.

Misinformation regarding COVID-19 circulated widely on social media and other platforms. Some of the strategies used to fight misinformation included fact-checking articles, using social media platforms to spread accurate information, using trusted messengers to amplify accurate information, and developing public health campaigns to educate the public, but misinformation still circulates today.

Data visualization is another critical tool for public health professionals and policy makers, as it provides the ability to quickly identify trends and patterns in complex datasets. Visualizations can also be an effective tool for communicating complex information to the public, building trust and transparency, and driving positive public health outcomes.

Recommendations:

- a. Through trusted messengers, connect with communities on best practices for promoting healthy living, prioritizing community voices when it comes to health and wellness.
- b. Require all state agencies to create formalized language access plans that include accessing emergency translation services for information and documents released from the state.
- c. Create a robust statewide emergency mass communications plan to ensure that state and local governmental entities have access to accurate, up-to-date policy changes. The plan should outline key partners, determine communication channels, and establish protocols for an effective and reliable communication strategy.
- d. Maintain routine behavioral economist and health education capacity and tools that can be quickly leveraged when developing emergency response messaging. It takes time and effort to understand human behavior, develop effective messaging, designing incentives, and tailoring messaging to communities. If the core public health education capability is in place for routine efforts, it can much more easily be applied in emergencies, than creating the capability for the emergency response.
- e. DOH should update and adopt a Washington state comprehensive emergency management plan (CEMP) emergency support function eight (ESF8) annex addressing mass vaccination that considers a regional approach to disseminate vaccines or other health-related materials during a health-related emergency.

8.5. Isolation and Quarantine

Area for Improvement G.9: Standardization of Protocols for Public Health Measures to Address Impacts on Marginalized Communities

Observation: There were unintended adverse consequences to marginalized communities and congregate living environments resulting from the mandates and initiatives, to contain transmission and spread of COVID-19 through travel bans, social distancing measures, and isolation and quarantine protocols.

Analysis: While successful, the public health protective measures and mandates implemented to stem to spread of the COVID-19 virus resulted in negative downstream effects in some historically vulnerable communities. For example, many migrant farmworkers reside in congregate settings- shared quarters, sleeping on bunkbeds and using shared bathrooms. They were not able to practice social distancing, nor were they able to isolate or quarantine when infected. In settings where spread occurred, 75 percent or more of the migrant worker crew residing in congregate living were infected. Further, incarcerated

individuals in congregate living under the care and oversight of the Department of Corrections were at increased risk of adverse health effects. In addition, stay-at-home orders or other COVID-19 response initiatives had unintended consequences on the health and well-being of domestic violence survivors.

In response to quarantine and isolation barriers, DOH implemented Care Connect, a program that provides food and other necessities through community health workers to people who have either tested positive for COVID-19 or have been exposed and need support to isolate or quarantine at home. The program operates under a region-by-region basis. Each region works with community-based partners to connect people to services they are eligible for, such as medication delivery, health care, help applying for unemployment, local housing agencies, food banks, childcare providers and more. Help is made based on need. Care Connect Washington provides personal care kits, nonperishable food kits, and fresh food orders delivered to their homes. If other essential needs are identified, such as financial assistance for paying bills, a local care coordinator helps people apply for local resources or services they may be eligible for or provides them direct assistance in paying bills such as rent, mortgage, and utilities.

Recommendations:

- a. Revise Quarantine & Isolation Emergency Operation Plans and associated annexes to include activation protocols for Care Connect services in a federally declared emergency where these services are forecasted to become necessary. The plan should address coordinating with LHJs on activating DOH care coordination regional liaisons. In addition, community engagement should be included in the emergency planning process. It is important to have a diverse group of planning contributors involved to ensure that various perspectives are considered and that the needs of the community are met.
- b. DOH should establish standard operating procedures and protocol guidance that may be adopted by LHJs on the setup, maintenance, and staffing of isolation and quarantine units during public health emergencies. DOH must also provide LHJs with plan templates, training, and technical support to ensure their success. More details for training and templates are included in the full report located on the Task Force website.

8.6. Public Health Supply Chain

Strength G.10: Public Health Supply Chain Management

Observation: Washington's planning in previous public health emergencies, such as the H1N1 pandemic, put the state in a better position to respond to the COVID-19 pandemic began and supply chain issues quickly presented challenges to jurisdictions nationwide.

Analysis: During the 2009 H1N1 epidemic, DOH and LHJs procured a large stockpile of medical supplies. After the response, the remaining supplies were put into storage where they remained for nearly a decade or disposed of as they expired (i.e., N95 masks). Fast-forward ten years, Washington state became ground zero for the COVID-19 pandemic in the United States with the first identified and confirmed case. Washington state was better situated to respond to the pandemic than other states, largely due to the medical supply cache that was carried over from H1N1. That's not to say that Washington wasn't impacted by national and global supply chain shortages, but many lives were saved because of the medical supply cache.

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A strong public health system is foundational to national security. Public Health supports the entire ecosystem for healthcare preparedness, including respirators, gowns, masks, testing equipment, etc. Given the increased risk of emerging zoonotic diseases manifested by climate change, it is vital that the state continues to secure and maintain an independent robust supply chain cache.

Recommendations:

- a. Maintain and expand the state-level medical supply cache for public health emergencies. This recommendation aims to build on the lessons learned from the H1N1 epidemic and the COVID-19 pandemic to ensure that Washington state is better prepared for future public health emergencies or disasters with human health impacts. Additional details on steps to carry out this recommendation is included located on the Task Force website.
- b. Complete a comprehensive risk assessment and resource inventory to ensure that regions, cities, counties, and communities are adequately prepared for emergency events. This policy recommendation should be implemented through collaboration between representatives from local and state authorities, as well as subject matter experts in emergency preparedness. Conducting a hazards risk assessment for each region, city, county, and community is a critical step in emergency preparedness planning. This assessment aims to identify the hazards and emergency scenarios that are most likely to occur in each area and assess the potential impact on the population. Additional details on steps to carry out this recommendation is included located on the Task Force website.
- c. Establish formal agreements with local manufacturers to produce PPE during an emergency response. This will help ensure that the state has a reliable source of PPE in the event of an emergency, and that the PPE is manufactured to meet the necessary quality standards. Follow state and federal procurement laws as it pertains to supplier diversity and prioritize minority and women-owned businesses in the procurement process. This policy recommendation should be implemented through collaboration between DOH, DES, DSHS, DFYS, Department of Commerce, and local manufacturers. Additional details on steps to carry out this recommendation is included in the full report located on the Task Force website.

8.7. Deploying Personnel

Area for Improvement G.11: Support for Non-Clinical Volunteers

Observation: The shortage of non-clinical volunteers such as janitorial staff and other support services, hindered operations in hospitals and other medical settings.

Analysis: During the COVID-19 pandemic, staffing issues were a major concern across multiple sectors, including public health, healthcare, and mortuary services. The Uniformed Emergency Health Volunteer Practitioner Act (RCW 70.15) was passed just prior to the pandemic, which allowed for out-of-state public health clinical volunteers to be registered and work in Washington. However, the act did not have a mechanism for non-clinical volunteers. This was a major issue, as support services such as janitorial, facility services, and food are essential for hospitals and healthcare facilities to function properly. The lack of these support services almost shut down hospitals not just in Washington but nationally.

Each jurisdiction had the autonomy to determine their personnel needs and when/where to deploy them. Many jurisdictions brought in volunteers through volunteer agencies, such as United Way and the Medical Reserve Corps (MRC) to supplement staffing for the response. This effort helped move the response

forward, but volunteer availability was not equitable across the state. For example, the MRC system is locally organized in mostly urban areas leaving equitable access to these resources in rural areas lacking. There were also concerns about the potential liability faced from volunteers possibly being exposed to hazardous situations during response efforts.

The shortage of healthcare workers and volunteer availability led organizations to hire contracted staff through staffing agencies. However, tracking the hours worked by these temporary staff caused problems as some agencies were over-reporting the hours worked, while others were under-reporting. Even today, efforts continue to balance reported hours with actual hours worked.

Throughout the COVID-19 response, Washington state was also responding to other emergencies, including fires, heat waves, droughts, civil unrest, and Monkeypox. Limited personnel and material resources posed a significant challenge in effectively responding to these additional emergencies. The DOH attempted to access resources from other states to support the added responses but were unable to without a governor's proclamation declaring a state of emergency.

Recommendations:

- a. Establish liability protection for clinical and non-clinical response volunteers during a surge event. Model the Public Readiness and Emergency Preparedness (PREP) Act liability, immunity, and compensation structure.
- b. Amend state law to allow for resource sharing between states during public health emergencies and providing more flexibility for DOH to respond to emergencies in the absence of a governor's proclamation.
- c. Implement a standardized tracking system to address the issue of inaccurate reporting of hours worked and positions filled by temporary staff. This centralized state system could be used by all staffing agencies and healthcare organizations to accurately track the hours and assignments worked by contracted staff. Additional details related to implementation of this recommendation is included located on the Task Force website.
- d. Conduct Jurisdictional Risk Assessments (JRA) to help identify potential staffing shortages and allocate personnel resources accordingly. Consider population growth forecasts when planning for staffing needs.
- e. Establish clear protocols and guidelines for activating resources during public health emergencies.
- f. To ensure equitable deployment of volunteers during an emergency, additional details on policy recommendations that should be considered are included located on the Task Force website.

8.8. Deploying Medical Supplies

Area for Improvement G.12: Distribution and Management of Public Health Resources

Observation: Parameters and priorities related to public health resources and supplies distribution, in addition to global supply chain issues, at times, resulted in an unequitable distribution of resources.

Analysis: During the COVID-19 pandemic, challenges were faced in obtaining and distributing PPE to healthcare providers. In the beginning, PPE was managed by DES and EMD. In November 2021, DOH took over PPE procurement and supply requests, and then in February 2022 DOH took over the operational

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management of the Medical Logistics Center (PPE warehouse) including the staff that were working at the warehouse. WebEOC, an EMD managed cloud-based database, was used to track supply requests from tribal, local, and state partners and used REUSE for inventory tracking.

Prioritization was provided to high transmission areas and distributed supplies amounts were based on population. However, due to funding from FEMA, they were only allowed to distribute supplies to entities within their legal authority, which put additional strain on local health and emergency management to distribute supplies to their communities. This method of distribution led to inherent inequities in the deployment of supplies.

The sudden surge in demand for PPE resulted in a global shortage of PPE. In response, DOH provided guidance on mask reuse, which permitted the use of masks for multiple times. The guidance on mask reuse was based on the limited disease information available at the time and aimed at conserving PPE. The guidance had to balance the risk of using a mask for an extended period against the benefits of preserving PPE, which was crucial for protecting healthcare workers and other essential workers. As more information became available, guidelines on mask use and reuse have been updated.

Obtaining and distributing PPE was challenging for smaller healthcare organizations, rural communities, and businesses, who had to navigate complex bureaucracy to make requests. In addition, several businesses and organizations were given supplies like N95 masks but were then fined by Labor & Industries (L&I) for not fit testing, despite fit testing being ceased and desisted at the time. There was a lack of centralized information on COVID-19 protocols and communication regarding supplies and inventory management, leading to delays, difficulties in tracking down needed supplies, and issues with receiving deliveries without sufficient lead time. There were also difficulties in obtaining freezers for vaccine storage once vaccines became available. These challenges persisted into the second year of the pandemic with the emergence of new variants. The state of Washington established a backstop and ordered PPE in large quantities but lacked visibility into the specific needs of healthcare providers. Healthcare coalitions and healthcare associations such as WSHA and Washington State Healthcare Association (WHCA) attempted to coordinate distribution, while the WSHA imported PPE directly from factories. Efforts were made to address this issue, including the establishment by DES of a State-run Medical Logistics Center to stockpile critical PPE.

Individuals with disabilities and their families faced unique challenges during the COVID-19 pandemic due to pre-existing health conditions that put them at a higher risk for severe illness if infected with the virus. The lack of understanding by decision-makers about the impact of policies and procedures on this population resulted in the implementation of safety measures and care that did not always address their specific needs. For example, policies that limited in-person visits to healthcare providers and hospitals created challenges for individuals with disabilities who require more frequent and specialized medical attention. Furthermore, the allocation of resources, including PPE and medical supplies, often competed with the critical materials and access needed by people with disabilities, creating additional risks for them and their families. This made it more challenging for individuals with disabilities and their families to access the care and resources they needed to stay safe and healthy during the pandemic.

The allocation of scarce medical resources during a crisis like the COVID-19 pandemic involves ethical considerations and requires balancing competing interests and values. Fair allocation can be influenced by cultural background and moral values, and allocating resources in a system with different policies, procedures, oversights, and authorities presents challenges. To ensure equitable distribution of resources during a crisis, there may need to be a shift in the current healthcare system.

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Recommendations:

- a. Continue the statewide use of WebEOC for improved coordination, communication, and resource requests. Analyze which governmental and non-governmental groups need access to WebEOC. Revise job aids and standard operation procedures. Offer virtual and in- person trainings on how to operate WebEOC.
- b. Expand the use of ambulance conversions for vaccine distribution. These vehicles provide more storage space for equipment and supplies, which can be especially helpful in remote or rural areas. The official medical appearance of these vehicles also helps to increase public trust and confidence in the vaccination process.
- c. Develop a more streamlined and accessible process for smaller healthcare organizations to obtain PPE and provide educational services and training to help them navigate the process of obtaining PPE and other necessary resources during emergencies. Additional details regarding development of these processes are included located on the Task Force website.
- d. Decision-makers should ensure that policies and procedures are designed with the needs of individuals with disabilities and their families in mind. This includes providing a safety net and access to critical materials and specialized medical equipment. There should also be collaboration with disability advocacy groups to ensure that their voices are heard, and their needs are addressed during emergencies and disasters. Finally, decision-makers should consider the unique needs of individuals with disabilities when developing emergency response plans, including providing specialized transportation, shelter, and medical care.
- e. Examine the current PPE allocation prioritization matrices and assess how healthcare and non-healthcare entities were identified. Specifically, it is important to consider non- traditional healthcare settings, such as correctional facilities and long-term care facilities that were not included in the early prioritization matrices but are high-risk settings. Additional details regarding this recommendation are included located on the Task Force website.
- f. Explore the issue of "crisis standards of care" more thoroughly and take measures to ensure that healthcare providers have access to adequate and appropriate PPE. First, it is essential to review and update federal guidelines, such as those provided by Det Norske Veritas, Inc., the Joint Commission or CMS, to ensure that they are aligned with the latest scientific evidence and best practices. Additional details regarding this recommendation are included located on the Task Force website.
- g. DOH should develop a centralized system to manage and track inventory of essential supplies, including PPE and vaccine storage equipment in the Medical Logistics Center. This system should also include clear communication channels to ensure that all relevant stakeholders are aware of inventory levels and delivery schedules. Regular follow- up should be conducted to ensure that requests are being met in a timely manner, and contingency plans should be developed to address any supply chain disruptions. The system should also incorporate feedback from stakeholders to continually improve the effectiveness and efficiency of inventory management.
- h. Ensure equitable allocation and deployment of medical resources during an emergency. This requires a multi-faceted approach. Additional steps to carry out this recommendation are included located on the Task Force website.

9. Focus Area H: Implementing Guidelines for School Building Closures During a Pandemic

This section provides strengths and areas for improvement for the K-12 education community and related activities during the COVID-19 pandemic.

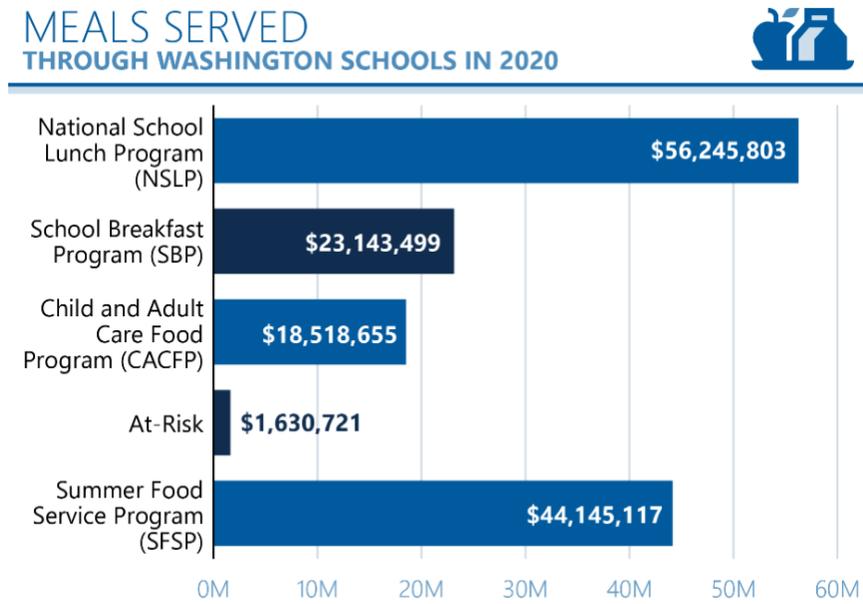
As part of this Task Force, OSPI was asked to gather perspectives on the topic of “guidelines for school building closures during a pandemic.” OSPI conducted a set of individual interviews, small group discussions, and structured webinars over the course of late Fall and early Winter of 2022-23 with education leaders and other staff from around the state. About 75 educators, principals, superintendents, school board directors, and other leaders from approximately 60 local education agencies participated in this information-gathering process. Generally, the interviews addressed strengths in the state’s response to the COVID-19 pandemic, as well as weaknesses/challenges and recommendations to improve response to future pandemics or other disasters. Additionally, some information contained in this section is based on additional research, best practice, lessons learned, and recommendations from IEM’s previous experience in other jurisdictions.

Strength H.1: School Districts Continued Meal Service to Students

Observation: School districts across Washington were able to maintain critical meal service to students in need once school buildings were closed.

Analysis: An important success during the COVID-19 pandemic was the ability of school districts to provide ongoing meal services to any student in need while school buildings were closed to in-person learning. Meals were provided to students using a variety of innovative methods, including but not limited to, home delivery, centralized grab and go sites, and grab and go sites located throughout the community. Planning for school building closures during future pandemics must include methods for ongoing

provision of school meals while school buildings are closed. One of the immediate challenges to school-aged children once school buildings closed was access to meals usually acquired at school, children living in vulnerable households being most affected. The threat of losing this access to food added an undue burden to the parents of these children. In addition to the obvious non-pandemic related benefits, ongoing universal access to school meals would greatly facilitate quick transition to provision of school meals to all students during school building closures.



COMPARISON OF SUMMER MEALS SERVED IN 2019 TO 2020



	2019	2020
Number of Sponsors for Summer Meal Programs	178	336
Number of Sites with Meals Available	993	1,856
Lunches Served in July	771,911	2,105,326
Lunches Served in August	887,410	1,449,305

Recommendations:

- a. The state should support and provide the necessary resources for OSPI, Child Nutrition Services Office to develop a guidebook that outlines the regulatory requirements, funding mechanisms, and best practices for such services that can be used to support local school district pandemic planning.
- b. Although the federal government allowed for universal feeding for a period of time when students returned to school buildings, the state should consider investment of state resources to supplement existing federal means-based school meal funding to ensure that all Washington K-12 students have sustained access to free meals as part of the school day.

Strength H.2: COVID-19 Diagnostic and Testing in Schools

Observation: The DOH implemented a successful COVID-19 testing program to ensure the safest learning environment possible.

Analysis: During the winter of 2020-2001, DOH successfully piloted a school-based COVID-19 testing program, primarily focused on diagnostic testing. This program, called "Learn to Return", was rapidly expanded throughout the end of the 2020-2021 school year and into the 2021-2022 school year. This program added robust diagnostic and screening testing resources for schools across the state. DOH also invested substantial resources to support the staffing costs to school districts to implement local COVID-19 testing strategies. These efforts were essential to safe delivery of in-person K-12 learning, particularly as testing technology evolved to deliver rapid, nearly immediate testing results to the user.

Recommendations:

- a. Capitalizing on this experience, DOH should memorialize this testing strategy as part of a review and update of the existing *Pandemic Influenza Plan*. A comprehensive testing program must be part of plans for in-person learning during future pandemic-related emergencies, and the program must be allocated adequate resources for successful implementation.
- b. The state should coordinate with DOH to identify resources required and the funding needed for successful implementation of comprehensive testing strategy for future pandemic-related emergencies.

Strength H.3: Strategies and Resources to Accelerate Post-Pandemic Learning and Recovery

Observation: The OSPI developed a recovery and acceleration plan early on, to address the challenges faced by students and families related to school building closures and impacts on learning.

Analysis: In 2021, federal and state law required Washington’s public schools and school districts to make plans for academic recovery and acceleration publicly available. To support this effort, OSPI developed *Academic and Student Well-Being Recovery Plan: Planning Guide 2021 for School Districts, Tribal Compact Schools, and Charter Schools*. This guide provided a framework for evidence-based strategies to support academic and well-being recovery and acceleration for all students. As the K-12 system evolves back toward some semblance of normalcy, education leaders and practitioners agree that the timeline for recovery is longer and more multifaceted than initially contemplated. Data helping educators understand the impacts of the pandemic on student academic progress and well-being are just now emerging, and most educators believe a realistic recovery horizon is 5–10 years rather than the 2–3-year timeline initially considered and currently resourced.

Recommendation:

- a. The state should support and provide the necessary resources to schools for intentional, ongoing, evidence-based academic and well-being recovery and acceleration initiatives spanning at least the next five years.

Strength H.4: Modifications to Regulatory Structures and Financial Support Systems in Education Systems to Address COVID-19 Pandemic Response Needs

Observation: OSPI implemented innovative solutions to maintain educational continuity for Washington’s students in response to the COVID-19 pandemic through use of emergency rules. Further, both the state and federal governments provided funding to school districts throughout the pandemic to support student learning and well-being recovery and acceleration. This includes federal Elementary and Secondary School Emergency Relief (ESSER) funds, which were incredibly flexible so they could be leveraged to support each school district’s unique needs, as well as state-appropriated enrollment stabilization dollars, which were provided on a one-time basis to districts who were most negatively impacted by declining student enrollments and needed the ability to maintain services during a critical time.

Analysis: Washington state education leaders were able to quickly and creatively modify regulatory structures (through use of emergency rule adoption and successive extension of these emergency rules) to ensure continuity of whole basic education funding for the public education system. Additionally, as many school districts experienced rapid declines in student enrollment at the height of the pandemic, the Washington State Legislature provided one-time stability funding so school districts had time to plan for and address more permanent decreases in state funding aligned with their enrollment changes. Related, federal ESSER funding is a critical, flexible set of resources for school districts to address the impacts of the pandemic on student learning and well-being as well as on school operations. These investments, making up 3-5% of an average school district's annual budget, have helped districts respond quickly to evolving student needs and provide supplementary learning and well-being supports.

While these one-time appropriations of additional resources have supported Washington's students through the pandemic, the dollars have an upcoming expiration date. However, the impacts of the pandemic on student learning and academic progress will extend well past these funding deadlines, and disproportionately affect students of color, students experiencing poverty, students experiencing homelessness, and students with disabilities, exacerbating existing inequities in the K-12 system. It remains to be seen whether the K-12 system will be resourced to address the long-term academic, social, and emotional consequences of the pandemic on Washington learners.

Recommendations:

- a. The Washington State Legislature should consider expanding the authorities residing within OSPI to allow for modifications in regulatory structures and basic education funding requirements should they be necessary in response to future large-scale public emergencies that cause a disruption in routine daily activities across the school system.
- b. The Washington State Legislature should consider appropriating state funding targeted specifically to address the long-term effects of the COVID-19 pandemic to ensure that Washington schools are able to recover as quickly as possible and be better resourced to respond to future emergencies. At minimum, this funding should provide additional resources to hire staff focused on student mental and behavioral health, to implement expanded learning opportunities, and to ensure equitable access to accelerated learning opportunities.
- c. As federal ESSER funding ends by September 2024, OSPI, ESDs, and school districts should document best practices and lessons learned from their investments in innovative strategies to support student learning and well-being recovery and acceleration and incorporate these practices and lessons in plans for addressing future pandemics.

Strength H.5: Establishment of a Centralized Authority Related to School System Operations

Observation: Early on in the COVID-19 pandemic, the state of Washington developed a centralized decision-making authority which provided much needed uniformity and clarity across the educational system.

Analysis: Washington's public K-12 system is characterized by approximately 315 units of local or sovereign governmental statutorily empowered with decision-making authority over nearly all aspects of their local k-12 operations. Local K-12 leaders were in near unanimity in expressing their appreciation of the establishment of central authority and decision-making (via Governor emergency orders and proclamations, and implementation of existing state and local health officer authority) during the early

days of the pandemic. This provided needed clarity and uniformity across local pandemic response and allowed local K-12 leaders to focus energy on response activities. Although there seemed to be a lack of clarity regarding who was the central decision authority especially as the state moved into a more sustained response mode. School leaders received information from OSPI, DOH, and their LHJs, and these messages, at times, conflicted with one another. The important learnings from the COVID-19 pandemic regarding establishing central decision-making authority, as well as the decisional and communications interplay among the Governor's office, DOH, OSPI, and local K-12 authorities must be clearly documented and layered into planning for future pandemics. Particular attention should be paid to procedures for returning to a "normal" framework of state-local authority as quickly as possible.

Recommendation:

- a. Document and memorialize the process for establishing the central decision-making entity including who has authority within this entity, what are parameters of this authority, who participates in the decision-making process, and how decisions are communicated within state-wide emergency preparedness plans for the educational system. Ensure implementation of this process at the beginning of a response to provide for a more consistent and clear decision-making and messaging process.

Area for Improvement H.6: Considerations for Impacts Related to In-Person Learning, Full School Building Closures, and Hybrid Models within the Education System

Observation: Considerations for impacts to school-aged children and their families (especially children in vulnerable communities) when implementing full school building closures and/or hybrid learning environments were not adequately built into pandemic response plans and decision-making.

Analysis: To minimize impacts and learning disruptions to school-aged children, prioritizing in-person learning, whenever possible, provides a more impactful learning environment for most learners. Additionally, in the long run, temporary full school building closures are less disruptive to the learning process than is a remote or hybrid learning environment. As with the COVID-19 pandemic, during future pandemics the health and safety of students, staff, and the community must be the priority. However, given what we've learned about the K-12 system impacts of Washington's response to the COVID-19 pandemic (including impacts on students, families, staff, and the community), which included approximately 5 weeks of full school building closure, and then months of remote and hybrid learning spanning across the end of the 2019-20 school year and the majority of the 2020-21 school year before returning to full scale in-person learning statewide, Washington should prioritize maintaining in-person learning during a pandemic, and if school building closures must occur, should engage in a more aggressive approach to resuming in-person learning.

Recommendations:

- a. The state should support and facilitate a collaboration with state agencies and local school administrators, and academic partners, to develop an aggressive state-wide strategy which prioritizes a return to in-person learning in the event that public health measures or other circumstances require a full school building closure.
- b. To the extent possible, short-term full closures should be prioritized over extended periods of remote or hybrid learning. Many weeks of full-time, in-person learning can be made up at the end of the school year calendar, if necessary. Where possible, this should take priority over quickly

deployed and poorly implemented remote learning that results in lost instruction and exacerbates existing inequities, particularly related to race, income status, language, and disability.

Area for Improvement H.7: Planning and Preparation for Remote Learning Environments

Observation: Pre-pandemic planning and resource considerations and allocation related to remote learning strategies were not adequate to ensure the most equitable, consistent and meaningful implementation possible for school-aged children across the state.

Analysis: Early in the COVID-19 pandemic, public health leaders across the country were faced with an unprecedented decision to close school buildings to address the spread of the pandemic. This was a decision not made lightly or without hesitation. As soon as the coronavirus began spreading in Washington, OSPI began issuing guidance to school districts, in partnership with DOH, to engage in contingency planning should school buildings need to close to prevent virus spread. In OSPI's initial COVID-19 guidance document, the importance of equity was specifically elevated should school districts decide on their own to transition to remote learning. Districts who did transition before the statewide mandate (i.e., Northshore School District) were prepared with devices for all students and internet hotspots for those who needed them. When the Governor announced long-term school building closures, OSPI immediately issued guidance to school districts recommending they perform an assessment of students' home access to technology to identify gaps and needs. All or nearly all districts did this, and then turned around and purchased devices to address the identified gaps and needs.

OSPI and the Governor's Office purchased devices with federal emergency relief dollars and partnered with the state's 9 regional educational service districts to delivery to schools throughout the state. OSPI entered into agreements with Comcast and other internet service providers to pay for home internet access for students in low-income families, and tens of thousands of students and their families participated.

Despite these extraordinary efforts, many children across the state struggled with lack of access to internet and/or the technology necessary to access the learning environments upon closure of schools. Students with unreliable service or no access to broadband internet in the home were especially challenged to maintain educational activities once remote learning plans were implemented. Educators reported having the greatest success with transition to remote learning when given ample time to plan for and prepare to deliver using remote teaching and learning methodologies.

Recommendations:

- a. The state should support a state-wide planning collaborative including local, regional, and state educators, emergency management, and public health entities to recognize the disparities existing for children in vulnerable communities during school building closures. This collaborative, as mentioned in the recommendation in Section 1.1.2, should consider the circumstances under which in-person, full closures, remote, or hybrid learning environments would be considered and develop plans to address these circumstances including resources necessary to ensure each and every student has equitable access to remote learning environments. This will serve to ensure the state is better equipped to address the needs and impacts of a future pandemic where extended periods of remote and/or hybrid learning before returning to in-person learning.
- b. The state should identify and support investments within the education system across the state to ensure every school district has an appropriate baseline of technology resources that can be

deployed in the event of a future pandemic (e.g., laptops, tablets, portable hotspot devices). This investment should include provision of appropriate assistive technology for students with disabilities. Collaboration with technology corporations operating within the state of Washington could be part of this effort.

- c. The state should identify funding to support planning initiatives with school districts across the state to identify children with unreliable or no access to broadband and lack of technology. Use this data to build an adequate inventory of broadband access technologies and establish strategies to mitigate lack of access to broadband in the event of transition to remote learning.
- d. The state should support and facilitate planning initiatives related to remote learning implementation processes that include ample time for educators to prepare for remote learning implementation. This includes ensuring educators are involved in the decision-making process, are informed of such implementations as soon as they are determined to be necessary and are provided the training necessary to transition their practices to remote and/or hybrid learning.
- e. The state should support the identification of mechanisms to ensure that educators are adequately financially compensated for the additional preparation time necessary for an effective remote learning implementation.
- f. The state should support and facilitate the development of awareness training designed for students and their families focused on learning how to utilize remote, online education tools, and how to access the necessary resources to support a meaningful remote learning experience when it becomes necessary.

Area for Improvement H.8: Planning and Preparation for Return to In-Person Instruction

Observation: As with the implementation of remote and hybrid learning environments discussed above, the return to in-person instruction lacked adequate planning to provide a cohesive return to in-person instruction across the state.

Analysis: Over the course of the 2020-21 school year, Washington experienced an evolving patchwork of remote and in-person learning across the full geography of the state. Many factors at the federal, state, regional, and local level influenced this variability. A more consistent, intentional at-scale approach to the return to in-person learning is needed to ensure that the implementation process within school districts across the state provide for the equitable return of students in all communities. Also, information gathered from school officials indicated that development of clear guidelines and implementation strategies based on lessons learned through the COVID pandemic response experience, ahead of a future pandemic is key. Moving forward, we know many things today that we did not know early in the COVID-19 pandemic regarding successful strategies to reduce disease transmission in K-12 schools and to safely deliver in-person learning, and this knowledge should inform the development of plans for successfully returning to in-person learning. To be most effective, the decision-making process and planning for closing schools should also include planning for the eventuality of reopening to in-person learning. In the pandemic, virtually every school lacked adequate PPE for staff, let alone for students. School leaders were left to compete across the global economy to procure necessary PPE. But for the creative and heroic efforts by Washington's regional Educational Service Districts (ESDs), lack of access to essential PPE would have substantially delayed re-opening schools. The ESDs stepped into the void to survey and quantify the statewide K-12 PPE need, aggregate this need into an economy of scale, and to procure and deliver PPE across the state to both public and private schools.

Recommendations:

- a. For future pandemics, DOH should collaborate with key, trusted education leaders and experts to develop clear, concise, evidence-based public health requirements and guidelines for re-opening based on on-the-ground practices and lessons learned. Requirements and guidelines should be developed and provided to school officials with ample time for them to integrate them into operational re-opening plans.
- b. The state should identify funding to support development of a resource procurement and management system to build capacity for the state to provide essential PPE to schools across the state. Alternatively, the state could review the work of the ESDs through COVID-19, and if it is collectively decided that this is a viable plan, the state should identify funding to support the ESDs in this role.

Area for Improvement H.9: Case Investigation, Contact Tracing, Isolation, and Quarantine (CICT) Procedures for Schools

Observation: The processes to address case investigation, contact tracing, isolation, and quarantine did not allow for resources or staff to adequately perform these activities.

Analysis: While the development of a K-12 COVID-19 testing program was a resounding success, the implementation of systems to address the need for case investigation, contact tracing, isolation, and quarantine in the K-12 setting was seen as a profound failure. School staff were overwhelmed by the demands that are required of these activities and the intensive labor required to effectively conduct these activities which meant that key school staff were required to focus on multiple tasks which detracted from the delivery of their core mission and thus, negatively impacted day-to-day school operations. Further, school staff struggled to complete case investigation, contact tracing, isolation, and/or quarantine activities within a timeline needed to adequately mitigate disease transmission, which had a profoundly negative impact on the morale of school staff.

Recommendation:

- a. DOH, in collaboration with local public health officials, emergency management planners and school administrators and school staff, with experience in addressing the challenges of CICT in the school setting, should develop a CICT implementation plan including resources required and staffing needs and expectations to allow for a more efficient and adequately resourced system to address CICT needs in the future.

Area for Improvement H.10: COVID-19 Vaccinations for School Staff

Observation: State of Washington leaders established a system to prioritize vaccine availability, but school staff were not included in the early priority tiers resulting in a delay in the return to in-person learning in schools across the state.

Analysis: As COVID-19 vaccines became available in early 2021, public health leaders and planners worked to prioritize access to the vaccine while supply was scarce. It is understandable that the medically vulnerable and/or the elderly, along with healthcare workers, should be at the top of the priority list. However, school staff were not included in this early priority tier. Had they been included in this essential group, there could have been an accelerated return to in-person learning and based on lessons learned regarding the impacts and challenges of remote and hybrid learning, especially in vulnerable communities, vaccination of school staff should also be considered a priority. This must be paired with

better systems of vaccine delivery across the state. Better organized and resourced systems designed to increase vaccination of school staff would have accelerated return to in-person learning across the state.

Recommendation:

- a. DOH should coordinate with state leaders to review and revise vaccination priority protocols to include essential school staff such as educators, teaching assistants and volunteers, administrators, as well as operations staff such as janitorial staff.

Area for Improvement H.11: Emergency Preparedness and Response Planning in Schools

Observation: While schools are currently required to have emergency preparedness and response plans, these requirements need to be expanded to include items such as COOP for extended building closures, along with a training and exercise component.

Analysis: The RCW 28A.320.125 requires that schools and school districts develop comprehensive safe schools plans that, among other things, must address emergency mitigation, preparedness, response, and recovery. All or nearly all schools and school districts have comprehensive safe schools plans in place that address the acute elements of planning and response (e.g., local hazard assessments, plans for evacuation/lockdown/shelter in place, reunification plans, etc.). However, the COVID-19 pandemic made clear most schools and districts had inadequate continuity of operations plans for provision of essential services, in particular provision of teaching and learning during extended closure of school facilities. Schools and school districts should be required to develop, practice (i.e., drills, tabletops, and exercises), and periodically update plans for the continuity of teaching and learning during an extended school building closure. These plans should be informed by technical expertise and other resources and support provided by the OSPI School Safety Center, the nine ESD-based Regional School Safety Centers, DOH, and EMD.

Recommendations:

- a. The state should support and facilitate a collaborative effort between OSPI School Safety Center, the nine ESD-based Regional School Safety Centers, DOH and EMD to develop expanded requirements to the current state law to include COOP and a training and exercise schedule. Requirements should also include more routine review and update of all plans.
- b. The state should support the development of a COOP template for school districts to use to implement COOP planning at the local level.
- c. Washington EMD should consider hosting a series of Train the Trainer workshops in collaboration with ESD Regional School Safety Centers to provide guidance to school administrators on development of COOP as well as trainings, and table-top style exercises that school districts can use to expand their emergency preparedness and response plans.

Area for Improvement H.12: Expanding the Capacity of the ESDs

Observation: While the ESDs were crucial during the state's response to the COVID-19 pandemic, expanding the available funding and their role in both emergency preparedness planning and actual response could result in a more resilient educational system and strengthen the state's schools' ability to respond and recover more quickly to future incidents.

Analysis: Washington's ESDs played a central, critical role in the state's response to the pandemic. As gaps were identified relative to ensuring continuity of the K-12 system, ESDs worked diligently and creatively to fill those gaps. In their regional service role, ESDs were critical in facilitating bi-directional communication within their respective regions as well as statewide, they coordinated numerous data collection initiatives that augmented situational awareness, and they provided necessary pandemic response services and supports to schools and school districts within their regions. Examples include procuring and delivering PPE, provided direct COVID-19 testing services and brokered access to the state's Learn to Return COVID-19 testing initiative, and worked with local health jurisdictions, local health services providers, tribal governments, and school districts to improve access to vaccines. Current state law mandates each ESD to host a regional school safety center.

Recommendation:

- a. The Washington State Legislature should consider identifying increased allotment of funding for the ESDs to better resource the Regional School Safety Centers. Modest expansion of existing funding for the regional school safety centers could better institutionalize the ESD preparedness and response role for future pandemics.

Area for Improvement H.13: Coordination and Communication Regarding Public Health Guidance to Schools

Observation: Communication to school districts was strong in the early months of the COVID-19 pandemic but became more of a challenge to ensure all school partners were consistently provided timely and accurate messaging to school administrators.

Analysis: The early months of the COVID-19 pandemic were characterized by excellent alignment of communication and messaging regarding the public K-12 system from the Governor's Office, OSPI, and DOH. As the pandemic progressed, messaging became more fractured with early visibility on decisions or requirements being made available to certain education stakeholders and not others. Because of the timing of most announcements, press conferences or other media availability, most educational staff, students, and families were left out of the communication loop. At times, guidance or requirements issued by some regulatory agencies (like DOH, LNI, OSPI) conflicted with each other or appeared to be developed outside the visibility of the other agencies. This created uncertainty and doubt among educational leaders, school staff, students, and families.

Recommendations:

- a. Develop a standard operating procedure (SOP) to ensure the consistent, transparent, timely and accurate dissemination of public health guidance or requirements for K-12 schools prior to release to the general public to give school adequate preparation time. Public Information Officers from appropriate state agencies and partners should collaborate to make certain that the message delivered is accurate and consistent with what is being disseminated to the general public.
- b. Ensure that all appropriate state agencies and partners involved with developing public health guidance or other requirements in response to an incident coordinate to ensure that all school districts across the state and their partners such as educators, students, and families, are receiving a uniform and consistent message. This alleviates confusion and promotes trust within the state education system.

10. Additional Information from Community Partners

Throughout the COVID-19 pandemic, many jurisdictions across Washington, through partnerships with community-based and private sector partners, developed innovative ways to expand access to vital information, healthcare, and COVID-19 testing and vaccines. The following stories were provided through members of the State Pandemic Task Force and served to highlight community experiences, impacts from the COVID-19 pandemic, and solutions created to address and combat inequities and disparities throughout many communities.

10.1. Stories from Community-Based Experiences, Impacts, and Solutions

The stories in the following figures illustrate various aspects of dealing with the COVID-19 pandemic. Under each figure is a link to the source.

NEWS STORY

Coronavirus testing is daunting if you can't get time off to quarantine. These folks have solutions.



COVID-19 greatly impacted Pacific Islander, American Indian, Hispanic, and black communities. Most community members within these populations are essential workers and the wages are very often low. During the pandemic, a great deal of the working population within these communities became unemployed. But those who maintained their jobs, were fearful of catching COVID. There was reasonable concern for their worries because going to work meant the possibility of not being able to pay rent, feed their families, or manage any other household needs – many of which are multigenerational households that lived in cramped living quarters. And for those who lost their jobs, many could not qualify for unemployment benefits because they were undocumented. To make matters worse, entire communities were failed by the government to properly address the growing needs of these populations during the COVID-19 response. There were limited resources and information that created barriers for those who spoke little to no English. This created confusion about the process and push back from getting tested. But communities decided to

take matters into their own hands and help their own people. Cultural and ethnic non-profit organizations directly provided grants to help pay for utilities, rent and food. Other non-profits when directly to the community and set up free food distribution sites.

Many minority communities had already lacked confidence in the U.S. government, but the pandemic revealed the inequities within America solidifying and further compounding on the existing mistrust. If the government isn't going to hold itself responsible for looking after the needs of the underserved populations, then they need to give each community the proper tools and resources to respond to their own needs. One way this can be done is by establishing testing sites at grassroot organizations that have strong ties with their communities. Another is providing emergency relief grants to non-profit organizations that can help assist undocumented workers who have lost their jobs due to pandemic or other unforeseen emergency disasters.

Link: <https://www.kuow.org/stories/another-solution-to-covid-food-rent-money-and-racial-equity>

Figure 2: News Story: Corona Virus Is Daunting

NEWS STORY

Temporary art piece tells story of 'hope, strength' during COVID-19 pandemic



The COVID-19 pandemic brought about negative and dark emotions and it seemed that nobody was exempt from these feelings. But within that darkness, it brought minority communities closer together to fuel hope within the bodies of its community members. While some communities established food banks and provided money to those who were out of work, others created and adorned their communities with illustrated symbols of hope. In 2020, the city of Kirkland, WA commissioned artists Angie Hinojos

Yusuf and Carlos Jimenez to craft four temporary pieces telling the story of "hope, strength and resilience in the face of COVID-19". The four pieces embody the Mexican cultural heritage of the artists and gives a different message. The four pieces are titled, "Life/La Vida," "Care/Cuidate," "Wisdom/Sabiduria" and "Hope/El Futuro." "Life" is a woman, "Care" a farmworker, "Wisdom" a senior resident and "Hope" depicts a new generation while embracing diversity and inclusion.

Link: <https://www.kirklandreporter.com/news/temporary-art-piece-tells-story-of-hope-strength-during-covid-19-pandemic/>

Figure 3: News Story: Art Tells a Story of Hope and Strength

NEWS STORY

Pop-up vaccine clinic in Redmond works to reach Latino community



In Redmond, WA, to address the low vaccination rates among the Latino population within the city, Overlake Medical Center, Evergreen Health, and Microsoft donated a shuttle to transport vaccinations to Latino communities with one pop-up clinic per week. The mobile clinic would pop up at parks and community events while playing Mariachi music to make the COVID-19 clinics feel less clinical and more comfort-

able for those who were hesitant about the vaccine. Before the next pandemic, community partners and local governments need to find unique and effective ways to connect with underserved populations by connecting and planning with community leaders to reach these populations and to gain their trust when it comes to vaccinations and testing.

Link: <https://www.king5.com/article/news/health/coronavirus/vaccine/pop-up-vaccine-clinic-in-redmond-works-to-reach-latino-community/281-a60891fc-e566-4712-a5fc-0c03297d5e11>

Figure 4: News Story: Pop-Up Vaccine Clinic in the Latino Community

NEWS STORY



Short Film: ¡Ya Es Tiempo! The Time is Now!

In this short film, Latino community members, many of which were migrants, in Washington state shared their personal experiences navigating the COVID-19 pandemic. The film interviewed single mothers who had more than 2 children in their household and tell their story of how unemployment caused an enormous amount of burden to maintain their family's living standards. Unemployment not only impacted the parent, but also affected the children who were still in school. Those children found it difficult to transition from traditional in-person classrooms to remote learning. Children's grades plummeted because they had limited technology or had to share tech equipment with their siblings making it difficult to keep up with classwork. They had to juggle schoolwork and their new responsibilities at home to help their unemployed parent around the house. Latino students have fallen behind the greatest in comparison to their peers and caused a drop in college enrollment. Business owners were interviewed and provided a view of hopelessness as they saw their business activities and finances plummet. Many

Latino-owned businesses were not able to recover and forced many to take on jobs as employees to maintain their income.

The film showed that in Latino communities, being physically close to other community members is an inherent part of the Latino culture. When COVID-19 hit that undid the deep-rooted social connections when it came to being quarantined and isolated from others. It made people fearful of getting tested and created mental health issues for many. But Latinos communities responded to help one another by setting up food banks and donating money to those who were economically impacted by the pandemic. The long-term effects will take years of undoing. And with the government not supporting these communities from the beginning will make the road to recovery for Latino communities an unforeseeable process. In the meantime, Latino community members are continuing to step up to the plate to see that each one of them is not struggling and left behind.

Link: <https://www.centroculturalmexicano.org/ya-es-tiempo-2>

Figure 5: News Story: Film Shows the Effects of COVID-19 on the Latino Community

NEWS STORY

King County Vaccination Partnership – Redmond: Redefining Collaboration in the Age of COVID-19



At the beginning of the COVID-19 pandemic, many large organizations in Washington state were challenged to quickly find solutions to protect their employees, customers, and the whole community. And when the vaccines began rolling out, there was limited to supplies to stick into people’s arms. To address the growing need to vaccinate as many people as possible, six things needed to happen. There needs to be a sufficient supply of vaccine, space to hold clinics, medical expertise, funding, vaccination systems and processes, and community outreach. An alliance called Challenge Seattle that was comprised of 21 CEOs from the largest employers in the region, including Microsoft, came together. It was understood that to bring all the resources together, there needed to a public-private partnership to accomplish this mission.

First, they needed to establish a team that shared the same interest in supporting the communities within the region. Microsoft partnered with King County’s medical organizations, Evergreen Health, and Overlake hospital to collaborate on mass vaccination site. Microsoft offered its campus and technology and the two medical organizations provided medical expertise. The technology giant also partnered with

Seattle & King County Public Health to provide the guidelines and operate the vaccination sites. Starbucks was also invited to collaborate by extending its expertise in applying human-centered design and optimizing workflows to ensure processes worked smoothly.

Great things began to blossom from the public-private partnership. They were able to connect with local community-based organizations which helped to understand the needs and make vaccines equitable. From that they connected with diverse communities from an inclusive perspective. This action brought in more appointments from underserved and high-risk individuals. And by Spring of 2021, the Microsoft vaccination site, 5,000 vaccines were being administered per day. In total, over 165,000 vaccines had been administered, making 6% of all vaccination in King County. The site also delivered 53% of its vaccines were given to at-risk BIPOC communities. The roles the public-private partnerships played during the pandemic, to unite and support the needs of its most vulnerable communities, shows that these types of influential collaborations must take place to ensure that everyone is equally involved and cared for.

Link: <https://kingcounty.gov/elected/executive/constantine/news/release/2021/February/10-vaccine-partnerships.aspx>

Figure 6: News Story: Vaccination Partnership during the COVID-19 Pandemic

Community Health Association of Spokane COVID-19 Testing Sites for Spokane Communities

When the COVID-19 pandemic hit our community, the Community Health Association of Spokane (CHAS Health) leveraged our unique attributes as a local CBO that could be nimble, resilient, and adaptable to support not just our patients, but the greater community. From providing community-wide testing and increasing telehealth capabilities to maintaining ongoing primary care services for our patients, including pharmacy services, CHAS Health has remained focused on our mission of caring for everyone in our community. We moved 70% of our staff to remote working environments, created a virtual primary care delivery system within a matter of weeks, stand up mass COVID-19 testing sites, increase home delivery pharmacy volumes, and implement tele-dentistry.





Conducting more than 86,000 COVID-19 tests across the communities we serve, CHAS Health was a primary location for COVID-19 testing throughout the pandemic. From creating stand-alone testing locations connected to our clinics to innovating a mass drive-through testing location at Spokane Arena to meet the testing needs of large numbers across our community who had never used CHAS Health services before, we remained nimble and focused on reducing the spread of COVID-19.

At the beginning of 2021, CHAS Health was the lead provider for mass vaccination efforts at Spokane Arena, standing up a vaccination effort that provided some of the earliest vaccine access in our community. After transitioning that site to DOH, we focused on how to bring vaccination to our patients and those who might not have easy vaccine access. We developed mass vaccination locations at Gonzaga University and Spokane Community College (both on major bus routes) in addition to providing COVID-19 vaccines at every CHAS Health primary care and urgent care location. We also implemented highly successful pop-up vaccine clinics to meet the needs of some of our most vulnerable populations and those who might be hesitant about traditional healthcare settings. CHAS Health provided more than 90,000 COVID-19 vaccines to more than 50,000 members of our community.



Selection of Media Stories:

- <https://www.spokanepublicradio.org/regional-news/2020-12-04/chas-to-consolidate-its-spokane-covid-testing-at-the-arena#stream/0>
- <https://www.spokesman.com/stories/2020/dec/04/chas-will-open-drive-up-covid-testing-at-spokane-a/>
- <https://www.krem.com/article/news/health/coronavirus/spokane-arena-coronavirus-testing-site/293-17fb2435-d89f-4a77-9719-10391117ff90>
- <https://www.spokesman.com/stories/2021/jan/22/spokane-arena-mass-vaccination-site-set-to-open-we/>
- <https://www.spokesman.com/stories/2021/mar/09/chas-vaccinates-more-than-7000-residents-at-gonzag/>

10.2. Additional Considerations and Recommendations from Community Partners

Information presented here includes additional research, analysis, and after-action findings that were conducted by State Pandemic Task Force member organizations, however, were conducted independent of the Task Force itself. This information is unedited for inclusion in this Task Force Summary. This information is especially relevant to the overall discussion of the challenges of equity and disparities highlighted throughout the COVID-19 pandemic.

Impacts, Considerations, and Recommendations for the Intellectual and Developmental Disabilities Community

The Arc of Washington State, a member of the State Pandemic Task Force, provided information presented in a webinar facilitated through the Interagency Committee on Disability Research titled, *COVID-19 Data on Individuals with Intellectual and Developmental Disabilities*. The presenters included Emma Plourde, Public Health Policy Analyst, and William (Chip) Haltermann III, Program Specialist, Office of the Assistant Secretary for Planning and Evaluation. **Table 3.** lists the key takeaways provided by the Arc of Washington state as they relate to the impacts and effects of the COVID-19 pandemic on individuals with intellectual and developmental disabilities (IDD).

Table 3: Key Takeaways on the Effects of COVID-19 Pandemic on Individuals with Intellectual and Developmental Disabilities

Key Takeaways on the Effects of the COVID-19 Pandemic on Individuals with Intellectual and Developmental Disabilities
❖ Federal, state, and local efforts to track and respond to the disproportionate impacts of COVID-19 on people with IDD were hindered by a lack of data.
❖ Once collected, data clearly showed that people with IDD had a greater risk of infection because of the greater likelihood they lived in a care setting with shared staff or caregivers and had greater reliance on personal care or other assistance. They also had a greater risk of severe COVID-19 outcomes due to the high prevalence of underlying medical conditions.
❖ The agencies that needed to better collaborate and collect data included the Developmental Disabilities Administration, the Aging and Long-Term Support Administration, Medicaid (HCA), and Public Health agencies.
❖ Data for people with IDD should include exposure rates, positivity rates, hospitalization, and mortality information.
❖ Data should also be collected on “direct support professionals”—their positivity rates and vaccination status.
❖ Data should include the number of people with IDD who in intensive care units and those who are ventilator-dependent
❖ There is a huge gap in information regarding exposure guidelines, vaccination priorities, PPE distribution, and resource allocation, including in (non-facility) community-based provider-owned, provider-operated residential settings and family residential settings, where most people with IDD reside.
❖ Data for people with IDD generally lacked additional data on race, ethnicity, age, and “other” health factors.
❖ Some states used data to improve targeted provider pay enhancements, in-person versus remote case management.

According to the Arc of Washington State, the best results about the impacts on those with IDD and their support seemed to come from combining data from Medicaid agencies with information from the Washington Developmental Disabilities Administration (DDA). **Figure 7** shows some considerations for improving these connections provided by the Arc of Washington State.

- ✓ **State agencies should establish data sharing agreements now with Medicaid, the Developmental Disabilities Administration, DOH, and public health agencies**
- ✓ **All systems should include self-reporting that asks for data on intellectual and developmental disabilities (IDD), race, ethnicity, and residential setting**
- ✓ **Partnering with DDA can provide the information needed from the “support intensity scale” which can be linked to Medicaid claims**
- ✓ **KEY will be an operational definition of the IDD population for public health and health research – this is probably a list of CODES developed**
- ✓ **The Aging and Long-Term Support Administration (AL TSA) should be included, and data should be disaggregated by IDD, dementia, traumatic brain injury, and others who need personal care**

Figure 7: Considerations for Improving Data Collection for Those with Intellectual and Developmental Disabilities

10.3. Considerations and Recommendations from Tribal Communities

In addition to the work that the AIHC contributed to the State Pandemic Task Force as a member, it also developed the *Tribal Comprehensive COVID-19 Report*, which reviewed the impacts of the COVID-19 pandemic on tribal communities and provided over 45 recommendations to be considered. The development of their AAR included facilitation of 44 webinars with individual tribes and Urban Indian Health Programs. Some key recommendations are highlighted in **Table 4**. The full report can be viewed here: <http://aihc-wa.com/wp-content/uploads/2023/05/Final-AIHC-Tribal-COVID-19-Pandemic-AAR-Report-5-18-23.pdf>.

Table 4: Recommendations from Tribal Communities

<i>Capability</i>	<i>Recommendation</i>
Community Recovery	<ul style="list-style-type: none"> • State and local governments should provide technical support and resources for tribal health jurisdictions and urban Indian health organizations to lead and conduct their own emergency response since community members look to them as the most-trusted source for how to keep safe during an emergency. • The state of Washington should provide mental health resources and debriefing exercises for public health jurisdictions, including tribal health

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Capability	Recommendation
	jurisdictions, and urban Indian health organizations to conduct or outsource mental health support to staff who responded during the pandemic.
Emergency Operations Coordination	<ul style="list-style-type: none"> • Create Incident Management Team positions and invite tribal representation to state, county, and local EOCs.
Emergency Public Warning and Information	<ul style="list-style-type: none"> • Coordinate information sharing to ensure that all health jurisdictions are sharing the same information at the same time. • Addressing broadband access, which is an ongoing issue on several reservations.
Information Sharing	<ul style="list-style-type: none"> • To ensure that tribal health jurisdictions can effectively communicate with their community members, provide critical services, and coordinate with federal, state, and local governments during the next pandemic, the state of Washington through their various agencies including the Department of Commerce and the Department of Natural Resources, should provide continued planning and support to tribal governments for the development of broadband infrastructure in rural areas. • DOH should create and maintain an online database for all tribal and local health jurisdictions to access up-to-date contact information. Tribal health jurisdictions should have a choice as to whether to opt in to the database and share their contact information with other tribal and local health jurisdictions.
Vaccines and Antivirals Acquisition and Dispensing	<ul style="list-style-type: none"> • DOH should regularly review and train staff on implementing Washington State Medical Countermeasures Plan, Annex 9 to ensure understanding and compliance with federal and state policies which include the right of tribal health jurisdictions to determine service populations and priority groups. • Indian Health Services (IHS) must amend the IHS COVID-19 Pandemic Vaccine Plan to be consistent with the CDC’s COVID-19 Vaccination Program Interim Playbook for Jurisdictions Operations Annex, which provides that Tribes shall determine their priority groups, not IHS.
Medical Material Management and Distribution	<ul style="list-style-type: none"> • DOH should maintain a set aside in their stockpile to ensure Tribes and urban Indian health organizations have access to PPE and medical supplies that are likely to be impacted by supply chain issues. • Provide technical support on government-to-government tribal-IHS-DOH calls facilitated by the AIHC during public health emergencies.
Medical Surge	<ul style="list-style-type: none"> • The state of Washington should prioritize funding to tribal health jurisdictions and urban Indian health organizations for at least 1.0 FTE public health staff position for each tribal health jurisdiction and urban Indian health organization
Nonpharmaceutical Interventions	<ul style="list-style-type: none"> • Future planning for isolation and quarantine facilities needs to have considerations on how to serve different population needs including those with behavioral health issues and transportation challenges. • Tribal health jurisdiction and local health jurisdiction planning for isolation and quarantine facilities needs should consider leveraging resources between jurisdictions, such as shared facility sites and staffing.

<i>Capability</i>	<i>Recommendation</i>
<i>Testing</i>	<ul style="list-style-type: none"> • State and local health should coordinate with Tribes to ensure joint mass testing efforts are represented in their plans where appropriate • DOH should ensure that all tribal health jurisdictions have access to the Washington Disease Reporting System to review the test results of their residents and coordinate follow-up.
<i>Public Health Surveillance and Epidemiological Investigation</i>	<ul style="list-style-type: none"> • Federal and state jurisdictions should make investments in emergency data systems a high priority and ensure these systems are better able to share more accurate information with tribal health jurisdictions. • Ensure that tribal health jurisdictions are properly notified of any exposure or potential exposures of a notifiable condition of their community members and recognize the sovereign authority of tribal governments to act as public health authorities, including amending Chapter 246-100 WAC to include requirements for notifications to tribal health jurisdictions.
<i>Cross-Jurisdictional Collaboration</i>	<ul style="list-style-type: none"> • Inclusion of Tribal Health Jurisdictions on all DOH maps and regional planning/information documents.

10.4. Additional Lessons and Recommendations Related to Crisis Decision-Making and Governance

The Washington State Legislature provided funding for fiscal year 2022–2023 to the Washington Military Department to contract with the William D. Ruckelshaus Center to compare the traditional Emergency Management decision-making systems in Washington state with other decision-making structures and provide recommendations for future emergency responses. The goal of the project was to implement a comprehensive, cross-jurisdictional exploration of lessons learned from the pandemic about the dynamic between traditional emergency management decision-making systems and other ways decision-making was structured for responses to the pandemic in Washington. This exploration included exploring potential embedded or practiced biases and/or structures that impact considerations of equity, inclusion, and diversity. The project engaged participants in developing a set of recommendations for decision-making systems used in governments, universities, businesses, and other entities. The William D. Ruckelshaus Center partnered with Berk Consulting and the Pacific North-West Economic Region (PNWER) to assist with this project. The Crisis Governing and Decision-Making: Reviewing Lessons from Emergency Management Systems in Washington complements the work of the Task Force and can be found at <https://ruckelshauscenter.wsu.edu/> under “Current Projects.”

10.5. Future Engagement Opportunities

The Task Force members recognized that the proviso language excluded areas of importance that were minimally explored during the Task Force meetings. For example, childcare and issues specific to rural communities were noted but not discussed to a great extent. The Task Force members recommended that these and potentially other important areas should be the focus of further work.

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During a recent Task Force meeting, discussions of areas for further exploration included the following:

➤ **Addressing workforce shortages**

Challenges during the COVID-19 pandemic included workforce shortages across many different sectors, especially in healthcare. There were regulatory barriers that adversely impacted the recruitment and retention of hospital staff. Researching practical and beneficial incentives for both employers and staff across the healthcare system and options and innovations for surge staffing could serve to build a more resilient system for the future.

➤ **Making positive impacts by leveraging innovations**

Early in the COVID-19 pandemic, many industries pivoted from traditional ways of doing business to maintain some level of service and income. Stay-at-home public health measures meant to keep the general public as safe as possible resulted in challenges to access critical services such as basic healthcare and mental health wellness. Innovations such as the growth of telemedicine and apps that provide expanded connections to mental health support resources allowed many individuals to receive the vital support they needed. Some of these innovations created a safe space for those who might have needed support but were reluctant to seek it out.

➤ **Expanding community collaboratives**

One of the key lessons learned in the aftermath of the COVID-19 pandemic is the criticality of engaging with diverse, vulnerable, and underserved communities before an emergency to best understand these communities, what their needs may be, and how best to support those needs. The mantra "Nothing About Us, Without Us" speaks to the importance of bringing communities to the planning space to understand the culture of a particular community, how they receive information and from who, considerations for communications platforms and formats, and how to reach people where they are. Government and community organizations working together to identify roles, support, and resources and building on existing networks can build more resilient communities.

11. Conclusion

Washington, like most other states, continues to recover from the effects of the COVID-19 pandemic. Effects that may not be fully understood for some time, such as the long-term effects of school facility closures on children, impacts of lost wages and employment, inability to pay rents and mortgages, and the long-lasting impacts on the overall healthcare system. Due to the magnitude of the pandemic, recovery efforts will likely be ongoing for quite some time.

This Task Force Summary provides key findings that demonstrate the strengths of documenting best practices and areas for improvement that can be addressed immediately, further improving recovery efforts and future responses to emergencies and disasters. This Task Force Summary, while focused on specific topics outlined by the Washington State Legislature, also sought to integrate considerations for a more equitable approach to future emergency response and recovery activities. The recovery from COVID-19 cannot be solved by one single entity, and the responsibility is on the entire state of Washington to address these gaps.

Washington state stakeholders and response partners are encouraged to reflect on the findings in this report in relation to all five phases of emergency management: mitigation, prevention, preparedness, response, and recovery, to integrate considerations for vulnerable and underserved constituents into plans, procedures, and training that support other emergency response efforts. This can support the building of a more equitable and resilient response and recovery framework for all Washingtonians.

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Appendix A: Race Equity, Accessibility, Diversity, Equity, Inclusion, and Belonging: Foundational Principles Document



RAEDEI-B: Foundational Principles

The goal of this document is to help you absorb, better understand, begin to embody and apply these principles in your thinking as you participate in this Task Force process and offer your recommendations - as well as improving how you show up in matters of equity.

The following are foundational operating assumptions. To advance Race Equity, Accessibility, Diversity, Equity, Inclusion, and Belonging (RAEDEI-B), we have found it requires us to accept fundamental principles listed below. To be successful in the work of RAEDEI-B, we must learn from the complexity, tragedy, and the under-education of our United States history and focus on where we go from here. In our work for RAEDEI-B, we acknowledge that some of you may disagree with some of the following. We encourage you to seek out additional learning opportunities and share lived experiences to further your education.

Within the context of the United States, the historically enduring, institutionally reinforced, unconscious social biased categories include: race, gender identity, place of birth, religious/spiritual practices, sexual orientation, indigenous heritage, access to land ownership, higher education, age, and unique mental and physical expression.

Fundamental Truths

1. All life is valuable and contributes uniquely to the collective wellbeing of all life.
2. We live in a highly Racialized Society, thus we lead with Race. Institutional, Structural, Systemic, Cultural, Individual, and Internalized Racism/Superiority is real.
 - a. Race has been foundational in creating this society that is built on White Supremacy principles. Racialization related to those with racial advantage and disadvantage impacts, economics, health, education, criminal justice, housing, environmental, and other life outcomes.
3. Sexism is real.
 - a. Women have been devalued and marginalized under US patriarchy, and it is a foundational ingredient in the formation of this country.
4. Colonialism and Manifest Destiny are the root of White Supremacy Culture and lead to the exploitation and erasure of Indigenous and African (enslaved Africans) cultures as well as explicit and implicit cultural traumas that continue to impact our society.
5. Peoples with differing abilities/disabilities have been marginalized and pushed to the fringes of our society.
 - a. They are valuable and contributing members of our society when we ensure all forms of access have afforded them to participate fully.

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6. Social hierarchies exist and are continuously constructed, reinforced and can be unconscious.
 - a. Socially constructed hierarchies are taught, learned and passed down through the generations, affecting us all, whether we realize it or not.
 - b. Socially constructed hierarchies are structurally upheld and reinforced through biased institutionalized policies and practices, and the creation and enforcement of biased laws enforced by local, state, and national government.
7. Although none of us asked for these socially constructed systems, we have lived within them for more than 500 years and they have become a part of our reality. Thus, we all have a part in remedying them, especially those who hold institutional and socially constructed power.
8. Government has had a profound role in constructing and the maintenance of these structures and systems, thus, government has a role in remedying and healing the impacts, effects and affects caused by Institutional systems and structures of Racism, Sexism, Ableisms, Audism, and other ism's.

READEI-B cultural transformation work is the practice of raising our individual and collective consciousness around socially constructed systems of power that can be both conscious and unconscious ways of being in which decisions are often engaged, interacted with and made.

Toolkit Questions:

People- Who is there? Who is missing?

Stakeholders/Representation/*Diversity of experience*

1. Who is participating in the conversation?
2. What real life stories do we need to inform this conversation?
3. Whose voices dominate most often?
4. Have we made space for multiple forms of communication? Language, ASL, Visually Impaired, etc.
5. Have/how have stakeholders been identified?
6. Who is missing from the conversation?
7. Who is/has been helped and who is/has been harmed?
8. Has community engagement happened?
9. Has access been given or denied at all community levels?
 - a. Engagement, Resource distribution, Communication, and Accessibility.
10. How has access been denied? (Communication and accessibility issues?)
11. Have we looked for stakeholders across economic and educational demographics?

Historical Influences & Context

History and Education

12. What are the known historical impacts and events that we should be aware of?
13. Is there any unknown history that we should be aware of?
14. What are the root causes of issues we are attempting to address and/or addressing?
15. What were the political motives that caused or influenced the issues?
16. Have political issues/causes been addressed? How have they been addressed?

Influences, Causation, Impact

17. *What barriers are we creating that prevent people from accessing services?*
18. How will we know when change has occurred?

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19. How will we know if lives have been improved or if harm has happened?
20. What issues are left unresolved?
21. What areas are we analyzing and evaluating?
22. What are our intended outcomes?
23. What are the racial demographics of the impacted area?
24. *What institutional barriers prevent change*
25. *How will the learnings or decisions be communicated, and to who?*

Analysis/Data/Research

Measuring Progress: Data and impacts

26. What data do we have? Qualitative or/and quantitative?
27. How will we analyze and evaluate what we have done for effectiveness?
28. What data do we need that is missing?
29. What methodology is being used?
30. What are the unknown factors when demographics are not desegregated?

Interpretation/ Introspection/ Self-Reflection

(Education/ correcting our beliefs and behaviors/ examining of systems and planning for dismantling)

31. Has White fragility showed up?
32. What are the White normative behaviors that are showing up?
33. How have White normative behaviors hindered success?
34. What are the power dynamics occurring in the space and at play?
35. What/How are the power dynamics happening in the design, implementation, and evaluation of solutions?
36. Were issues funded for success or failure?
37. What are the Micro (people/personal) issues and the Macro (community/societal) issues?

Accountability/Action/Implementation

38. What is necessary for accountability?
39. How will we manage conflict?
40. How will we evaluate the results of our actions?
41. Will solutions presented increase or decrease READEI-B
42. What might be the unintended consequences?

Policymaking

What would you add here?

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Appendix B: References

Washington State Agency After-Action Reports Reviewed

- Washington State Department of Commerce
- Washington State Department of Corrections
- Washington State Department of Ecology
- Washington State Department of Enterprise Services
- Washington State Department of Financial Institutions
- Washington State Department of Health
- Washington State Department of Licensing
- Washington State Department of Social Health Services
- Washington State Employment Security Department
- Washington State Office of Financial Management
- Washington State Office of Insurance Commissioner
- Washington State Department of Agriculture
- Washington State Department of Transportation
- Washington State Department of Labor and Industries
- Washington State Patrol

Washington State Pandemic Task Force Materials/Additional Documents Reviewed or Referenced

- Washington State Emergency Operations Center (SEOC) *COVID-19 Interim AAR*
- American Indian Health Commission, *Tribal Comprehensive COVID-19 Report, May 18, 2023*. <http://aihc-wa.com/wp-content/uploads/2023/05/Final-AIHC-Tribal-COVID-19-Pandemic-AAR-Report-5-18-23.pdf>
- Washington State Department of Commerce, *Time, Trust, Technology: Community First for Small Business Opportunity*. <https://www.commerce.wa.gov/about-us/reports-publications/ta-report/>
- The Presidential COVID-19 Health Equity Task Force, *Final Report and Recommendations*, dated October 2021. https://www.minorityhealth.hhs.gov/assets/pdf/HETF_Report_508_102821_9am_508Team%20WIP11-compressed.pdf
- The Presidential COVID-19 Health Equity Task Force, *Proposed Implementation Plan and Accountability Framework*, dated October 2021. https://www.minorityhealth.hhs.gov/assets/pdf/HETF_ProposedImplementationPlanPlus_508_CR.pdf
- The U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR), *Crimson Contagion 2019 Functional Exercise After-Action Report*, dated October 5, 2020.
- Results for America Collaboration Case Study, *COVID-19 Vaccine Distribution: City of Seattle and King County Washington*, dated February 2022. https://results4america.org/wp-content/uploads/2022/04/Seattle_King-County-COVID-19-Vaccine-Distribution-Case-Study_020222.pdf

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Appendix B: References

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Appendix C: Acronyms

Acronym	Definition
AAR	After-Action Report
ADA	Americans with Disabilities Act
AIHC	American Indian Health Commission
AL TSA	Aging and Long-Term Support Administration
ARPA	American Rescue Plan Act
ASPR	Office of the Assistant Secretary for Preparedness and Response
BIPOC	Black, Indigenous, and People of Color
CARES	Coronavirus Aid, Relief, and Economic Security Act
CBO	Community-Based Organization
CBP	Customs and Border Protection
CDC	Centers for Disease Control and Prevention
CDWA	Consumer Direct Care Network Washington
CEMP	Comprehensive Emergency Management Plan
CHAS Health	Community Health association of Spokane
CMS	United States Centers for Medicare and Medicaid Services
CICT	Case Investigation, Contact Tracing, Isolation, and Quarantine
COOP	Continuity of Operations
COVID-19	Coronavirus Disease-2019
CSFRF	Coronavirus State Fiscal Recovery Funds
DCYF	Washington State Department of Children, Youth, and Families
DDA	Washington Developmental Disabilities Administration
DES	Washington State Department of Enterprise Services
DFI	Washington State Department of Financial Institutions
DOH	Washington State Department of Health
DOSH	Washington State Department of Occupational Safety and Health
DOT	Washington State Department of Transportation
DSHS	Washington State Department of Social and Health Services
EEOC	Equal Employment Opportunity Commission
EMD	Washington Military Department, Emergency Management Division
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOP	Emergency Operations Plan

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Acronym	Definition
ERPP	Eviction Resolution Pilot Program
ESD	Educational Service Districts
ESF	Emergency Support Function
ESSB	Engrossed Substitute Senate Bill
ESSER	Elementary and Secondary School Emergency Relief
EUA	Emergency Use Authorization
FAQ	Frequently Asked Questions
FDA	U.S. Food and Drug Administration
FEMA	Federal Emergency Management Agency
FERPA	Family Educational Rights and Privacy Act
HIS	Indian Health Service
HHS	U.S. Department of Health and Human Services
HR	Human Resources
ICS	Incident Command System
ICU	Intensive Care Unit
IDD	Intellectual and Developmental Disability
IS	Independent Study
LHJ	Local Health Jurisdiction
LNI	Washington Department of Labor and Industries
LPN	Licensed Practical Nurse
LTC	Long Term Care
MAC	Multi-Agency Coordination Group
MOU	Memorandums of Understanding
MRC	Medical Reserve Corps
MWE	Modern Work Environment
NGO	non-governmental organization
NIMS	National Incident Management System
NRF	National Response Framework
OFM	Washington State Office of Financial Management
OSPI	Washington Office of the Superintendent of Public Instruction
PA	Public Assistance
PHSKC	Public Health Seattle and King County
PNWER	Pacific Northwest Economic Region
PPE	personal protective equipment
PPP	Paycheck Protection Program

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Acronym	Definition
RCW	Revised Code of Washington
RN	Registered Nurses
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SBA	Small Business Administration
SBRN	Small Business Resiliency Network
SEOC	State Emergency Operations Center
SOP	standard operating procedure
UCG	Unified Coordination Group
WAC	Washington Administrative Code
WDRS	Washington Disease Reporting System
WHCA	Washington State Healthcare Association
WMD	Washington State Military Department
WSDA	Washington State Department of Agriculture
WSHA	Washington State Hospital Association
WHO	World Health Organization