King County

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Meeting Agenda

Health, Housing, and Human Services Committee

Councilmembers:
Teresa Mosqueda, Chair;
Reagan Dunn, Vice-Chair;
Jorge L. Barón, De'Sean Quinn

Lead Staff: Sam Porter (206-263-2708)
Committee Clerk: Angelica Calderon (206-477-0874)

9:30 AM | **Tuesday, March 4, 2025** | **Room 1001**

Hybrid Meetings: Attend King County Council committee meetings in person in Council Chambers (Room 1001), 516 3rd Avenue in Seattle, or through remote access. Details on how to attend and/or provide public comment remotely are listed below.

Pursuant to K.C.C. 1.24.035 A. and F., this meeting is also noticed as a meeting of the Metropolitan King County Council, whose agenda is limited to the committee business. In this meeting only the rules and procedures applicable to committees apply and not those applicable to full council meetings.

HOW TO PROVIDE PUBLIC COMMENT: The Health, Housing and Human Services Committee values community input and looks forward to hearing from you on agenda items.

There are three ways to provide public comment:
1. In person: You may attend the meeting and provide comment in the Council Chambers.

2. By email: You may comment in writing on current agenda items by submitting your email comments to kcccomitt@kingcounty.gov. If your email is received before 8:00 a.m. on the day of the meeting, your email comments will be distributed to the committee members and appropriate staff prior to the meeting.

3. Remote attendance at the meeting by phone or computer: You may provide oral comment on current agenda items during the meeting's public comment period by connecting to the meeting via phone or computer using the ZOOM application https://zoom.us/join, and entering the Webinar ID number below.

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TTY Number - TTY 711.
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To show a PDF of the written materials for an agenda item, click on the agenda item below.

1. **Call to Order**

2. **Roll Call**

3. **Approval of Minutes** p. 4

   Minutes of February 4, 2025 meeting.

4. **Public Comment**

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Consent

5. Proposed Motion No. 2024-0008 **p. 10**

A MOTION acknowledging receipt of the new pandemic response plan required by Motion 15650.

Sponsors: Balducci

Erica Newman, Council staff

6. Proposed Substitute Motion No. 2024-0228.2 **p. 333**

A MOTION acknowledging receipt of the second annual report on the second Best Starts for Kids initiative, in accordance with Ordinance 19354.

Sponsors: von Reichbauer and Mosqueda

Miranda Leskinen, Council staff

Discussion and Possible Action

7. Proposed Ordinance No. 2025-0030 **p. 419**

AN ORDINANCE approving the King County Consortium Consolidated Plan for 2025-2029.

Sponsors: Mosqueda

Olivia Brey, Council staff

Briefing

8. Briefing No. 2025-B0028 **p. 606**

DESC and DCHS Joint Briefing: Expansion of Mobile Crisis Teams and System Overview

Kelly Rider, Director, Department of Community and Human Services (DCHS)
Dan Williams, Director of Housing, Downtown Emergency Service Center (DESC)
Katrina Plewinski, Director of Mobile Response, DESC

9. Briefing No. 2025-B0027 **p. 607**

2025 Health, Housing, and Human Services Committee Look Ahead.

Sam Porter, Council staff

Other Business

Adjournment

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Meeting Minutes

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1. Call to Order

Chair Mosqueda called the meeting to order at 9:31 a.m.

2. Roll Call

Present: 4 - Dunn, Barón, Mosqueda and Quinn

3. Approval of Minutes

Councilmember Dunn moved approval of the minutes of the July 2, 2024 meetings. Seeing no objections, the minutes were approved.

4. Public Comment

There are no individuals present to provide public comment.

Consent

5. Proposed Motion No. 2024-0056

A MOTION confirming the executive's appointment of Gracie McDanold, who resides in council district nine, to the King County children and youth advisory board.

Sponsors: Dunn

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

6. Proposed Motion No. 2024-0335

A MOTION confirming the executive's appointment of Shawn Armour, who resides in council district nine, to the King County children and youth advisory board, as an at-large representative.

Sponsors: Dunn

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

7. Proposed Motion No. 2024-0336

A MOTION confirming the executive's appointment of Merob Kebede, who resides in council district six, to the King County children and youth advisory board, as the youth representative.

Sponsors: Balducci

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

8. Proposed Motion No. 2024-0337

A MOTION confirming the executive's appointment of Kristina Brown, who resides in council district three, to the King County children and youth advisory board, as an at-large representative.

Sponsors: Perry

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

9. Proposed Motion No. 2024-0338

A MOTION confirming the executive's appointment of Hattie Steward, who resides in council district five, to the King County children and youth advisory board, as an at-large representative.

Sponsors: Upthegrove

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

10. Proposed Motion No. 2024-0339

A MOTION confirming the executive's appointment of Angela Phan, who resides in council district six, to the King County children and youth advisory board, as an at-large representative.

Sponsors: Balducci

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

11. Proposed Motion No. 2024-0350

A MOTION confirming the executive's appointment of Julia Colson, who works in council district four, to the King County veterans, seniors and human services levy advisory board's vulnerable populations committee, as the district four representative.

Sponsors: Barón

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

12. Proposed Motion No. 2024-0351

A MOTION confirming the executive's appointment of Theresa Demeter, who resides in council district four, to the King County veterans, seniors and human services levy advisory board's seniors committee, as the district four representative.

Sponsors: Barón

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

13. Proposed Motion No. 2024-0352

A MOTION confirming the executive's appointment of Brenda Farwell, who works in council district five, to the King County veterans, seniors and human services levy advisory board's seniors committee, as the district five representative.

Sponsors: Upthegrove

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

14. Proposed Motion No. 2024-0120

A MOTION confirming the executive's appointment of Leslie Kae Hamada, who resides in council district nine, to the King County women's advisory board, as a council at-large representative.

Sponsors: Upthegrove

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

15. Proposed Motion No. 2024-0330

A MOTION confirming the executive's appointment of Maria Langbauer, who resides in council district eight, to the King County women's advisory board, as the district eight representative.

Sponsors: Mosqueda

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

16. Proposed Motion No. 2024-0368

A MOTION confirming the executive's appointment of Michelle Maley, who resides in council district seven, to the King County women's advisory board, as the district seven representative.

Sponsors: von Reichbauer

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

Discussion

17. Proposed Motion No. 2024-0008

A MOTION acknowledging receipt of the new pandemic response plan required by Motion 15650.

Sponsors: Balducci

Joy Carpine-Cazzanti, Government Relations, Public Health – Seattle & King County, Brendan Mccluskey, Director of OEM, Dr. Eric Chow, Interim Health Officer, Public Health – Seattle & King County and Nick Solari, Preparedness Director, Public Health – Seattle & King County, were present to brief the Committee via PowerPoint presentation and answer questions from the members.

This matter was Deferred

18. Proposed Substitute Motion No. 2024-0228.2

A MOTION acknowledging receipt of the second annual report on the second Best Starts for Kids initiative, in accordance with Ordinance 19354.

Sponsors: von Reichbauer and Mosqueda

Miranda Leskinen, Council staff, briefed the Committee on the legislation and answered questions from the members. Dr. Jamalia Jones, BSK Co-Lead, DCHS, and Jessica Tollenaar Cafferty, BSK Co-Lead, PHSKC were present to brief the Committee via PowerPoint presentation and answer questions from the members.

This matter was Deferred

Discussion and Possible Action

19. Proposed Motion No. 2024-0243

A MOTION approving the 2023 annual mental illness and drug dependency evaluation summary report, in compliance with K.C.C. 4A.500.309.

Sponsors: von Reichbauer

Sam Porter, Council staff, briefed the Committee on the legislation and answered questions from the members. Kelly Rider, Director, Department of Community and Human Services (DCHS), and Robin Pfohman, MIDD Coordinator, BHRD, DCHS, were present to briefed the Committee via PowerPoint presentation and answer questions from the members.

A motion was made by Councilmember Dunn that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:

Yes: 4 - Dunn, Barón, Mosqueda and Quinn

Other Business

There was no other business to come before the committee.

Adjournment

The meeting was adjourned at 10:58 a.m.

Approved this _____ day of _____

Clerk's Signature

King County

Metropolitan King County Council
Health, Housing, and Human Services Committee

STAFF REPORT

Agenda Item:	5	**Name:**	Erica Newman
Proposed No.:	2024-0008	**Date:**	March 4, 2025

SUBJECT

A motion acknowledging receipt of the new pandemic response plan as required by Motion 15650.

SUMMARY

Proposed Motion 2024-0008 would acknowledge receipt of the King County Biological Incident Response Annex (Annex), formerly known as the Pandemic Influenza Response Plan[1].

As required under Motion 15650, Public Health Seattle & King County created a new Pandemic Response Plan, building on the existing Pandemic Influenza Response Plan and using lessons learned from the COVID-19 pandemic. The new Pandemic Response Plan, known as the Annex, incorporates plans for pandemics (influenza and other viruses, such as coronaviruses) and other biological pathogens. The term "Annex" is an emergency preparedness term that refers to an operational plan and moving forward, the Annex will continue to be updated over time as science, strategies, and circumstances change or evolve.

According to the report, the recommendations were developed by the Public Health project team, community partners, stakeholders, and the consultant.

This report appears to meet the requirements as outlined under Motion 15650.

BACKGROUND

Public Health Seattle & King County (PHSKC) is the public health department for King County, Washington which includes 39 cities, including the City of Seattle, and unincorporated areas. Public Health is one of the largest metropolitan health departments in the United States and serves over approximately 2.3 million people of King County that live in urban, rural, shoreline, foothill, and mountain communities with distinct environments and unique public health needs. King County is an international

[1]"Annex" is an emergency preparedness term that refers to an operational plan.

port of entry, welcoming nearly 40 million visitors annually and serves residents that speak over 100 different languages.

The work of PHSKC includes the following:

Disease Control. Protecting the public through disease control functions, such as tuberculosis, HIV, and communicable disease epidemiology and immunizations.

Health Promotion. Promoting health by leading efforts to prevent chronic conditions and promoting healthy, equitable communities by preventing chronic conditions and injuries, ensuring the air is safe to breathe, and ensuring water and food are safe to consume.

Equitable Access to Healthcare. Influencing systems that enable equitable access to quality healthcare by connecting people to services and working with the healthcare system.

King County Office of Emergency Management (OEM) works in partnership with cities, counties, state and federal agencies, tribes, special purpose districts, non-profit organizations, community groups, and private businesses to develop a regional approach to emergency preparedness and emergency operations across the five mission areas of prevention, protection, mitigation, response, and recovery. King County OEM has four priorities to include the following:

- Emergency Operations Center (EOC) Readiness
- Situational Awareness
- Public Awareness and Education
- Disaster Risk Reduction

In addition to the above priorities, King County OEM also maintains the following plans:

- Comprehensive Emergency Management Plan
- Regional Hazard Mitigation Plan
- Regional Coordination Framework
- Continuity of Government Plans
- Pandemic Influenza Response Plan

Ordinance 15596. In September 2006, Council adopted Ordinance 15596 which approved the Response Plan that addressed King County's role as a regional emergency preparedness and public health provider, government services provider, and large employer. The plan included three components that consisted of a Public Health Pandemic Influenza Response Plan (PH PIRP), Continuity of Operations Plan, and a Human Resources Division Pandemic Influenza Emergency Response Manual.

Ordinance 15986. In December 2007, Council adopted Ordinance 15986, which accepted the updates to the King County Pandemic Influenza Response Plan. The updates were the plans outlined under Ordinance 15596, in addition to requesting the Executive to coordinate and collaborate with separately elected officials in the planning efforts.

Motion 15650. In July 2020, Council passed Motion 15650, which required the Office of Emergency Management (OEM) to update all relevant emergency management and disaster recovery plans and documents to address pandemics and required that Public Health – Seattle & King County (PHSKC) create a pandemic response plan for King County. The motion required the plan to include the following topics:

NOW, THEREFORE, BE IT MOVED by the Council of King County:

A. The office of emergency management should work with public health - Seattle & King County to update the Comprehensive Emergency Management Plan, the Regional Hazard Mitigation Plan, the Regional Coordination Framework, King County continuity of operations plans, the King County Continuity of Government Plan and any other relevant emergency management or disaster plans or documents to address the threat of pandemics to King County, using the lessons learned from the COVID-19 pandemic and building upon the pandemic response plan described in section B of this motion.

B. Public health - Seattle & King County, in coordination with the King County office of emergency management, should create a new pandemic response plan and update other relevant planning documents, expanding on the existing Pandemic Influenza Response Plan and other emergency and disaster planning efforts, using lessons learned from the COVID-19 pandemic. The plan should include the following topics, at a minimum:

1. A response plan or plans addressing each pandemic phase identified by the Centers for Disease Control and Prevention, including a description of the responsibilities of relevant governmental and nongovernmental agencies in each pandemic phase, both with and without presence of local cases;

2. Identification of critical infrastructure or resources that are currently lacking that would be required in order to respond to pandemics, the barriers to acquiring or developing the infrastructure or resources and recommendations for how to fill these gaps; and

3. Any other information or strategies deemed appropriate by public health - Seattle & King County.

C. The King County office of emergency management is requested to transmit all updated plans and documents described in section A of this motion, and a proposed motion acknowledging receipt of the updated plans and documents, by September 1, 2022. The plans and documents should be filed in the form of a paper original and an electronic copy with the clerk of the council, who will retain the original and provide an

electronic copy to all councilmembers, the council chief of staff and the lead staff to the committee of the whole or its successor.

D. Public health - Seattle & King County is requested to transmit the pandemic response plan and other updated documents and a proposed motion acknowledging receipt of the pandemic response plan and other updated documents by September 1, 2022. The plan and documents should be filed in the form of a paper original and an electronic copy with the clerk of the council, who will retain the original and provide an electronic copy to all councilmembers, the council chief of staff and the lead staff to the committee of the whole or its successor.

E. The King County office of emergency management and public health - Seattle & King County are requested to provide a briefing to the council on the status of the pandemic response plan and other plan updates no later than September 1, 2021.

ANALYSIS

Proposed Motion 2024-0008 would acknowledge receipt of the new pandemic response plan that was required under Motion 15650. According to the report, the recommendations were developed by the Public Health project team, community partners, stakeholders, and the consultant.

Section A of Motion 15650 reads:

A. ***The office of emergency management should work with public health - Seattle & King County to update the Comprehensive Emergency Management Plan, the Regional Hazard Mitigation Plan, the Regional Coordination Framework, King County continuity of operations plans, the King County Continuity of Government Plan and any other relevant emergency management or disaster plans or documents to address the threat of pandemics to King County, using the lessons learned from the COVID-19 pandemic and building upon the pandemic response plan described in section B of this motion****.*

According to the report, this section of the proviso was not addressed in the report as this section was directed to the King County Office of Emergency Management.

Section B of Motion 15650 reads:

B. Public health - Seattle & King County, in coordination with the King County office of emergency management, should create a new pandemic response plan and update other relevant planning documents, expanding on the existing Pandemic Influenza Response Plan and other emergency and disaster planning efforts, using lessons

learned from the COVID-19 pandemic. The plan should include the following topics, at a minimum:

1. ***A response plan or plans addressing each pandemic phase identified by the Centers for Disease Control and Prevention, including a description of the responsibilities of relevant governmental and nongovernmental agencies in each pandemic phase, both with and without presence of local cases.***

According to the report, Public Health's updated pandemic response plan has been renamed as the King County Biological Incident Response Annex (Annex)[2]. The Annex addresses each pandemic phase identified by the Centers for Disease Control and Prevention (CDC), to include descriptions and responsibilities of relevant governmental and nongovernmental agencies during a pandemic.

The Table 1 below displays the pandemic phases identified by the Centers for Disease Control and Prevention (CDC) and includes descriptions of the responsibilities of government and non-government entities[3].

Table 1.
CDC Pandemic Phase Summary Table

CDC Pandemic Phase	Plan Focus
Investigation	When a novel virus or other cause of a biological incident is identified and poses a health risk to humans, public health focuses on monitoring and investigation. A risk assessment of the virus is conducted to evaluate the potential to cause a pandemic.
Recognition	When increasing numbers of human cases of an illness are identified and the virus has the potential to spread from person-to-person, public health focuses on monitoring and control of the outbreak, including data collection, analysis, and reporting, and treatment of sick persons.
Initiation	A pandemic occurs when people are easily infected with a new virus that can spread from person-to-person.

[2] According to the transmittal letter, the new pandemic influenza response plan is now called the King County Biological Incident Response Annex, which is more comprehensive than past influenza pandemic response plans. With this broader name, the plan addresses responses to other viruses in addition to influenza, other natural causes of outbreaks, and human-caused biological incidents or outbreaks. "Annex" is an emergency preparedness term that refers to an operational plan.

[3] The table also shows when the response varies depending on the presence or absence of local cases.

Acceleration	There is an upward acceleration (or "speeding up") of the epidemiological curve as the new virus infects susceptible people. Public health focuses on use of appropriate non-pharmaceutical interventions in the community (e.g., use of PPE, environmental measures and physical distancing including potential facility closures), as well as the use of medications (e.g., antivirals) and vaccines, if available. Effective implementation of these combined actions can reduce the spread of disease and prevent illness or death.
Deceleration	The deceleration stage happens when cases consistently decrease in the U.S. Public health actions include continued vaccination, monitoring the virus circulation and illness, and phasing out the use of non-pharmaceutical interventions in the community.
Preparation	When the pandemic has subsided, public health actions include continued monitoring of infectious disease activity and preparation for potential additional waves of infection. An influenza pandemic, for example, is declared ended when data show that the virus has a similar spread and severity as a seasonal influenza virus.

Authorities and Responsibilities of Government Agencies. The Washington State Governor, State Board of Health, State Secretary of Health, King County Executive, local Board of Health, executives of cities and towns, and the Local Health Officer each have defined authorities and responsibilities to protect the public's health during a pandemic[4]. Under state law, King County's Public Health Department has the responsibility to lead an incident response when there is health impacts involved[5]. This effort is called a Health and Medical Area Command (HMAC) in King County. Hospitals, clinics, providers, and other health system partners have their own set of federal requirements to fulfill during a pandemic[6].

Responsibilities of Non-Governmental Entities. Healthcare system entities, including hospitals, clinics, providers, and other health system partners have specific

[4] State and local public officials have overlapping authorities regarding protecting public health and safety, and each can implement authorities within the scope of their jurisdiction aimed at protecting the public's health.
[5] RCW 70.05.070
[6] Appendix B (pages 46-48) of the report provide more detail regarding the powers of each authority.

responsibilities during a pandemic[7]. According to the report, the specific responsibilities of healthcare system entities, include the following:

- During a pandemic, employ all efforts to sustain the functionality of the healthcare system.
- Maximize the healthcare system's ability to provide medical care during a pandemic by working with the Northwest Healthcare Response Network.
- Hospitals and other healthcare facilities must develop pandemic response plans consistent with the healthcare planning guidance contained in the U.S. Department of Health and Human Services Pandemic Influenza Plan[8].
- Hospitals may screen and or limit individuals from entering the hospital.
- Healthcare facilities and healthcare providers will participate in local influenza and when requested, novel pathogen surveillance activities.
- Hospitals will develop infection control plans to triage and isolate infectious patients and protect staff from disease transmission.

According to the report, effective coordination and collaboration among government and non-governmental agencies takes place through HMAC during an emergency response, which is described in more depth in Appendix B.

2. ***Identification of critical infrastructure or resources that are currently lacking that would be required in order to respond to pandemics, the barriers to acquiring or developing the infrastructure or resources and recommendations for how to fill these gaps.***

According to the report, critical infrastructure refers to the people, supplies, systems, relationships, and other resources needed by Public Health to carry out a response. Additionally, prior evidence from local, regional, and national responses to infectious disease outbreaks, identified insufficient critical infrastructure and potential adverse consequences as the following:

- Isolation and Quarantine
- Equity and Community-centered Processes
- Guidance and Information
- Care Coordination
- Surge Staffing
- Medical Countermeasures

The report notes that when there is an insufficient critical infrastructure, such as personnel, facilities, equipment, supplies, and funding, it delays both Public Health's emergency response and partners' abilities to carry out response operations and provide support to affected communities.

[7] Page 18 of the report provides more detail regarding healthcare system responsibilities.
[8] Healthcare facility pandemic response plans address medical surge capacity and resource management and conservation to sustain healthcare delivery and communication capabilities when routine systems are overwhelmed.

The report states that despite King County's successes around the COVID-19 pandemic, there was a lack of critical infrastructure and resources in the COVID-19 response, such as disability access, racial and ethnic representation, and overwork and responder stress. Furthermore, after emergency declarations were approved for COVID-19, authorities simplified funding, contracting, and hiring processes in an effort to facilitate a flow of resources to the response efforts. Despite these efforts, some barriers to acquiring resources for the response remained despite the availability of funds. The report identifies barriers to resources as document compliance, complex reimbursement rules, and hiring protocols, in addition to the following:

Hiring and Onboarding Constraints. Hiring and onboarding were critical to scaling up the workforce to meet public health response needs, however these processes faced organizational challenges. While acknowledging the unprecedented nature of the pandemic, PHSKC experienced notable administrative burdens and significant time constraints associated with filling positions. Additionally, PHSKC's front line responders were taken away from emergency response responsibilities to complete administrative hiring processes. After hiring, many new staff reported they did not receive adequate onboarding information. These barriers limited scalability and contributed to staff burnout.

Lack of "Bridge Funding". Bridge funding refers to local, state, or federal funding that is allocated between larger emergencies, such as pandemics. Over the years, public health as a field has often experienced a boom-and-bust cycle of funding during and immediately after emergencies. Meaning that public health emergency response funds are allocated at the start of an emergency, but funding recedes as the emergency recedes. Planning activities are among the first to be reduced during times of budget shortfalls. Pandemic and other biological incident response planning, including continuity of operations planning, merit bridge funding to ensure that robust, current, equitable, and well-informed plans are in place when most needed.

The report recommends building trust through relationships and communications; customizing emergency response actions to specific groups to prevent inequitable outcomes; improve emergency response operations by using standard processes and coordination methods and adding workforce flexibility to surge in response to pandemic peaks and crests.

3. ***Any other information or strategies deemed appropriate by public health - Seattle & King County****.*

The report encourages PHSKC to continue improvements in equitable response planning and intentional strategy design in partnership with specific populations, given the racially inequitable outcomes of COVID-19. PHSKC recommends allocating adequate funding for staff and community member compensation, so that meaningful relationships and ongoing dialogues can be developed and maintained before, during, and after pandemics with groups at higher risk of poor health outcomes.

According to the report, inequitable outcomes are due to structurally racist policies and practices in healthcare systems. The report states that if PHSKC wants to make King

County a welcoming community for all people, it is important to document inequities and continue the work towards eliminating those barriers.

As required by Motion 15650, PHSKC in partnership with OEM created this updated Annex, as it continues to implement COVID-19 prevention strategies and respond to other emergencies.

This report appears to meet the requirements of Motion 15650.

INVITED

1. Nick Solari, Preparedness Director, Public Health – Seattle & King County (PHSKC)
2. Dr. Eric Chow, Interim Health Officer, PHSKC
3. Joy Carpine-Cazzanti, Government Relations, PHSKC

ATTACHMENTS

1. Proposed Motion 2024-0008 (and its attachments)
2. Transmittal Letter

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Motion

Proposed No. 2024-0008.1 **Sponsors** Balducci

A MOTION acknowledging receipt of the new pandemic response plan required by Motion 15650.

WHEREAS, Motion 15650 requires the executive to transmit a new pandemic response plan, and

WHEREAS, the motion further requires the executive to submit a motion that acknowledges receipt of the plan;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

The receipt of the new pandemic response plan, which is Attachment A to this motion, in compliance with Motion 15650 is hereby acknowledged.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Rod Dembowski, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Dow Constantine, County Executive

Attachments: A. Motion 15650 Updated Pandemic Influenza Response Plan Report, including a New Biological Incident Response Annex and COVID-19 After Action Report

Motion 15650: Updated 'Pandemic Influenza Response Plan' Report, including a New Biological Incident Response Annex and COVID-19 After Action Report

December 2023

King County

I. Contents

II. Executive Summary

Motion 15650: Motion 15650 calls for Public Health – Seattle & King County (Public Health or PHSKC) to create a new Pandemic Response Plan, building on the existing Pandemic Influenza Response Plan and using lessons learned from the COVID-19 pandemic. See Appendix A. The King County Pandemic Influenza Response Plan is now called the Biological Incident Response Annex (Annex). The Annex is summarized in this report. It incorporates plans for pandemics (influenza and other viruses, such as coronaviruses) and other biological pathogens. "Annex" is an emergency preparedness term that refers to an operational plan.[1] The new Annex is an ongoing body of work that will continue to be updated over time as science, strategies, and circumstances change.[2] The Annex is included as Appendix B.

Key Historical Conditions: Since February 2020 there have been almost 600,000 reported cases, close to 18,000 hospitalizations, and more than 3,600 deaths from COVID-19 in King County.[3] As significant as these numbers and losses are, King County experienced one of the lowest death rates due to COVID-19 of the 20 largest metropolitan areas in the country.[4] Data shows that the burdens of COVID-19, however, were not evenly borne across the population. Throughout the US, the virus has had disproportionate impacts on the elderly, people with weakened immune systems, those with several pre-existing chronic medical conditions and disabilities, and communities of color. In King County, American Indian/Alaskan Native, Black, Hispanic, and Native Hawaiian/Pacific Islander residents experienced higher rates of COVID-19 cases, hospitalizations, and deaths than Asian and White residents.[5]

PHSKC led an intense and lengthy response to the COVID-19 pandemic from 2020 through 2023. This included operating COVID-19 testing sites that conducted over 200,000 tests in 2020, and, by March 2021, had conducted 1 million COVID-19 tests. Public Health's Language Access team worked with 88 translators in 33 languages and completed translations on 375 topics, totaling 4,200 documents in 2021. The Public Health call center averaged 700 to 1,000 calls per day, with a one-day record of 1,600 calls answered on January 3, 2022. Public Health established and led an ambitious goal to vaccinate 70 percent (N=1.3 million) of eligible adults overall, and across all regional, race/ethnicity, and age groups. By September 2021, over 3 million vaccine doses had been administered and 77 percent (N=1.5 million) of eligible King County residents had been vaccinated equitably, efficiently, and quickly for the initial series. By February 2022, King County had distributed over 1.4 million N95 masks, 3.7 million surgical masks, 20 million gloves, and 1.6 million gowns to long term care facilities, health clinics, first responders, congregate settings, community-based organizations, and other critical care agencies.[6]

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[1] FEMA, Guide for All-Hazard Emergency Operations Planning, September 1996, [LINK]
[2] Motion 15650 calls a new Pandemic Response Plan, building on the existing Pandemic Influenza Response Plan and using lessons learned from the COVID-19 pandemic. The report was originally due September 1, 2022. In March 2022, Public Health submitted a progress report. The due date of this report was changed to December 2023.
[3] PHSKC, COVID-19 in King County, Washington, October 18, 2023, [LINK]
[4] PHSKC, COVID-19 After Action Report, September 2022, p 3, [LINK]
[5] Public Health Insider. May 1, 2020. New Analysis Shows Pronounced Racial Inequities among Covid-19 Cases, Hospitalizations and Deaths, [LINK]
[6] PHSKC, COVID-19 After Action Report, [LINK]

Multiple Emergencies at Once – Public Health's first response to COVID-19 in January 2020 took place while hepatitis A and seasonal influenza outbreaks were underway. Healthcare systems were reporting high patient loads prior to the arrival of COVID-19. From the start, Public Health and emergency response partners were responding to multiple ongoing emergencies at the same time as COVID-19, including extreme heat, cold weather, mpox (the disease formerly known as monkeypox),[7, 8, 9] and wildfire smoke incidents. Handling multiple complex emergencies at the same time places additional demands on the County's critical infrastructure and resources necessary to respond.

A Response Plan that Addresses Each Centers for Disease Control and Prevention (CDC) Pandemic Phase: In responding to Motion 15650, this report describes key features of Public Health's updated pandemic response Annex and addresses each pandemic phase identified by the CDC.

Descriptions of the Responsibilities of Governmental and Non-Governmental Agencies: The Washington State Governor, the State Board of Health, the State Secretary of Health, the King County Executive, the local Board of Health, the executives of cities and towns, and the Local Health Officer each have defined authorities and responsibilities to protect the public's health during a pandemic.[10] Per the Revised Code of Washington (RCW) 70.05.070, King County's Public Health Department has the responsibility to lead an incident response when there are health impacts involved. This effort is called a Health and Medical Area Command (HMAC) in King County. Hospitals, clinics, providers, and other health system partners have their own set of federal requirements to fulfill during a pandemic.[11]

Identification of Critical Infrastructure or Resources that are Lacking: Public Health used two processes to identify critical infrastructure and resources that were lacking during the COVID-19 response and to develop recommendations to fill these gaps. First, the King County Auditor highlighted racial and ethnic inequities in the COVID-19 response and population health outcomes and directed Public Health to address these gaps in its January 2022 report, "Emergency Preparedness Limited by Planning Gaps."[12] As a result, Public Health updated its Equity Response Annex in 2023[13] The Equity Response Annex provides detailed plans about how to integrate equity into HMAC operations.

Second, Public Health carried out after-action analyses of the COVID-19 response in 2021 and 2022. PHSKC was the first health department in Washington State to issue a COVID-19 After Action Report.[14] Public Health staff and a consultant, Constant Associates, carried out 159 interviews of response team

[7] WHO Recommends New Name for Monkeypox Disease https://www.who.int/news/item/28-11-2022-who-recommends-new-name-for-monkeypox-disease

[8] Mpox is a disease caused by a virus, often with a rash or flu-like symptoms. Infections with the strain of mpox virus identified in the U.S. are rarely fatal and most people recover in 2-4 weeks, [LINK]

[9] King County, Executive Constantine Proclaims a Local Public Health Emergency for Monkeypox *(now called mpox)*, August 19, 2022, [LINK]

[10] Washington State Governor's authority is in RCW 43.06.010(120); 38.52.050 and 43.06.0220. The State Board of Health's authority is in RCW 43.20.050. The State Secretary of Health's authority is in 43.70.130. The King County Executive's authority is in KCC 12.52.030. The King County Board of Health's authority is in RCW 70.05.035 and 70.05.060. The Local Health Officer's authority is in RCW 70.05.070.

[11] U.S. Centers for Medicare and Medicaid Services, 2021, [LINK] and U.S. Department of Health and Human Services, 2005, [LINK]

[12] King County Auditor, Emergency Preparedness Limited by Planning Gaps, January 11, 2022, [LINK]

[13] PHSKC, Equity Response Annex, June 2023, available in English and Spanish, [LINK]

[14] PHSKC, COVID-19 After Action Report, September 2022, [LINK]

members to collect strengths, areas for improvement, and recommendations. Community engagement was conducted at four online townhall meetings with 31 community partners who played active roles in the COVID-19 response. The sessions were held in English with Communication Access Real-time Translation (CART) and live interpretation in multiple languages.

This report summarizes critical infrastructure required for future responses to pandemics. It highlights gaps observed in the County's response to the COVID-19 pandemic with regard to disability access, racial and ethnic representation in Public Health and in the Public Health Reserve Corps, and gaps resulting from overwork of Public Health and other response staff.

Barriers to Acquiring Infrastructure or Resources: King County faces several barriers to acquiring needed infrastructure for emergency responses. These barriers include limited staffing and funding levels, a lack of flexibility in workforce hiring and retention procedures; a funding cycle that goes up and down in response to emergencies; a lack of bridge funding between funding cycles; and limited racial and ethnic diversity among staff and volunteers.

Recommendations for How to Fill these Gaps: Public Health identified four types of recommendations to improve future infectious disease responses. These recommendations are:

1. Build and deepen community trust through relationships and communication;
2. Enact equity strategies to tailor actions and information to better serve specific communities, including Black, Indigenous, other people of color, people with disabilities, and residents living in less resourced locations;
3. Improve emergency response operations by using standard processes and coordination methods, and
4. Add workforce flexibility to allow staffing to surge in response to demands on Public Health during a pandemic.

Implementing these recommendations requires that local, state, and federal funders consistently fund ongoing emergency planning and other foundational public health services.[15] At the same time, this report recognizes that as a local government, King County is experiencing a funding crisis in its flexible funding source, the General Fund. So, while the report identifies opportunities to fill gaps, those recommendations that require financial investment must be evaluated alongside all budgetary decisions by the Executive and the Council.

The recommendations in this report build on lessons learned by King County from the successes and challenges it experienced throughout the COVID-19 pandemic response. Efforts to address these recommendations represent important ways for King County to demonstrate its commitment to building a culture of equity and quality improvement and will require significant time and resources to fully accomplish.

[15] WA Department of Health, Foundational Public Health Services, 2023, [LINK]

III. Background

Department Overview: Public Health – Seattle & King County (Public Health or PHSKC) works to protect and improve the health and well-being of all people in King County, Washington. It seeks to increase the number of healthy years that people live and eliminate health inequities. It is one of the largest metropolitan health departments in the United States with 1,200 employees, 40 sites, and a biennial budget of $686 million. The Department serves a resident population of nearly 2.5 million people in a county with 19 acute care hospitals, including the state's only Level 1 Trauma Center, and more than 7,000 medical professionals.[16] Department responsibilities are carried out through prevention programs, environmental health programs, community-oriented personal health care services, emergency medical services, correctional facility health services, preparedness programs, and community-based public health assessment and practices. Public Health also provides data, reports, and other health-related information to the public and stakeholders.[17]

Key Context: The mission of Public Health's Preparedness program is to protect the health and safety of the whole community before, during, and after emergencies and disasters. It is responsible for conducting a continuous cycle of planning, organizing, training, exercising, and taking corrective action to build Public Health's capability to respond to future emergencies. Preparedness staff work within the scope of the federally defined Emergency Support Function (ESF) #8 - Public Health, Medical, and Mortuary Services, relying on partners and supporting agencies such as the Northwest Healthcare Response Network, the King County Office of Emergency Management (KCOEM), the City of Seattle Office of Emergency Management, and others to coordinate services, resources, and information during a response.[18]

This report builds on the 2006 King County Pandemic Influenza Response Plan adopted by Ordinance 15596, the 2007 update to the same plan adopted by Ordinance 15986, and the 2013 Pandemic Influenza Response Plan update.[19] Notably, the King County Pandemic Influenza Response Plan is now called the Biological Incident Response Annex (Annex). "Annex" is an emergency operations term that refers to an operational plan.[20] The 2023 King County Biological Incident Response Annex, which is included in Appendix B, incorporates plans for pandemics (influenza and other viruses, such as coronaviruses) and other biological pathogens. The Biological Incident Response Annex is more comprehensive than previous plans, which only addressed influenza threats. The new annex represents an ongoing body of work that will continue to be updated as science, strategies, and circumstances change.

Key Historical Conditions: *Washington State and King County COVID-19 Context* – The unprecedented nature of the COVID-19 pandemic during its height from 2020 to 2023 presented challenges in King County and across the globe. It forced organizations inside and outside of the public health field to manage extended response operations. Planning and initiating responses for other emergency incidents had to occur as response teams navigated the pandemic's impacts on public health staffing and

[16] PHSKC, About Us, [LINK]
[17] PHSKC, About Us, [LINK]
[18] PHSKC, Emergency Preparedness, [LINK]
[19] PHSKC, Pandemic Influenza Response Plan, October 2013, [LINK]
[20] FEMA, Guide for All-Hazard Emergency Operations Planning, September 1996, [LINK]

infrastructure. The COVID-19 pandemic made historical inequities, including structural ableism and racism, more apparent in both government and healthcare systems.[21]

According to Public Health data, from February 2020 through October 2023, there have been 572,342 reported cases, 17,606 hospitalizations, and 3,647 deaths from COVID-19 in King County.[22] As significant as these numbers and losses are, given the size of its population, King County experienced among the lowest death rates due to COVID-19 of the 20 largest metropolitan areas in the country.[23] The burdens of COVID-19, however, were not borne evenly across the population. Throughout the US, the virus had disproportionate impacts on the elderly, persons with weakened immune systems, those with several pre-existing chronic medical conditions and disabilities, and, in particular, communities of color. In King County, American Indian/Alaskan Native, Black, Hispanic/Latinx, and Native Hawaiian/Pacific Islander groups experienced higher rates of COVID-19 cases, hospitalizations, and deaths compared to Asian and White populations.[24]

COVID-19 Emerges in January 2020 – The first case of novel coronavirus in Washington and the US was identified on January 21, 2020, in Snohomish County, which is part of the Seattle Metropolitan Area (as defined by the US Census Bureau). Public Health's Health and Medical Area Command (HMAC) was partially activated on January 21, 2020, to manage King County's ESF #8 response using the incident command system.[25] The next day, the state of Washington activated its State Emergency Operation Center to conduct emergency operations and support local jurisdictions responding to COVID-19 cases. Public Health HMAC activation was elevated to a Level 1 – Full Activation to manage emergency operations for Public Health on January 24, 2020.

At the state level, efforts to contain the disease in January to mid-February 2020 included encouraging employers to allow employees to work from home when possible, purchasing and distributing personal protective equipment (PPE), and increasing response funding. At the local level, Public Health began to disseminate key messages and respond to inquiries in late January 2020. In early 2020, the health department:

- Established a dedicated COVID-19 website;
- Provided guidance to healthcare providers on diagnosis, management, and infection control measures;
- Caried out the assessment and monitoring of incoming travelers deemed by the CDC's Division of Global Migration and Quarantine to be at risk for COVID-19, and when necessary, arranging quarantine, isolation, and/or testing;
- Conducted surveillance for detection of disease;
- Developed materials, presentations, and webinars for outreach to community members and partners;
- Connected residents with suspected infections to available testing;
- Arranged isolation services for those waiting for test results;

[21] PHSKC, COVID-19 After Action Report, [LINK]
[22] PHSKC, COVID-19 in King County, Washington, Accessed on October 18, 2023, [LINK]
[23] PHSKC, COVID-19 After Action Report, [LINK]
[24] Public Health Insider. May 1, 2020. New Analysis Shows Pronounced Racial Inequities among Covid-19 Cases, Hospitalizations and Deaths, [LINK]
[25] PHSKC, COVID-19 After Action Report, [LINK]

- Launched a Public Information Contact Center (PICC) that answered phone calls for 15 hours per day/7 days per week during surges, and
- Coordinated with the CDC, the Washington State Department of Health (DOH), and other local health jurisdictions on suspected cases and key messages.

Public Health confirmed the first known case of COVID-19 in King County on February 27, 2020. On February 29, 2020, the CDC reported the first U.S. COVID-19 death and additional presumptive positive COVID-19 cases in King County, including a suspected outbreak in a long-term care facility (Life Care Center of Kirkland) where more than 50 individuals were ill. King County activated its Emergency Operations Center, and the Governor issued a State of Emergency to facilitate the flow of additional local and state resources to the outbreak response. The CDC sent a large field team to assist Public Health in responding to the Life Care Center outbreak. The Life Care Center outbreak was the first of many outbreaks reported in long-term care facilities in King County and across the U.S. that led to multiple deaths in this at-risk population. Thirty-nine residents of the Life Care Center died within four weeks. During March 2020, more than half of the COVID-19 cases investigated by Public Health were exposed in healthcare settings, with one third exposed in long-term care facilities.

Behavior Change Interventions, Testing, and Face Masks – From the end of March 2020 through June 2020, Public Health and its partners continued to expand the response to COVID-19. This included setting up the first COVID-19 community-based testing site; launching a Stand Together, Stay Apart campaign to promote physical distancing in conjunction with the state's Stay Home, Stay Healthy Order, and establishing a detailed, public COVID-19 data dashboard. Public Health recommended, strongly directed, and then issued a health directive for masks to be worn in public. Public Health distributed COVID-19 tests locally. Public Health, along with the King County Office of Emergency Management (KCOEM), continued to provide supplies (PPE, hand sanitizer, etc.) to high priority populations as established by DOH, and supported the coordination of regional medical surge operations, which was led by the Northwest Healthcare Response Network. By May 2020, the HMAC structure had expanded to include over 500 responders directly assigned to a large stand-alone incident command system.[26]

COVID-19 Vaccines in 2021 – In late December 2020, COVID-19 vaccines became available, initially to healthcare providers and other first responders and then to segments of the general population according to guidance from DOH. Older adults began receiving vaccines in January and February 2021, and in April 2021, all Washington residents over age 16 became eligible for the COVID-19 vaccine. By June 15, 2021, 70 percent (N=1.3 million) of King County residents ages 16+ across all race/ethnic groups had completed their initial vaccine series. This high level of population vaccination prompted an end to Public Health's mask directive two weeks later. Many of the COVID-19 prevention restrictions were lifted in King County and across the state in the summer of 2021.

Continued COVID-19 Work, On-going Infections, and Surges – Throughout the COVID-19 response in 2021 and 2022, Public Health's teams undertook contact tracing, disease investigation, information management, testing, vaccination, PPE distribution, public information, community engagement, data analysis and reporting, and more. See Appendix C for a detailed timeline of response efforts at the state and local levels.

[26] PHKSC, COVID-19 After Action Report, [LINK]

COVID-19's Inequitable Burden on Older, Disabled, Black, Indigenous, and other People of Color – The COVID-19 pandemic, like many health conditions, revealed the impact of structural racism in American healthcare and society. Racism against people of Asian descent significantly increased during the pandemic, with a documented 77 percent rise (N= 279) in hate crimes against Asian people living in the U.S. from 2019 to 2020.[27] The CDC stated that, out of the 65 percent of COVID-19 cases in the U.S. where race and ethnicity data were available, Black people accounted for 14 percent of deaths related to COVID-19, despite making up only 13 percent of the total population. Hispanic/Latinx people represent 24 percent of COVID-19 cases, despite only making up 18 percent of the US population. In King County, in mid-2022 age-adjusted death rates of confirmed cases were highest among residents who were Native Hawaiian/Pacific Islander (749 per 100,000), American Indian/Alaska Native (452 per 100,000), Hispanic/Latinx (260 per 100,000), and Black (219 per 100,000). Rates for most communities of color were several times higher than among White residents (106 per 100,000). People who were incarcerated also experienced a higher burden of the disease than non-incarcerated individuals. In 2020, 40 of the 50 biggest outbreaks of COVID-19 in the U.S. occurred in prisons. People with disabilities experienced unique impacts due to health inequity during the COVID-19 pandemic, as a lack of appropriate data collection and accessibility barriers in information, testing, and vaccination exposed them to greater disparities in the public health response.[28]

Responding to Multiple Emergencies at the Same Time – Public Health's first response to COVID-19 in January 2020 took place while a hepatitis A outbreak and a seasonal influenza outbreak were underway. Healthcare systems were reporting high patient loads and stress prior to the arrival of COVID-19 locally. Starting with a cold weather event in the early winter of 2021, Public Health and emergency response partners needed to respond to multiple on-going emergencies at the same time as COVID-19, including extreme heat events, cold weather, mpox (the disease formerly known as monkeypox),[29],[30, 31] and wildfire smoke incidents.

Key Current Conditions: In October 2023, the CDC classification of COVID-19 community transmission level in King County was low, but the virus was still present and causing illness, hospitalizations, and deaths. In October 2023, an average of 25 new cases were reported every day (although public health experts agree that this is likely an undercount, as reporting is not required and fewer people are testing), three people were hospitalized daily, and one person died on average from COVID-19 per day. COVID-19 continued to be most prevalent among older residents and among Black, Indigenous, and other people of color. For example, those over age 65 were three times more likely to be hospitalized and those over 80 years were 13 times more likely to be hospitalized than the county population average (30.5 hospitalizations per 100,000 residents for those 80 years and older, versus 2.3 hospitalizations per 100,000 residents for the county population as a whole). Unvaccinated residents were almost four times more likely (N=147 hospitalizations in the last 90 days) to be hospitalized with COVID-19 compared to those who had been vaccinated. American Indian/Alaska Native residents were

[27] PHSKC, COVID-19 After Action Report, [LINK]
[28] PHSKC, COVID-19 After Action Report, [LINK]
[29] WHO Recommends New Name for Monkeypox Disease https://www.who.int/news/item/28-11-2022-who-recommends-new-name-for-monkeypox-disease
[30] Mpox is a disease caused by a virus, often with a rash or flu-like symptoms. Infections with the strain of mpox virus identified in the U.S. are rarely fatal and most people recover in 2-4 weeks. [LINK]
[31] King County, Executive Constantine Proclaims a Local Public Health Emergency for Monkeypox *(now called mpox)*, August 19, 2022, [LINK]

three times more likely to be hospitalized than the county average. Black residents were 53 percent (N=16 patients in the last month) more likely to be hospitalized than the county average.[32]

Alignment with King County Executive Priorities, County Ordinances, and Declarations: This report and the two reports in its appendices are aligned with the 2008 King County Equity and Social Justice Ordinance 16948, the King County Equity and Social Justice Strategic Plan,[33] and the 2020 King County declaration that racism is a public health crisis.[34] Public Health has documented the harms of racism and ableism in its COVID-19 after action reviews, made changes in its response protocols, and included recommendations to continue improving emergency response equity.[35] A King County Auditor's report in 2022 highlighted inequities in the COVID-19 response, "Emergency Preparedness Limited by Planning Gaps."[36] As a result, Public Health updated its Equity Response Annex in June 2023.[37] The Equity Response Annex provides detailed plans about how to integrate equity into HMAC operations. Public Health continues to strive to implement its emergency preparedness vision of a community resilient to the health impacts of disasters.

Report Methodology: This report was written by Public Health staff. The report relies on two documents to fulfill the Motion's requirements: 1) a response plan addressing all CDC pandemic phases is included in the updated Biological Incident Response Annex in Appendix B and 2) the identification of critical infrastructure and recommendations to fill these gaps are included and are based on the PHSKC COVID-19 After Action Report in Appendix C. The updated Biological Incident Response Annex in Appendix B also includes other information and strategies that are appropriate to consider for future emergency responses. The report was written in coordination with the King County Office of Emergency Management (KCOEM), as was the Biological Incident Response Annex. KCOEM staff also contributed to the development of the PHSKC COVID-19 After Action Report (AAR), see Appendix C.

Biological Incident Response Annex Methodology – Staff from several Public Health sections and divisions, including Preparedness, Prevention, Community Health Services, the Office of Equity and Community Partnerships, Communications, the Chief of Nursing, and the Local Health Officer participated in updating the Biological Incident Response Annex, in Appendix B. Public Health staff reviewed all past pandemic influenza response plans, followed current state and federal response plan guidance, and used lessons learned from the COVID-19 response to draft the new plan.

PHSKC COVID-19 After Action Report Methodology – Public Health staff selected and oversaw a consulting firm, Constant Associates, to produce the COVID-19 AAR. Public Health staff on the AAR project team monitored, participated in, and reviewed the consultant's research, analysis, and findings (see Appendix C). Constant Associates is a health security and emergency management consultant firm. It used standard incident response evaluation principles and best practices consistent with Homeland Security Exercise and Evaluation Program (HSEEP) approaches in its King County COVID-19 after action analysis. Constant Associates reviewed 15 reports and 25 incident action plans. Public Health staff and the consultant conducted 111 interviews of department and partner leadership, including response

[32] PHSKC, Current COVID-19 Metrics, Accessed on October 18, 2023, [LINK]
[33] King County, Equity and Social Justice Strategic Plan, [LINK]
[34] PHSKC, Racism is a Public Health Crisis, June 11, 2020, [LINK]
[35] PHSKC, Equity Response Annex, June 2023, available in English and Spanish, [LINK]
[36] King County Auditor, Emergency Preparedness Limited by Planning Gaps, January 11, 2022, [LINK]
[37] PHSKC, Equity Response Annex, June 2023, available in English and Spanish, [LINK]

leads. Public Health staff facilitated 48 additional debrief discussions with response team members to collect strengths, areas for improvement, and recommendations for future responses. Two staff surveys also were conducted.

Community and Stakeholder Engagement Informed the COVID-19 After Action Report – Community engagement was carried out in four online town hall meetings with 31 community partners. Stakeholder engagement with emergency response partners through interviews, surveys, and town hall participation also informed the COVID-19 After Action Report. Lists of the COVID-19 After Action Report project team members, community partners, stakeholders, and documents reviewed are in Appendix C.

Recommendations were developed by the Public Health project team, community partners, stakeholders, and the consultant.

IV. Report Requirements

This section is organized to align with the Motion requirements. Note that this section begins with item B rather than A, following the Motion, as item A is directed to the King County Office of Emergency Management and is not addressed in this report.

B. Public health - Seattle & King County, in coordination with the King County office of emergency management, should create a new pandemic response plan and update other relevant planning documents, expanding on the existing Pandemic Influenza Response Plan and other emergency and disaster planning efforts, using lessons learned from the COVID-19 pandemic. The plan should include the following topics, at a minimum:

1. A response plan or plans addressing each pandemic phase identified by the Centers for Disease Control and Prevention, including a description of the responsibilities of relevant governmental and nongovernmental agencies in each pandemic phase, both with and without presence of local cases.

This subsection describes key features of Public Health's updated pandemic response plan, the King County Biological Incident Response Annex. It addresses each pandemic phase identified by the Centers for Disease Control and Prevention (CDC). The subsection includes descriptions of the responsibilities of relevant governmental and nongovernmental agencies during a pandemic, and notes when there are differences when local cases are present or not.

Updated Pandemic Response Plan: The King County Biological Incident Response Annex
The King County Biological Incident Response Annex (the Annex) is included in Appendix B. The term "biological incident" is more broadly applicable than "pandemic influenza," because it refers to responses for influenzas, coronaviruses, and other pathogens that may or may not be subject to a declaration of a pandemic.

King County Biological Incident Response Annex Purpose and Goals
The King County Biological Incident Response Annex provides guidance for actions that Public Health and regional partners take before, during, or after a biological incident. Biological incidents are

situations in which a biological agent causes a significant local, regional, or national impact. Biological incidents can include infectious disease outbreaks, identification of another type of pathogen with significant health risks, emergence of a novel infectious disease, or a suspected or confirmed bioterrorism event. The Annex establishes an equity-centered framework for the CDC phases of a pandemic: investigation, recognition, initiation, acceleration, deceleration, and preparation that guide response coordination and decision-making during a response.[38] The Annex describes roles and responsibilities, effective communication, and ongoing planning across partners to protect community health and center equity during an outbreak or incident response.

Public Health and regional partners will use the Annex to fulfill the following goals:

- Reduce spread and limit the number of illnesses, hospitalizations, and deaths,
- Prioritize the most disproportionately impacted groups,
- Preserve continuity of essential functions in government, healthcare, education, and business sectors, and
- Minimize societal disruption and economic losses.

King County Biological Incident Response Annex Scope

The Annex is intended for use when the response to a biological incident requires a response exceeding Public Health's Communicable Disease Epidemiology and Immunization Section's routine capacity. It is a supporting document to the ESF #8 Annex of the King County Comprehensive Emergency Management Plan (CEMP).[39,40]

The Annex may be referenced by Public Health leadership and staff to facilitate effective incident management and a coordinated regional response during all phases of an infectious disease outbreak or other biological incident. An effective response from the County requires timely, equitable, and coordinated use of public health and medical resources, including facilities, personnel, equipment, mental and behavioral health services, information, data, communication systems, pharmaceuticals, and other supplies. The Annex primarily focuses on the roles, responsibilities, and activities of Public Health in preparing for and responding to a biological incident. Specific responsibilities for key partners are included to highlight points of coordination between governmental and non-governmental agencies during a response.

Planning Constraints

The Annex was developed under non-emergency conditions and includes Public Health's general procedures for responding to future biological incidents. Although the Annex attempts to anticipate needs for response to a biological incident, it is impossible to plan for every contingency or every aspect of a response. Public Health plans, including the Annex in Appendix B, are not intended to be prescriptive, but rather to guide equitable decision-making, response operations, and resource allocations used by leaders. The Annex provides a detailed starting point for incident management and

[38] CDC, Pandemic Intervals Framework, Nov 3, 2016, [LINK]

[39] King County Office of Emergency Management, King County Comprehensive Emergency Management Plan, 2020, [LINK]

[40] The King County Comprehensive Emergency Management Plan (CEMP) is organized into a basic plan, Emergency Support Function (ESF) annexes, and various appendices, in accordance with federal guidance provided by the Federal Emergency Management Agency (FEMA).

response, and Public Health staff who adapt or implement the Annex should maintain flexibility for action and innovation to best meet community needs during the response to a biological incident.

Annex Maintenance
The King County Biological Incident Response Annex will be regularly updated through an iterative process and may include the addition of operational guides, processes, and/or templates. The revision process will include on-going engagement with community advisory groups and relevant Public Health staff.

Following any activation of the Annex, Preparedness staff in Public Health will seek feedback on the response from other staff, community partners, and other key response partners across the county. Preparedness staff will share findings from the evaluation process with those involved in and impacted by the event. The King County Biological Incident Response Annex will be updated regularly based on feedback and items outlined in future AARs. This process uses continuous quality improvement methods to incorporate lessons learned and address recommended improvements.

Pandemic Phases Identified by the CDC
This subsection addresses the pandemic phases identified by the Centers for Disease Control and Prevention (CDC) and includes descriptions of the responsibilities of government and non-government entities.[41] When the response varies depending on the presence or absence of local cases, it is noted below.

Table 1. CDC Pandemic Phase Summary Table

CDC Pandemic Phase	Plan Focus
Investigation	When a novel virus or other cause of a biological incident (in this table referred to as a virus) is identified and poses a health risk to humans, public health actions focus on monitoring and investigation. A risk assessment of the virus is conducted to evaluate the potential to cause a pandemic.
Recognition	When increasing numbers of human cases of an illness are identified and the virus has the potential to spread from person-to-person, public health actions focus on monitoring and control of the outbreak, including data collection, analysis, and reporting, and treatment of sick persons.
Initiation	A pandemic occurs when people are easily infected with a new virus that can spread in a sustained manner from person-to-person.
Acceleration	There is an upward acceleration (or "speeding up") of the epidemiological curve as the new virus infects susceptible people. Public health actions focus on the use of appropriate non-pharmaceutical interventions in the community (e.g., use of PPE, environmental measures and physical distancing including potential facility closures), as well as the use of medications (e.g., antivirals) and vaccines, if available. Effective implementation of these combined actions can reduce the spread of the disease and prevent illness or death.
Deceleration	The deceleration (or "slowing down") stage happens when cases consistently decrease in the U.S. Public health actions include continued

[41] CDC, Pandemic Intervals Framework, Nov 3, 2016, [LINK]

CDC Pandemic Phase	Plan Focus
	vaccination, monitoring the virus circulation and illness, and phasing out the use of non-pharmaceutical interventions in the community.
Preparation	When the pandemic has subsided, public health actions include continued monitoring of infectious disease activity and preparation for potential additional waves of infection. An influenza pandemic, for example, is declared ended when data show that the virus has a similar spread and severity as a seasonal influenza virus.

Appendix B provides additional detail for these phases. It includes objectives and strategies for relevant biological incident emergency response operations such as data collection, analysis and reporting functions; isolation and quarantine; testing; therapeutics; and vaccination.

Authorities and Responsibilities of Government Agencies

The Washington State Governor, the State Board of Health, the State Secretary of Health, the King County Executive, the local Board of Health, the executive heads of cities and towns, and the Local Health Officer each have authorities and responsibilities to protect the public's health when responding to a pandemic, as provided by Washington State, King County, and municipal statutes. Synopses of these authorities and responsibilities are below, with additional detail in Appendix B.

Table 2. Responsibilities of Relevant Governmental Agencies

Government Entity/Agency	Responsibility	Authorizing Statutes
Washington State Governor	• May proclaim a state of emergency after finding that a disaster affects life, health, property, or the public peace. • May assume direct operational control over all or part of local emergency management functions if the disaster is beyond local control. • Has the authority to restrict public assembly, order periods of curfew, and prohibit activities that they believe should be prohibited to maintain life and health after proclaiming a state of emergency.	RCW 43.06.010(12) RCW 38.52.050 RCW 43.06.220
State Board of Health	• May adopt rules to protect the public's health, including those for isolation and quarantine and the prevention and control of infectious diseases. • State Board of Health rules are enforced by local boards of health, health officials, law enforcement officials, and other officers of the state or any county, city, or town.	RCW 43.20.050(2) RCW 43.20.050(4)

Government Entity/Agency	Responsibility	Authorizing Statutes
State Secretary of Health	• Enforces laws for the protection of the public's health, and enforces rules, regulations, and orders of the State Board of Health. • Investigates outbreaks and epidemics and advises Local Health Officers about measures to prevent and control outbreaks. • Enforces public health laws, rules, regulations, and orders in local matters when there is an emergency, and the local Board of Health has failed to or is unable to act with sufficient promptness or efficiency.	RCW 43.70.130(3) RCW 43.70.130(5) RCW 43.70.130(4)
King County Executive	• May proclaim a state of emergency within King County when extraordinary measures are necessary to protect public peace, safety, and welfare. • Has the authority to impose curfews, close any or all private businesses, close public buildings and places, including streets, alleys, schools, parks, beaches, and amusement areas if they are imminently necessary for the protection of life and property after proclaiming a state of emergency.	K.C.C. 12.52.030.A K.C.C. 12.52.030.B
King County Board of Health	• Supervises matters pertaining to the preservation of the life and health of the people within King County. • Enforces, through the Local Health Officer, state public health statutes and State Board of Health and Secretary of Health rules. • May enact rules, regulations, and enforcement methods to preserve and promote the public's health.	RCW 70.05.035 RCW 70.05.060 RCW 70.05.060(1) RCW 70.05.060(3)
Mayor of Seattle	• May proclaim a state of civil emergency within the city when extraordinary measures are necessary to protect public peace, safety, and welfare. • May impose curfews, close business establishments, close public buildings and places including streets, alleys, schools, parks, beaches, and amusement areas, direct the use of public and private health, medical, and convalescent facilities and equipment to provide emergency health and medical care for injured persons, and proclaim any such orders as are necessary for the protection of life and property after proclaiming a civil emergency.	SMC 10.02.010.A SMC 10.02.020
Suburban City Executive Heads	• May exercise emergency functions per state law. • May have additional emergency powers and authorities in their municipal codes.	RCW 38.52.070 Municipal codes

Government Entity/Agency	Responsibility	Authorizing Statutes
Local Health Officer	• Enforces the public health statutes of the state, rules of the State Board of Health and the Secretary of Health, and local health rules, regulations, and ordinances within King County. • Takes actions necessary to maintain health and sanitation, and control and prevent the spread of dangerous, contagious, or infectious diseases in King County. • Informs the public about the causes, nature, and prevention of disease and disability and the preservation, promotion, and improvement of health within King County.	RCW 70.05.070(1) RCW 70.05.070(2) RCW 70.05.070(3) RCW 70.05.070(4)

In addition, public health governmental agencies have specific responsibilities during an infectious disease response or pandemic. These public health responsibilities are carried out in a coordinated way among local, state, national, and global entities. As above, synopses follow, and additional detail is in Appendix B.

Public Health – Seattle & King County, Health and Medical Area Command (HMAC)

1. Facilitate countywide pandemic planning and preparedness efforts.
2. Coordinate the community's emergency public health response through Emergency Support Function #8 – Public Health, Medical, and Mortuary Services and the Regional Disaster Coordination Framework.
3. Provide trainings for HMAC staff and responders on their role and topics such as Incident Command System (ICS), HMAC operations, the Washington System for Tracking Resources, Alerts, and Communications (WATrac), and ESF #8 plans and functional annexes.
4. Educate the public, healthcare system partners, response partners, businesses, schools, childcare centers, community-based organizations, and elected leaders about pandemics, expected impacts and consequences, and preventive measures.
5. Monitor and ensure the safety and well-being of Public Health responders and other public health staff.
6. Conduct county-wide surveillance to track the spread of the human disease and its impact on the community. When indicated, through liaisons with veterinary, agriculture, and wildlife agencies, facilitate disease surveillance in animals in King County and monitor surveillance data.
7. Identify and declare diseases of public health significance during a biological incident and communicate such declarations to health system partners.
8. Coordinate processes for medical countermeasures (medicines and medical supplies), including requesting, distribution, and dispensing and administration of these, with healthcare system, state, and federal partners.
9. Coordinate the implementation of non-pharmaceutical interventions including identifying personal protective equipment (PPE) supply needs and stockpiling.
10. In partnership with the Northwest Healthcare Response Network and the Medical Examiner's Office, support the healthcare system's planning and response efforts for medical surge capacity including mass casualty and mass fatality incidents.

State Department of Health

1. Coordinate statewide pandemic planning and preparedness efforts.
2. Coordinate statewide surveillance activities.
3. Operate a CDC Laboratory Response Network public health reference laboratory for testing of novel pathogens.
4. Coordinate submission of pandemic epidemiological data to the CDC and dissemination of statewide data and situation updates to local health jurisdictions.
5. Provide state assistance, when available, and request federal assistance to support the local health and medical response.
6. May receive medical countermeasures from the Strategic National Stockpile (SNS) and immediately distribute these supplies or facilitate direct shipments to Public Health, first responders, or healthcare providers.
7. Educate and inform the public on the course of the pandemic and preventive measures in coordination with local partners.

U.S. Department of Health and Human Services

1. Provide overall guidance on pandemic planning within the United States.
2. Coordinate the national response to a pandemic.
3. Provide guidance and tools to promote pandemic preparedness planning and coordination for States and local jurisdictions.
4. Provide guidance to state and local health departments regarding prioritization of limited supplies of antiviral medications and vaccines.
5. Facilitate development of treatments, vaccines, and other medical countermeasures.

Centers for Disease Control and Prevention

1. Conduct national and international disease surveillance.
2. Serve as a liaison to the World Health Organization.
3. Develop reference strains for vaccines and conduct research to understand transmission and pathogenicity with pandemic potential.
4. Develop, evaluate, and modify disease control and prevention strategies.
5. Investigate pandemic outbreaks and define the epidemiology of the disease.
6. Monitor the nation-wide impact of a pandemic.
7. Coordinate the stockpiling of antiviral drugs and other essential materials within the Strategic National Stockpile.
8. Coordinate the implementation of international – U.S. travel restrictions.
9. Provide updated pandemic response guidance to state and local health departments.

World Health Organization

1. Monitor global pandemic conditions and provide information updates.
2. Facilitate enhanced global pandemic preparedness, surveillance, vaccine development, and health response.
3. Declare global pandemic phase and adjust phases based on current outbreak conditions.
4. Provide international guidance on responding to the situation.

Responsibilities of Non-Governmental Entities

Healthcare system entities have specific responsibilities during a pandemic.[42] These include:

Local Hospitals, Clinics, Providers, and other Health System Partners

1. During a pandemic, employ all efforts to sustain the functionality of the healthcare system, including, if necessary:
   - Prioritize the provision of healthcare services to patients with urgent health problems.
   - Take steps to increase healthcare system capacity for patients who would normally require inpatient care.
   - Mobilize, reassign, and deploy staff within and between healthcare facilities to address critical shortfalls.
   - Implement patient triage and resource management processes.
   - Implement crisis standards of care framework.
   - Provide alternative mechanisms for patients to address non-urgent healthcare needs such as telephone and internet-based (telehealth) consultation.
2. Maximize the healthcare system's ability to provide medical care during a pandemic by working with the Northwest Healthcare Response Network, including:
   - Identify and prioritize response and resource issues affecting the county-wide health system during a pandemic.
   - Develop mechanisms to efficiently share information and resources between the healthcare system and HMAC and relevant emergency operations centers, as appropriate.
   - Assure that healthcare professionals receive relevant communications from HMAC in a timely and efficient manner.
   - Serve as convener of healthcare system leadership to facilitate outbreak response and coordination and/or address specific response needs at the request of Public Health.
3. Hospitals and other healthcare facilities must develop pandemic response plans consistent with the healthcare planning guidance contained in the U.S. Department of Health and Human Services Pandemic Influenza Plan.[43] Healthcare facility pandemic response plans address medical surge capacity and resource management and conservation to sustain healthcare delivery and communication capabilities when routine systems are overwhelmed.
4. Hospitals may screen and/or limit individuals from entering the hospital.
5. Healthcare facilities and healthcare providers will participate in local influenza and when requested, novel pathogen surveillance activities.
6. Hospitals will develop infection control plans to triage and isolate infectious patients and protect staff from disease transmission.

Effective coordination and collaboration among these government and non-governmental agencies takes place in an organized way through HMAC during an emergency response as described more in Appendix B.

[42] U.S. Centers for Medicare and Medicaid Services, 2021, [LINK]

[43] U.S. DHHS, HHS Pandemic Influenza Plan, 2005, [LINK]

2. Identification of critical infrastructure or resources that are currently lacking that would be required in order to respond to pandemics, the barriers to acquiring or developing the infrastructure or resources and recommendations for how to fill these gaps

This subsection identifies critical infrastructure and other resources currently lacking or insufficient that would be required to respond to future pandemics or other biological incidents. This subsection also describes barriers to acquiring needed capacity and makes recommendations for how to fill these gaps. This subsection draws on the Biological Incident Response Annex in Appendix B and the PHSKC COVID-19 After Action Report in Appendix C.

Critical Infrastructure: Resources Required to Respond to Pandemics
Critical infrastructure refers to the people, supplies, systems, relationships, and other resources needed by Public Health to carry out a response. Existing resources may need to be diverted from their usual applications and/or responsibilities to support an emergency response. When sufficient critical infrastructure, such as personnel, facilities, equipment, supplies, and funding are not available, it delays both Public Health's emergency response and partners' abilities to carry out response operations and provide support to affected communities.

During the initial stages of a biological incident, there may be an opportunity to contain or significantly delay the spread of the disease. It is critical to quickly and adequately resource priority strategies to implement response measures and help prevent systems from being overwhelmed.[44]

Critical infrastructure must be supported by standard emergency response organizational structures, decision-making frameworks, and information sharing networks to function effectively. Given evidence from local, regional, and national responses to infectious disease outbreaks in the past, insufficient critical infrastructure and the corresponding potential adverse consequences can include:[45]

- *Isolation and Quarantine (IQ)* – Inadequate supply of IQ sites and services (such as hotel, motel, and adult family home space) and staff (to assess eligibility for and arrange IQ for those meeting criteria, offer transportation, and monitor those in IQ) can cause response challenges and barriers to using IQ sites. In addition, staff with behavioral health training to triage and support complex guest needs are needed at most IQ sites.

- *Equity and Community-centered Processes* – Funding and training opportunities during a response are limited for Public Health staff to practice developing community- and accessibility-centered approaches and are best done before a response. Limited funding and community engagement expertise can lead to members of the public not being informed or not understanding prevention and treatment strategies. Limited contract funds, staffing, translation, and technical advisor positions can be barriers to implementing the identified equity objectives and strategies in Appendix B.

[44] Prevent Epidemics, 2020, Box It In, [LINK]
[45] U.S. DHHS Administration for Strategic Preparedness and Response, COVID-19 After Action Report Resources and Examples, January 2023, [LINK]

- *Guidance and Information* – Limited Public Health resources to support translation, interpretation, and culturally appropriate outreach needs can create gaps in the public's awareness about the pandemic and how to respond. Limited existing translations of key infectious disease response information also can cause awareness and information gaps. Limited support for this area can result in a lack of funding for community liaison positions who work on equitable and effective implementation of pandemic response strategies. Similarly, gaps in this area can result in under-funded public information contact center (call center) operations, which were in great demand during the COVID-19 response. Gaps in this area also can restrict the department's ability to share information rapidly and stay up to date with evolving response information.

- *Care Coordination* – Limited staff and resources for care coordination (connecting people to social services and basic needs resources) can result in missing information about when to launch *Emergency Support Function #6 – Mass Care, Emergency Assistance, Housing, and Human Services* during the early stages of infectious disease spread. These gaps can also cause inadequate transportation, housing, and human services contracts, resources, and staffing in an ongoing response.[46]

- *Surge Staffing* – Gaps in Public Health's capacity to increase staff in line with pandemic surges can result in limited foundational core capacity staffing; budget constraints; employee scope limitations and reassignment limitations; limited capacity to convene and manage private sector partners, and limited mechanisms for training and reassignment.

- *Medical Countermeasures* – Insufficient supply of medical countermeasures (such as supplies, medications, and vaccines) can lead to conflicting decision-making authority about how to prioritize limited testing, treatment, and vaccination resources; limited resources to support Public Health-led distribution, dispensing, and administration directly to partners' communities; Public Health laboratory and clinic service capacity limitations, and challenges to coordinating with DOH and nearby local health jurisdictions in regional efforts and resource prioritization and allocation.

Policies, funding, and improved critical infrastructure in the above areas can support faster, more effective, and more equitable biological incident response operations across King County.

Strengths in the COVID-19 Response

Before identifying gaps in infrastructure, this subsection highlights many strengths in King County's COVID-19 response including: collaboration across county departments, the creation of the nation's first civilian isolation and quarantine system, ambitious initial vaccine goals and accomplishments among all race/ethnicity groups, informative and timely data dashboards, an equity-oriented Community Mitigation and Recovery branch, and one of the lowest death rates due to COVID-19 out of the 20 largest metropolitan areas in the US.[47]

[46] U.S. FEMA, Emergency Support Function #6 – Mass Care, Emergency Assistance, Housing, and Human Services Annex, January 2008, [LINK]

[47] PHSKC, COVID-19 After Action Report, [LINK]

Public Health developed two documents to guide key operational elements of the response — the King County Unified Strategy for Vaccine Delivery and Principles for Equitable Vaccine Delivery. These were made public, and they reflected the strength of government and decision-maker collaboration during the response.

COVID-19 Response by the Numbers
The County's COVID-19 pandemic entailed responses many times larger and more intense than previous emergency responses in recent decades. In addition to the numbers in the Context section on pages 7 and 8, other examples include:

- King County testing sites conducted more than 200,000 tests in 2020, and by March 2021, testing sites had conducted 1 million polymerase chain reaction (PCR) tests. In January 2022, an average of over 11,000 tests were being performed daily at testing sites.[48]

- In 2020, PHSKC's Language Access team translated information on 375 topics, resulting in 4,200 translated documents, working with 88 translators in 33 languages.[49]

- In early 2021, the Public Health call center averaged 700 to 1,000 calls per day. The call center reached a new single-day call record on January 3, 2022, with 1,600 calls answered.[50]

- Public Health met and exceeded an ambitious goal of vaccinating 70 percent of eligible residents by vaccinating 77 percent (N=1.5 million) of all eligible King County residents on September 1, 2021. This rate was achieved within the first five months of vaccines being available to those over 16 years old.[51]

- By February 2022, King County had distributed more than 1.4 million N95s, 3.7 million surgical masks, 20 million gloves, and 1.6 million gowns to long term care facilities, health clinics, first responders, congregate settings, community-based organizations, and other critical care agencies.[52]

Gaps
Despite King County's successes around the COVID-19 pandemic, some critical infrastructure and resources were lacking in the COVID-19 response.

Disability Access
People with disabilities experienced gaps regarding translation and interpretation services, gaps in testing and vaccine site accessibility in early phases of the pandemic, inadequate disability representation on public health data dashboards, and limited transportation options to obtain COVID-19 resources.

[48] PHSKC, COVID-19 After Action Report, [LINK]
[49] PHSKC, COVID-19 After Action Report, [LINK]
[50] PHSKC, COVID-19 After Action Report, [LINK]
[51] PHSKC, COVID-19 After Action Report, [LINK]
[52] PHSKC, COVID-19 After Action Report, [LINK]

The distribution of information through internet technology created another limitation identified in the COVID-19 After Action report. Some AAR contributors noted that pictorial or video versions of information could have reached a larger audience, including those with disabilities.[53]

Public Health used the demographic data available to it to guide decision-making on how to prioritize scarce resources and serve the public. However, data on disability status is not routinely collected or reported and people with disabilities did not appear on dashboards due to these data limitations. Tracking the vaccination and testing rates of people with disabilities in the future would help Public Health understand this part of the community more fully.[54]

Racial and Ethnic Representation

Another gap in the County's critical public health infrastructure was the limited number of Black, Indigenous, and other people of color in Public Health and in the Public Health Reserve Corps. A more racially and ethnically diverse and representative Public Health staff and Reserve Corps volunteers could contribute to building trust with communities, resulting in improved language access and more insightful planning for people with disabilities and other groups for future events. Similarly, a lack of racial equity training across all activated staff left some connections with community members untapped, thereby missing their perspectives from emergency response conversations.

Overwork and Responder Stress

Public Health teams widely reported that they were overwhelmed with workload during many phases of the COVID-19 pandemic. Response demands often outpaced Public Health resources. For example, many Public Health employees, particularly early in the response, worked 80–100-hour work weeks, often going months without a day off. Unprecedented demands on Public Health and other response staff demanded long hours. For example, in January 2022, department outbreak investigators were supporting 467 active outbreaks and had closed 407 facility investigations in the prior two weeks.[55] The contact tracing team interviewed 90 percent of named contacts in the community and conducted approximately 500 investigations per week.[56] Reluctant to take time away from the job, many felt they could not reduce their workloads, take needed breaks, nor address their physical, emotional, or mental health needs.

Additional Strengths and Areas for Improvement for the COVID-19 Response

The COVID-19 After Action Report in Appendix C details strengths, areas for improvement, and areas of mixed findings for the key components of the emergency response, including incident management, epidemiological investigation and surveillance, equity and community partnerships, public information, healthcare system support, isolation and quarantine, resource management, the public information contact center, community-based initiatives, testing, fatality management, vaccination, Public Health internal operations, and responder safety and health.[57] Highlighted findings from the COVID-19 After Action Report are below, with details presented in Appendix C.

[53] PHSKC, COVID-19 After Action Report, [LINK]
[54] PHSKC, COVID-19 After Action Report, [LINK]
[55] PHSKC, COVID-19 After Action Report, [LINK]
[56] PHSKC, COVID-19 After Action Report, [LINK]
[57] PHSKC, COVID-19 After Action Report, pages 49 to 119, [LINK]

Table 3. Significant Strengths and Areas for Improvement for the COVID-19 Response, King County, WA, 2020 through 2022

Response	Strengths	Areas for Improvement
Incident Management	• HMAC consistently used standard emergency response processes. • HMAC coordinated effectively with multiple partners.	• Designate an ADA coordinator. • Greater speed establishing priorities to support timely response. • Familiarize all staff with incident management structure.
Epidemiological Investigation and Surveillance	• The Analytics and Informatics team scaled data reporting in unprecedented ways. • Created informative COVID-19 Dashboards. • Strong teamwork and adaptability.	• Establish interoperability between state and county data for contact tracing. • Include categories, such as disability, housing, detailed race/ethnicity groups, and LGBTQ+ status in notifiable conditions data.
Equity and Community Partnerships	• Leveraged existing relationships to share information. • Distributed resources and information to community-based and faith-based organizations.	• Provide translation and interpretation for people with disabilities. • Establish stronger connections with tribes, especially at the pandemic's onset, were needed.
Public Information	• Positive relationships with subject matter experts, media, community media, social media, and external communications teams contributed to effective communications through many channels.	• Streamline hiring and contracting processes to speed up communications operations.
Healthcare System Support	• Hospitals, medical directors, and emergency medical services (EMS) coordinated effectively as the pandemic progressed.	• Ensure coordination between EMS and emergency preparedness teams. • Establish county-specific regional medical surge plan.
Isolation and Quarantine	• Coordinated communication channels, daily huddles and progress tracking, a centralized scheduling system, and strong leadership were key elements of the IQ team's success. • Guests at IQ sites received integrated behavioral health, medical care, and harm reduction services.	• Develop staffing, logistics, and information technology support to meet 24/7 operational needs. • Determine staffing forecast approach to match patient surge needs.
Resource Management	• The Logistics and Supply Management team created effective standard ordering processes, forms, and job action sheets.	• Scale contracting operations. • Secure adequate supplies, including personal protective equipment, as quickly as possible.
Public Information Contact Center (PICC)	• Staff were obtained from many partners, such as registered and student nurses, Peace Corps volunteers, and the Public Health Reserve Corps.	• Prioritize information technology tools to PICC operations.

Response	Strengths	Areas for Improvement
Community-Based Initiatives	• New services for businesses, such as Vax Verify, Safe Start, and Ventilation and Air Quality programs, were developed quickly. • Technical assistance, supplies, and some cost reimbursements were offered.	• Communicate mandates and requirements to businesses.
Testing	• Teams established partnerships across agencies, jurisdictions, and labs to meet the needs of testing sites. • Recommendations from community partners helped inform where sites were located.	• Familiarize team members with ICS processes. • Establish plans for setting up and scaling testing sites. • Strengthen coordination and communication across the laboratory system.
Fatality Management	• Pre-pandemic planning for mass fatality incidents created relationships and a foundation for the Medical Examiner's Office (MEO) response.	• Streamline and clarify data reporting structures to support data reporting.
Vaccination	• The vaccine delivery team enacted a community-centered approach, a critical factor for the success of vaccine operations. • Healthcare system partners and volunteers staffed clinics worked in coordinated ways. • King County IT and county departments selected and implemented a vaccine registration system.	• Ensure consistent messaging to reduce confusion on the ground. • Eliminate language access and disability accessibility barriers at vaccine sites. • Increase mobile vaccination teams.
Public Health Internal Operations	• Public Health created multi-disciplinary teams to implement complex strategies, such as vaccinations and tests for people experiencing homelessness, and the creation of facility ventilation guidance.	• Recognize impacts of workload demands on staff capacity • Create predictability in disaster response funding levels.
Responder Safety and Health	• The Safety Officers offered on-site counseling, safety guidance, and therapy dog visits, as well as online support meetings and wellbeing surveys. • Security teams supported staff working in the field.	• Include Safety Officers in program design phases where relevant. • Structure work such that team members can access mental and physical health wellbeing resources.

Source: COVID-19 After Action Report, September 2022. [LINK]

Barriers to Acquiring Resources

After making emergency declarations for COVID-19, authorities simplified many funding, contracting, and hiring processes to facilitate a swift flow of resources to the response efforts. However, some barriers to acquiring resources for the response remained despite the availability of funds. These included documenting compliance with complex reimbursement rules and following all steps in hiring processes.

Hiring and Onboarding Constraints – Hiring and onboarding were critical to scaling up the workforce to meet public health response needs, however these processes faced organizational challenges. While recognizing the unprecedented nature of the pandemic, we experienced notable administrative burdens and significant time constraints associated with filling positions. Public Health's front line responders were taken away from emergency response responsibilities to complete administrative hiring processes. After hiring, many new staff reported they did not receive adequate onboarding information. These barriers limited scalability and contributed to staff burnout.

Lack of "Bridge Funding" – Over the years, public health as a field has often experienced a boom-and-bust cycle of funding: during and immediately after emergencies, public health emergency response funds are allocated, but as the emergency recedes, funding recedes. Planning activities are among the first to be reduced during times of budget shortfalls. Pandemic and other biological incident response planning, including continuity of operations planning, merit bridge funding to ensure that robust, current, equitable, and well-informed plans are in place when most needed. Bridge funding refers to local, state, or federal funding that is allocated between larger emergencies, such as pandemics. The federal public health infrastructure grants are examples of bridge funding.[58]

Recommendations to Fill These Gaps

Based on the findings of the COVID-19 After Action Report, Public Health has identified four types of recommendations intended to improve future infectious disease and other biological incident responses. These recommendations are in the categories of building trust through relationships and communications; customizing emergency response actions to specific groups to prevent inequitable outcomes; continuing to improve emergency response operations by using standard processes and coordination methods, and adding workforce flexibility to surge in response to pandemic peaks and crests. Within these four areas, more specific recommendations are to:

1. *Develop Relationships and Building Trust* – Support, leverage, and formalize relationships developed during the COVID-19 response. Continue to regularly convene community partner organizations to strengthen partnerships. Invite partners to join emergency planning activities. Utilize two-way communication strategies to encourage partnerships with subject matter experts and community leaders.

2. *Improve Equity and Customizing Response* – Emergency response structures and approaches must include tailored actions and information to equitably serve communities, including Black, Indigenous, other people of color, people with disabilities, and King County residents in less resourced locations. Improve the diversity of the Public Health Reserve Corps. Designate an internal team, such as the Equity Response Team, to conduct initial equity reviews of proposed Public Health policies and programs. Ensure that continued work with community leaders includes compensation.

3. *Fine Tune Operations* – Improve the use of response plans and standard processes during a response and continue to improve cross-team coordination capacities. Evaluate innovations that worked well during COVID-19 and determine how they can be documented for use in the future. Establish standard ways for the logistics team to cover inventory tracking, shipping, and

[58] CDC, Public Health Infrastructure Grant, August 2023, [LINK]

handling before initiating distribution. Formalize incident command system refresher training processes for staff. Review structures to promote greater internal, cross-team coordination to help response teams stay aligned with changing guidance and awareness of activities being led by other teams.

4. *Increase Workforce Flexibility* – Increase Public Health's capacity to hire and deploy staff on a surge basis and do more to ensure first responder staff safety. Use dedicated hiring staff rather than program staff working on the frontline to carry out hiring and onboarding tasks. Develop job responsibilities and roles needed for human resources as part of the workforce mobilization team. Improve Public Health's capacity to hire, retain, and promote diverse staff. Make organization policy changes, such as establishing response priorities, cross-training staff members so staff can cover for others going on break, hiring staff more quickly, and allowing responders to rotate out of the response more frequently to better meet individual self-care needs.[59]

Public Health staff and other governmental and non-governmental participants in the COVID-19 response identified these recommendations to help prepare Public Health for future emergencies. The recommendations build on lessons learned from successes and challenges experienced throughout the COVID-19 pandemic response. More detailed recommendations are in the COVID-19 After Action Report.[60] Efforts to address these recommendations represent important ways for King County to demonstrate its commitment to building a culture of equity and quality improvement and will require significant time and resources to accomplish fully.

V. Conclusion

The first three years of the COVID-19 global pandemic created an unprecedented public health emergency that resulted in thousands of illnesses and deaths, and tested health systems at all levels of government. During this difficult time, the King County Council, the Executive, and Public Health recognized the importance of pausing to reflect and incorporate lessons learned into an updated biological incident response annex. As required by Motion 15650, Public Health, in coordination with KCOEM, created an updated King County Biological Incident Response Annex, as it continues to implement COVID-19 prevention strategies and respond to other emergencies. Public Health identified critical infrastructure and other resources that were lacking, identified barriers to meeting these gaps, and made recommendations to improve responses going forward.

The COVID-19 pandemic spotlighted and exacerbated health inequities that have long been present in the U.S., and resulted in signification racial and ethnic disparities in COVID-19 cases, hospitalizations, and deaths across the country.[61] Public Health and its partners took steps to mitigate the impacts of COVID-19 on individuals and communities disproportionately impacted by COVID-19 with varying degrees of success, even as these communities faced structural racism and social and economic

[59] PHSKC, COVID-19 After Action Report, [LINK]
[60] PHSKC, COVID-19 After Action Report, [LINK]
[61] PHSKC, COVID-19 After Action Report, September 2022, [LINK]

vulnerabilities. The COVID-19 After Action Report and the Equity Response Annex address these complex issues more fully.[62,63]

While emergency response processes cannot address health inequities fully, they must continually adapt to be more equitable to Black, Indigenous, other people of color, people with disabilities, and King County residents in less resourced locations. Continued improvements in equitable response planning and intentional strategy design — in partnership with specific populations — are needed, given the racially inequitable outcomes of COVID-19. Public Health recommends allocating adequate funding for staff and community member compensation, so that meaningful relationships and ongoing dialogues can be developed and maintained before, during, and after pandemics with groups at higher risk of poor health outcomes.

In addition, Public Health recommends continuing to develop and streamline standard operational processes during a response, with a focus on improving cross-team coordination capacities. It recommends developing staffing mechanisms that can respond effectively to outbreak surges and decelerations while ensuring first responder safety throughout the response, including ensuring breaks and self-care during long responses.

The COVID-19 response in King County had many strengths and weaknesses. Examining the inequitable outcomes by race/ethnicity and disability status from COVID-19 is critical in assuring equitable emergency response outcomes in the future and advancing King County's equity and social justice goals as laid out in the King County Equity and Social Justice Strategic Plan. These inequitable outcomes exist because there are persistent structurally racist policies and practices in the public health and healthcare systems. Documenting these inequities transparently and working to eliminate them reflects the values of being racially just and of aspiring to make King County a welcoming community where every person can thrive.

VI. Appendices

Appendix A: Motion 15650
Appendix B: King County Biological Incident Response Annex
Appendix C: COVID-19 After Action Report

[62] PHSKC, COVID-19 After Action Report, September 2022, [LINK]
[63] PHSKC, Equity Response Annex, [LINK]

King County

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Motion 15650

Proposed No. 2020-0183.3 **Sponsors** Dunn

A MOTION requesting that the King County office of emergency management and public health - Seattle & King County work collaboratively to update the King County Comprehensive Emergency Management Plan, the Regional Hazard Mitigation Plan, the Regional Coordination Framework, continuity of operations plans, the King County Continuity of Government Plan and all other relevant emergency management plans and documents to address the risks from and response to pandemics, incorporating lessons learned from the COVID-19 outbreak, and to develop a pandemic response plan for King County.

WHEREAS, on February 29, 2020, public health - Seattle & King County confirmed the first cases of the novel coronavirus ("COVID-19"), including one death, in the county, and

WHEREAS, COVID-19 is a respiratory disease that can result in serious illness or death and can easily spread from person to person; and is classified by the World Health Organization as a pandemic that spreads easily from person to person and may result in serious illness or death, and

WHEREAS, as of April 23, 2020, King County had reported 5,569 confirmed cases of COVID-19, and at least 384 individuals in King County had died as a result of the virus, and

WHEREAS, while COVID-19 is the worst pandemic to affect King County in several generations, the possibility of pandemics of similar or greater impact in the future is omnipresent, and changing climatic conditions are expected to multiply the threat of zoonotic and other pandemics, and

WHEREAS, the mission of the office of emergency management is "to provide for the effective direction, control and coordination of county government emergency services functional units, and to provide liaison with other governments and the private, nongovernmental sector, in compliance with a state-approved comprehensive emergency management plan and to serve as the coordinating entity for cities, county governmental departments and other appropriate agencies, during incidents and events of regional significance," and the office is tasked with developing a comprehensive plan and program for emergency management, and

WHEREAS, public health - Seattle & King County is responsible for planning and developing local and regional capacity for responding to public health emergencies and providing for the direction and mobilization of health resources, information and personnel during emergencies and disasters in the county, and

WHEREAS, in 2005, Ordinance 15348 required the executive to develop a pandemic influenza response plan, and

WHEREAS, Ordinance 15596 adopted the County's Pandemic Influenza Response Plan in 2006, and Ordinance 15986 adopted an updated version of the plan the

following year, and

WHEREAS, public health - Seattle & King County has, in the past, developed other planning documents relating to influenza pandemics, such as the Influenza Pandemic Planning Guide for Homeless and Housing Service Providers, and

WHEREAS, the COVID-19 pandemic presents an emergency with similar characteristics to a pandemic influenza, with public health responses generally following what is contained in the Pandemic Influenza Response Plan, but future pandemics of different origins may require different responses, and

WHEREAS, the King County office of emergency management develops and maintains a number of planning documents, such as the Regional Hazard Mitigation Plan, the Comprehensive Emergency Management Plan, the Regional Coordination Framework, King County continuity of operations plans and the King County Continuity of Government Plan, and

WHEREAS, the COVID-19 pandemic is the first real-world test of these plans in a large-scale, global pandemic outbreak affecting King County, and the lessons learned in the outbreak must be used to prepare for future pandemics, whether they be viral, bacterial or parasitic in origin, and

WHEREAS, the lessons learned during the COVID-19 pandemic outbreak have application outside pandemic planning and should be used to prepare for other types of emergencies under an all-hazards approach to emergency management;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

A. The office of emergency management should work with public health - Seattle & King County to update the Comprehensive Emergency Management Plan, the

Regional Hazard Mitigation Plan, the Regional Coordination Framework, King County continuity of operations plans, the King County Continuity of Government Plan and any other relevant emergency management or disaster plans or documents to address the threat of pandemics to King County, using the lessons learned from the COVID-19 pandemic and building upon the pandemic response plan described in section B of this motion.

B. Public health - Seattle & King County, in coordination with the King County office of emergency management, should create a new pandemic response plan and update other relevant planning documents, expanding on the existing Pandemic Influenza Response Plan and other emergency and disaster planning efforts, using lessons learned from the COVID-19 pandemic. The plan should include the following topics, at a minimum:

1. A response plan or plans addressing each pandemic phase identified by the Centers for Disease Control and Prevention, including a description of the responsibilities of relevant governmental and nongovernmental agencies in each pandemic phase, both with and without presence of local cases;

2. Identification of critical infrastructure or resources that are currently lacking that would be required in order to respond to pandemics, the barriers to acquiring or developing the infrastructure or resources and recommendations for how to fill these gaps; and

3. Any other information or strategies deemed appropriate by public health - Seattle & King County.

C. The King County office of emergency management is requested to transmit all

updated plans and documents described in section A of this motion, and a proposed motion acknowledging receipt of the updated plans and documents, by September 1, 2022. The plans and documents should be filed in the form of a paper original and an electronic copy with the clerk of the council, who will retain the original and provide an electronic copy to all councilmembers, the council chief of staff and the lead staff to the committee of the whole or its successor.

D. Public health - Seattle & King County is requested to transmit the pandemic response plan and other updated documents and a proposed motion acknowledging receipt of the pandemic response plan and other updated documents by September 1, 2022. The plan and documents should be filed in the form of a paper original and an electronic copy with the clerk of the council, who will retain the original and provide an electronic copy to all councilmembers, the council chief of staff and the lead staff to the committee of the whole or its successor.

E. The King County office of emergency management and public health - Seattle

& King County are requested to provide a briefing to the council on the status of the pandemic response plan and other plan updates no later than September 1, 2021.

Motion 15650 was introduced on 5/12/2020 and passed by the Metropolitan King County Council on 7/7/2020, by the following vote:

Yes: 9 - Ms. Balducci, Mr. Dembowski, Mr. Dunn, Ms. Kohl-Welles, Ms. Lambert, Mr. McDermott, Mr. Upthegrove, Mr. von Reichbauer and Mr. Zahilay

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

DocuSigned by:
Claudia Balducci
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Claudia Balducci, Chair

ATTEST:

DocuSigned by:
Melani Pedroza
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Melani Pedroza, Clerk of the Council

Attachments: None

Appendix B: Biological Incident Response Annex

December 2023

King County

EMERGENCY SUPPORT FUNCTION (ESF) #8 ANNEX
VERSION 1.0
DECEMBER 2023

TABLE OF CONTENTS

Public Health
Seattle & King County

DOCUMENT USE

This document, i.e., the King County *Biological Incident Response Annex* including all affiliated attachments created by Public Health – Seattle & King County (Public Health), represents an integration and modernization of multiple plans including, but not limited to, Public Health's *Influenza Pandemic Response Plan* and *Medical Countermeasures Plan*. Effective at the publish date, this *Biological Incident Response Annex* will provide the operational guidance moving forward for public health activities in King County within the purpose and scope as defined in the Introduction section. All previous plans have been archived.

This document reflects the best available information and documentation at the time of the initial or most recent publishing. In alignment with the Plan Maintenance section, a Record of Changes will be maintained to keep track of version history, including dates of when changes are implemented and summaries of changes.

RECORD OF CHANGES

Version	Date	Summary of Changes
1.0	11/15/2023	Initial Publication

ANNEX INTRODUCTION

PURPOSE

The *Biological Incident Response Annex* (Annex) provides guidance for actions Public Health and regional partners might take before, during, or after a biological incident. Biological incidents are situations in which an agent of biological origins causes a significant local, regional, or national impact. These may include biological incidents such as outbreaks and pandemics, emergence of a novel infectious disease with significant health risks, or a suspected or confirmed bioterrorism event. "Annexes" are the parts of emergency operations plans that begin to provide specific information and direction. Annexes focus on operations: what the function is and who is responsible for carrying it out.[1]

Some biological incidents will require limited response activities from Public Health, manageable with existing resources; other situations will require large-scale response efforts that involve multiple divisions within Public Health and the cooperation and coordination of Washington State Department of Health (DOH), tribal nations, neighboring jurisdictions, other King County departments, and additional Emergency Support Function #8 – Public Health, Medical, and Mortuary Services (ESF #8) partners.

Emergency proclamations at all levels of government will be implemented for bioterrorist incidents warranting activation of medication dispensing plans and the mobilization of medical equipment and supplies from federal stockpiles. The Annex establishes an equity-centered framework for incident recognition, response coordination, and decision-making during a response. The Annex also describes roles and responsibilities, effective communication, and ongoing planning across partners to protect community health and center equity during an outbreak.

During a biological incident, Public Health and regional partners will utilize the Annex to achieve the following goals:

- Limit the number of illnesses, hospitalizations, and deaths.
- Prioritize the most disproportionately impacted groups.
- Preserve continuity of essential functions (government, healthcare, education, and business).
- Limit societal disruption and economic losses.

The Annex coordinates with other Public Health preparedness plans and response activities at the local, national, and global level.

SCOPE

This Annex is an annex to the *Emergency Support Function #8 – Health, Medical and Mortuary Services* (ESF #8) *Plan* of the *King County Comprehensive Emergency Management Plan*, the *City of Seattle Comprehensive Emergency Management Plan*, and the *Regional Disaster Coordination Framework*. The *ESF #8 Plan* and its annexes are referenced in this Annex as they provide a broad description of the responsibilities, authorities, and actions associated with public health emergencies.

[1] US Federal Emergency Management Agency, Guide for All-Hazard Emergency Operations Planning.

This Annex can be referenced by Public Health leadership and staff to facilitate effective incident management and a coordinated regional response during all phases of a biological incident. The Annex may be activated for a biological incident including outbreaks of existing reportable conditions, emerging infectious diseases, bioterrorism event, or pandemic that threatens the public's health. Public Health's Communicable Disease Epidemiology and Immunization Section (CD-Imms) routinely conducts surveillance for notifiable conditions, case and outbreak investigation, and disease response and prevention activities. The Annex is intended to be used for any biological incident requiring a response that exceeds any Department program or division's disease control capacity. A biological incident response will require timely and effective cross-collaborative use of public health and medical resources, including facilities, personnel, equipment, mental and behavioral health services, information, data, communication systems and resources, and pharmaceutical and other supplies.

This Annex primarily focuses on the roles, responsibilities, and activities of Public Health and the command structure, Health and Medical Area Command (HMAC) (led by Public Health), in preparing for and responding to a biological incident. However, specific responsibilities for key response partners are included to highlight points of coordination between agencies during a pandemic. Based on guidance from the Centers for Medicare and Medicaid Services, healthcare facilities, healthcare professionals (including business leaders), essential service providers, and local government officials, are required to develop and incorporate procedures and protocols addressing infectious disease preparedness and response activities into their respective emergency response plans.[2]

PLANNING CONSTRAINTS

This Annex includes Public Health's general procedures for responding to future biological incidents including biological terrorism. Although this Annex attempts to anticipate a range of needs and associated response options to a biological incident, it is impossible to predict and plan for every contingency and every aspect of a response. Public Health plans are not intended to be prescriptive, but rather they guide decision-making, resource allocation, and centering equity in all response actions. This Annex should be considered a framework for incident management and response, and Public Health leadership and staff who adapt or implement this Annex should maintain flexibility for action and innovation to best meet community needs during an infectious disease incident.

PLANNING ASSUMPTIONS

This Annex integrates key concepts of communicable disease control and prevention with emergency management principles and structure. The ability of Public Health and regional partners to provide a coordinated response to a biological incident is dependent upon the scope and severity of the event, impacted communities, countermeasure and other resource availability, and needs and the status of preparedness and organizational response capabilities. With these factors in mind, a biological incident response must account for the assumptions below.

Disease Severity and Population Impact: Planning will include biological incidents characterized by the severity of the spread of infection with outbreaks occurring locally, regionally, nationally, or globally.

[2] US Centers for Medicare and Medicaid Services: Emergency Preparedness Rule.

Severity of spread will be considered in terms of both the rapidity of the spread of infection as well as the impact on populations, i.e., the operations outlined in this plan could be used to address large scale exposures to pathogens that may spread slowly but cause severe illness outcomes.

- Communities across the state and the country may be impacted simultaneously.
- It is not possible to predict the impact of a future biological incident or the staffing capacity at the time thus response plans must be flexible and scalable to the actual epidemiologic features of the outbreak, including mechanism of transmission, Public Health capacity, healthcare facility capacity, disease outcomes, case fatality rate, availability of medical countermeasures, and differential impacts on subgroups of the population.
- Initial response stages may require short-notice resource coordination and prioritization of response activities including needs around isolation and quarantine, availability of personal protective equipment, engagement of the regional health care delivery system, and mobilization/coordination of available medical countermeasures.
- There could be significant disruption of public and privately owned critical infrastructure including transportation, commerce, utilities, public safety, agriculture, education, healthcare, and communications.

Surveillance systems: Strong and robust surveillance systems in place at the local, state, and federal level are needed to detect threats and send alerts and notifications.

- Staff designated for monitoring mandatory reporting of infectious diseases – local public health departments, laboratories, regional and federal partners, and health care providers – will communicate through established processes, policies, and procedures regarding possible and confirmed cases, however, infectious disease threats may present unique challenges that require additional information needs and epidemiological capacity beyond what current systems can support.
- It will be important to coordinate infectious disease response strategies across Tribal partners, counties in the Puget Sound area, and the State because of population mobility across borders and a desire to provide consistent public health approaches across the region.

Information sharing: Frequent and effective communication and information sharing across jurisdictions and between the public and private sectors will be needed.

- Public Health officials will be expected to communicate clear, consistent, and timely public information and risk messaging based upon the best available data and infection control principles known at that time; the expectation is that this information may change rapidly and will be updated accordingly.
- The public, healthcare system, response agencies, and elected leaders will need frequent updates on the status of the outbreak, impacts on critical services, the steps HMAC is taking to address the incident, and steps response partners and the public can take to protect themselves.

Healthcare system impact: The number of ill people requiring outpatient medical evaluation and care, hospitalization, home care, and isolation/quarantine resources could overwhelm the local healthcare system.

- Infections with high attack rates and large scale events causing significant clinical illness and/or case fatality rates will likely place overwhelming demands on the public health and healthcare systems, as well as other critical infrastructure. These systems will implement their surge plans to best attempt to mitigate the impact on operations and the healthcare system.
- Healthcare facilities and providers may need to modify their operational structure to respond to high patient volumes (e.g., telehealth options) and maintain functionality of critical systems, and increased demands for services while the medical workforce experiences absenteeism due to illness; shifts in resource allocation should be weighed against increasing risk for other disease threats (i.e., limiting clinic appointments for other urgent medical conditions or that may impact preventive care such as cancer screening and childhood immunizations)
- Resource management and conservation strategies may need to be implemented especially in settings where supply chain issues are present and significant demands are made on personal protective equipment (PPE) as well as certain pharmaceuticals and equipment.
- Infection prevention and control measures and strategies specific to management of the pathogen may need to be developed for implementation in congregate settings (i.e., community-based organizations, correctional facilities, schools and universities, faith-based organizations, homeless shelters, and encampments), and public spaces (i.e., businesses, healthcare facilities including acute care hospitals and long-term care facilities), and by those providing home-based care.
- Public Health may need to ensure implementation of alternate care facilities and services to relieve demand on inpatient and outpatient healthcare facilities to care for persons not ill enough to merit hospitalization or those in need of isolation or quarantine, but who cannot be cared for at home or are experiencing homelessness.
- Emergency Medical Service (EMS) responders may face extremely high call volumes for several weeks and may face reductions in available staff.
- The number of fatalities experienced during the first few weeks of a significant bioincident could overwhelm the resources of the Medical Examiner's Office, hospital morgues, and funeral homes.
- The demand for social and mental health services may increase dramatically.

Medical countermeasures (MCM): MCM, such as antibiotics (e.g., antibacterial, antiviral, and antifungal), treatment, pre- and post-exposure prophylaxis, anti-toxin, and other treatments, may be in extremely short supply.

- In consultation with DOH, a limited allocation of MCMs may need to be prioritized for use in certain groups at increased risk and/or providing essential services, (e.g., hospitalized patients, healthcare workers providing care for patients, first responders, and other groups based on national guidelines and local epidemiology). We are committed to centering equity in decision making regarding the allocation of scarce resources.

Vaccination: Vaccines may not be available initially for emerging disease threats or may be in short supply early in an outbreak event.

- As a vaccine becomes available, it may be ordered, distributed, and/or administered by Public Health based on state and federal guidance and coordination and local epidemiology.
- Insufficient supplies of vaccines will require an equity-led framework for the allocation and distribution of pharmaceutical interventions to reach the most disproportionately impacted groups and those at greatest risk of disease transmission, morbidity, and mortality.

- Insufficient supplies or lack of effective pharmaceutical interventions might also place greater emphasis on non-pharmaceutical infection control and public education tailored to the known modes of pathogen transmission to mitigate spread of the disease.

Equity: Equity should be included in incident response operations and centered in decision making.

- The *Equity Response Annex* (ERA) provides guidance and recommendations for how to meaningfully partner with communities during a response. The ERA includes decision making tools that can support response leadership with centering equity and communities along every step of the response.[3]
- Prioritize access to medical countermeasures based on local epidemiology and by centering individuals with less access to healthcare resources including those who are un/underinsured as well as those at high risk of illness.
- Identify multi-modal strategies for the dispensing and administration of medical countermeasures, including points of dispensing that are safe, familiar, and accessible to all community groups, as well as serving those who are homebound.
- Certain infection prevention and control strategies [e.g., social distancing, wearing a mask, closing schools and moving to alternate learning options (e.g., remote learning), closing community centers and other public gathering points, canceling public events] may cause social disruption and isolation, especially among population groups with a strong communal culture (as is present in many immigrant communities in King County). When making implementation decisions, Public Health, with input from relevant stakeholders, will weigh the known and potential benefits of such measures against their known and potential unintended consequences.
- Some persons will be unable or unwilling to comply with isolation and quarantine directives. For others, social distancing strategies may be less feasible (for example, homeless populations who live or are sheltered in congregate settings).
- Individuals with access and functional needs (including, but not limited to, people who are homeless, homebound, economically or transportation disadvantaged, hearing or visually impaired, or who have limited English proficiency) are often disproportionately affected by emergencies and may require additional assistance in an emergency.

Mutual aid: If the outbreak is widespread (regional, national, or global), it may not be possible to obtain resources from other areas. King County will not be able to rely on mutual aid resources, State, or Federal assistance to support local response efforts.

[3] Public Health – Seattle & King County, 2023, Equity Response Annex.

INCIDENT OVERVIEW

HAZARD DEFINITION

Biological incidents are situations in which an agent of biological origins causes a significant local, regional, or national impact. These may include identification of a pathogen or bio-toxin with significant health risks, emergence of a novel infectious disease, or a suspected or confirmed bioterrorism event.

Some biological incidents will require limited response activities from Public Health; other situations will require large-scale response efforts that involve multiple divisions within Public Health and the cooperation and coordination of federal partners (e.g. Centers for Disease Control and Prevention Port Health Stations), Washington State Department of Health (DOH), tribal nations, neighboring jurisdictions, other King County departments, and additional ESF #8 partners (including businesses).

In addition to the definition above, an infectious disease emergency may also include a declaration or order issued by the President of the United States or by the Governor of Washington under RCW 43.06.010(12) in every county in the state concerning any infectious or contagious disease outbreak, including a pandemic, that is of national or regional concern.[4] Special and immediate actions are required to limit the spread of disease to the broader community.

Since 2000, there have been several large-scale biological incidents, which have had a devastating impact on lives and livelihoods around the globe, including the 2003 SARS outbreak, 2009 H1N1 influenza pandemic, 2014 Ebola outbreak, 2015 Zika epidemic, COVID-19 pandemic, and the 2022-2023 mpox outbreak. The complexities of planning for and responding to the emergence of novel pathogens emphasize the need for systematic frameworks for the following: describe the populations impacted and progression of a disease outbreak, weigh potential public health impacts, evaluate pathogen characteristics including transmissibility, risk factors, resistance to countermeasures, and disease severity, assess availability of effective medical countermeasures, determine gaps in healthcare resource access that may exacerbate existing health inequities and, make decisions about interventions.

Based on experiences from different pandemic responses, the Centers for Disease Control and Prevention (CDC) updated its Pandemic Intervals Framework.[5] This framework, while focused on influenza pandemic planning, provides an overview for large-scale biological incidents caused by other pathogens. In this document, phases of a pandemic are described using six intervals. TABLE 1 shows Pandemic Intervals Framework alongside the World Health Organization (WHO) pandemic phases, and state and local indicators for CDC pandemic intervals. The Pandemic Intervals Framework provides recommendations for risk assessment, decision making, and a common methodology to describe pandemic activity that can inform public health actions. The duration of each pandemic interval may vary depending on the characteristics of the pathogen and the public health response. At this time, the CDC Pandemic Intervals Framework has not been updated following the COVID-19 pandemic.

[4] Washington State Legislature. Occupational diseases – Public health emergency – Infectious or contagious diseases.

[5] US Centers for Disease Control and Prevention. 2016. Pandemic Intervals Framework.

RECENT HISTORY

Severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease 2019 (COVID-19), was first identified in Wuhan, China in December 2019. On January 20, 2020, the first case of COVID-19 in the United States was identified in Washington state. The onset of the COVID-19 pandemic occurred at a time of global awakening to the deeply rooted inequities in our healthcare and social institutional structures. Locally, the COVID-19 pandemic further drew back the curtain on the impact of structural racism on health and healthcare in the United States. Through June 12, 2022, King County has had 2,850 deaths (0.6% of positive reported cases). Age-adjusted death rates of confirmed cases are highest among residents who are Native Hawaiian/Pacific Islander (749 per 100,000), American Indian/Alaska Native (452 per 100,000), Hispanic/Latinx (260 per 100,000), and Black (219 per 100,000). Case rates for most communities of color are higher than among White residents (106 per 100,000).

In May 2022, an outbreak of mpox (formerly known as monkeypox virus disease) suddenly and rapidly spread across Europe, the Americas, and all six WHO regions, with 110 countries reporting a combined approximate 87,000 cases and 112 deaths. Cases of mpox were reported from countries where the disease was not endemic and cases were increased in several endemic countries, i.e., most confirmed cases with travel history reported travel to countries in Europe and North America, rather than West or Central Africa where the mpox virus is endemic. The global outbreak affected primarily (but not only) gay, bisexual, and other men who have sex with men and spread person-to-person through touching, kissing, sex, or contact with contaminated sheets, clothes, or needles.

TABLE 1. PREPAREDNESS AND RESPONSE FRAMEWORK FOR NOVEL INFLUENZA A VIRUS PANDEMICS.

WHO Pandemic Phases	CDC Pandemic Intervals	CDC Pandemic Indicators
Interpandemic phase: **Period between influenza pandemics**	***Investigation***. When novel influenza A viruses are identified in people, public health actions focus on targeted monitoring and investigation. This can trigger a risk assessment of that virus with the Influenza Risk Assessment Tool (IRAT), which is used to evaluate if the virus has the potential to cause a pandemic.	Identification of novel influenza A infection in humans or animals anywhere in the world with potential implications for human health.
Alert phase: **Influenza caused by a new subtype has been identified in humans**	***Recognition***. When increasing numbers of human cases of novel influenza A illness are identified and the virus has the potential to spread from person-to-person, public health actions focus on *control* of the outbreak, including treatment of sick persons.	Increasing number of human cases or clusters of novel influenza A infection anywhere in the world with virus characteristics, indicating increased potential for ongoing human-to-human transmission.
Pandemic Phase: Global spread of human influenza caused by a new subtype	***Initiation.*** A pandemic occurs when people are easily infected with a novel influenza A virus that can spread in a sustained manner from person-to-person.	Confirmation of human cases of a pandemic influenza virus anywhere in the world with demonstrated efficient and sustained human-to-human transmission.
	Acceleration. There is an upward acceleration (or "speeding up") of the epidemiological curve as the new virus infects susceptible people. Public health actions at this time may focus on the *use of appropriate non-pharmaceutical interventions* in the community (e.g., school and child-care facility closures, social distancing), as well the *use of medications* (e.g., antivirals) *and vaccines*, if available. These actions combined can reduce the spread of the disease and prevent illness or death.	Consistently increasing rate of pandemic influenza cases identified in the United States, indicating established transmission.
	Deceleration. The deceleration (or "slowing down") stage happens when pandemic influenza cases consistently decrease in the United States. Public health actions include continued vaccination, monitoring of pandemic influenza A virus circulation and illness, and reducing the use of non-pharmaceutical interventions in the community (e.g., school closures).	Consistently decreasing rate of pandemic influenza cases in the United States.
Transition Phase: Reduction in global risk, reduction in response activities, or progression toward recovery actions	***Preparation.*** When pandemic influenza has subsided, public health actions include continued monitoring of pandemic influenza A virus activity and preparing for potential additional waves of infection. It is possible that a second pandemic wave could have higher severity than the initial wave. An influenza pandemic is declared ended when enough data shows that the influenza virus, worldwide, is similar to a seasonal influenza virus in how it spreads and the severity of the illness it can cause.	Low pandemic influenza activity but continued outbreaks possible in some jurisdictions.

HEALTH AND MEDICAL IMPACTS

There are several characteristics of biological incidents that differentiate them from other public health emergencies. First, biological incidents have the potential to suddenly cause illness in a very large number of people and/or animals and can overwhelm healthcare systems. A pandemic outbreak could also jeopardize essential community services by causing high levels of absenteeism in critical workforce for essential services. It is likely that initial doses of vaccines against a new virus will not be available for six to eight months following the emergence of the virus. Basic services, such as healthcare, law enforcement, fire, emergency response, communications, transportation, and utilities, could be disrupted during a pandemic. Additionally, a pandemic, unlike many other emergency events is expected to last for months to years.

In addition to disease characteristics, structural racism is a significant root cause of many health disparities during a biological incident, manifesting through laws and policies that create barriers to equitable and high-quality protective measures and treatment. In addition to individual acts of discrimination, structural racism pervades systems of power, informing decision-making and furthering health inequity. The existence of structural racism within our health and social institutions results in the systematic exclusion of people of color, Indigenous communities, people with disabilities, and incarcerated individuals when decisions are made during a public health emergency, contributing to ongoing health disparities among these groups. 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 based on ability, gender, or socioeconomic status.

The circumstances of biological incidents may vary based on multiple factors, including type of biological agent, scale of exposure, mode of transmission, and the social determinants of health in the areas where the pathogen is spreading. Public health measures to contain outbreaks are especially important for diseases with high morbidity or mortality and limited availability of medical countermeasures. Planning and preparing in advance of a biological incident is critical for an equitable and effective response. Planned response actions, when executed equitably, early, and efficiently, have the potential to limit community transmission, center racial equity and social justice, and reduce health impacts of exposure to an infectious disease or agent.

AUTHORITIES AND RESPONSIBILITIES

AUTHORITIES

Various state and local public officials have overlapping authorities regarding protecting public health and safety. The Governor of Washington, the State Board of Health, the Washington State Secretary of Health, the King County Executive, the King County Board of Health, the executive heads of cities and towns, and the Local Health Officer each can implement authorities within the scope of their jurisdiction aimed at protecting the public's health.

During a pandemic, the presence of overlapping authorities will necessitate close communication and coordination between elected leaders and the Local Health Officer to ensure decisions and response actions are clear and consistent.

A. Governor of Washington State

The Governor has authority to proclaim a state of emergency after finding that a disaster affects life, health, property, or the public peace. RCW 43.06.010(12). The Governor may assume direct operational control over all or part of local emergency management functions if the disaster is beyond local control. RCW 38.52.050. After proclaiming a state of emergency, the Governor has the authority to restrict public assembly, order periods of curfew, and prohibit activities that they believe should be prohibited to maintain life and health. RCW 43.06.220.

B. State Board of Health

The State Board of Health has authority to adopt rules to protect the public health, including rules for the imposition and use of isolation and quarantine, and for the prevention and control of infectious diseases. RCW 43.20.050(2). Local boards of health, health officials, law enforcement officials, and all other officers of the state or any county, city, or town shall enforce all rules that are adopted by the State Board of Health. RCW 43.20.050(4).

C. The State Secretary of Health

The Secretary of Health shall enforce all laws for the protection of the public health, and all rules, regulations, and orders of the State Board of Health. RCW 43.70.130(3). The Secretary also shall investigate outbreaks and epidemics of disease and advise Local Health Officers about measures to prevent and control outbreaks. RCW 43.70.130(5). The Secretary shall enforce public health laws, rules, regulations, and orders in local matters when there is an emergency, and the local Board of Health has failed to act with sufficient promptness or efficiency or is unable to act for reasons beyond its control. RCW 43.70.130(4). The Secretary has the same authority as Local Health Officers but will not exercise that authority unless: (a) the Local Health Officer fails or is unable to do so; (b) by agreement with the Local Health Officer or local board of health; or (c) when in an emergency the safety of the public health demands it. RCW 43.70.130(7).

D. King County Executive

The King County Executive may proclaim a state of emergency within King County when, in the judgment of the Executive, extraordinary measures are necessary to protect public peace, safety, and welfare. K.C.C. 12.52.030.A. Under a state of emergency, the Executive may impose

curfews, close any or all private businesses, close any or all public buildings and places including streets, alleys, schools, parks, beaches, and amusement areas, and proclaim any such orders as are imminently necessary for the protection of life and property. K.C.C. 12.52.030.B.

E. King County Board of Health

The jurisdiction of local Board of Health is coextensive with the boundaries of the county. RCW 70.05.035. The local Board of Health shall supervise all matters pertaining to the preservation of the life and health of the people within its jurisdiction. RCW 70.05.060. The Board shall enforce through the Local Health Officer the public health statutes of the state and the rules promulgated by the State Board of Health and the Secretary of Health. RCW 70.05.060(1). The Board may also enact such local rules and regulations as are necessary to preserve and promote the public health and to provide the enforcement of those rules and regulations. RCW 70.05.060(3).

F. Mayor of Seattle

The Mayor of Seattle may proclaim a state of civil emergency within the city when, in the judgment of the Mayor, extraordinary measures are necessary to protect public peace, safety, and welfare. SMC 10.02.010.A. Under a state of civil emergency, the Mayor may impose curfews, close any or all business establishments, close any or all public buildings and places including streets, alleys, schools, parks, beaches, and amusement areas, direct the use of all public and private health, medical, and convalescent facilities and equipment to provide emergency health and medical care for injured persons, and proclaim any such orders as are imminently necessary for the protection of life and property SMC 10.02.020.

G. Suburban City Executive Heads

Each political subdivision is authorized to exercise emergency functions. RCW 38.52.070. Suburban cities throughout King County may have explicit emergency powers and authorities in their municipal codes.

H. Local Health Officer

The Local Health Officer will exercise powers and duties outlined in RCW 70.05.070. The Local Health Officer has the authority to control and prevent the spread of any dangerous, contagious, or infectious diseases that may occur within his or her jurisdiction RCW 70.05.070(3).

The Local Health Officer will have the following responsibilities:

1. The Local Health Officer shall, when necessary, conduct investigations and institute disease control measures, including medical examination, testing, counseling, treatment, vaccination, decontamination of persons or animals, isolation, quarantine, and inspection and closure of facilities. WAC 246-100-036(3). The Local Health Officer may initiate involuntary detention for isolation and quarantine of individuals or groups pursuant to provisions of state regulations. WAC 246-100-040 through -070.
2. The Local Health Officer has the authority to carry out steps needed to verify a diagnosis reported by a healthcare provider, and to require any person suspected of having a reportable disease or condition to submit to examinations to determine the presence of the disease. The Local Health Officer may also investigate any suspected case of a reportable disease or other condition if necessary and require notification of additional conditions of public health importance occurring within the jurisdiction. WAC 246-101-505(11).

3. The Local Health Officer shall establish, in consultation with local healthcare providers, health facilities, emergency management personnel, law enforcement agencies, and other entities deemed necessary, plans, policies, and procedures for instituting emergency measures to prevent the spread of communicable disease. WAC 246-100-036(1).
4. The Local Health Officer may take all necessary actions to protect the public health in the event of a contagious disease occurring in a school or day care center. Those actions may include, but are not limited to, closing the affected school, closing other schools, ordering cessation of certain activities, and excluding persons who are infected with the disease. WAC 246-110-020(1). Prior to acting, the Local Health Officer shall consult with the State Secretary of Health, the superintendent of the school district or the chief administrator of the day care center and provide them and their board of directors a written decision directing them to take action. WAC 246-110-020 (2).
5. The Local Health Officer's powers are not contingent on a proclamation of emergency by the county Executive or an executive head of a city or town.

RESPONSIBILITIES

A. Public Health – Seattle and King County, Health and Medical Area Command (HMAC)

1. Facilitate countywide pandemic planning and preparedness efforts.
2. Coordinate the community's emergency public health response through ESF #8 and the Regional Disaster Coordination Framework.
3. Provide trainings for HMAC staff and responders on their role and topics such as Incident Command System (ICS), HMAC operations, Washington System for Tracking Resources, Alerts, and Communication (WATrac), and ESF #8 plan and functional annexes.
4. Educate the public, healthcare system partners, response partners, businesses, schools, childcare centers, community-based organizations, and elected leaders about pandemics, expected impacts and consequences, and preventive measures (Reference: *Risk Communication Plan*).
5. Monitoring and ensuring the safety and well-being of responders and public health staff.
6. Conduct county-wide surveillance to track the spread of the human disease and its impact on the community. Through liaison with veterinary, agriculture, and wildlife agencies, facilitate disease surveillance in animals in King County and monitor surveillance data.
7. Identify and declare diseases of public health significance during a biological incident and communicate such declarations to health system partners.
8. Establish a prioritized set of operational objectives and implementation strategies (*Incident Action Plan*) for the countywide health and medical response.
9. Jointly coordinate the accuracy and dissemination of health and medical information to the public through a Joint Information System.
10. Coordinate medical countermeasures requesting, distribution, and dispensing with state and federal partners.
11. Coordinate the implementation of non-pharmaceutical interventions including identifying personal protective equipment (PPE) supply needs and stockpiling.
12. Ensure the collection and development of situational awareness information for the health and medical response (Reference: *Health and Medical Area Command Procedures Manual*).
13. Coordinate planning for and implementation of disease containment strategies and authorities.

14. Provide ongoing technical support within established expectations to the healthcare system including current surveillance guidelines, recommendations for clinical case management, infection control measures, and laboratory testing.
15. Through the Northwest Healthcare Response Network (NWHRN), support the healthcare system's planning and response efforts for medical surge capacity including mass casualty and mass fatality incidents (Reference: *Region 6 Hospital Emergency Preparedness and Response Plan*).

B. Multi-Agency Coordinating (MAC) Group

If needed, a Multi-Agency Coordinating group may be formed and called upon to accomplish the following:

1. Provide policy-level guidance and establish overall direction and priorities for the health, medical and mortuary response across King County. The following parties within the King County healthcare system will participate on the MAC:
   - Local Health Officer.
     - See responsibilities outlined under *Authorities, Section H*.
   - Healthcare partners including veterinary partners.
   - Northwest Healthcare Response Network Executive Council.
     - Comprised of chief executives from the healthcare systems.
     - Informs and advises the Local Health Officer on issues and resource needs within the healthcare system.
   - EMS Medical Directors.
     - Comprised of the EMS Medical Directors for King County and the City of Seattle.
     - Direct the implementation of response protocols for all paramedics and Emergency Medical Technicians in King County.
     - Direct the implementation of the *Emergency Medical Services Pandemic Response Plan*, September 2023.
   - King County Medical Examiner.
     - Directs the county-wide response to mass fatalities events.
     - Maintains legal authorities governing the identification, transportation, and final disposition of human remains during mass fatalities events.
   - MAC Coordinator.
     - Develop briefing materials and communications for MAC Group.
     - Facilitate conference calls and in-person meetings.

An organizational structure utilizing Area Command and MAC to lead the health and medical response across King County will ensure that each agency involved in the response is aware of the plans, actions, and constraints of all others. No agency participating under HMAC will compromise their legal authorities or requirements. Participating agencies will minimize inefficiency and duplication of effort, improve information flow, and combine efforts toward achieving a single set of response objectives.

C. Local Hospitals, Clinics, Providers, and other Health System Partners

1. During a pandemic, all efforts will be employed to sustain the functionality of the healthcare system while maintaining the highest possible level of medical care. To accomplish this, healthcare system partners might need to:

- Limit the provision of healthcare services to patients with urgent health problems.
- Take steps to increase healthcare system capacity for patients who require inpatient care.
- Mobilize, reassign, and deploy staff within and between healthcare facilities to address critical shortfalls.
- Implement patient triage and resource management processes.
- Implement the crisis standards of care framework.[6]
- Provide alternative mechanisms for patients to address non-urgent healthcare needs such as telephone and internet-based (telehealth) consultation.

2. Maximize the healthcare system's ability to provide medical care during a pandemic by working with the Northwest Healthcare Response Network. Specific steps include:
   - Identify and prioritize response issues and resources affecting the county-wide health system during a pandemic.
   - Develop mechanisms to efficiently share information and resources between the healthcare system and HMAC and relevant emergency operations centers, as appropriate. Centralize and consolidate requests as needed.
   - Through the Multi Agency Coordinating Group, coordinate with the Local Health Officer regarding policy level decisions affecting the operations of healthcare system.
   - Assure that healthcare professionals receive relevant communications from HMAC in a timely and efficient manner.
3. Hospitals and other healthcare facilities will develop pandemic response plans[7] consistent with the healthcare planning guidance contained in the *Health and Human Services Pandemic Influenza Plan*[8]. Healthcare facility pandemic response plans will address medical surge capacity and resource management and conservation to sustain healthcare delivery and communication capabilities when routine systems are overwhelmed and resource management and conservation to sustain healthcare delivery and communication capabilities when routine systems are overwhelmed.
4. Hospitals may screen and/or limit individuals from entering the hospital.
5. Healthcare facilities and healthcare providers will participate in local influenza surveillance activities.
6. Hospitals will develop infection control plans to triage and isolate infectious patients and protect staff from disease transmission.

D. Washington State Department of Health

1. Coordinate statewide pandemic planning and preparedness efforts.
2. Coordinate statewide surveillance activities.
3. Operate a CDC Laboratory Response Network public health reference laboratory for testing of novel pathogens.
4. Coordinate submission of pandemic epidemiological data to CDC and dissemination of statewide data and situation updates to local health jurisdictions.
5. Provide state assistance, when available, and request federal assistance to support the local health and medical response.

[6] Washington State Department of Health. 2021. Crisis Standards of Care.
[7] US Centers for Medicare and Medicaid Services. 2021. Updated Emergency Preparedness Guidance.
[8] US Department of Health and Human Services. 2005. HHS Pandemic Influenza Plan.

6. May receive medical countermeasures from the Strategic National Stockpile (SNS) and immediately distribute these supplies to Public Health, first responders, or healthcare providers.
   - In consultation with Public Health, may request and place orders on behalf of Public Health for direct shipment to the department's vaccine depot or selected healthcare providers.
7. Educate and inform the public on the course of the pandemic and preventive measures in coordination with local partners.

E. US Department of Health and Human Services

1. Provide overall guidance on pandemic planning within the United States.
2. Coordinate the national response to a pandemic.
3. Provide guidance and tools to promote pandemic preparedness planning and coordination for states and local jurisdictions.
4. Provide guidance to state and local health departments regarding bioincident and pandemic response, including for prioritization of limited supplies of antiviral medications and vaccines.

F. US Centers for Disease Control and Prevention

1. Conduct national and international disease surveillance.
2. Serve as a liaison to the WHO.
3. Develop reference strains for vaccines and conduct research to understand transmission and pathogenicity with pandemic potential.
4. Develop, evaluate, and modify disease control and prevention strategies.
5. Lead for recommendations regarding disease control measures including administration of pandemic vaccine and guidance for implementation of vaccination programs; monitor vaccine safety.
6. Provide guidance to state and local health departments regarding bioincident and pandemic response, including for prioritization of limited supplies of antiviral medications and vaccines.
7. Provide field teams when available and requested to assist in local pandemic response.
8. Investigate pandemic outbreaks; define the epidemiology of the disease.
9. Monitor the nation-wide impact of a pandemic.
10. Coordinate the stockpiling of antiviral drugs and other essential materials within the Strategic National Stockpile.
11. Activate the SNS when the WHO declares a state of alert and deploy antiviral supplies to each state.
12. Coordinate the implementation of international – US travel restrictions.
13. Under federal authority, implement isolation, quarantine, and social distancing measures on tribal lands, as needed.

G. World Health Organization

1. Monitor global pandemic conditions and provide information updates.
2. Facilitate enhanced global pandemic preparedness, surveillance, vaccine development, and health response.
3. Provide international guidance on responding to the situation. Declare global pandemic phase and adjust phases based on current outbreak conditions.

INITIAL RESPONSE PROCESS

The *Biological Incident Response Annex* is intended for use in any biological incident that requires a response exceeding Communicable Disease Epidemiology and Immunization Section's (CD-Imms) established routine service capacity and/or requires an increased level of communication and coordination between Public Health – Seattle & King County (Public Health) department programs and external partners. Biological incidents are situations in which an agent of biological origins causes a significant local, regional, or national impact. These may include infectious disease outbreaks, identification of a pathogen with significant health risks, emergence of a novel infectious disease, or a suspected or confirmed bioterrorism event. Some biological incidents will require limited response activities from Public Health; other situations will require large-scale response efforts that involve multiple divisions within Public Health and the cooperation and coordination of Washington State Department of Health (DOH), tribal nations, neighboring jurisdictions, other King County departments, and additional Emergency Support Function #8 – Public Health, Medical, and Mortuary Services (ESF #8) partners.

This initial response process also serves as a model for warning and notification among Public Health divisions and programs outside of CD-Imms, such as Environmental Health Services Division (Environmental Health), Community Health Services Division, and other Prevention Division (Prevention) programs such as the Tuberculosis Control program, about local biological incidents or possible threats to the local communities. For responses to suspected or confirmed bioterrorism events, Public Health follows applicable State[9] and Federal[10] guidelines, in addition to the process below.

WARNING AND NOTIFICATION

The initial response process defines the routes of warning to and notification within Public Health of a biological incident. Some situations will warrant consideration of immediate Health and Medical Area Command (HMAC) activation depending on CD-Imms capacity to respond to the incident, while other incidents might include situational monitoring and other assessment steps before an activation is recommended. Biological incident response needs may vary by situation and additional considerations may factor into activation of HMAC. Once activation is recommended, the Public Health Preparedness Section (Preparedness) will convene appropriate staff to begin the process of organizing, prioritizing, and staffing Public Health's response.

WARNING

Public Health receives warning of a potential biological incident through multiple routes, including:

- Routine surveillance and investigations conducted by CD-Imms staff, including reports from DOH, healthcare providers and hospital partners, acute care facilities, clinical laboratories, the public, and others for all suspected, probable, and confirmed notifiable conditions.

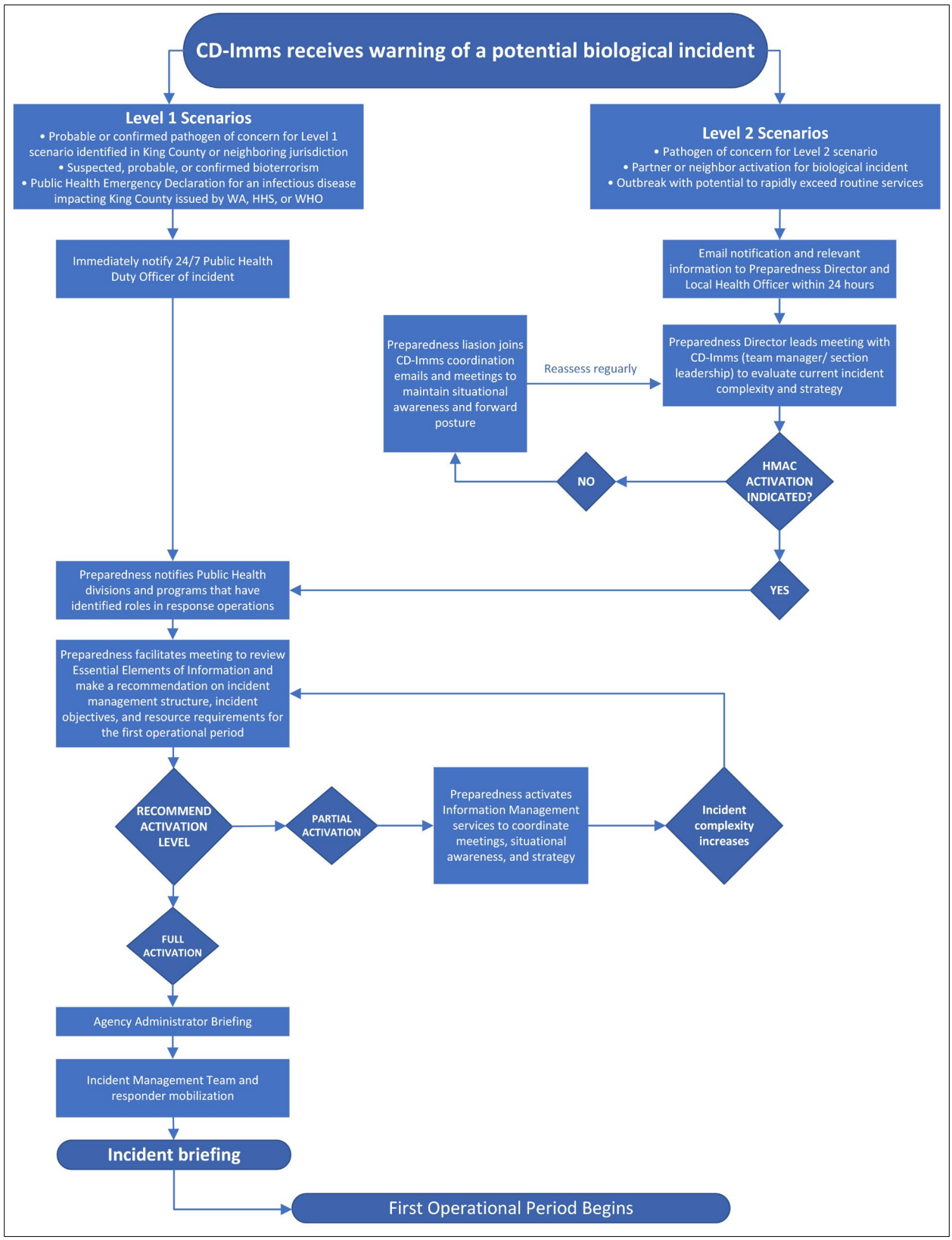
[9] Washington State Department of Health. Bioterrorism and Terrorism.
[10] US Centers for Disease Control and Prevention. Bioterrorism.

- Surveillance reports and alerts from external public health agencies or response partners about biological incidents with the potential to impact King County, such as:
    - World Health Organization (WHO).
    - Centers for Disease Control and Prevention (CDC) via the Health Alert Network (HAN).
    - US Department of Health and Human Services (HHS).
    - The Washington Secure Electronic Communications, Urgent Response and Exchange System (WA SECURES).
    - Northwest Healthcare Response Network (NWHRN) updates and WATrac alerts.
    - Neighboring local health jurisdiction or emergency management.
    - Federal Bureau of Investigation (FBI).
    - BioWatch Alert notification of an airborne pathogen detected by BioWatch program sensors.

NOTIFICATION

Warning of a biological incident may trigger two notification processes across Public Health and key response partners, depending on potential for rapid incident escalation. Please see **Figure 1** for process illustration.

FIGURE 1. FLOW DIAGRAM FOR WARNING OF A POTENTIAL BIOLOGICAL INCIDENT.



Level 1 Scenarios

Level 1 Scenarios include high-consequence pathogens and scenarios with significant potential to cause a severe, large and/or rapidly expanding event requiring a coordinated response.

Public Health defines Level 1 Scenarios as:

- Suspected or confirmed identification of specified pathogen of concern for Level 1 Scenarios or pathogen categories in King County or a neighboring jurisdiction.
- Suspected, probable, or confirmed bioterrorism.
- Public Health Emergency Declaration for an infectious disease impacting King County issued by Washington State, US Department of Health and Human Services (National Public Health Emergency), or World Health Organization (Public Health Emergency of International Concern).

Level 1 scenarios require immediate notification to the 24/7 Public Health Duty Officer and generally necessitate activation of HMAC.

TABLE 2. PUBLIC HEALTH LEVEL 1 SCENARIOS.

Level 1 Scenarios	
The following scenarios require immediate telephone notification to the Public Health 24/7 Duty Officer, Prevention Division Director/Deputy Director, CD-Imms Disease Control Officer, and Local Health Officer. • Probable or confirmed identification of specified pathogen of concern for Level 1 scenarios or pathogen categories in King County or neighboring jurisdiction. • Suspected, probable, or confirmed bioterrorism. • Public Health Emergency Declaration for an infectious disease impacting King County issued by Washington State, US Department of Health and Human Services (National Public Health Emergency), or World Health Organization (Public Health Emergency of International Concern).	
Examples of Pathogens of Concern for Level 1 Scenarios (not an exhaustive list)	
Disease or agent of suspected bioterrorism origin,[11] including but not limited to: • Anthrax (*Bacillus anthracis*) • Cholera (non-travel related) • Plague (*Yersinia pestis*) • Ricin • Smallpox (*Variola major*) • Typhus fever • Viral Hemorrhagic Fevers[12]	Initial case(s) of an emerging infectious disease or biological incident with potential for significant illness or death, including: • Highly pathogenic Coronavirus (MERS-CoV, SARS-CoV-1, Other Novel Coronavirus) • Influenza, novel • Waterborne outbreak (municipal drinking water supply)[13] • Paramyxoviruses (Nipah virus, Hendra virus)

[11] US Centers for Disease Control and Prevention. Bioterrorism Agents / Diseases.
[12] US Centers for Disease Control and Prevention. Viral Hemorrhagic Fevers.
[13] US Centers for Disease Control and Prevention. Water, Sanitation, & Hygiene (WASH)-related Emergencies & Outbreaks.

LEVEL 2 SCENARIOS

Level 2 scenarios are situations in which the scope of Public Health response operations may initially be limited but have the potential to escalate if departmental resources are not immediately reprioritized to quickly respond to the disease. In these cases, CD-Imms might need support and resources from Preparedness to manage communication and resource coordination to effectively expand the Public Health's response capacity.

Public Health defines Level 2 Scenarios as:

- Identification of pathogen of concern for a Level 2 Scenario in King County.
- An outbreak which might quickly exceed CD-Imms' (or relevant Public Health program) initial capacity to manage the investigation and/or communication and coordination across Public Health and ESF #8 partners, including situations that involve:
    - Increased call or electronic message volumes to CD-Imms or other Public Health programs surpassing routine capacity with potential to require surge staffing support.
    - Increased inquiries from media or political representatives that would benefit from centralized and coordinated messaging through public information support.
    - Increased demand for information sharing and coordination with ESF #8 partners or other jurisdictions that would benefit from Information Management or Liaison functions.
    - Need for rapid communication, assessment, distribution, and administration of medical countermeasures.
    - Significant involvement of multiple internal Public Health programs stressing existing pathways for coordination, shared decision making, and exchange of situational awareness.
    - Isolation and quarantine capacity is required as part of the incident response.
    - Investigation or containment activities require resources that surpass routine service capacity.
- Response partner or neighboring jurisdiction Emergency Operations Center (EOC) activation notification for response to a biological incident that may impact King County.

Level 2 scenarios require a notification of the situation, emailed or otherwise, to the acting Preparedness Director and Local Health Officer within 24 hours for situational awareness. Key elements of information relating to the situation, such as scale, potential complexity, population impacted, and additional relevant information regarding programmatic capacity should be shared as known. This information will inform an assessment of incident complexity, the need for ongoing situational awareness, and the capability to quickly expand support should HMAC activation be indicated.

TABLE 3. PUBLIC HEALTH LEVEL 2 SCENARIOS.

Level 2 Scenarios	
The following scenarios require notification to the Preparedness Director and Local Health Officer within 24 hours for ongoing situational awareness and assessment of incident complexity. • Identification of a pathogen of concern for a Level 2 scenario in King County. • An outbreak or concern for a sudden increase in prevalence of any pathogen in King County with the potential to rapidly exceed routine services provided by CD-Imms (or relevant Prevention Division program), necessitating a large scale, coordinated response requiring multiple division and/or program areas. • Response partner or neighboring jurisdiction EOC activation notification for an infectious disease response that may impact King County. Additional notifications may be required per CD-Imms (or relevant Prevention Division program) protocol.	
Examples of Pathogens of Concern for Level 2 Scenarios (this list is not exhaustive)	
• Arboviral disease – locally acquired (West Nile virus, dengue, chikungunya, Zika, eastern and western equine encephalitis, St Louis encephalitis, and Powassan). • *Candida auris* (outbreak). • Diphtheria (toxigenic *C. diphtheriae* infections). • Emerging condition with outbreak potential. • Flaviviruses. • *Haemophilus influenzae* (invasive disease, children aged < 5 years). • Hantavirus pulmonary syndrome (cluster of locally acquired cases). • Hepatitis A (outbreak). • Hepatitis C (outbreak).	• Legionellosis (outbreak). • Lyme Disease (local exposure only). • Measles. • Meningococcal disease (outbreak). • Mumps (outbreak). • Poliovirus infection. • Rabies (human, suspected or confirmed). • Rubella (acute disease). • Large outbreaks of suspected foodborne origin. • Plague (*Yersinia pestis*) (not suspected intentional). • Tuberculosis (in congregate settings, schools, or childcare setting).

ASSESSMENT

For Level 1 Scenarios, Preparedness will work with CD-Imms and other relevant programs and partners to begin collecting essential elements of information to inform initial incident action planning and

response activities in anticipation of an HMAC activation. For Level 2 Scenarios, an ongoing period of situational awareness and assessment to determine need for HMAC activation is described below.

LEVEL 2 SCENARIO SITUATIONAL AWARENESS AND ASSESSMENT

When an emergency does not indicate immediate HMAC activation, Preparedness will take a forward-leaning posture through ongoing situational awareness and assessment of evolving incident complexity.

Following notification by CD-Imms (or relevant Prevention Division program), the Preparedness Director will lead an initial meeting with CD-Imms or relevant Prevention Division program (team manager/section leadership) and Prevention Division Director/ Deputy Director, or their designees, to evaluate current incident complexity using the *Incident Complexity Assessment*. If current support needs for communication, coordination, and resourcing operations do not indicate activation of HMAC, parties will establish a strategy for ongoing monitoring. The Local Health Officer will participate in or be promptly informed of result of this assessment.

The strategy should establish:

- Incident-specific thresholds which may indicate partial or full HMAC activation.
- Potential resource, administrative and other response needs.
- A meeting cadence between the Preparedness Director and CD-Imms or relevant Prevention Division program (team manager/section leadership), or their designees, to reevaluate for any changes in incident complexity.
- An identified Preparedness staff member to act as a liaison and ensure situational awareness is maintained between CD-Imms (or relevant Prevention Division program) and Preparedness.
- CD-Imms (or relevant Prevention Division program) incident coordination emails and meetings in which to include a Preparedness staff liaison for situational awareness.

Public Health's Preparedness Section and CD-Imms (or relevant Prevention Division program) will maintain this posture until:

- Incident trajectory does not indicate potential for the current outbreak or incident to rapidly exceed routine services and resources managed by CD-Imms (or relevant Prevention Division program).
  or
- Incident-specific thresholds or incident complexity indicate activation of HMAC to support divisions and programs in preparing for and responding to a biological incident emergency.

ESSENTIAL ELEMENTS OF INFORMATION (EEI)

For both Level 1 and Level 2 responses, ongoing situational awareness should include an assessment of essential elements of information (EEI) to develop a shared understanding of the situation and inform assessment of incident needs and complexity. Key information areas for a biological incident response include:

- *Scale*
  - Current and projected outbreak size.
  - Exposure sites.

    - Impacted population(s).
- *Urgency*
    - Disease characteristics, including transmissibility, severity, and clinical outcomes.
    - Availability of effective treatment and containment measures.
- *Complexity*
    - Political sensitivity and media interest.
    - Multitude of partners and actors.
    - Disease-specific factors, especially those including ongoing zoonotic transmission.
    - Potential resource, administrative, and other response needs.
- *Capacity*
    - Competing Public Health priorities.
    - Demand for services.
    - Funding and staff availability.
- *Equity*
    - Impacted population vulnerability.
    - Additional service needs.

INITIAL INCIDENT ACTION PLANNING

When HMAC activation is indicated, Preparedness will notify Public Health divisions and programs that have identified roles in response operations, which may include:

- Administration (Admin).
- Assessment, Policy Development & Evaluation Unit/ Chronic Disease and Injury Prevention (APDE/CDIP).
- Communications.
- Environmental Health Services (EH).
- Emergency Medical Services (EMS).
- Medical Examiner's Office (MEO).
- Office of Equity and Community Partnerships (OECP).
- Preparedness Section.
- Prevention Division.
- Nursing Office.

Public Health divisions and programs with identified roles in response operations will be asked to attend a meeting facilitated by Preparedness to review essential elements of information (EEIs) regarding the biological incident and make a timely and informed decision on the need to initiate incident action planning.

Prior to meeting, Preparedness will seek to gather information from King County Office of Emergency Management (King County OEM), City of Seattle Office of Emergency Management (Seattle OEM), Washington State Department of Health (DOH), and the Northwest Healthcare Response Network (NWHRN) regarding any current or planned actions by local emergency management, other city and county departments, and healthcare systems. These actions may further inform the need to initiate incident action planning.

After reviewing EEIs and any other critical information requirements, meeting participants should:

- **Make a recommendation on an appropriate incident management structure.** Given the anticipated incident complexity for most infectious disease responses, it is recommended that Public Health's HMAC be partially or fully activated to support divisions and programs in preparing for a biological incident and managing any subsequent emergency response operations.
- **Make a recommendation on incident objectives and resource requirements for the first operational period.** Public Health should manage biological incidents by developing objectives that define what must be accomplished to protect community health and limit health disparities. The availability of personnel, equipment, supplies, and facilities should be considered when developing objectives. The length of the operational period (e.g., 8 hours, 12 hours, 24 hours, 1 week) will be determined by the needs of the incident, dependent on disease characteristics, evolving epidemiology, and ongoing impact on the community. In the case of a bioterrorist incident, ongoing needs would also be determined on the identification and neutralization of the source of the event. In rapidly escalating or highly complex incidents, the operational periods should be shorter to allow for an effective response to rapidly evolving events.

Participants should share meeting outcomes with other Public Health staff within their teams who may be responsible for responding to the biological incident. The following information should be shared as available and as authorized to responders:

- Trigger or level of activation met.
- Consolidated EEIs and other critical information requirements.
- Projected workforce needs and potential assignments.
- Any pre-incident steps staff need to take to prepare to respond.
- Responder safety information, including disease-specific PPE and infection control recommendations.

Public Health's *Workforce Mobilization Annex* includes additional considerations for communicating with potential responders.

AGENCY ADMINISTRATOR BRIEFING

Preparedness will schedule an *Agency Administrator Briefing* with the Public Health Director, Public Health Deputy Director, and Local Health Officer (LHO) and present the following:

- Trigger or level of activation met.
- Consolidated EEIs and other critical information requirements.
- Recommended incident management structure.
- Set and confirm expectations of response scope and operational capacity.
- Recommended incident objectives and resource requirements for the first operational period.
- Potential resource, administrative and other response needs.

Other Public Health Office of the Director (ODIR) staff may also attend the Agency Administrator briefing at the request of the Director of Public Health Director, Public Health Deputy Director, or Local Health Officer (LHO). Preparedness may also ask other Public Health divisions and programs that have identified roles in response operations to attend.

Briefing participants should agree to a final incident management structure as well as incident objectives and resource requirements for the first operational period.

INCIDENT MANAGEMENT TEAM AND RESPONDER MOBILIZATION

If HMAC is activated, Preparedness will mobilize staff from its HMAC Incident Management Team (IMT) roster to fill Command and General Staff positions within the Incident Command System (ICS). The following ICS positions are typically staffed by the HMAC IMT:

- Agency Administrator
- Incident/Area Commander
- Safety Officer
- Liaison Officer
- Equity Officer
- Public Information Officer
- Operations Section Chief
- Planning Section Chief
- Logistics Section Chief
- Finance and Administration Section Chief

The Area Commander (AC) will staff Command and General Staff positions as needed to manage the incident's coordination and organization, information sharing, equity considerations, and resource needs. They may also choose to staff more positions depending on what is needed to facilitate effective incident management.

Public Health divisions and programs with identified roles in biological incident response operations are responsible for assigning staff as responders to the HMAC Operations Section. Staffing for the following response areas within the Operations Section may be required:

- Epidemiology and Surveillance (including disease investigations and testing).
- Data Analysis and Management.
- Medical Countermeasures (including vaccination and therapeutics).
- Nonpharmaceutical Interventions (including PPE, isolation, and quarantine).
- Health Guidance and Public Information (including community mitigation, community wellbeing, and the Public Information Contact Center (PICC).

Public Health's *Workforce Mobilization Annex* includes additional considerations for identifying and assigning responders.

HMAC activation is assumed in the proceeding sections of this Annex, but if HMAC is not activated, Public Health divisions and programs are still encouraged to use National Incident Management System (NIMS)-compliant concepts to effectively manage the impacts of a biological incident as they carry out response operations. Even if not initially activated, HMAC can also be partially or fully activated in support of divisions and programs as a biological incident unfolds.

INCIDENT BRIEFING

The Area Commander should deliver an *Incident Briefing* to the HMAC IMT and other responders. An *ICS 201 Incident Briefing* may be used to help prepare for and facilitate the briefing. An *HMAC Activation Notice* should be sent to Public Health leadership and staff and external partners, the HMAC IMT, and any other responders.

Following the briefing, HMAC begins its first operational period of the response.

OPERATIONS INTRODUCTION

The Incident Briefing leads into the initial operational period and marks the start of proactive incident management for an infectious disease response. Facilitated by the Health and Medical Area Command (HMAC) Planning Section, an *Incident Action Plan (IAP)* should be developed for the first operational period and then executed. The following objectives and strategies should be considered for inclusion in an IAP for an infectious disease response.

OVERVIEW

This section of the *Biological Incident Response Annex* serves to document the full scope of Public Health's concept of operations for responding to a biological incident. Different objectives and strategies may be selected to respond effectively and with a focus on health equity during different pandemic intervals. The following listed objectives and strategies are recommendations only; **all objectives can be used at any point during a biological incident response,** as required by the scope of the response and at the discretion of the Area Commander.

The following response objectives are organized by response areas which fall within the scope of *Emergency Support Function #8 – Public Health and Medical Services* (ESF #8). They include:

- Epidemiology, Surveillance, and Data
- Health Guidance and Public Information
  - Public Information
  - Guidance synthesis and dissemination
  - Public Information Contact Center (PICC) Services
- Information Management
- Medical Countermeasures
  - Vaccination
  - Therapeutics
- Non-pharmaceutical Interventions
  - Infection Control
  - Personal Protective Equipment
  - Isolation and Quarantine
- Responder Safety and Wellbeing
- Testing

A brief description of each response area is provided below. Objectives are intended to inform resource and operational priorities for each operational period of a response and are captured in the Incident Action Plan's *ICS 202* document.

RESOURCING OPERATIONS

Public Health operations require resources and personnel to be reprioritized, acquired, staged, transported, dispensed, tracked, and eventually demobilized throughout the course of a response. There are three critical resourcing dependencies which impact the status of Public Health's preparedness and response capabilities: finance, policy, and critical infrastructure. Limitations and

stipulations in these areas constrain the ability to rapidly activate and conduct emergency response operations.

During the initial response process, a review of needs in these three areas should be conducted prior to the first operational period. Elements to consider include:

FINANCE

- Available emergency funding sources.
- Emergency time codes.
- Existing memorandums of agreement or understanding (MOUs), contracts, and emergency contracting processes.

POLICY

- Federal, state, and local policies and emergency rulings relating to biological incident response capabilities. Changes to these policies during a response may supersede planned assumptions and processes, particularly with respect to laboratory testing, medical countermeasures, and non-pharmaceutical interventions.
- County and Department contracting policies.
- County and Department policies and protocols relating to language access services, such as translation, interpretation, and a culturally informed review of material for distribution.
- County and Department staffing policies and labor agreements relating to deployment of staff outside their normal duties, particularly with respect to public health nurses and Environmental Health Division staff.

CRITICAL INFRASTRUCTURE

Resources must be diverted from steady state routine operations to support an emergency response. When sufficient resources and critical infrastructure such as personnel, facilities, equipment, supplies, and funding are not available, it delays the ability to carry out response operations and provide support to affected communities. Further, critical infrastructure must be supported by common emergency response organizational structures, decision-making frameworks, and information sharing networks that maximizes its use. Given historical responses to infectious disease outbreaks, **capabilities that may have insufficient critical infrastructure or have insufficient support include**:

- **Equity and community-centered processes**: funding and staffing may be significantly reduced for positions that built key relationships with communities during responses once response operations are demobilized, this has the potential to create barriers to positive, sustained relationships with communities; funding and training opportunities for Public Health staff to practice developing community- and accessibility-centered approaches during response are essential; additional contracts, staffing, translation, and technical advisor positions are necessary to adequately staff and carry out the identified equity objectives and strategies in this annex.
- **Medical countermeasures**: resolving conflicting decision-making authority for prioritization of limited testing, treatment, and vaccination resources; limited resources to support Public Health-led distribution, dispensing, and administration directly to partners and communities; Public Health laboratory and clinic service capacity; ensuring alignment process with

Washington State Department of Health (DOH) and neighboring local health jurisdictions in regional efforts and resource prioritization and allocation.

- **Isolation and Quarantine (IQ):** planning for IQ sites and services, such as hotel, motel, and adult family home availability and related contracts; ability to use of DOH IQ site; resources required to establish an IQ site or facility; availability of staff with behavioral health training to triage and support complex guest needs.
- **Care coordination:** define triggers for *Emergency Support Function #6 – Mass Care* (ESF #6) support during early stages of infectious disease spread; Public Health staff and resources to provide these services directly; necessary transportation contracts, resources, and staffing.
- **Surge staffing:** foundational department staffing; budget constraints; needed employee scope of work and reassignment procedures; needed mechanisms for reassignment.
- **Guidance and information:** Public Health resources to support translation, interpretation, and culturally appropriate outreach needs; availability of existing translations of key biological incident response information.

During the initial stages of a biological incident, there may be an opportunity to *contain or limit the spread*[14] of the disease and it is critical to adequately resource priority strategies as quickly as possible. Policies, funding, and improved critical infrastructure in the above areas will directly support quicker, more effective biological incident response operations across King County.

USING OBJECTIVES AND STRATEGIES

The following objectives and strategies are arranged to both guide the development of incident priorities and strategic direction and direct operational staff to relevant guidance and operational documentation.

PLANNING AND PRIORITIZING RESPONSE ACTIVITIES

The objectives can be used to inform development of the *Incident Action Plan*, documented in *ICS 202*. Objectives are templates to be adapted to fit the response scope and remain responsive to community needs. By identifying lead and support positions, the objectives below can also support development of an initial incident organizational chart and better identify relevant positions required to manage the activated response areas.

The *Lead* and *Support* components refer to HMAC functional areas, organizational elements, and leadership positions, unless otherwise stated (King County Human Resources Department, King County Information Technology (IT), etc.). Identified *Lead* and *Support* roles may include command staff and functional areas, such as the HMAC Planning Section, and key organizational elements within the HMAC Operations Section, such as an *Epidemiology and Surveillance Branch* or the *Community Mitigation and Wellbeing Branch*.

While these elements are named in the *Concept of Operations* below, there is no one way to structure the response to a biological incident. HMAC's organizational structure will develop in a modular fashion based on the incident's size and complexity. A single position may be enough to oversee isolation and quarantine response activities in a small-scale response, or an entire *Isolation and Quarantine Group*

[14] Prevent Epidemics. Box It In: Executive Summary.

may be required. Leads are identified to ensure accountability for each objective and strategy, with the understanding that supervisory positions may delegate responsibility and supervisory levels may be added to the organizational structure as needed.

OPERATIONS SECTION USE

Objectives can also be used to quickly find operational documents to support the identified strategies and carry out tactical activities by Operations Section branches. Relevant documents are linked as *Resources*. These documents serve to direct responders from this annex to Public Health's virtual response space, which includes more operational documents and response tools. The objective and strategy layout includes (see FIGURE 2):

FIGURE 2. OPERATIONS SECTION LAYOUT.

Response Area:

A defined scope of response activities within the responsibilities defined in *ESF #8.*

Objective:
High level priority action statement which aligns with scope of Public Health's roles and responsibilities outlined in *ESF #8*.

- *Strategy*:
  Targeted action statement relating to the objective. Not all strategies may be implemented; they are strategies to select or prioritize based on the biological incident.
  - **Lead:**
    HMAC element responsible for carrying out the objective and strategy.
  - **Support:**
    HMAC element with whom the *Lead* should coordinate with while carrying out the response activity. This may include external partners, like King County Office of Emergency Management or King County Department of Human and Community Services.
    - **Resource:**
      Documents which may include further guidance or information to support carrying out an objective or strategy, including: 1) existing Public Health response documents which can inform the objective/strategy, such as the *HMAC Playbook* and procedures, *Equity Response Annex*, *Risk Communications Annex*; 2) a DOH, CDC, or relevant guidance and evidence-based document which informs how this objective/strategy should be carried out, such as the *WA DOH NPI Guide*.

CONCEPT OF OPERATIONS

The following section provides a description of each response area and a list of objectives and strategies within their scope of response.

1 | EPIDEMIOLOGY, SURVEILLANCE, AND DATA

The Epidemiology and Surveillance response operations will primarily focus on establishing a case definition and identifying cases, contacts of cases and other exposed persons, the populations most at risk, characterize the clinical illness and severity, identifying and responding to outbreaks in the community, identifying source(s) of the infectious disease emergency, and coordinating with laboratory services. The information obtained by epidemiology and surveillance activities will be used to guide response activities including but not limited to disease containment, medical countermeasures needs and distribution, non-pharmaceutical interventions, situational awareness and messaging to response partners and the public.

Data response operations emphasize maintaining an efficient data system that stores and analyzes rapidly changing epidemiological surveillance data before, during, and after an infectious disease response. During an infectious disease response, the *Data Branch* will identify data sources to inform response operations, provide analyses, and develop surveillance reports that facilitate informed decision-making by response leadership. The branch will also provide subject matter expertise to inform the development of public messaging and guidance to response partners. The branch's analyses, along with information gathered through case interviews, help identify trends, hotspots, and emerging challenges, enabling the identification and implementation of proactive response measures. In addition, the branch develops data visualizations and dashboards that are accessible to the public and complement the implementation of disease response activities.

In an infectious disease response, the *Epidemiology and Surveillance Branch* and *Data Branch* will work closely together to ensure efficient response operations. Information gathered through contact tracing and disease investigations by the Epidemiology and Surveillance team will bolster the analyses of the *Data Branch*. Additionally, insights generated by the *Data Branch* will contribute to refining surveillance strategies and targeting outreach and interventions. Consequently, the objectives and strategies outlined in this section incorporate the interplay of response operations between the *Data Group* and *Epidemiology and Surveillance Branch,* while also providing a high-level overview of the independent operations of each of the two teams.

DETERMINE AND PREPARE

OBJECTIVE: IDENTIFY APPROPRIATE COUNTYWIDE DISEASE SURVEILLANCE STRATEGIES AND COORDINATE WITH LOCAL, REGIONAL, AND NATIONAL PARTNERS ON SURVEILLANCE STRATEGIES AND REPORTING.

- *Strategy*: Use existing national, state, and local data sources and/or information to assess disease characteristics and additional essential elements of information to determine appropriate local surveillance and disease investigation activities.

    - **Lead**: Epidemiology and Surveillance Branch; Data Branch.
- *Strategy*: Coordinate surveillance activities with the disease control activities of the CDC, state agencies, and health departments in adjacent jurisdictions (i.e., aligning case definitions, identifying populations at risk, routes of transmission, new sources of the disease agent, etc.).
    - **Lead**: Area Commander; Data Branch; Epidemiology and Surveillance Branch.
    - **Support**: Operations Section Chief.

OBJECTIVE: DEVELOP TOOLS AND SYSTEMS TO CARRY OUT CASE INVESTIGATIONS, DATA COLLECTION, AND ANALYTICS.

- *Strategy*: Develop informatics infrastructure including processes for data management, cleaning, integration, transfer, and analyses.
    - **Leads:** Data Branch; Epidemiology and Surveillance Branch.
- *Strategy*: Develop data collection forms and databases based on epidemiology of the infectious disease.
    - **Leads:** Data Branch; Epidemiology and Surveillance Branch.
- *Strategy*: Develop investigation protocol, toolkit, and other materials relevant to the epidemiology of the infectious disease to support provision of standardized guidance that synthesizes national/state/local guidance on mitigating disease spread for external partners.
    - **Lead**: Epidemiology and Surveillance Branch.
    - **Support**: Data Branch.

OBJECTIVE: PROVIDE GUIDANCE ON LOCAL EPIDEMIOLOGY AND INFECTION CONTROL PRACTICES TO PUBLIC, HEALTHCARE PROVIDERS, OTHER RESPONSE PARTNERS, AND COMMUNITY PARTNERS.

- *Strategy*: Develop standardized guidance/letters that synthesize national/state/local guidance for external partners
    - **Leads**: Epidemiology and Surveillance Branch; Local Health Officer; Public Information Officer.
- *Strategy*: Coordinate with internal partners to translate communications materials into the relevant languages
    - **Leads**: Epidemiology and Surveillance Branch; Public Information Officer.
        - **Resource**: *Risk Communications Annex.*
        - **Resource**: *Equity Response Annex.*

OBJECTIVE: IDENTIFY EPIDEMIOLOGICAL INVESTIGATION AND DATA AND ANALYTICS DATA/INFORMATICS AND STAFFING NEEDS AND DEVELOP TOOLS AND PROCESSES TO TRAIN STAFF TO CARRY OUT EPIDEMIOLOGICAL INVESTIGATIONS.

- *Strategy*: Develop a sustainable Epidemiology, Surveillance, and Data staffing structure that meets the needs and complexity of response operations.
    - **Lead**: Epidemiology and Surveillance Branch; Data Branch.
    - **Support**: Logistics Section.
        - **Resource**: *Workforce Mobilization Annex.*
- *Strategy*: Identify training needs for Epidemiology, Surveillance, and Data response staff
    - **Leads**: Operations Chief; Epidemiology and Surveillance Branch; Data Branch.
    - **Support**: Logistics Section.

- Strategy: Identify data collection, cleaning, analysis, and reporting mechanisms that may be needed based on the epidemiology of the disease.
    - **Lead**: Data Branch.

IMPLEMENT

OBJECTIVE: CARRY OUT CASE AND CONTACT INVESTIGATIONS TO DETERMINE THE CAUSE OF DISEASE, THE SOURCE OF DISEASE, THE MODE OF TRANSMISSION, CLINICAL MANIFESTATIONS, RISK FACTORS FOR DISEASE, EXPOSURES AND ANY OTHER FACTORS THAT MAY BE ASSOCIATED WITH ILLNESS.

- *Strategy*: Implement active and passive symptom monitoring processes for the public and response staff as appropriate and determine a cadence for reporting surveillance activities
    - **Lead:** Operations Section Chief; Epidemiology and Surveillance Branch; Data Branch
- *Strategy*: Collect information about suspected and confirmed cases, possible contacts, other exposed persons and exposure risk settings, disease characteristics, and clinical characteristics in a methodologically appropriate and efficient manner.
    - **Lead:** Epidemiology and Surveillance Branch; Data Branch.
- *Strategy:* Conduct facility investigations and provide subject matter expertise around coordination of response activities focused on those at greatest risk and those most negatively impacted (e.g., healthcare facilities, long-term care facilities, homeless shelters, Emergency Medical Services (EMS), correctional facilities, and other high-risk congregate facilities).
    - **Lead:** Operations Section Chief; Epidemiology and Surveillance Branch; Data Branch.

OBJECTIVE: COORDINATE, ANALYZE, AND/OR UNDERTAKE LABORATORY TESTING AS REQUIRED TO MONITOR THE EMERGENCY AND FOR INDIVIDUAL PATIENT CARE.

- *Strategy*: Establish and maintain laboratory testing criteria with WA PHL, KC PHL, and commercial laboratories.
    - **Lead:** Epidemiology and Surveillance Branch.
- Strategy: Staff testing response unit as needed.
    - **Lead:** Epidemiology and Surveillance Branch.
- *Strategy*: Establish and maintain internal specimen tracking process (if coordinating testing via DOH/CDC).
    - **Lead:** Epidemiology and Surveillance Branch.
    - **Support**: Data Branch.
- *Strategy*: Obtain, prioritize, and submit specimens for laboratory testing.
    - **Lead:** Logistics Section; Epidemiology and Surveillance Branch.
    - **Support**: Safety Officer.

OBJECTIVE: PROVIDE SUBJECT MATTER EXPERTISE ON SURVEILLANCE AND EPIDEMIOLOGY TO HEALTHCARE PROVIDERS/FACILITIES AND OTHER HIGH RISK NON-HEALTHCARE SETTINGS.

- *Strategy:* Prepare data for reporting and surveillance by integrating data sources, cleaning data, applying case and outbreak definitions to the data, and setting up data dashboards/reports.

  - **Lead**: Data Branch.
  - **Support**: Epidemiology and Surveillance Branch; Public Information Officer.
- *Strategy*: Coordinate with relevant HMAC Operations teams on laboratory testing, treatment guidelines, and infection control guidance.
  - **Lead***:* Data Branch; Epidemiology and Surveillance Branch.

OBJECTIVE: PROVIDE SUBJECT MATTER EXPERTISE ON INFECTION CONTROL TO HEALTHCARE PROVIDERS/FACILITIES AND OTHER HIGH RISK NON-HEALTHCARE SETTINGS.

- *Strategy*: Provide coordinated guidance, advice on infection control, and surveillance-related communications to local health partners (i.e., UW/HMC Health System, NWHRN, health advisories) and community partners (i.e., HCHN/HSP network, community health boards, school/childcare networks, animal facilities) regarding epidemiology, testing, infection control, and treatment guidelines.
  - **Lead**: Public Information Officer; Data Branch; Epidemiology and Surveillance Branch; Local Health Officer.
- *Strategy*: Coordinate with Community Mitigation and Wellbeing Branch, King County Office of Emergency Management and Washington State Department of Health on the allocation and distribution of personal protective equipment in accordance with the statewide guidelines for prioritization.
  - **Lead**: HMAC Operations leadership; Epidemiology and Surveillance Branch.
  - **Support:** Data Branch.

MONITOR AND ASSESS

OBJECTIVE: MONITOR AND ASSESS IMPLEMENTED EPIDEMIOLOGY, SURVEILLANCE, AND DATA RESPONSE STRATEGIES.

- *Strategy*: Adjust implementation to active and passive disease monitoring processes as needed.
  - **Lead:** Epidemiology and Surveillance Branch; Data Branch.
- *Strategy*: Monitor disease trends to assess for changing needs, evaluate effectiveness of strategies to drive continuous quality improvement in response activities, and modify strategies as needed.
  - **Lead:** Epidemiology and Surveillance Branch; Data Branch.
- *Strategy:* Utilize community feedback mechanism and data to monitor and assess implemented strategies, evaluate effectiveness, and modify strategies as needed.
  - **Lead:** Epidemiology and Surveillance Branch; Data Branch; Community Mitigation and Wellbeing Branch.
- *Strategy*: Expand capacity for disease investigation, community-wide testing, non-pharmaceutical intervention strategies, and medical surge resources, to support changes in implementation of non-pharmaceutical intervention strategies, as needed.
  - **Lead:** Logistics Section; Epidemiology and Surveillance Branch; Data Branch.

INTEGRATE

OBJECTIVE: PROVIDE SUBJECT MATTER EXPERTISE AND TECHNICAL GUIDANCE TO INTEGRATE ACTIVITIES ACROSS HMAC STRUCTURE AND IN ALIGNMENT WITH JURISDICTIONAL PARTNERS.

- *Strategy***:** Provide technical input on surveillance, epidemiology, and clinical issues for the development of internal and external guidance, communications, and policy development.
    - **Lead***:* Data Branch Team; Epidemiology and Surveillance Branch.
    - **Support***:* Public Information Officer; Community Mitigation and Wellbeing.
- *Strategy*: Consistently coordinate with HMAC leadership, King County Office of Equity and Social Justice, and community partners to assess communities' needs and seek input on key strategies for at-risk populations.
    - **Lead**: Data Branch; Epidemiology and Surveillance Branch.
- *Strategy*: Provide subject matter expertise through data and guidance to *Community Mitigation and Wellbeing Branch* and *Isolation and Quarantine Group*.
    - **Leads**: Isolation and Quarantine Group; Epidemiology and Surveillance Branch; Data Branch.
    - **Support**: Equity Officer.
- *Strategy*: Participate in coordination of regional medical surge operations, such as community wellness, alternate care systems and crisis standards of care.
    - **Lead**: Operations Section Chief.
- *Strategy*: Coordinate data reporting with *Public Information Officer* and *Community Mitigation and Wellbeing Branch*.
    - **Lead**: Data Branch; Public Information Officer.
    - **Support**: Community Mitigation and Wellbeing; Equity Officer.
- *Strategy:* Coordinate with *Safety Officer* to provide technical guidance on standards and guidelines for responder safety and health.
    - **Lead**: Safety Officer; Epidemiology and Surveillance Branch.
    - **Support**: Public Information Officer; Equity Officer.
- *Strategy:* Coordinate with *Logistics Section* for staff, supplies, and resources that may be needed to support epidemiology, surveillance, and data operations.
    - **Lead**: Data Branch; Epidemiology and Surveillance Branch.
    - **Support**: Logistics Section; Equity Officer.

2 | HEALTH GUIDANCE AND PUBLIC INFORMATION

Providing accurate, timely, and accessible information about disease outbreaks and emerging infections to the public, healthcare providers, and response partners is integral to an infectious disease response. Coordination of federal, state, and local health guidance ensures that providers and the public receive clear and consistent information. Expanding collaborations beyond traditional state and territorial public health partners to include impacted and at-risk community groups is a key component for effectively and inclusively developing and disseminating information about an emerging infectious disease.

Response operations focused on Health Guidance and Public Information emphasize collaboration across response teams to create timely, evidence-based communications that are inclusive of community groups. It is well-documented that the accessibility and comprehensibility of health information significantly impact the public's response to infectious diseases and biological incidents. Consequently, disseminating health guidance in multiple formats and languages is instrumental in reaching different community groups, reducing transmission, and ensuring adherence to recommended interventions. Central to the objectives and strategies outlined below are rooted in scientific rigor, equity-based best practices, and a commitment to inclusivity in risk communication.

These objectives and strategies describe response activities conducted by the Public Information Officer and their support staff, *Communications Response Team*. The guidance development and outreach components describe response activities overseen by a *Community Mitigation and Wellbeing Branch*. As communications and guidance development are cross cutting functions, a *Health Guidance and Public Information Task Force* may need to be created, and should include staff with communications, equity, policy, and disease-specific subject matter expertise. Communications technical advisors may also be embedded in other organizational units across the Operations Section as needed.

DETERMINE

OBJECTIVE: DETERMINE APPROPRIATE RISK COMMUNICATIONS STRATEGIES TO PROVIDE ACCURATE AND ACTIONABLE INFORMATION TO IMPACTED COMMUNITIES, RESPONSE PARTNERS, AND THE PUBLIC.

- *Strategy*: Assess essential elements of information (EEIs) to inform an initial assessment of the situation.
    - **Lead***:* Public Information Officer.
- *Strategy*: Develop recommendations, including identified resource needs, for HMAC Command Staff regarding implementing risk communications strategies.
    - **Lead***:* Public Information Officer.
- *Strategy*: Approve recommendations and planning steps.
    - **Lead**: Public information Officer.
    - **Support**: Area Commander; Operations Section Chief.
- *Strategy*: Staff relevant HMAC positions to manage implementation of recommendations.
    - **Lead***:* Public Information Officer.

OBJECTIVE: DETERMINE GUIDANCE DEVELOPMENT AND DELIVERY NEEDS BASED ON INFECTIOUS DISEASE CHARACTERISTICS AND AFFECTED POPULATION.

- *Strategy*: Assess essential elements of information (EEIs) to inform an initial assessment of the situation.
    - **Lead***:* Public Information Officer.
    - **Support:** Epidemiology and Surveillance Branch*;* Equity Officer; Operations Section Chief
- *Strategy*: Develop recommendations, including identified resource needs, for HMAC Command Staff regarding implementation of guidance development strategies.
    - **Lead***:* Public Information Officer.
    - **Support:** Epidemiology and Surveillance Branch*;* Equity Officer; Operations Section Chief; Logistics.
- *Strategy*: Approve recommendations and planning steps.
- *Strategy*: Staff relevant HMAC positions to manage implementation of recommendations.
    - **Lead***:* Public Information Officer.
    - **Support***:* Logistics, Operations Section Chief.
- *Strategy:* Embed *Communications Response Team* staff and communications subject matter experts within key Operations Section branches to coordinate priority tasks and information sharing with the Public Information Officer.
    - **Lead***:* Public Information Officer.
    - **Support:** Operations Section Chief.
- *Strategy*: Staff *Health Guidance and Information Task Force* with staff from *Community Mitigation and Wellbeing Branch, Communications Response Team,* and other technical experts as needed. This task force may be expanded or duplicated to address key populations and settings, and should include staff with communications, equity, police, and disease-specific subject matter expertise.
    - **Lead***:* Public Information Officer.
    - **Support***:* Logistics, Operations Section Chief.

PREPARE

PUBLIC INFORMATION

OBJECTIVE: DEVELOP **COMMUNICATIONS MANAGEMENT** PROCESS.

- *Strategy*: Develop and maintain responder resource documents to communicate core messages on current situation, risk to key populations, risk to public, and additional information relevant to the response.
    - **Lead**: Public Information Officer.
    - **Support**: Communications Response Team; Epidemiology and Surveillance Branch; Planning Section – Situation Unit.
- *Strategy*: Establish information release process to ensure accurate public information is shared in a timely manner.
    - **Lead**: Public Information Officer.
    - **Support**: Communications Response Team; Epidemiology and Surveillance Branch; Planning Section – Situation Unit.
- *Strategy*: Develop priority content translation process to ensure messaging and recommendations are available in multiple languages, formats, and with the option for interpretation for where to seek ongoing and critical health services.
    - **Lead**: Public Information Officer.

    - **Support**: Equity Officer; Language Access; Community Mitigation and Wellbeing Branch
        - **Resource**: *Equity Response Annex; Risk Communications Annex.*
- *Strategy*: Determine need and scope of responsibilities for internal communications, including messaging to non-response Public Health employees, support for leadership messaging, and alignment with King County Human Resources messaging.
    - **Lead**: Public Health Director of Communications.
    - **Support**: Public Information Officer; Communications Response Team; Public Health Employee Services, King County Human Resources (Safety & Claims), Safety Officer.
        - **Resource**: *Equity Response Annex; Risk Communications Annex.*

OBJECTIVE: DEVELOP **MEDIA** ENGAGEMENT AND MANAGEMENT PLAN.

- *Strategy*: Develop schedule for regular media updates via press conferences, interviews, and other interactions with the media.
    - **Lead**: Public Information Officer.
- *Strategy*: Develop process to receive and manage media inquiries and requests.
    - **Lead**: Public Information Officer.
- *Strategy*: Develop process to manage media at Public Health sites.
    - **Lead**: Public Information Officer.
- *Strategy*: Develop process to prepare and train spokespeople, as needed.
    - **Lead**: Public Information Officer.
- *Strategy*: Develop process to identify and monitor media coverage, including broadcast, print, social media, and online media.
    - **Lead**: Public Information Officer.
        - **Resource**: *Risk Communications Annex.*

OBJECTIVE: DEVELOP **SOCIAL MEDIA** ENGAGEMENT AND MANAGEMENT PLAN.

- *Strategy*: Develop process for developing online content, including blogs, social media posts, videos, and other content, across all social media platforms in an accessible and relevant way.
    - **Lead**: Public Information Officer.
- *Strategy*: Develop process to review social media engagement for rumor control and elevation to appropriate responders for response, as needed.
    - **Lead**: Public Information Officer.

OBJECTIVE: DEVELOP **COMMUNITY ENGAGEMENT AND OUTREACH** PLAN TO PROVIDE ACCURATE, RELEVANT, AND ACTIONABLE INFORMATION TO AT-RISK COMMUNITIES AND SETTINGS.

- *Strategy*: Synthesize input from community partners, *Equity Officer* and team, and *Epidemiology and Surveillance Branch* to determine at-risk community needs and outreach strategies to address health disparities, risk disparities, and information gaps.
    - **Lead***:* Community Mitigation and Wellbeing Branch.
    - **Support**: Equity Response Team, Equity Officer.
        - **Resource**: *Equity Response Annex; Risk Communications Annex.*
- *Strategy*: Develop process to conduct in-language and culturally informed outreach to Populations Impacted by Inequity and most impacted communities.
    - **Lead**: Public Information Officer.

- *Strategy***:** Develop process to promote health and safety messages on platforms in addition to Public Health's regular channels, considering alternative outlets to target specific at-risk groups (radio channels; community blogs and newspapers; community centers; faith-based organizations; schools; libraries; etc.)
    - **Lead**: Public Information Officer.
    - **Support:** Equity Officer; Community Mitigation and Wellbeing Branch.
        - **Resource**: *Equity Response Annex; Risk Communications Annex.*
- *Strategy*: Develop process to collect feedback to monitor and assess effectiveness of community engagement and outreach, including guidance effectiveness and community recommendations.
    - **Lead**: Public Information Officer.
- *Strategy*: Staff additional community engagement HMAC positions to support engagement and outreach plan, as needed.
    - **Lead**: Public Information Officer, Communications Response Team.
    - **Support**: Community Mitigation and Wellbeing Branch; Logistics Section; Operations Section Chief.
- *Strategy*: Develop process to provide risk communications support to outreach and dissemination strategies and team.
    - **Lead**: Community Mitigation and Wellbeing Branch.

OBJECTIVE: DEVELOP RISK COMMUNICATIONS TO PROVIDE ACCURATE, RELEVANT, AND ACTIONABLE INFORMATION TO **IMPACTED COMMUNITIES AND POPULATIONS**.

- *Strategy*: Develop social media content designed to reach impacted communities and populations.
    - **Lead**: Public Information Officer.
- *Strategy*: Develop media content and engagement opportunities (press releases, interviews, Q&A sessions) designed to reach impacted communities and populations.
    - **Lead**: Public Information Officer.
- *Strategy*: Develop direct outreach and community engagement content and engagement opportunities (community radio spots, community engagement and information sessions) designed to reach impacted communities and populations.
    - **Lead**: Community Mitigation and Wellbeing Branch.

OBJECTIVE: DEVELOP RISK COMMUNICATIONS TO PROVIDE ACCURATE, RELEVANT, AND ACTIONABLE INFORMATION TO **RESPONSE PARTNERS**.

- *Strategy*: Develop social media content designed to inform and support key response partners (hospitals, healthcare systems, emergency services partners, distribution partners, emergency management partners, etc.).
    - **Lead**: Public Information Officer.
- *Strategy*: Develop media content and engagement opportunities designed to inform and support key response partners (hospitals, healthcare systems, emergency services partners, distribution partners, emergency management partners, etc.).
    - **Lead**: Public Information Officer.
- *Strategy*: Develop direct outreach and community engagement content and engagement opportunities designed to inform and support key response partners (hospitals, healthcare systems, emergency services partners, distribution partners, emergency management partners, etc.).

- **Lead**: Public Information Officer.
- **Support**: Community Mitigation and Wellbeing Branch.

OBJECTIVE: DEVELOP RISK COMMUNICATIONS TO PROVIDE ACCURATE, RELEVANT, AND ACTIONABLE INFORMATION TO THE **PUBLIC**.

- *Strategy*: Develop social media content designed to inform and support the public.
- *Strategy*: Develop media content and engagement opportunities (press releases, interviews, Q&A sessions) designed to inform and support the public.
  - **Lead**: Public Information Officer.
- *Strategy*: Develop direct outreach and community engagement content and engagement opportunities (community radio spots, community engagement and information sessions) designed to inform and support key response partners the public.
  - **Lead**: Public Information Officer.
  - **Support**: Community Mitigation and Wellbeing Branch*;* Epidemiology and Surveillance Branch; Equity Officer.

HEALTH GUIDANCE

OBJECTIVE: DEVELOP HEALTH AND SAFETY GUIDANCE SYNTHESIS AND DISSEMINATION PROCESS.

- *Strategy*: Determine and approve key sources of health and safety guidance (WA DOH, CDC) to be used across response branches and functions.
  - **Lead**: Public Information Officer.
  - **Support**: Epidemiology and Surveillance Branch; Equity Officer; Operations Section Chief, Planning Section – Situation Unit.
- *Strategy*: Develop process to synthesize health and safety guidance relevant to the incident for priority populations and settings.
  - **Lead**: Public Information Officer.
  - **Support**: Epidemiology and Surveillance Branch; Safety Officer; Equity Officer; Community Mitigation and Wellbeing Branch.
- *Strategy*: Develop process to integrate language access (including translation and interpretation services) and culturally informed language into guidance synthesis and dissemination process.
  - **Lead**: Public Information Officer.
  - **Support**: Epidemiology and Surveillance Branch; Safety Officer; Equity Officer; Community Mitigation and Wellbeing Branch.

IMPLEMENT

COMMUNICATION STRATEGIES

OBJECTIVE: COMMUNICATE ACCURATE AND ACTIONABLE RISK COMMUNICATIONS FOR **IMPACTED COMMUNITIES AND POPULATIONS**.

- *Strategy*: Utilize *social media platforms* to communicate key risk messages to impacted communities and populations.
    - **Lead**: Public Information Officer.
- *Strategy*: Utilize *media channels* to communicate key risk messages to impacted communities and populations.
    - **Lead**: Public Information Officer.
- *Strategy*: Utilize *community engagement and outreach process* to communicate key risk messages to impacted communities and populations.
    - **Lead:** Community Mitigation & Wellbeing Branch.
- *Strategy*: Provide messaging and recommendations in multiple languages, formats, and with the option for interpretation for where to seek ongoing and critical health services.
    - **Leads**: Public Information Officer.
    - **Support**: Equity Officer; Community Mitigation and Wellbeing Branch
        - **Resource**: *Equity Response Annex.*
        - **Resource**: *Risk Communications Annex.*

OBJECTIVE: COMMUNICATE ACCURATE AND ACTIONABLE RISK COMMUNICATIONS FOR **AT-RISK POPULATIONS AND SETTINGS**.

- *Strategy*: Utilize *social media platforms* to communicate key risk messages to at-risk communities and populations.
    - **Lead**: Public Information Officer.
- *Strategy*: Utilize *media channels* to communicate key risk messages to at-risk communities and populations. Promote health and safety messages on platforms in addition to Public Health's regular channels, considering alternative outlets to target specific at-risk groups (radio channels; community blogs and newspapers; community centers; faith-based organizations; schools; libraries; etc.).
    - **Lead**: Public Information Officer.
    - **Support**: Equity Officer; Community Mitigation and Wellbeing Branch.
        - **Resource**: *Equity Response Annex.*
- *Strategy*: Utilize *community engagement and outreach process* to communicate key risk messages to at-risk communities and populations.
- *Strategy:* Establish Speakers Bureau to support direct outreach and engagement with the public, key response partners, and key at-risk populations.
- *Strategy*: Provide messaging and recommendations in multiple languages, formats, and with the option for interpretation for where to seek ongoing and critical health services.
    - **Lead**: Public Information Officer.
    - **Support**: Equity Officer; Community Mitigation and Wellbeing Branch.
        - **Resource**: *Equity Response Annex.*

OBJECTIVE: COMMUNICATE ACCURATE AND ACTIONABLE RISK COMMUNICATIONS FOR **RESPONSE PARTNERS**.

- *Strategy*: Utilize social media platforms to communicate key risk messages to response partners.
  - **Lead**: Public Information Officer.
- *Strategy*: Utilize media channels to communicate key risk messages to response partners.
  - **Lead**: Public Information Officer.
- *Strategy*: Utilize community engagement and outreach process to communicate key risk messages to response partners.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Equity Officer; Public Information Officer.

OBJECTIVE: COMMUNICATE CORE RISK COMMUNICATIONS TO PROVIDE ACCURATE AND ACTIONABLE INFORMATION FOR **THE PUBLIC.**

- *Strategy*: Utilize social media platforms to communicate key risk messages to the public.
  - **Lead**: Public Information Officer.
- *Strategy*: Utilize media channels to communicate key risk messages to the public.
  - **Lead**: Public Information Officer.
- *Strategy*: Utilize community engagement and outreach process to communicate key risk messages to the public.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Equity Officer; Public Information Officer.

OBJECTIVE: COMMUNICATE KEY RISK MESSAGING INTO LANGUAGES RELEVANT TO IMPACTED AND AT-RISK POPULATIONS AND COMMUNITIES.

- *Strategy*: Utilize priority content translation process with Language Access, *Equity Response Team*, and *Equity Officer* to translate key information is available in relevant languages other than English.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Equity Officer; Public Information Officer.
- *Strategy*: Develop content for social media, media, and direct community outreach and engagement.
  - **Lead**: Public Information Officer; Community Mitigation and Wellbeing Branch.
  - **Support**: Equity Officer.
- *Strategy*: Staff an education and outreach cadre with appropriate translators included (such as a *Health Educators Surge Team*).
  - **Lead**: Public Information Officer; Community Mitigation and Wellbeing Branch.
  - **Support**: Equity Officer.
- *Strategy*: Provide messaging and recommendations in multiple languages, formats, and with the option for interpretation for where to seek response services.
  - **Leads**: Public Information Officer; Equity Officer; Community Mitigation and Wellbeing Branch
    - **Resource**: *Equity Response Annex.*

GUIDANCE SYNTHESIS AND DISSEMINATION STRATEGIES

OBJECTIVE: SYNTHESIZE AND DISSEMINATE HEALTH GUIDANCE SPECIFIC TO THE BIOLOGICAL INCIDENT FOR **IMPACTED COMMUNITIES AND POPULATIONS**.

- *Strategy*: Synthesize and disseminate guidance addressing symptom identification, testing, treatment, and containment.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Epidemiology and Surveillance Branch, Public Information Officer, Community Mitigation and Wellbeing Branch; Health Guidance and Information Task Force, if activated.

OBJECTIVE: SYNTHESIZE AND DISSEMINATE HEALTH GUIDANCE SPECIFIC TO THE BIOLOGICAL INCIDENT FOR **AT-RISK POPULATIONS AND SETTINGS.**

- *Strategy*: Develop and disseminate guidance addressing prevention, testing, containment, contact tracing, zoonotic health guidance, and related resources that centers the needs of populations impacted by inequities and at-risk groups and settings.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Epidemiology and Surveillance Branch; Public Information Officer; Communications Response Team; Health Guidance and Information Task Force, if activated; Testing Group; Therapeutics Group; Vaccination Group; Isolation and Quarantine Group.
- *Strategy:* Support Environmental Health with development and dissemination of sanitation, hygiene, and indoor air quality guidance related to the infectious disease response.
    - **Lead**: Public Information Officer; Communications Response Team.
    - **Support**: Environmental Health.
- *Strategy:* Ensure that guidance and resources include anti-racist language developed in multiple formats (to support Access and Functional Needs (AFN) communities), languages, and include the option for interpretation.
    - **Leads***:* Public Information Officer; Equity Officer.
    - **Support:** Community Mitigation and Wellbeing Branch.
        - **Resource***: Equity Response Annex.*

OBJECTIVE: SYNTHESIZE AND DISSEMINATE HEALTH GUIDANCE SPECIFIC TO **RESPONSE PARTNERS**.

- *Strategy*: Synthesize and disseminate guidance for handling and storing of vaccines, treatments, and other medical countermeasures.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Public Information Officer; Vaccination Group; Therapeutics Group; Communications Response Team.

OBJECTIVE: SYNTHESIZE AND DISSEMINATE HEALTH GUIDANCE SPECIFIC TO THE BIOLOGICAL INCIDENT FOR **THE PUBLIC**.

- *Strategy*: Develop guidance for general public actions for prevention, mitigation, containment, and treatment.

  - **Lead**: Public Information Officer.
  - **Support***:* Epidemiology and Surveillance Branch.
- *Strategy*: Disseminate guidance for public actions for prevention, mitigation, containment, and treatment.
  - **Lead**: Public Information Officer.
  - **Support:** Communications Response Team, Community Mitigation and Wellbeing Branch, Health Guidance and Information Task Force, if activated.

DIRECT OUTREACH STRATEGIES

OBJECTIVE: CONDUCT IN-LANGUAGE AND CULTURALLY INFORMED OUTREACH TO AT-RISK AND MOST IMPACTED COMMUNITIES.

- *Strategy*: Distribute relevant information and guidance to populations impacted by inequity and most impacted communities.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Equity Officer or Equity Technical Advisor; Communications Response Team; Health Guidance and Information Task Force, if activated.
    - **Resource**: *Equity Response Annex.*
- *Strategy*: Conduct outreach to community-based organizations, faith-based organizations, community centers, and other organizations active in disasters to ensure guidance and information is disseminated effectively.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Public Information Officer; Communications Response Team; Equity Officer
    - **Resource**: *Equity Response Annex.*
    - **Resource**: *Workforce Mobilization Annex*.
- *Strategy*: Provide volunteer management support for outreach activities, if necessary.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Logistics Section; Operations Section.
    - **Resource**: *Equity Response Annex.*
    - **Resource**: *Workforce Mobilization Annex*.

MONITOR AND ASSESS

COMMUNICATION STRATEGIES

OBJECTIVE: CONTINUALLY COLLECT, DOCUMENT, AND ANALYZE INFORMATION FROM HMAC, MEDIA, AND OTHER PARTNER AGENCIES TO ENSURE CONTENT IS ACCURATE AND ACTIONABLE.

- *Strategy*: Utilize communications management process to ensure response communications and guidance documents are accurate and updated regularly.
  - **Lead**: Public Information Officer.
- *Strategy*: Report on major updates regarding media or social media reports, outreach strategies, response partner communications, and other risk communications-related information to response Command and General Staff.

- **Lead**: Public Information Officer.
- **Support**: Equity Officer.

OBJECTIVE: MONITOR AND ASSESS SOCIAL MEDIA SITES FOR COMMUNITY NEEDS, MISINFORMATION, AND GAPS IN INFORMATION RELATING TO THE HAZARD AND AVAILABLE RESOURCES AND SERVICES.

- *Strategy*: Coordinate with *Community Mitigation and Wellbeing Branch* to identify sources of information utilized by at-risk populations and settings.
  - **Lead**: Public Information Officer.
- *Strategy***:** Utilize communications management process to manage rumor control and obtain verification of all information prior to release to the public or response partners.
  - **Lead**: Public Information Officer.
  - **Support**: Equity Officer.

GUIDANCE SYNTHESIS AND DISSEMINATION STRATEGIES

OBJECTIVE: MONITOR AND ASSESS EFFECTIVENESS OF GUIDANCE CONTENT.

- *Strategy*: Utilize engagement and feedback process to assess effectiveness of guidance, including data elements around health literacy and cultural appropriateness.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Public Information Officer; Equity Officer; Equity Response Team; Public Health Language Access Program.

OBJECTIVE: MONITOR AND ASSESS EFFECTIVENESS OF GUIDANCE SYNTHESIS AND DEVELOPMENT PROCESS.

- *Strategy*: Identify gaps and process improvements to streamline guidance synthesis and development roles and responsibilities between *Public Information Officer*, *Communications Response Team,* and *Community Mitigation and Wellbeing Branch*.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Public Information Officer; Communications Response Team.

DIRECT OUTREACH STRATEGIES

OBJECTIVE: MONITOR AND ASSESS EFFECTIVENESS OF GUIDANCE DISSEMINATION.

- *Strategy*: Utilize engagement and feedback process to assess effectiveness of guidance dissemination to intended communities and audiences.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Public Information Officer; Equity Officer.
- *Strategy*: Share qualitative and quantitative guidance feedback with *Epidemiology and Surveillance Branch*, *Data Branch*, and other relevant HMAC operations to improve health outcomes.
  - **Lead**: Community Mitigation and Wellbeing Branch.

- **Support**: Epidemiology and Surveillance Branch, Data Branch, Equity Officer, Operations Section Chief.

INTEGRATE OPERATIONS

OBJECTIVE: DEVELOP PROCESS TO ENSURE COMMAND AND GENERAL STAFF RECEIVE TIMELY UPDATES RELATING TO COMMUNICATIONS PROCESSES.

- *Strategy*: Ensure process of updating information integrates guidance changes from *Epidemiology and Surveillance Branch* and is shared among General and Command Staff at regular intervals.
  - **Lead:** Public Information Officer.
- *Strategy*: Socialize location of key internal information documents with *Public Information Contact Center (PICC) Group*, *Safety Officer*, *Epidemiology and Surveillance Branch*, *Equity Officer*
  - **Lead:** Public Information Officer.

OBJECTIVE: TRACKING PROGRESS OF COMMUNICATIONS PRODUCT DEVELOPMENT.

- *Strategy*: Track content development, including translations, in central location to support outreach and engagement efforts by vaccination, testing, treatment, and other operational teams.
  - **Lead**: Public Information Officer.
- *Strategy*: Develop and implement templates and communications guides for content being developed by response site locations, such as community vaccination events, testing sites, treatment sites, and other operational sites.
  - **Lead:** Public Information Officer.
  - **Support:** Communications Response Team.

OBJECTIVE: MAINTAIN PROCESS TO INTEGRATE ACTIVITIES OF THE *COMMUNITY MITIGATION AND WELLBEING* ACTIVITIES WITH *COMMUNICATIONS RESPONSE TEAM* AND *PUBLIC INFORMATION OFFICER*.

- *Strategy*: Establish scope and responsibilities of content creation and support between Community Mitigation and Wellbeing Branch with *Communications Response Team* and *Public Information Officer*; consider ongoing need for joint *Health Guidance and Information Task Force*.
  - **Lead**: Public Information Officer; Community Mitigation and Wellbeing Branch.
- *Strategy*: Establish regular check ins and approval process between *Communications Response Team* and *Community Mitigation and Wellbeing Branch*, as needed.
  - **Lead**: Public Information Officer; Community Mitigation and Wellbeing Branch.

OBJECTIVE: COORDINATE COMMUNICATIONS TO INTERNAL PUBLIC HEALTH EMPLOYEES, INCLUDING INTERNAL COMMUNICATIONS ON EMPLOYEE SAFETY AND WELLBEING, AS WELL AS LEADERSHIP MESSAGES.

- *Strategy*: Support Safety Officer in dissemination of safety and wellbeing messaging across response and to non-response Public Health employees, as needed.
- *Strategy*: Coordinate support for internal Public Health and King County employee messaging with Public Health Human Resources and King County Human Resources Department, as needed.
    - **Lead:** Public Information Officer.
    - **Support:** Communications Response Team.

OBJECTIVE: MAINTAIN COORDINATION PROCESS FOR GUIDANCE DISSEMINATION STRATEGIES AND COMMUNITY ENGAGEMENT STRATEGIES.

- *Strategy*: Coordinate with *Epidemiology and Surveillance Branch* and *Data Branch* to identify and align guidance strategies and direct outreach strategies with gaps in health impacts to key at-risk populations.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Epidemiology and Surveillance Branch; Data Branch; Communications Response Team.

OBJECTIVE: MAINTAIN AWARENESS OF UPDATES OR CHANGES TO CENTERS FOR DISEASE CONTROL AND PREVENTION GUIDANCE, WA DEPARTMENT OF HEALTH GUIDANCE, AND OTHER RELEVANT GUIDANCE AND BEST PRACTICES.

- *Strategy*: Work with *Planning Section – Situation Unit* to track changes to official guidance, relevant policies, or other policies which may impact Public Health's response. This may include state and federal response policies, CDC guidance on infection control, nonpharmaceutical interventions, and availability or access to vaccines, testing, and treatment.
    - **Lead**: Public Information Officer.
    - **Support**: Planning Section; Communications Response Team.

PUBLIC INFORMATION CONTACT CENTER (PICC)

DETERMINE

OBJECTIVE: DETERMINE APPROPRIATE PICC SERVICES TO ACTIVATE TO PROVIDE ACCURATE AND ACTIONABLE INFORMATION TO IMPACTED PATIENTS, AT-RISK POPULATIONS AND SETTINGS, RESPONSE PARTNERS, AND THE PUBLIC.

- *Strategy*: Assess essential elements of information (EEIs) to inform an initial assessment of the situation.
    - **Lead***:* HMAC Operations Section Chief
    - **Support***:* Surveillance and Epidemiology Branch*;* Public Information Officer; Equity Officer*.*
- *Strategy*: Develop recommendations, including identified resource needs, for HMAC Command Staff regarding implementing PICC services.
- *Strategy*: Approve recommendations and planning steps.

- *Strategy*: Staff relevant HMAC positions to manage implementation of recommendations.
    - **Lead***:* Planning Section – Resource Unit.
    - **Support***:* Logistics.

PREPARE

OBJECTIVE: DEVELOP CALL TRIAGE PROCESS TO SUPPORT EPIDEMIOLOGY AND SURVEILLANCE BRANCH RESPONSE NEEDS.

- *Strategy*: Develop tracking system in support of Epidemiology and Surveillance Branch response needs, particularly around isolation and quarantine measures; individuals experiencing homelessness; and additional criteria as determined by Epidemiology and Surveillance Branch.
    - **Lead**: PICC Director.
    - **Support**: Epidemiology and Surveillance Branch; Data Branch; Public Information Officer.
- *Strategy*: Develop triage process for potential callers, including healthcare providers and alternate healthcare settings, impacted communities and settings (patients, exposed individuals, high risk settings such as gyms, businesses, etc.), at-risk populations and settings (congregate settings, schools, those experiencing homelessness, etc.), response partners, and public.
    - **Lead**: PICC Director.
    - **Support**: Epidemiology and Surveillance Branch; Data Branch; Public Information Officer.
- *Strategy*: Identify and document resources to support queries, including information around: isolation and quarantine, vaccination, treatment, wraparound services, and other response service areas relevant to the response.
    - **Lead**: PICC Director.
    - **Support**: Epidemiology and Surveillance Branch; Data Branch; Public Information Officer.

OBJECTIVE: DEVELOP PROCESS WITH EPIDEMIOLOGY AND SURVEILLANCE BRANCH TO ENSURE PICC HAS ACCURATE AND UPDATED INFORMATION AND HEALTH GUIDANCE TO SHARE WITH CALLERS.

- *Strategy*: Develop process which includes steps for health data and guidance input, resource material creation (hot sheets, factsheets), and PICC organization process.
    - **Lead:** PICC Director.
    - **Support:** Epidemiology and Surveillance Branch; Data Branch; Public Information Officer.

OBJECTIVE: DEVELOP RESOURCE MATERIALS FOR PICC STAFF TO EFFECTIVELY ANSWER QUERIES FROM HEALTHCARE PROVIDERS, AT-RISK POPULATIONS, AND SETTINGS, IMPACTED INDIVIDUALS (PATIENTS AND SITE CLIENTS), AND THE PUBLIC.

- *Strategy*: Develop hot sheets, contact lists, and other material required by PICC staff to effectively answer and triage caller queries prior to PICC number being shared publicly.
- *Strategy*: Develop PICC staff training and onboarding resources and material.

- *Strategy*: Develop feedback mechanism to capture and address queries falling outside of staff knowledge or resources.
- *Strategy*: Develop process with Language Access and *Equity Officer* to prioritize translation and interpretation services relating to PICC materials and call queries.

OBJECTIVE: DEVELOP STRATEGY TO COMMUNICATE PICC CONTACT INFORMATION, HOURS, AND SCOPE OF SERVICES TO INTENDED AUDIENCES.

- **Lead**: PICC Director.
- **Support**: Public Information Officer; Operations Section Chief; Epidemiology and Surveillance Branch.

IMPLEMENT

OBJECTIVE: TRIAGE AND ADDRESS REQUESTS FOR INFORMATION FROM **HEALTHCARE PROVIDERS** AND ALTERNATIVE HEALTHCARE SETTINGS.

OBJECTIVE: TRIAGE AND ADDRESS REQUESTS FOR INFORMATION FROM **IMPACTED POPULATIONS AND SETTINGS.**

OBJECTIVE: TRIAGE AND ADDRESS REQUESTS FOR INFORMATION FROM **AT-RISK POPULATIONS AND SETTINGS**.

- *Strategy*: Address queries from callers at higher risk due to the disease characteristics and outbreak, such as age-specific populations, due to workplace settings, school or other congregate settings, and other higher risk factors related to the infectious disease.
- *Strategy*: Address queries from community members at higher risk due to broader social determinants of health and barriers to preventative, containment, or treatment information or resources.
- *Strategy*: Address queries from service providers, community and faith-based organizations, and others who serve at-risk populations and settings.

OBJECTIVE: TRIAGE AND ADDRESS REQUESTS FOR INFORMATION FROM THE **GENERAL PUBLIC**.

MONITOR AND ASSESS

OBJECTIVE: MONITOR AND ASSESS CALLER QUERY TOPICS AND IDENTIFY GAPS IN AVAILABLE INFORMATION.

- *Strategy*: Develop and utilize call monitoring dashboard, if needed.
- *Strategy*: Share assessments with *Epidemiology and Surveillance Branch*, *Public Information Officer* and *Communications Response Team*, Equity Officer, and other relevant response partners, such as *Isolation and Quarantine Group*, as applicable.

OBJECTIVE: MONITOR AND ADDRESS EFFECTIVENESS OF CALL TRIAGE PROCESS.

- *Strategy*: Use monitoring and feedback mechanism to assess effectiveness of PICC services, including triage process, and implement improvements to meet changing response needs.

INTEGRATE OPERATIONS

OBJECTIVE: INTEGRATE FEEDBACK ON PICC RESOURCES, TRIAGE INFORMATION, AND CALLER EXPERIENCE INTO EPIDEMIOLOGY AND SURVEILLANCE BRANCH, PUBLIC INFORMATION OFFICER/COMMUNICATIONS RESPONSE TEAM, AND EQUITY OFFICER OPERATIONS.

- *Strategy*: Provide feedback to *Epidemiology and Surveillance Branch* on guidance and information gaps and collaborate to improve resources available to PICC staff.
- *Strategy*: Provide feedback and develop improvement process on triage thresholds and triage flow chart.
- *Strategy*: Provide feedback and recommendations on common questions and information which may be better shared through Public Information Officer or *Communications Response Team's* public information channels and platforms.
- *Strategy*: Provide feedback to Equity Officer to better inform equity impact analysis and response operations.

3 | INFORMATION MANAGEMENT

These response activities describe the collection, assessment, documentation, and dissemination of information across the HMAC response structure, ensuring situational awareness of both response operations and the ongoing biological incident.

IMPLEMENT

COORDINATION

OBJECTIVE: IMPLEMENT AND MAINTAIN ESTABLISHED INCIDENT PLANNING CYCLE.

- *Strategy:* Coordinate and facilitate meetings to establish incident objectives; clarify issues and concerns; identify limitations and restrictions; discuss intra-agency issues.
    - **Lead:** Planning Section.
        - **Resource:** *HMAC Playbook; Command and General Staff Meeting agenda*.
- *Strategy:* Coordinate and facilitate meetings to plan strategies, tactics, and resource needs to meet established incident objectives; share information relevant to the incident objectives; discuss current operations and completed response activities.
    - **Lead:** Operations Section.
    - **Support:** Planning Section.
        - **Resource:** *HMAC Playbook; Operations Strategy & Tactics Meeting agenda.*
- *Strategy:* Coordinate meetings to prepare and disseminate the established action plan and resource assignments.
    - **Lead:** Planning Section.
        - **Resource:** *HMAC Playbook; Planning Meeting Agenda.*
- *Strategy:* Coordinate meetings to execute the action plan and relevant situational awareness information.
    - **Lead:** Planning Section.
        - **Resource:** *HMAC Playbook; Operational Briefing Agenda.*

INFORMATION GATHERING

OBJECTIVE: TRACK RELEVANT DATA AND INFORMATION SOURCES TO MAINTAIN SITUATIONAL AWARENESS OF THE INCIDENT RELATING TO KEY RESPONSE ELEMENTS SUCH AS DISEASE CHARACTERISTICS, AFFECTED POPULATIONS, PREVENTION, TESTING, TREATMENT, AND CONTAINMENT STRATEGIES.

- *Strategy:* Monitor epidemiology and surveillance updates through channels established by the *Epidemiology and Surveillance Branch*.
    - **Lead:** Planning Section.
    - **Support:** Epidemiology and Surveillance Branch.
        - **Attachment:** *Situational Awareness Tracker.*
        - **Resource:** *Situation Unit Job Aid.*

- *Strategy*: Monitor relevant external information sources approved by the Public Information Officer and *Epidemiology and Surveillance Branch*.
    - **Lead:** Planning Section.
    - **Support:** Public Information Officer; Epidemiology and Surveillance Branch
        - **Attachment:** *Situational Awareness Tracker.*
        - **Resource:** *Situation Unit Job Aid.*

OBJECTIVE: MAINTAIN SITUATIONAL AWARENESS OF KEY HMAC, ESF #8, AND RELATED PARTNER RESPONSE ACTIVITIES.

- *Strategy*: Utilize information collection process to maintain awareness of HMAC directed, conducted, and planned response activities.
    - **Lead:** Planning Section.
        - **Resource:** *Situation Unit Job Aid*; *Operational Summary Form.*
- *Strategy*: Monitor relevant ESF #8 and emergency management response partner briefings, reports, and communication channels to maintain situational awareness of response activities.
    - **Lead:** Planning Section.
        - **Attachment:** *Situational Awareness Tracker.*
- *Strategy:* Monitor status of other Public Health departmental services.
    - **Lead:** Planning Section.
    - **Support:** Public Health Office of the Director; Continuity of Operations (COOP) Lead.
        - **Resource:** *Public Health Continuity of Operations Plan.*

OBJECTIVE: MONITOR RELEVANT LOCAL, STATE, NATIONAL, AND INTERNATIONAL POLICY, PROCLAMATIONS, AND MANDATES IMPACTING RESPONSE ACTIVITIES AND RESOURCES.

- *Strategy*: Monitor relevant state and federal channels for policy proclamations, mandates, and strategies impacting response activities.
    - **Lead**: Public Information Officer.
    - **Support***:* Planning Section.
- *Strategy*: Monitor relevant response partner briefings, reports, and communication channels to maintain situational awareness of policy and response activities impacting King County.
    - **Lead**: Policy Officer.
    - **Support:** Planning Section.
        - **Attachment**: *Situational Awareness Tracker.*
        - **Resource:** *Situation Unit Job Aid; Government Liaison Job Description; Policy Officer Job Description.*

ANALYSIS

OBJECTIVE: PREPARE SITUATIONAL BRIEFINGS, REPORTS, DISPLAYS, BRIEFING TOOLS, AND OTHER INFORMATION PRODUCTS AS NEEDED TO EFFECTIVELY ASSESS THE SITUATION.

- *Strategy*: Integrate *Epidemiology and Surveillance Branch* reports, vaccination, testing, other response tracking data, and relevant external data visualization products into coordination meeting resources (briefing documents, PowerPoints, attachments) and HMAC displays (projected displays, written, on HMAC television screen, etc.).

- **Lead:** Planning Section.
  - **Resource:** *HMAC Playbook.*

DOCUMENTATION

OBJECTIVE: DOCUMENT KEY SITUATIONAL AWARENESS DATA ELEMENTS, INCLUDING EPIDEMIOLOGICAL DATA, COMMUNITY SPREAD, VACCINE, TREATMENTS, GUIDANCE RECOMMENDATIONS, AND RELATED INFORMATION.

- *Strategy*: Maintain updated documentation of key situational awareness data for use by HMAC responders, in alignment with Public Information Officer and *Communications Response Team* documents.
  - **Lead**: Planning Section.
    - **Resource:** *Risk Communications Response Annex*; *Situation briefing for internal and partner communications***.**
- *Strategy*: Document key data elements for use by response partners, such as ESF #8 responders, emergency managers, emergency response, key healthcare partners, and other response agencies and organizations in routine snapshots or situation reports.
  - **Lead**: Planning Section.
    - **Resource:** *Situation Report Template; Snapshot Template.*

OBJECTIVE: DOCUMENT CONDUCTED AND PLANNED HMAC AND PARTNER RESPONSE ACTIVITIES, INCLUDING OPERATIONAL ACTIVITIES, POLICY UPDATES, STRATEGIC OBJECTIVES, AND OTHER INFORMATION RELEVANT TO THE RESPONSE.

- *Strategy*: Document, record, and file notes from operational period meetings, as needed.
  - **Lead:** Planning Section.
    - **Resource:** *HMAC Playbook.*
- *Strategy*: Document incident goals, operational period objectives, response strategies, safety messages, meeting schedule, and critical updates in an Incident Action Plan, as necessary.
  - **Lead:** Planning Section.
    - **Resource**: *HMAC Playbook; IAP Templates.*
- *Strategy:* Use responder tracking mechanism to document Organizational Chart, Organizational Assignment List, and Communications list for key response rolls.
  - **Lead:** Planning Section.
    - **Resource:** *HMAC Playbook; Resource Unit Job Aid; IAP Templates.*
- *Strategy*: Document incident goals, operational period objectives, response strategies, and critical updates in format for sharing during Incident Briefings, as necessary.
  - **Lead**: Planning Section
  - **Support**: Operations Section Chief.
    - **Resource:** *HMAC Playbook; Incident Briefing template.*

OBJECTIVE: MAINTAIN AND MANAGE DOCUMENTATION.

- *Strategy*: Maintain document duplication and filing system to ensure HMAC sections maintain and submit appropriate files for post-incident documentation purpose.
    - **Lead**: Planning Section.
        - **Resource**: *HMAC Playbook; Documentation Unit job aid.*
- *Strategy:* Clarify and communicate responses expectations for documentation, reporting, and retention requirements.
    - **Lead:** Planning Section.
        - **Resource:** *Documentation Unit job aid.*
- *Strategy:* Maintain a document security plan to manage the confidentiality and security of any classified, confidential, sensitive, and FOUO (for official use only) documentation, intelligence, data, or incident information.
    - **Lead:** Planning Section.
        - **Resource:** *Documentation Unit job aid.*
- *Strategy:* Ensure all units within section that handle data or intelligence are aware of and maintain a document security plan to manage the confidentiality and security of any classified, confidential, sensitive, and FOUO documentation, intelligence, data, or incident information.
    - **Lead:** Planning Section.
        - **Resource:** *Documentation Unit job aid.*

DISSEMINATION

OBJECTIVE: DISSEMINATE INFORMATION ACROSS RESPONSE OPERATIONS AND TO RESPONSE PARTNERS.

- *Strategy*: Disseminate information via HMAC snapshots, situation reports, and IAPs as needed.
    - **Lead**: Planning Section.
        - **Resource:** *HMAC Playbook*; *WebEOC SOP*; *HMAC Distribution List*.

OBJECTIVE: RESPOND TO HMAC AND RESPONSE PARTNER REQUESTS FOR RESPONSE-RELATED INFORMATION AND RESOURCES.

- **Lead**: Planning Section.
- **Support**: Public Information Officer; Policy Officer.

OBJECTIVE: MAINTAIN SYSTEMS OF INFORMATION EXCHANGE THAT ARE SECURE, RELIABLE, AND SCALABLE.

- Strategy: Use responder tracking mechanism to maintain HMAC distribution lists for responders that should receive HMAC notifications and relevant meeting invitations.
    - **Lead:** Planning Section.
        - **Resource:** *HMAC Playbook; Resource Unit job aid.*
- Strategy: Maintain HMAC distribution lists for supporting ESF #8 agencies, other ESFs, city, county, and/or state EOCs that should receive HMAC notifications.
    - **Lead:** Planning Section.
        - **Resource**: *HMAC Playbook; HMAC Distribution List.*

- *Strategy*: Maintain a dissemination security plan to manage the confidentiality and security of any classified, confidential, sensitive, and 'For Official Use Only' (FOUO) documentation, intelligence, data, or incident information shared with responders or partners.
    - **Lead:** Planning Section.
- *Strategy*: Maintain dissemination lists to meet situational awareness needs across response operations both internal and external to HMAC.
    - **Lead:** Planning Section.

4 | MEDICAL COUNTERMEASURES

Medical countermeasures (MCM) are medicines and medical supplies that can be used to diagnose, prevent, or treat diseases in response to an intentional, accidental, or naturally occurring biological incident, such as an emerging infectious disease or bioterrorist attack. These supplies may include, but not be limited to, those which are FDA-approved, under Emergency Use Authorization (EUA), under Expanded Access (often referred to as "compassionate use"), or an investigational new drug (IND). MCM include a broad spectrum of medical assets, such as diagnostic devices, personal protective equipment (PPE), vaccines or antibiotics (e.g., antibacterials, antivirals, antiparasitics, and antifungals), which are used to provide pre-exposure prophylaxis (PrEP), treatment, or post-exposure prophylaxis (PEP). Ensuring the timely and equitable provision of MCM is critical to minimizing morbidity and mortality, preserving continuity of essential business functions, minimizing social disruptions, and minimizing economic losses and exacerbated health disparities during a biological incident. The objectives and strategies outlined specifically for vaccination and therapeutics should meet the needs of a widespread event that impacts King County, but also be scalable to cover smaller-scale incidents for localized, focally affected communities. Throughout a response, these objectives and strategies may vary depending on the size and characteristics of the population impacted, the availability and type of MCM, changes in understanding of disease epidemiology or shifts in disease characteristics, as well as resources such as internal staffing and capacity of governmental, community, and private partners. For instance, the number of health care personnel qualified to administer vaccines or dispense pharmaceuticals, and the number of available volunteers to perform support functions, may limit the rate at which MCM is dispensed.

THERAPEUTICS

To ensure the timely and equitable provision of therapeutics, which include but are not limited to antibiotics, (such as antibacterials, antivirals, antiparasitics, and anti-fungal), immunoglobulins, or monoclonal antibodies, in response to an intentional, accidental, or naturally occurring biological incident, such as an emerging infectious disease outbreak or bioterrorist attack. The objectives and strategies below should meet the needs of a widespread event that impacts King County, but also be scalable to cover smaller-scale incidents for localized populations. Strategies for vaccines and other medical countermeasures are covered elsewhere throughout the *Biological Incident Response Annex*.

PREPARATION

OBJECTIVE: COORDINATE WITH LOCAL, STATE, AND FEDERAL PARTNERS TO ENSURE READINESS TO REQUEST, DISTRIBUTE, AND/OR DISPENSE MEDICATION TO HEALTHCARE PROVIDERS FOR ADMINISTRATION TO AFFECTED POPULATIONS WITHIN KING COUNTY.

- *Strategy:* Engage early with internal and external planning partners who are critical to supporting response efforts and providing treatment services.
    1. Coordinate with the Washington State Department of Health (DOH) to:
        a. Develop eligibility, prioritization, and allocation criteria, based on the local epidemiology of the disease, with efforts to have consistency across the state.
        b. Develop or update documentation, such as screening forms, consent forms, and standing orders).

c. Write and sign standing orders where appropriate to rapidly expand capacity to administer therapeutics.
d. Ensure Public Health – Seattle & King County (Public Health) activities center equity in eligibility and allocation decision-making when demand for medical supplies exceed availability.
e. Assess existing stock of medications available at the DOH Medical Logistics Center, as well as locally within healthcare facilities and pharmacies.
f. Confirm processes for medication order requests from the Strategic National Stockpile (SNS).[15]
g. Establish roles and responsibilities for receiving and distributing medication between the DOH Medical Logistics Center, Public Health locations, healthcare facilities, including pharmacies, and healthcare professionals.
h. Engage with federally recognized and non-recognized tribal nations.

2. Coordinate with the Northwest Healthcare Response Network (NWHRN), convene leadership from local healthcare systems and clinics to provide clinical guidance, critical updates, and identify their availability, capacity, and needs in order to dispense and administer therapeutics.
3. Coordinate with the Washington State Pharmacy Association (WSPA) to:
    a. Identify local pharmacy capacity for storing and handling therapeutics.
    b. Identify local pharmacy capacity for dispensing and administering therapeutics.
    c. Identify sites for Points of Dispensing (PODs) that are safe and accessible to impacted populations and communities through existing agreements and contracts.
    d. Identify need for closed PODs, such as hospitals serving their own staff and patients, private businesses serving employees and their families, or universities serving their students.
    - **Lead:** Medical Countermeasures (MCM) Branch.
    - **Support:** Operations Section Chief, Logistics Section, Liaison Officer, Equity Officer, Local Health Officer (LHO) or their designee.

- *Strategy:* Review and establish Public Health's roles and responsibilities for augmenting existing infrastructure related to ordering, receiving, storing, distributing, dispensing and/or administering medication that can be used to treat or prevent illness among individuals.
    1. Explore new sites for open PODs that are safe and accessible to impacted populations and communities.
    2. Ensure clinical and non-clinical staff and volunteers are properly trained across all POD operations.
    3. Provide technical guidance to partners organizing and leading their own POD operations.
    4. Coordinate internally with King County departments, divisions, and programs that serve high-risk groups, such as Healthcare for the Homeless, King County Jails, and the Department of Community and Human Services, to ensure access to therapeutics for people experiencing homelessness or reside in unstable or temporary housing.
    5. Coordinate with Emergency Medical Services (EMS) to support potential medication dispensing.
    6. In the event of serving as a regional distribution hub, ensure the Chinook pharmacy site, currently serving as a vaccine depot, can be properly staffed, and is able to accommodate the receiving, storage, and distribution of therapeutics.

[15] Administration for Strategic Preparedness and Response. Strategic National Stockpile.

7. Ensure residents who are unable to receive therapeutics at existing PODs or healthcare facilities (such as individuals who are home-bound or in long-term care facilities) have access through alternative channels or mobile teams that can delivery or administer at their place of residence.
    - **Lead:** Medical Countermeasures Branch.
    - **Support:** Operations Section Chief, Logistics Section, Liaison Officer, Equity Officer, Local Health Officer or their designee.

- *Strategy*: In the event of bioterrorism identified by the United States Postal Service's (USPS) Biohazard Detection System Program (BDS) or the Department of Homeland Security's (DHS) BioWatch Program, support initial response efforts as outlined in regional plans.
    - **Lead:** Epidemiology and Surveillance Branch.
    - **Support:** Medical Countermeasures Branch, Area Commander, Operations Section Chief, Logistics Section, Liaison Officer, Public Information Officer (PIO), Local Health Officer or their designee.
- *Strategy:* Provide technical input into local guidance, policy development, communications, and content development.
    - **Lead:** Epidemiology and Surveillance Branch.
    - **Support:** Medical Countermeasures Branch, Operations Section Chief, Logistics Section, Policy Officer, Liaison Officer, Public Information Officer, Local Health Officer or their designee.
- *Strategy:* Identify, and potentially develop, the data systems and technology that will be required for order requests, inventory tracking, dose dispensing, reporting, and data sharing.
    - **Lead:** Epidemiology & Surveillance Branch.
    - **Support:** Medical Countermeasures Branch, Logistics Section Chief.

DISTRIBUTION AND DISPENSING IMPLEMENTATION

OBJECTIVE: FOR THERAPEUTIC ADMINISTRATION AND/OR DISPENSING, IMPLEMENT AN EQUITABLE STRATEGY TO ENSURE A WIDE RANGE OF ACCESS POINTS TO IMPACTED AND HIGHEST-RISK POPULATIONS.

- *Strategy*: When necessary, open PODs operated by Public Health at Public Health Clinics or other locations established through Memorandums of Understanding (MOUs).
    1. Ensure sites are accessible, provide appropriate accommodations, and interpretation is available.
    2. Coordinate with law enforcement if security is required on-site.
        - **Lead:** Medical Countermeasures Branch.
        - **Support:** Operations Section Chief, Epidemiology and Surveillance Branch, Logistics Section Chief, LHO or their designee.
            - **Resources:** Preparedness MCM MOUs; COVID Community Vaccination Events (CVE) and POD playbooks (inclusive of site layouts, staffing structures, supply lists, and job action sheets).
- *Strategy:* Coordinate with public and private partners to operate open and closed PODs throughout King County.
    - **Lead:** Medical Countermeasures Branch.
    - **Support:** Operations Section Chief, Logistics Section, Liaison Officer, Equity Officer.

        - **Resources**: Preparedness MCM MOUs; COVID POD playbooks (inclusive of site layouts, staffing structures, supply lists, and job action sheets).
- *Strategy:* Address the unique needs and circumstances of communities and populations at higher risk during the incident, as well as those who may be disproportionately impacted due to historical and current inequities.
    1. Utilizing data, current epidemiology, and input from community, identify barriers, possible solutions and outreach strategies for populations and sectors at highest risk.
    2. Ensure educational materials and information shared is in language and formats accessible to all groups.
    3. Build upon established relationships with community partners.
    4. Collaborate with community navigators.
    5. Partner with healthcare systems, clinics, providers, and community-based organizations who specialize in serving the impacted population.
        - **Lead:** Therapeutics Group and Community Mitigation and Wellbeing Branch.
        - **Support:** Medical Countermeasures Branch Director, Epidemiology and Surveillance Branch, Operations Section Chief, Logistics Section, Liaison Officer, Equity Officer**.**
- *Strategy:* Coordinate with DOH and healthcare partners to support and facilitate provider enrollment and onboarding for a Food and Drug Administration (FDA) Investigational New Drug (IND) Application. Consider partnering with a healthcare system to serve as a regional hub for receiving and distributing treatment; develop protocols for providers to accessing available inventory.
    - **Lead:** Therapeutics Group.
    - **Support:** Operations Section Chief.

MONITOR AND ASSESS:

OBJECTIVE: CONTINUOUSLY REVIEW THERAPEUTIC ADMINISTRATION AND DISPENSING RATES AND DEMOGRAPHICS, AND UPDATE STRATEGIES FOR RESOURCE ALLOCATION AND TARGETED OUTREACH APPROACHES TO MEET THE NEEDS OF THE COMMUNITY.

- Strategy: Solicit on-going community feedback and enhance outreach strategies specifically focused on impacted populations, communities, and/or sectors experiencing hesitancy or barriers to access.
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Therapeutics Group Supervisor, Epidemiology and Surveillance Branch, Operations Section Chief, Logistics Section Chief, Liaison Officer, Equity Officer**.**
- *Strategy*: Ensure public messaging and information included on the public health website is tailored to address the specific concerns of disproportionately impacted communities and those historically impacted by inequity in healthcare resource access.

    Lead: Therapeutics Group.

    Support: Epidemiology and Surveillance Branch, Operations Section Chief, Logistics, Section Chief, Community Mitigation and Wellbeing Branch, Liaison Officer, Equity Officer**.**

OBJECTIVE: MAINTAIN ONGOING AWARENESS OF EVOLVING SAFETY PROTOCOLS AND CLINICAL BEST PRACTICES

- *Strategy*: Report adverse reactions experienced at public health operated PODs.

1. Coordinate with DOH to ensure protocols and procedures for reporting and follow-up are developed and updated as necessary.
2. Ensure staff have received the proper training on responding to and reporting adverse reactions.

- *Strategy:* Coordinate with DOH to follow-up on reported adverse reactions experienced at all King County sites administering treatment or dispensing medication.
    - **Lead:** Epidemiology and Surveillance Branch.
    - **Support:** Therapeutics Group Supervisor, POD Group supervisor, Policy officer, PIO, communications response team, Local Health Officer or their designee**.**

INTEGRATE OPERATIONS

OBJECTIVE: MEDICAL COUNTERMEASURES BRANCH DIRECTOR AND THERAPEUTICS GROUP SUPERVISOR WILL INTEGRATE EFFORTS ACROSS THE HEALTH AND MEDICAL AREA COMMAND (HMAC) STRUCTURE TO ENSURE COORDINATION, PROPER SAFETY MEASURES, APPROPRIATE INTERNAL AND EXTERNAL COMMUNICATION, IDENTIFICATION OF NEEDED RESOURCES AND ADMINISTRATIVE SUPPORT, AND THAT EFFECTIVE UTILIZATION AND PRIORITIZATION OF AVAILABLE RESOURCES ARE IMPLEMENTED.

- *Strategy:* Track and escalate issues and problems related to distribution, dispensing, or administration to Operations Section Chief, Logistics Section, or others as needed.
- *Strategy*: Ensure Policy Officer and Government Affairs response staff are equipped to advocate for and communicate around current and projected response needs and countermeasure allocation and distribution.
- *Strategy:* Provide ongoing technical input into local guidance related to therapeutics, policy development, and communications.
    1. Technical input supports the PIO, PICC, or risk communication teams with:
        a. Responding to inquiries from internal groups, external partners, and the public
        b. Developing, sharing, and disseminating timely information to the public and partners through different communication channels, which may include social media, Public Health blog, local media outlets, Public Health website, healthcare facility listservs, regional partners (i.e., NWHRN) and during coordination meetings.
        c. Technical input may also be used to support content development for responder safety materials.
- *Strategy:* Ensure standards and guidelines for responder safety and health, including personal protective equipment (PPE) and respirator fit testing, are identified, and implemented (refer to Responder Safety and Health guide).
- *Strategy:* Coordinate with Safety Officer to develop guidelines and processes for reporting and reviewing adverse events experienced at Public Health operated PODs.
- *Strategy:* Coordinate with Logistics Section for supplies and resources that may be needed to support Public Health operated PODs.
- *Strategy:* Coordinate with Finance and Administration Section for staffing needs at public health operated PODs, as well as facilitating contracts or MOUs for sites or staffing.
    - **Lead:** Medical Countermeasures Branch and Therapeutics Group.

VACCINATION

Ensuring the timely and equitable provision of authorized and/or approved vaccines may be necessary to minimizing morbidity and mortality during a biological incident. The objectives and strategies below should meet the needs of a widespread event that impacts King County, but also be scalable to cover smaller-scale incidents for localized and affected populations. Throughout a response, these objectives and strategies may vary depending on the size and characteristics of the population impacted, the availability of vaccines, epidemiology of the disease, and resources such as internal staffing and capacity of governmental, community and private partners.

PREPARATION

OBJECTIVE: COORDINATE WITH LOCAL, STATE AND FEDERAL PARTNERS TO ENSURE READINESS FOR LOCAL VACCINATION OPERATIONS.

- *Strategy*: Engage early with internal and external planning partners who are critical to vaccine outreach and delivery services.
    1. Coordinate with the Washington State Department of Health (DOH) to:
        a. Center equity in allocation decision-making when demand for vaccine exceeds availability.
        b. Develop eligibility, prioritization, and allocation criteria, based on local epidemiology of the disease.
        c. Develop required documentation (e.g., screening and intake forms, standing orders).
        d. Establish a local vaccine uptake goal based on the severity of illness, local epidemiology, and availability of supply, acknowledging that goals may shift as the incident evolves. Uptake goals should consider equitable rates across race, ethnicity, and geography.
        e. Establish anticipated timelines, expected allocations, roles, and responsibilities for receiving and distributing vaccines between the DOH Medical Logistics Center, Public Health locations, healthcare facilities, pharmacies, and healthcare professionals.
    2. Identify Public Health's role in ordering, receiving, storing, distributing and/or administering vaccine based on the epidemiology of the outbreak and characteristics of available vaccine products, including (but not limited to) one or more of the potential options below:
        a. Serving as a regional vaccine distribution hub (depot).
        b. Operating Points of Dispensing (PODs) at Public Health Clinics
        c. Operating a medium to high-volume fixed site.
        d. Deploying Public Health mobile teams to individual homes, congregate settings, or community locations (such as homeless service sites, long-term care facilities, senior centers, schools and child-care, businesses, and faith-based organizations).
        e. Creating a Community Vaccination Events (CVE) Team to identify and prioritize vaccine access points for groups and communities in locations including, but not limited to senior centers, farmer's markets, faith-based organizations, and community-based organizations.

f. Utilizing existing contracts, or developing new contracts, with mobile vaccinators to augment federal and local efforts to vaccinate high-risk populations in their homes, congregate settings, or community sites.
g. Leveraging existing programs focused on serving other high-risk populations, such as the mobile medical van or Jail Health Services Division.
h. Coordinating between the Centers for Disease Control and Prevention (CDC), DOH, and healthcare partners on forms and processes related to investigational vaccines.
i. In some circumstances, during a local or state-level emergency proclamation, the local health officer or their designee may coordinate with the King County Executive to request the Governor waive state laws and rules associated with prescribing, storing, handling, and dispensing medications for the duration of the incident.
j. In coordination with the Northwest Healthcare Response Network (NWHRN), convene leadership from local healthcare systems and vaccine delivery partners to identify their availability, capacity, and needs to be able to administer vaccine to their own personnel, their patients, and the community.
k. Identify POD sites for immediate and first wave operations through existing agreements and contracts.
l. Explore new sites for temporary or fixed PODs that are safe and accessible to impacted populations and communities.
m. Provide technical input into local guidance, policy development, communications, and content development.
n. Identify the data systems and technology that will be required for vaccine inventory and dose administration tracking, reporting, data sharing, depot requests, community clinic requests, referrals, or POD operations (e.g., scheduling/registration platforms).

- **Lead:** Medical Countermeasures Branch.
- **Support:** Epidemiology and Surveillance Branch; Public Information Officer; Operations Section Chief; Logistics Section; Liaison Officer; Equity Officer; Policy Officer; Local Health Officer (LHO) or their designee.

- *Strategy:* Address the unique needs and circumstances of communities and populations at *higher risk during the incident, as well as those who may be disproportionately impacted* due to historical and current inequities.
  1. Ensure educational materials and information shared is in language and formats accessible to all groups.
  2. Build upon established relationships with community partners.
  3. Collaborate with community navigators.
  4. Partner with healthcare systems, clinics, pharmacies, providers, and community-based organizations who specialize in serving the impacted population, or communities at higher risk of disease burden.
     - **Lead:** Community Mitigation and Wellbeing Branch.
     - **Support:** Medical Countermeasures Branch; Epidemiology and Surveillance Branch; Operations Section Chief; Equity Officer**.**
- *Strategy*: Draft regional vaccine delivery strategy based on federal and state guidance, community feedback, and local resource availability.
  1. Update equity principals for vaccine delivery based on community feedback.
     - **Lead:** Medical Countermeasures Branch.

- **Support:** Epidemiology and Surveillance Branch; Public Information Officer; Operations Section Chief; Equity Officer; Policy Officer**.**

DISTRIBUTION AND DISPENSING IMPLEMENTATION

OBJECTIVE: IMPLEMENT A MULTI-MODAL VACCINE STRATEGY AS APPROPRIATE TO THE SPECIFIC BIOLOGICAL INCIDENT, CENTERED IN EQUITABLE APPROACHES TO ENSURE A DIVERSE RANGE OF ACCESS POINTS TO SERVE IMPACTED AND HIGHEST RISK POPULATIONS.

- *Strategy*: Open PODs led by public health at public health clinics or other locations established through Memorandums of Understanding (MOUs).
  1. Ensure sites are accessible, provide appropriate accommodations, and interpretation is available.
  2. Ensure clinical and non-clinical staff and volunteers are properly trained across all POD operations.
  3. Coordinate with law enforcement if security is required on site.
     - **Lead:** Vaccination Group.
     - **Support:** Epidemiology and Surveillance Branch; Community Mitigation and Wellbeing Branch; Operations Section Chief; Logistics Section; Policy Officer; Equity Officer; Safety Officer.
- *Strategy:* Coordinate with external partners to operate open and closed PODs throughout King County. Explore private/public partnerships to support medium to high-volume fixed sites.
  - **Lead:** Vaccination Group.
  - **Support:** Operations Section Chief; Logistics Section Chief; Policy Officer; Equity Officer.
- *Strategy*: Identify intake and referral processes for scheduling and assigning mobile vaccinators to community locations or private residences.
  - **Lead:** Vaccination Group.
  - **Support:** Public Information Contact Center (PICC) Group; Operations Section Chief.
- *Strategy:* Utilizing data, current epidemiology, and input from community, identify barriers, possible solutions and outreach strategies for populations and sectors at highest risk.
  - **Lead:** Vaccination Group.
  - **Support:** Epidemiology and Surveillance Branch; Community Mitigation and Wellbeing Branch; Operations Section Chief.

MONITOR AND ASSESS

OBJECTIVE: REVIEW VACCINE UPTAKE RATES TO UPDATE STRATEGIES FOR RESOURCE ALLOCATION AND TARGETED OUTREACH APPROACHES TO MEET THE NEEDS OF THE COMMUNITY.

- *Strategy*: Evaluate uptake goals throughout the vaccination campaign, as goals may shift as epidemiology and severity of incident evolves.
  1. In partnership with community and faith-based partners, continuously review delivery strategies to ensure the needs of the community are being met, including but not limited to information being disseminated in diverse languages and formats, vaccine access points are in safe and familiar locations, transportation barriers are addressed, vaccine sites are

universally accessible and accommodating, translation services are offered, and technology barriers are addressed.
2. Solicit on-going community feedback to better understand concerns and barriers to vaccination efforts.
3. Enhance outreach strategies specifically focused on populations, communities, and/or sectors in which vaccine uptake is low, but disease burden is high.
    - **Lead:** Vaccination Group.
    - **Support:** Epidemiology and Surveillance Branch; Community Mitigation and Wellbeing Branch; Operations Section Chief; Equity Officer.

- *Strategy*: Ensure public messaging is tailored to address the specific concerns of disproportionately impacted and communities impacted by historic inequities in healthcare resource access.
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Medical Countermeasures Branch; Operations Section Chief; Public Information Officer.

OBJECTIVE: MAINTAIN ONGOING AWARENESS OF EVOLVING SAFETY PROTOCOLS AND CLINICAL BEST PRACTICES.

- *Strategy*: Ensure adverse reactions experienced at public health operated PODs are reported into the Vaccine Adverse Event Reporting System (VAERS) within the required timeframe.
- *Strategy*: Ensure local healthcare providers are aware of procedures for identifying and reporting potential vaccine adverse events (e.g., VAERS reports) and facilitate reporting of such events when appropriate.
- *Strategy:* Coordinate with Washington State Department of Health (DOH) to *f*ollow- up reported adverse reactions experienced at all King County vaccination sites.
    - **Lead:** Safety Officer.
    - **Support:** Medical Countermeasures Branch; Operations Section Chief; Policy Officer; Local Health Officer (LHO) or their designee.

INTEGRATE OPERATIONS

OBJECTIVE: INTEGRATE EFFORTS ACROSS THE HMAC STRUCTURE TO ENSURE COORDINATION, PROPER SAFETY MEASURES, APPROPRIATE INTERNAL AND EXTERNAL COMMUNICATION, AND EFFECTIVE UTILIZATION AND PRIORITIZATION OF AVAILABLE RESOURCES ARE IMPLEMENTED.

- *Strategy:* Track and escalate issues and problems related to vaccine distribution and dispensing to *Operations Section Chief*, *Logistics Section*, or others as needed.
- *Strategy*: Ensure *Policy Officer* and Government Affairs response staff are equipped to advocate for and communicate around vaccine allocation, distribution, and administration.
- *Strategy:* Provide ongoing technical input into local guidance related to vaccines, development of internal and external guidance, policy development, and communications.
    1. Technical input supports the *Public Information Officer (PIO)*, *Public Information Contact Center (PICC) Group*, or *Communications Response Team* with:
        a. Responding to inquiries from internal groups, external partners, and the public
        b. Developing, sharing, and disseminating timely information to the public and partners through different communication channels, which may include

social media, Public Health blog, local media outlets, Public Health website, healthcare facility listservs, regional partners (i.e., NWHRN), and during coordination meetings.

c. Technical input may be used to support content development for responder safety materials.
d. Technical input may also be offered to support decision-making related to implementation of vaccine mandates or verification policies by the Policy Officer, Local Health Officer, or Director of Public Health.

- *Strategy:* Ensure standards and guidelines for responder safety and health, including PPE and respirator fit testing, are identified, and implemented.
- *Strategy:* Coordinate with *Safety Officer* to develop guidelines and processes for reporting and reviewing adverse events experienced at Public Health-operated PODs.
- *Strategy:* Coordinate with *Logistics Section* for supplies and resources that may be needed to support Public Health-operated PODs.
- *Strategy:* Coordinate with *Finance and Administration Section* for staffing needs at Public Health-operated PODs, as well as facilitating contracts or MOUs for sites or staffing.
    - **Lead:** Vaccination Group.

5 | NON-PHARMACEUTICAL INTERVENTIONS

These objectives guide implementation of non-pharmaceutical interventions (NPIs) to minimize the spread of infectious disease in the community, prioritizing measures to support high risk populations and settings. NPIs encompass an array of objectives and strategies that, when effectively implemented, often serve as the initial line of defense in curtailing the transmission of infectious disease agents, especially when pharmaceutical interventions such as vaccines or antiviral medications may not be readily available or highly efficacious. This section of the *Biological Incident Response Annex* is dedicated to an exploration of NPI objectives and strategies with a primary focus on three pivotal areas:

- *Infection Prevention and Control* practices across different settings and communities.
- *Personal Protective Equipment.*
- *Isolation and Quarantine.*

The implementation of the objectives and strategies outlined in this section will require coordination across the Health and Medical Area Command (HMAC) and will be guided by resources such as the *Non-Pharmaceutical Interventions and Community Mitigation Guide.* The strategies outlined here are a menu of strategies from which response operations may be crafted, although not all may be possible, and activities may be implemented sequentially and not simultaneously.

INFECTION PREVENTION AND CONTROL

PREPARE

OBJECTIVE: COORDINATE WITH LOCAL AND STATE PARTNERS TO DISCUSS (OR REVIEW) NATIONAL GUIDANCE AND LOCAL EPIDEMIOLOGICAL DATA FOR INFECTION PREVENTION AND CONTROL INTERVENTIONS.

- *Strategy***:** Based on current data and in collaboration with key response and community partners, assess the current potential utility and feasibility for implementing personal infection prevention and control measures, e.g., masking, voluntary home isolation, respiratory etiquette, hand hygiene.
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Epidemiology and Surveillance Branch; Public Information Officer.
- *Strategy***:** Based on epidemiological data and in collaboration with key response and community partners, assess the potential utility and feasibility of implementing community infection prevention and control measures (e.g., voluntary home isolation, masking in community settings, closures of schools, workplaces and other congregate settings, cancellations of public gatherings).
    - **Lead:** Local Health Officer**;** Community Mitigation and Wellbeing Branch; Policy Officer
    - **Support:** Epidemiology and Surveillance Branch; Public Information Officer.
- *Strategy***:** Based on epidemiological data and in collaboration with key response and community partners, assess the potential utility and feasibility of implementing environmental infection prevention and control measures (e.g., community-wide sanitation and hygiene protocols, congregate setting sanitation and hygiene protocols, ventilation guidance).
    - **Lead:** Local Health Officer; Community Mitigation and Wellbeing Branch.

  - **Support:** Epidemiology and Surveillance Branch; Public Information Officer.
- *Strategy:* Prepare for the implementation of infection prevention and control measures that involve budgetary and staffing considerations (i.e., setting-specific infection prevention and control technical assistance).
  - **Lead**: Operations Section Chief; Community Mitigation and Wellbeing Branch.
  - **Support**: Epidemiology and Surveillance Branch.
- *Strategy:* Convene local community partners for informational sessions to identify barriers and potential adverse effects associated with the implementation of infection prevention and control strategies in different settings (e.g., schools, daycares, workplaces, faith-based organizations, shelters).
  - **Lead***: Community Mitigation and Wellbeing Branch.*

OBJECTIVE: DEVELOP INFORMATION SHARING AND COMMUNITY ENGAGEMENT PLAN TO DISSEMINATE INFECTION PREVENTION AND CONTROL INITIATIVES.

- *Strategy***:** Collaborate with internal partners (within Public Health and across King County) to plan for public information and community engagement campaigns to disseminate information regarding personal, community, and environmental infection prevention and control measures.
  - **Lead:** Community Mitigation and Wellbeing Branch.
  - **Support:** Public Information Officer.
- *Strategy***:** Reach out to external partners (including businesses and other community partners) that have existing relationships with programs at Public Health and King County to collaboratively develop public communications and plan for disseminating information regarding personal, community, and environmental infection prevention and control measures to communities.
  - **Lead:** Community Mitigation and Wellbeing Branch.
  - **Support:** Public Information Officer.
- *Strategy***:** Coordinate across HMAC leadership to consider a compensated community taskforce, convening community partners through informational sessions to gather feedback on infection prevention and control strategy implementation, or other approaches.
  - **Lead:** Community Mitigation and Wellbeing Branch.
  - **Support**: Operations Section Chief.

IMPLEMENT

OBJECTIVE: INCREASE PUBLIC AWARENESS AND UNDERSTANDING OF INFECTION PREVENTION AND CONTROL MEASURES IN DIFFERENT SETTINGS ACROSS KING COUNTY.

- *Strategy:* Create informational resources about infection prevention and control measures in multiple languages and formats (i.e., ASL, Braille, audio) that are reflective of the diverse linguistic needs of the county's population.
  - **Lead:** Community Mitigation and Wellbeing Branch.
  - **Support:** Public Information Officer.
- *Strategy:* Create compensated community task forces comprised of community leaders, healthcare professionals, and representatives from community groups to guide the development of guidance for infection prevention and control implementation efforts.
  - **Lead:** Community Mitigation and Wellbeing Branch.
  - **Support:** Public Information Officer.

- *Strategy:* Conduct culturally appropriate and targeted outreach campaigns by utilizing established and trusted communication and outreach channels (including but not limited to digital platforms, social media, and local media outlets) to share information regarding personal, community, and environmental infection prevention and control measures.
    - **Lead:** Public Information Officer; Communications Response Team.
    - **Support:** Community Mitigation and Wellbeing Branch.
- *Strategy*: Organize culturally tailored informational sessions on infection prevention and control measures for community members, healthcare providers, and local organizations to foster a shared understanding, get feedback on implementation, and foster a collaborative approach.
    - **Lead:** Community Mitigation and Wellbeing Branch; Communications Response Team.
    - **Support:** Public Information Officer.

OBJECTIVE: CARRY OUT APPROPRIATE INFECTION PREVENTION AND CONTROL STRATEGIES THAT ALIGN WITH THE EPIDEMIOLOGY AND SEVERITY OF THE DISEASE AND ARE INFORMED BY COMMUNITY PRACTICES.

- *Strategy***:** Support implementation of specific *personal* infection prevention and control strategies that mitigate the spread of community transmission based on the epidemiology of the disease and communicate recommended measures to the public (e.g., voluntary home isolation, respiratory etiquette, hand hygiene, mask use, improved indoor air quality).
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Epidemiology and Surveillance Branch; Public Information Officer.
- *Strategy***:** Support implementation of specific *community* infection prevention and control strategies that mitigate the spread of community transmission based on the epidemiology and severity of the disease and communicate recommended measures to the public (e.g., voluntary home quarantine of non-ill household members of infected persons, masking in community settings, respiratory etiquette, hand hygiene).
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Epidemiology and Surveillance Branch; Public Information Officer.
- *Strategy***:** Support implementation of specific *environmental* infection prevention and control strategies that mitigate the spread of community transmission based on the epidemiology and severity of the disease and communicate recommended measures to the public.
    - **Lead:** Community Mitigation and Wellbeing Branch
    - **Support:** Epidemiology and Surveillance Branch; Public Information Officer
- *Strategy:* Assess the feasibility of recommending closures, cancellations, and/or physical distancing measures of mass gathering sites, workplaces, schools, and community events.
    - **Lead:** Local Health Officer; Area Commander.
    - **Support**: Public Information Officer; Community Mitigation and Wellbeing Branch**.**

OBJECTIVE: ADDRESS BARRIERS TO INFECTION PREVENTION AND CONTROL MEASURE ADOPTION WITHIN UNDERSERVED AND AT-RISK COMMUNITIES IN KING COUNTY.

- *Strategy:* Identify barriers to infection prevention and control measure adoption using feedback from the *Isolation and Quarantine Group*, *Equity Officer*, and *Communications Response Team.*
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Isolation and Quarantine Group; Equity Officer; Communications Response Team.

- *Strategy:* Develop community-specific strategies and resources, considering cultural norms, language preferences, and socioeconomic considerations to enhance infection prevention and control measure adherence and sustainability within diverse communities.
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Public Information Officer.
- *Strategy:* Develop communication campaigns that consider language, cultural norms, and socio-economic factors to effectively convey the importance and benefits of infection prevention and control measures within specific communities to support response communications efforts.
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Public Information Officer.
- *Strategy:* Establish programs that offer financial assistance for individuals from low-income backgrounds to access essential infection prevention and control supplies.
    - **Lead:** Community Mitigation and Wellbeing Branch**.**

MONITOR AND ASSESS

OBJECTIVE: UTILIZE DATA FOR EVIDENCE-BASED DECISION-MAKING AND TO MONITOR AND ASSESS IMPLEMENTATION OF INFECTION PREVENTION AND CONTROL MEASURES TO IDENTIFY ONGOING CHALLENGES, DISPARITIES, AND ADJUST STRATEGIES ACCORDINGLY.

- *Strategy*: Maintain community engagement mechanisms to connect with community members, community-based organizations, and leaders to gather insights and perspectives on implementation of infection prevention and control measures, ensuring community involvement in decision-making processes.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Epidemiology and Surveillance Branch; Public Information Officer.
- *Strategy:* Based on response staff capacity, conduct periodic surveys focused on infection prevention and control measure adherence, knowledge, and attitudes, with a particular emphasis on collecting data from diverse racial, ethnic, and socioeconomic groups. Utilize stratified sampling techniques to ensure representative data collection.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Epidemiology and Surveillance Branch; Public Information Officer.
- *Strategy*: Analyze monitoring and assessment data regularly to identify trends, patterns, and disparities in implementation of infection prevention and control measures across racial, ethnic, and socioeconomic groups. Use this evidence to inform targeted interventions and adjust strategies as needed.
    - **Lead**: Epidemiology and Surveillance Branch; Data Branch.
    - **Support**: Public Information Officer; Community Mitigation and Wellbeing Branch.
- *Strategy:* Share monitoring and assessment data with local health departments, healthcare providers, and policymakers, fostering collaboration and collective action in addressing disparities and improving implementation of infection prevention and control strategies.
    - **Lead**: Public Information Officer.
    - **Support**: Community Mitigation and Wellbeing Branch; Epidemiology and Surveillance Branch.

- *Strategy:* Conduct equity assessments and use health equity metrics including economic and social impact of infection prevention and control measures on impacted populations (i.e., considering factors such as unemployment rates, housing stability, food security, and access to healthcare).
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Epidemiology and Surveillance Branch.

INTEGRATE OPERATIONS

OBJECTIVE: INTEGRATE INFECTION PREVENTION AND CONTROL IMPLEMENTATION EFFORTS ACROSS HMAC STRUCTURE TO ENSURE COORDINATION AND EFFECTIVE UTILIZATION AND PRIORITIZATION OF AVAILABLE STAFFING AND RESOURCES.

- *Strategy:* Track and escalate issues and problems related to implementation of setting specific infection prevention and control measures to *Operations Section Chief*, *Logistics Section*, or others as needed.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support:** Epidemiology and Surveillance Branch; Public Information Officer.

- *Strategy:* Establish a meeting series with *Epidemiology and Surveillance Branch* to identify trends in adherence to infection prevention and control measures and any associated changes in community health outcomes.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Epidemiology and Surveillance Branch.

PERSONAL PROTECTIVE EQUIPMENT

PREPARE

OBJECTIVE: COORDINATE WITH LOCAL, STATE, AND FEDERAL PARTNERS ON SPECIFIC PPE GUIDANCE AND IMPLEMENTATION, POTENTIAL SUPPLY SHORTAGES, AND PROCUREMENT OPTIONS.

- *Strategy*: Coordinate with state and develop a plan for addressing potential PPE supply shortages by reviewing existing warehouse inventory of all PPE supplies and identifying demand across response and community partners.
    - **Lead**: Logistics Section.
    - **Support**: Operations Section Chief.
- *Strategy:* In coordination with the Northwest Healthcare Response Network (NWHRN), convene healthcare partners to discuss PPE guidelines and assess for any shortages of supplies across King County facilities.
    - **Lead**: Operations Section Chief.
    - **Support**: Logistics Section.
- *Strategy*: In coordination with the Emergency Medical Services Division (EMS), convene regional EMS agencies to discuss PPE guidelines and assess for any shortages of supplies.
    - **Lead:** Operations Section Chief.
    - **Support:** Logistics Section.
- *Strategy:* In coordination with local community partners (CBOS, FBOs, community centers, schools, etc.), identify any shortages and/or PPE supply needs.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Operations Section Chief; Logistics Section Chief.
- *Strategy*: Identify vendors that can supply required PPE.
    - **Lead**: Logistics Section.
    - **Support**: Operations Section Chief.
- *Strategy*: Begin outlining prioritization criteria for PPE distribution to prepare for scarce supplies.
    - **Lead**: Operations Section Chief.
    - **Support**: Logistics Section.

IMPLEMENT

OBJECTIVE: USING A DATA-DRIVEN APPROACH, SUPPORT ALLOCATION PRIORITIZATION AND DISTRIBUTION OF PPE TO IMPACTED GROUPS AND FACILITIES IN ACCORDANCE WITH STATEWIDE GUIDANCE (AS AVAILABLE).

- *Strategy:* Use data to assess most frequently requested items and order available supplies through regular procurement channels.
    - **Lead**: Logistics Section.
    - **Support**: *Epidemiology and Surveillance Branch.*
- *Strategy:* In the event of supply shortages, coordinate with King County OEM and DOH to request supplies from the Strategic National Stockpile.
    - **Lead**: Logistics Section.

  - **Support**: Operations Section Chief.
- *Strategy*: Coordinate with King County Office of Emergency Management and Washington State Department of Health on the allocation and distribution of PPE.
  - **Lead:** Logistics Section; Operations Section.
- *Strategy:* Utilize allocation prioritization tool developed during COVID-19 response to ensure equitable distribution of PPE supplies to facilities and communities at highest risk and need, with particular focus on communities with highest disease burden rate and limited resources.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Operations Section Chief; Logistics Section; Equity Officer.

OBJECTIVE: ENSURE EQUITABLE ACCESS TO PPE RESOURCES AND SUPPORT FOR HIGH-RISK, HIGH-NEED POPULATIONS IN KING COUNTY.

- *Strategy:* Distribute affordable or free PPE supplies to high-risk residents who may face financial barriers through partnerships with local businesses, King County departments (Library System, Department of Local Services, Department of Community and Human Services), local community and faith-based organizations, and others.
  - **Lead:** Community Mitigation and Wellbeing Branch.
  - **Support:** Public Information Officer.
- *Strategy:* Identify diverse communication channels and platforms to reach at-risk populations, including multilingual informational spaces where individuals can seek guidance on accessing PPE and receive assistance tailored to their specific needs.
  - **Lead:** Community Mitigation and Wellbeing Branch.
  - **Support:** Public Information Officer.
- *Strategy*: Coordinate delivery and appropriate use of sanitation and hygiene resources to key congregate settings at high risk of or disproportionately affected by disease transmission.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Epidemiology and Surveillance Branch; Washington State Department of Health Incident Management Team.

OBJECTIVE: COORDINATE WITH LOCAL AND STATE PARTNERS TO IMPLEMENT PPE ALLOCATION PRIORITIZATION AND DISTRIBUTION APPROACH.

- Strategy: Coordinate with King County Office of Emergency Management (King County OEM) and Washington State Department of Health (DOH) to request supplies from the Strategic National Stockpile.
  - **Lead:** Community Mitigation and Wellbeing Branch.
  - **Support:** Logistics Section.
- *Strategy*: Coordinate with King County OEM and DOH on the allocation and distribution of PPE.
  - **Lead:** Community Mitigation and Wellbeing Branch.
- *Strategy:* Utilize prioritization tool to ensure equitable distribution of supplies to facilities and communities at highest risk.
  - **Lead**: Community Mitigation and Wellbeing Branch.
  - **Support**: Operations Section Chief; Logistics Section Chief; Equity Officer.

MONITOR AND ASSESS

OBJECTIVE: REVIEW IMPLEMENTATION OF PPE STRATEGIES FOR ONGOING CHALLENGES.

- *Strategy*: Review ongoing supply shortages and support for distributing PPE to local community partners.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Operations Section Chief; Logistics Section Chief.
- *Strategy*: Continue to coordinate with local and state partners on prioritization, allocation, and distribution, scaling as needed.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Operations Section Chief; Logistics Section Chief.
- *Strategy*: Coordinate with the warehouse to monitor supply and track expiration date.
    - **Lead**: Community Mitigation and Wellbeing Branch.
    - **Support**: Operations Section Chief; Logistics Section Chief.

INTEGRATE OPERATIONS

OBJECTIVE: INTEGRATE AND UPDATE PPE IMPLEMENTATION EFFORTS TO ALIGN WITH LOCAL AND STATE INITIATIVES TO ENSURE EFFECTIVE UTILIZATION AND PRIORITIZATION OF AVAILABLE RESOURCES.

- *Strategy:* Coordinate with state and local partners on changes to PPE guidance based on resource supply and epidemiology of the disease.
    - **Lead**: IQ Group Supervisor.
    - **Support**: Operations Section Chief; Logistics Section Chiefs.

OBJECTIVE: INTEGRATE PPE IMPLEMENTATION EFFORTS ACROSS HMAC STRUCTURE TO ENSURE COORDINATION AND EFFECTIVE UTILIZATION AND PRIORITIZATION OF AVAILABLE RESOURCES.

- *Strategy:* Work with *Safety Officer* to develop PPE acquisition and distribution process for incident response staff.
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Operations Section Chief.
- *Strategy:* Track and escalate issues and problems related to prioritization and distribution of PPE to *Operations Section Chief*, *Logistics Section*, or others as needed.
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Operations Section Chief.
- *Strategy*: Ensure *Policy Officer* and Government Affairs response staff are equipped to advocate for and communicate around distribution and allocation of PPE.
    - **Lead:** Community Mitigation and Wellbeing Branch.
    - **Support:** Operations Section Chief.

ISOLATION AND QUARANTINE

DETERMINE

OBJECTIVE: DETERMINE WHETHER ISOLATION AND/OR QUARANTINE MEASURES ARE APPROPRIATE DISEASE CONTAINMENT AND MITIGATION STRATEGIES TO ADDRESS THE SPREAD OF DISEASE IN THE COMMUNITY.

- *Strategy*: Assess disease characteristics and additional essential elements of information to determine appropriate containment and/or mitigation strategies.
    - **Lead**: Epidemiology and Surveillance Branch.
    - **Support**: Operations Section Chief; Local Health Officer; Area Commander; Equity Officer; Data Branch.
        - **Resource**: DOH Non-Pharmaceutical Interventions (NPI) Implementation Guide.[16]
- *Strategy*: Develop strategy implementation recommendations to present to HMAC Command Staff.
    - **Lead**: Epidemiology and Surveillance Branch.
    - **Support**: Operations Section Chief.
        - **Attachment**: *Isolation and Quarantine Joint Service Plan*.
        - **Attachment**: *Non-Pharmaceutical Interventions and Community Mitigation Guide.*
- *Strategy*: Approve disease containment and/or mitigation recommendations and planning steps.
    - **Lead**: Local Health Officer; Area Command; Operations Section Chief.
    - **Support**: Equity Officer; Public Information Officer; Safety Officer; Logistics Section.
- Strategy: Determine and recommended resource needs to implement isolation and quarantine measures. Consider support from Washington Department of Health and Washington Health and Human Services, where applicable.
    - **Lead**: Epidemiology and Surveillance Branch.
    - **Support**: Logistics Section.
- *Strategy*: Staff appropriate HMAC positions to manage implementation plan, as needed.
    - **Lead**: Epidemiology and Surveillance Branch Director.
    - **Support**: Logistics Section; Epidemiology and Surveillance Branch
        - **Attachment**: *Isolation and Quarantine Joint Service Plan.*
        - **Attachment**: *Non-Pharmaceutical Interventions and Community Mitigation Guide.*

OBJECTIVE: DETERMINE NEED FOR ACTIVATION OF EMERGENCY SUPPORT FUNCTION #6 – MASS CARE (ESF #6).

- *Strategy*: Define scope of care coordination and wraparound services needed to support individuals isolating and quarantining at home and at other locations (hotels, motels, and IQ sites).
- *Strategy*: Define roles and responsibilities between *Isolation and Quarantine Group* aligning with ESF #8 scope and that of ESF #6.

[16] Washington State Department of Health. Non-Pharmaceutical Interventions (NPI) Implementation Guide.

- **Lead**: Operations Section Chief.
- **Support**: King County ESF #6 lead agency.
  - **Resources**: *Emergency Support Function #6 – Mass Care Plan.*

PREPARE

OBJECTIVE: DEVELOP PROCESS TO MANAGE ISOLATION AND QUARANTINE REQUESTS AND REFERRALS.

- *Strategy*: Define priority populations and resources required to support IQ referrals and care coordination support.
- *Strategy*: Develop IQ referral and triage coordination process with *Epidemiology and Surveillance Branch* to align with approved mitigation strategies.
- *Strategy*: Develop IQ care coordination support process with *Epidemiology and Surveillance Branch* to align with determined levels of care coordination and wraparound services.
- *Strategy*: Develop initial fact sheets or protocol guides with answers to legal questions and other matters for staff engaging with affected individuals, key settings (healthcare, etc.) or the public.
- *Strategy*: Identify a call line to handle IQ questions.
  - **Lead**: Isolation and Quarantine Group.
  - **Support**: Epidemiology and Surveillance Branch; Public Information Contact Center (PICC) Group.

OBJECTIVE: DEVELOP PROCESS TO IDENTIFY, MONITOR, AND TRACK CASES AMONG INDIVIDUALS EXPERIENCING HOMELESSNESS AND/OR LIVING IN CONGREGATE SHELTER SETTINGS AND CONNECT THEM TO APPROPRIATE HEALTHCARE OR IQ FACILITIES AND RESOURCES.

- *Strategy*: Develop congregate setting and shelter outbreak reporting process and community feedback mechanism.
  - **Support**: Epidemiology and Surveillance Branch; Data Branch; Community Mitigation and Wellbeing Branch.
- Strategy: Monitor and track cases identified as experiencing homelessness by case investigators and data staff for follow up regarding care coordination and out of home IQ services.
  - **Support**: Epidemiology and Surveillance Branch.
- *Strategy*: Recommend expansion of isolation and quarantine services to meet community needs, as needed.

OBJECTIVE: INTEGRATE DISEASE INVESTIGATIONS, REPORTING, AND DATA REQUIREMENTS INTO ISOLATION AND QUARANTINE OPERATIONAL PROCESSES.

- *Strategy:* Develop monitoring, reporting, and/or data sharing processes with *Epidemiology and Surveillance Branch* to manage and continually assess isolation and quarantine implementation measures.
- *Strategy:* Coordinate clinical monitoring data submission to the *Data Branch* for relevant operations, specifically implementation of isolation and quarantine sites and services strategy.
  - **Lead**: Isolation and Quarantine Group.
  - **Support**: Epidemiology and Surveillance Branch; Public Information Contact Center (PICC) Group; Logistics Section.

OBJECTIVE: DEVELOP PROCESS TO RECEIVE AND MONITOR COMMUNITY FEEDBACK AND EMBED FEEDBACK MECHANISM INTO OPERATIONS.

- **Lead**: Isolation and Quarantine Group.
- **Support**: Public Information Officer; Community Mitigation and Wellbeing Branch; Equity Officer; Equity Response Team.

OBJECTIVE: IDENTIFY CARE COORDINATION AND WRAPAROUND SERVICE NEEDS FOR THOSE DISPROPORTIONATELY IMPACTED BY ISOLATION AND QUARANTINE MEASURES AT HOME OR IN AN EXTERNAL LOCATION.

- *Strategy:* Identify priority at and high-risk populations and settings in need of care coordination support.
- *Strategy*: Identify needs relating to healthcare and behavioral health services; grocery and food delivery; laundry services; and additional care coordination resources.
- *Strategy*: Develop process to connect individuals in isolation and quarantine in need of care coordination to the appropriate support services.
  - **Lead**: Isolation and Quarantine Group.
  - **Support**: Emergency Support Function #6 – Mass Care (ESF #6).

IMPLEMENT

OBJECTIVE: IMPLEMENT APPROPRIATE INDIVIDUAL AND COMMUNITY ISOLATION AND QUARANTINE MEASURES.

- **Lead:** Isolation and Quarantine Group.
- *Strategy*: Develop and disseminate isolation and quarantine recommendations and guidance to support community-based isolation and quarantine, prioritizing at-risk settings based on disease epidemiology and severity (examples include healthcare settings, congregate settings, schools, long-term care facilities, and adult family homes), and guidance for general public.
  - **Support**: Public Information Officer*;* Communications Response Team; Community Mitigation and Wellbeing Branch*.*
- *Strategy*: Implement and manage isolation and quarantine external site services.
- *Strategy*: Develop and disseminate Local Health Officer orders, directives, and/or involuntary compliance measures relating to isolation and quarantine.
- *Strategy*: Implement port of entry isolation and quarantine measures.

OBJECTIVE: IMPLEMENT IQ CARE COORDINATION SUPPORT PROCESS.

- *Strategy*: Receive and review requests for care coordination and wraparound services for individuals isolating and quarantining at home, including requests for meals, medication support, transportation for essential medical care, etc.
  - **Lead**: Isolation and Quarantine Group.
  - **Support**: Epidemiology and Surveillance Branch; Public Information Contact Center (PICC) Group; Community Mitigation and Wellbeing Branch.

OBJECTIVE: IMPLEMENT IQ REFERRAL AND TRIAGE PROCESS.

- *Strategy*: Receive and review out of home IQ referrals from *Epidemiology and Surveillance Branch*.
    - **Lead**: Isolation and Quarantine Group.
    - **Support**: Epidemiology and Surveillance Branch; Public Information Contact Center (PICC) Group.

MONITOR AND ASSESS

OBJECTIVE: MONITOR AND ASSESS IMPLEMENTED MEASURES TO ENSURE THEY MEET COMMUNITY AND RESPONSE NEEDS.

- *Strategy:* Utilize *Epidemiology and Surveillance Branch* data to track isolation and quarantine measures' impact on transmission and key at-risk population health outcomes, as possible.
    - **Lead**: Isolation and Quarantine Group.
    - **Support**: Epidemiology and Surveillance Branch.
- *Strategy:* Utilize community feedback mechanisms to monitor and assess isolation and quarantine measures (including guidance development) for accessibility, usability, cultural relevance, and accuracy.
    - **Lead**: Isolation and Quarantine Group.
    - **Support**: Community Mitigation and Wellbeing Branch; Communications Response Team; IQ Site Supervisors.
- *Strategy*: Utilize monitoring system to ensure individuals experiencing homelessness and those living in congregate settings have alternative locations to isolate and quarantine effectively and that resources are matching demand.
    - **Lead**: Isolation and Quarantine Group.
    - **Support**: Epidemiology and Surveillance Branch; Data Branch; Community Mitigation and Wellbeing Branch.
- *Strategy*: Utilize monitoring and feedback processes to address gaps in care coordination services for individuals isolating and quarantining at home as well as at external sites.
    - **Lead**: Isolation and Quarantine Group.
    - **Support**: Emergency Support Function #6 – Mass Care (ESF #6).

INTEGRATE OPERATIONS

OBJECTIVE: INTEGRATE ISOLATION AND QUARANTINE OPERATIONS ACROSS HMAC STRUCTURE TO ENSURE COORDINATION AND EFFECTIVE UTILIZATION AND PRIORITIZATION OF AVAILABLE RESOURCES.

- *Strategy***:** Develop isolation and quarantine public information content which can be provided to at-risk or affected populations, based on implemented IQ strategies.
    - **Lead:** Isolation and Quarantine Group.
    - **Support:** Public Information Officer; Operations Section Chief; Community Mitigation and Wellbeing Branch.
- *Strategy:* Distribute isolation and quarantine guidance among HMAC and Public Health field responders.
    - **Lead:** Isolation and Quarantine Group.
    - **Support:** Safety Officer; Operations Section Chief.

OBJECTIVE: RESOLVE, TRACK, AND ESCALATE ISSUES AND PROBLEMS RELATED TO ISOLATION AND QUARANTINE TO *OPERATIONS SECTION CHIEF.*

- *Strategy:* Report operational updates at Operations Meetings; elevate concerns, issues, or feedback to relevant HMAC Operations branches and Command Staff, such as the *Equity Officer*, through the *Operations Section Chief.*
    - **Lead**: Isolation and Quarantine Group Supervisor.
- *Strategy*: Provide requested isolation and quarantine data, such as data on individuals served, planning considerations and requirements, and additional reporting deliverables defined by the *Operations Section Chief.*
    - **Lead**: Isolation and Quarantine Group Supervisor.
    - **Support**: Data Branch.

OBJECTIVE: PROVIDE RELEVANT INFORMATION AND GUIDANCE TO *POLICY OFFICER* AND GOVERNMENT AFFAIRS RESPONSE STAFF TO ENSURE THEY ARE EQUIPPED TO ADVOCATE FOR AND SHARE INFORMATION ON ISOLATION AND QUARANTINE MEASURES.

- *Strategy*: This may include discussions on isolation and quarantine site considerations and criteria, isolation, and quarantine impacts on workforce among King County employees, and requests for policy decisions relating to employees and staffing.
    - **Lead**: Isolation and Quarantine Group.
    - **Support**: Policy Officer.
- *Strategy*: Elevate gaps in measures which can be addressed through partner support, such as Washington State Department of Health (DOH) isolation and quarantine facility, coordinated care services, including transportation and meal support needs, etc.
    - **Lead**: Isolation and Quarantine Group.

OBJECTIVE: INTEGRATE OPERATIONS INTO EXISTING HMAC PROCESSES TO GATHER FEEDBACK FROM AT-RISK COMMUNITIES AND SERVICE PROVIDERS.

- *Strategy*: Establish process to receive community feedback from *Community Wellbeing and Mitigation Branch* operations. Consider feedback from homelessness service providers, refugee service providers, and other at-risk communities and settings.
- *Strategy*: Include *Community Mitigation and Wellbeing Branch* and *Equity Officer* in any development of processes to receive feedback from community and service providers directly.

6 | RESPONDER SAFETY AND WELLBEING

During the response to any biological incident, the safety and wellbeing of Health and Medical Area Command (HMAC) response staff is paramount. Within the HMAC structure, the Safety Officer is responsible for overseeing and implementing infection control measures, safety measures, and wellbeing measures to be followed and utilized by all response staff. The scope of this response area includes measures that are applicable to HMAC response staff only and field sites directly managed or staffed by Public Health response staff. This response area does not include developing guidance for response partners, such as healthcare employees or emergency medical services systems. Processes for external safety and health guidance can be found in the *Health Guidance and Public Information* response area.

DETERMINE

OBJECTIVE: DETERMINE APPROPRIATE MEASURES TO PROTECT THE SAFETY AND WELLBEING OF RESPONSE STAFF.

- *Strategy*: Assess essential elements of information (EEIs) to inform an initial safety assessment of the situation and responders.
    - **Lead:** Safety Officer.
    - **Support**: Epidemiology and Surveillance Branch; Logistics Section.
- *Strategy*: Develop policies and processes, which include identified resource needs, for HMAC Command Staff regarding implementing safety and wellbeing measures for response staff.
    - **Support:** Public Health Employee Health; King County Human Resources
- *Strategy*: Approve recommendations and planning steps.
- *Strategy*: Staff relevant HMAC positions to manage implementation of recommendations.
    - **Lead***:* Safety Officer.

PREPARE

OBJECTIVE: DEVELOP RESPONDER SAFETY AND WELLBEING **MONITORING PROCESS** TO IDENTIFY AND ADDRESS RESPONDER NEEDS.

- *Strategy:* Determine whether the response requires enhanced systems to monitor responder health and wellbeing.
- *Strategy*: Contribute safety and wellbeing components into the responder tracking system to accurately meet response scope and needs, as needed.
    - **Lead***:* Safety Officer.
    - **Support***:* Planning Section – Resource Unit; Logistics Section.
- *Strategy*: Develop responder feedback mechanism to identify burnout, stress, and other impacts to workforce.
- *Strategy*: Develop responder wellbeing assessment or survey to inform provision of Employee Assistance Program (EAP) and other wellbeing resources.
- *Strategy*: Develop process to disseminate feedback and use of feedback to response staff.

OBJECTIVE: DEVELOP NECESSARY **INFECTION CONTROL MEASURES** FOR RESPONSE STAFF.

- *Strategy*: Develop health and safety infection control protocols for key operational sites, such as testing, vaccinations, and isolation and quarantine sites.
  - **Lead:** Safety Officer.
- *Strategy*: Develop sanitation and hygiene recommendations in line with *Epidemiology and Surveillance Branch* recommendations, as needed.
- *Strategy*: Develop PPE protocols, training, and guidance to access available PPE, including fit testing processes and protocols.

OBJECTIVE: DEVELOP NECESSARY **SAFETY MEASURES** FOR RESPONSE STAFF AND OPERATIONAL SITES.

- *Strategy*: Develop safety protocols and guidance relating to additional or cascading hazards, including sharps guidance, severe weather exposure guidance, and physical safety guidance.
  - **Lead**: Safety Officer.
- *Strategy*: Develop safety protocols and guidance for key operational sites, such as testing, vaccinations, and isolation and quarantine sites.
  - **Lead**: Safety Officer.
  - **Support:** Site Safety Officers.

OBJECTIVE: DEVELOP SAFETY AND WELLBEING **GUIDANCE AND TRAINING** FOR RESPONSE STAFF ACROSS ALL RESPONSE OPERATIONS.

- *Strategy:* Conduct assessment of responder health and safety training needs, as needed.
- *Strategy*: Develop relevant responder safety and wellbeing guidance resources, including recommendations for external resources and tools.
- *Strategy*: Develop appropriate responder safety and wellbeing training in relevant formats and including feedback mechanism and contact process for staff to receive further guidance, as needed.
  - **Lead**: Safety Officer.
  - **Support**: Public Information Officer*;* Risk Communications Team; King County IT (KCIT); Logistics; Operations Section Chief.

OBJECTIVE: DELINEATE ROLES AND RESPONSIBILITIES REGARDING **EMPLOYEE AND RESPONDER** HEALTH AND SAFETY.

- *Strategy:* Delineate roles and development of system for monitoring responder and non-response employee health between *Safety Officer* and *Public Health Employee Health*.
  - **Lead***:* Safety Officer.
  - **Support***:* Public Health Employee Health.
- *Strategy:* Advise on appropriate guidance and resources required to protect the health and safety of Public Health employees not involved in the response.
  - **Lead***:* Safety Officer.
  - **Support***:* Public Health Employee Health; King County Human Resources; King County Employee Assistance Program and Balanced You; Equity Officer.
- *Strategy*: Establish a *Responder Safety Team* to manage objectives and response activities.
  - **Lead**: Safety Officer.
  - **Support**: Public Health Employee Health; King County Human Resources; Planning Section; Logistics Section.
- *Strategy*: Establish a *Responder Wellbeing Team* to manage objectives and response activities.

- **Lead**: Safety Officer.
- **Support**: Public Health Employee Health; King County Human Resources; Planning Section; Logistics Section; King County Employee Assistance Program (EAP) and Balanced You.

IMPLEMENT

OBJECTIVE: IMPLEMENT **INFECTION CONTROL MEASURES** TO SUPPORT RESPONDER SAFETY.

- *Strategy*: Customize any health screening tools based on the needs of the response.
- *Strategy*: Implement fit-testing processes and protocols for response staff.
- *Strategy*: Recommend provision of infection control measures (HEPA filters, personal protective equipment, and other environmental controls) in HMAC response spaces.
  - **Lead**: Safety Officer.
  - **Support**: Logistics Section.

OBJECTIVE: IMPLEMENT **SAFETY MEASURES** TO SUPPORT RESPONDER SAFETY.

- *Strategy*: Implement relevant safety measures across *Operations Section's* response activities to protect the safety of responders, such as: sharps guidance, severe weather exposure guidance, physical safety guidance, etc.
  - **Lead**: Safety Officer.
- *Strategy*: Implement relevant safety measures across other HMAC sections' scope of response activities to protect the safety of responders, such as: severe weather exposure guidance, physical safety guidance, etc.
  - **Lead**: Safety Officer.

OBJECTIVE: IMPLEMENT **WELLBEING MEASURES** TO SUPPORT RESPONDER WELLBEING.

- *Strategy*: Recommend safe work/rest ratio and staffing support accommodations (e.g., childcare, meals, overnight needs, ergonomic resources).
  - **Lead**: Safety Officer.
- *Strategy*: Integrate wellbeing check-ins and available wellbeing resources into response staff's operational processes (e.g., staff facilitation, classes, EAP resources).
  - **Lead**: *Responder Wellbeing Team.*
- *Strategy*: Integrate available wellbeing support into response staff's operational processes.
  - **Lead**: *Responder Wellbeing Team.*

OBJECTIVE: DELIVER SAFETY AND WELLBEING **GUIDANCE AND TRAINING** TO RESPONSE STAFF ACROSS ALL RESPONSE OPERATIONS.

- *Strategy*: Provide appropriate PPE guidance and training for response staff.
  - **Support**: Logistics Section; Operations Section Chief; Public Health Employee Health.
- *Strategy:* Provide appropriate safety trainings and guidance (sharps, severe weather, physical safety) to response staff.
- *Strategy*: Deliver relevant responder safety and wellbeing guidance resources in accessible formats, including recommendations for external resources and tools.
  - **Lead**: Safety Officer.
  - **Support**: Logistics Officer; Operations Section Chief.

- *Strategy*: Deliver appropriate responder safety and wellbeing training in accessible formats. Include feedback mechanism and contact process for staff to receive further guidance, as needed.
    - **Lead**: Safety Officer.
    - **Support**: Communications Response Team; Equity Officer; King County IT.

MONITOR AND ASSESS

OBJECTIVE: CONDUCT RESPONDER SAFETY AND WELLBEING **MONITORING AND SURVEILLANCE** BASED ON IDENTIFIED RISKS, RESPONDER ROLES, AND RECOMMENDATIONS OF SUBJECT MATTER EXPERTS THROUGHOUT RESPONSE.

- *Strategy*: Utilize responder safety and wellness monitoring process to continually assess and determine appropriateness and effectiveness of wellness and safety measures.
    - **Lead:** Safety Officer.
    - **Support:** Public Health Employee Health.

OBJECTIVE: CONTINUOUSLY ASSESS **SAFETY NEEDS** AND REVISE SAFETY STAFFING PLAN AS NECESSARY.

- *Strategy*: Assess and recommend changes to responder safety requirements and recommendations, including infection control measures, safety measures, and wellbeing measures to meet the needs and scope of the response.
- *Strategy*: Conduct regular site visits to engage with field staff to review safety of facility and procedures used by staff and make recommendations for improvements.
    - **Lead:** Safety Officer or delegated Responder Safety Team.
    - **Support**: Operations Section Chief and/or appropriate Branch or Group Supervisor.
- *Strategy*: Establish reporting process with Public Health site safety staff.
- *Strategy*: Request additional staffing for Assistant Safety Officer and/or safety and wellbeing Technical Specialist positions to support scope of safety activities.

OBJECTIVE: CONTINUOUSLY ASSESS **WELLBEING NEEDS** AND REVISE WELLBEING STAFFING PLAN AS NECESSARY.

- *Strategy*: Assess and recommend changes to wellbeing measures and resources, including available resources from EAP, Balanced You, and others.
- *Strategy*: Request additional staffing for Assistant Safety Officer and/or wellbeing Technical Specialist positions to support scope of safety activities.
    - **Lead**: Safety Officer.
    - **Support**: King County Employee Assistance Program, Responder Wellbeing Team.

INTEGRATE OPERATIONS

OBJECTIVE: MAINTAIN ACCURACY AND ALIGNMENT OF **SAFETY RECOMMENDATIONS AND PROTOCOLS** WITH INFECTIOUS DISEASE GUIDANCE.

- *Strategy*: Align responder safety recommendations and protocols with *Epidemiology and Surveillance Branch* infection prevention and control guidance.

  - **Lead**: Safety Officer.
  - **Support**: Epidemiology and Surveillance Branch.
- *Strategy*: Recommend alignment of employee safety recommendations and protocols with *Epidemiology and Surveillance Branch* infection prevention and control guidance.
  - **Lead**: Safety Officer.
  - **Support**: Responder Safety Team; Epidemiology and Surveillance Branch; Public Health Employee Health.

OBJECTIVE: INTEGRATE **RESPONDER FEEDBACK** INTO SAFETY AND WELLBEING RECOMMENDATIONS AND PROTOCOLS.

- *Strategy*: Develop information sharing process to ensure feedback informs available safety and wellbeing guidance resources and trainings.
- *Strategy*: Develop information sharing process to ensure feedback informs equitable distribution of PPE and hygiene and sanitation resources among staff.
  - **Lead:** Safety Officer.
  - **Support**: Operations Section Chief; Logistics Section Chief.

OBJECTIVE: INTEGRATE SAFETY AND WELLBEING TRAININGS, RESOURCES, AND GUIDANCE INTO **RESPONDER ONBOARDING AND ORIENTATION PROCESS**.

- *Strategy*: Work with *Resource Unit* to incorporate documents, links, and other resources directing onboarding responders to safety and wellbeing resource, requirements, and support options.
  - **Lead**: Safety Officer.
  - **Support**: Planning Section – Resource Unit; Logistics Section.

OBJECTIVE: UTILIZE **DEMOBILIZED RESPONDER TRACKING PROCESS** TO TRACK PREVIOUSLY REPORTED AND NON-REPORTED ILLNESSES, INJURIES, ACCIDENT, AND INCIDENTS.

- *Strategy*: Integrate tracking process with *Logistics Section's* demobilization process to ensure accuracy.
  - **Lead:** Safety Officer.
  - **Support**: Logistics Section; Planning Section – Resource Unit.
- *Strategy***:** Establish an *Employee Health Group* or similar unit to follow up and address employee needs following the response, as needed.
  - **Lead:** Safety Officer.

7 | TESTING

To limit the spread of infection and risk of severe disease by ensuring that the community has equitable access to testing resources through a variety of modalities, such as provider offices, fixed testing locations, or at-home kits, when community-based diagnostic tests are available and indicated in the Public Health – Seattle & King County (Public Health) response. Timely testing can be important for determining necessary treatment and isolation measures for minimizing exposure to others.

PREPARE

OBJECTIVE: COORDINATE WITH LOCAL, STATE, AND FEDERAL PARTNERS TO UNDERSTAND TESTING METHODS, GUIDELINES AND AVAILABILITY OF SUPPLIES DURING THE INITIAL STAGES OF A BIOLOGICAL INCIDENT.

- *Strategy*: Coordinate with the Centers for Disease Control and Prevention (CDC) and Washington State Department of Health (DOH) on establishing testing criteria, protocols, and guidance for interpretation of results for provider referrals, specimen collection and handling, reporting, and shipping. Coordination may also include ensuring local labs are vetted and approved for testing.
    1. Just in time training on specimen collection, handling, storage, and shipping may be required for bioterrorism agents and other novel organisms that not covered by standard processes.
        - **Lead:** Epidemiology and Surveillance Branch.
        - **Support:** Operations Section Chief; Logistics Section.
- *Strategy*: Engage early with internal and external planning partners who are critical to testing services.
    1. Identify Public Health's role in providing low-barrier direct testing services, from individuals to large-scale fixed sites.
        a. Explore site options for fixed-site testing operations.
        b. Identify need for Public Health staff to conduct testing services in congregate settings that may include long-term care facilities and locations frequented by people experiencing homelessness.
        c. Identify need for Public Health to conduct testing services in focused on highest risk populations in collaboration with community leaders and community-based organizations.
        d. Identify the Public Health lab's role for testing samples.
        e. Identify the role of Public Health programs, such as Jail Health Services or Sexual Health Clinic, for supporting testing operations of their own patients. At some locations, testing community members may be appropriate, and necessary.
        f. Coordinate with DOH, healthcare systems, pharmacies, and neighboring jurisdictions to plan for a regional approach to community testing across high-risk sectors, such as schools and businesses.
        g. Coordinate with CDC's Division of Global Migration and Quarantine (DGMQ) to align workflows and responsibilities when testing needs to be arranged for travelers at SeaTac International Airport.
        h. Contract with mobile testing partners to augment Public Health's capacity to provide services in congregate settings and for individuals who are homebound.

    i. Coordinate with state and federal partners in the event that diagnostics need to be requested from the Strategic National Stockpile.
    - **Lead:** Epidemiology and Surveillance Branch.
    - **Support:** Operations Section Chief; Logistics Section; Community Mitigation and Wellbeing Branch; Liaison Officer; Equity Officer**;** Policy Officer.
- *Strategy*: Coordinate with DOH and NWHRN to update healthcare community on testing guidelines and protocols.
    1. Assess partner's capacity for providing direct testing services in a healthcare or community setting.
        - **Lead:** Epidemiology and Surveillance Branch.
- *Strategy:* Provide technical input into local guidance, policy development, communications, and content development.
    - **Lead:** Epidemiology and Surveillance Branch.
    - **Support:** Operations Section Chief; Public Information Officer (PIO): Equity Officer; Policy Officer; Community Mitigation and Wellbeing Branch.
- *Strategy:* Identify any technology that may be required for testing services at Public Health-operated sites (e.g., scheduling platforms, documentation, reporting).
    - **Lead:** Epidemiology and Surveillance Branch.
    - **Support:** Operations Section Chief; Logistics Section.
- *Strategy*: Order supplies in preparation for Public Health's direct service role during initial stages of testing (e.g., Public Health clinics or congregate settings).
    - **Lead:** Logistics Section**.**
    - **Support:** Epidemiology and Surveillance Branch; Operations Section Chief; Equity Officer**;** Policy Officer.

IMPLEMENT

OBJECTIVE: WHEN APPROPRIATE, CONDUCT AND COORDINATE TARGETED COMMUNITY-BASED TESTING FOR HIGH-RISK POPULATIONS AND ESSENTIAL SERVICE PERSONNEL.

- *Strategy*: Based on community feedback and recommendations, we well as local epidemiology, determine testing locations to reach highest-risk populations, ensuring equitable access to testing, and addressing the unique needs of historically marginalized groups, such as those with access and functional needs and people who speak a primary language other than English.
    1. Ensure educational materials and information shared is in language and formats accessible to all groups.
    2. Build upon established relationships with community partners.
    3. Collaborate with community navigators.
    4. Partner with healthcare systems, clinics, providers, and community-based organizations who specialize in serving the impacted population.
    5. Consider additional accommodations at testing sites for reducing stigma for high-risk groups, such as measures that support maintaining the privacy of individuals seeking testing.
        - **Lead:** Testing Group**.**
        - **Support:** Operations Section Chief; Equity Officer**;** Policy Officer; Logistics Section; Community Mitigation and Wellbeing Branch.

- *Strategy*: When necessary, operate one or more Public Health fixed-site testing locations in King County.
    - **Lead:** Testing Group**.**
    - **Support:** Operations Section Chief; Equity Officer**;** Policy Officer; Logistics Section; Community Mitigation and Wellbeing Branch; Isolation and Quarantine Branch.
- *Strategy*: Ensure partner-operated sites are located in "testing deserts" and are accessible to high-risk groups and communities with historic inequities in healthcare access who may be at risk for infection.
    - **Lead:** Testing Group**.**
    - **Support:** Operations Section Chief, Equity Officer**,** Policy Officer, Logistics Section, Community Mitigation and Wellbeing Branch.
- *Strategy*: Coordinate with the healthcare community to provide testing for their patients and staff.
    - **Lead:** Testing Group.
- *Strategy:* Provide guidance to healthcare community on connecting eligible patients to available treatment options.
    - **Lead:** Testing Group**.**

OBJECTIVE: COORDINATE DISTRIBUTION OF HOME TEST KITS (WHEN INDICATED).

- *Strategy*: Procure and store test kits at a Public Health Warehouse.
    - **Lead:** Testing Group**.**
    - **Support:** Logistics Section.
- *Strategy*: Using an equity prioritization tool, coordinate with internal programs and external partners to distribute kits to highest risk groups (FBOs, CBOs, libraries, schools, businesses, long-term care facilities).
    - **Lead:** Testing Group**.**
    - **Support:** Logistics Section, Community Mitigation and Wellbeing Branch, Operations Section Chief, Equity Officer.

MONITOR AND ASSESS

OBJECTIVE: EVALUATE TESTING NEEDS IN THE COMMUNITY AND EXPAND, SCALE OR TRANSITION FIXED TESTING SITES AND DISTRIBUTION OF HOME TESTING KITS IN RESPONSE TO DEMAND, AVAILABLE RESOURCES AND PARTNER CAPACITY.

- *Strategy:* Engage with community for ongoing feedback related to testing access for high-risk groups.
- *Strategy*: Review case rates and ensure testing needs are met in geographical areas with highest disease burden.
- *Strategy*: Increase or decrease the volume or location of testing sites based on local Epidemiology.
    - **Lead:** Testing Group**.**
    - **Support:** Logistics Section, Community Mitigation and Wellbeing Branch, Operations Section Chief, Equity Officer, Policy Officer.

INTEGRATE OPERATIONS

OBJECTIVE: INTEGRATE TESTING OPERATIONS ACROSS HEALTH AND MEDICAL AREA COMMAND (HMAC) STRUCTURE TO ENSURE COORDINATION, PROPER SAFETY MEASURES, APPROPRIATE INTERNAL AND EXTERNAL COMMUNICATION, AND EFFECTIVE UTILIZATION AND PRIORITIZATION OF AVAILABLE RESOURCES ARE IMPLEMENTED.

- *Strategy:* Provide ongoing technical input into local guidance related to testing, development of internal and external guidance, policy development, and communications.
    1. Technical input supports the PIO, Public Information Contact Center (PICC), or communication response teams with:
        a. Responding to inquiries from internal groups, external partners, and the public.
        b. Developing, sharing, and disseminating timely information to the public and partners through different communication channels, which may include social media, Public Health blog, local media outlets, Public Health website, healthcare facility listservs, regional partners (i.e., NWHRN) and during coordination meetings.
        c. Technical input may also be used to support content development for responder safety materials.
        d. Ensure information is in languages and formats that reach as many communities as possible in King County.
- *Strategy:* Resolve, track and escalate issues and problems related to testing to Operations Section Chief, Isolation and Quarantine Group Supervisor, or others as needed.
- *Strategy*: Ensure Policy Officer and Government Affairs response staff are equipped to advocate for and communicate around testing needs and challenges.
- *Strategy:* Coordinate with Safety Officer to develop guidelines and processes for testing in the field.
    1. Ensure standards for responder safety and health, including PPE and respiratory fit-testing, are identified and implemented.
- *Strategy:* Coordinate with Logistics Section for supplies and resources that may be needed to support Public Health testing activities.
- *Strategy:* Coordinate with Finance and Administration Section for staffing needs, as well as facilitating contracts or Memorandums of Understanding (MOUs) for sites or staffing.
    - **Lead:** Epidemiology and Surveillance Branch/Testing Group.

DEMOBILIZATION

Demobilization refers to activities that focus on disengaging response resources as incident objectives are met and transitioning response staff and activities to routine services. Planning for demobilization begins at the start of the response to ensure an orderly and appropriately phased conclusion of response activities. During a larger biological incident response, different activities and/or roles may demobilize or transition to division-led operations at different stages of the outbreak. Transition planning is a key component to effective demobilization of response operations. This Section will describe how response personnel and activities will be reduced and/or closed out as the biological incident abates.

Demobilization and transition actions may commence with consideration of the following factors: decision-making criteria, phased demobilization, continual surveillance and monitoring, logistics and supply chain, communication and public engagement, and after-action review and corrective action planning.

DECISION-MAKING CRITERIA

Epidemiological Metrics: The demobilization timeline should be closely linked to epidemiological data, such as infection rates, case-fatality rates, hospitalization rates, and test positivity rates. In addition, the scale and size of the current outbreak/progression of the incident, sites of potential exposure and where disease transmission risk is highest, any additional unique disease characteristics (i.e., evolution of the pathogen), and availability of effective treatment, vaccination, and containment measures. A sustained decline in these metrics may trigger the initiation of demobilization plans.

Healthcare System Capacity: The status of healthcare facilities, including bed availability, ventilator capacity, and medical supply stocks, must be continuously assessed. Demobilization should be contingent on the healthcare system's ability to manage cases without being overwhelmed.

Vaccine and Therapeutics Availability: Availability and distribution of vaccines and therapeutics play a pivotal role in demobilization. Widespread vaccination coverage may allow for a more expedited demobilization.

Local Response Partner Input: Collaboration with other local health departments, healthcare providers, and community groups and leaders are essential in the decision-making process for demobilizing response operations. Specifically, identifying the status of critical infrastructure and essential services as well as impacts on different community groups. Their insights can inform decisions on demobilization readiness.

PHASED DEMOBILIZATION

Response Staff and Personnel: Demobilization should occur in a phased approach, identifying essential operations and prioritizing the release of staff that work in operations that are deemed as no longer essential, while maintaining a core workforce for ongoing surveillance and response. Rotate personnel to mitigate exhaustion and ensure a capable response team is retained.

Resource Deactivation: Gradual deactivation of resources and facilities is key. Maintain a sufficient reserve of resources in case of resurgence. Medical equipment, field hospitals, and stockpiles must be carefully assessed for repurposing or redeployment.
Community Education: A demobilization phase should include a concerted effort to educate the public about continued hygiene practices, vaccination opportunities, and potential risks, emphasizing the need for continued vigilance.

CONTINUAL SURVEILLANCE AND MONITORING

Notifiable Disease and Syndromic Surveillance: Continue surveillance to detect potential outbreaks or resurgence. Maintain a robust reporting system for rapid response to any suspicious clusters.

Testing Infrastructure: Sustain testing infrastructure for early case detection, contact tracing, and surveillance. Adapt testing capacity to evolving community needs.

Healthcare Preparedness: Maintain the ability to rapidly expand healthcare capacity if needed. Develop protocols for timely reactivation of field hospitals and other surge resources in case of resurgence.

LOGISTICS AND SUPPLY CHAIN

Strategic Stockpile Management: Maintain a strategic stockpile of essential medical supplies, personal protective equipment, and pharmaceuticals to support healthcare facilities. Ensure these supplies are rotated to prevent expiration.

Resource Redistribution: Resources that are no longer needed in the primary response area should be strategically redistributed to regions still grappling with the outbreak or stored for future needs.

COMMUNICATION AND PUBLIC ENGAGEMENT

Clear Messaging: Continue clear and consistent communication with the public, using appropriate channels to disseminate information on the state of the infectious disease emergency and the rationale behind demobilization decisions.

Psychosocial Support: Provide access to psychosocial support services to address the mental health needs of responders and the public as they adapt to changes in emergency response services and/or the end of the infectious disease emergency.

AFTER-ACTION REVIEW AND CORRECTIVE ACTION PLANNING

Debriefing and Evaluation: Following the demobilization of response operations, conduct a comprehensive after-action review (AAR) involving all response partners to identify strengths and areas for improvement in the demobilization and transition process. This evaluation to collect lessons learned

and recommendations for improvement. Public Health staff involved in the response are expected to participate in evaluation or debrief sessions as part of the demobilization process. For longer activations there may be one or more debrief sessions part-way through the response to have feedback at different stages of the response. Focus on things that went well, areas for improvement, and recommendations for the future. As needed, also gather feedback via interviews, surveys, at staff meetings during the response, and through other methods. A compilation and analysis of lessons learned gathered through the debrief sessions and other activities will make up the After-Action Report and Corrective Action Plan.

Documentation: Maintain detailed records of demobilization activities, lessons learned, and recommendations for future planning, updating the infectious disease response plan accordingly. In conclusion, the demobilization and transition phase in an infectious disease emergency response plan requires a structured and adaptable approach, founded on epidemiological data, healthcare capacity, and community needs. By strategically phasing the demobilization, maintaining surveillance, safeguarding logistics, and fostering clear communication, public health agencies can ensure a smooth transition from emergency response to recovery and readiness for future challenges. Demobilization is a dynamic process that necessitates close collaboration with all stakeholders and ongoing monitoring to safeguard public health.

DEMOBILIZATION CHECKLIST

Demobilization checklist

- ☐ Review the Incident Action Plan and resources to determine the size and extent of the demobilization effort.
- ☐ Coordinate demobilization with Command and General Staff and the Continuity of Operations Branch.
- ☐ Identify surplus resources and probable release time in coordination with the Logistics Section. Identify logistic (including transportation and supply) needs to support demobilization and transition activities.
- ☐ Develop a plan detailing specific responsibility, release priorities, procedures, and necessary checklists to guide staff who are being demobilized and/or transition.
- ☐ Track progress of demobilization and transition
- ☐ Ensure that all Operations Section Branches understand their demobilization and/or transition responsibilities and the procedure for demobilizing.
- ☐ Hold a debrief with all activated staff.
- ☐ Gather feedback from staff via interviews, surveys, email, and/or other methods.
- ☐ Write the After-Action Report and Corrective Action Plan.

TRANSITION

A critical aspect of the demobilization of response operations is the transition of activities back to being led by Department divisions and programs. The process of transitioning Health and Medical Area Command (HMAC) response activities must focus on building back departmental activities that emphasize staff and community well-being and highlight lessons learned from the response. Transition processes must be inclusive of and responsive to community voices highlighting the importance of continued response services and center equity impacts of transitioning or demobilizing those services. Transition processes must also sustain cross-departmental relationships and collaborations which were built during the response while minimizing administrative burdens on staff and partners. To accomplish the goals of effectively transition response services, HMAC leadership and staff may reference resources developed during the COVID-19 HMAC activation, including but not limited to *Future State Decision Briefing Template, Transition Principles, Division/Program Expansion Planning, Activity Transition Plan,* and *Transition Planning SBARs.*

TRANSITION OF RESPONSE STAFF

Identify the roles and responsibilities of response staff that are serving in Special Duty Assignments and Term-Limited Temporary positions and note where shifts in team staffing, i.e., sunsetting of certain roles or staff returning to base positions, may introduce challenges to transitioning operations to partners or into routine services. Staff cross-training needs must be considered when transitioning staff and services to routine operations or transitioning response operations to external partners.

A set of questions to consider for decision-making around demobilization and future planning of response staff across operational areas includes the following:

- *What are the key functions of the response team?*
- *Of the identified functions, which functions plan to ramp down and which functions need to continue beyond HMAC demobilization?*
- *How is this work currently staffed (i.e., how many King County staff and contracted staff)? How do you anticipate this changing by [estimated HMAC demobilization date]?*
- *What is the anticipated staffing need beyond HMAC demobilization? What types of positions and skills may be needed? Special considerations (e.g., need for multi-lingual staff or ability to work nights and weekends, etc.)?*
- *What work is currently being contracted out?*
    - *Who with?*
    - *What is the work?*
    - *Until when?*
- *What is the funding source(s) that support response roles?*

TRANSITION OF RESPONSE OPERATIONS

Planning for a gradual scale down of response operations across multiple phases must include consideration of the unique set of challenges that different operational teams may navigate, i.e., staffing, funding, and community priorities. For instance, teams engaged in direct service to high-risk groups and groups impacted by inequities must ensure that a scale down of services does not instigate

additional disparities in access to and the quality of services that those groups are seeking. Effective demobilization of operations may require engaging in an SBAR (Situation-Background-Assessment-Recommendation) analysis to identify funding, policy, and service priorities for each operational response area. Furthermore, response teams may approach demobilization with a focus on equity while considering funding and resource realities by considering the following:

- Being responsive to the changing nature of a biological incident
- Demand for services
- Changes in funding
- Opportunities to integrate with other existing Public Health services or transition to external partners
- Whether the service is unique to Public Health and there are no other options available

PLAN MAINTENANCE

REVIEW AND REVISION

The *Biological Incident Response Annex* will be regularly updated through an iterative process and if needed, may include the addition of operational guides, processes, and/or templates. The revision process will be reflective of ongoing engagement with community advisory groups and outreach to relevant Public Health divisions and programs represented in the annex, to ensure response activities and services are documented accurately and equitably. This version of the *Biological Incident Response Annex* represents information compiled through a collaborative planning process that occurred between 2022-23 with submission in November 2023. Future revision processes for this annex will include outreach to community partners (i.e., Community Advisory Group for Public Health Emergency Preparedness, Equity Response Team, Community Navigators Team, Community Based Organizations, and Faith-based Organizations) and relevant Public Health divisions and programs represented in the annex, to ensure their response activities and services are documented accurately.

Following any activation of the plan, Public Health will seek feedback on the response from HMAC responders, Public Health divisions and programs involved in the response, community partners, and other key response partners across the county. Findings from the evaluation process will be shared with those involved in and impacted by the event. Based on this feedback as well as items outlined in the Corrective Action Plan, the *Biological Incident Response Annex* will be updated to include lessons learned and address recommended improvements.

SOCIALIZATION

Relevant portions of the updated plan will be shared with the following groups during each review process:

- Public Health divisions and programs
- Office of Equity and Community Partnerships, including but not limited to the following groups:
    - Equity Response Team
    - Community Navigators Team
    - Community Advisory Group for Public Health Emergency Preparedness
- King County Office of Emergency Management
- City of Seattle Office of Emergency Management
- Northwest Healthcare Response Network
- Relevant county departments and agencies
- Washington State Department of Health – Office of Resiliency and Health Security (ORHS)

Socialization is intended to seek feedback from as well as to inform partners of changes to the contents of this annex. Public Health divisions and programs directly involved in emergency response and key community partners will participate in the revision process, ensuring thorough engagement prior to any socialization.

TRAINING AND EXERCISES

Preparedness maintains an Integrated Preparedness Plan (IPP), which details the training and exercise priorities for Public Health response actions. Portions of the *Biological Incident Response Annex* may be integrated into the IPP to ensure key capabilities are exercised and relevant training developed.

LIST OF ACRONYMS AND ABBREVIATIONS

Acronym or Abbreviation	Description
AC	Area Commander
APDE/CDIP	Assessment, Policy Development & Evaluation Unit/ Chronic Disease and Injury Prevention (Public Health)
BDS	Biohazard Detection System (USPS)
CDC	US Centers for Disease Control and Prevention
CD-Imms	Communicable Disease Epidemiology and Immunization Section (Public Health)
CMS	US Centers for Medicare and Medicaid Services
COOP	Continuity of Operations Plan
DOH	Department of Health (Washington State)
EAP	Employee Assistance Program (King County)
EEI	Essential Element of Information
EH	Environmental Health Division (Public Health)
EMS	Emergency Medical Services (Public Health)
EOC	Emergency Operations Center
ERA	Equity Response Annex (Public Health)
ESF	Emergency Support Function
FBI	Federal Bureau of Investigation
FOUO	For Official Use Only
HAN	Health Alert Network (CDC)
HCHN	Healthcare for the Homeless Network (Public Health)
HHS	US Department of Health and Human Services
HMAC	Health and Medical Area Command (Public Health)
HMC	Harborview Medical Center
IAP	Incident Action Plan
ICS	Incident Command System
IMT	Incident Management Team
IQ	Isolation and Quarantine
IT	Information Technology
LHO	Local Health Officer
MAC	Multi-Agency Coordinating Group
MCM	Medical Countermeasures
MEO	Medical Examiner's Office (Public Health)
MOU	Memorandum of Understanding
NIMS	National Incident Management System
NWHRN	Northwest Healthcare Response Network
ODIR	Office of the Director (Public Health)
OECP	Office of Equity and Community Partnerships (Public Health)
OEM	Office of Emergency Management
ORHS	Office of Resiliency and Health Security (DOH)
PICC	Public Information Contact Center

Acronym or Abbreviation (continued)	Description
PIO	Public Information Officer
POD	Point of Dispensing
PPE	Personal Protective Equipment
Public Health	Public Health - Seattle & King County
RCW	Revised Code of Washington
SARS-CoV-2	Severe acute respiratory syndrome Coronavirus 2
SMC	Seattle Municipal Code
SNS	Strategic National Stockpile
SOP	Standard Operating Procedure
USPS	United States Postal Service
UW	University of Washington
VAERS	Vaccine Adverse Event Reporting System
WA SECURES	Washington Secure Electronic Communications, Urgent Response and Exchange System
WAC	Washington Administrative Code
WATrac	Washington System for Tracking Resources, Alerts, and Communication
WHO	World Health Organization

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Appendix C

Public Health
Seattle & King County

Salud Pública
Seattle y el condado de King

PUBLIC HEALTH - SEATTLE AND KING COUNTY

COVID-19 After Action Report

EXECUTIVE SUMMARY

The unprecedented nature of the COVID-19 pandemic presented challenges across the globe. It forced leaders in public health to sustain extended response operations while balancing planning for potential incidents and initiating active response measures. The pandemic made historical inequities, including structural ableism and racism, more apparent in both government and healthcare systems.

The disproportionate impact of COVID-19 on communities of color and individuals with disabilities has been documented across the United States. In King County, data analyses show that Hispanic/Latinx, Native Hawaiian/Pacific Islanders, Blacks, and American Indian/Alaskan Natives experienced higher rates of COVID-19 cases and hospitalizations compared to Whites.[1] Historical inequities, prejudicial practices and policies, and continued discrimination and injustices in many institutions contributed to added risk and inadequate access to services for many people. From the beginning of the pandemic, Public Health – Seattle King County (PHSKC) and community-facing task forces were concerned that COVID-19 could exacerbate health inequities and take the biggest toll on communities already disadvantaged due to a long history of structural racism, systemic oppression, discrimination, and violence. For people with disabilities in King County during this pandemic, these inequities could be truly catastrophic. The need to prioritize addressing impacts on individuals with disabilities was of primary importance due to the disproportionate impacts of COVID-19. Providing healthcare and services that were accessible to all communities was an equity and social justice issue and aligned with PHSKC's mission to serve King County's most vulnerable communities.

Despite the ongoing challenges, personnel from public health, healthcare, and government as well as first responders and community organizations demonstrated immense self-sacrifice and public service. Staff within PHSKC and their internal and external partners continue to rally around each other, supporting one another and filling needs when they arise.

This After-Action Report (AAR) was created to better understand the efforts undertaken by PHSKC during the COVID-19 pandemic and identify ways to improve future responses to public health emergencies. An AAR is a document that summarizes key information related to a disaster response to help evaluate activities and memorialize the efforts of those who responded. This report analyzed the response from January 2020 – January 2022 and the findings in the report identified strengths and areas for improvement raised by stakeholders and partners. This report is not inclusive of all work related to COVID-19 but is a sampling of activities collected from PHSCK. The end of this report includes a brief list of recommended actions for PHSKC to address, as areas for improvement. Staff within PHSKC collected a comprehensive list of these actions and recommendations, which are being tracked internally to improve PHSKC's response to future emergencies.

[1] Public Health Insider. May 1, 2020. New Analysis Shows Pronounced Racial Inequities Among Covid-19 Cases, Hospitalizations And Deaths. Accessed 5/23/22. https://publichealthinsider.com/2020/05/01/new-analysis-shows-pronounced-racial-inequities-among-covid-19-cases-hospitalizations-and-deaths/

The After-Action Report Methodology

The report generation process was undertaken by Constant Associates, Inc. (CONSTANT), a health security and emergency management consultancy firm. Standard incident response evaluation principles and best practices were followed in the creation of this report and it is consistent with Homeland Security Exercise and Evaluation Program (HSEEP) doctrine. A team of experts collected data through a multi-pronged process which included documentation reviews and facilitated feedback sessions with external partners. A substantial amount of feedback from department staff was collected by PHSKC. This included transcripts and summary reports of facilitated discussions, interviews, and a survey of department staff. These documents were part of the documentation review conducted by CONSTANT. After a thorough analysis of the data collected, key findings were outlined. Best practices are highlighted throughout the document to share procedures, tactics, and solutions utilized during the PHSKC COVID-19 pandemic response. Recommendations have been developed by the PHSKC response teams, community partners, and CONSTANT to support PHSKC's readiness for future emergencies. The most notable strengths and areas for improvement are highlighted below.

Significant Strengths

- PHSKC's collaboration across departments, including the prominent leadership role it played for the nation in the pandemic response, was award-winning. Leadership steps included creating the nation's first civilian isolation and quarantine system that served over 2,300 residents by January 2022. They also set and met ambitious vaccination goals focused heavily on equity while creating strategies to support the vaccination of older adults and Black, Indigenous, and people of color (BIPOC). They also maintained the lowest death rate due to COVID-19 of the 20 largest metropolitan areas in the country.

- PHSKC's COVID-19 dashboards, such as those created by the Analytics and Informatics (A&I) Team, enabled public health decision-making supported by data. The dashboards showed cases counts, community transmission, syndromic surveillance, and vaccination uptake overlayed with demographics and geographic information. Dashboards, such as the Communities Count COVID-19 Vulnerable Communities Data Tool, also revealed very early in the pandemic the disproportionate impacts of COVID-19 on BIPOC populations and were recognized for their effectiveness and innovation by the National Association of County and City Health Officials (NACCHO). The use of these dashboards allowed PHSKC to focus its response on specific communities and provide additional services to those most impacted by the pandemic.

- Community navigators were consistently seen as a strength by PHSKC staff, partners, and stakeholders. The community navigators represented diverse populations dealing with a lack of transportation, job loss, food insecurity, and loss of housing. Imbedded in their communities, navigators served as conduits to get resources to their communities, dispel misinformation, and highlight the known fears and barriers to resources and healthcare. Additionally, community navigators provided important information and feedback to PHSKC staff to help shape and improve their response work to better serve their communities. There are numerous examples throughout this report detailing the community navigators bridging the gap between public health efforts and communities that needed it the most.

- PHSKC's Language Access Team raised the standard for language accessibility through innovation and collaboration with key partners. The team demonstrated that translating public health information into forty languages with short turnarounds is achievable and can be done in a cost effective and culturally sensitive manner. The team partnered with Washington State Coalition for Language Access (WASCLA) to develop a system of just-in-time locally certified and experienced translators allowing for same day, 24-hour, and 48-hour turnaround times. To elevate the effectiveness of the system, PHSKC opened the system to partners who were able to leverage the language capability for their roles in the public health response.

Significant Areas of Improvement

- There remain numerous barriers to achieving equity in PHSKC's response. 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. While proud of the organizations and communities they were able to engage, teams primarily focused on ensuring equity noted there were connections with community members left untapped and groups that were missing from the conversation. There was a noted lack of BIPOC providers in the Public Health Reserve Corps which raised concerns about the ability for those systems to serve communities disproportionately impacted by the pandemic.

- Access and Functional Needs planning was noted as a significant area for improvement throughout the response. Many of the people at highest risk of infection and death from COVID-19 were unable to access early interventions such as testing and then later vaccines until substantial communication and assistance was provided by CBOs and advocacy groups. PHSKC had an Equity Response Annex but did not have an Access and Functional Needs plan or an Americans with Disabilities Act (ADA) coordinator. This highlighted gaps in translation and interpretation services for residents with disabilities, testing and vaccine site accessibility, representation on public health dashboards, and transportation to make use of COVID-19 resources and support.

- PHSKC teams widely agreed that they were overwhelmed with workload, and response demands dramatically outpaced their resources. Many employees, particularly early in the response, worked 80–100-hour work weeks, often going months without a day off. Aside from taking time away from the job, many felt they could not reduce their workloads, take needed breaks, or address their physical, emotional, or mental health. PHSKC employees expressed they felt they were not adequately compensated for the exponential increase in responsibilities. This was compounded for some staff by the fact that they were ineligible for overtime pay and are unable to use additional compensation in the form of paid vacation due to response demands. Staff recognized and appreciated that leaders encouraged teams to work less and practice self-care, but many felt it was not feasible because the encouragement was not reflected by a reduction in workload or adequate staffing to meet needs.

- Hiring and onboarding was critical to scale up the workforce to meet the public health response needs. While recognizing the unprecedented nature of the pandemic, there were notable administrative

burdens and a significant amount of time required to fill positions. This limited scalability and contributed to staff burnout. Many staff noted that potential hires were lost as a result, and they were forced to use staffing agencies to temporarily fill gaps. The staffing agencies exacerbated inequities with PHSKC because those individuals were paid a lower rate and did not have the benefits that PHSKC employees were offered. Many of the new hires were also engaged in temporary positions making job security a constant concern. This created uncertainty and stress for both new employees and PHSKC teams to which they were assigned. Furthermore, some staff expressed worry that since new hires were in temporary positions, the added diversity they brought to the workforce would be lost at the end of their employment with the county.

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INTRODUCTION

RACISM AS A PUBLIC HEALTH CRISIS

Racism is a public health crisis. 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.[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.

The COVID-19 pandemic further drew back the curtain on the impact of structural racism in American healthcare. Racism against people of Asian descent significantly increased during the pandemic, with a documented 77% rise in hate crimes against Asian people living in the United States between March 2020 and June 2021.[4] Additionally, health inequity in pandemic response was also documented. The CDC states that out of the 65% of COVID-19 cases in the United States where race and ethnicity data were available, Black people accounted for 14% of deaths related to COVID-19, despite making up only 13% of the total population.[5] Hispanic people represent 24% of COVID-19 cases, despite only making up 18% of the US population. Through June 12, 2022, King County has had 2,850 deaths (0.6% of positive cases). Age-adjusted death rates of confirmed cases are highest among residents who are Native Hawaiian/Pacific Islander (749 per 100,000), American Indian/Alaska Native (452 per 100,000), Hispanic/Latinx (260 per 100,000), and Black (219 per 100,000). Rates for most communities of color are higher than among White residents (106 per 100,000). People who are incarcerated also experienced a much higher burden of the disease than non-incarcerated individuals. In 2020, 40 of the 50 widest outbreaks of COVID-19 occurred in prisons.[6] People with disabilities experienced unique impacts due to health inequity during the COVID-19 pandemic, as a lack of appropriate data collection and accessibility barriers in information, testing, and vaccination exposed them to greater

[2] CDC, “Health Equity,” https://www.cdc.gov/chronicdisease/healthequity/index.htm
[3] Rugaijah Yearby, Brietta Clark, and José F. Figueroa, “Structural Racism in Historical and Modern US Health Care Policy,” *Health Affairs* vol. 41:2, https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01466February 2022.
[4] Mary Finding, "COVID-19 Has Driven Racism and Violence Against Asian Americans," *Health Affairs,* April 12, 2022.
[5] CDC, “Demographic Trends of COVID-19 Cases and Deaths in the US Report,” updated May 27, 2022, https://covid.cdc.gov/covid-data-tracker/#demographics.
[6] Alexandria Macmadu et al., "COVID-19 and Mass Incarceration," *The Lancet* vol 5:11, October 9, 2020.

disparities in the public health response.[7] As recovery efforts continue, historically marginalized populations continue to face greater challenges due to racism and its intersection with other forms of discrimination.

The COVID-19 pandemic centered what many professionals, advocates, and communities have known for a very long time: racism threatens the livelihoods of millions by causing health inequity and must be addressed as a public health crisis. King County, alongside three states and several other municipalities, declared racism a public health crisis in June 2020, establishing core values, measurable goals, policy priorities, and budget allocations to support its commitment to being intentionally anti-racist and accountable to Black, Brown, and Indigenous People of Color (BIPOC).[8] As part of the Whole Community approach to all-hazard response, health inequity must be at the forefront of planning and response efforts to support resiliency in the face of public health crises.

Overview of PHSKC

PHSKC works to protect and improve the health and well-being of all people in King County. It measures this by seeking to increase the number of healthy years that people live and eliminate health disparities. It is one of the largest metropolitan health departments in the United States with 1,400 employees, 40 sites, and a biennial budget of $686 million. The department serves a resident population of nearly 2.2 million people in an environment of great complexity and scale, with 19 acute care hospitals and over 7,000 medical professionals. Over 100 languages are spoken in the jurisdiction, and King County is an international destination welcoming nearly 40 million visitors annually.[9]

Table 1: Washington State and King County Demographics

Race	Washington State 2019 Estimate	King County 2019 Estimate
Total population	7,614,893	2,252,782
One race	94.0%	93.7%
Two or more races	6.0%	6.3%
White	74.2%	62.1%
Black or African American	4.0%	6.7%
American Indian and Alaska Native (AIAN)	1.4%	0.7%
Asian	9.0%	18.9%

[7] The National Institute for Health Care Management, "Disability, Health Equity, and COVID-19," updated October 14, 2021, https://nihcm.org/publications/disability-health-equity#:~:text=Risk%20of%20Poor%20Outcomes%20from,other%20members%20of%20the%20population.
[8] King County, "Racism as a Public Health Crisis," June 11, 2020. https://kingcounty.gov/elected/executive/constantine/initiatives/racism-public-health-crisis.aspx#values
[9] PHSKC, "About Us," https://kingcounty.gov/depts/health/about-us.aspx

Race	Washington State 2019 Estimate	King County 2019 Estimate
Asian Indian	1.7%	4.3%
Chinese	2.1%	5.6%
Filipino	1.5%	2.1%
Japanese	0.5%	1.0%
Korean	0.9%	1.4%
Vietnamese	1.1%	2.3%
Other Asian	1.3%	2.3%
Native Hawaiian and Other Pacific Islander (NHOPI)	0.7%	0.7%
Native Hawaiian	0.1%	0.1%
Guamanian or Chamorro	0.2%	0.1%
Samoan	0.1%	0.3%
Other Pacific Islander	0.2%	0.3%
Other	4.8%	4.5%

PHSKC's mission is to eliminate health inequities and maximize opportunities for every person to achieve optimal health. PHSKC department functions are carried out through core prevention programs, environmental health programs, community-oriented personal health care services, emergency medical services, jail health services, public health preparedness programs, and community-based public health assessment and practices. The department operates these comprehensive set of public health services using eight divisions:

- **Cross-cutting services** includes the Assessment, Policy Development, and Evaluation (APDE) unit; Communications; Preparedness; Health Policy and Planning; and local government relations, including the King County Board of Health.
- **Prevention** serves the community by monitoring, investigating, controlling, and preventing transmission of over 60 notifiable communicable diseases. The division also includes the Medical Examiner's Office and Vital Statistics.
- **Chronic Disease and Injury Prevention** addresses some of the leading causes of chronic diseases and injuries and their social determinants through seven programs.

- **Community Health Services** provides direct services to King County's most vulnerable individuals through Parent-Child Health, Family Planning, Oral Health, Primary Care, and a variety of community partnership programs.
- **Environmental Health** focuses on prevention of disease through sanitation, safe food and water, proper disposal of wastes and toxins, and promoting safe and healthy environmental conditions throughout King County for the benefit of all residents and visitors.
- **Emergency Medical Services** operates a coordinated regional partnership providing a continuum of care for people in need of emergency medical care.
- **Jail Health Services** provides health services to detained individuals by assessing and stabilizing serious health problems with a focus on transitioning patients back to services in the community.
- **Administrative Services** includes finance, compliance, electronic health record and billing management, contracts, procurement, real estate services, and human resources.

There were many services and response efforts across the department that took place during COVID-19 and were organized by divisions. This AAR focuses on key activities largely coordinated through the incident management structure.

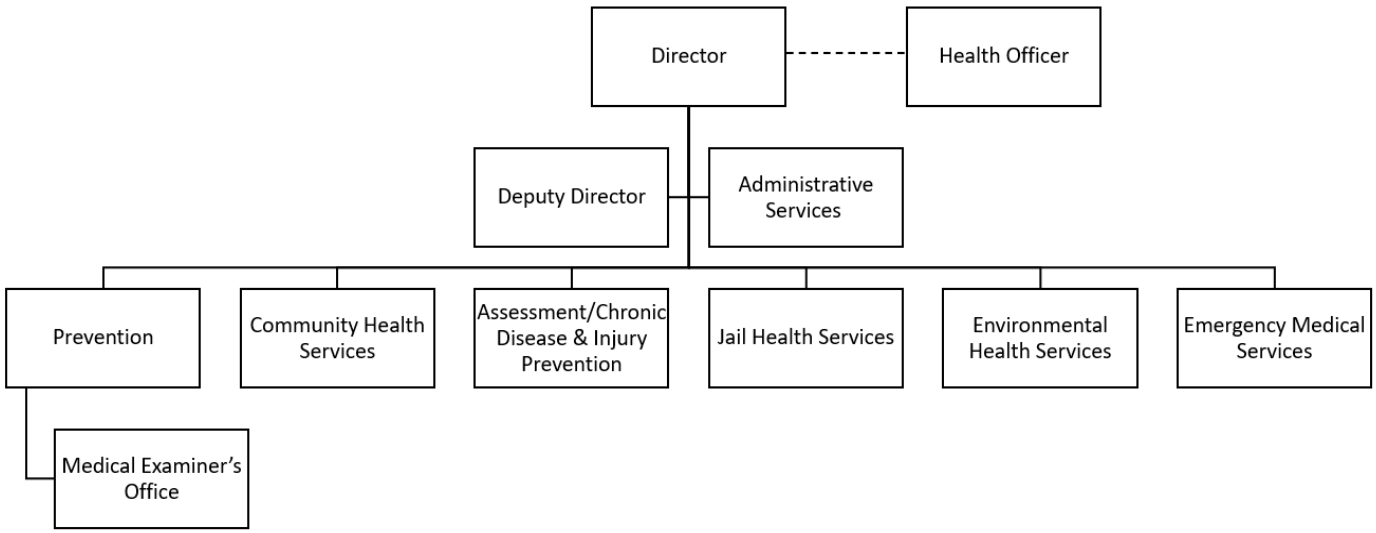


Figure 1: PHSKC Organizational Chart

PHSKC followed federal and state best practices to guide how it would respond to the COVID-19 pandemic as it grew in complexity and scope. In the federal and state systems used to organize emergency responses, Emergency Support Functions (ESFs) are used to group services and organize how they will be managed throughout a disaster. PHSKC's Health and Medical Area Command (HMAC), the department's incident management and coordination structure, was activated on January 21, 2020 to manage King County's ESF #8 (Public Health and Medical Services) using the incident command system (ICS). More details on the response

structure and the PHSKC teams and programs that supported emergency operations can be found the Health and Medical Area Command (HMAC) and Incident Management Structure section.

SCOPE OF THE COVID-19 AFTER-ACTION REPORT

This AAR focuses on the PHSKC response to the COVID-19 pandemic. The intent of this COVID-19 AAR is to comprehensively collect best practices and lessons learned from January 2020 – January 2022 to strengthen the capabilities of PHSKC. This AAR reflects the emerging practices that have benefitted the pandemic response, and which should be continued or enhanced for future pandemic responses. It is the hope of the authors of this document that this COVID-19 AAR will present recommendations for implementation to further improve future PHSKC emergency response efforts. This report is not inclusive of all work related to COVID-19 but is a sampling of activities collected from PHSCK.

METHODOLOGY

This COVID-19 AAR has been compiled using a mixed method data gathering approach. This included a comprehensive review of stakeholder interview notes and facilitated discussion summaries from PHSKC. Additionally, the data was reviewed and approved by the PHSKC AAR Project Management Team. All data was reviewed and analyzed by a third-party emergency management and public health consulting firm, Constant Associates (CONSTANT), contracted by Public Health - Seattle & King County to conduct a fair and independent review of response efforts and to develop this report. CONSTANT's team of emergency management and public health professionals aimed to conduct a transparent and honest analysis of the response and develop realistic and actionable improvement recommendations that align with HSEEP doctrine and other standard incident response evaluation principles and best practices.

PHSKC COLLECTED DATA

A variety of data was collected by PHSKC to ensure response teams, staff, and volunteers participated in the creation of the AAR. The following data types were the primary sources used to create this report.

Interviews

One hundred eleven stakeholder interviews were conducted by PHSKC to review major events that determined the critical areas for improvement and strengths related to the response efforts. Interviewees were identified by PHSKC as key stakeholders and teams during the COVID-19 response period covered by this AAR. All interviews were conducted in 2021. The first series of interviews were with PHSKC management, leadership, and select response area leads. The second set of interviews were with a broader range of response area leads. These interviews allowed participants to outline critical preparedness activities and describe self-identified response strengths, areas for improvement, and recommendations for future implementation. Transcripts of these interviews were analyzed by CONSTANT for the purpose of this AAR.

Facilitated Discussions

PHSKC staff facilitated 48 discussions with each of the response teams within the organization. These sessions are often called "hotwashes." Through these discussions, participants detailed strengths, areas for improvement, and recommendations based on their experiences during the response. The sessions allowed

teams to express their perspectives and opinions, while fostering awareness of the best practices implemented and challenges faced during different phases of the COVID-19 response. Summary reports of these meetings were compiled by PHSKC and analyzed by CONSTANT for inclusion in this report.

Surveys

Two surveys provided a forum for respondents to contribute to the AAR and enabled CONSTANT to identify key issues and themes. An electronic survey to capture PHSKC staff perspectives regardless of their response role was developed and distributed widely by PHSKC. CONSTANT conducted an analysis of the 414 responses received for the purpose of this AAR. A full summary report is included in the appendices and data from the survey informed the construction of emerging and common themes. A second survey was created by PHSKC to solicit feedback from its Public Health Reserve Corps (PHRC) volunteers. This survey was launched from May – June 2021. A summary report of the 462 responses was created by PHSKC and the data was reviewed and incorporated where appropriate by CONSTANT.

Document Review

An extensive library of documents related to the COVID-19 response was compiled and managed by PHSKC. CONSTANT reviewed the collected documentation and resources to identify supplemental information to complement interview, facilitated discussion, and survey findings. Additionally, CONSTANT researched online and publicly available references, as needed. The documents consisted of 15 reports related to lessons learned and partner AARs, 25 HMAC Incident Action Plans, Situation Reports, and messages, and 9 blogs and media articles detailing PHSKC response efforts. A list of the documents reviewed and included within this AAR can be found in the references list within the appendices.

Facilitated Feedback Sessions With Partners (i.e., Townhalls)

To ensure community partners were also offered an opportunity to contribute their perspectives, PHSKC and CONSTANT worked together to identify groups to invite to facilitated feedback sessions (also called “townhalls”). CONSTANT hosted four of these sessions with 31 participants attending. These discussions served as an opportunity to elicit input from community-based organizations, faith-based organizations, governmental and tribal partners, healthcare providers, and other key partners. Participants provided their perspectives on strengths, areas for improvements, and recommendations based on their experiences during the COVID-19 pandemic response. CONSTANT then incorporated the findings into the AAR. Community and Faith-Based Organizations were provided incentives for participating in sessions. The sessions were held in English with Communication Access Real-time Translation (CART) and live interpretation for multiple languages.

Table 2: PHSKC COVID-19 Townhall Participant Details

TOWNHALL PARTICIPANT DETAILS	COUNTS (n=31)
TYPE OF ORGANIZATION	
Community Based Organization	8
Other (e.g., tribal and/or healthcare coalitions, fire departments, laboratories, mobility management)	7
Other Healthcare Partner	7
Faith Based Organizations	2
Hospitals	2
Residential Facilities (Long Term Care, Skilled Nursing)	2
Philanthropic Partner	1
Public Health - Seattle & King County	1
Tribe or Tribal Organization	1
TYPE OF RESPONSE EFFORTS **could include more than one response type per attendee*	
Vaccination (includes mobile and mass vaccination)	21
Testing	17
Public information sharing	16
PPE Distribution	12
Food Distribution/Care Coordination	9
Other (e.g., response planning for congregation, maintaining healthcare situational awareness, relationship building,	8
Healthcare delivery	8
Contact tracing	7
Isolation and Quarantine	5
Transportation	2

ORGANIZATION OF THE REPORT

The report is organized to include an Incident Overview, Health and Medical Area Command (HMAC) and Incident Management Structure summary, and Analysis of Key Findings related to response efforts. Given the length and breadth of the pandemic and the unprecedented scope of the response efforts for PHSKC, **this report is not meant to be comprehensive of all activities conducted in response to the pandemic**. Instead, this report is meant to focus on major strengths and areas for improvement noted by stakeholders to identify opportunities for impact on future emergency responses.

The major findings make up the core content of the report and are found in the Analysis of Findings Section. The following focus areas are intended to group the findings by similar topics and, to the extent possible, are in chronological order by when related efforts started during the pandemic.

- Incident Management
- Epidemiological Investigation and Surveillance
- Equity and Community Partnerships
- Public Information
- Healthcare System Support
- Isolation and Quarantine
- Resource Management
- Public Information Contact Center (PICC)
- Community-Based Initiatives
- Testing
- Fatality Management
- Vaccination
- PHSKC Internal Operations
- Responders Safety and Health

Each focus area links to at least one CDC Public Health Emergency Preparedness and Response (PHEP) capability which serves as a framework to evaluate the ability of public health preparedness programs to prepare for, respond to, and recover from public health emergencies such as COVID-19. Within each focus area the findings are presented as strengths or areas for improvement. However, throughout the public health

response to the pandemic, many findings were not strictly strengths or areas for improvement, but a combination of both. Findings were recorded as mixed where stakeholders shared information that was positive but also expressed there were challenges and room for growth. The duration of the response also led to the resolution of some areas of improvement as PHSKC worked to continuously improve.

To show commonalities throughout the findings, this report uses recurring themes. These themes follow survey findings conducted with PHSKC staff. Respondents were asked to identify up to three key strengths of their teams/work areas and three challenging areas their teams endured in relation to the PHSKC response and recovery efforts. Respondents overwhelmingly chose the organization's flexibility/adaptability, teamwork, equity, and coordination/collaboration as strengths.[10] The key challenges noted were staff and team capacity, hiring and onboarding, and unclear processes. Some options, such as team coordination and collaboration, were identified by a notable number of respondents as both a strength and a challenge. The identified themes include:

Table 3: PHSKC COVID-19 Responder Survey Themes

STRENGTHS	AREAS FOR IMPROVEMENT
Flexibility/Adaptability	Lack of Flexibility
Teamwork	Team or Staffing Capacity
Equity	Equity Concerns
Coordination/Collaboration	Lack of Coordination/Collaboration
Communication	Lack of Communication
Relationship Building	Needed Relationship Building *(not an option in the survey)*
Standardization of Processes	Unclear Processes
Quality Assurance and Control	Quality Assurance and Control Concerns
Information Technology	Information Technology Concerns
Systems or Infrastructure	Lack of Systems or Infrastructure *(not an option in the survey)*
Safety or Wellbeing *(not an option in the survey)*	Safety or Wellbeing Concerns
	Unpredictable Funding
	Hiring and Onboarding Concerns

Where there were instances that multiple findings within a topic area were related to the same theme, an

[10] COVID-19 PHSKC Staff Surveys (2022)

additional title was added to differentiate each finding. These are found with an italicized header.

STATE AND LOCAL INCIDENT OVERVIEW

The first case of novel coronavirus in Washington was identified on January 21, 2020, in Snohomish County, WA. After returning from a trip to Wuhan, China, the patient developed symptoms and sought care at a medical facility within the state. As the first confirmed case of COVID-19 in the United States, the state of Washington immediately moved into the spotlight for COVID-19 coordination efforts early in 2020.

PHSKC activated its emergency operations structure, HMAC, at Level 2 - Partial Activation on January 21, 2020. The next day, the state of Washington activated its State Emergency Operation Center (SEOC) [11] to conduct emergency operations and support local jurisdictions responding to COVID-19 cases. PHSKC HMAC activation was elevated to a Level 1 – Full Activation to manage emergency operations on January 24, 2020. At the state level, efforts to contain the disease in January to mid-February 2020 continued by encouraging stay-at-home orders, PPE procurement, and increasing response funding. At the local level, PHSKC began to disseminate key messages and respond to inquiries, including through its Public Health Insider blog and a dedicated COVID-19 website. The department also provided guidance to healthcare providers on diagnosis, management, and infection control measures, conducted surveillance for detection of disease, developed materials for outreach to community members and partners, and closely coordinated with the CDC, DOH, and other local health jurisdictions on suspected cases and messages.[12] In this initial phase of COVID-19 response, PHSKC worked with community leaders to address COVID-19 misinformation, stigma, and racism surrounding Chinese and broader Asian American communities, holding a press conference on February 7, 2020 and releasing outreach materials to make clear that viruses do not discriminate and neither should the King County community.[13]

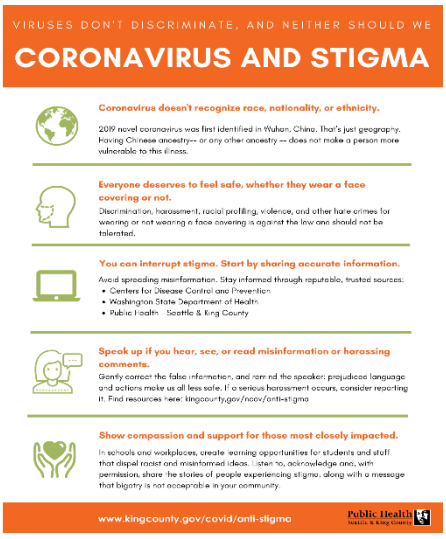


Image 2: Community outreach materials

[11] State Emergency Operations Center. Situation Report. November 5, 2020. https://lewiscountywa.gov/media/documents/SEOC_COVID19_SitRep_110520-181.pdf
[12] PHSKC. HMAC Incident Action Plan #01
[13] PHSKC. 02.07.2020. Public Health Insider. Addressing Stigma United Response to Coronavirus. Accessed 5.31.22. https://publichealthinsider.com/2020/02/07/addressing-stigma-united-response-to-coronavirus/

PHSKC confirmed the first known case of COVID-19 in King County on February 27, 2020. Just one day later, on February 28, 2020, the first recognized COVID-19 death in the United States was recorded in King County, though postmortem testing would demonstrate that undercounted deaths and lack of testing contributed to delays in reporting and that the first COVID-19 death in the United States was actually in January. On February 29, 2020, the CDC reported this first COVID-19 death in the United States and described additional presumptive positive COVID-19 cases in King County with two hospitalized patients originating from a suspected outbreak in a Long-Term Care Facility (LTCF), Life Care, where more than 50 individuals associated with Life Care were ill with respiratory symptoms.[14]

Unable to track the source of infection, CDC officials stated that circumstances now suggested person-to-person spread in the community, including in the LTCF. Subsequently, King County activated its Emergency Operations Center (EOC), and Governor Jay Inslee issued a State of Emergency, facilitating the allowance of additional local and state resources to be utilized to respond to the outbreak. Through the end of February and into March of 2020, Life Care continued to be a focus of PHSKC and state cases due to the increased risk to residents with underlying health conditions.[15] Due to the magnitude of the outbreak, collaboration with federal officials was also necessary to support an overwhelmed local infrastructure and augment clinical staffing, particularly because almost a third of Life Care staff tested positive for the virus. CDC staff were deployed to Life Care within a couple of days of the known outbreak to perform evaluations, examine response activities, and measure supply needs. A U.S. Department of Health and Human Services (HHS) strike team arrived the following week, completing COVID-19 testing for all Life Care residents. As the first known outbreak of COVID-19 in the U.S., the Life Care facility outbreak was high profile, garnering international attention, and its response greatly scrutinized. In addition to the support from the CDC and HHS, PHSKC worked with Life Care to treat ill patients while protecting those unaffected.

This LTCF outbreak was the first of many reported in the United States that led to multiple deaths in this vulnerable population.[16] Thirty-nine residents of this nursing home died in a four-week span.[17] During the month of March, 51% of all COVID-19 cases investigated by PHSKC were exposed within a healthcare setting, including 33% of all cases being linked to a LTCF outbreak. Through September 1, 2020, more than 90% of those who died from COVID-19 in King County were over age 60.[18]

On the local front, by March 1, 2020, a King County Proclamation of Emergency was signed that delineated PHSKC's role as lead agency for King County's COVID-19 response, waived procurement protocols, and authorized overtime for hourly county employees. PHSKC also began to add workers to their team in an effort

[14] CDC. 2.29.20. Washington State Report First COVID-19 Death. Accessed 5.31.22. https://www.cdc.gov/media/releases/2020/s0229-COVID-19-first-death.html

[15] Weise, Harmon and Fink, New York Times, *Why Washington State? How Did It Start? Questions Answered on the U.S. Coronavirus Outbreak,* March 4, 2020

[16] CDC Newsroom, *Washington State Report First COVID-19 Death Media Statement,* February 29, 2020, https://www.cdc.gov/media/releases/2020/s0229-COVID-19-first-death.html

[17] History.com, *First confirmed case of COVID-19 found in U.S.,* Accessed May 5, 2021, https://www.history.com/this-day-in-history/first-confirmed-case-of-coronavirus-found-in-us-washington-state

[18] PHSKC. 11.23.20. Summary Report on Outbreaks and Exposure Settings for COVID-19 Cases in King County, WA. Accessed 5.31.22 https://kingcounty.gov/depts/health/covid-19/data/~/media/depts/health/communicable-diseases/documents/C19/report-outbreaks-exposure-settings-covid-19.ashx

to combat the effects of COVID-19 on the county, and soon after, on March 3, 2020, activated and staffed a contact center to provide information to the community.[19] A critical focus during this initial response was also disease investigation and surveillance, which included conducting surveillance for community level transmission and monitoring the impact of disease on King County in terms of containment, community level indicators, and focused case and cluster investigation.[20] And while contact tracing would initially focus on priority cases for LTCFs, healthcare workers, schools, and institutions, this would expand throughout the remainder of March and into the month of April in coordination with partners. Such activities made it possible for PHSKC to collect and share surveillance data, monitor trends, and inform modifications to non-pharmaceutical interventions.

Throughout the month of March 2020, more information was also available regarding the potential impact of COVID-19 on different populations. Other populations identified by PHSKC to be at higher risk for severe illness from COVID-19 included people 60 and older, people with underlying health conditions, people who are immunocompromised, and people who are pregnant. Local health officials recommended that those vulnerable to severe illness from COVID-19 take concerted steps to reduce their risk of exposure.[21] PHSKC created a cross-sector forum for representatives from community, business, and government sectors to contribute to helping to slow the spread of COVID-19, forming an advisory group initially called the Pandemic Community Advisory Group (PCAG). An initial meeting of the PCAG was held on March 5, 2020.[22] The PCAG initially focused on how representatives could share COVID-19-related information and messages internally, within their sectors, and to the public, how organizations could join PHSKC in responding to misinformation and stigma, and how PHSKC could work with these sectors to inform each other of opportunities, successes, and barriers to implementing recommended measures. The discussions held, as well as the mission of the

[19] King County. 3.01.20. Proclamation of Emergency. Accessed 5.31.22 https://kingcounty.gov/~/media/operations/policies/documents/PHL104Proclamation_of_Emergency.ashx?la=en
[20] HMAC COVID-19 IAP #18
[21] King County. 3.4.20. Local Health Officials Announce New Recommendations to Reduce Risk of Spread of COVID-19. Accessed 5.31.22. https://kingcounty.gov/depts/health/news/2020/March/4-covid-recommendations.aspx
[22] King County. 3.5.20. King County Pandemic Advisory Group. Access 6.14.22. https://kingcounty.gov/depts/health/covid-19/community-faith-organizations/~/media/depts/health/communicable-diseases/documents/C19/parcag/PARCAG-2020-Mar-5-minutes.ashx

PCAG, would evolve over time, covering topics such as mental and behavioral health, COVID-19 data tools,

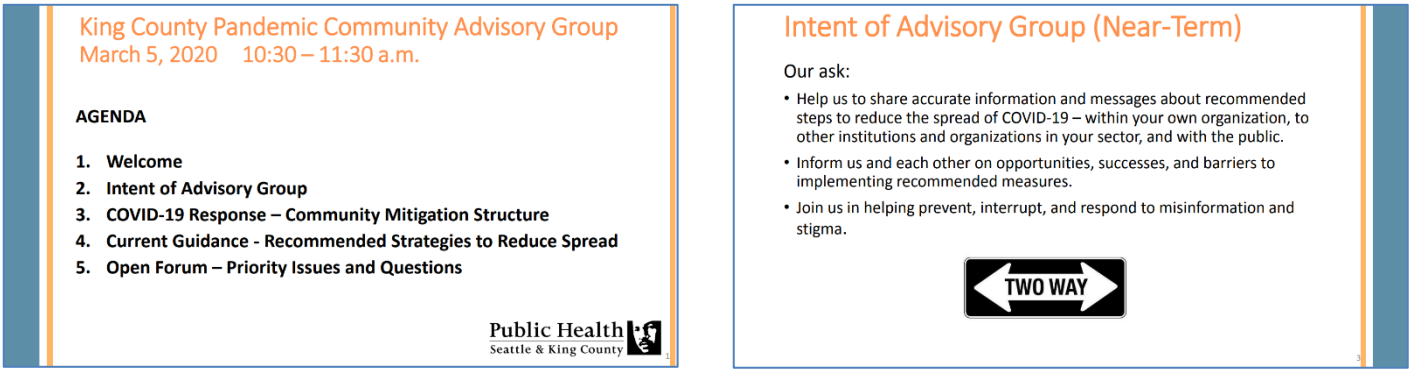


Image 3: PCAG slide examples

pro-equity strategies and equity impacts, and food security.

The initial COVID-19 outbreak was not confined to merely the Life Care facility, however. Between March 1, 2020 and March 15, 2020, when social distancing was advised in King County and bars, restaurants, events, and other gatherings were ceased for an initial two-week period, the total COVID-19 case count grew to 420 and the total number of recorded deaths was 37.[23] During this critical period in response, actions taken across the state and local levels included: area colleges moving to virtual instruction; King County opening isolation and quarantine sites; King County, United Way of King County, and Seattle opening a 'supply store' to pool together resources and funnel in and out bulk purchases; large events over 250 people being suspended; and schools closing in King County through April 24, 2020 (initially). In addition to the LTCF outbreaks, tribal communities were affected early on in this pandemic. The state of Washington is home to 29 federally recognized Indian Tribes. DOH, in coordination with a tribally driven non-profit organization, the American Indian Health Commission (AIHC), worked together early in the pandemic on behalf of these tribes to mitigate the risk to their tribal communities.[24] As PHSKC noted when they announced their Principles for Equitable Vaccine Delivery in April 2021, the impact was also felt in several high-risk communities because of historical inequities, government distrust, and existing barriers to access.

Other communities disproportionately impacted by COVID-19 both during the pandemic's early stages and throughout as attributable to structural racism and social and economic vulnerabilities were service workers, immigrants, BIPOC communities, communities with limited access to health services, people without housing, and people with disabilities and other access and functional needs.

Some examples of how PHSKC strove to serve communities disproportionately impacted by COVID-19 during initial response in March and April 2020, are described in the following paragraphs. Many of these efforts

[23] King County. 3.15.20. Executive Constantine and King County Health Officer Announce New Orders to Limit Spread of COVID-19. Accessed 5.31.22. https://kingcounty.gov/elected/executive/constantine/news/release/2020/March/15-COVID-order.aspx
[24] Lou Schmitz, American Indian Health Commission for Washington State, *AIHC Tribal Communicable Disease Emergency Reponses Planning Project 2019-2020*, March 11, 2020

were stood up during initial response and continued to be carried out for over two years and/or are still in place at the time of writing of this report (June 2022).

- PHSKC, the broader King County government, and the State shared information and provide services to people experiencing homelessness such as convening information calls with homeless and shelter services providers, providing guidance on sanitation and infection control to homeless services sites, including through site visits, and deploying clinical strike teams.

- Public information was tailored to reach the whole community with PHSKC's Language Access Team translating COVID-19 materials and resources into 40 languages.[25] As of April 9, 2020, King County COVID-19 fact sheets were made available in 21 languages, and COVID-19 "Stay Home, Stay Healthy" Public Service Announcements on YouTube were available in 12 languages.[26]

- Food and shelter needs were addressed by efforts such as deploying extra drivers and vehicles for paratransit and Community Access Transportation services to food banks, launching an Individual Food Assistance Program and a King County Regional Donations Connector, suspending WorkFirst Participation requirements for Temporary Assistance for Needy Families (TANF), and expanding eligibility for the Family Emergency Assistance Program (FEAP).

- A statewide residential eviction moratorium was enacted, and COVID-19 emergency shelter and housing response was expanded.[27]

- Individuals who were incarcerated were provided single bunks in correctional facilities and steps were taken to safely decrease the number of adults in custody.[28]

- PHSKC sought to promote community emotional health and resilience during both COVID-19 and the public health crisis of racism by creating a Community Well-Being Group focusing on the health and well-being of BIPOC communities and convening a task force on older adults and people with disabilities to inform COVID-19 guidelines and decisions.[29]

- As mentioned previously, the PCAG (which would re-establish its mission in September 2020 as described below) as well as an Equity Response Team (ERT) were stood up to address the

[25] PHSKC. 4.10.20. How We are Monitoring COVID-19 Preliminary Data by Race, Ethnicity. Accessed 5.31.22. https://publichealthinsider.com/2020/04/10/how-we-are-monitoring-covid-19-preliminary-data-by-race-ethnicity/
[26] PHSKC. 4.9.2020. King County Pandemic Community Advisory Group. Access 6.15.22. https://kingcounty.gov/depts/health/covid-19/community-faith-organizations/~/media/depts/health/communicable-diseases/documents/C19/parcag/PARCAG-2020-April-9-minutes.ashx.
[27] King County. 3.25.20. King County and Seattle Expand COVID-19 Emergency Shelter and Housing Response. Accessed 5.31.22. https://kingcounty.gov/elected/executive/constantine/news/release/2020/March/25-kingcounty-seattle-covid-19-shelter.aspx
[28] King County. 3.24.20. Quickly, Safely, Reducing the Jail Population so Staff can Ensure the Health of Everyone in Correctional Facilities. Accessed 5.31.22. https://kingcounty.gov/elected/executive/constantine/news/release/2020/March/24-jail-population.aspx
[29] PHSKC. May 2020. Media Release: Protecting Rights of People with Disabilities as Face-Covering Directive Goes into Effect Monday. Accessed 5.31.22. https://publichealthinsider.com/2020/05/15/media-release-protecting-rights-of-people-with-disabilities-as-face-covering-directive-goes-into-effect-monday/

disproportionate negative impacts of COVID-19 for the various communities considered to be at greater risk. The purpose of the ERT was for PHSKC to internally develop and provide recommendations and actionable information for PHSKC leadership to support communities most impacted by inequities, and communities experiencing hate and bias.[30]

Despite these efforts, several concerning trends emerged within the King County region and/or the broader U.S. including:[31]

- A reawakening of anti-Chinese and anti-Asian American rhetoric resulting in racism, and at times, harassment and violence being experienced by the Asian-American communities.
- COVID-19 mitigation efforts unintentionally increasing the number of residents who were unemployed, furloughed, and/or required food, utility, housing, and health care access assistance.[32]
- BIPOC communities disproportionately experiencing loss of employment, and subsequently in most cases, loss of health care coverage. This exacerbated disparities in financial and non-financial burdens that were already preventing BIPOC populations from receiving health care services prior to the pandemic.[33]
- Summary data released on May 1, 2020, showing that rates of confirmed COVID-19 cases in King County for Hispanics, Native Hawaiians, and Pacific Islanders being four times that of Whites and the rate of confirmed cases for Blacks being double that of Whites. Disparities were also present in COVID-19-related hospitalizations.
- Increased death rates in 2020 compared to prior years being observed among communities of color reflected exacerbated inequities.[34]
- Essential workers filling critical jobs being vulnerable to infection and unable to telecommute.

[30] COVID-19 AAR Summary_ERT
[31] PHSKC. 5.1.21. Making Meaning of the COVID-19 Race and Ethnicity Data: A Conversation with Our Health Officer and Our Equity Director. Accessed 5.31.22. https://publichealthinsider.com/2020/05/01/making-meaning-of-the-covid-19-race-and-ethnicity-data-a-conversation-with-our-health-officer-and-our-equity-officer/
[32] PHSKC. 7.15.20. Behavioral Health Needs and Services in King County, WA: March - May 2020. Accessed 5.31.22. https://kingcounty.gov/depts/health/covid-19/data/~/media/depts/health/communicable-diseases/documents/C19/report-behavioral-health-needs.ashx
[33] PHSKC. 7.14.21. Health Care Access in King County, WA March 2020 – June 2021. Accessed 5.31.22. https://kingcounty.gov/depts/health/~/media/depts/health/communicable-diseases/documents/C19/health-care-access-king-county.ashx
[34] PHSKC. 2.3.21. Changes in Death Rates During the COVID-19 Pandemic in King County, WA January 1 – December 31, 2020. Accessed 5.31.22. https://kingcounty.gov/depts/health/covid-19/data/~/media/depts/health/communicable-diseases/documents/C19/changes-in-death-rates-report.ashx

- Communities of colors being less likely to have available testing and lacking access to healthcare and available resources and more likely to be living in multigenerational households where quarantine and isolation may be difficult.
- Undocumented individuals being unable to access federal programs such as stimulus checks.
- Case rates varying widely by geography, with wide swaths of South King County, areas of south Seattle, and pockets in the far north and east of King County experiencing positivity rates that are five times higher than in other areas.

From the end of March 2020 through June 2020, PHSKC and its broader partners continued to expand the response to COVID-19. This included setting up the first COVID-19 testing site in Shoreline, launching a Stand Together, Stay Apart campaign on March 25, 2020 in conjunction with the State's Stay Home, Stay Healthy Order and launching a public data dashboard. PHSKC recommended, strongly directed, and then finally issued a health directive for masks to be worn in public. Once available, PHSKC distributed COVID-19 tests locally and later made tests available to individuals who had only mild symptoms. PHSKC, along with Emergency Management, provided supplies (PPE, hand sanitizer, etc.) to both Tier 1 and Tier 2 settings in alignment with DOH's Prioritization Guideline for Allocation of PPE[35] and also ensured coordination of regional medical surge operations.

Image 4: Stand Together, Stay Apart campaign images

By June 5, 2020, King County was approved for a modified version of Phase 1 for the State's Safe Start Plan, allowing businesses, recreational opportunities, and social activities to gradually reopen, which would be followed by Phase 2 on June 19, 2020, prompting restaurant and retail reopening and the return of small

[35] DOH. 9.27.2021. Prioritization Guideline for Allocation of PPE. Accessed 6.14.22. https://doh.wa.gov/sites/default/files/2022-02/PPEPrioritizationofAllocation.pdf.

gatherings. As state and local officials continued to expand COVID-19 response throughout the summer of 2020 by opening additional testing sites and consistently communicating continued social distancing, PHSKC and the broader County also continued to take actions to equitably serve its community. A King County-wide declaration of racism as a public health crisis was made on June 11, 2020. By September 20, 2020, the PCAG was reestablished as the King County Pandemic and Racism Community Advisory Group (PARCAG) and PARCAG's mission was modified to "identify, inspire, and mobilize bold solutions in response to the urgent, interconnected crises of COVID-19 and systemic racism." PHSKC in partnership with King County's Office of Equity and Social Justice (OESJ) also launched several new data dashboards and tracking systems including one to delineate COVID-19 impacts on individuals experiencing homelessness, a Food Finder to encourage support of local farms, and a behavioral health dashboard to evaluate impacts on social, economic, and overall health in King County.

In addition to the activities outlined thus far, additional steps taken by PHSKC to serve its community included distributing masks to Community Based Organizations (CBOs), launching a COVID-19 Health Ambassador Program, and dedicating $41M for rental assistance and eviction prevention.[36] One substantial focus of the summer of 2020 was back-to-school planning, and it was announced on July 22, 2020, that King County school districts would begin with remote learning in the fall. That same week, on July 24, 2020, PHSKC had the highest seven-day average of new COVID-19 cases since the beginning of April.[37] PHSKC was better positioned to perform case investigations during this surge in comparison to early response, however, with a team of approximately 61 members who were able to investigate over 500 COVID-19 cases per week. Though the rate of new daily COVID-19 infections would generally decline from this period up until early September 2020, this would be short-lived as rates of new daily COVID-19 infections then increased from early September 2020

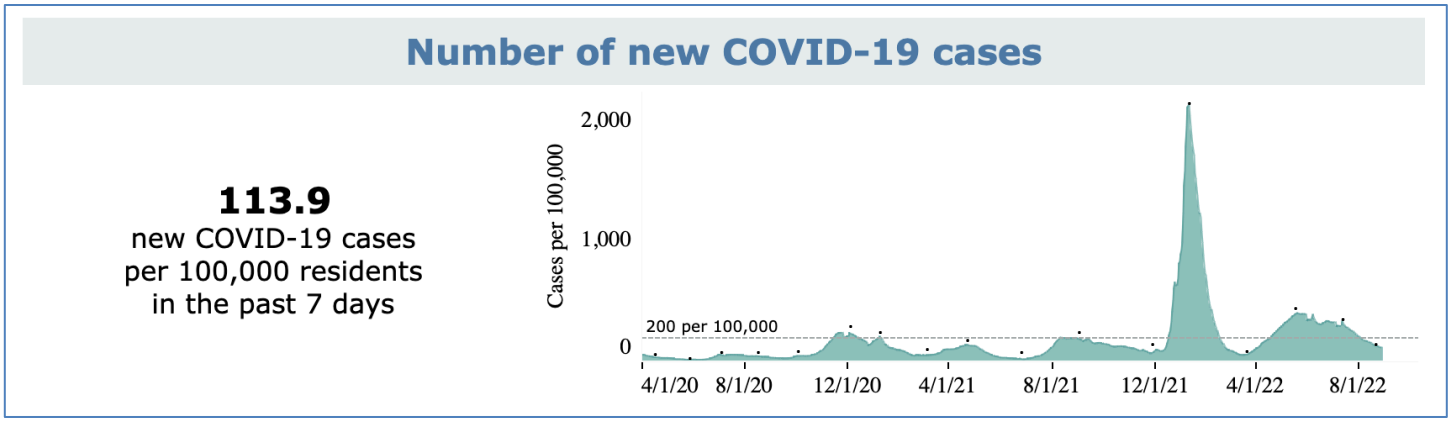


Figure 2: Number of New COVID-19 Cases in King County from 4/1/2020 – 8/1/2022. Accessed Sept. 1, 2022 https://kingcounty.gov/depts/health/covid-19/data/community-level.aspx

[36] Department of Community and Health Services. 8.5.20. Former Metro Drivers Take a New Role as King County Health Ambassadors to Slow the Spread of COVID-19. Accessed 5.31.22. https://dchsblog.com/2020/08/05/former-metro-drivers-take-on-new-role-as-king-county-health-ambassadors-to-slow-the-spread-of-covid-19/; King County. 8.20.20. King County Dedicates $41 Million to COVID-19 related Rental Assistance and Eviction Prevention. Accessed 5.31.22. https://kingcounty.gov/elected/executive/constantine/news/release/2020/August/20-rental-assistance.aspx

[37] PHSKC. 7.24.20. Video: July 24, 2020 Update on COVID-19 in King County with Dr. Jeff Duchin. Accessed 5.31.22. https://publichealthinsider.com/2020/07/24/video-july-24-2020-update-on-covid-19-in-king-county-with-dr-jeff-duchin/

until mid-December 2020 for King County and the broader U.S. Impacts experienced during this time included Washington rolling back its phased reopening plan by enacting a four-week statewide set of restrictions beginning on November 16, 2020.

Despite this increase of new daily COVID-19 cases in the fall and winter of 2020, associated with holiday gatherings and colder weather, progress was being made on the vaccination front. On December 14, 2020, Washington's COVID-19 vaccination program began, following the vaccine's Emergency Use Authorization. Healthcare workers (including community health workers), first responders, people who live or work in long-term care facilities, and all other workers in health settings at high risk of exposure to COVID-19 were the first groups eligible for vaccinations. The first doses of the vaccine arrived in King County soon after, on December 16, 2020.[38]

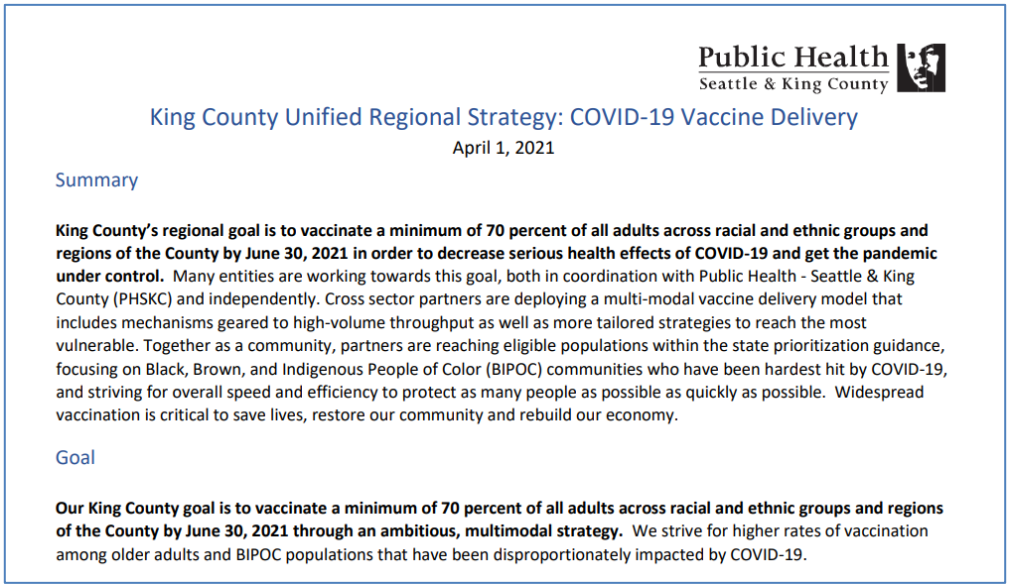
On January 8, 2021, King County announced that it would be allocating $7M for the creation of high-volume community vaccination sites and mobile teams to equitably vaccinate residents, complementing vaccinations provided through the healthcare system and pharmacies.[39] By January 18, 2021, eligibility was expanded to include people ages 65 years of age and older as well as individuals aged 50 years of age or older who lived in a multigenerational household.[40]

Extensive challenges managing the vaccination tiers and the associated distribution of the vaccine emerged in Washington and throughout the country. As demand for the vaccine exceeded supply well into the spring of 2021 and guidance from both federal and state authorities was constantly changing, county health officials had to rapidly pivot and decide whether to adopt new recommendations or pursue their original vaccination plans. Subsequently, the public expressed frustration as not only were they impacted by the changing guidance relating to vaccination tiers, but they also faced challenges registering for vaccines and getting appointments. As vaccination eligibility initially increased, PHSKC was frank about limited supply of the vaccine both nationally and locally preventing access to the COVID-19 vaccine, even to those eligible.[41] By early February of 2021, however, PHSKC set up two high-volume vaccination sites, one at the accesso ShoWare Center in Kent and one at the General Services Administration Complex in Auburn, with more planned. These sites were designed to serve those who may face barriers to accessing the COVID-19 vaccine through traditional healthcare systems, including older adults (ages 75+) in south King County.[42]

As vaccine tiers opened, King County established a goal to vaccinate a minimum of 70 percent of all eligible

[38] PHSKC. 12.16.20. First Doses of Vaccine Arrive in King County. Accessed 5.31.22. https://publichealthinsider.com/2020/12/16/first-doses-of-vaccine-arrive-in-king-county/
[39] PHSKC. 1.8.21. King County Announces New Funding for Community Vaccination Efforts. Accessed 5.31.22. https://publichealthinsider.com/2021/01/08/king-county-announces-new-funding-for-community-vaccination-efforts/
[40] Washington State Department of Health. February 10, 2021. COVID-19 Vaccination Coverage by Race and Ethnicity and Age in Washington State. https://doh.wa.gov/sites/default/files/2022-03/348-791-COVID19VaccinationCoverageRaceEthnicityAgeWAState.pdf?uid=6282e74a61b25
[41] PHSKC. 1.18.21. Expanding Vaccination To Older Adults In King County. Accessed 5.31.22. https://publichealthinsider.com/2021/01/18/expanding-vaccination-to-older-adults-in-king-county/
[42] PHSKC. 1.29.21. King County Opens Covid-19 Vaccination Sites In Kent And Auburn To Provide Access For Vulnerable Older Adults And Their Caretakers. Accessed 5.31.22. https://publichealthinsider.com/2021/01/29/king-county-opens-covid-19-vaccination-sites-in-kent-and-auburn-to-provide-access-for-vulnerable-older-adults-and-their-caretakers/

adults equitably, efficiently, and quickly across all racial and ethnic groups and regions of the county by June 30, 2021.[43] This included creating and publishing the King County Unified Regional Strategy: COVID-19 Vaccine Delivery and the Principles for Equitable Vaccine Delivery in April 2021.



Public Health
Seattle & King County

King County Unified Regional Strategy: COVID-19 Vaccine Delivery

April 1, 2021

Summary

King County's regional goal is to vaccinate a minimum of 70 percent of all adults across racial and ethnic groups and regions of the County by June 30, 2021 in order to decrease serious health effects of COVID-19 and get the pandemic under control. Many entities are working towards this goal, both in coordination with Public Health - Seattle & King County (PHSKC) and independently. Cross sector partners are deploying a multi-modal vaccine delivery model that includes mechanisms geared to high-volume throughput as well as more tailored strategies to reach the most vulnerable. Together as a community, partners are reaching eligible populations within the state prioritization guidance, focusing on Black, Brown, and Indigenous People of Color (BIPOC) communities who have been hardest hit by COVID-19, and striving for overall speed and efficiency to protect as many people as possible as quickly as possible. Widespread vaccination is critical to save lives, restore our community and rebuild our economy.

Goal

Our King County goal is to vaccinate a minimum of 70 percent of all adults across racial and ethnic groups and regions of the County by June 30, 2021 through an ambitious, multimodal strategy. We strive for higher rates of vaccination among older adults and BIPOC populations that have been disproportionately impacted by COVID-19.

Image 5: King County Unified Regional Strategy

Starting April 15, 2021, all people in Washington ages 16 and older became eligible for the COVID-19 vaccine. Grounding principles to adopt an intentional equity driven COVID-19 vaccination strategy included removing barriers to deter access, creating an inclusive process, and being intentionally anti-racist and accountable to BIPOC communities, something that PHSKC intended to apply across a multi-modal vaccine delivery approach that included hosting a series of community vaccination events with non-profit organizations with strong community ties. PHSKC and transit partners also prioritized transportation options to facilitate access to vaccination sites including Metro, Via to Transit, Access paratransit, and more.[44]

On April 19, 2021, PHSKC announced the launch of a new vaccination program for homebound populations, where mobile teams would deliver vaccines to residents at their homes.[45] By April 29, 2021, PHSKC developed a county vaccination partnership with multiple health care institutions and was advertising COVID-19 walk-in vaccinations at sites in Kent, Auburn, Seattle, Renton, Redmond, and Shoreline, speaking to the ease of COVID-19 vaccine supply issues where demand no longer exceeded supply.[46] The Pfizer vaccine then became available for children ages 12-15 on May 13, 2021. By June 15, 2021, 70% of King County's residents ages 16+

[43] PHSKC Principles for Equitable Vaccine Delivery.
[44] PHSKC. 2.23.21. Take Transit To Take Your Shot: Here Are Ways To Get To Your Vaccination Appointment. Accessed 5.31.22. https://publichealthinsider.com/2021/02/24/take-transit-to-take-your-shot-here-are-ways-to-get-to-your-vaccination-appointment/
[45] PHSKC. 4.19.21. Public Health's In-Home Vaccination Launches Across The county. Accessed 5.31.22. https://publichealthinsider.com/2021/04/19/public-healths-in-home-vaccination-launches-across-the-county/
[46] PHSKC. 4.29.211. Getting Vaccinated Just Got Easier (At Last!). Accessed 5.31.22. https://publichealthinsider.com/2021/04/29/getting-vaccinated-just-got-easier-at-last/

had completed their vaccine series, prompting an end to PHSKC's mask directive two weeks later alongside lifting of restrictions for the broader State and indicating that the goal outlined in the King County Unified Regional Strategy for COVID-19 Vaccine Delivery was met.

Approximately 81.8% of Washington's population 5 years of age and older has received at least one dose of the COVID-19 vaccine and 74.4% are fully vaccinated as of May 9, 2022. In King County approximately 93.5% of the population 5 years of age and older has initiated the primary series of the vaccine and 85.8% had completed the primary series. For those who provided information on their race and ethnicity, the percentage of individuals who have initiated their primary series of the vaccine by population group include:[47]

Table 4: Vaccination Data from PHSKC Dashboard as of May 9, 2022

Race	% Completed Primary Vaccine Series	Percent of King County Population (One Race)
AIAN	>95%	.7%
NHOPI	>95%	.7%
Asian	>95%	18.9%
Hispanic	76.4%	9.9%
Black	80.9%	6.7%
White	80.8%	62.1%

As vaccination rates increased throughout the spring and into the summer of 2021, new daily COVID-19 cases generally declined until the Delta variant emerged toward the end of July, at which point daily COVID-19 cases generally increased through January 2022 with a few exceptions. The CDC recommended mask wearing in public indoor settings, even for vaccinated individuals. The State of Washington then enacted an indoor mask mandate on August 23, 2021, one that would continue until March 11, 2022. State and local officials continued to enact mitigative actions including vaccination mandates for education personnel and vaccination verification orders for large indoor and outdoor events. King County additionally enacted a vaccine verification policy for other indoor recreational establishments such as restaurants, gyms, and bars.

Declining rates of efficacy for the COVID-19 vaccine in the fall of 2021 drove booster eligibility. By October 22, 2021, individuals statewide at severe risk of COVID-19 illness and/or high risk of exposure were eligible for a booster, followed by the expansion of eligibility statewide to those ages 18+ on November 20, 2021. At the

[47] Washington State Department of Health. *COVID-19 Data Dashboard*. Accessed May 17, 2022. https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard

time of the writing of this report (June 2022) 53% of King County residents 5+ years of age have received a booster of the COVID-19 vaccine.

Table 5: Vaccination Data from PHSKC Dashboard as of May 9, 2022

Race	% Completed Primary Series + Booster
AIAN	62.4%
NHOPI	54.5%
Asian	66.1%
Hispanic	34.2%
Black	35.4%
White	55.4%

The Omicron Variant then emerged in December 2021, substantially driving an increase in daily COVID-19 cases and hospitalizations (including a 700% increase from the month prior) in January 2022. King County hospitals and healthcare partners urged the public to continue to take COVID-19 seriously by getting vaccinated and/or boosted, upgrading masks, avoiding crowded spaces, and saving hospital emergency departments for emergencies.[48] The impact of the Omicron variant cannot be underscored, particularly in the context of responder safety and support for mental and physical well-being as exhausted responders faced their toughest challenge yet as the highest recorded new daily COVID-19 case count was recorded on January 4, 2022. PHSKC had to conduct and coordinate community testing in response to increased demand and reconvene preparations for and later response to the surge. Though this report is intended to merely cover an operational period concluding on January 31, 2022, COVID-19 response continued throughout the early months of 2022, with new daily COVID-19 cases declining significantly from that early January of 2022 peak.

[48] UW Medicine. 1.22.22. King County Hospitals Issue Urgent Call To Action. Accessed 5.31.22. https://newsroom.uw.edu/news/king-county-hospitals-issue-urgent-call-action

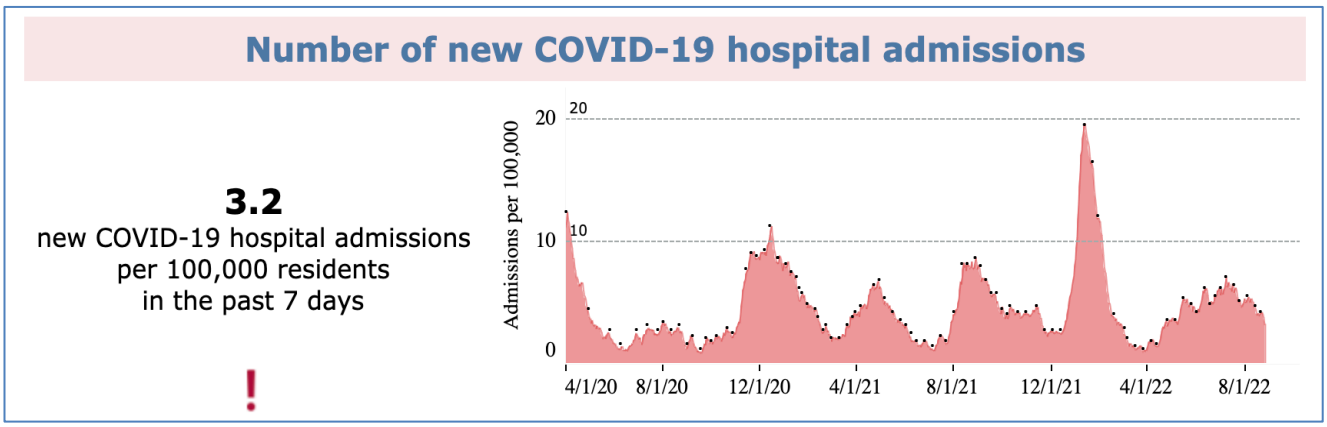


Figure 3: Number of Hospital Admissions in King County from 4/1/2020 – 8/1/2022. Accessed Sept. 1, 2022 https://kingcounty.gov/depts/health/covid-19/data/community-level.aspx

In closing, PHSKC worked tirelessly throughout the over two-year period of January 21, 2020 to January 31, 2022 being addressed in this report to execute its mission of protecting the health and well-being of all people in King County. PHSKC's activities in response to COVID-19 spanned contact tracing, disease investigation, information management, testing, vaccination, PPE distribution, public information, community engagement, and much more. The State and Local Timeline in the appendices includes more information about the timeline and progression of PHSKC's activities in the context of other federal and state actions. At the time of writing of this report (May 2022), PHSKC is demobilizing its incident management structure, with its last operational period being May 11 through May 25, 2022. However, PHSKC has ongoing COVID-19 response and recovery activities and will continue to ensure continuity of support for these through its divisions and programs.

HEALTH AND MEDICAL AREA COMMAND (HMAC) AND INCIDENT MANAGEMENT STRUCTURE

On January 21, 2020, PHSKC activated Level 2 HMAC to coordinate and manage the public health response as cases were identified in Washington State. Three days later, HMAC was elevated to Level 1. The purpose of HMAC is to coordinate and, in some cases, manage public health and associated medical operations during an emergency. Activities include messaging and communications, deployment and management of personnel and resources, and maintaining situational awareness. HMAC is activated when an incident is unable to be managed through existing infrastructure or routine operations, public information and partner coordination needs are high, and the situation is dynamic. The mission of HMAC for the COVID-19 response was to provide an incident management and coordination structure to support rapidly evolving public health-led activities or novel strategies to minimize disease transmission.

Compared to later iterations, the size and structure of the HMAC started small with the first known case and evolved throughout the response to meet the ever-increasing demands. Included in the initial organization structure was an Area Commander and Command Staff, Local Health Officer (no direct reports), Operations Section with five branches, Logistics Section with one branch, Planning Section with three units, and the Finance & Administration Section.[49]

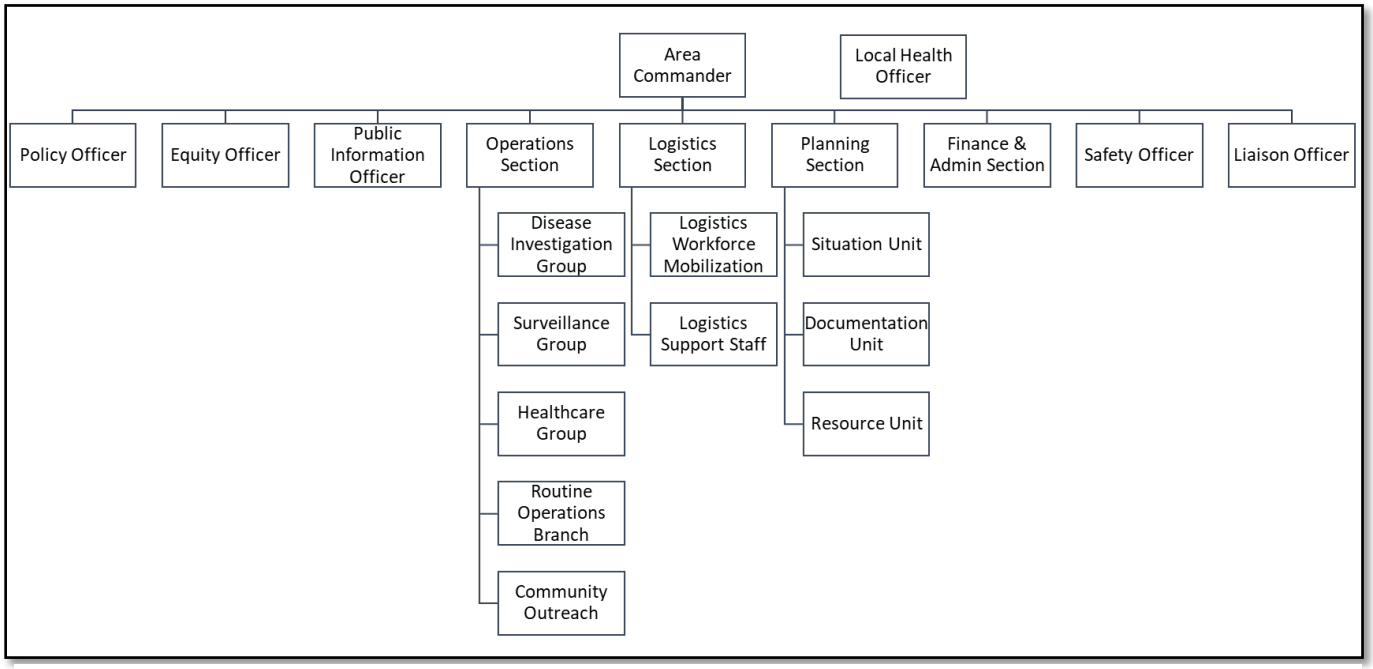


Figure 4: ICS 207 HMAC IAP #1

[49] ICS 207, HMAC IAP #1

EXPANDING HMAC STRUCTURE: MARCH 2020 - MAY 2020

By May 2020 the HMAC structure expanded to consist of over 500 responders directly assigned in a large stand-alone incident command structure. The responders were King County employees, agency staff, consultants, and contractors from partner organizations. Included in the organization structure was an Area Commander and Command Staff, Local Health Officer (no direct reports), Operations Section with five branches and sixteen groups, Logistics Section with one branch, Planning Section with four units, and the Finance & Administration Section with three units.[50] Of note, the below graphics are from IAP #78 and do not include the full extent of the operations section. The operations section ultimately included over 65 Task Forces, Strike Teams, Advisor Teams, and other Coordinating Teams.

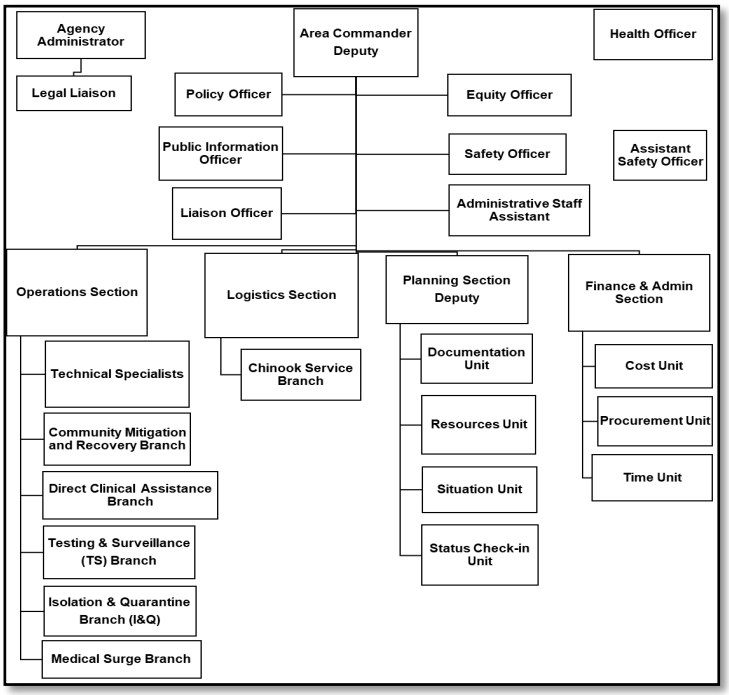


Figure 1: ICS 207 HMAC IAP #78

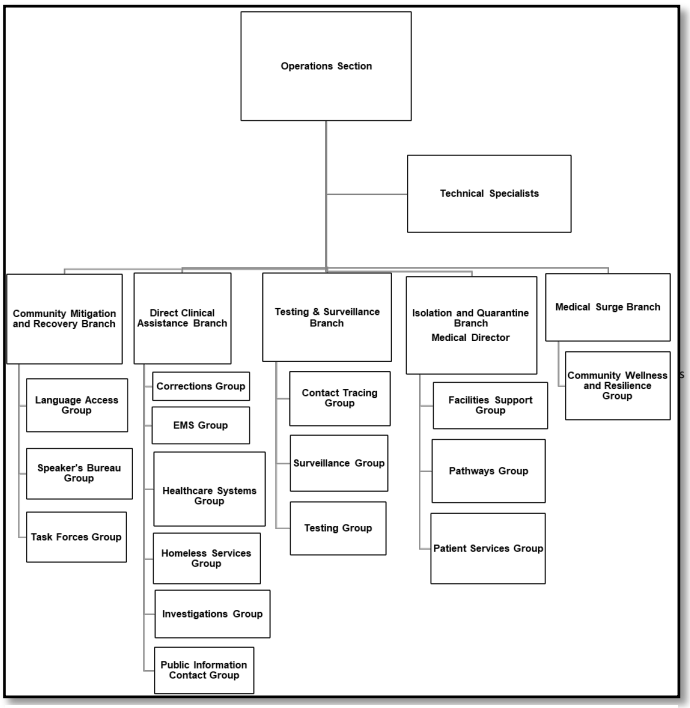


Figure 6: ICS 207A HMAC IAP #78

[50] ICS 207, HMAC Org Chart_Ops Period 78

STREAMLINING HMAC: JUNE 2020 - DECEMBER 2020

In May 2020 PHSKC evaluated HMAC operations to recommend response activities that may no longer need to be managed in the response structure. Although there were not considerable changes to the scope of responsibility, purpose, or mission, the mission now included three parameters: Decision-Making and Policy Role, Current PHSKC Major Response Operations and Planning Focus, and Organizational Management Structure. The parameters also included several subtasks within each. Response activities that became relatively predictable and stable or were expected to continue for an extended period were considered for alternate management structures.

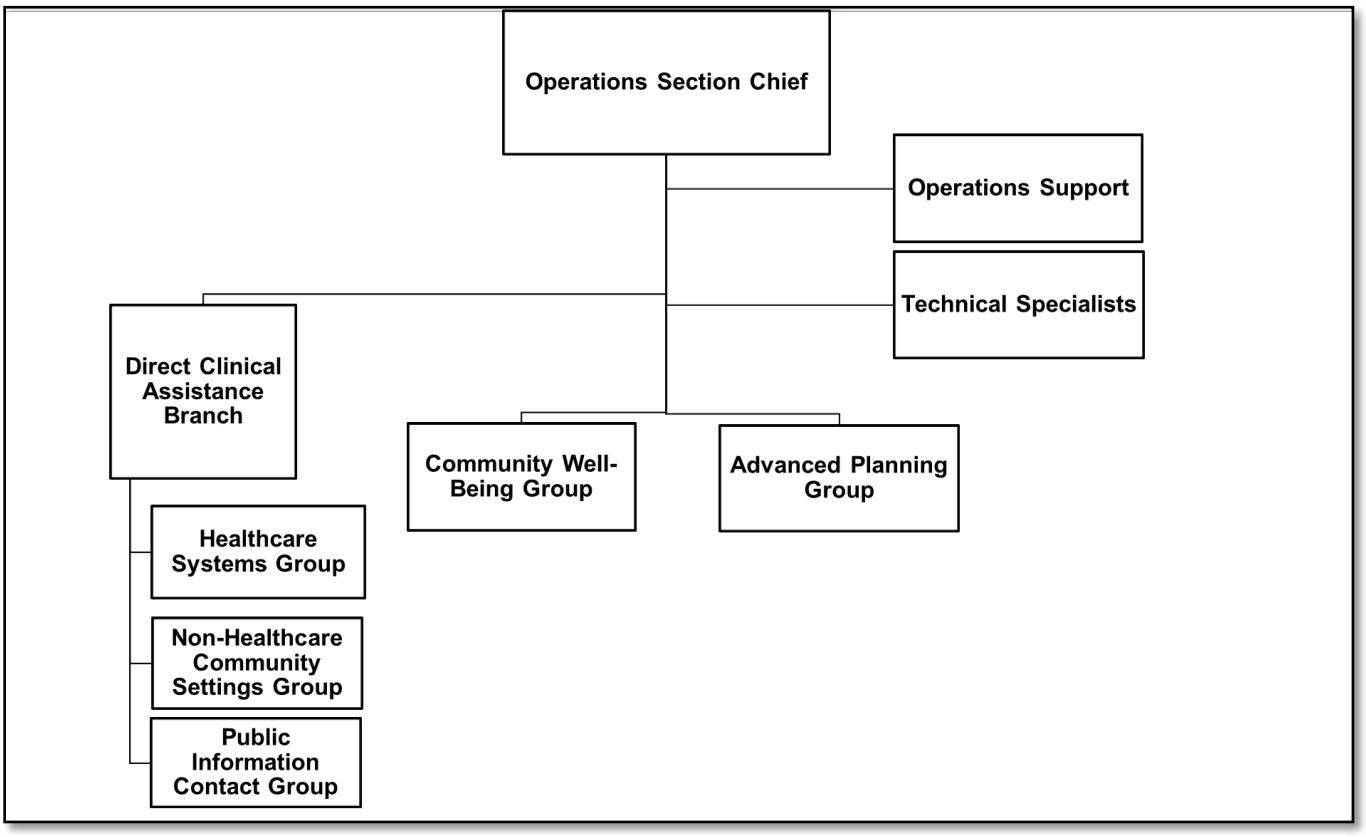


Figure 7: ICS 207 HMAC IAP #112

Departmental Coordination Model: December 2020 - May 2022

In October 2020, PHSKC began planning additional changes to HMAC that would become operational in December 2020. The new incident management structure relied on a standard departmental structure where response activities were embedded in regular divisions. The new HMAC structure incorporated PHSKC's departmental leads to ensure continuity of key incident management roles beginning December 9, 2020. HMAC continued to use NIMS principles for command and coordination, and all major elements of the response continued to be supported to ensure the capacity necessary for effective operations.

Departmental Approach for Response Coordination:

- Use incident management functions and principles for ongoing departmental response coordination and accountability. This will ensure alignment with national practices and compliance with federal requirements.
- Realign HMAC roles with departmental leads for each incident management function. Current incident management staff will be incorporated to support corresponding functions, as appropriate.
- Provide consistent coordination and support for all major response activities across the department. The majority of operational response activities are now occurring within, and under the direction of, departmental divisions. The departmental response structure will serve as a central coordination and support entity.
- Streamline current response meetings to maximize efficient decision-making and coordination. Redundant meetings will be sunset, and a common set of core meetings will be used to facilitate response activity coordination and collaboration across the department.
- Utilize consistent information sharing processes and expectations for all incident management and response activity roles. Ensuring processes for efficiently sharing and using essential information will facilitate increased visibility of activities, cross-cutting coordination, and ability to address challenges.

The new structure consisted of an Area Commander with direct reports of Liaison Officer, Policy Officer, Public Information Officer, Operational Coordination Chief, Information Management Chief, Equity & Community Partnerships Officer, Safety Officer, Financial Management Chief, and Resources Management Chief.[51] The Operational Coordination Section now included eleven Groups, Administrative Support, and Technical Specialists. The Local Health Officer remained part of HMAC but outside of the command structure. Although there was additional streamlining, the structure has remained largely in place through 2021 and into 2022. The additional changes were in response to dynamic levels of activity where coordination shifted with testing, vaccines, surge responses, and isolation and quarantine.

[51] HMAC IAP 113

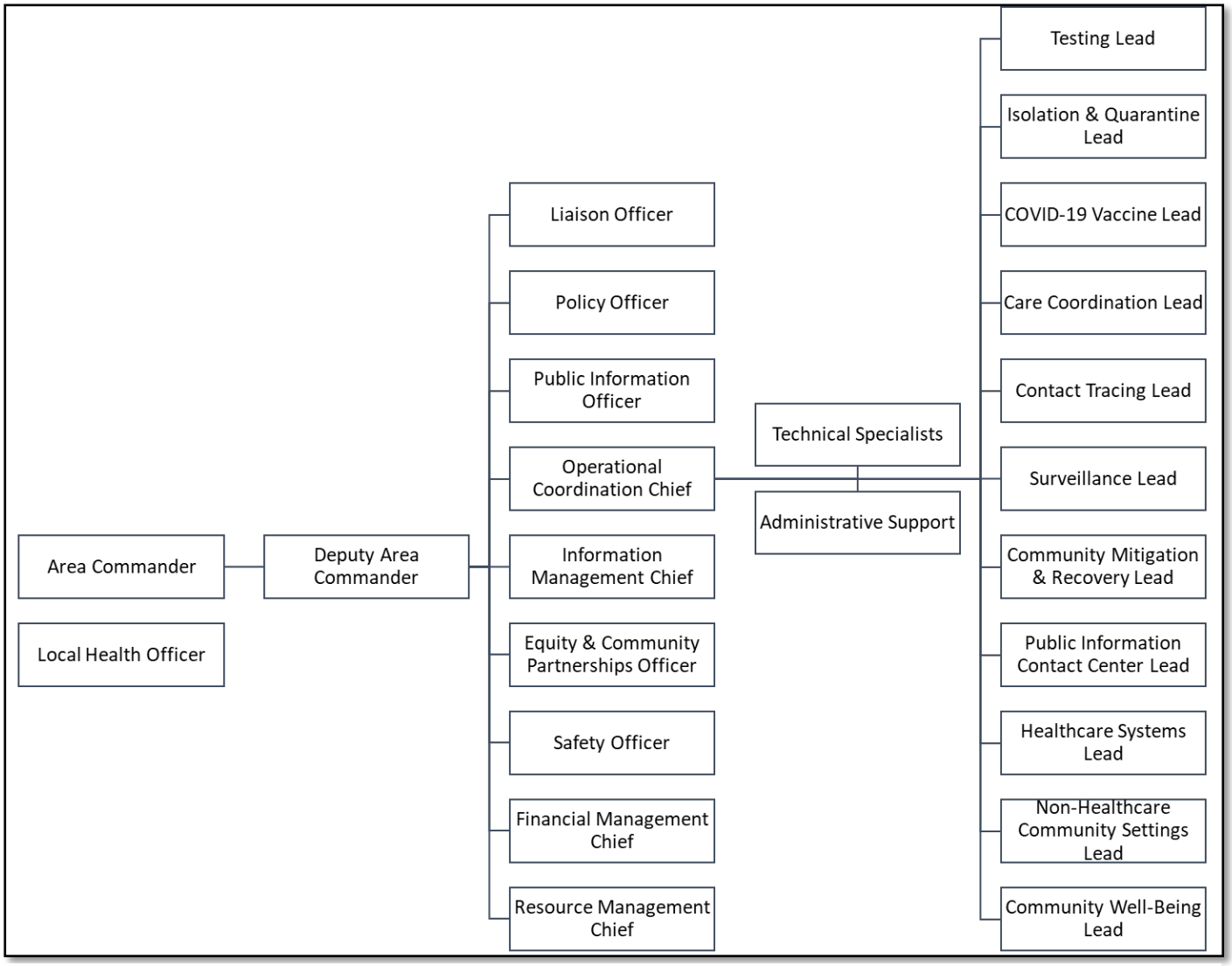


Figure 8: ICS 207 HMAC IAP #113

PHSKC Response Areas

The following table outlines the key response areas and teams for PHSKC. This table is not inclusive of all PHSKC response activities related to COVID-19 and additional groups within the department may have been engaged in activities not reflected below.

Table 6: PHSKC Key Response Areas and Teams

COVID-19 Response Team	Team Objectives	Team's Activities Description
Analytics and Informatics; Epidemiological Investigation and Surveillance	Provide a dedicated staff with data system tools (Tableau/REDCap) to analyze data for senior level decision-making. Conduct epidemiological and statistical analysis using local, state, and federal databases to support disease investigations and determine trends, incidence and prevalence of communicable disease and immunization topics. Respond to data requests by creating custom queries, reports, and surveillance summaries using a combination of data visualizations and narratives. Support data systems management and analysis activities, and ensure data quality Provide population and community data to inform community response that also addressed the social determinants of health	Comprehensive analysis of data with already available data system tools throughout the pandemic. A&I were applied to programmatic decisions and the public facing COVID-19 dashboards. Analyzes syndromic surveillance data from emergency departments, hospitalizations, and school absenteeism Summarizes data in written reports and dashboards; prepare data and report to DOH and external partners, directly and via HMAC. Manage analysis and interpretation of illness reported within facilities such as long-term care, acute care, and homeless shelters; review deaths from the MEO
Care Coordination	King County's Care Coordination services support people isolating and quarantining by providing and arranging immediate supports and linking them to longer term supports.	Immediate Support: Grocery delivery; Mailing PPE kits; Assisting with bills through the Household Assistance Request (HAR) program Longer Term Support: Food assistance; Utilities assistance; Housing; Healthcare; Unemployment supports

COVID-19 Response Team	Team Objectives	Team's Activities Description
Community Mitigation and Recovery (*Now known as Equity and Community Partnerships*)	Help limit and prevent exposure to COVID-19. Lessen the negative social and economic consequences of COVID-19 mitigation measures.	Center principles of equity: prioritize racial, ethnic, cultural, linguistic, and economic groups at higher risk, and promote community-guided solutions.
Community Wellbeing Initiative	Promote emotional health in our communities centering BIPOC children, youth, families, and communities who are most impacted by the intersection of racism and the pandemic.	Build community capacity to share information, resources, and provide culturally relevant supports for emotional health and well-being. Reduce stigma associated with mental health. Reinforce compassion, connection, and care in our communities.
Contact Tracing	Conduct case investigations (collecting key demographic and outbreak indicators) and contact tracing for King County COVID-19 cases Provide information about COVID-19 disease, what to do after testing positive, and vaccination options to COVID-19 cases and their contacts Provide access to support services for cases and their contacts to enable them to adhere to the full period recommended for isolation and quarantine	Interview, educate and provide clinical guidance to contacts of confirmed cases Conduct data entry and ensure completeness and quality of data Assess households' needs for wrap-around services to support I&Q and, if needed, refer to I&Q Care Coordinator or for a medical consult.
Disease Investigations	Ensure the timeliness and quality of communicable disease investigations and response activities related to COVID-19 across King County. Engage community partners to improve access	Oversee COVID-19 surveillance, contact tracing, outbreak investigations and response, and prevention activities in healthcare, non-healthcare congregate, youth, and community settings across King County: Improve access to testing and vaccines for racial and ethnic minority populations, especially Black, Indigenous, People of Color, people experiencing

COVID-19 Response Team	Team Objectives	Team's Activities Description
	to testing, vaccines, and other health-related services for communities disproportionately affected by COVID-19 Generate data and evidence to inform best practices	homelessness, and people living in congregate settings, such as long-term facilities, transitional housing, jails, encampments, and shelters. Coordinate with internal and external stakeholders to enhance partners' capability to respond to COVID-19 by improving service delivery (improving ventilation systems in facilities, performing ICARs, offering on-site testing and vaccination, providing PPEs, etc.)
Emergency Medical Services – Regional Coordination Team	Meet regularly for updates in the various sectors (hospitals, pre-hospital, DOH) and raise any issues for discussion and potential resolution.	Ensured PH and EMS understood the capabilities and responsibilities of each other to enable effective collaboration. Hosted regular meetings conducive to problem solving, representative of stakeholders, and coordination of response strategies.
Equity Response Team	Provide recommendations and actionable information to support communities most impacted by inequities, and communities experiencing hate and bias. Assure that equity considerations are included in public health policy-level decisions, resource allocation, communications, and response priorities related to the HMAC's crisis response. Support responder understanding and practice of ESJ principles through workshops or other informal dialogues.	ERT regularly conducted equity reviews of proposed policies and provided recommendations that made policies more equitable. ERT staff cultivated a positive, accepting, and respectful culture, which set the team up for success when discussing sensitive or challenging topics. ERT had excellent diversity and its members brought a wealth of knowledge, backgrounds, education, and experience to the team. Strong leadership enabled great dialogue and facilitated the collaboration with multiple partners to reach those facing inequity.
Finance	Oversee financial aspects of the incident, including estimating and reporting on incident costs. Ensuring expenses are recorded accurately and documented appropriately. Communicated expense tracking to responders, including time	Finance supported HMAC organization structure (HMAC F&A Section) with response programs in HMAC (Beginning of response - Fall 2020) Finance supported the Departmental Coordination organizational structure with response programs back in their home divisions (Fall 2020 - onward)

COVID-19 Response Team	Team Objectives	Team's Activities Description
	& effort documentation. Coordinated the establishment of contracts	
Food Security Assistance Program	Distribute $2,150,000 worth of food vouchers, in partnership with CBOs, to people deemed food insecure via a standardized screening tool. Award $2,600,000 to organizations to purchase culturally appropriate foods from ethnic markets and local farms, as well as cover the operational costs of distributing food (such as staff time, supplies, and equipment).	Provided food vouchers to individuals through FBOs/CBOs and partnership with Safeway. Allowed resourcing culturally appropriate foods and supported local grocers when possible. Resourced an Impactful need to underserved communities during prolonged COVID-19 crisis mitigating potential future public health problems
Human Resources and Workforce Mobilization	Recruit, process, and train HMAC personnel Mobilize responders to achieve operational activities Provide policy expertise in HR related areas like labor management, COVID-19 related leave, and the use of contract workers	Updated old and built new processes, procedures, and systems on how to mobilize responders as described in the Workforce Mobilization Annex Coordinated with King County departments including PH, DHR, KCOEM, and DCHS around response staffing needs and redeployment Worked with trusted partners, volunteer groups, and staffing agencies to staff high-need areas
Information Management (also known as the ICS Planning Section)	Responsible for managing all information relevant to the COVID-19 HMAC Response Collect, evaluate, process, and disseminate information for use in the COVID-19 response through Incident Action Plans, Operational Response Summaries, Situation Reports, All-Hands briefings, and other response meetings	Massive information sharing and reporting with IAPs and SitReps utilizing ICS structure for role and task management.
Isolation and Quarantine (I&Q)	Provide isolation and quarantine services for KC residents who either cannot I&Q at home or who do not have a home	Provide medical and behavioral health eligibility screening of referred guests; coordination of transportation to and from I&Q sites; and provision of limited scope behavioral health and medical services with the goal of supporting I&Q

COVID-19 Response Team	Team Objectives	Team's Activities Description
		period completion and preventing life threatening complications from COVID-19 illness. Operate and maintain the physical I&Q sites, including supply and inventory management; logistical support for delivery of 24/7 clinical care and operations; and hiring, training and maintenance of appropriate staffing to including nursing, behavioral health, site operations, and security.
Jail Health Services COVID-19 Programs	Manage COVID-19 prevention, case and outbreak investigation, testing, and infection control activities for individuals within the King County correctional facilities Provide release planning services to COVID+ patients releasing from King County correctional facilities	Provide intake testing, surveillance testing, diagnostic testing, testing for close contacts, and testing upon releases as needed. Perform additional infection prevention and control activities such as patient vaccinations, contact tracing, and COVID+ patient monitoring. Collaborate with Public Health CD-Epi to provide guidance to DAJD regarding infection prevention and control activities such as quarantine, droplet precaution, and COVID+ housing determinations. Coordinate with I&Q team with direct referral and release into an isolation facility if an incarcerated individual is being released and is COVID+. Provide education and resources to COVID+ patients releasing to a non-I&Q facility or location.
Liaison	Serve as a conduit of information and assistance between Public Health and other agencies supporting or cooperating with PHSKC's COVID-19 response (other governmental depts/organizations; jurisdictions; private sector partners; etc.)	Monitor response operations to identify current or potential coordination activities and resource needs between response agencies.
Logistics	Provide for all internal logistical support needs for the incident, such as ordering resources, providing supplies, facilities, transportation, equipment maintenance, security, and food	Developed standardized forms used across modalities to make ordering and delivery processes consistent. Integrated WebEOC into the resource tracking process

COVID-19 Response Team	Team Objectives	Team's Activities Description
	service for incident personnel, and support staff for these activities and coordinate with other King County departments and divisions Create, order and manage contracts, provide facilities management support, order, store, and distribute supplies and resources for community partners across King County, including other government entities, hospitals, health centers, long-term care facilities, emergency medical services, childcare agencies, restaurants, and other groups from key sectors	Developed an automated process and algorithm to match inventory, manage PPE requests, and allocate PPE to help improve efficiency and create a more data-driven, objective system for allocating resources Developed and created cross-team coordination and partner relationships Expanded warehousing, distribution capacity, contracting, procurement, fleet services, and facilities management to support internal and external operations. Implemented non-standard processes for incident personnel to allow for take home vehicles, that included more than 72 vehicles.
Mobile Assessment Teams / Homeless Health Emergency Action & Response Teams (HEART)	Support response efforts for homeless service providers, provide clinical assistance, and liaison to Guidance and Public Information Coordinate testing opportunities for high-risk populations and priority groups who otherwise lack access to testing	Ensure coordination and availability of testing (MAT or community partner) to identified sites, such as long-term care facilities and homeless service sites Coordinate the resources and logistics necessary to respond appropriately, work closely with I&Q and EMS to coordinate additional support Update homeless response strategy based on lessons learned and availability of resources Provide shelter assessment, clinical assistance, education, infection prevention & environmental health guidance, and behavioral health support
Medical Examiner's Office	Contribute to accurate surveillance and death numbers due to COVID-19 related illness by testing decedents coming into the office, as well as testing decedents at funeral homes who have circumstances indicating that COVID-19 may have been a factor in their deaths and analyses of any possible vaccine related deaths	Train HMAC response personnel in proper methodologies for sample collection of bio-infectious specimens and protocols for safe handling, transport, and transition of chain of custody for COVID-19 samples for laboratory testing. Post-mortem specimen collection and coordinating specimen transport to the WA State Public Health Lab Collect and enter test results and vaccine data, coordinate test results with

COVID-19 Response Team	Team Objectives	Team's Activities Description
	Coordinate and develop strategies for increased fatality capacity planning across departments and partners	medical history and autopsy findings, discuss test results with health care providers and family members, and analyze the data
Nursing and Professional Services, including Pharmacy, Infection Prevention and Occupational Health	Bring clinical subject matter experts into the planning stage of response work to ensure safe practices	Provide technical assistance and support for clinical operations across the response, including for PICC, AC/RC & I&Q, COVID-19 testing, and COVID-19 Vaccination Lead planning and fulfillment of clinical staffing needs across the response by working with leadership to develop staffing models, working with HR & HR Division Liaisons on recruitment & onboarding of new hires, and working with the Public Health Reserve Corps on volunteer staffing Supervise of credentialing and privileging teams Support internal Continuity of Operations work Onsite leadership for PICC and mas vax operations
Operations Coordination and PPE	Implement strategies and develop tactics to carry out the incident objectives Develop, manage, and refine a data-driven process to allocate PPE in King County based on state Department of Health guidelines and equity principles	Coordinated with team leads from response activities and supported collaboration among different teams and cross-cutting sections Developed the Operational Summary to share activities both internally and to external partners Developed processes for efficiently and equitably allocating and shipping PPE to facilities and partners in need. Collaborated with Logistics and other stakeholders to distribute PPE based on community needs and available resources.
PIO and Communications	Provide culturally appropriate, in-language information to a variety of audiences including the general public, media, elected officials, and staff	Organized by teams, including Content, Media, Community Media, Digital and Social Media and External. Develop messages, materials and guidance related to Public Health Orders and NPIs and other COVID-19 topics in English and for translation.

COVID-19 Response Team	Team Objectives	Team's Activities Description
		Track, assess, and respond to inquiries, comments, and information requests generated through media, social media and through other requests from PICC, Navigators, other units in the response, the general public, elected officials, partners, and others. Craft and develop culturally responsive content, based on key public health messages, to be shared over a wide range of communications channels and platforms, including social media, web, media, community and business partner networks, staff messages, and through large public information campaigns. Develop and execute social media strategies, and build, continually update and monitor COVID-19 website in partnership with KCIT web developer. Manage media requests, inbox, and messaging and conduct routine press conferences, and place speakers on multilingual, community, and mainstream media outlets. Assist residents in scheduling vaccination and testing appointments.
Public Information Contact Center (PICC)	Provide Public Health support, education, guidance, linkage to services, and respond to COVID-19 emerging issues through call and contact center	Answer and triage calls from the community regarding COVID-19 and providing callers with guidance and resources. This includes individuals who do not speak English and community members who do have access to care, do not have health benefits, and may not have access to the information needed to obtain medical assistance. Screen calls to determine if testing is needed; escalate to CD/EPI for decision. Provide guidance for testing sites and timing for testing if exposed. The PICC also provides assistance for individuals who have been tested but cannot access their results. Develop and implement screening tools and scripts for contact center operations.

COVID-19 Response Team	Team Objectives	Team's Activities Description
		Coordinate with PIO & Communication teams for updated messaging, scripts, and referral processes. Ongoing coordination with Communications to get the most recent information to provide callers and for help with developing scripts as new information has been made available. Coordinate with other response teams to clarify guidance, provide clinical assessments, and provide resources as well as assist/support teams with other tasks needed Receive calls for Isolation and Quarantine requests for individuals who cannot safely I&Q in their place of residence and/or are living homeless. Create and/or facilitate the creation of content that was community, language, and culturally appropriate.
Policy	Responsible for developing policy that guides HMAC operations Liaise with Public Health and other King County agencies to create aligned, harmonized, and equitable policies	Helped lead production of key policy and strategy documents (e.g., The King County Principles for Equitable Vaccine Delivery) that guided key operational elements of the overall response. Assisted with bringing the right staff to the decision-making table and making documents public.
Safe Start for Taverns and Restaurants (SSTAR)	Provide community education and outreach to increase community awareness of COVID-19 prevention measures Distribute resources to increase food establishment compliance with the Safe Start reopening requirements	Provide technical assistance to food establishment operators on COVID-19 prevention requirements for food facility operations during the COVID-19 Pandemic and periods during the Safe Start WA and WA Road Map to Recovery phases Conduct compliance enforcement for egregious violations of the Governor's safe start reopening requirements for food facility operations Administer financial assistance for small business food establishments that have incurred additional operating costs to comply with the Safe Start Reopening Requirements
Safety and	Monitor and assess incident-related hazardous	Develop measures to ensure the safety and health of incident personnel

COVID-19 Response Team	Team Objectives	Team's Activities Description
Employee Health	situations and identify actions to mitigate risks and hazards with the greatest potential for serious accident or injury	Develop and share resources to promote the well-being of incident personnel Notify and support incident personnel during workplace exposures, providing N95 fit testing when possible
Testing	Provide COVID-19 19 testing to the most vulnerable populations in King County with compassion and dignity to those that are served during the pandemic Use a data-driven approach merged with community feedback embedded in operations and partnership with A&I to ensure resources were brought across the county to those in need, including determining priority testing site locations and appropriate site type	Build partnerships and coordinate with local elected officials, municipalities, community organizations, health care institutions, research organizations, labs, and other agencies to quickly set up testing sites and find resources available across the county. Develop strategies, blueprints, protocols, and processes to guide operations. Support and coordinate matters related to testing, including acquisition and distribution of OTC test kits, supplies, strategy, results interpretation, data and metrics, new technologies and reimbursement Perform testing at critical setting sites (DTPH clinic, LTCF and homeless service sites) and coordinate testing opportunities for high-risk populations and priority groups
Vaccination Delivery: Community Events, High Volume Sites, Mobile and Public Health Clinics, Place-Based Strategy and Regional Partnerships	Equitably promote and provide COVID-19 vaccination access and vaccinations to Public Health patients and KC residents with a focus on serving vulnerable populations Work with trusted leaders and places to host temporary, small- to medium-sized clinics planned in partnership with community and focused on addressing the priorities and needs of the focus population Offer vaccinations to King County residents (e.g., S King County,)), including critical workers,	Provide community vaccine events that enabled maximum vaccine distribution to citizens of the county by pairing providers with empowered CBOs and other partners. Provide vaccination access and vaccinations in culturally sensitive and inclusive manner (e.g., language access, disability access, partnering with CBOs, etc.) Provide mobile vaccination to reach high-risk individuals who cannot leave their homes or facilities or face other barriers to accessing vaccination (COVID, Hep, Flu) Provide high quality, safe, efficient, and cost sensitive care. Support and coordinate COVID-19 vaccine clinics with King County's 19 school districts and

COVID-19 Response Team	Team Objectives	Team's Activities Description
	underserved medical communities, homebound individuals, and those most at risk to get COVID-19 and most at risk for poor outcomes, working in collaboration with teams across the response and partnerships	many local institutes of higher education. Partner with regional health care institutions to ensure equitable delivery of vaccines and access throughout King County Provide vaccinations at PHSKC-run mass vax and fixed clinic sites in areas of high need (e.g., south King County) and ensure equitable access to the appointment registration system for at risk populations Partner with DOH and FEMA to add additional vaccine opportunities in South King County.
Vaccination Strategy: Planning, Coordination & Readiness	Analysis of COVID-19 vaccinations, disease prevalence, vaccine provider distribution and capabilities Create access points in an equity centric way and address community needs head-on Advocate for changes within DOH, PHSKC, and regional health systems to address the needs of King County residents	Collaborate with A&I to ensure decisions were data-driven and allocation decisions were grounded in equity principles Conduct outreach to providers and pharmacies enrolling in the vaccine program to help identify partners Build connections and relationships with the community and collaborate with the Long-Term Care Sector Offer COVID-19 vaccination promotion, education, clinical services, and support to youth serving systems from childcare through K-12 and higher education Established a clear, community-centered model in which the community partners (CBOs/FBOs) led discussions, planning, and decision-making processes for events. Developed an Equity Tool (based on existing County equity impact review tools) and an Equity Review Process that was used for planning and prioritization both internally and with regional partners. Work with communities, CBOs and other organizations to determine location of vaccine services for each modality (mass vaccination, community events, etc.)

COVID-19 Response Team	Team Objectives	Team's Activities Description
		Vaccine Verification Program: Conduct in-person educational site visits to non-compliant businesses
Ventilation and Indoor Air Quality Program	Provide technical assistance to businesses, schools, childcares, and faith-based and community-based organizations to improve indoor air quality in facilities open to the public in order to reduce COVID-19 transmission risks	Distribute HEPA filtration units to facilities to improve indoor air quality where other means of improving indoor air quality in order to reduce COVID-19 transmission risk are not available Provide community education and outreach regarding the importance of indoor air quality and strategies that can be employed to reduce COVID-19 transmission risks in indoor environments

ANALYSIS OF FINDINGS

INCIDENT MANAGEMENT

PHSKC activated its incident management and coordination structure, Health and Medical Area Command (HMAC) on January 21, 2020 in response to the first case of novel coronavirus in Washington State. By May 2020 the HMAC structure expanded to consist of over 500 responders directly assigned in a large stand-alone incident command structure. Throughout its COVID-19 response, PHSKC incorporated key incident management functions and principles from the National Incident Management System, emphasizing both standardization and flexibility. PHSKC Incident management response closely aligns with CDC PHEP capability *3 - Emergency Operations Coordination* and incorporates several aspects of other PHEP capabilities such as *1 - Community Preparedness, 2 - Community Recovery,* and *6 -Information Sharing*. In addition to response structures and preparedness activities, this section includes leadership, policy and decision-making, collaboration with response partners, and equity considerations related to overall incident management and coordination.

Strengths

Standardization of Processes

HMAC Information Management/Planning Section observed that teams across the response and the HMAC structure as a whole were able to deploy and leverage several key concepts and tools from the National Incident Management System (NIMS). When implemented effectively, responders noted that the HMAC structure and Incident Command System (ICS) processes provided a foundation for effective cross-team coordination and information sharing.[52] Organizational structure was clearly communicated through Incident Action Plans (IAP) and the protocols of ICS helped some teams avoid scope creep to focus on their core mission.[53] The Planning Section also noted that the use of the "Planning P" and related operational tempo helped establish a consistent flow of information which was key to situational awareness early in the response.[54] Finally, the best practices of utilizing standard operating guides, job action sheets, and standardized processes was key for onboarding new staff and growing the response operation.[55]

In early 2020, Wiland Associates (a company specializing in developing incident management capabilities) deployed incident management teams who in total spent two months with PHSKC's incident management team. In June 2020, Wiland produced an AAR that identified opportunities to enhance HMAC functions and leadership expectations.[56] Although only covering the operational periods from March 27 to May 23, 2020, the report highlighted numerous strengths and challenges Wiland Associates observed in the incident management structure and HMAC. The report also included recommendations in a proposed improvement

[52] Marx, C. (2021); PHSKC COVID-19 Intra Action Quad Chart_SSTAR
[53] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[54] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[55] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[56] AAR Wiland Associates

plan. The recommendations were taken by PHSKC, and many are currently being addressed. Some activities that are in the process of being addressed include:

- Clarity on HMAC Function and Leadership Expectations
- Command Titles
- HMAC Decision-Making Model
- Single Command versus Unified Command
- Diffusion of Staff
- Incident Command Sustainability
- On-boarding Interface with HMAC Resource Management Process
- Emergency Planning

Coordination/Collaboration

King County was recognized as the early epicenter for the COVID-19 pandemic and turned into an example for the country with multiple departments coming together to respond to the COVID-19 pandemic and pursuing equity, diversity, and inclusion to support the health and wellbeing of the community. For example, PHSKC led innovative isolation and quarantine programs and used those programs to also benefit people experiencing homelessness and other vulnerable populations. There was a total of $800 million in funds distributed in efforts to reduce the COVID-19 impact.[57] These efforts were recognized by American City & County, a magazine serving city, county, and state officials selecting King County as the winner of the 2021 Crown Communities Award.

In the HMAC Policy & Government affairs hotwash, participants noted that as the response progressed, they developed better coordination with the City of Seattle, business partners, and cross-division collaborations.[58] The City, County, and PHSKC came together to advance science-based policy. This was accomplished by working with elected officials and externally collaborating with community partners. The team attributed the development of key documents as a strength by bringing the right people to the decision-making table. These documents, which were made public, included a King County Unified Strategy for Vaccine Delivery and Principles for Equitable Vaccine Delivery. These documents guided key operational elements of the overall

[57] Havich, Michelle M.,"2021 Crown Communities Award winner: King County's enterprise-wide COVID-19 response." American City and County, https://www.americancityandcounty.com/2022/01/28/2021-crown-communities-award-winner-king-countys-enterprise-wide-covid-19-response/. 30 March 2022.
[58] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

response. Another element that enabled coordination was the activation of a policy officer, which PHSKC had not done before COVID-19.

Innovation/Success: King County's Enterprise Response to COVID-19

King County's enterprise-wide response to COVID-19 was selected as the winner of the American City and County's 2021 Crown Communities Award for its collaboration across departments, including the prominent leadership role that PHSKC played in the pandemic response. Overall, seven isolation and quarantine (I&Q) facilities were established along with comprehensive procedures. Together, these efforts comprised the nation's first civilian I&Q system. By January 28, 2022, this system served 2,300 residents, a large percentage of which were persons experiencing homelessness. When vaccinations became available, the county set ambitious vaccination goals and focused heavily on equity, creating strategies to support the vaccination of older adults and BIPOC individuals. King County went on to recognize the inequities magnified by the public health pandemic and declared racism a public health crisis. Overall, due to the collaborative and dedicated efforts of the county, as of January 2022, it had maintained the lowest COVID-19 death rate of the 20th largest metropolitan areas in the country. *

* Havich, Michelle. "2021 Crown Community Award Winner: King County's Enterprise-Wide Response to COVID-19." American City and County. https://www.americancityandcounty.com/2022/01/28/2021-crown-communities-award-winner-king-countys-enterprise-wide-covid-19-response/. 28 January 2022.

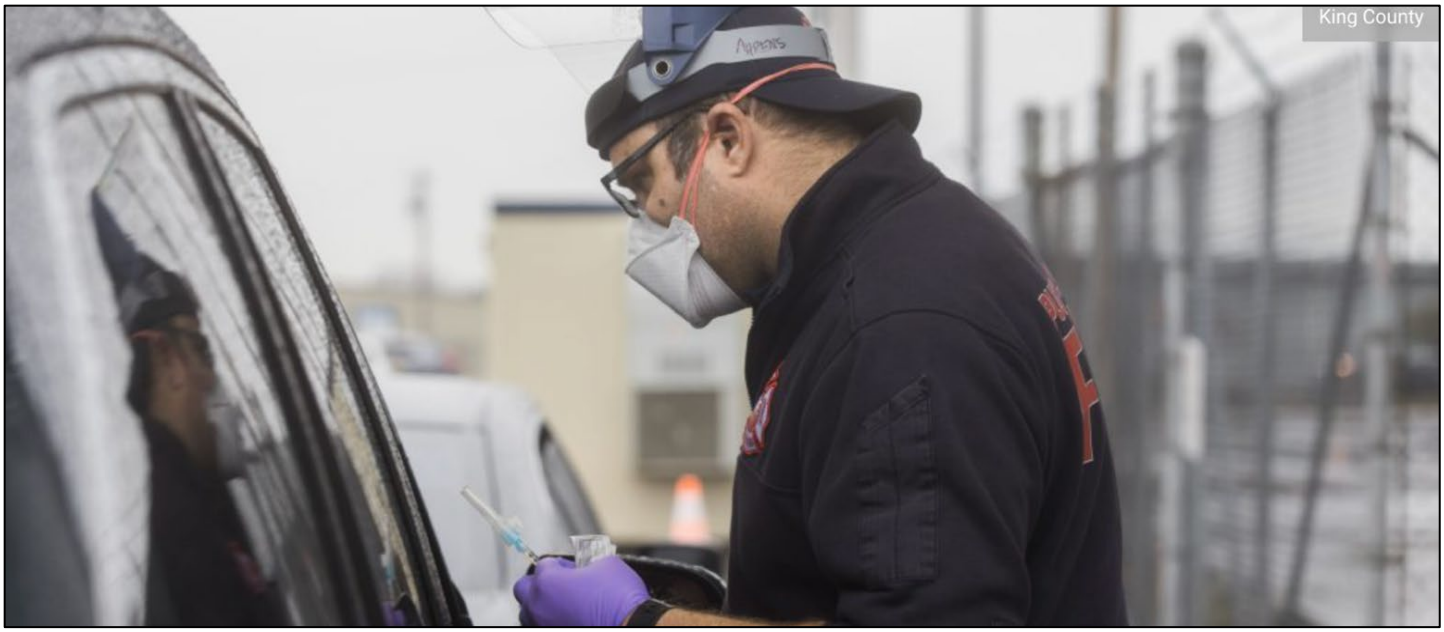


Image 2: Magazine Featuring PHSKC Response to COVID-19

Areas for Improvement

Equity

Although strides were made providing an equitable public health response, there remained barriers to achieving equity across different areas of PHSKC's response. Some of the barriers may have stemmed from limitations of the PHSKC Equity Response Annex or a lack of existing systems in place for building equity into a disaster response. For instance, the Annex did not have an Access and Functional Needs plan and PHSKC did not have an Americans with Disabilities Act (ADA) coordinator.[59] Such a plan or having someone in that role could have outlined an equitable and consistent process on practices to improve the delivery of emergency information to the public in addition to informing the response and recovery strategy.

An issue that emerged during the course of the response was that PHSKC experienced a delay from when information was shared with the public and when the accessible version of that same information would be available for public dissemination. Another example was that ADA compliance was not extended to contracts and partnerships with community groups or third-party providers working on behalf of King County resulting in a widening disparity in accessible products produced by the vendor in alignment with their contractual duties and responsibilities.

Members of some teams also noted delays in leadership decisions that compromised work, to include emphasizing urgency over equity, decisions made without community input, occasional difficulty identifying how to influence work in established coordination structures, and a lack of equity training across activated staff. [60] Additionally, equity not being centered in some PHSKC processes such as procurement was an opportunity for further growth.[61] A particular challenge was prioritizing requests from the wide array of departments and programs given limited resources.[62] Finally, without established processes for soliciting follow-up from response teams and established channels for communicating with equity teams from partner agencies and organizations, equity teams felt that there was missed opportunities for collaboration.[63] And while proud of the organizations and communities they were able to engage, all teams primarily focused on ensuring equity noted that there were connections with community members left untapped and groups that were missing at the table.[64]

[59] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[60] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[61] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[62] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[63] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[64] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Unclear Processes

Leadership Direction

Although overall responders expressed the belief that leaders largely did an incredible job "steering the ship" and managing incident structures, teams noted multiple issues related to prioritization across the response.[65] Staff indicated there was often not enough leadership direction or an effective process to prioritize response activities.[66] Without clearly established priorities, response teams felt like there were unrealistic expectations put upon their operations and in turn sacrificed responder wellbeing trying to meet expectations.[67] Additionally, frequently shifting leadership among section chiefs with different expectations, backgrounds, and skillsets made establishing consistent priorities difficult.[68]

An example of where decision-making processes impacted operations was in relation to contact tracing and disease investigation teams. These teams noted a lack of a clear strategic vision from HMAC and PHSKC leadership regarding this operational area, difficulty in prioritizing work from the response, and a lack of role clarity between related teams which compromised team efficacy. Several teams indicated their roles were malleable or unclear, and at times required unrealistic pivots, which reduced efficiency among the larger effort and created duplicative work.[69] Without a clear strategic vision, leaders of these teams found it difficult to effectively establish priorities as teams became overloaded and work was often reactionary opposed to proactive.[70] At times, these contact tracing and surveillance teams felt a disconnect from leadership-level decision-makers in terms of both leaders' awareness of operational activities and the team's ability to negotiate scope of work.[71] Despite these challenges, it is important to note that team leads and staff still conducted successful contact tracing and surveillance programs in a pandemic of unprecedented scale.

Preparedness and Training

Despite decreases in staff and funding over the last decade, PHSKC developed a multitude of response plans and conducted extensive trainings during that time to prepare teams to conduct a large-scale disaster response operation.[72] While these efforts undoubtably bolstered the county's response, feedback from responders indicated significant ongoing preparedness work is still needed. Trainings on the HMAC structure and Incident Command System (ICS) have been offered by PHSKC but were optional trainings for most individuals.[73] This meant a great deal of those activated for COVID-19 had little-to-no understanding of the systems and structures utilized in disaster response.[74] This led to confusion about who to report to, what teams were responsible for specific tasks, agency roles and jurisdictional authority, and a lack of

[65] Marx, C. (2021)
[66] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[67] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[68] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[69] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[70] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[71] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[72] Marx, C. (2021)
[73] Marx, C. (2021);
[74] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

understanding regarding disaster response norms and practices.[75] Respondents (36%) to the COVID-19 AAR survey conducted by PHSKC noted unclear processes as an area for improvement. Additionally, 30%+ of respondents were either neutral or disagreed to some extent that they had adequate training for their response role. Multiple survey participants indicated in open ended responses that HMAC and incident command processes could be clearer, better organized, and staff would benefit from more training.[76]

While the department had a roster of plans to support the response, they were not universally helpful to teams implementing those plans. A key challenge was awareness; many of the individuals responsible for implementing activities had no knowledge of existing plans, processes, and procedures. When this occurred, teams often wasted time recreating established procedures which delayed work and complicated response activities.[77] Another challenge was that for some staff being shifted into emergency response roles, familiarity with emergency management terms were limited, making plans difficult to understand because of the terminology.

Aside from broader awareness training on established plans and expanded incident onboarding training, a clear suggestion from responders was the need for succinct operational guides that distill down key tasks for implementation.[78] As noted by one responder, "during an incident, staff don't have time to read dense, 20-40 page plans."[79] Brief guides could also address the potential challenge of staff unfamiliar with emergency response efforts.

Utilization of ICS structure at the field team level also appeared to be inadequate or not apparent to field team members.[80] The ICS structure identifies roles and responsibilities, even at lower levels, which could have been used at the field team level. This would have reduced confusion about job tasks and unclear reporting structures.

Shared Understanding

Although collaboration across county departments was generally successful, a shared understanding of response structures, roles, cultural norms, and expectations was difficult to maintain at times. Different response structures between departments complicated decision-making and created confusion amongst teams. This confusion was amplified by a lack of single unified response structure across the departments which sometimes led to miscommunication and duplication of efforts.[81] Responders noted frustration, stress, additional work, and confusion from differences in the organizational cultures and expectations. For example, despite being largely successful in mobilizing the county's workforce, staffing teams noted difficulty in maintaining visibility across the agencies involved and, at times, inconsistent coordination from departments

[75] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[76] COVID-19 PHSKC Staff Surveys (2022)
[77] Marx, C. (2021)
[78] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[79] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[80] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[81] Marx, C. (2021)

with different response structures, expectations, and norms.[82] Additionally, both finance and operational teams noted confusion around role clarity, decision-making authority, budget considerations, and process surrounding hiring, contracting, and purchasing. [83]

While required to meet the needs of the response, changes in organization response structure produced additional challenges and uncertainty for teams. In the summer of 2020, several operations shifted into divisions and programs and in the fall of 2020, HMAC moved from an ICS structure to an incident management structure. As structures changed and processes adapted, some teams had trouble maintaining awareness of the changes and felt they lost established supports in the transition.[84]

Mixed Findings

Systems or Infrastructure

According to results from the PHSKC COVID-19 After Action Report survey, most respondents agreed or strongly agreed that they understood their role in Public Health's overall COVID-19 response. Even when evaluating the first three months of the response, 79% of people agreed to some extent. When rating the last three months (January - March 2022), 87% of respondents felt they understood their roles. Additionally, respondents indicated they knew who to contact if they had any issues as part of Public Health's COVID-19 response.

However, this was not completely reflected in the discussions with staff. Some team members had difficulty understanding role clarity due to lack of experience with the Incident Command System (ICS), others struggled due to a lack of clearly defined roles between different operational groups and partner agencies.[85] A lack of clarity around decision-making authority, role division between response teams and departments, coordination roles with elected officials and governmental partners, and responsibilities shared or split between jurisdictions were also commonly noted challenges.[86] Understanding of roles and how teams coordinated may have improved over time. The survey responses showed that perceived coordination between teams improved from the first three months (43% agreed or strongly agreed) to the last three months (54% agreed or strongly agreed).

[82] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[83] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[84] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[85] Marx, C. (2021); PHSKC COVID-19 Intra Action Quad Chart_SSTAR
[86] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

EPIDEMIOLOGICAL INVESTIGATION AND SURVEILLANCE

A critical focus throughout stages of PHSKC's response were disease investigation and surveillance activities, including during the December 2021 disease surge, when daily case counts reported to PHSKC reached a new high of 2,973 new cases. Activities in this focus area include the work of A&I to analyze and interpret data, including development of new databases and dashboards to support transparency and decision-making. Disease investigation activities focused on preventing and responding to community outbreaks. For example, in January 2022, PHSKC outbreak investigators were supporting 467 active outbreaks and had closed 407 facility investigations in the prior two weeks. PHSKC conducted case investigation and contact tracing activities, including providing clinical guidance to contact of confirmed cases, as well as assessing needs and making linkages for isolation and quarantine support services. PHSKC's execution of epidemiological investigation and surveillance closely matches the doctrinal CDC PHEP capabilities of 13 - Public Health Surveillance and Epidemiological Investigation, 6 - Information Sharing, and 12 -Public Health Laboratory Testing. This section outlines their implementation of this critical component of disease emergency response

Strengths

Systems or Infrastructure

Despite experiencing significant challenges in establishing, scaling, and transitioning both IT and data systems, contact tracing and investigation teams rose to the challenge to create systems and processes able to support operations at an unprecedented scale. Specifically, the Analytics and Informatics (A&I) Team being in place prior to the pandemic with established bodies of work and system tools made the scale up easier.[87] The team had experience with a recent measles outbreak and the surveillance tools used in the response to that event served as a model for COVID-19 initial response allowing teams to jump start their operations.[88] Additionally, proactive monitoring of the pandemic in early 2020 allowed the A&I team to begin to establish systems, dedicate staff to distinct bodies of work, and begin to scale operations.[89] This created a higher level of awareness and allowed them to automate their processes early.

PHSKC's COVID-19 Dashboards, created by the A&I Team, were invaluable in enabling public health decision-making supported by data. The dashboards showed cases counts, community transmission, syndromic surveillance, and vaccination uptake. Combining this information with demographics and geographic information, allowed PHSKC to focus its response to specific communities and provide additional services. These dashboards revealed very early in the pandemic that Blacks, Hispanic/Latinx, Native Hawaiian/Pacific Islanders, and American Indian/Alaskan Natives had notably higher rates of COVID-19 cases, hospitalizations, and rate of death per 100,000 as compared to Whites. Reflective of the effectiveness and innovation, National Association of County and City Health Officials (NACCHO) recognized the APDE Unit for the development of the economic, social, and overall health impacts data dashboard (image 7).

[87] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[88] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[89] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

The A&I Team also went a step beyond the public facing dashboards to provide additional detail and analysis via daily reports disseminated for much of the response. The report detailed key surveillance and outbreak information for many responders across many teams to establish critical epidemiological situational awareness. They presented key information from these data at the start of regular Epidemiological Briefings, which were typically attended by approximately 150 staff, including many in department leadership and numerous teams leads.

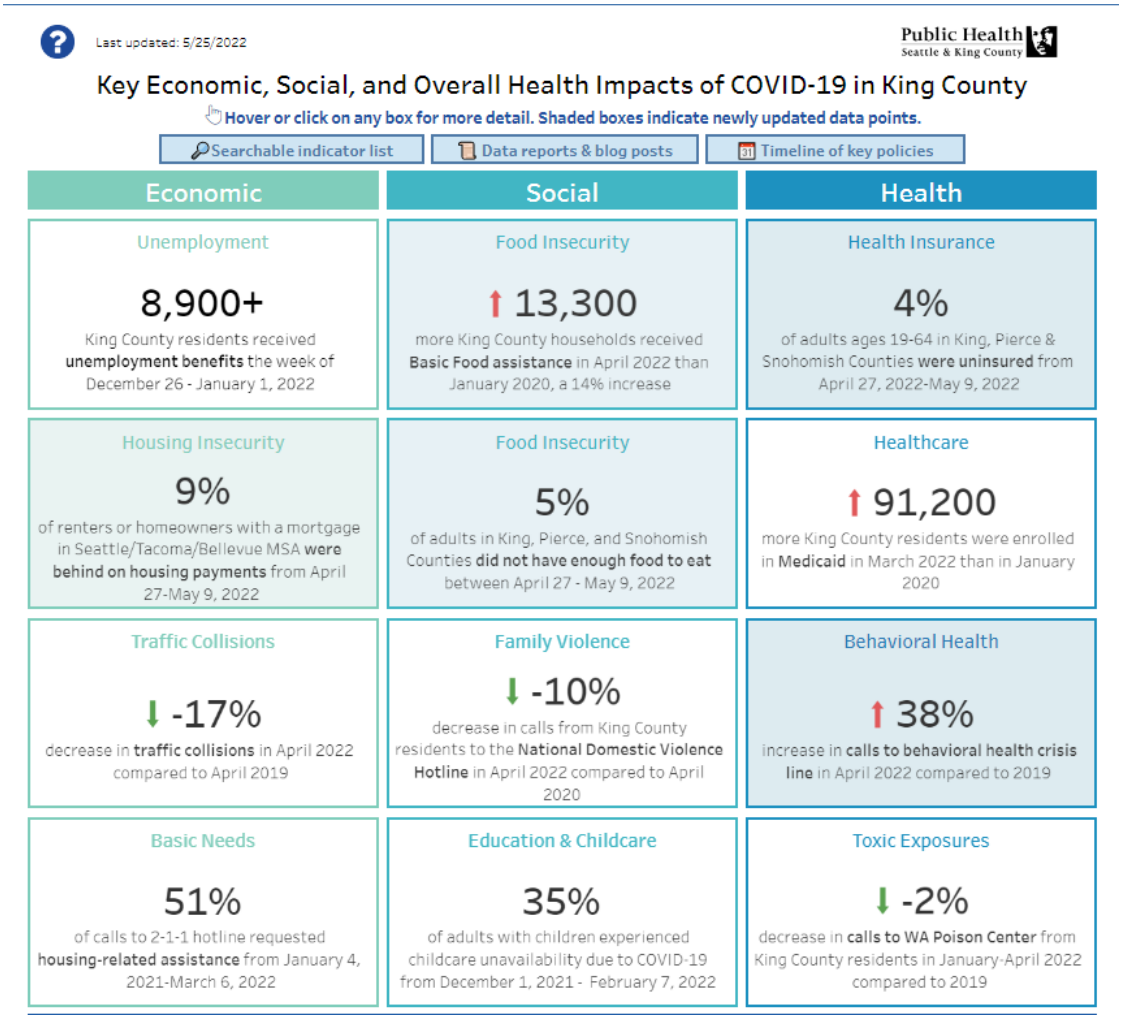


Image 3: Snapshot of PHSKC Economic, Social, and Overall Health Impacts Dashboard (https://kingcounty.gov/depts/health/covid-19/data/impacts.aspx)

Autonomy and flexibility in how data systems were established gave the team a sense of ownership and investment as they created internal infrastructure to support the response. The importance of flexibility in these systems was emphasized by the Contact Tracing Program as well which noted having a flexible, modifiable system (REDCap) allowed them to adapt to the changing needs of the incident and the response.[90] To increase their ability to provide contact tracing at scale while protecting personal information, these teams integrated the InContact system to improve outreach in addition to identifying and securing HIPPA HIPAA-compliant phone systems.[91]

Innovation/Success: Impacts Dashboard

PHSKC's Assessment, Policy Development, and Evaluation (APDE) Unit was recognized by the National Association of County and City Health Officials (NACCHO) for the development of the economic, social, and overall health impacts data dashboard. This dashboard helped track the impacts of public health measures implemented to slow the spread of COVID-19 throughout the county. The data dashboard revealed key insights of the pandemic and guided data-based decision-making. For instance, the dashboard helped PHSKC determine that 18% of households with school-aged children lacked Internet access for educational purposes. *

*"Public Health Receives National Recognition for Innovation in Pandemic Response." Public Health Insider, Public Health- Seattle & King County, https://publichealthinsider.com/2021/06/09/public-health-receives-national-recognition-for-innovation-in-pandemic-response/. 9 June 2021.

Teamwork

A&I teams noted several strengths regarding prioritization, effective management, and teamwork within the groups. Established and reliable communication channels, such as morning and evening check-ins/debriefs, were extremely beneficial for maintaining shared situational awareness across the teams.[92] Other routine meetings like the weekly leads meeting and epidemiology huddles were also noted as important for team success. Cross-training of staff, redundancy and work-sharing, robust process and guidance documents, and a team culture of flexibility allowed these teams to adapt and grow with the response.[93] These teams also noted effective leadership by their leads who were effective at case prioritization, supportive, consistent with communication, and prioritized responder wellbeing by managing individual caseloads.[94] All of these factors led to success within these operational teams.

The Contact Tracing Team noted that their team was unified in quality improvement and building the program.[95] This reflected their service first approach that was well received by community members. They

[90] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[91] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[92] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[93] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[94] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[95] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

often received comments about their professionalism and helpfulness. The team leads consistently reported that members felt the team was supportive and built a strong community of contact tracers with a culture of listening and responding. Members of the investigation teams noted similar teamwork features with their teams.[96] These teams noted additional levels of support from their team leadership by providing self-care, fun spaces away from COVID-19 work, checking in on team members, and listening to concerns about their personal boundaries.

Flexibility/Adaptability

Contact tracing and disease surveillance was conducted throughout the county. To meet the staffing needs for these operations, 61 people were added to contact tracing efforts. The PHSKC team interviewed 90% of named contacts in the community and conducted approximately 500 investigations per week. Many contacts were already in their seven-day “infectious window” despite the aim to reach them the same day PHSKC received their names. The contact tracing outreach team made the most of the opportunity to speak directly to community members and provide advice on economic, financial, and medical assistance as needed.[97]

Jail Health Services (JHS) also took a proactive approach to tracking and monitoring potential outbreaks among people who were incarcerated and staff working in the jails. JHS maintained low COVID-19 positivity numbers through the early and middle phases of the pandemic when compared to similar sized facilities.[98] Initially, JHS anticipated outbreaks solely in congregate jail settings but began to find it was actually the inmate worker population where COVID-19 infections were being found. JHS used a "COVID-19 Positive Unit" and a "Precaution Unit" when individuals had flu-like symptoms. They started COVID-19 screening early, transitioned to rapid testing as soon as it was available, and used targeted surveillance testing for higher risk. Some JHS staff interviewed for this report stated there was a concern about testing disparities within the inmate population. As a result, staff began interviewing inmates and making intentional efforts to promote testing and provide education. This adjustment and pivoting in approach was not something that had been done before and was an effort to reduce any potential disparities among inmates.

JHS also showed adaptability when they began to run into issues with receiving rapid antigen tests which were key to maintaining low positivity rates and testing at intake.[99] The jail had established its procedures based on a specific rapid antigen test, and, as supplies became limited, they pivoted and retrained a large number of staff on a new test.

[96] COVID-19 PHSKC Facilitated Discussions/ Team ‘Hotwashes’. (2020-2021)
[97] "King County's COVID-19 Contact Tracing Efforts Gain Strength." Public Health Insider, Public Health- Seattle & King County, https://publichealthinsider.com/2020/09/16/covid-19-contact-tracing-efforts/. 5 April 2022.
[98] COVID-19 PHSKC Facilitated Discussions/ Team ‘Hotwashes’. (2020-2021), COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[99] COVID-19 PHSKC Key Informant Interviews. (2020-2021)

Areas for Improvement

Information Technology Concerns

Access to Data

Although teams were able to find success and scalability over time in data and IT systems, there were significant hurdles for surveillance and contact tracing teams throughout the response. In addition to routine IT challenges, contact tracing teams noted a lack of interoperability in how data was structured between the county and state.[100] Getting privileges to new databases was also a challenge especially with new hires and temporary staff.[101] This was further complicated by frequent and difficult transitions between different data systems such as the Washington Disease Reporting System (WDRS) and REDCap.[102] Finally, like many teams, these groups noted challenges in locating, organizing, and updating resources through SharePoint and Microsoft Teams.[103]

Accuracy of Data

Multiple databases and systems used in contact tracing depended on accurate data.[104] Early in the response, the A&I Team noted access to and integration with the King County and Washington DOH information systems was a challenge.[105] As the emergency unfolded and CDC staff were brought in, it was difficult to maintain the integrity of data, its storage, and incorporation of other data sources. DOH hosted the data but their infrastructure was unable to process the high number of laboratories involved and began crashing.

With multiple teams and organizations creating records for cases in different systems and limited communication between systems often resulted in cases getting multiple calls in a day from different teams. Initially there was also no care coordination, just notification and contact tracing. Ultimately, the Communicable Disease Outbreak Response Team was given backend access to the DOH system and DOH improved the infrastructure. However, the team noted they still do not have full access to the system and utilize secondary systems and then update the DOH system, WDRS.

Coordination/Collaboration

Contact Tracing and Disease Investigation related teams noted significant challenges related to internal and external coordination during the response. Internally, teams reported feeling siloed, noted there was a lack of a cohesive vision or strategy, and felt there was reactive opposed to proactive collaborations. There were also challenges working across teams due to a lack of a shared common operating picture, unclear and changing process flows, no formalized decision-making process across teams, an unfamiliarity with ICS, and ineffective

[100] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[101] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[102] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[103] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[104] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[105] COVID-19 PHSKC Key Informant Interviews. (2020-2021)

integration into HMAC structures.[106] Contact tracing teams also noted the need for expanded collaboration with public messaging teams to ensure messages are clear and effective.[107]

Externally, effective communication and collaboration with Washington State Department of Health was a challenge across the contact tracing and surveillance related teams. There was a lack of clarity around roles regarding specific cases and test results, especially regarding referrals to care coordination. Changing and contradictory information or a lack of community around specific settings also led to difficulties collaborating.[108] From the perspective of JHS, communicable disease – epidemiology teams did not understand the capacity of the jail and missed key elements including a lack of documenting interfacility transmission. JHS felt they could have been more involved in information sharing and the development of best practices that would have helped others. JHS noted there may be a stigma to working with the jail and that the relationship between teams could, at times, feel condescending.

Although these challenges were present, successful collaborations were routinely found throughout the response. Successful partnerships existed with school taskforces, Environmental Health, and the Adult Family Home Council. Strong relationships were built with both facilities and service providers among many others.[109]

EQUITY AND COMMUNITY PARTNERSHIPS

PHSKC prioritized collaboration with community partners to mitigate and address the disproportionate impacts of the pandemic, as well as to combat stigma, discrimination and racism that further compounded inequities. PHSKC's Equity Officer and the Equity Response Team (ERT), comprised of PHSKC staff and community partners, provided internal guidance on equity and social justice concepts, culturally relevant resources, recommendations on planned response activities and elevation of COVID-19 equity concerns reported to the agency. Pursuing great equity in the COVID-19 response with community partners allowed PHSKC to increase CDC PHEP capabilities *1 - Community Preparedness and 2 - Community Recovery*. PHSKC also created several collaborative groups, such as the Pandemic and Racism Community Advisory Group (PARCAG), along with the Community Mitigation and Recovery team and community navigators, to work on equity and fairness throughout the response. The Community Well-being Initiative promoted emotional health by building community capacity to share resources and provided support centered on BIPOC children, youth, families, and communities who are most impacted by the intersection of racism and the pandemic. Additionally, PHSKC supported the community by leveraging existing and new funding streams to support community outreach and education. Some organizations were able to redirect resources to meet emerging needs on their own (e.g., Best Starts for Kids). PHSKC was also able to provide resources from the CDC, Patient-Centered Outcomes Research Institute, and Gates Ventures to partner agencies to fund COVID-19 work. PHSKC integrated the incident management liaison function through government affairs and policy staff who promoted information sharing and collaboration with government and non-government partners to create aligned and equitable policies.

[106] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[107] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[108] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[109] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Strengths

Relationship Building

Intergovernmental partnerships were a key component of successful COVID-19 operations for PHSKC. Governmental Affairs teams were able to establish a regular cadence of meetings and standardized processes to build and maintain positive relationships with elected officials and key stakeholders such as Sound Cities Association, the King County Executive, King County Council, the Seattle Mayor's Office, and Seattle City Council.[110] These relationships empowered and informed response activities allowing them to understand community needs while getting a head start in adapting programs and services as required.[111] Coordination with federal partners was also an important component and these efforts helped mobilize activities like the deployment of approximately 50 CDC staff to assist with the first outbreak in the country in a long-term care facility.[112]

Community partners reflected that PHSKC also did an excellent job distributing resources to Community-Based Organizations (CBOs) and Faith-Based Organizations (FBOs).[113] Similar reflections were heard about information sharing, PHSKC was noted as a tremendous partner in both bringing people to the table, creating advisory groups, and going to community partners to share information. The CBOs/FBOs noted they had more than enough PPE from PHSKC, and they received public health information almost immediately when it became available. In one townhall, community partners noted they were surprised at how PHSKC was always able to answer their phone calls and emails, or they received a response within 48-hours.

Early in the response, PHSKC was able to rapidly put together contracts with community partners. This was aided by pre-existing relationships with first responder agencies that were staffing and standing up vaccine and testing sites.[114] First response agency partners believed testing sites were rapidly set up and felt seamless. Similarly, many community partners appreciated that PHSKC connected partner organizations with private entities to assist them in providing COVID-19 resources to the communities they served.

Coordination/Collaboration

Effective community engagement amplified the internal equity focus within response activities and decisions. Both the Community Well-being Initiative and Community Mitigation and Recovery Teams noted community partnerships as being a key driver for response success.[115] Established relationships and mechanisms for feedback and input allowed the response to provide a more holistic and community centered approach over time in both communications and operations. By engaging community groups through initiatives such as the PARCAG and utilization of community navigators, response teams were able to get timely qualitative feedback

[110] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[111] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[112] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[113] COVID-19 PHSKC External Partner Townhalls (2022)
[114] COVID-19 PHSKC External Partner Townhalls (2022)
[115] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

from the communities they were serving.[116] This allowed the teams to adapt the response as needed. For example, PHSKC provided information in multiple languages, expanded testing to underserved communities, improved guest comfort at isolation and quarantine facilities, and created equitable vaccine distribution strategies.[117] These initiatives allowed PHSKC to collect information in near real time and build partnerships that will extend past the response.

PARCAG

By September 20, 2020, the PCAG was reestablished as the King County Pandemic and Racism Community Advisory Group (PARCAG) and PARCAG's mission was modified to "identify, inspire, and mobilize bold solutions in response to the urgent, interconnected crises of COVID-19 and systemic racism."

Equity:

Community Involvement

PHSKC ERT and community navigators developed specific plans for engaging different communities within the county for public health information dissemination.[118] These community specific plans identified key leaders and points of contacts to engage. For example, the Marshallese community plan identified four women leaders to consult regarding vaccines and PPE who could provide a culturally competent perspective and understanding of the community to inform tailored messaging and promote community-centered strategies for communications to support overall positive health outcomes.

Additionally, community navigators were an important component to success in several operational areas. This team of approximately 30 people filled in gaps that had not been previously identified and were made apparent due to the scale of the pandemic.[119] The community navigators represented a diverse population that was dealing with a lack of transportation, job loss, food insecurity and loss of housing. Imbedded in their communities, navigators served as conduits to get resources to their communities, dispel misinformation and highlight the known fears and barriers to resources and healthcare.[120]

They were critical to successful community outreach and sustained communication throughout the pandemic. Community navigators provided valuable immediate or weekly feedback to PHSKC on the issues that their communities were facing.[121] They assisted community members in accessing public health information in their native language, helped individuals fill out required forms for testing, vaccination or other available resources, and provided assistance reaching the right testing or vaccination locations.[122] Many PHSKC staff noted the that

[116] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[117] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021); PHSKC COVID-19 Intra Action Quad Chart_SSTAR
[118] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[119] COVID-19 PHSKC External Partner Townhalls (2022)
[120] COVID-19 PHSKC External Partner Townhalls (2022)
[121] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[122] COVID-19 PHSKC External Partner Townhalls (2022)

community navigators were an important part of the PHSKC response and should continue to be funded.[123] Community organizations also spoke highly of the speed that PHSKC established the program and for its wide reach.[124]

As a Key Focus

As a leader in equity-driven response, PHSKC established expectations that equity would be a key focus and built an internal structure to support those efforts.[125] Rather than leaving equity related issues to be addressed by individuals to identify and navigate, the HMAC established an Equity Officer to serve as part of the leadership team, formed an ERT responsible for tracking and raising equity related issues and concerns, and centered equity as a focus in every meeting where decisions were made.[126] The Emergency Response Bill of Rights put forth the principles of equity, anti-racism, and social justice to ground policy decisions, resource allocation, and response priorities during crisis response.[127] The ERT regularly conducted equity reviews of proposed policies and provided recommendations to leadership and operational teams. Teams across the response, such as the Community Well-Being Initiative, modeled equity and trauma-informed practices such as meeting groundings and land acknowledgements to create an inclusive and resilient culture.[128]

[123] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[124] COVID-19 PHSKC External Partner Townhalls (2022)
[125] Marx, C. (2021)
[126] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[127] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021); COVID-19 AAR Key Documents Summary Matrix
[128] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

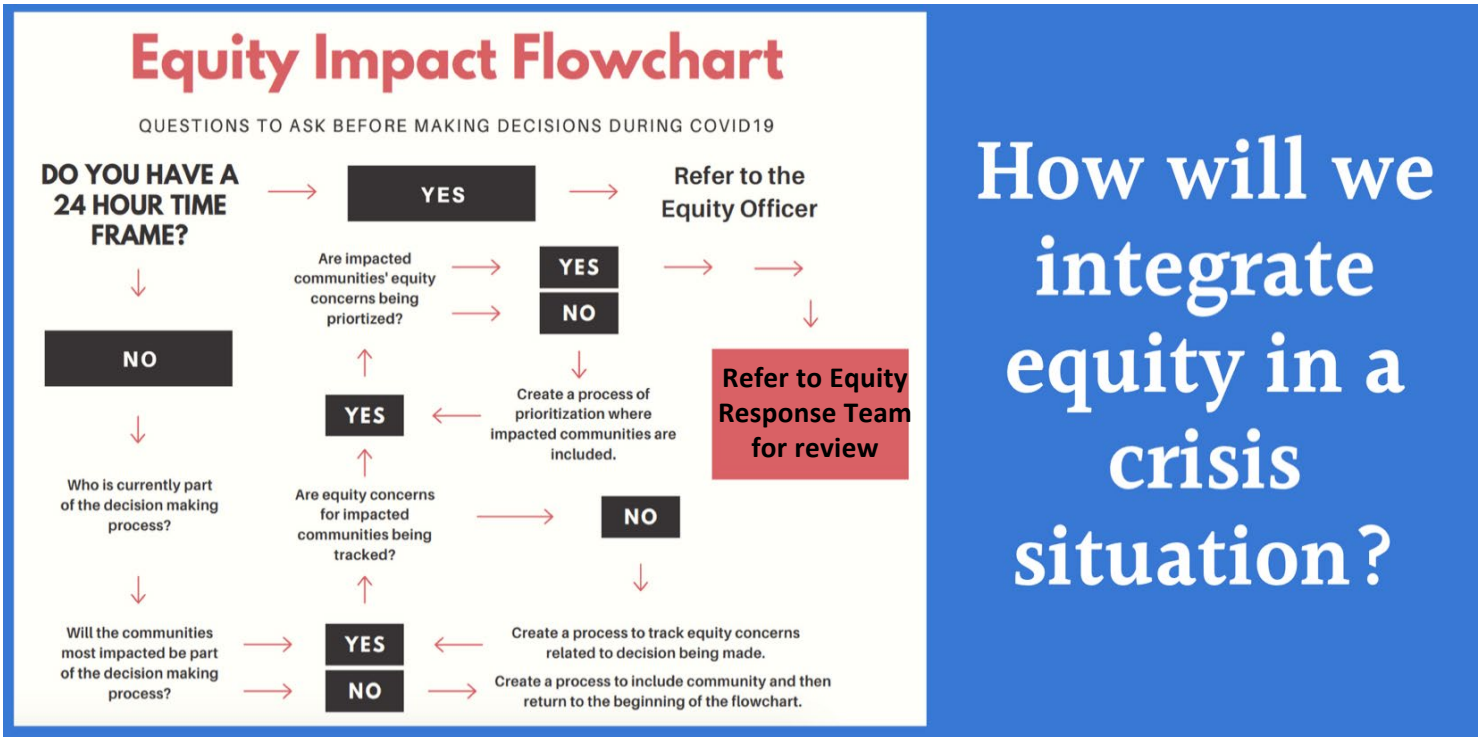


Image 4: Equity Impact Flowchart

Flexibility/Adaptability

An assessment of the PHSKC disaster behavioral health response during COVID-19 was conducted and a report was generated itemizing strengths and recommendations. It provided a particular focus on the inclusion and integration of behavioral health into response activities and supplemented the 2021 Disaster Behavior Health Annex. PHSKC conducted 16 interviews across departments, a literature review, and ongoing meetings to gather details relevant to disaster behavioral health. The assessment found that "COVID-19 had a widespread and often disproportionate impact on King County residents. These inequities were influenced, and often predisposed, by many factors including barriers to accessing healthcare and mental health services, inequitable distribution or foundations of education supports, food insecurities, an overburdened workforce, overworked and maxed out hospitals with limited capacity, shortages of personal protective equipment, inpatient psychiatric units that were overflowing with patients yet had a dearth of beds, and other structural elements."[129]

To address the needs of the community, behavioral health competencies were woven into aspects of the county's response. Disaster behavioral health teams were integrated within congregate and non-congregate isolation and quarantine facilities. They provided trainings, coordinated volunteers, and collaborated with partner agencies to fill growing gaps in emotional wellness care in the community. They also tended to the behavioral health needs of clinical providers and responders. However, the assessment found there was a lack

[129] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

of preparedness specific to disaster behavioral health and a need to build the infrastructure to better tend to the emotional wellbeing of impacted individuals and communities in future disasters.[130]

Innovation/Success: Post Card Project

As of August 2021, volunteers from organizations like Valley Cities, Cities Rise, and ReOpp as well as PHSKC staff and PHRC volunteers wrote over 2,900 wellness messages to youth on postcards that included links to CWI resources. Seattle Children's Hospital, Learning Center North, King County Opportunity Youth Programs, Federal Way Black Collective, YMCA of Greater Seattle, and Kent School District distributed them. Volunteers writing on the cards reported "it gave them space to think positively" and felt it was a form of self-care. Youth were grateful for the postcards and visits to the wellbeing website increased. *

* PHSKC. August 11, 2021. Post-Card Project Report

Image 9: Youth Post Card Project Examples

Areas for improvement

<u>Needed Relationship Building</u>

Larger private organizations often benefited from public health decisions and could contribute to accomplishing shared goals. However, there was a noted cultural barrier to PHSKC working with these types of organizations. Additionally, there were concerns by PHSKC staff that external partnerships formed during the response, such as those made with CBOs, FBOs, community navigators, etc., may not be maintained beyond the pandemic.[131] Some staff suggested a need to create a public health role focused on outreach and establishing external partnerships with private sector agencies.[132]

This concern about maintaining relationships after the pandemic response ended was raised by other stakeholders as well. Many community partners expressed concern that progress that was made in building

[130] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[131] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[132] COVID-19 PHSKC Key Informant Interviews. (2020-2021)

relationships could be lost once response efforts ended. They saw a strong need to sustain and build upon partnerships and to use them during other public health emergencies or disasters.[133]

Equity Concerns

Addressing Access and Functional Needs

Tremendous efforts were made translating information in various languages to serve the diverse community, however, translation services were not sufficient for many residents with disabilities. The distribution of information through internet technology was one limitation and some CBOs felt that pictorial or video versions of information might reach a larger audience including those with functional needs.[134] Additionally, some CBOs noted that creating resources with a focus on "plain talk" would make it more accessible while simultaneously making it easier to translate.

PHSKC captured demographic data on their residents to guide decision-making on where to prioritize scarce resources and serve the public. People with disabilities did not appear to be represented as frequently on dashboards and this lack of representation may have contributed to the feeling that testing and vaccinating these residents was not as important.[135] Tracking the vaccination and testing rates of people with disabilities would help PHSKC understand this important part of the community more fully. One townhall representative noted that 25% of the King County population are people with disabilities and they span every demographic.[136] These respondents felt PHSKC did not have the required conversations to deal with this complex access problem and although there is a significant expense associated with accessibility, that should not be a reason for a lack of inclusion.[137]

Community members expressed that transportation was another an area where accessibility could have been improved for both testing and vaccine distribution.[138] Initially, mass testing sites were only available for those with vehicles. Community organizations noted the PHSKC did not give enough attention to transportation needs and planning. This disproportionately affected people with disabilities and senior citizens who had a greater need for transportation. They could not be picked up and dropped off at vehicle only sites and could not wait in line if there were mobility issues.[139] As a result, community partners invited PHSKC to a coordination group focused on transportation equity.

PHSKC's efforts in promoting the organization's resources and participating in the meetings greatly improved collaboration and trust between the two groups. Attending the meetings allowed the transportation group to be heard and understood. PHSKC listened to this community input and modified their transportation practices with certain sites.[140] This community group advocated for improving the accessibility of vaccine and testing

[133] COVID-19 PHSKC External Partner Townhalls (2022)
[134] COVID-19 PHSKC External Partner Townhalls (2022)
[135] COVID-19 PHSKC External Partner Townhalls (2022)
[136] COVID-19 PHSKC External Partner Townhalls (2022)
[137] COVID-19 PHSKC External Partner Townhalls (2022)
[138] COVID-19 PHSKC External Partner Townhalls (2022)
[139] COVID-19 PHSKC External Partner Townhalls (2022)
[140] COVID-19 PHSKC External Partner Townhalls (2022)

sites and filled the information gap by connecting transportation resources with those in need through a contact center and website. The group felt that because they were providing a critical resource funding would have helped. The group was often paying for transportation or had received ride credits from private partners. The community group has since sunset and the group noted it is now unclear who to contact about transportation resources.

Emergency Managers in King County expressed similar concerns about transportation planning for older populations, populations in South King County and Seattle, and school districts.[141] They felt that these limited transportation populations were not fully accounted for within the equity planning. Similarly, the decisions about vaccine allocations did not account for those same transportation needs.

PHSKC Representation

Some team members expressed that the available resources and PHSKC itself did not meet the equity considerations for people of color and minorities. There was a noted lack of BIPOC providers in the Public Health Reserve Corps which raised concerns about the ability for those systems to serve communities disproportionately impacted.[142] It was also expressed that county leadership should recognize the disproportionate experiences of BIPOC in the workplace and the challenges that emerged throughout the response.[143] While it was recognized PHSKC took initiative around pro-equity and anti-racist values, some indicated that the communication was insufficient and not all employees saw equity as "their job".[144]

Lack of Coordination/Collaboration

While many community partners noted their ability to reach staff was a strength, they also note there were challenges when staff transitioned out of their response positions.[145] This was made difficult because there was not an organizational chart that listed a position and phone number for partners to contact. The community had an established connection with a single person filling a role but, when they left, the organization found it difficult to connect with the new person filling the position. Some partners also noted there was a lack of clarity around the roles or responsibilities of PHSKC teams. For instance, when staff attended partner meetings, it was unclear what their response role was and when there were questions about public health guidance, there were times when staff were unsure who within their agency could provide the answer.[146] This same sentiment was reflected by King County Emergency Management staff, which said an organizational chart would have been valuable to outline the roles people were filling and to know who to contact.[147]

[141] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[142] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[143] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[144] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[145] COVID-19 PHSKC External Partner Townhalls (2022)
[146] COVID-19 PHSKC External Partner Townhalls (2022)
[147] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Emergency Managers in King County also noted that timeliness especially on guidance related to schools was a challenge.[148] They believed they did not have enough time to process the guidance into procedures with education partners. There was a disconnect between what the guidance was saying and how it would be operationalized in schools. Emergency Management partners also stated that many of their information requests related to how to operationalize the guidance went unfulfilled.

Needed Relationship Building: Sovereign Tribal Nations

During the townhalls, community partners noted there was not a direct connection between tribal governments and PHSKC.[149] The tribal governments, as sovereign entities, were not able to establish a government-to-government relationship with PHSKC until later in the response. A pre-existing tribal liaison within PHSKC, especially between Public Health and the Seattle Indian Health Board was needed. A specific example given was when tribal health services was providing support to homeless populations within their community early in the response but were having trouble getting their patients resources. Since there was no direct connection with PHSKC, the tribal government did not receive assistance or know what resources were available. Later in the response, there was a meeting between tribal health services and PHSKC which resulted in direct mobile teams to assist tribal communities.

Lack of Coordination/Collaboration

Many community partners noted that while PHSKC was great at sharing information and brought them to the table, they could improve their follow-through and follow-up with community partners.[150] The community organizations did not feel PHSKC had to implement all of their ideas, but they should explain why their ideas were not implemented or if the proposal was going to be addressed differently. This extended to submission for funding requests and support from PHSKC. In one example, a community organization noted that after submitting a grant proposal to PHSKC, they never heard back as to why it was not funded.[151] Closing the loop, even when news was bad, was noted as an important step to building trust between organizations and communities.

Mixed Findings

Communication

Frequently changing guidance, messaging, and strategies produced significant hurdles. Government Affairs teams noted that national and state guidance would change constantly and at times without warning. This made it extremely challenging to understand the scope of changes, gather questions from staff and partners, and provide adequate answers to advance planning and operations.[152] This extended to public information as well where national and state public messaging strategies changed frequently and with little to no notice.[153]

[148] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[149] COVID-19 PHSKC External Partner Townhalls (2022)
[150] COVID-19 PHSKC External Partner Townhalls (2022)
[151] COVID-19 PHSKC External Partner Townhalls (2022)
[152] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[153] Marx, C. (2021)

This caused confusion amongst the public regarding conflicting messaging and policy teams had to scramble to synchronize with recent changes.[154]

However, even with the frequently changing guidance, PHSKC was seen by partner agencies as the best source of truth that aligned with the science. They were available to answer questions quickly and were often the conduit for community partner groups to receive accurate information around COVID-19 intervention and prevention measures. For partner agencies with healthcare memberships, they disseminated information to (e.g., long term care, adult family homes, clinics), PHSKC messaging was often copied or pushed out to constituents.[155] A few healthcare partners specifically acknowledged the use of the data on PHSKC dashboards as a critical source of Information for their decision-making.[156]

Equity Concerns

Community members from historically marginalized communities were reported by townhall participants to have not used I&Q services due to distrust of government and the lack of accounting for cultural differences.[157] Many community members perceived that I&Q was only for people experiencing homelessness or heard rumors that scared them from utilizing the resource.[158] Some members of the community also viewed these services as trauma inducing and as increasing stigmas about their own communities. In addition, because some cultures are organized around large multigenerational families, they would not use I&Q housing as it could cause cascading impacts to their families and isolate them from support systems.[159] Many community partners had to teach the communities they served how to safely isolate at home because they would refuse to leave. Community stakeholders also reported that community members had a similar reaction to the proposed or perceived use of the National Guard at mass testing sites.

Prior to the pandemic, PHSKC had been working to build relationships in the community and overcome negative perceptions around their agency. Community partners noted that once the pandemic happened, there was no longer time to slowly overcome the long-standing memories and negative perceptions.[160] Therefore PHSKC needed to make a concerted effort to earn the trust of the community and leverage trusted messengers to break down barriers right away. Partners noted that PHSKC staff worked hard to address power dynamics and approach community outreach in a humble way by recognizing the influence and expertise that partner agencies had to reach the community.[161] Several partners and stakeholders expressed concern that relationships made during COVID-19 would diminish or not be continued. They feared all that was gained by identifying relationships and partnerships would be lost. The result would be needing to start over at the beginning during the next emergency and a missed opportunity to improve services in steady state.

[154] Marx, C. (2021)
[155] COVID-19 PHSKC External Partner Townhalls (2022)
[156] COVID-19 PHSKC External Partner Townhalls (2022)
[157] COVID-19 PHSKC External Partner Townhalls (2022)
[158] COVID-19 PHSKC External Partner Townhalls (2022)
[159] COVID-19 PHSKC External Partner Townhalls (2022)
[160] COVID-19 PHSKC External Partner Townhalls (2022)
[161] COVID-19 PHSKC External Partner Townhalls (2022)

PUBLIC INFORMATION

Throughout the response, PHSKC's robust communications activities provided information to a variety of audiences including the general public, media, elected officials, and staff. This included networked approaches with teams leading equity and community partnerships areas to guide the development of culturally responsive messages related to public health guidance and other COVID-19 topics. They produced messages in English and for translation in several other languages. In 2020 alone, PHSKC's Language Access team completed 375 jobs, totaling 4,200 documents with 88 translators in 33 languages. These and other critical public health messages were shared through a variety of communications channels and platforms, such as social media, press conferences, community and business partner networks, and large public information campaigns. The PHSKC Public Information campaign engaged all actionable functions within the CDC PHEP capability of *4 - Emergency Public Information and Warning* and contributed to *1 - Community Preparedness and 2 – Community Recovery*. PHSKC's communications activities worked closely with other areas of its COVID-19 response, including responding to inquiries received through social media, community navigators, PICC, email and other communications platforms.

Strengths

Teamwork

Like the PICC, the Public Information Officer (PIO) team noted a focus on teamwork and creation of a collaborative safe space as key to their success. Managers and staff came together quickly to solve problems and team members treated one another with respect and kindness. Staff leveraged existing relationships from prior work as a foundation for trust and collaboration.[162] Staff were onboarded effectively and, over time, the public information team was able to develop a flexible roster of staff with a variety of skills and interests to meet needs as they arose.[163]

Relationship Building

Achieving the mission of public information, especially in a way that reaches all communities, required extensive resources and partnerships. The PIO team leaned heavily into partnerships to achieve success within their operational areas of content, media, community media, social media, and external communications. The City of Seattle noted in their AAR that there was strong collaboration between PHSKC and City departments and multiple messaging strategies to distribute information and cited the collaboration as a success.[164]

The COVID-19 Language Access Team initially ran into challenges with the traditional process of translating public health information into the required forty languages because of the frequency of changes, turnaround time from translation agencies, and cost.[165] In response, the Language Access Team and Washington State Coalition for Language Access (WASCLA) developed a listserv of just-in-time translators. These were locally

[162] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[163] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[164] Seattle COVID-19 AAR
[165] COVID-19 PHSKC Key Informant Interviews. (2020-2021), COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021), Marx, C. (2021)

certified and experienced translators. The listserv allowed same day, 24-hour, and 48-hour turnaround times whereas the traditional method was taking the team up to 12 days. In addition, the new group of translators was more cost-effective and more culturally responsive as new information became available. PHSKC staff who filled the roles of PIO noted that there were substantial gains made in language accessibility that need to be sustained to address pre-COVID-19 equity gaps.[166] During the townhalls and Emergency Manager feedback sessions, community partners commended the language access program for their ability to rapidly translate documents into so many languages and for sharing accessible materials with community organizations involved in response.[167] There was consistent agreement across stakeholder groups that the language access program was a best practice.

Equity

The strong focus on equity allowed PHSKC to break down barriers of public perceptions around public health as a government agency. Maintaining a consistent focus on inclusion was noted by community partners to be a major strength in PHSKC's approach. With this focus, PHSKC made sure that information reached the people who needed it in the places that made sense. Trusted messengers were engaged to create and share culturally appropriate and accurately translated messaging. This included outreach to urban, rural, native, indigenous populations using trusted community members, spiritual leaders, and community organizations.[168] Establishment of dedicated community/multilingual media partners for external communications was also essential to promoting equity. Internally, identifying SMEs who were go-tos on topics like disease transmission streamlined and assured consistency in information.

There was a focused effort to ensure that plain language and common terminology was used to make translation easier and the messages more understandable. To ensure that the information shared with the community was applicable, PHSKC liaisons worked with community partners to determine the information that was needed and empowered trusted messengers, such as community navigators, with the information so that they could share it with their communities. There was also grant funding made available to CBOs translating and creating public health messaging to support work that was already being done by community partners.[169]

Community partners also noted that PHSKC shared public information in a way that was non-judgmental and personal. Representatives from PHSKC attending public meetings listened first and provided information and explanations after understanding where questions and concerns came from. This created an environment where stigma was reduced and mistrust could be addressed openly.[170]

While equity was an area of success for Public Information, accessible communications remains an area for growth. Dedication of more resources to health literacy needs, website organization and access, and creation of materials in visual and other alternate formats would have further improved information accessibility and

[166] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[167] COVID-19 PHSKC External Partner Townhalls (2022), COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[168] COVID-19 PHSKC External Partner Townhalls (2022)
[169] COVID-19 PHSKC External Partner Townhalls (2022)
[170] COVID-19 PHSKC External Partner Townhalls (2022)

understanding.

Areas for Improvement

Coordination/Collaboration

Changing guidance or rule changes from both federal and state partners were confusing and made it difficult to maintain up to date messaging.[171] Producing consistent and clear messaging for partners and the public required continual effort and resources. Operational updates from response teams, relied on by the PIO team to update partners and the public on response activities, were occasionally slow to arrive or inconsistent. When this occurred, the PIO team sometimes had an incomplete or inaccurate picture of current response activities.[172] The PICC sometimes received misdirected calls from the public or were referred calls by partners which could have been answered directly by DOH and other information lines.[173]

In the City of Seattle's AAR, it was noted that communications incident management structures worked well for coordination, but a formalized process should be in place prior to the next disaster and practiced in exercises. The report recommended that the Joint Information System (JIS) which evolved during the pandemic be formalized through liaisons between major governmental information centers.[174]

Systems or Infrastructure

The pace and scope of public Information needs challenged the team's ability to edit, refine and simplify materials. The volume, length and complexity of PIO resources created secondary challenges for both staff and the public. Designating a strong deputy content lead is valuable to help the team better prioritize and edit information products. Additionally, backlogs and delays in department administrative services such as human resources, procurement and contracting hindered the PIO's ability to keep pace with the rapidly evolving incident.

Lack of Flexibility

In the Seattle COVID-19 AAR, it was noted that the role of PHSKC should be informed by broader public health considerations.[175] The report indicated that public health's reluctance to provide guidance without scientific certainty created challenges implementing strategies in a timely manner. It stated, "this reticence, and the compounding fact that many public health directives were issued and later retracted or refined, certainly made it difficult for leaders who had committed to following the lead set by public health agencies." A similar sentiment was raised by a community stakeholder. Although they appreciated PHSKC's commitment to

[171] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[172] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[173] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[174] Seattle COVID-19 AAR
[175] Seattle COVID-19 AAR

following the science, there were times that things were delayed because the science was unclear and PHSKC was slow in releasing information or guidance.[176]

Mixed Findings

Information Technology Concerns

Similar to other groups, the PIO team saw both strengths and opportunities in the use of IT to support PIO activity. Innovations such as the creation of a media inbox, and use of Trello and slack to manage information will become an ongoing part of Communications team operations. At the same time, PIO staff experienced difficulty using established county resources such as SharePoint, OneNote, and Microsoft Teams.[177] System dependability, bugs and data loss, and limited training time while in an active response were common challenges identified. Externally, Public information teams experienced challenges accessing information from DOH's databases, hindering work during the response.[178]

HEALTHCARE SYSTEM SUPPORT

PHSKC's established and leveraged various existing partnerships to enhance coordination with healthcare system partners. Building on the rapid provision of clinical and technical assistant to LTCFs early in the response, PHSKC maintained regular presence at meetings with healthcare partners and direct communication with partners to share public health guidance and answer questions. PHSKC's Emergency Medical Services division also convened and facilitated a Regional Coordination Team that brought together representatives of healthcare system sectors (hospitals, pre-hospital, DOH) for updates, discussion, problem solving, and to coordinate response strategies. PHSKC collaborated closely with healthcare and other partners to monitor healthcare system capacity and implement or inform medical surge strategies when needed. This coordination and collaboration allowed for appropriate implementation of CDC PHEP capabilities *10 - Medical Surge,* and aspects *13 - Public Health Surveillance and Epidemiological Investigation*.

Strengths

Coordination/Collaboration

The EMS Division convened a Regional Coordination Team as an effective framework to coordinate between hospitals, medical program directors, and pre-hospital partners. Participants felt the meeting size, group makeup, and format allowed them to share ideas and problem solve openly.[179] The participants' expertise and flexibility allowed the group to pivot as needed to meet the changing needs of partners throughout the

[176] COVID-19 PHSKC External Partner Townhalls (2022)
[177] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[178] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[179] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

pandemic. With newly developed data dashboards and effective use of meeting minutes, the group was able to keep partners engaged and informed despite ongoing response demands and conflicts.[180]

Several healthcare partners felt that PHSKC's leadership as an agency throughout the pandemic was instrumental in their success at vaccinating large numbers and mitigating potentially higher death rates. They were impressed during the initial stages of the pandemic at the public health response to the first outbreak at a LTCF. The accessibility, leadership, resources, and expertise that the department brought forward made an incredible difference during incredibly challenging situations.[181] The group further commented that they felt very fortunate to have the leaders of PHSKC, with their experience, leading the county and the state in COVID-19 response measures.[182] Partners noted that PHSKC seemed to continue to refine their services and accessibility over time and their expertise and efforts to write the guidance made them a leader among peers.[183]

> *"The [PHSKC] team was very responsive, communicative and did a nice job steering our healthcare community in being collaborative in our response." – Townhall Participant*

PHSKC was also described by healthcare partners as being proactive and vested in ensuring healthcare providers received the supplies and support, they needed. It made a concerted effort before other Washington jurisdictions to reach at-home care providers (e.g., adult family homes, long term care homes) through outreach efforts with local fire departments. Teams from PHSKC also leaned in to anticipate future needs such as the impacts of a concurrent flu season and continued COVID-19 surge and looked beyond a traditional public health perspective to advocate for health needs in their community. One healthcare partner provided the example of PHSKC supporting interventions to address the long-term impacts of the pandemic on children's mental health and developmental needs.[184]

Relationship Building

Townhall participants representing healthcare membership organizations, such as Healthier Here, Adult Family Home Council, Northwest Healthcare Response Network, also noted that liaisons from PHSKC were beneficial. PHSKC liaisons were able to understand the needs of healthcare member organizations and provided a consistent contact to PHSKC more fully. The liaisons attended membership meetings, as well as community facing meetings, to share public health guidance and answer questions. While they served as subject matter experts, they spoke to meeting attendees as their neighbors.[185] They created a personable environment that encouraged members to feel comfortable asking questions and following up with the liaisons to build direct relationships and seek guidance when needed. Some partners noted that although their membership spread

[180] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[181] COVID-19 PHSKC External Partner Townhalls (2022)
[182] COVID-19 PHSKC External Partner Townhalls (2022)
[183] COVID-19 PHSKC External Partner Townhalls (2022)
[184] COVID-19 PHSKC External Partner Townhalls (2022)
[185] COVID-19 PHSKC External Partner Townhalls (2022)

across multiple jurisdictions, PHSKC was one of the only public health departments to consistently attend meetings and provide support to the organizations and their members.[186]

Standardization of Processes

King County had one of the first major outbreaks in a LTCF reported in the United States and responded in a proactive and timely manner. The PHSKC investigative team combined with experts from the CDC identified which policies, procedures and lack of equipment were most responsible for the outbreak within the LTCF. [187] These findings were widely published by the Centers for Disease Control (CDC) in mid-March, potentially improving preventative care at numerous long term care facilities throughout the county, state, and country and saving lives.

While findings were limited based on knowledge of COVID-19 at the time, five different factors that were problematic and six proposed actions to slow the spread of the outbreak within a long-term care facility setting were proposed. The areas identified as problematic were a combination of unintentional spread by staff members, lack of PPE and training to increase early identification of COVID-19 symptoms. King County implemented the identified findings of screening staff and visitors, introducing policies which actively monitored symptoms in residents, restricted group activities, trained staff, and ensured PPE availability by coordinating with supply chains at the county and state levels.[188]

PHSKC identified every facility with COVID-19 cases and prioritized those facilities for emergency testing, assessment, training, and support. The rapid response of PHSKC to identify specific populations that were highly vulnerable to the disease and implementing an effective strategy to mitigate that threat demonstrated a timely and comprehensive response in initiating the appropriate public health interventions and medical countermeasures.

Mixed Findings

Lack of Coordination/Collaboration

Public Health, healthcare, and governmental partners collaborated to monitor the capacity of the healthcare system and implement medical surge strategies when needed. Public Health provided subject matter expertise and worked to issue local health officer directives when appropriate. Examples of actions taken by healthcare in coordination with PHSKC were collecting and analyzing data on the shared WAHealth platform, following a consistent visitor policy, interpreting state and national guidance and advocating for policy changes, expanding and contracting capacity, accepting patients from other areas of the state, modifying discharge procedures, developing consistent procedures for vaccine roll out to priority populations, and sharing information through regular calls and other forums. The most severe healthcare system impacts

[186] COVID-19 PHSKC External Partner Townhalls (2022)
[187] McMichael TM, Clark S, Pogosjans S, et al. COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020. MMWR Morb Mortal Wkly Rep 2020;69:339-342.
[188] McMichael TM, Clark S, Pogosjans S, et al. COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020. MMWR Morb Mortal Wkly Rep 2020;69:339-342.

experienced in other areas of the country were avoided in King County by strong collaboration and swift decisive action.

The EMS Division team noted that public health and emergency preparedness staff often did not understand EMS operations within King County and vice versa being true as well.[189] This made it difficult to rapidly develop strategies without first spending time establishing a common foundation of knowledge. Adequate representation of hospital interests was also a challenge due to Harborview Medical Center being the sole representative of hospitals on the group. Although this hospital's leadership was expected since it was the Disaster Medical Coordination Center, representation from more hospitals would have allowed them to have a stronger voice within the coordination team to ensure their interests were represented.[190] Finally, the EMS Regional infectious Disease Plan was noted as being out of date by not reflecting "current hazards and the concept of operations" used in the pandemic.[191] While each challenge is unique in its own right, all share a common cause of a long delay between activation of the Regional Coordination Team. As noted by the team, "relationships needed to be refreshed and procedures socialized again to maximize the team's productivity."

Multiple starts and stops over the years for regional medical surge planning, competing stakeholder visions, evolving best practices at the national level, healthcare system consolidation and turnover meant that King County started the Covid-19 pandemic response without a county-specific detailed regional healthcare surge plan. A healthcare surge framework for Western Washington existed but did not provide the necessary specificity or speak to King County's unique resources and needs. One notable exception is crisis standards of care where King County had done extensive planning and long been a lead for the nation.

Detailed, regional pre-planning on alternate care systems incorporating needs such as federal and state resources like Federal Medical Stations, Disaster Medical Assistance Teams, resource prioritization, expansion of the workforce would have reduced some of the complexity and time necessary for working out these issues during the response.

ISOLATION AND QUARANTINE (I&Q)

PHSKC clinical and frontline staff, and in coordination with other King County departments, led critical isolation and quarantine (I&Q) services for King County residents who either cannot I&Q at home or who do not have a home. Early in the pandemic, these services included arranging quarantine for travelers at hotels. They later grew to conducting medical and behavioral health screening of referred guests and provision of services on site, operating multiple I&Q facilities that served both adults and families, and coordinating transportation to and from I&Q sites. In January 2021, King County I&Q served its 2,000th guest and in January 2022, occupancy at PHSKC's primary I&Q facility averaged 90 guests per night and was still rising. PHSKC's care coordination services supported people isolating and quarantining by providing and arranging immediate supports (e.g., grocery deliver, PPE kits, bill assistance) and linking them to longer term supports (e.g., food and utility assistance,

[189] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[190] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[191] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

housing, healthcare, unemployment supports). PHSKC's exemplary efforts in isolation and quarantine directly reflect appropriate implementation of CDC PHEP capability *11 - Nonpharmaceutical Interventions* and the application of capability *7 - Mass Care*.

Strengths

Teamwork

By utilizing diverse subject matter expertise and a culture of teamwork, I&Q teams were able to rapidly build and implement a capability beyond the scope envisioned by previous planning and response efforts. Having departmental leadership support to pivot early and often, staff felt empowered to act and meet needs in innovative ways.[192] Bringing together team members from public health, emergency management, medical, and behavioral health backgrounds, these teams established a culture of unity, collaboration, and flexibility that allowed them to navigate challenges throughout the response.[193] Effectively coordinated communication channels, daily huddles and progress tracking, a centralized scheduling system, and an expanded leadership structure including charge nurses to meet supervision needs were noted as key functional elements of the teams' success. [194]

Quality Assurance and Control

I&Q sites operated by PHSKC and Department of Community and Human Service (DCHS) teams were seen as a major success and community members who stayed in them gave mostly positive feedback.[195] Aside from providing typical services to support guest comfort during isolation and quarantine, a highly successful strategy was the integration of care across behavioral health, medical care, and harm reduction approaches. Collaboration between behavioral health and public health staff improved overall care, increased patient advocacy, and facilitated better clinical decision-making.[196] In addition to behavioral health staff and registered nurses working as a team during assessments, staff were able to maintain a continuity of care by following up with patients in emergency rooms and care coordination systems.[197] These features combined with a harm reduction approach made I&Q facilities more accessible and allowed the program to serve target populations more effectively.[198]

Areas for Improvement

Team or Staffing Capacity

While I&Q operations were successful overall, involved teams noted consistent challenges around staffing, logistics, IT, and a need for 24/7 support for their operations. Although nearly every response team struggled with staffing challenges, I&Q teams faced unique hurdles. One interview noted that PHSKC was aware from

[192] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[193] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[194] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[195] Marx, C. (2021)
[196] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[197] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[198] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

previous disease outbreaks that they had insufficient resources for I&Q operations.[199] Identified information gaps included knowing ahead of time where to shelter individuals with no access to housing and identifying behavioral health resources to ensure quarantine was preserved.[200]

As the complexity of the pandemic increased, it became incredibly difficult for these teams to forecast staffing requirements due to uncertainty surrounding patient surge and acuity. It was difficult to ensure facilities were staffed with individuals possessing strong clinical skills required to meet clients' needs and there was a need to develop a sustainable staffing model given the qualifications required for staff.[201] It is important to note that while this was initially a challenge, lessons learned over time were used for ongoing I&Q process improvements.[202]

Lack of Systems or Infrastructure

Adequate logistical and IT support produced difficulty for these teams as well. Onsite there was insufficient storage space and it was sometimes difficult to access materials from storage.[203] Existing I&Q protocols also did not include establishing a communication infrastructure onsite which delayed these systems. For example, it took roughly a month for a mailstop to be established for these teams.[204] It was also noted that facilities often lacked proper equipment such as wheelchairs that could fit into rooms, sufficient PPE, and food to meet dietary requirements of guests.[205] Furthermore, challenges regarding specialized technology for client care and broad departmental IT systems were common across the teams. Participants noted these systems were at times cumbersome, not user friendly, and individuals experienced difficulty and delays in getting access to systems.[206] Given I&Q operations occurred 24/7, it was a unified finding that these teams required 24/7 support to be able to operate.[207] Changes in process, protocols, and site locations over time amplified these ongoing challenges significantly.[208]

Lack of Coordination/Collaboration

Screening and clinical services teams expressed significant challenges around partner coordination and referrals for I&Q sites. Specifically, teams found it difficult to communicate with hospitals and other external partners due to HIPPA limitations and a lack of clarity around boundaries of care that PHSKC facilities could provide.[209] This led to hospitals often sending individuals back to I&Q that were too ill or required higher levels of care. Referrals were also a noted challenge as sites had no way to contact individuals coming from jails in advance, referrals often came in late at night due to 24/7 operations, and some people making the referrals

[199] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[200] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[201] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[202] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[203] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[204] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[205] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[206] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[207] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[208] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[209] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

were not with the individuals they were referring.[210] These challenges dramatically complicated intake and coordination processes for I&Q teams.

I&Q teams also noted there were no plans for guests with care needs that were beyond the scope of PHSKC facilities but also below acuity thresholds for inpatient care.[211] This left some groups of patients unserved by existing systems. Harm reduction approaches were also challenging to implement due to staff's limited experience with harm reduction and differing personal opinions and approached about the topic.[212]

Mixed Finding

Standardization of Processes

PHSKC's Care Coordination Program provided innovative assistance to individuals and families allowing them to follow I&Q guidelines by providing resources and service coordination. This program encountered both successes and challenges in its development and implementation. One strength was the deliberate focus on addressing needs of impacted populations opposed to undertaking more formal and slow planning processes.[213] With an equity focus, the Care Coordination Program developed diverse teams to meet community needs and responded to feedback about a lack of race/ethnicity data by improving demographic data collection.[214] Effective team practices provided a foundation for operations through strategies such as an open chat to resolve questions in real time, staff training on mental health first aid and motivational interviewing, and a buddy system to balance workload and staff coverage. County-funded programs provided more certainty that applicants would receive aid and programs such as Stipend for Workers in Isolation and Quarantine (SWIQ) and Household Assistance Request (HAR) helped fill gaps in existing resources.

Although largely successful, this program ran into multiple challenges during stand-up and operation. While the rapid mobilization of the program was successful, building it from the ground-up required significant time and coordination.[215] Program requirements related to paperwork, application and verification timelines, and household composition requirements all produced barriers in meeting needs. Issues regarding payment delays and errors also hindered assistance while insufficient assistance amounts and inconsistent funding meant needs were left unmet.[216] Finally, inconsistent program requirements from the state, differing processes between DOH and PHSKC contact tracing programs, and delays in PPE/food kits from DOH presented challenges for effective program implementation.[217]

[210] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[211] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[212] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[213] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[214] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[215] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[216] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[217] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

RESOURCE MANAGEMENT

PHSKC conducted a number of logistical and resource management activities in support of the COVID-19 pandemic response. PHSKC teams provided or coordinated internal logistical support needs for Public Health's COVID-19 operational response activities. This included the capable execution of CDC PHEP capabilities such as *3 - Emergency Operations Coordination* and *9 - Medical Materiel Management and Distribution* in areas such as resource ordering, facilities, transportation, equipment maintenance, security, food service, fleet services, and supply distribution. PHSKC logistical teams also supported resources for community partners involved in the Public Health response, such as healthcare facilities, childcare agencies, local governments. A key logistical and resource management focus area for PHSKC, in coordination with and with support from several other King County departments (e.g., OEM, FMD, FBOD), was procuring, warehousing, allocating, and distributing personal protective equipment (PPE). As of February 2022, PHSKC distributed over 1.4 million N95s, 3.7 million surgical masks, 20 million gloves, and 1.6 million gowns to long term care facilities, health clinics, EMS, congregate settings, community-based organizations, and other critical care agencies.

Strengths

Standardization of Processes

The COVID-19 pandemic created incredible demands on existing and emergency response resource management systems across the world. Rising to meet this significant challenge, HMAC Logistics and Supply Management teams were able to establish effective internal and external communication channels, improve situational awareness through a use of a single point of contact for each supply team, and develop close partnerships with HMAC Operations and external partners.[218] By developing standardized ordering processes, forms, and job actions sheets, logistics was further able to provide structure and clarity to an otherwise complex and opaque function.[219] This structure was supported by the use of shared inboxes to centralize communication and WebEOC to conduct resource tracking. A unified core mission and a culture of adaptability allowed the team to "bend without breaking" despite demanding and uncertain operational conditions.[220]

In response to scarce PPE resources, logistics and supply management teams developed a PPE algorithm to manage requests, improve overall efficiency, and create a data-driven system for allocating resources.[221] Although the algorithm's priorities and role were not clear for internal and external partners initially, this system allowed logistics teams to automate many portions of the allocation process and equitably prioritize limited PPE resources.[222]

[218] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[219] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[220] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[221] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[222] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Teamwork

The Logistics Section noted in their hotwash that their teamwork was a strength.[223] They cited that the core mission brought the team together to navigate the demanding and uncertain situation. The team also demonstrated high levels of adaptability and flexibility as processes changed. The team felt there was strong internal support and support from other King County departments. The team also cited a specific relationship with FMD through a direct liaison as a best practice. The support allowed them to communicate across groups early on and work with appropriate sections as needed.

Areas for Improvement

Unclear Processes

Despite generally strong coordination with other teams, logistics staff indicated difficulty maintaining awareness of the various response teams' responsibilities and experienced a lack of role clarity between other groups and organizations.[224] Warehousing functions also had several noted issues including non-centralized resources leading to multiple systems across warehouses and consistent uncertainty regarding the longevity of warehouse operations.[225] Without an integrated, efficient inventory management system across logistics and supply management activities, these teams routinely had difficulty maintaining situational awareness of resources and effectively coordinating supply requests.

There was also confusion and administrative burdens created by the purchasing processes for Logistics and Supply Management teams. Understanding who was eligible to order what, who could approve purchases, who was responsible for tracking supply deliveries, a lack of proper paperwork for requests, and limited available staff with purchasing authority were routine challenges for these teams.[226] Additionally, as contracting became a major body of work, PHSKC was unable to scale contracting operations to match response teams' needs.[227] It is important to note that, despite these process challenges, staff were able to establish strong collaboration between PHSKC staff and external institutions to expedite contract development as the response progressed.[228]

Systems or Infrastructure

Among teams utilizing PPE, such as isolation and quarantine and testing teams, there were significant difficulties in securing sufficient PPE to conduct safe operations during the response in the early response phases. Old and expired equipment, supply chain disruptions, limited supply relative to demand, and inadequate preparedness stockpiles were noted as contributing factors.[229] Determining which staff required the limited resource of fit testing was also a challenge, particularly for nursing and professional service

[223] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[224] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[225] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[226] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[227] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[228] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[229] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

teams.[230] These challenges combined with a high volume of resource requests presented significant logistical hurdles and impacted operations.

Flexibility/Adaptability

Some health providers that were eligible for supplies were initially unable to access them. PHSKC offered hygiene and PPE, but providers were required to go to the warehouse to pick them up. It was not possible for some providers due to the logistics of leaving the people they care for unattended and concerns about potential exposure. Once PHSKC was made aware of these limitations, distribution was adapted and became more accessible. Teams distributing resources were credited with learning from challenges early on and making changes.[231]

PUBLIC INFORMATION CONTACT CENTER (PICC)

PHSKC launched a dedicated Public Information Contact Center (PICC) on March 3, 2020. During much of the response, it was staffed at least eleven hours per day to assist callers seeking COVID-related medical information. In addition to triaging calls from the community and providing education and guidance regarding COVID-19, the PICC supported other response operations and provided community with linkages to services, such as testing, vaccinations, and isolation and quarantine. The PICC was an additional demonstration of the CDC PHEP capability *4 - Emergency Public Information and Warning* beyond what was already accomplished with their efforts in the Public Information focus area presented earlier in this report. The PICC served callers in many languages and with disability accommodation needs. In December 2020 alone, the PICC received over 30,000 calls. In early 2021, the PICC was averaging 700-1,000 calls per day, with calls per day trending upward until the PICC reached a new single-day call record on January 3, 2022 with 1,600 calls answered.

Strengths

Teamwork

The PICC noted a focus on teamwork and a collaborative environment as key to its success. Managers and staff came together quickly to solve problems and team members treated one another with respect and kindness. Teams recognized response as a continual learning process[232] Although understaffed early in the response, the PICC received robust staffing support through engaging registered and student nurses, the National Peace Corps, and the Public Health Reserve Corps.[233] PICC operators were onboarded using developed trainings, desk aids, and workflows created by PICC administrative support. To ensure effective internal coordination, the PICC hosted a weekly leads meeting which featured guest speakers presenting on

[230] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[231] COVID-19 PHSKC External Partner Townhalls (2022)
[232] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[233] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021); Marx, C. (2021)

issues impacting the teams' work,[234] as well as weekly operations meetings with HMAC staff. Staff reported working in the PICC a meaningful experience and would work in the PICC again.

Quality Assurance and Control

It proved critical to have a clinical provider on staff each shift at the PICC to manage calls related to medical concerns, assess eligibility for I&Q services, and refer callers for additional medical services. Different ratios of clinical and non-clinical call takers were experimented with during the response and having the majority of call takers non-clinical seemed to best meet caller needs and manage costs. Future conversations are needed about the balance of clinical and non-clinical call takers and will depend on decisions about the future scope and direction of the PICC.

Relationship Building

Achieving the mission of public information in a way that reached all communities required extensive resources and partnerships. The PICC used partnerships to achieve success within its operational areas. By collaborating with Seattle-Customer Service Bureau (CSB), the PICC was able to redirect nonmedical calls to their center reducing the call volume for the team and allowing them to focus on medical calls.[235] Within the response, the PICC coordinated closely with both HMAC operations and King County Information Technology (KCIT) to ensure they maintained situational awareness of response activities and received the technical and other support required to conduct their work.[236] Successful collaboration and redirection of calls between the PICC, King County business line, and collaboration with the City of Seattle CSB, helped lower caller wait times and enhance the detail and timeliness of information provided to callers. These relationships and systems were built over time. A preexisting roster of community partners like the City of Seattle CSB, Crisis Clinic, or King County customer care line that can immediately assist with contact center operations would have helped the PICC expand more rapidly to accommodate increasing call volume.

Equity

Strong support exists for maintaining the PICC as an ongoing community resource. Trust in Public Health and trust for nurses as a profession uniquely positions the department to provide support, education, guidance, and linkage to services. Sustainment of the PICC could uplift all in our community especially groups that experience health inequities and access issues.

"They showed up and listened first asking 'What kinds of questions are you getting from community members you're serving?' and then provided information." - Townhall Participant

[234] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[235] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[236] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Areas for improvement

Lack of Communication

The PICC noted that, at times, "…the scope of work and overall purpose was not clearly defined, and stakeholders had different visions about the purpose of the PICC…".[237] This made it difficult for PICC management to navigate roles, priorities, and strategies amongst the uncertainty.[238] Consequentially, significant work was required to produce consistent messages with clear information for partners and the public. Unexpected and changing guidance also produced significant challenges. Guidance and rules from federal and state partners were confusing and sometimes contradictory. The PICC and public Information teams did not always receive Information at the same time.[239]

Partner coordination around referrals also presented a challenge. The PICC coordinated with an extensive list of outside partners such as labs, businesses, and shelters to resolve caller concerns. There was some overlap between various Information lines available to the public.

Communications

Receiving what needed to be nearly real time updates from Communications will always be a challenge for a PICC. The PICC often learned of new updates from the public before they were shared by Communications. In the vast majority of situations, the PIO team skillfully provided updated content and current, approved advice. PICC managers and Public Health programs sometimes had competing visions for the PICC and PICC management felt their recommendations did not always receive sufficient weight or their voice was not always heard. PICC management sometimes lacked a clear understanding of their priorities. Response operations overall lacked clarity in defining which public calls should be answered by the PICC and which should be referred to other PH programs.

Information Technology Concerns

Public Information Contact Center staff experienced challenges throughout the pandemic navigating and coordinating with technology resources. Both the PICC and PIO groups noted difficulty using established county resources such as SharePoint, OneNote, and Microsoft Teams.[240] A lack of dependability, issues with bugs and data loss, and limited time to learn systems while in an active response were common challenges identified. Some technology did not meet the PICC's operational needs such as Skype for Business lacking quality control tools and InContact being unable to meet the performance requirements of call agents.[241]

[237] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[238] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[239] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[240] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[241] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

System access issues, KCIT response times, and information management further Impacted operations, even with a part-time KCIT liaison assigned. Development of a chatbot could have decreased calls to live operators.

Systems or Infrastructure

Even with PHSKC's prior experience operating contact centers for H1N1 Influenza and Zika to draw on, systems and infrastructure were not without Its challenges. Lack of integration of PICC staff into forums where Incident Information and resources needs were discussed, the short time commitment of PICC staff like nursing students, and the brutal work required to staff 7-day, 15-hour operations created a constant need for training and onboarding, gaps in coverage, varying levels of proficiency among call takers, and burnout among staff. Limited access but high expectation to interact with information in a DOH database for vaccination records was also difficult. High quality system and process documentation supported staff onboarding and smooth operations but was time intensive to produce and maintain.

COMMUNITY-BASED INITIATIVES

PHSKC launched a number of community-based initiatives designed to provide technical assistance and resources to the community as needed public health guidance and policies evolved, such as vaccine verification requirements. In its first month (July 3 - Aug 3, 2020), PHSKC's Safe Starts for Taverns and Restaurants (SSTAR) provided community education and completed 423 inspections of food establishments to support compliance with Safe Start WA reopening requirements. PHSKC's Ventilation and Indoor Air Quality program worked with businesses, schools, childcares, faith-based and community-based organizations to improve indoor air quality in facilities open to the public to reduce transmission of COVID-19. PHSKC's Food Security Assistance Program worked with community partners to provide people deemed food insecure with food vouchers and supports to purchase local, culturally appropriate food. These initiatives also provided tangible resources to businesses and nonprofits, including HEPA filters/air cleaner units, grocery vouchers, and economic assistance. This important work with partners fulfilled several CDC PHEP capabilities such as *1 - Community Preparedness, 2 - Community Recovery, 7 - Mass Care,* and *8 - Medical Countermeasure Dispensing and Administration*. Partnerships with funders to support community outreach and education, including redirecting existing resources to meet community needs resulting from COVID, were incredibly valuable. Together these programs outreached to diverse communities and built relationships to support community members and establishments as the county navigated COVID-19 public health policies and guidance.

Strengths

Relationship Building

COVID-19 brought significant challenges and additional requirements for businesses to operate safely. The Vax Verify, EHS Safe Start, EHS Ventilation & Indoor Air Quality Program, and Government Affairs teams engaged the business sector through strategic partnerships that made their efforts successful. At a high level, HMAC Policy & Government Affairs teams established coordination with stakeholders through a regular cadence of

meetings and a model designed to facilitate collaboration between businesses and operational areas.[242] These partnerships were then operationalized by both the EHS and Vax Verify teams. Both programs represent a rapid development of new services that required extensive cross-divisional collaboration to be successful. By collaborating closely with the business and non-profit communities, these services were able to successfully build trust and support highly impacted sectors.[243]

EHS teams noted that collaborating with organizations to understand their challenges helped ease tension and improve cooperation, proper signage increased legitimacy, and many businesses appreciated the information being provided.[244] Instead of only issuing guidance and requirements, these programs provided tangible support to organizations through technical assistance, supplies, and cost reimbursement support.[245] Data from other portions of the response, such as syndromic surveillance data and weekly situational reports, helped inform effective decision-making around program efforts.[246] Additionally, while being able to leverage public health authorities to undertake regulatory efforts through emergency rule making was helpful, these teams found great success with cooperative compliance via education and technical assistance as well.[247] Furthermore, by engaging with community-based organizations to support outreach and providing information across multiple languages, these teams were able to engage diverse communities that may have otherwise been missed.[248] EHS teams noted that clear programmatic structure and roles, effective internal communication practices, and team onboarding programs significantly contributed to the success of these efforts.[249]

[242] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[243] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[244] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[245] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[246] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[247] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[248] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[249] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Innovation/Success: Safe Start for Taverns and Restaurants (SSTAR) Team

A Bronze Innovation Practice Award was awarded to PHSKC's SSTAR Team by the National Association of County and City Health Officials (NACCHO). The SSTAR Team was developed in the summer of 2020 to mitigate the Impact of COVID-19 on businesses and the local economy. This team helped food businesses comply with COVID-19 regulations to protect the health and safety of customers and staff and served as a resource to owners and managers to limit the likelihood of business Interruptions. The SSTAR Team provided guidance to 3,400 food businesses on how to Implement public health guidance and $400,000 In financial assistance to small food companies to help limit the financial Impact of Implementing COVID-19 regulations. A recipient of the SSTAR financial assistance noted that they "felt like they [the SSTAR Team] went above and beyond in helping people."*

*"Public Health Receives National Recognition for Innovation in Pandemic Response." Public Health Insider, Public Health- Seattle & King County, https://publichealthinsider.com/2021/06/09/public-health-receives-national-recognition-for-innovation-in-pandemic-response/. 9 June 2021.

Image 10: Mask requirement signs in different languages.

Equity

The Food Security Assistance Program was established to rapidly distribute $2,150,000 worth of food vouchers for people deemed food insecure and awarded $2,600,000 to organizations to purchase culturally appropriate foods. Recognizing this is a significant task that requires community partnerships, the team partnered with trusted community-based organizations and local grocers, restaurants, and farms to reach communities in need.[250] These partnering efforts resulted in successfully reaching communities most impacted by food insecurity, allowed the program to provide culturally appropriate foods, and supported community grocers.[251]

By partnering with Safeway, the company was able to design, print, and distribute 21,500 $100 vouchers to community-based organizations at no charge. These vouchers were also valuable because they gave individuals autonomy in their food choices.[252] The initiative of awarding 2.6 million in funds for food distribution and covering the operational cost of distributing food allowed King County to meet a known gap of providing culturally appropriate foods.[253] This initiative also allowed the county and community organizations to support local grocers, restaurants, and farms which needed the economic support during the pandemic. Empowered CBOs also developed new distribution points which expanded the reach of food assistance.[254]

[250] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[251] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[252] After Action Report, 2020 Food Security Assistance Program, March 2021
[253] After Action Report, 2020 Food Security Assistance Program, March 2021
[254] After Action Report, 2020 Food Security Assistance Program, March 2021

Innovation/Success: Safeway Vouchers

Between October 1 and December 31, 2020, 95% (or 20,398) of Safeway vouchers distributed were redeemed totaling $2,025,645.09. Transaction details showed that 90% of the food vouchers redeemed were used in areas of South Seattle and South King County, communities that were disproportionately impacted by COVID-19 and experienced food insecurity at higher rates. *

* After Action Report, 2020 Food Security Assistance Program, March 2021

The Food Security Assistance Program was not without challenges, but the discovery and acknowledgement of these difficulties was captured due to the diligence of the King County AAR team. King County completed a thorough analysis of this effort and published those results in March 2021.[255] Despite these challenges, the Food Security Assistance Program was able to successfully implement an innovative and community-centered approach to meeting food security needs during the pandemic.

Areas for Improvement

Quality Assurance and Control Concerns

While experiencing many successes in partnering with organizations, both Vax Verify and EHS programs encountered a multitude of challenges related to organizational non-compliance. These challenges stemmed from a lack of trust and fear resulting in animosity directed towards PHSKC teams working with business owners and their customers. Engagement teams noted that some businesses were not aware of the mask or vaccine mandates, some halted enforcement due to concerns around loss of business or aggressive responses from patrons, and others were hostile to public health engagement.[256] These barriers were amplified by navigators entering areas they were not familiar with, inconsistent communication and follow-up, and conflicting messaging and coordination around pandemic restrictions.[257] Broad public discourse regarding the pandemic, effectiveness of mitigation measures, role of public health, in addition to the "rumor mill" at times made it difficult to secure compliance from organizations. Rapid changes in guidance at state and national levels made it even more difficult for EHS teams and the organizations they were supporting.[258] The teams noted ongoing community engagement, outside of response activities, and engagement of the community as emergency rules/programs are being developed would significantly mitigate these challenges.[259]

Equity Concerns

Although largely successful, the food security program experienced challenges meeting demand which dramatically outpaced supply, encountered challenges with restricted funding, suffered impacts from supply

[255] After Action Report, 2020 Food Security Assistance Program, March 2021
[256] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[257] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[258] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[259] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

chain disruptions, and noted significant administrative burden placed on partnering community-based organizations. The voucher program was unable to provide a sufficient amount of culturally appropriate foods and King County was unable to support the 32 organizations administratively which limited some of the distribution of funds. [260] Transportation was a barrier at times for both the CBOs and their populations. This was especially true for those experiencing homelessness and with limited mobility. The effort to purchase foods from smaller ethnic grocery stores was hampered by the ability to meet the capacity required by CBOs for this initiative or to offer gift cards.[261] Supply chain Issues also complicated this effort as there were manufacturing and transportation issues that impacted the availability of goods. Longer funding periods and greater flexibility in purchasing from ethnic restaurants as well would allow grocers to work through some of the stocking and supply issues. [262] The capacity of the county to manage the contracts with all CBOs assisting with the food security program could be better executed by hiring more staff to manage this effort or outsourcing this contract management.[263] The transportation barrier for the distribution of vouchers could be mitigated with centralized distribution point, mailing system and partnering with an organizations like Public Health Women, Infants, and Children (WIC).[264]

[260] After Action Report, 2020 Food Security Assistance Program, March 2021
[261] After Action Report, 2020 Food Security Assistance Program, March 2021
[262] After Action Report, 2020 Food Security Assistance Program, March 2021
[263] After Action Report, 2020 Food Security Assistance Program, March 2021
[264] After Action Report, 2020 Food Security Assistance Program, March 2021

TESTING

PHKSC conducted a range of testing activities across a range of programs, including high volume sites, testing at County operated public health centers and correctional facilities, and through distribution of rapid antigen over the counter tests to community organizations. Testing services were at first limited to healthcare workers, first responders, and individuals in high-risk groups, but expanded rapidly as more supplies were available from the federal government and vendors. King County testing sites conducted over 200,000 tests in 2020, and by March 2021, testing sites had conducted 1 million PCR tests. PHSKC testing efforts closely align with CDC PHEP capabilities *12 - Public Health Laboratory Testing* and *13 - Public Health Surveillance and Epidemiological Investigation*, but as in many areas they fulfilled this capability in an extraordinary way over a long period of time. In January 2022, an average of over 11,000 tests were being performed daily at testing sites. King County employed a data-driven approach to its testing strategy, which was informed by community feedback and focused on providing testing to populations at highest risk of serious illness or death from COVID-19.

Strengths

Coordination/Collaboration

Externally, testing teams collaborated with local elected officials and research organizations to quickly set up sites with different models to adapt to the needs of that individual site.[265] Teams were successful in establishing partnerships across various agencies, jurisdictions, and labs to meet the operational needs of testing sites.[266] They worked with partners and internal PHSKC teams to identify areas of highest need for COVID-19 testing and worked extensively with municipalities, businesses, etc. to set up and run PHSKC testing sites in the community. To ensure they were meeting community needs, the Testing Strategy Team coordinated with key stakeholders by participating in routine meetings such as the South Sound Regional Testing Meeting.[267]

Through coordination with community partners, appropriate sites were located, and contract leasing of the locations was established for PHSKC run testing sites. The PHSKC team organized staffing and ensured labs received and processed tests. For department run sites, the team also adapted and configured the testing registration system and worked with community groups to ensure equitable access to testing.

Outside of larger routine meeting groups, specific collaborations to meet the needs of partner facilities were also successful, such as a partnership with long-term care facilities to develop and implement policies to increase testing.[268] Collaboration with the Department of Adult & Juvenile Detention (DAJD) also enabled the JHS team to establish effective surveillance testing schedules, testing processes, and contact tracing processes keeping positive rates extremely low compared to similar settings.[269] A culture of collaboration and willingness

[265] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[266] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[267] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[268] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[269] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

to "drop what we were doing to address urgent issues/needs" was identified as a key to success between the teams.[270]

CDC staff integration and assistance for testing was also noted as a valuable partnership in the early stages of large-scale testing.[271] CDC staff were able to reduce the steep learning curve for PHSKC staff and volunteers by providing information about testing supplies, standards, and PPE. This also included PPE procedures associated with testing. The CDC arrived with some protocols and others in draft for COVID-19 testing. These protocols were combined with guidance to create a protocol and training plan for the mobile testing team. The CDC staff assisted in training Public Health Reserve Corps members and staff that would support mobile testing operations.

Teamwork

In the early stages of the response, PHSKC was able to leverage multidisciplinary teams within their department to make decisions on testing supplies and priorities. Internal expertise about various testing modalities helped navigate early information on emerging testing modalities to identify PCR tests as a target option. PHSKC staff with strong connections to the community were able to target high-impact locations for testing sites.[272] Combining the two components allowed for data driven decision-making around high throughput testing sites that would benefit the community most.[273]

Among other components for success, these teams noted leadership support and timely decision-making, multi-disciplinary makeup of teams, diversification of vendors and labs, operational autonomy and flexibility among the teams and staff, and data-driven decision-making as being particularly important.[274]

Equity

PHSKC's equity efforts around testing represent best practices for other public health agencies.[275] Specifically, notable efforts included focusing testing efforts in South King County due to COVID-19's prevalence in that area. Testing sites were placed in locations with high throughput because of data driven analysis.[276] In addition, the testing website provided information in 13 languages through downloadable PDFs. The testing website also provided information on steps that lower barriers to testing such as testing availability regardless of citizenship/immigration status, no ID requirement, and no cost testing/no insurance requirements.

On June 14-15, 2020, Ms. Tina Knowles-Lawson #IDidMyPart campaign and Beyoncé's BeyGood Initiative partnered with King County and local health organizations to help provide free drive-through COVID-19 testing. This testing was available for anyone who had COVID-19 symptoms or who believed they had been

[270] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[271] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[272] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[273] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[274] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021); PHSKC COVID-19 Feedback from Zone 1,3,5 EMs
[275] Bay Area Regional Health Inequities Initiative (BARHII) and the Public Health Alliance ff Southern California (The Alliance), Embedding Equity into Emergency Operations: Strategies for Local Health Departments During COVID-19 & Beyond. July 2020.
[276] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

exposed to the virus. The Somali Health Board led the outreach effort alongside King County, with over 30 community organizations supporting.[277] The outcome of this unique event was reaching a large portion of the community who were people of color, immigrants, refugees, and essential workers. Over the two days, King County administered 1,205 COVID-19 tests and provided face coverings and care packages to over 3,500 individuals and families.[278] King County also provided onsite interpretation services in over 25+ languages and written material with up-to-date public health information.[279] Additional outreach such as playing cultural music, having a greeter, and providing mental health resources added to this remarkable event. The testing was provided by King County Seattle - Public Health and testing was conducted by SeaMar Community Health Center, HealthPoint Health Center, and Harborview Medical Center. This event was indicative of the outreach demonstrated by King County to reach populations disproportionally effected by COVID-19 and historically distrustful of the healthcare system.

Systems or Infrastructure

Selecting multiple labs to support testing sites was valuable in preventing a single point of failure, if a lab was unable to process testing samples.[280] For example, in the early part of the pandemic, there were often limited laboratories that could process COVID-19 test samples, leading to delays in receiving results. Having multiple labs selected increased scalability as more testing sites came online, since testing sites were not sending their samples to the same laboratory for processing. This supported continuity, scalability, and reducing wait times for results which allowed for timely notification to help prevent the spread of the virus.

Areas for Improvement

Unclear Processes

While testing teams were able to find success over time, there were significant challenges noted across the testing teams in establishing and maintaining operations early in the response. Many team members were unfamiliar with ICS and there were not existing detailed plans for setting up testing facilities at the scale required.[281] Communication clarity was another noted issue with confusion as to which testing group or partner had specific communication responsibilities.[282] Testing teams indicated there was a similar lack of clarity early in the response related to available materials, approvals and process changes, conflicting

[277] Mohamed, Hamdi and Senayet Negusse, #IDIDMYPART King County Drive Through Testing Report, King County Office of Equity and Social Justice. Date unknown.
[278] Mohamed, Hamdi and Senayet Negusse, #IDIDMYPART King County Drive Through Testing Report, King County Office of Equity and Social Justice, date needed.
[279] Mohamed, Hamdi and Senayet Negusse, #IDIDMYPART King County Drive Through Testing Report, King County Office of Equity and Social Justice, date needed.
[280] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[281] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[282] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

guidance, and funding.[283] In terms of resources, testing teams initially struggled getting access to required IT systems, and experienced significant difficulty in forecasting and receiving both PPE and testing supplies.[284]

Lack of Systems or Infrastructure

As the pandemic unfolded, significant demands were placed on laboratory systems across the country to adapt to new testing protocols and provide results at scale. Coordination and communication across the laboratory system was a noted issue at several points of the response. Between Washington DOH, PHSKC, and various lab partners statewide, communication and coordination were inconsistent.[285] At times, the PHSKC testing team had difficulty maintaining adequate awareness and visibility over labs within the area. Additionally, challenges arose around understanding and implementing Clinical Laboratory Improvement Amendment (CLIA) waivers and the ability of PHSKC to reimburse early testing providers.

The PHSKC testing team was also challenged by long test result turnaround times from the CDC early in the pandemic.[286] When testing supplies were scarce, agencies such as FEMA only offered PHSKC supplies if it agreed to adhere to the entirety of federal directions and guidance, which included shipping specimens to labs on the east coast with federal contracts. PHSKC ultimately refused to comply with these requirements and began working with local labs to process completed tests in order to return results quicker.

Needed Relationship Building

Although community partnerships were an overall success for PHSKC, having to quickly establish partnerships that did not exist prior to the pandemic put a significant burden on communities and testing teams.[287] Additionally, one interviewee pointed out that PHSKC would have benefitted from pre-existing relationships with public and private sector partners and emergency contracts with testing and laboratory services to reduce wait time in receiving testing resources. These capabilities would make it easier to respond to outbreak data and stand-up testing capabilities at high-priority sites.[288] Recommendations by staff also included having templates and blueprints for the creation of testing sites to enhance the ability to respond quicker and avoid needing to redo contracts and find partners.[289]

[283] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[284] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[285] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[286] Robert Klemko. Seattle area used early social distancing, testing, to help begin flattening the coronavirus curve, Washington Post. April 9, 2020.
[287] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[288] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[289] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

FATALITY MANAGEMENT

During the period covered by this report, the King County Medical Examiner's Office (MEO), which is housed within PHSKC, contributed to accurate surveillance and death numbers due to COVID-19 related illness. The MEO tested decedents coming into the office, as well as tested decedents at funeral homes who have circumstances indicating that COVID-19 may have been a factor in their deaths. The MEO also developed strategies for increased fatality capacity planning across departments and partners. PHSKC accurately implemented the CDC PHEP capability *5 - Fatality Management* in a way that supported their public health agency and mental health of survivors.

Strengths

Systems or Infrastructure

Prior to the pandemic, there were previous planning efforts conducted by PHSKC focused on mass fatality incidents. Relationships developed during those planning periods provided a strong foundation for the Medical Examiner's Office's (MEO) response. Systems like morgue racking and response strategies such as the use of CONEX containers came out of those planning efforts and allowed the MEO to jumpstart their response.[290] By leveraging these established relationships, medical examiners and coroners across the state were able to quickly convene, plan, and share resources. Newly established partnerships and those strengthened during the COVID-19 response have also supported planning efforts for other disasters.[291]

Standardization of Processes

Like many other parts of the public health and medical system, the MEO needed to modify operations in response to the significant increase in cases being assigned. In collaboration with partners, the MEO staff developed guidelines for when to perform autopsies and temporarily reduced the types of cases being assigned while focusing limited resources where they would be most impactful.[292] To support these guidelines, algorithms and workflows were additionally created to guide the testing of decedents for COVID-19.[293] By creating these resources and standards, the team provided an effective unified approach to addressing surge created by the pandemic.

Areas for Improvement

Unclear Processes

The role of the MEO was not consistently known or understood by internal staff and external stakeholders, including when the MEO had jurisdictional authority.[294] This caused confusion, delays, and a need to manage expectations resulting in increased workload. This challenge was compounded by competing priorities from

[290] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[291] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[292] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[293] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[294] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

within PHSKC such as frequently changing requests for data.[295] Changes in priorities and requests for data reporting outside of regular channels made it difficult to complete steady-state work, conduct planning for anticipated response needs, and made establishing standards for data collection methods challenging.[296]

VACCINATION

PHSKC used a multi-modal vaccine delivery approach that provided vaccinations through high volume mass vaccination and fixed clinic sites in areas of high need, culturally sensitive community vaccination events in partnership with empowered CBOs and other partners, mobile vaccination for high-risk individuals, vaccine clinics with King County's 19 school districts, as well as supporting additional regional and healthcare institution partnerships. PHSKC used an intentional equity driven COVID-19 vaccination strategy while creating strategies to support the vaccination of older adults and BIPOC communities. CDC PHEP capabilities 8 - Medical Countermeasure Dispensing and Administration and 9 - Medical Materiel Management and Distribution are clearly demonstrated through PHSKC exceptional efforts in vaccine distribution. The success of this challenging work was demonstrated in their results. PHSKC met ambitious vaccination goals to vaccinate a minimum of 70% of all eligible adults equitably, efficiently, and quickly across all identified racial and ethnic groups and regions of the county, with over 3 million vaccine doses administered and 77% of eligible King County residents vaccinated as of September 1, 2021.

Strengths

<u>Coordination/Collaboration</u>

Multiple vaccine-focused teams noted that a community-centered approach was critical to success of their operations and collaborative relationships built should continue into preparedness activities.[297] Healthcare facility and mobile vaccination teams also developed strong partnerships with EMS agencies, long-term care facilities, hospitals, pharmacies, and providers that developed into "…symbiotic relationship[s] that built on each other's strengths…".[298] PHRC volunteers were critical in staffing testing sites, mobile testing, and vaccine clinics.[299] These partnerships across a multitude of sectors and communities played a major role in the success of PHSKC's vaccination efforts.

An example of successful vaccination efforts included outreach to long term care facilities and adult family homes. Collaboration with pharmacies and regional partners enabled PHSKC to distribute vaccines to locations where people at high risk lived rather than forcing them to travel to a vaccination site. Additionally, PHSKC was the only county in Washington to track vaccination rates in adult family homes to ensure equitable opportunities for individuals living and working within these homes to receive vaccines.[300]

[295] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[296] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[297] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[298] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[299] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[300] COVID-19 PHSKC External Partner Townhalls (2022)

Relationship Building

A consistent finding across the teams involved in vaccination efforts was the importance and success of partnering with organizations and engaging communities. Collaboration with school districts and their leadership was very beneficial for youth vaccine efforts and the contact list provided by the Higher Education Task Force was very helpful in reaching these partners.[301] Partnerships were formed with the University of Washington Schools of Nursing, Pharmacy and Medicine and Bellevue College's Nursing program. The students became vaccinators and assisted covering short notice staffing gaps. Emergency Managers in King County noted it was a strength that PHSKC embraced the PHRC and as a result the PHRC grew rapidly.[302] They cited the PHRC's involvement in contact tracing and vaccine efforts specifically as a strength that enable those responses. Although management of these partnerships was, at times, difficult to track and coordinate between teams, resources such as outreach lists and strategies such as partner compensation were particularly helpful.[303]

Information Technology

Although there were challenges initially setting up a vaccination registration system, PHSKC worked closely with King County Department of Information Technology (KCIT) to address the issues. Together the departments created a vaccination registration selection committee to quickly and successfully choose a new registration system. It was then rapidly installed to enable more efficient and accessible COVID-19 vaccine registration by community members. Over the course of the pandemic, PHSKC and KCIT have worked closely together to successfully maintain and upgrade the registration system. This has included enhancing the system to increase language access, an especially important improvement for community members in South King County

[301] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[302] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[303] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Innovation/Success: Community Partnerships Promote Vaccination

PHSKC worked closely with numerous partners to promote vaccination across the county. Partner organizations promoted equity in vaccine efforts as they served as trusted agents to historically marginalized and underrepresented communities as well as other populations with diverse needs. For instance, community organizations worked to connect vaccines to individuals who lacked internet access, had limited English proficiency, and/or had past experiences with racism in the medical system. The actions of PHSKC and all the community organizations who provided support to the vaccine effort helped limit the disproportional impacts of COVID-19 on immigrants, refugees, African American and Black communities, Latinx communities, Indigenous people and Native Americans, Pacific Islanders, and People of Color.*

*"One Million Shots and Counting: A Tribute to the Community Partners Who Helped us get Here." Public Health Insider, Public Health- Seattle & King County, https://publichealthinsider.com/2021/04/07/one-million-shots-and-counting/. 04.07.21

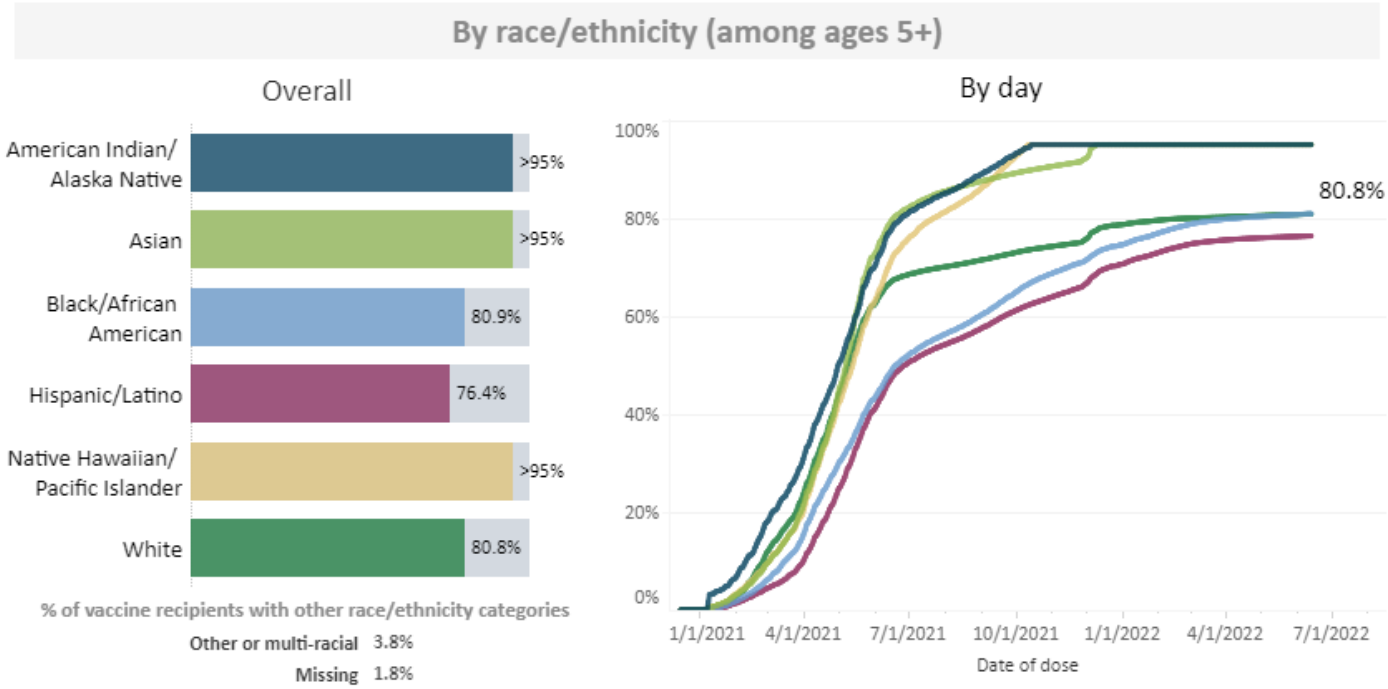


Figure 2: Primary series of vaccines completed by race/ethnicity (https://kingcounty.gov/depts/health/covid-19/data/vaccination.aspx)

Areas for Improvement

Unclear Processes

Teams conducting vaccine operations consistently noted a lack of clarity regarding their team's specific mission and scope. They indicated the target populations were not always clearly defined and lines of responsibilities between vaccine teams were often blurred during the response.[304] For departmental supervisors, a lack of clarity regarding response policies such as leaves of absence to support the mission of vaccine teams was experienced within the internal organizational structure. Additionally, a lack of clarity on environmental and patient safety policies as well as ever-changing federal and state guidance updates resulting in evolving policy and command staff decisions further reduced clarity for vaccine teams.[305] These factors produced significant challenges for response leaders and vaccine teams attempting to navigate complex partnerships and operational environments.

Information Technology

Vaccine teams routinely experienced challenges with data and IT systems which reduced their operational effectiveness. While the teams made use of information produced by the Analytics and Informatics team, vaccine groups noted there were gaps in data making it difficult to identify equity-related needs.[306] Since data was initially not available in a timely manner, some vaccine teams were unable to make timely decisions related to equity issues and found it difficult to rely on data or measure progress at times during the response.[307] Although the departments involved eventually transitioned to more effective systems which increased ease and use of data, these initial shortcomings impeded early vaccine efforts and produced additional response operation costs as teams had to transition their documentation, training, and processes to the new systems.[308]

Mixed Findings

Equity

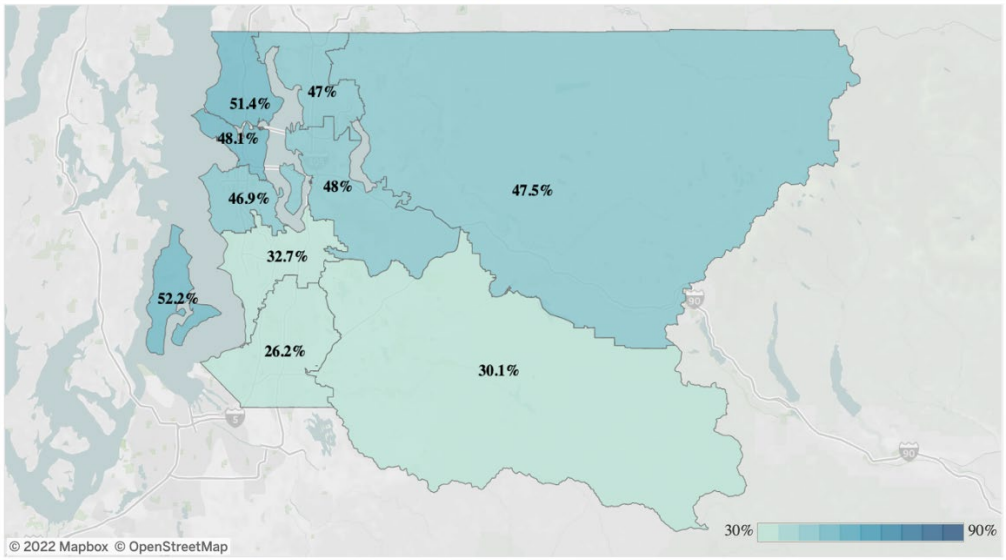
Vaccine related teams communicated a mixture of equity and inclusion successes and areas for improvement. A resounding finding was that the broad response and vaccine efforts centered equity in decision-making and operations.[309] The King County Unified Regional Strategy: COVID-19 Vaccine Delivery (April, 1, 2021) outlined the goal of King County to not only vaccinate a minimum of 70% of adults but to strive for higher rates of

[304] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[305] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[306] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[307] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[308] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[309] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

vaccination among older adults and BIPOC populations that have disproportionately been impacted by COVID-19.[310] The grounding principles for equitable vaccine delivery included:[311]

- Removing barriers deterring access
- Creating an inclusive process
- Being intentionally anti-racist and accountable to Black, Brown, and BIPOC communities

Map of All KC residents who are up to date on vaccination among all ages



Compare across:
- Age Groups
- (•) Race/Ethnicity

Table by Race/Ethnicity of KC residents who are up to date on vaccination among all ages

		All	White	Asian American	Black/Africa American	Hispanic/ Latinx	American Indian/Alaski Nati..	Native Hawaiian/Pa Isla..
Overall	King County	42.4%	43.3%	55.3%	26.7%	28.3%	50.7%	42.1%
10 Regions	Auburn, Kent, and Federal Way	26.2%	24.6%	39.6%	24.7%	19.9%	36.8%	28.8%
	Bellevue, Issaquah and Mercer Island	48%	41.9%	63.9%	37.7%	32%	71.6%	69.6%
	Burien, Renton, Tukwila and Seatac	32.7%	37.3%	40.5%	22.1%	23.1%	46.5%	28.9%
	Central Seattle	48.1%	50.2%	65.2%	23.2%	38.4%	46.5%	70.5%
	East King County	47.5%	39.9%	76.6%	50.9%	35.4%	58%	94.7%
	Kirkland, Redmond, Bothell, and Woodinv	47%	42%	68.9%	38.4%	27.2%	63.4%	60.9%
	N Seattle and Shoreline	51.4%	55.2%	51.9%	33.6%	38.5%	55%	69.3%
	South East King County	30.1%	27.9%	50%	31.8%	24%	47.7%	50.8%
	Vashon Island	52.2%	55.6%	40%	39.9%	29.3%	49.8%	
	W Seattle, S Seattle, Delridge and Highline	46.9%	63.2%	40.3%	23.7%	32.4%	56.4%	51.2%

Image 5: Vaccine Equity in Coverage Graphic PHSKC Dashboard (https://kingcounty.gov/depts/health/covid-19/data/vaccination.aspx)

[310] PHSKC. April 1, 2021. King County Unified Regional Strategy: COVID-19 Vaccine Delivery. Accessed 5/23/22. https://kingcounty.gov/~/media/depts/health/communicable-diseases/documents/C19/king-county-strategy-for-vaccine-delivery.ashx?la=en

[311] PKSKC. April 26, 2021. Principles for Equitable Vaccination. Accessed 5/23/22. https://kingcounty.gov/~/media/depts/health/communicable-diseases/documents/C19/king-county-principles-vaccine-delivery.ashx?la=en

Additionally, teams noted the Equity Tool and Equity Review Process was fundamental for effective prioritization and decision-making related to vaccine operations. Community organizations involved in addressing homelessness and housing noted that the Equity Tool was valuable for the mobile team's vaccine distribution.[312] The same providers noted that the mobile teams were instrumental in providing testing and vaccines to people experiencing homelessness.

Although there was a focus on equity in portions of the response, vaccine teams noticed challenges implementing inclusion and equity objectives in some of their operations. Language access of materials was a significant barrier for several of these teams in terms of both available translations and accessibility standards (formatting, font size, etc.).[313] Another major hurdle for onsite vaccine teams was ADA accessibility of their services and a lack of resources to adequately plan for site locations to be ADA accessible.[314] Community organizations noted that there were not enough mobile teams to meet the needs of people experiencing homelessness or housing challenges.

Two special vaccination clinics were held for people with access and functional needs which had mixed results. The first event successfully vaccinated 175 people with disabilities and the second event, co-sponsored by the Seattle Fire Department only vaccinated 75 people.[315] The lower numbers at the second event appeared to prompt the cancellation of the next event co-sponsored by the Seattle Fire Department for this very important population. People with disabilities did not understand why this event that they pre-registered for was cancelled and received the news of cancellation with a very negative perception of their place in the community.

Coordination/Collaboration

Vaccine-related teams expressed a combination of strengths and areas for improvement related to internal response and cross-team coordination. Multiple teams noted strong collaboration and communication between vaccine teams, robust information sharing with the PICC, and effective partnerships with operational coordination and policy teams.[316] Within the teams themselves, some noted effective internal communication, clarity of vision and strategy, consistent workflows, a positive team culture, staff flexibility, and open communication as foundational pieces of their success.[317] Most PHSKC COVID-19 AAR survey respondents generally agreed they had the information necessary to perform in their COVID-19 response roles. They also agreed or strongly agreed the information was shared in a timely manner and with enough frequency.

[312] COVID-19 PHSKC External Partner Townhalls (2022)
[313] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[314] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[315] COVID-19 PHSKC External Partner Townhalls (2022)
[316] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[317] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Alternatively, some individuals noted a lack of internal communication, transparency, and integration across the vaccine programs. Specifically, the Government Affairs Team was recognized as needing to be integrated into vaccine planning and operations earlier to support engagement of elected officials. There was also a noted lack of clarity about responsibilities between the vaccine teams which led to inefficiencies in operations. A lack of consistent messaging across the response regarding vaccination activities confused partners and the public and lines of communication between operational teams and departments were unclear.[318]

An additional group that was seen as important to involve early in the vaccination campaign development was pediatric healthcare partners. Pediatric providers have a high level of experience providing vaccines and could have provided that expertise early in the planning for COVID-19 vaccination efforts.[319] A broader approach to distributing vaccines throughout healthcare entities was also seen by health partners as a missed opportunity. Much of the allocation of vaccines went to hospitals in large quantities and could have instead been distributed to an array of healthcare providers who could have disseminated them more quickly.[320]

PHSKC Internal Operations

Key infrastructure and administrative functions, such as finance, contracting, human resources, and workforce mobilization, were critical to the full range of PHSKC response operations. These included estimating incident cost, ensuring accurate expense documentation, communicating time and effort reporting to responders, as well as executing and managing a range of new contracts. Internal Operations of PHSKC includes activities that most closely align with CDC PHEP capabilities 3 – Emergency Operations Coordination and 15- Volunteer Management. The appropriate execution of these two capabilities was critical to the success of the response. Human resource and workforce mobilization tasks included using existing and new processes to recruit, hire, mobilize, and train responders to achieve operational activities. The appropriate management of personnel and financial resources ensured that operations continued efficiently and effectively despite the length of the response.

Strengths

Teamwork

Despite the incredible demands created by the pandemic and the disruption of routine working environments, cooperation between different divisions within PHSKC facilitated information sharing and strengthened the COVID-19 response.[321] The broad perspective expressed in feedback was that teams and departments typically worked well together and strengthened relationships throughout response activities.[322] The PHSKC survey results also showed that 65% of the 414 respondents felt flexibility and teamwork was a strength of the

[318] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[319] COVID-19 PHSKC External Partner Townhalls (2022)
[320] COVID-19 PHSKC External Partner Townhalls (2022)
[321] Marx, C. (2021), COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[322] Marx, C. (2021)

response. Collaboration and coordination were also mentioned by at least 35% of that survey population as a strength.[323] It was noted in particular that support was provided through staff activations, coordination of some aspects of the response, and information sharing.[324] Regular huddles of response teams with other departments, such as Human Resources, to provide updates was a key strategy for staying ahead of response needs and challenges.[325]

The benefit of teams coming together from across PHSKC was the creation of multidisciplinary teams. For example, vaccination and testing initiatives for people experiencing homelessness and the creation of facility ventilation guidance were two situations where multidisciplinary teams were assembled with successful results.[326] For the response efforts to support people experiencing homelessness, PHSKC incorporated a toxicologist, public health nursing, behavioral and mental health, health environmental investigator epidemiologists, community health workers, and a staff physician. Each of the disciplines brought their own experience, guides, and checklists to help the team.[327] This effort merged Field Assessment Support and Technical Assistance (FAST) and Strike teams to form the Homeless HEART.[328] For the ventilation guidance, crafted before other similar guidance was available, the team included clinical, epidemiological, and health environmental investigator review. The team recognized it was indoor transmission of COVID-19, not just droplets. This allowed them to focus on airborne virus mitigation through ventilation.

Teams primarily focused on ensuring equity specifically noted that leadership support, team composition, culture, and norms were all critical to their success.[329] Teams were often noted as diverse in terms of background and knowledge. Additionally, teams' culture was positive and respectful, and group agreements helped guide behavior and norms.[330]

[323] COVID-19 PHSKC Staff Surveys (2022)
[324] Marx, C. (2021)
[325] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[326] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[327] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[328] PHSKC. Summary of King County COVID-19 Homeless Response Health Care for the Homeless Network (HCHN) Governance Council Meeting. June 15, 2020. https://kingcounty.gov/depts/health/locations/homeless-health/healthcare-for-the-homeless/~/media/depts/health/homeless-health/healthcare-for-the-homeless/documents/2020-june/covid-19-homeless-response.ashx
[329] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[330] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Innovation/Success: Multidisciplinary Teams Address the Needs of Homeless Shelters

PHSKC established a national standard for response to cluster outbreaks in homeless shelters which was recognized by the Centers for Disease Control and Prevention (CDC) as a best practice to limit the impacts of disease on shelter clients and staff. PHSKC deployed rapid multidisciplinary response teams to homeless shelters with a suspected case or cases of COVID-19. The team assessed the extent of the impact of COVID-19 and connected the organization with resources and support services such as environmental assessments, COVID-19 education, COVID-19 screening and testing services, personal protective equipment, and referrals to I&Q facilities.*

*"Rapid Response In Homeless Shelters can Help Prevent Spread of COVID-19; How to Protect Older Adults at Home; Latest on Antibody Testing." Public Health Insider, Public Health- Seattle & King County, https://publichealthinsider.com/2020/04/22/rapid-response-in-homeless-shelters-can-help-prevent-spread-of-covid-19-how-to-protect-older-adults-at-home-latest-on-antibody-testing/.

Systems or Infrastructure

An incident response requires extensive management of financial and administrative components for long-term success and cost-recovery. To meet this challenge, the HMAC Finance and Administration Section and later teams within PHSKC departments established structures, processes, and communication channels as a foundation for successful collaboration. Early in the response, the HMAC Finance and Administration Section conducted daily huddles to track to-dos and maintain situational awareness across the team.[331] This was supported by having dedicated communication channels to push information out to responders, such as the IAP Special Message section, and a centralized place to receive inquiries such as the shared Finance inbox.[332]

A key task of the Finance and Administration team was interpreting federal and other guidance about the use of coronavirus funding. The team went to great lengths to maintain compliance, educate program managers, and keep meticulous records for future audits and reimbursement. A number of revenue streams supported COVID-19 activities, each with their own timeline, processes and restrictions and Finance managers advised department leadership and response team leads on the use of each. To provide structure to the enormous task of tracking expenditures and documentation, HMAC Finance & Administration developed a single spreadsheet to map out budgeting for each response program, utilized an extensive document management system in place prior to COVID-19, and relied on their experience with LEAN worksheets to document response procedures to standardize processes. These foundational processes, along with the team's ICS trainings, helped form the foundation and guide the team's work through the pandemic.[333]

The Facilities Management Division as well as the Contracts, Real Estate, and Procurement Section were also noted as extremely important and successful teams within the PHSKC COVID-19 response. In one interview, it

[331] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[332] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[333] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

was noted that the teams were “working miracles” to secure PPE for staff.[334] They also helped secure other scares resources such as swabs and tubes when mass testing was being established.

Standardization of Processes

One area uniquely captured by the PHSKC COVID-19 AAR Survey was that most of the over 400 respondents felt they understood their roles and had the skills and training to complete their work. Many respondents acknowledged a stressful learning phase as the county adapted to the rapid pace required for the response, but they felt the team supported each other to solve problems.[335] Approximately 90% of respondents felt they understood their roles and had the skills required in the last three months which is a laudable accomplishment with a high level of reported staff turnover during this two year period.[336] This internal statistic demonstrated the county's commitment to defining roles and ensuring their teams had the skills or training required to serve the residents of the county. Continuous training was also supported by some divisions (e.g., Community Health Services) which implemented specific training strategies to help with teambuilding, competencies, safety, etc.

Areas for Improvement

Team or Staffing Capacity

The COVID-19 pandemic overwhelmed public health, medical, and response systems across the world. As such, it is not surprising that workload and staff capacity was a consistent topic across most feedback received for this report.[337] A widely held sentiment across team-level facilitated discussions was that staff were overwhelmed with the workload and the response demands dramatically outpaced teams’ resources.[338] This issue was most pronounced at the start of the response as PHSKC Human Resource processes were adapting to the pace and style of response-focused recruiting, The PHSKC survey also supported this finding, when asked about staffing, more than 50% of respondents were nueturalneutral, disagreed or strongly disagreed that they had the necessary staffing. This was an area of continous improvement for PHSKC. Some respondents expressed they all were "working beyond capacity" and people could not be hired fast enough.[339]

Many employees, particularly earlier in the response, worked 80–100-hour work weeks often going months without a day off. Aside from taking time away from work, many felt they could not reduce their workload, take needed breaks, or address their physical, emotional, or mental health. Workers across classifications expressed they felt they were not adequately compensated for the exponential increase in work.[340] This challenge was compounded for some staff by the fact that many were ineligible for overtime pay and were unable to use additional compensation in the form of paid vacation time due to response demands. Staff recognized and appreciated that leaders often encouraged teams to work less and practice self-care, but many

[334] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[335] PHSKC Internal COVID-19 AAR Survey, March 2022.
[336] PHSKC Internal COVID-19 AAR Survey, March 2022.
[337] Marx, C. (2021)
[338] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team ‘Hotwashes’. (2020-2021)
[339] COVID-19 PHSKC Staff Surveys (2022)
[340] Marx, C. (2021)

felt it was simply not feasible due to no reduction in workloads or adequate staffing to meet the need. Many staff noted that structural changes to reduce workload, cross-training to allow for better coverage, and incorporating rotating off of HMAC work more frequently would have been more beneficial for their physical and mental health than individual self-care.

Teams also experienced challenges managing work in their home departments and varied expectations around "split work." While many employees were activated to support the COVID-19 response, teams in their home departments often had to shoulder additional workloads in their absence.[341] Employees outside of the response noted it was difficult to meet the additional workload, especially as people activated in the response may take weeks to reply to inquiries, if they replied at all.[342] Resistance to deployment of staff rose in some departments which created the need to recruit for positions that may have been able to be filled through staff activation.[343] Some employees, trying to meet these needs and support their home teams, attempted to juggle both their "day to day" and response positions. This understaffing reduced capacity in routine public health services and increased stress among both response and departmental teams.[344]

"there's a core group of people who, who have great knowledge and expertise, then they get overwhelmed and, by the time you try to bring help on it may be later than ideal."

-Leadership/Management Interviewee

Hiring and Onboarding Concerns

Onboarding Processes

Part of the reason for limited staffing capacity was that many teams noted initial recruiting, hiring, and onboarding processes were unable to operate at the speed and flexibility required to scale operations for the response.[345] While significant efforts were made to rapidly hire and onboard new employees, response teams noted they often did not have adequate time or resources to properly train and engage new employees.[346] Some new team members did not know who their supervisor was after onboarding.[347] When asked in the PHSKC COVID-19 AAR Survey about key challenges during the response, the top three areas were staff capacity, onboarding, and unclear processes.[348] Onboarding was one area mentioned several times in the

[341] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[342] Marx, C. (2021)
[343] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[344] Marx, C. (2021)
[345] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[346] Marx, C. (2021)
[347] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[348] COVID-19 PHSKC Staff Surveys (2022)

survey comments. Respondents felt it could have been more organized and was often neglected at the team level as well because their attention was required by the response.[349]

> *Onboarding is an essential part of bringing new staff into Public Health. Things like obtaining an ID badge, gaining computer access, and learning about standard Public Health benefits and processes continue to need to be standardized and easier to access (for both supervisors and newly onboarded team members). When staffing is stretched thin, training and onboarding of new staff members also burdens the supervisory staff, who work heroically to ensure that their team is well trained.*
>
> *- Survey Respondent*

Teams that were overwhelmed with urgent response activities were often unable to find time to adequately train new members. New team members often had to adapt to a chaotic response environment with limited onboarding and training support. Since many of the new hires were engaged in temporary positions, job security was a constant concern. This created uncertainty and stress for both the new employees and the teams they were assigned to support making it difficult to plan and forecast.[350] Furthermore, some staff expressed concern that since new hires were in temporary positions, the added diversity they brought to the workforce would be lost at the end of their employment with the county.

Volunteers

Volunteers filled a variety of needs during the COVID-19 response. The volunteer pool expanded and contracted depending on outside factors like volunteer policies of area employers or the availability of vaccine. Some volunteers such as PHRC and volunteers lent by philanthropic or academic organizations, were not seen as effectively integrated into the response.[351] Factors included supervisors' lack of time to train and supervise volunteers, the suitability of sensitive/complex roles for volunteers, responder safety, and challenges integrating volunteers who rotate daily depending on their availability. Programs who more successfully integrated volunteers designed roles without significant safety risks, able to be staffed by different people each day, which did not require in-depth expertise, and featured a well-planned onboarding process and supervision.

Early in the pandemic, badging and credentialing were an issue. Credentialing systems were backed up as medical license status and similar credentials were being queried all across the country. A national shortage of badging materials prevented HMAC from issuing badges to volunteers at the start of an assignment.[352] This hindered easy identification of responders and prevented them from accessing buildings and spaces such as

[349] COVID-19 PHSKC Staff Surveys (2022)
[350] Marx, C. (2021)

[352] COVID-19 PHSKC Key Informant Interviews. (2020-2021)

the EOC. The situation resolved later in the response as individuals became more familiar with the badging process, the massive number of credential checks diminished, and supply chain challenges eased.

Some volunteer assignments proved difficult to tailor to volunteer needs and preferences. Certain roles required medical credentials, a continued commitment by a single person, or proficiency working with populations Public Health serves such as people living unhoused. Volunteers demonstrated tremendous motivation and commitment in their assignments with Public Health, but still felt the department could have done more to enhance the volunteer experience. Specific concerns raised by volunteers included requiring an ongoing commitment to certain roles; minimal advanced notice provided for some assignments; some programs' preference to limit assignments to PHSKC employees only, and insufficient training.

PHRC volunteers who responded to a survey on their experiences shared mixed opinions on their experiences, while also crediting with PHSKC with making space for and supporting volunteers as it coordinated the regional COVID-19 response.

Equity

Although there was a noted success of increased workforce diversity through new hires during the response, several operational and equity related teams raised concerns regarding workforce representation. First, staff expressed concern that since new hires were in temporary positions, the added diversity they brought to the team could be lost at the end of their employment with the county.[353] Secondly, while it was widely noted that outside support was appreciated, some felt groups that were engaged did not reflect the broader PHSKC community.

Workforce members recruited via staffing agencies were less diverse than those hired by PHSKC according to several teams.[354] Additionally, teams felt the contracted incident management teams (IMT) comprised of public safety staff established a "…a command structure out of touch with Public Health's values, equity goals, and cultural norms."[355] A consistent message was that PHSKC's workforce should "reflect the communities served" and that equity in hiring practices should be formally adopted.[356]

> *"[g]iven public health's focus on racism as a public health crisis, it's especially important to retain contact tracing's diverse staff as part of PHSKC's workforce." – Hotwash Participant*

PHRC and other volunteer groups were also noted as being less diverse than PHSKC employee teams. Although incorporating volunteers into the public health response was important to alleviate staffing issues and build capacity for various response functions, PHRC did not fully represent the communities it served. According to the PHRC Engagement Survey, the PHRC's largest demographic was straight white women over

[353] Marx, C. (2021)
[354] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[355] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[356] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

65 years of age, many of whom have graduate education and/or clinical licensure.[357] New volunteers who joined during 2020 and 2021 to respond to COVID-19 tended to be younger and of more diverse backgrounds. However, even this group of new volunteers was not reflective of communities in Seattle and King County.

Table 7: King County Compared to PHRC Self-Reported Demographics

Race/Ethnicity	King County	PHRC (survey respondents)
American Indian or Alaskan Native	1.0%	0.6%
Asian	19.7%	14.5%
Black or African American	7.0%	2.6%
Hispanic or Latino/Latina/Latinx	9.9%	3.7%
Native Hawaiian/Pacific Islander	0.8%	0.4%
North African Middle Eastern	No Data	0.4%
White (Not Hispanic or Latino)	58.1%	78%
Two or more races	5.2%	1.0%-2.8%

Unpredictable Funding

Disaster response funding is frequently uncertain in both its amount and duration; this has been especially true during the COVID-19 pandemic. This uncertainty presents a spectrum of challenges including difficulty in forecasting operational timelines, available staffing, time to scale up/down, and clarity over duration of mission. This uncertainty also impacted responder well-being. Since funding sources were uncertain, it was difficult for finance teams to establish the appropriate level of granularity for response expenditures. One example was for COVID-19 vaccination, hiring and procuring resources was hampered in the summer of 2020 due to funding uncertainty. Additionally, FEMA funding occurs at a transactional level which is incompatible with how PHSKC typically approaches funding and creates additional review work for already overloaded finance team.

Environmental health teams also noted challenges around funding for their activities in addition to unique considerations for resourcing EHS operations. The EHS Safe Start team noted that SSTAR funding was too cumbersome for both the EHS team and those seeking assistance due to documentation requirements.[358] Internal funding was also a challenge as the team noted that cost recovery requirements under BOH 2.06.008 and BOH Resolution 08-07 limited the ability for EHS to rapidly mobilize teams and that an emergency fund for staff engagement may be required for future incidents.[359] In regard to resources, the EHS Ventilation & Indoor

[357] PHRC Engagement Survey
[358] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[359] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Air Quality Program noted that due to cost recovery requirements, EHS was unable to procure monitoring equipment outside of established programs, and obtaining specialized environmental staff required was extremely challenging due to funding only being able to be used for short-term and temporary hires.[360] These limitations without funding alternatives produced delays and inefficiencies in response efforts.

Information Technology

While support from King County Information Technology (KCIT) colleagues was noted and appreciated, challenges around information technology (IT) support and interoperability arose during the response. As teams onboarded members to PHSKC, they often experienced delays in accessing core systems, such as email and payroll, that created bottlenecks to engaging new staff.[361] This was particularly a challenge for response teams with clinical hires, such as Nursing Professional Services, that required credentialing and privileging work.[362] At times, work had to be halted for extended periods due to difficulty in getting support for IT issues.[363] Furthermore, many of the recruiting and onboarding systems did not easily interface with other groups making it difficult to coordinate hiring and onboarding for staff.[364] In regards to contracting, teams that utilized technology related vendors noted there was a lack of a comprehensive vendor selection process and that some compliance contracts were resolved after the fact causing delays in work.[365]

Massive department and IT resources were also dedicated to building and launching Microsoft's Vaccine Management System (MVM) within two weeks. However, once it was established, existing systems could not scale to match this new system.

Mixed Findings

Hiring and Onboarding Concerns

To meet the staffing needs created by the COVID-19 response, hiring into PHSKC positions had to dramatically scale up in both speed and capacity. Early in the incident, this function was unable to meet the needs of response teams. PHSKC staff noted that the workforce hiring process was cumbersome and took too long.[366] In addition to being overwhelmed, the Human Resources system was not built to hire as large of cohorts as the pandemic needed.[367] It often took 2-3 months from a job being posted to an employee starting in that position. In some cases, the applicant would have found another position before the process could be finished. HR noted that it would take approximately six weeks for the recruitment process to be done efficiently.[368] In their observation, some of the delay was on the individual being recruited. The proportion of

[360] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[361] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[362] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[363] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[364] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[365] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[366] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[367] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[368] COVID-19 PHSKC Key Informant Interviews. (2020-2021)

the qualified workforce already working in COVID-19 related roles and candidates' desire to provide longer notice to current employers impacted the speed with which candidates accepted and onboarded.

Recruiting for response roles, particularly nurses, became more difficult as the pandemic wore on. Many potential applicants were already employed, the labor market was tightening, people were burned out, and PHSKC was often limited to offering less-attractive short-term positions for many roles. The complexities of COVID-19 funding necessitated the department creating most new positions as Term Limited Temporary (TLTs) of varying length. Overall, hiring supervisors noted short-term roles received fewer applicants. Positions which could not be hired for were sometimes filled with contract workers from staffing agencies.

There was a belief that if HR had significantly increased their capacity by adding staff and implementing procedural changes earlier, the hiring process could have been improved. Greater emphasis on communication with managers and supervisors about t employment types, optimum scenarios for each employment type, and how to initiate a recruitment would have eased some pain points. Many in COVID-19 management roles were not previously managers or supervisors with King County and awareness of HR process and policies varied. Midway through the response, Command Staff implemented a process to more formally assign priority levels to open recruitments, helping assure the most critical roles were filled first. Strategies like using a single job posting to hire multiple similar positions also helped.

Existing department and county human resource policies were not developed with anticipation of a massive surge in demand for HR services. Although HR was overall successful in flexibly adapting policies in a rapidly changing environment, challenges with specificity, Interpretation, and awareness still existed. One PHSKC staff member felt they did not have enough HR policies to reference when making decisions about staffing and noted they received push back from HR about decisions they made without knowing the procedure.[369] Example policies cited as challenges were employee classifications and performance evaluations, discipline, and the credentialing and demobilization processes. Additionally, the creation of generic job descriptions for roles like Public Health Nurse, Investigator, and Program Manager that could be updated annually were identified as a way to reducing time spent creating job postings.[370] HR had templates available but non-HR staff hiring for their sections spent extra time updating and reviewing the job descriptions. The job descriptions could then be turned into a job posting.

Temporary staffing agencies were used however there were concerns voiced related to equity. Contract workers did not have access to many of the responder support services offered to KC employees, like Balanced You or career placement services. The wages of contract workers were not consistent with those paid by the county for the same body of work - some higher, some lower. For example, nurses hired by King County to work in the contact center were paid below the market competitive rate and the PICC struggled to hire nurses. The contact center eventually had to turn to nursing agencies to fill staffing gaps. Temporary staffing agencies also had fewer workers available as the response wore on.

[369] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[370] COVID-19 PHSKC Key Informant Interviews. (2020-2021)

Over time, the ability to meet the staffing challenge became a strength as "new employees were brought on faster and in greater numbers than had ever been done before."[371] The speed and scale at which new employees were brought on went from a major issue to something that was celebrated as a success by many PHSKC teams and provided critical aid to understaffed teams.[372] Labor unions were valued partners as systems adapted to a rapidly changing workforce. Key strategies that improved staffing included a higher degree of flexibility in hiring, expanded agreements with schools around use of students, mobilization of the PHRC, engaging contractors to meet surge staffing needs, cross divisional mobilization of PHSKC staff, and integration of Human Resources team members into staff forecasting conversations. [373] Eventually tools that assisted managers and supervisors were created and shared, such as guidance on how to successfully engage staffing agencies to assist with recruitment and onboarding.[374] Onboarding processes were streamlined through changes and standardized processes, such as shifted Public Health's New Employee Orientation to a virtual self-paced training.

PHSKC staff also noted their overall workforce diversified during the COVID-19 response due to a combination of intentional hiring practices and the sheer number of recruitments required. Participants felt the workforce now was more varied in terms of race and ethnicity, along with professional and educational backgrounds.[375]

Unclear Processes: Workforce Mobilization

The Workforce Mobilization Plan to recruit, deploy, support, and demobilize responders during an emergency was outdated and not necessarily helpful. Response plans are drafted as guiding frameworks designed to be adapted to the specifics of a particular emergency response. For example, much of the prior documentation around workforce mobilization did not detail how to mobilize staff.[376] A PHSKC staff member noted that the plan provided a structure to start with, but the scale and complexity of the event forced the plan to evolve.[377] A staff member who filled an HR role noted that the plan would describe what should be done but provided little guidance as to how it would be accomplished.[378] Plan attachments referenced outdated systems no longer in use and there were not templates available for standard tasks. Two specific areas that needed building out were onboarding and credentialing.

Early on, some workforce mobilization was decentralized with teams managing some of their own recruiting and onboarding processes, but soon everything was centralized into the Workforce Mobilization unit. Mobilization initially relied upon manual, slow processes to deploy employees. Basic systems did not exist, such as a way for HMAC Finance & Administration to view staffing needs and personnel costs of for budget and cost tracking purposes. The workforce team underwent a laborious process to create an excel-based real-time list of responders available for deployment (along with start and end dates, classifications, credentials,

[371] Marx, C. (2021)
[372] Marx, C. (2021), COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[373] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[374] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[375] Marx, C. (2021); COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[376] Marx, C. (2021)
[377] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[378] COVID-19 PHSKC Key Informant Interviews. (2020-2021)

and prior training.).[379] Additionally, several policy and administrative concerns had to be resolved which amplified backlogs for the team. Job classification requirements, equity and parity issues across newly created positions, FEMA reimbursement requirements, and appropriate exceptions to Human Resource policies are examples of issues PHSKC had to address to mobilize the workforce.[380] The impact of an emergency declaration on personnel management was for the most part undefined at the onset of the response. The response would have also benefitted from more and earlier coordination with DCHS and DHR around HR practices.

However, as the response progressed, many of the initial challenges were resolved. Systems used in the pandemic and provided an opportunity to be formalized into processes, systems, and plans for future preparedness. Less successful systems create learnings for future improvements. PHSKC created new processes to mobilize staff.[381] Also, later in the response, teams began implementing technological tools and systems that supported the deployment of PHSKC staff to response operations.

Responder Safety and Health

PHSKC conducted a range of activities in support of physical health and mental wellbeing of its staff and volunteer responders, largely led by the Safety Officer and Employee Health teams. PHSKC, with support from King County's Employee Assistance Program and Balanced You programs, implemented several initiatives to monitor responder well-being and provide support, and encouraged response teams to focus on individual well-being in the face of the high stress environment of the pandemic. PHSKC efforts throughout the duration of the response met CDC PHEP capability 14 - Responder Safety and Health in challenging conditions. PHSKC's safety leads also supported physical health of employees at PHSKC COVID-19 field sites by conducting general safety hazard checks, offering safety trainings, providing consultation on safety issues, and responding to concerns that arose during concurrent events such as demonstrations and inclement weather.

[379] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[380] Marx, C. (2021)
[381] Marx, C. (2021)

Strengths

Safety and Wellbeing

Emotional and Psychological Wellness

In the face of significant professional and personal challenges created by the pandemic, PHSKC staff were buoyed by both responder wellbeing initiatives and peer support. Across the response, a nearly unilateral feeling was expressed that the staffs' "…biggest source of support during the response was their peers and coworkers."[382] Teams achieved this through different ways depending on their team structure and assignments. Some utilized regular check-ins, mindfulness practices, and virtual social engagements to bolster their teams.[383] For others, it was a profound willingness to be flexible and support one another through challenging assignments and environments.[384]

Innovation/Success: PHSKC Recognizes Staff, Partners, and Volunteers

To recognize the important work of PHSKC and its partners, a photo gallery was created to memorialize and honor the work of individuals who supported the COVID-19 response. PHSKC thanked all those who responded stating, "Whether you worked long hours behind the scenes or braved the front lines at testing sites and in the community, your perseverance, compassion and efforts to protect and improve the health and well-being of all people in King County did not go unnoticed. This tribute is for you."*

"One Year of the Pandemic: Recognizing our Staff Partners and Volunteers." Public Health Insider, Public Health- Seattle & King County, https://publichealthinsider.com/2021/01/26/one-year-of-the-pandemic-recognizing-our-staff-partners-and-volunteers/. 26 January 2021.

In addition to peer support, responder wellbeing initiatives were appreciated by many of the groups involved in the response. Incident safety teams maintained a strong focus on responder wellbeing throughout the response and developed partnerships, such as Employee Assistance Program and Community Wellbeing, to provide resources to responders.[385] Aside from providing information and routine check-ins, these programs involved on-site counseling services, meals and therapy dog visits when staff were onsite, online support meetings, wellbeing surveys, and other services as teams transitioned to remote working environments.[386] While not entirely mitigating the challenges presented by the pandemic, teams noted that resources focused on coping with stress and burnout were helpful to their teams.[387] Effective teamwork, coordination, and team composition

[382] Marx, C. (2021)
[383] Marx, C. (2021)
[384] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[385] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[386] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[387] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

of the incident safety team were noted as key components that facilitated success of safety and wellbeing initiatives.[388]

Image 6: Photos of PHSKC response efforts.

Physical Safety

There was an increase in security efforts to protect PHSKC staff since PICC and field staff regularly faced verbal abuse and threatening situations during the response. The safety team built a strong presence at field sites to conduct general safety hazard checks, offer safety trainings, and provide consultation on safety issues. PHSKC also responded to concerns that arose during concurrent events such as demonstrations and inclement weather. Alerts were issued and daily virtual huddles were held to have field operational leads check in and receive updates on any potential safety concerns. At the main PHSCK offices, FMD security escorts, onsite parking, badged building access was provided to offer protection to staff. There was also a focus on training staff on de-escalation strategies to manage threatening situations.

[388] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

Areas for Improvement

Lack of Standard Processes

The HMAC safety team experienced challenges completing their mission. For instance, with an overly broad initial scope of work, Safety Officers had to juggle responsibilities from non-response roles and had limited administrative support, which made it difficult to accomplish their mission.[389] The team also experienced challenges maintaining situational awareness of other response teams' roles and operations because they were not included in the planning stages for sites and operations.[390] Occasionally the Safety Officer identified was consulted too late in planning to Implement safer practices before the activity began; this was the case with I&Q .[391]

A lack of a standardized orientation to HMAC Safety for new responders may have contributed to limited engagement and made it challenging for the safety team to integrate across response teams. With limited bandwidth and an incredible number of response operations happening simultaneously, the HMAC Safety team was unable to conduct safety checks across many of the sites where response operations were occurring.[392]

Additionally, the safety team lacked key resources to conduct their work including a consistent responder tracking system and a centralized file management approach for safety documents. Yet in spite of all this, the team was still able to build effective cross-team communication and collaboration during the response, becoming a trusted source for guidance among response teams.[393]

Safety or Wellbeing Concerns

While PHSKC implemented a wide array of responder wellbeing initiatives and teams practiced extensive peer support, the severe mental and physical health impacts of the pandemic response on PHSKC staff were found across nearly all teams. Insufficient resources to achieve assignments and an inability to take time for self-care was a consistent concern.[394] Teams and individuals felt unable to take advantage of wellbeing resources or to get "space" from the pandemic due to the incredible workloads facing them.[395] Most teams noted this impacted their physical and mental health and personal relationships. Staff also noted navigating difficult decisions, public criticism at local and national levels, angry or frustrated clients, challenges of facing long-term structural inequities, personal impacts from the pandemic, and the challenging nature of disaster response work as significantly detrimental to their wellbeing.[396] Many PHSKC staff members stated that a focus on making structural changes, such as establishing response priorities, cross-training staff members so people were able to cover for others going on break, hiring staff more quickly, and allowing responders to

[389] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[390] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[391] COVID-19 PHSKC Key Informant Interviews. (2020-2021)
[392] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[393] COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[394] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[395] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)
[396] Marx, C. (2021); COVID-19 PHSKC Facilitated Discussions/ Team 'Hotwashes'. (2020-2021)

rotate out of the response more frequently, would have been more helpful than a focus on individual self-care.

RECOMMENDATIONS

Synthesis and analysis of the data collected through the after-action process resulted in 43 high level recommendations grouped across seven cross-cutting themes. These were identified to help prepare PHSKC for future emergencies by building on learnings from successes and challenges experienced through the COVID-19 pandemic response. Efforts to address these items are highly encouraged and are aligned with a culture of quality improvement but require significant time and resources to accomplish fully. Competing priorities, including emerging incidents, and limited staffing and resources may necessitate prioritization and recalibration of these recommendations.

RELATIONSHIP BUILDING

- 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.
- Develop process to link philanthropic organizations and businesses with community-based organizations (CBOs), faith-based organizations (FBOs), healthcare, and other partners. When funding is made available that community partners could use for disaster response activities, take steps to share the information and link partners with funding opportunities.
- Formalize relationships forged during COVID-19. Embrace these relationships and develop a program to ensure the valued partnerships are maintained and strengthened. Consider:
  - Establishing a formal process where stakeholders and partners are officially recognized
  - Inviting stakeholders and partners to become involved in emergency planning meetings
  - Encouraging the participation of these groups in training and exercises
  - Seeking their counsel in areas where they possess a unique knowledge of the issue, problem, or question.
  - Continuing to pay community members, stakeholders, and partners for their work with PHSKC.
  - When appropriate, formalizing relationships with agreements, charters, or memorandums of understanding (MOUs).

STANDARDIZATION OF PROCESSES

- Evaluate innovations that worked during COVID-19 to determine if/how they could be documented for use in the future, including during an infectious disease response. Incorporate revised standard operating procedures into relevant response plans for programmatic areas (e.g., vaccination, testing, contact tracing, public information), as well as departmental coordination of incident management functions (e.g., centralized financial systems).
- Establish dedicated Logistics Unit to cover inventory tracking, shipping, and handling needs, and establish clear process prior to initiating distribution.
- Clearly define decision-making capacity for each role and who needs to sign off on various types of decisions and document in relevant standard operating procedures (SOPs), job descriptions, and staffing plans.
- Develop and document a policy that outlines clear expectations around existing PHSKC staff participating in emergency responses to Division leadership.

- Formalize incident command system (ICS) refresher training and just-in-time training for all personnel participating in response operations or who may be called upon to contribute.
- Explore using systems other than WebEOC to capture resource requests from non-traditional emergency management partners.

Hiring and Onboarding

- Develop and document standardized classifications in advance by selecting basic bodies of response work and documenting potential appropriate classifications.
- Develop job responsibilities and roles needed for human resources (HR) as part of the workforce mobilization team. This may include identifying a trigger for assigning HR staff or outlining necessary subject matter expertise needed around employment types.
- During responses, continue to offer HR a platform to reinforce the expectation that response teams should involve HR in their staffing conversations early and often. Ensure that HR is included in the agenda and standard attendees for relevant meetings.
- Document the protocol and lessons learned from working with staffing agencies during the response.
- Prioritize activities targeted at improving the ability of Public Health Reserve Corps (PHRC) to attract and retain diverse volunteers. Efforts should strive to significantly improve the diversity of newly recruited PHRC members and active participation of Black, Indigenous, People of Color (BIPOC) volunteers.
- Update or create policies which address maintaining or increasing diversity of PHSKC staff. Develop deliberate policies engaging diversity and equity issues from the lessons learned in the response. For example, prioritize activities targeted at improving the ability of PHSKC to attract and retain diverse applicants and hires.

Team or Staffing Capacity

- Develop and document a staffing model including number of staff needed during surges.
- Hire and cross-train additional program staff to enable the use of vacation without fearing their absence will create more workload and stress for colleagues on their team.
- Identify reliable funding for public health to effectively respond to public health emergencies.
- Identify bridge funding between infusions of federal and state emergency response money to avoid disruptions in response activities and prevent staff layoffs and rehires.
- During steady state, maintain open continuous recruitments for rosters of surge staff on standby until deployment during an emergency.

Safety or Wellbeing Concerns

- Consult with Employee Assistance Program (EAP), Balanced You, Safety Officer, and other relevant groups to develop and document plans to ensure targeted access to culturally competent mental health/well-being resources for responders.
- Develop and document plans to allocate time and space for training and professional development so that staff feel supported in their role and can maintain a balanced workload between ongoing and response duties during longer responses.

- Create plans that focus on making structural changes, such as establishing response priorities, cross-training staff members so people are able to cover for others going on break, hiring staff more quickly, and allowing responders to rotate out of the response more frequently, in order to allow staff to take advantage of individual self-care needs.
- Explore making safety and wellbeing resources available to all responders, not just those who are King County employees.

EQUITY

- Work with emergency response leadership to hold more conversations about white supremacy and white dominance in the workplace.
- Continue collaborative work on disability equity/accessibility. Integrate and institutionalize successful practices from COVID-19 response into public health services and future emergency responses.
- Consult with leadership from the Equity and Community Partnerships team to designate one group (e.g., Equity Response Team) of internal staff as the official body for conducting initial equity reviews of proposed policies and programs.
- 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 vs. a secondary review that involves feedback from external stakeholders.
- Hire more career service equity positions and build equity work into job descriptions. Add accountability for racial justice and equity goals into job descriptions and performance evaluations.
- 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 documented Americans with Disabilities Act (ADA) accessibility best practices for programs/services, or creating protocols and training for incorporating ADA standards into operations.
- Ensure all plans for continued work with CBOs, community navigators, and other community leaders include compensation.
- Invest time for each public health program to better align with the values established by the declaration of Racism as a Public Health Crisis. The declaration identifies a shared vision for equity to strengthen engagement of all staff in the department's equity and anti-racist agenda, unify efforts, and better center community needs.
- Address pay disparities between Special Duty Assignments and incoming higher negotiated amounts for Temporary Limited Term which created structural inequity among new hires.

COORDINATION/COLLABORATION

- 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 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 like navigators, translators, and presenters. Work with Equity Response Team to review analysis and prioritize barriers for removal.
- Establish a quarterly or annual meeting to bring equity teams from key partner organizations together to connect and share best practices.
- Establish and maintain regular systems to continue relationships and planning in advance of an emergency with partners (e.g., municipalities and state agencies, businesses, healthcare systems and laboratories) that supported and/or would have a key role in collaborating during future response operations, such as testing, vaccination, or emergency medical services. This could include regular communications, meetings, contributions to emergency planning, and opportunities to train or practice response plans together.
- Recommend teams such as CBOs task force, FBOs task force should have a consistent seat at the table early on in response planning. Ensure avenues of participation for community partners who may not have the capacity to engage via comment periods, sharing of meeting content, and accessibility to meetings via means other than in-person.
- Seek ways to include direct community participation in ICS structures for smaller, less complex, or shorter duration events, to center community voices and empower the community to allocate response resources. Document these enhancements in the Emergency Services Function (ESF) #8 plan.
- Consider adopting a formal shadowing/mentoring process for departments seeking to launch community-led projects in the future to learn from PHSKC divisions that successfully engaged the community during COVID-19. For example, community-driven models for decision-making and ways to engage the community in programmatic design and implementation.
- Model with community members our willingness to engage in uncomfortable conversations. While being aware of our “county hat” and our shared humanity, make space to talk about barriers impacting our communities. This could include training or guidance for staff on active listening, conflict mediation, or receiving critical feedback during community meetings.
- Continue to support and further incorporate language access capabilities facilitating broader coordination and collaboration.
- Support purchasing and support of auxiliary devices for people accessing county services. Auxiliary devices are often labeled as supports for people with disabilities such as people who are deaf or hard of hearing but are useful to many community members.

CONCLUSION

The COVID-19 pandemic is an unprecedented public health emergency, testing health systems at all levels of government. To add to the already complex nature of the COVID-19 response, local governments across the country simultaneously responded to civil unrest, extreme weather, and catastrophic fires throughout 2020, further straining the already overwhelmed response infrastructure and complicating the COVID-19 response. With this complex disaster landscape, PHSKC acknowledged the importance of critically evaluating their disaster response to date and identified corrective actions to improve response efforts going forward, continuing this process as the COVID-19 response endures.

This AAR details the strengths and areas for improvement exhibited during PHSKC's response to COVID-19 in the operational period of assessment from January 2020 – January 2022. All recommendations identified during the creation of this report are synthesized into a COVID-19 Improvement Plan, which provides a roadmap for PHSKC to guide efforts to improve their response to future communicable disease outbreaks and other public health emergencies.

APPENDICES

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ICS 207, HMAC Org Chart Operational Period 78

JHS Lessons Learned_COVID-19 Testing

JHS Lessons Learned ICS 7.21.21

Marx Capstone Final

PHRC Engagement Survey

PHSKC COVID-19 Feedback from Zone 1,3,5 EMs

PHSKC COVID-19 Intra Action Quad Chart AirVent

PHSKC COVID-19 Intra Action Quad Chart_SSTAR

PHSKC Internal COVID-19 AAR Survey, March 2022.

PHSKC Principles for Equitable Vaccine Delivery

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The list below is reflective of the agencies who participated in an after-action review interview, facilitated discussion/hotwash, or a town hall event. Many thanks to the incredible PHSKC staff, King County departments, volunteers, community organizations, trusted leaders, healthcare organizations, and public and private sector response partners that provided insights and feedback into the after-action review process. We are grateful for all that you have done to support PHSKC's COVID-19 response and for sharing your reflections and expertise.

PHSKC COVID-19 AAR Participants
PHSKC PLANNING TEAM MEMBERS
Resham Patel (Project Manager)
Alison Levy
Carina Elsenboss
Mariel Torres Mehdipour
Nick Solari
Rosheen Birdie
GOVERNMENT PARTNERS
King County Departments
Local Emergency Management Agencies throughout King County
Washington State Department of Health
NON-GOVERNMENTAL PARTNER AGENCIES
Adult Family Home Council
Allegro
Altius
American Indian Health Commission for Washington State
Amigos de Seattle
Atlas Genomics
Center for Multicultural Health
Central Area Senior Center
Church of Mary Magdalene at Mary's Place

Evangelical Lutheran Church in America
EvergreenHealth
Fred Hutchinson Cancer Research Center
HealthierHere
HealthPoint
Hopelink
India Association of Western Washington
International Community Health Services
Kaiser Permanente
King County Promotores Network
Latino Community Health Advocates team
Neighborcare Health
Northwest Healthcare Response Network
Public Health Reserve Corps
Puget Sound Regional Fire Authority
Seattle/King County Coalition Homelessness
Shoreline Fire
Sound Generations - Ballard, Shoreline, and Lake City/Northgate locations
The Alliance of People with disAbilities
University of Washington

CONSTANT ASSOCIATES TEAM

Susie Schmitz, Project Manager
Casey Moes, Deputy Project Manager
Kristen Baird, Project Sponsor
Trevor Covington, Townhall Facilitators, AAR Writer
Bill Pepler, Townhall and AAM Facilitator
Amanda Ozaki-Laughon, Project Support
Derek Morrison, Project Support
Dylan Yates, Project Support
Hieu Vo, Project Support
Nicole Christensen, Project Support

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PHSKC COVID-19 AAR ONLINE STAFF SURVEY SUMMARY

PHSKC COVID-19 AAR Online Survey Overview

A total of 414 respondents completed the Public Health Seattle - King County (PHSKC) COVID-19 After-Action Report Survey that collected data regarding the response between January 2020 - March 2022. The respondents were PHSKC personnel from an array of teams with a variety of response roles. With the range of respondent experiences, and the numerous questions asked about PHSKC COVID-19 response, there were many valuable takeaways.

Survey Respondent Characteristics

All respondents (N=414) completed at least the first four questions of the survey providing their general characteristics and overall perception of PHSKC's response efforts. The following bar chart shows the distribution of respondents based on the work area with which they were primarily affiliated. The most common primary work areas were Public Information Contact Center (PICC), Community Health Services (not otherwise listed), Disease Investigations, and Contact Tracing. Those who chose "other" as their primary work area listed roles that included Child Care Taskforce, Public Health Clinics, EPIC, etc.

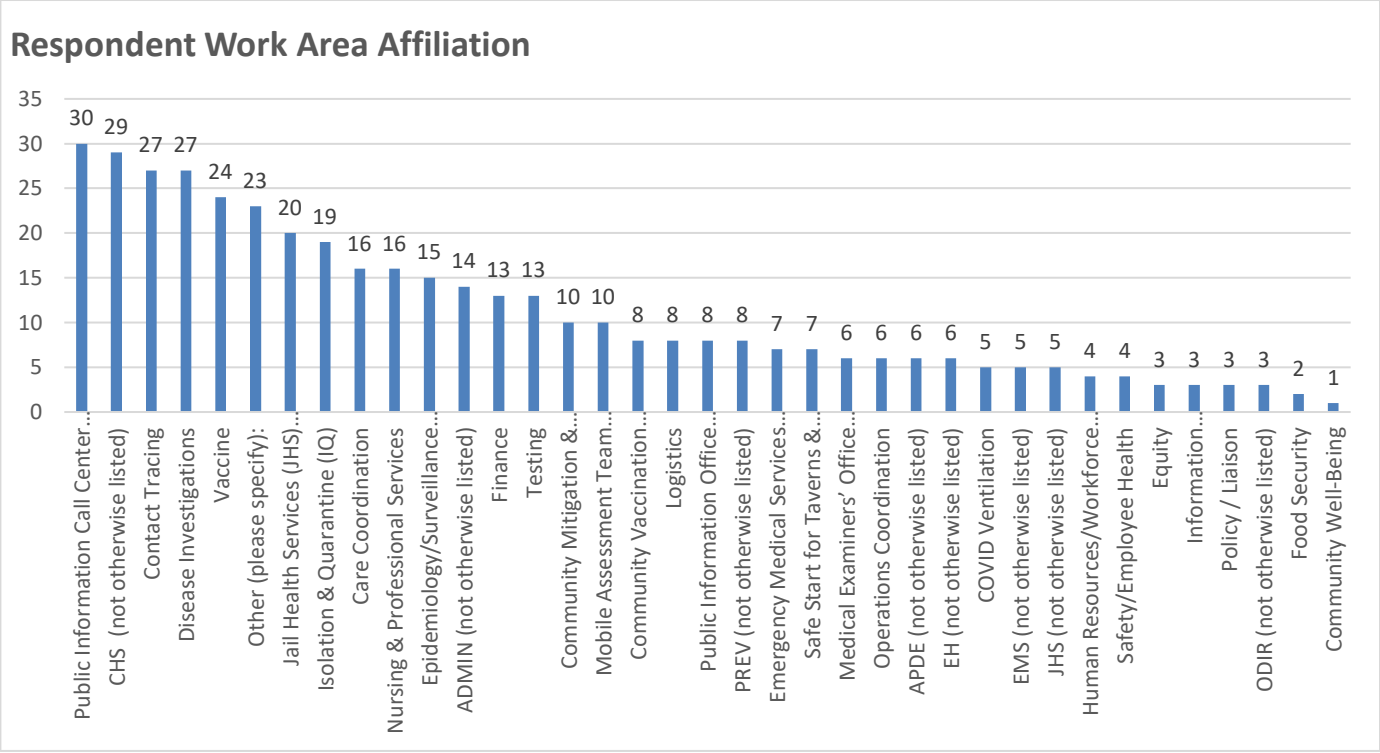

Chart 1: Respondent Work Area Affiliation

Out of the 414 respondents, the majority of those were a team member (71%) and not directly in charge of any specific work area. Those who indicated they held a leadership position included team leads (14%), division leads (5%) and department leadership (3%). There was a significant amount (7%) that did not identify with any of those roles. Some of the personnel that answered "other" for their role in the COVID-19 response felt they filled multiple roles or were leads but not in a supervisory capacity.

Staffing COVID-19 Response Roles

There were several comments throughout the survey as to staffing levels, rates of hiring, and overall turnover. Respondents were asked to list the first day of the month and year that they started in their COVID-19 team/work areas. The chart below depicts the number of personnel dedicated to reducing the effects of COVID-19, by their start date. Very early in the pandemic, many survey respondents joined PHSKC's response efforts. By February 2020, at least 55 of the staff responding to the survey were working in their COVID-19 teams/work areas and 88 survey respondents joined these efforts in the month of March 2020 alone. The number of PHSKC staff respondents starting their roles tapers off after April and May 2020. However, there is a steady number noting they joined the effort throughout 2020 and 2021. Some respondents even began their PHSKC COVID-19 role as late as March 2022.

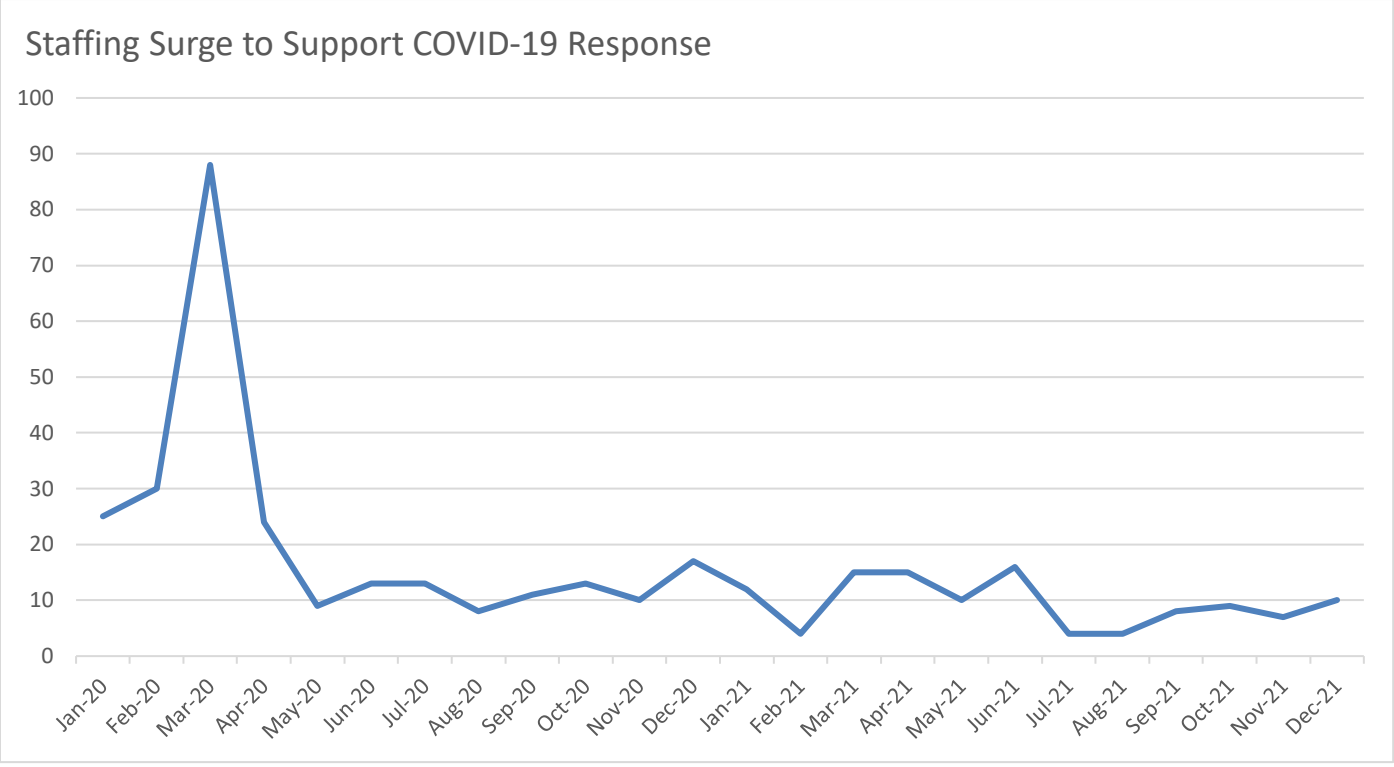

Chart 2: Start Date to Support COVID-19 Response

PERCEPTIONS OF PHSKC RESPONSE

Overall Rating

Respondents overwhelmingly approved of PHSKC's response to COVID-19 with 78% rating the response good or excellent. There were few respondents that believed the response was poor or fair (10%). Of the respondents who were members of leadership or led their team/area, 84% felt the PHSKC response overall was good or excellent. Only 5% of leadership perceived the response as poor or fair. For those who contributed to a team, 77% rated the response as good or excellent while 12% scored PHSKC as poor or fair. Overall, most respondents indicated that they approved of the PHSKC response.

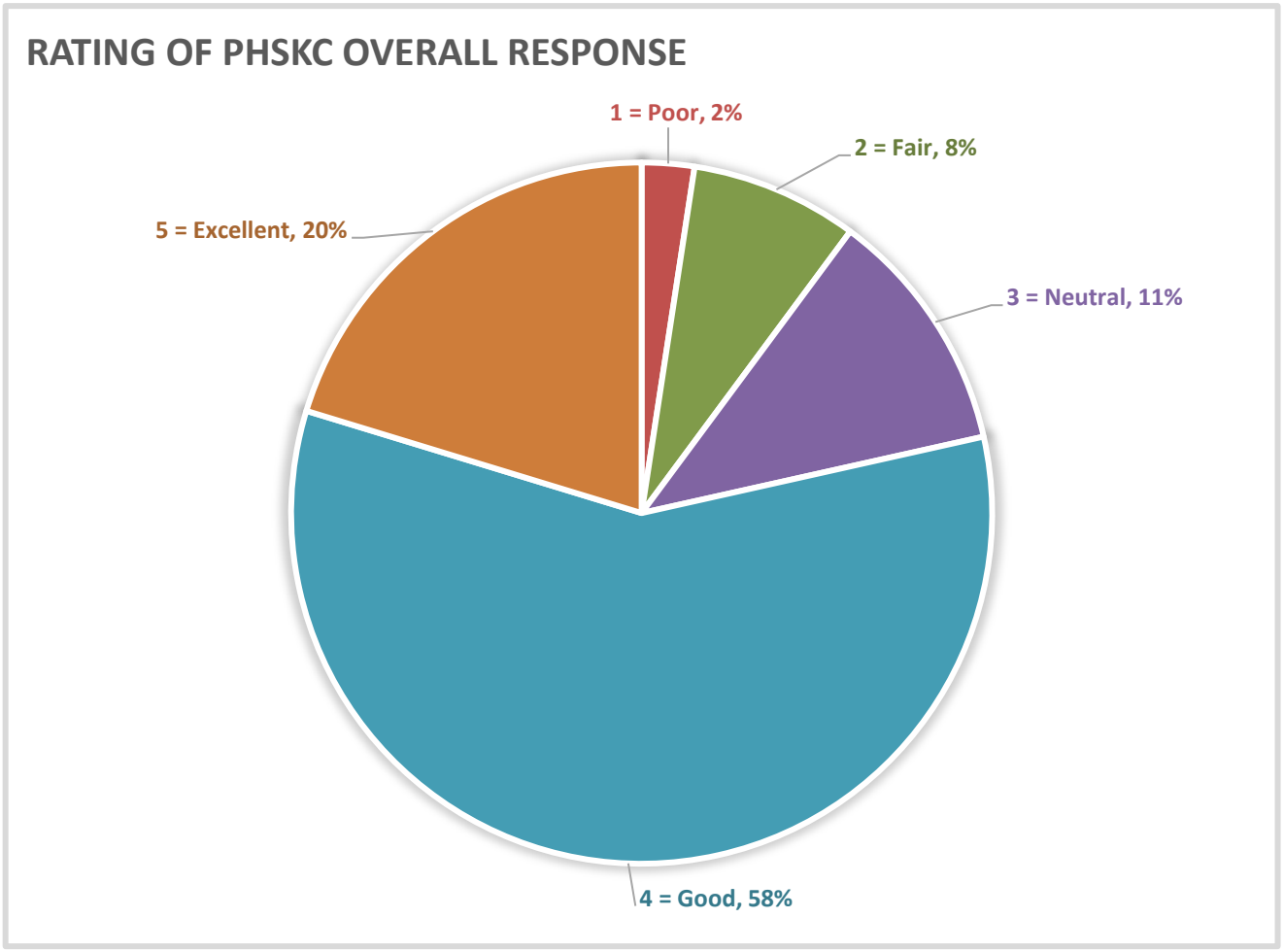

Chart 3: Rating of PHSKC COVID-19 Response Overall

First Three Months and the Last Three Months of Response Operations

The next series of charts graphically depicts a comparison of PHSKC team thoughts on major stress areas of responding to the pandemic. All respondents were asked to think through their roles, skills, training, staffing, resources, information, and coordination capabilities during the first three months of the response. They were then asked to examine those same areas in the last three months to see If there were noticeable changes. The graphs demonstrate with transparency if/to what extent the perspectives of staff towards programs and processes changed over time.

Staff Roles, Skills, and Training

Many of the staff survey respondents felt confident about understanding their primary response roles even early in the pandemic and believed they had the appropriate skills and training to complete their work. In the first three months, 78% of respondents agreed or strongly agreed that they understood their role. One respondent expressed an escalation of stress and responsibility in their role as local cases evolved but took their concerns to leadership and found support and productive solutions.[397] Other respondents agreed that PHSKC went through a "learning phase" but felt the team supported each other to solve problems.[398] Many spoke of the first three months as overwhelming until more personnel were hired and processes evolved. When rating the last three months of the period of time the survey was evaluating (January - March 2022), 87% of respondents understood their roles. Overall, this demonstrated that there was clarity around what response roles entailed and the responsibilities people were expected to fill.

[397] PHSKC COVID-19 AAR Survey Respondent Question 5
[398] PHSKC COVID-19 AAR Survey Respondent Question 5

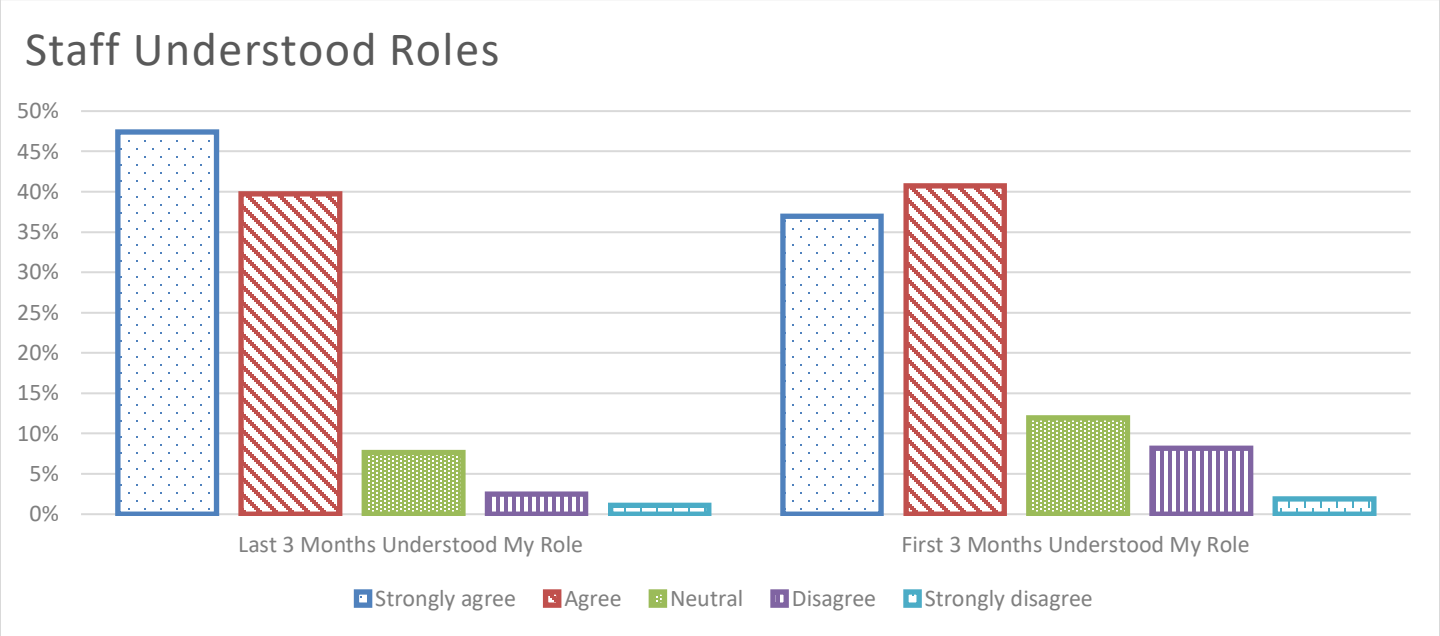

Chart 4: Staff Understood Roles

"I felt lacking in understanding or training related to my role, and this feeling seemed shared by most in the response. Fortunately, there was an almost unanimous comradery and solidarity to support each other, cross-train, explain processes and response-related ways of doing things, give grace and understanding, and be committed to creatively finding a way to accomplish the work. Where we were lacking in formal training and structure, we more than made up in smart, savvy staff."[399]

Thinking back to the first three months of the response, 86% of respondents felt they had the necessary skills which did not change substantially compared to the last three months. However, having adequate training scored lower in the first three months with only 56% agreeing or strongly agreeing. Some respondents noted they were hired to fill one role but it was quickly rebranded to another or they created the training for others as they learned their job duties.[400] There was a marked improvement in the last three months around training with 67% of respondents agreeing or strongly agreeing that they had the training required to complete their work. Continued improvement in understanding of roles and acquisition of skills is a laudable accomplishment with a high level of reported staff turnover during this two year period. However, with 30%+ of respondents regardless of timeframe either neutral or disagreeing they had adequate training for their response role there are still opportunities to improve in this area going forward.

[399] PHSKC COVID-19 AAR Survey Respondent Question 5
[400] PHSKC COVID-19 AAR Survey Respondent Question 5

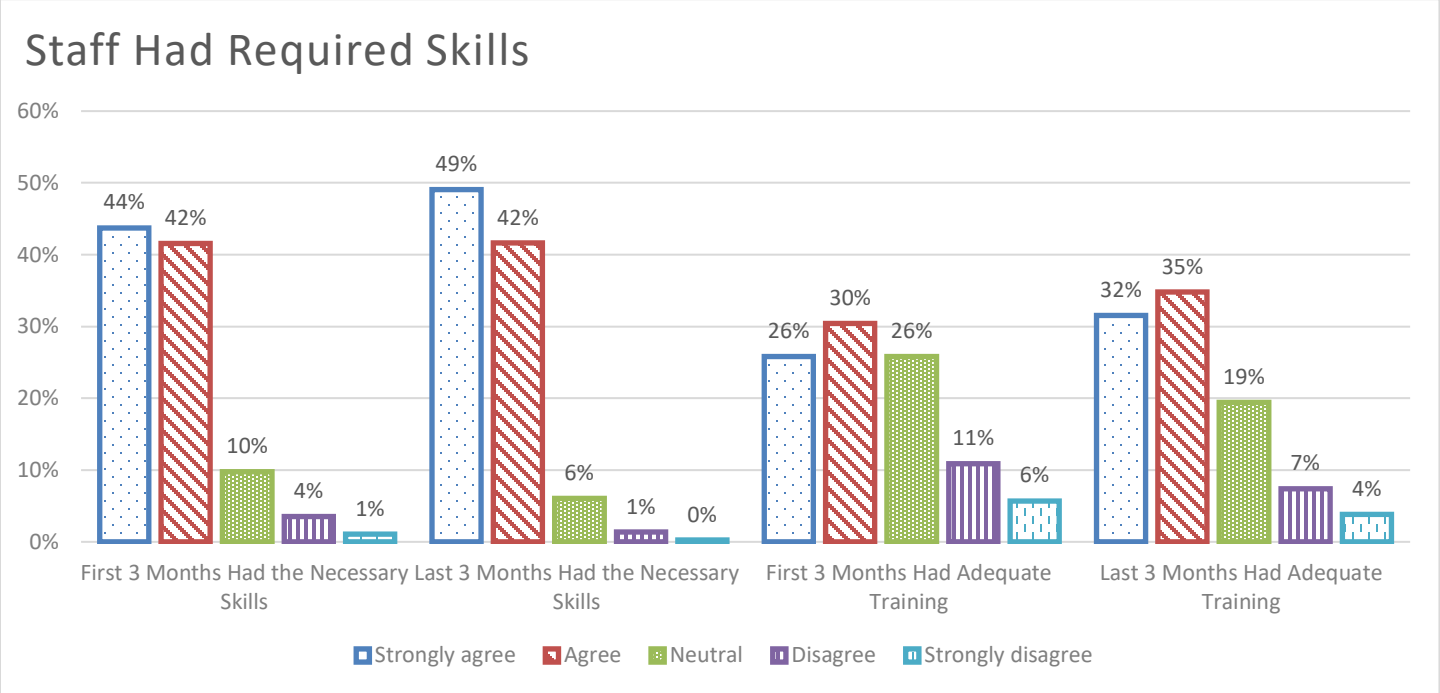

Chart 5: Staff Had Required Skills and Training

Staffing and Resources

Over half of respondents were neutral, disagreed, or strongly disagreed that they had adequate staffing during the pandemic. Compared to the others statements being evaluated by respondents, “I feel my team/work area was adequately staffed to perform our function in Public Health’s COVID-19 response” was the only one to have more than 50% of respondents neutral or disagreeing with it.

Although agreement on adequate staffing increased in the last three months to 48%, this was only a slight improvement (3% increase). Some respondents expressed they all were "working beyond capacity" and people could not be hired fast enough.[401] There were consistent remarks by survey respondents regarding some response areas being underresourced as far as personnel and some salaried employees filling with long hours or work weeks to meet the needs of the response.[402]

[401] PHSKC COVID-19 AAR Survey Respondent Question 6
[402] PHSKC COVID-19 AAR Survey Respondent Question 6

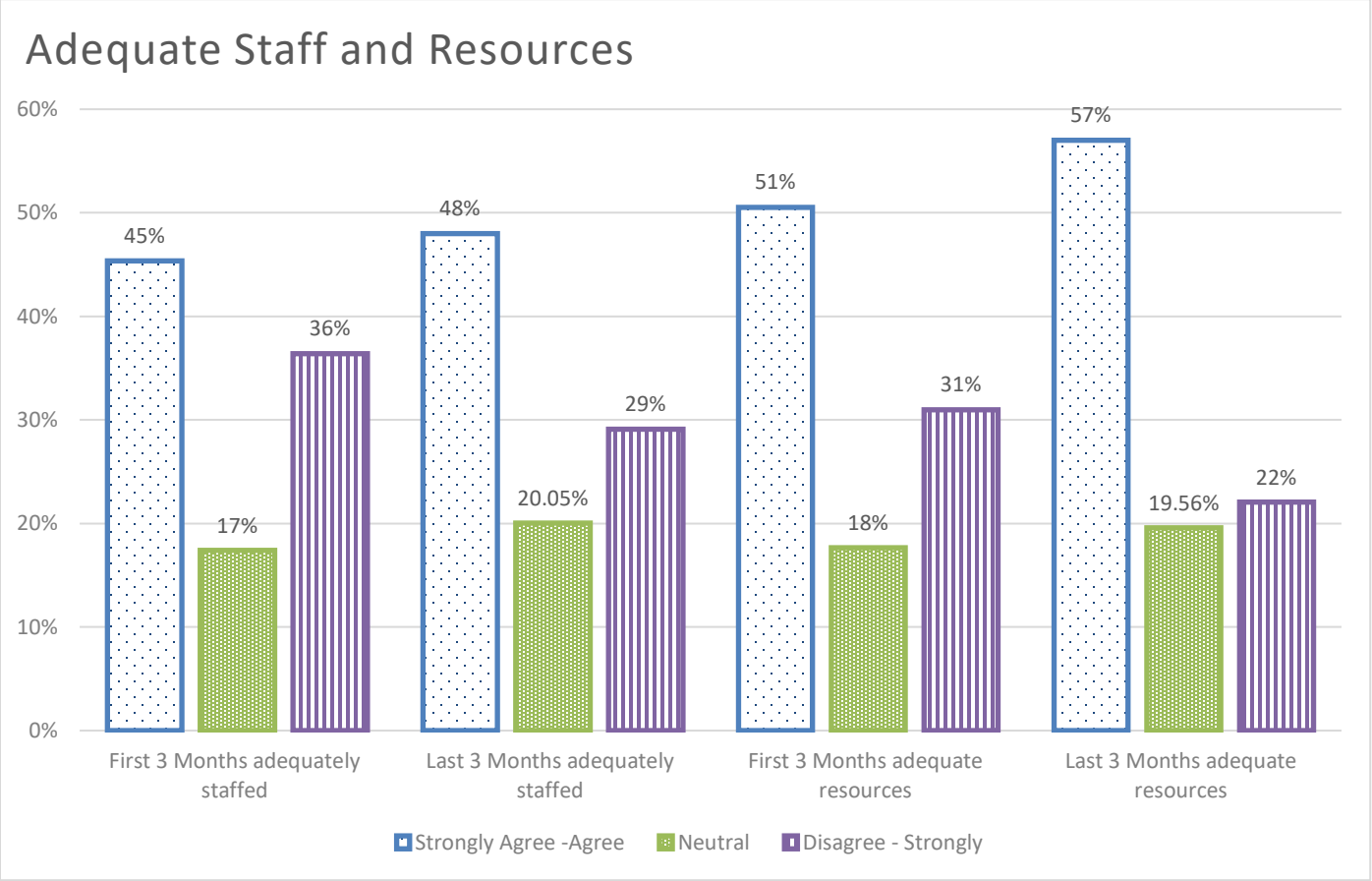

Chart 6: Adequate Staff and Resources

Slightly more than half of respondents (51%) felt there were adequate resources in the first three months. This improved slightly for the last three months, with the total number of staff that agreed to some extent or were neutral over adequate resources increasing. However, it is still notable that 42% of respondents were neutral or disagreed to some extent that they had enough resources to perform their function in the response.

When asked what resources, trainings, or information would have helped the respondent and/or their team/work area, over 200 people provided open-ended feedback. There were a range of suggestions including additional staffing, more training on response roles, improved communication and coordination between teams in the field as well as those between departments, administrative and human resources support, etc. Some of the most frequent types of suggestions are listed below along with examples from open ended responses.

- COVID-19 Safety: Staying self-informed of CDC guidance; sharing medical and non-medical knowledge
- Communication: Better communication and coordination among teams; need for continuous liaison
- Emergency Prep/Management: Frequent emergency preparedness training; staff accountability

- Information Management: Improved centralized data systems, information sharing, public reporting
- Onboarding: Uniform training for all new hires; gap in knowledge among early hires in the pandemic
- Resource availability: Inequities in PPE and testing kit supply and distribution; training on risk reduction
- Staff Care: Implement rotations and breaks; combat burnout; encourage self-care
- Staffing: Increase staffing to manage surge; recruited diverse backgrounds; inadequate HR resources

Internal Information

There was not a drastic change in respondents thoughts on having relevant information available and the frequency in which it was shared. Most respondents generally agreed they had the information necessary to perform in their COVID-19 response roles. They also agreed or strongly agreed the information was shared in a timely manner and with enough frequency. Some respondents felt the information mangement could have been more organized in first three months of their assigned role as they had challenges knowing where to go for information.[403] The location of information, who to contact for certain data, and an Information Library were suggestions for areas of improvement by respondents.[404]

[403] PHSKC COVID-19 AAR Survey Respondent Question 5
[404] PHSKC COVID-19 AAR Survey Respondent Question 7

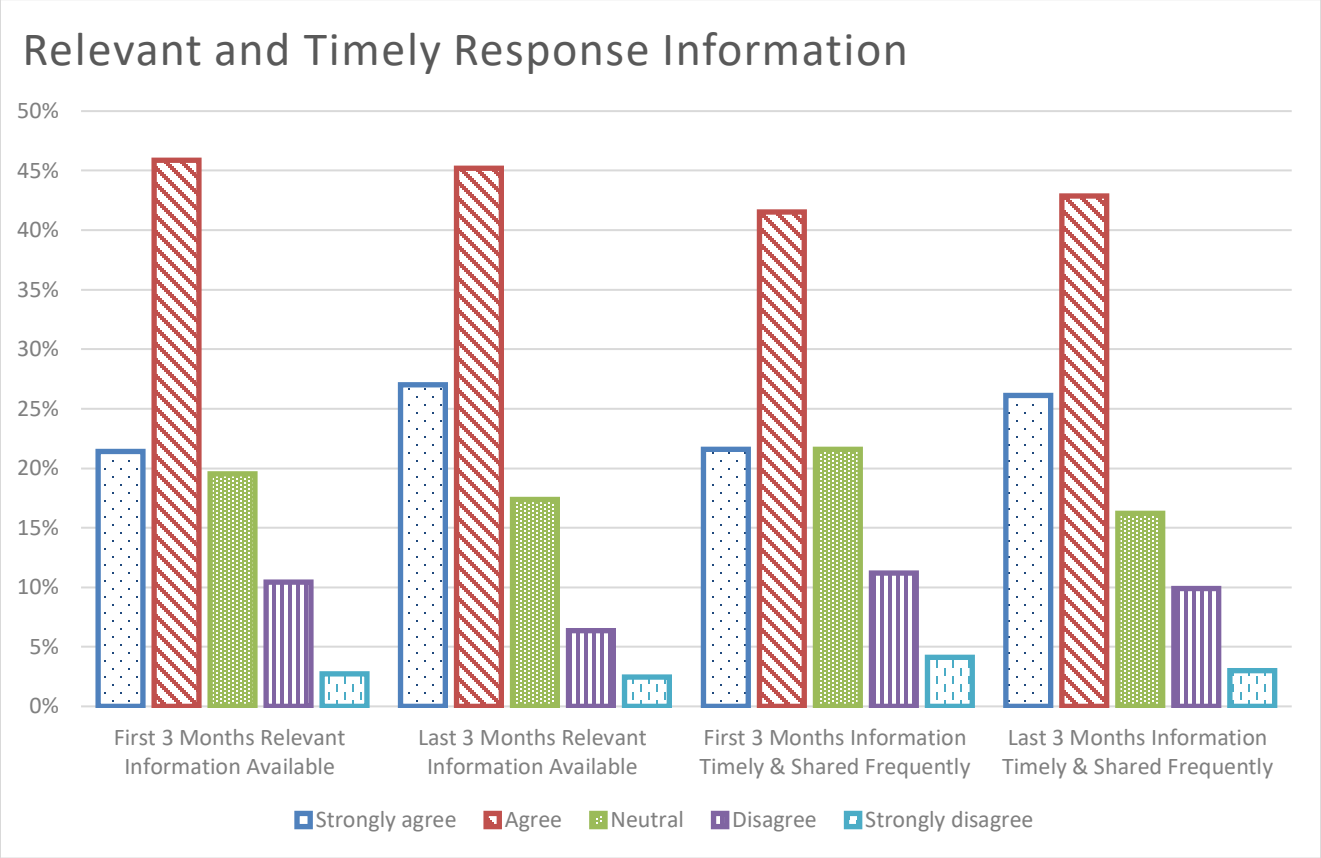

Chart 7: Relevant & Timely COVID-19 Response Information

Coordination and Known Points of Contact

The improvement in coordination and knowing who to contact on specific issues within PHSKC is depicted in the charts below. Perceived coordination between teams improved from the first three months (43% agreed or strongly agreed) to the last three months (54% agreed or strongly agreed). Although this was a slight increase, it showed improvements in coordination between other teams and work areas in Public Health's COVID-19 response. Similarly, there was an increase in the amount of people who indicated they knew who to contact if they had any issues as part of Public Health's COVID-19 response. It went from 64% agreeing in the first three months to 74% agreeing to some extent in the last three months.

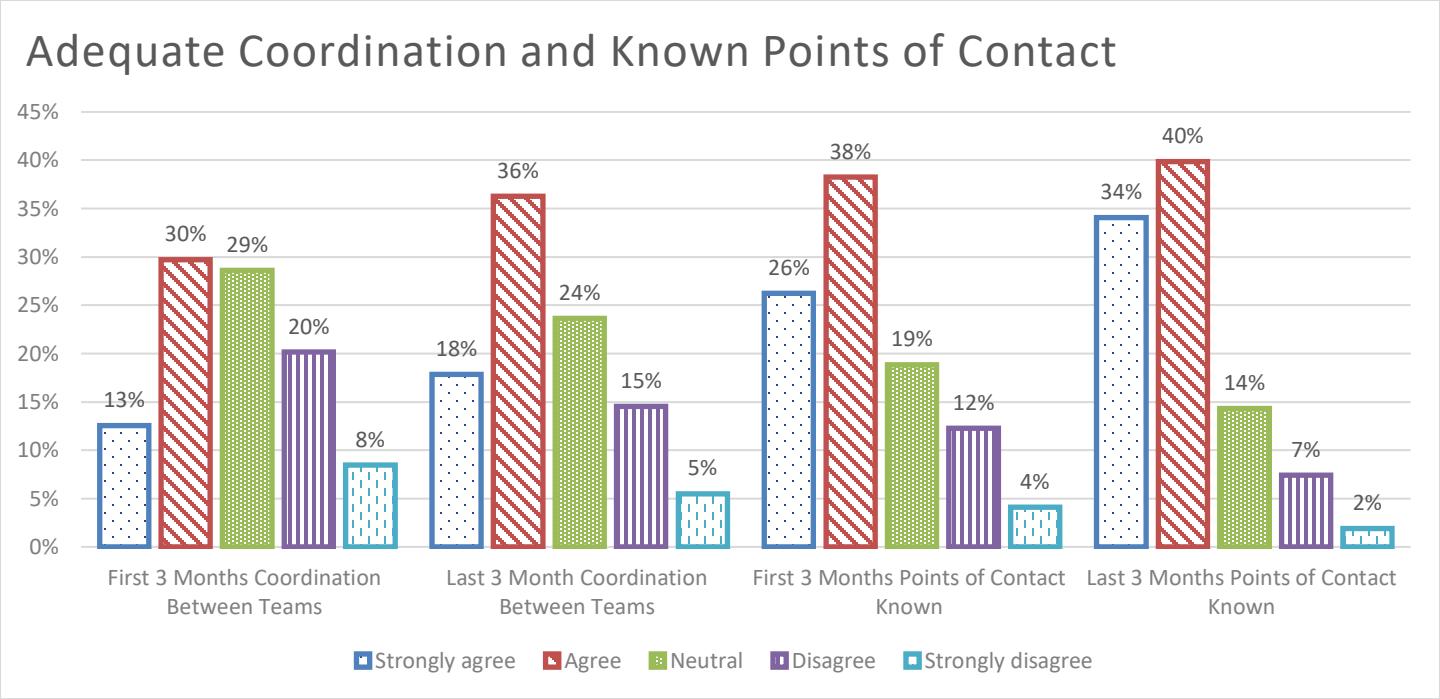

Chart 8: Adequate Coordination and Known Points of Contact

"The coordination between teams has greatly improved and I have been able to learn different resources and people to connect me to resources now."[405]

[405] PHSKC COVID-19 AAR Survey Respondent Question 6

KEY STRENGTHS (FROM SURVEY)

Respondents were asked to identify up to three key strengths of their teams and work areas in relation to the PHSKC response and recovery efforts from a list of options. Please note that since each respondent could choose up to three options totals will be more than 100%. Respondents overwhelmingly chose the organization's flexibility/adaptability and teamwork with approximately 65% of respondents choosing those two areas. Equity considerations and collaboration also scored highly with 36% and 35% respectively. These strengths were echoed in the comments provided by many as to the pride they felt in the overall PHSKC response to COVID-19 and its commitment to the communities they serve.[406]

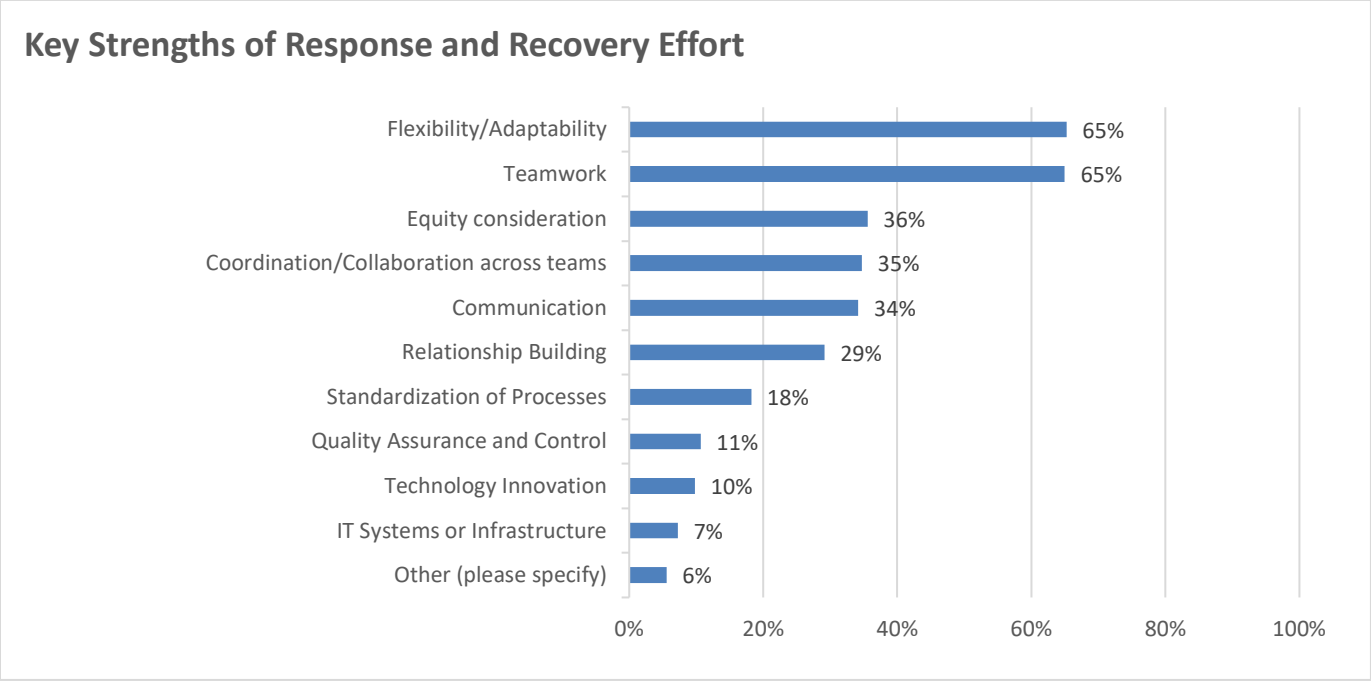

Chart 9: Key Strengths of Response and Recovery Effort

"This was truly an unprecedented experience and considering the circumstances, I felt public health did an amazing job. Despite many challenges and frustrating aspects, I was blown away by the brilliance and perseverance of my team members and others working on the response. It has been an honor supporting this work at public health."[407]

[406] PHSKC COVID-19 AAR Survey Respondent Question 13
[407] PHSKC COVID-19 AAR Survey Respondent Question 13

Respondents also offered through open-ended questions best practices, protocols, or systems that their team has in place to build long-term resilience and/or use in a future response. Regular communication with teams and trainings created during the pandemic were frequent topics. The following are some of the common types of best practices along with examples related to the types of information.

- Community Outreach and Coordination: Including community members; relationships that have been built; Community Mitigation and Recovery; Teamwork
- Equity: Equity Response Team's flowchart; language access team; care coordination team; community navigators
- PICC: Nurses in PICC; expand the PICC to cover general public health concerns; phone line provides public health information
- Resources: Expenditure back up repository; automating information retrieval
- Training: Cross training; standardizing training; training check lists; mentorship relationships
- Team and Self Care: Had grace with each other; leads were willing to help; daily opportunities to connect and relax as a team
- Work Schedule Flexibility: Flexible hours; Telecommuting

KEY CHALLENGES (FROM SURVEY)

Respondents were asked to identify up to three challenging areas that their teams endured in relation to the PHSKC response and recovery efforts from a list of options. Please note that since each respondent could choose up to three options totals will be more than 100%. The key areas noted were staff and team capacity (57%), hiring and onboarding (36%), and unclear processes (36%). Although team coordination and collaboration was a strength, it was also noted as an area for improvement as 29% of respondents chose this area as a challenge. Staffing and onboarding was mentioned numerous times in the open-ended comments as an area for improvement with an understanding that their HR department was hiring as quickly as possible.[408] Onboarding was an area that several survey respondents felt could have been more organized and was neglected in the effort to put time and attention into the response.[409]

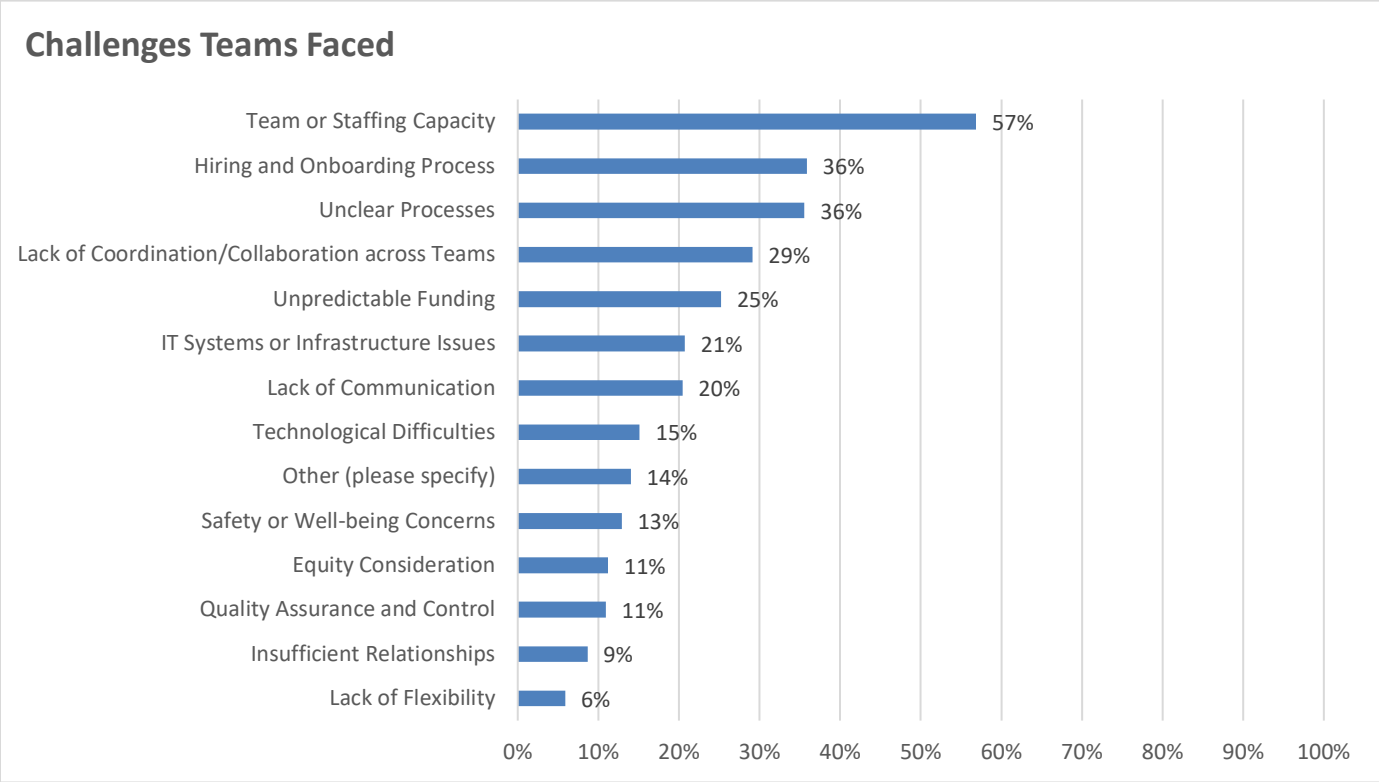

Chart 10: Challenges Teams Faced

[408] PHSKC COVID-19 AAR Survey Respondent Question 7
[409] PHSKC COVID-19 AAR Survey Respondent Question 7

RECOMMENDATIONS (FROM SURVEY)

Survey respondents were provided a space to provide their recommendations for future actions to address areas for improvement. Over 200 respondents offered their opinions. Answers were related to topics ranging from improving internal communication and collaboration, supporting staff onboarding, improving employee wellness, maintaining equity and fairness, and continuing partnerships with community organizations. Open ended suggestions included the following, organized by similar types of recommendations.

- Collaboration: Compensate trusted community partners; Keep talking to our community partners
- Communication: Clarify the infection control/prevention needs; put out information while acknowledging it's the "best we know for now"; consistent messaging
- Disaster Planning: Preparedness plans that proactively address equity; systemic review of response focused on equitable access and distribution of resources
- Equity: Clear processes; plan to reach the most marginalized populations with an abundance of resources
- HMAC and Incident Response: Clearly identify roles and responsibilities across sections; stable funding of key roles and improvements to the HMAC system
- Hiring Staff: Career service positions; streamlining the interview processes; adding emergency staff to the recall pool
- Staff Retention: Adding paid time off for those working on the response; financial compensation; flexible schedules; health insurance for all staff
- Training: Emergency response training in every employee's onboarding; Regular trainings to increase comfort; training on ICS

GRAPHICS AND INCIDENT STATISTICS

PHSKC COVID-19 DASHBOARD SUMMARY

As COVID-19 tracking data was collected for King County, it was stored and reported on the Dashboard. This summary report was displayed on the Public Health - Seattle & King County website (https://kingcounty.gov/depts/health/covid-19/data/summary-dashboard.aspx). The following screenshots provide cumulative case information, hospital admissions, inpatient rates, and vaccination rates as of May 27, 2022.[410]

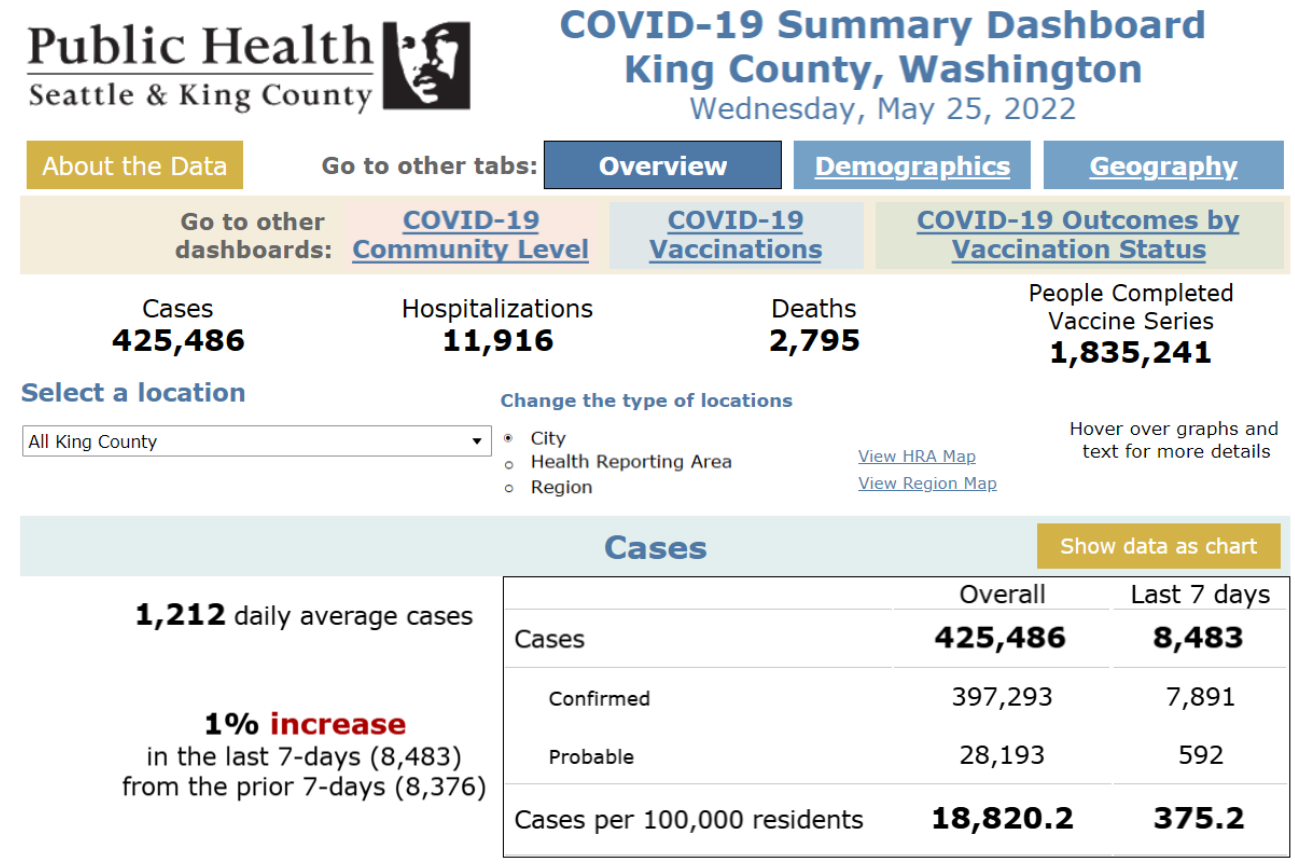

Image 7: King County COVID-19 Activity and Cases

[410] Public Health Seattle & King County. COVID-19 Summary Dashboard. Accessed May 27, 2022. https://kingcounty.gov/depts/health/covid-19/data/summary-dashboard.aspx

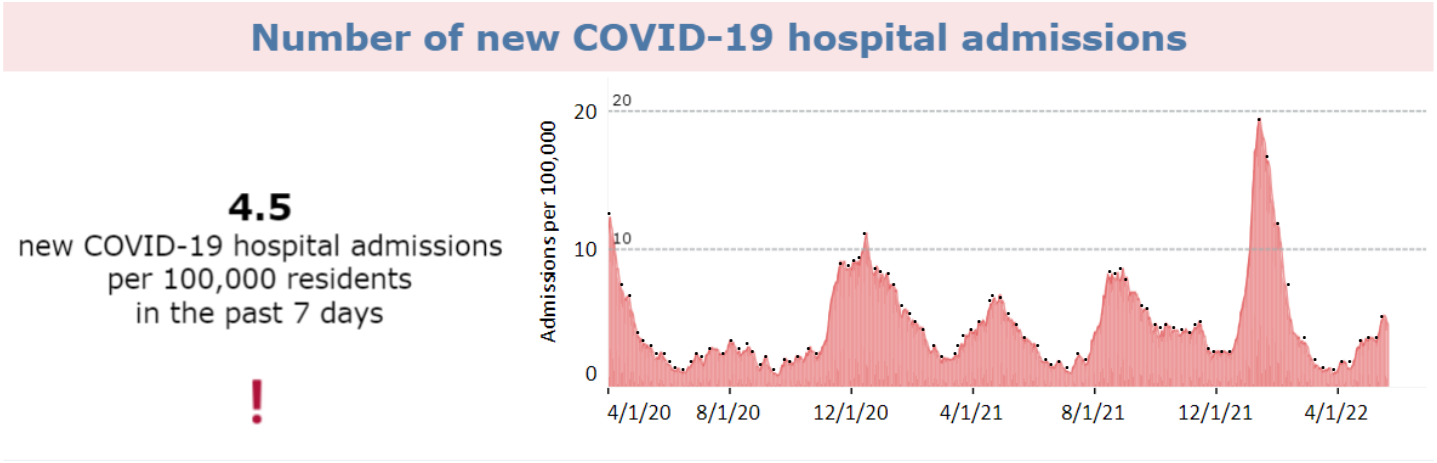

Image 9: Seattle & King County COVID-19 Hospitalization Rates

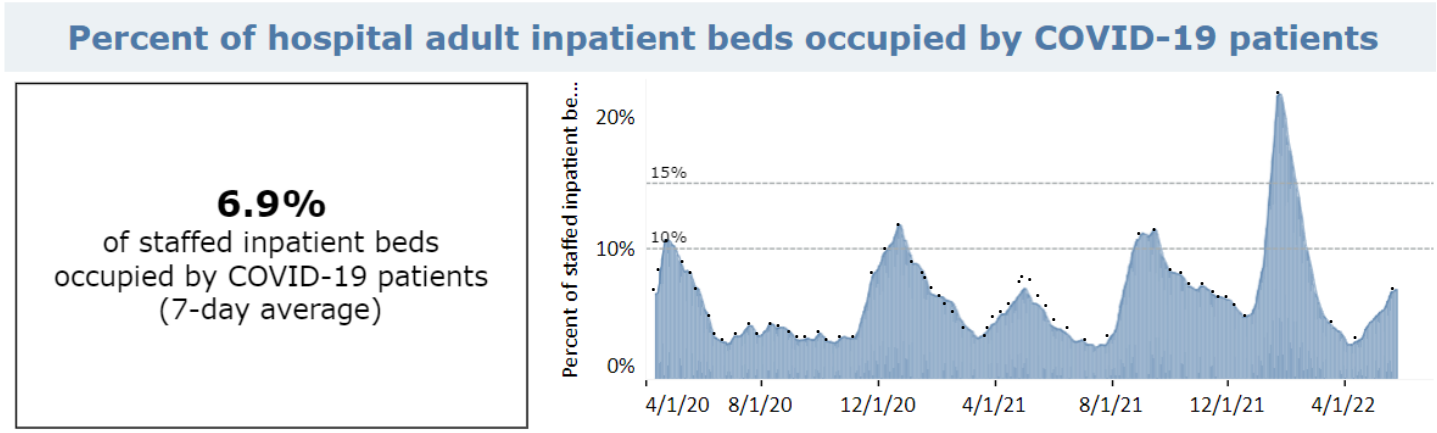

Image 8: Seattle & King County COVID-19 Inpatient bed Usage

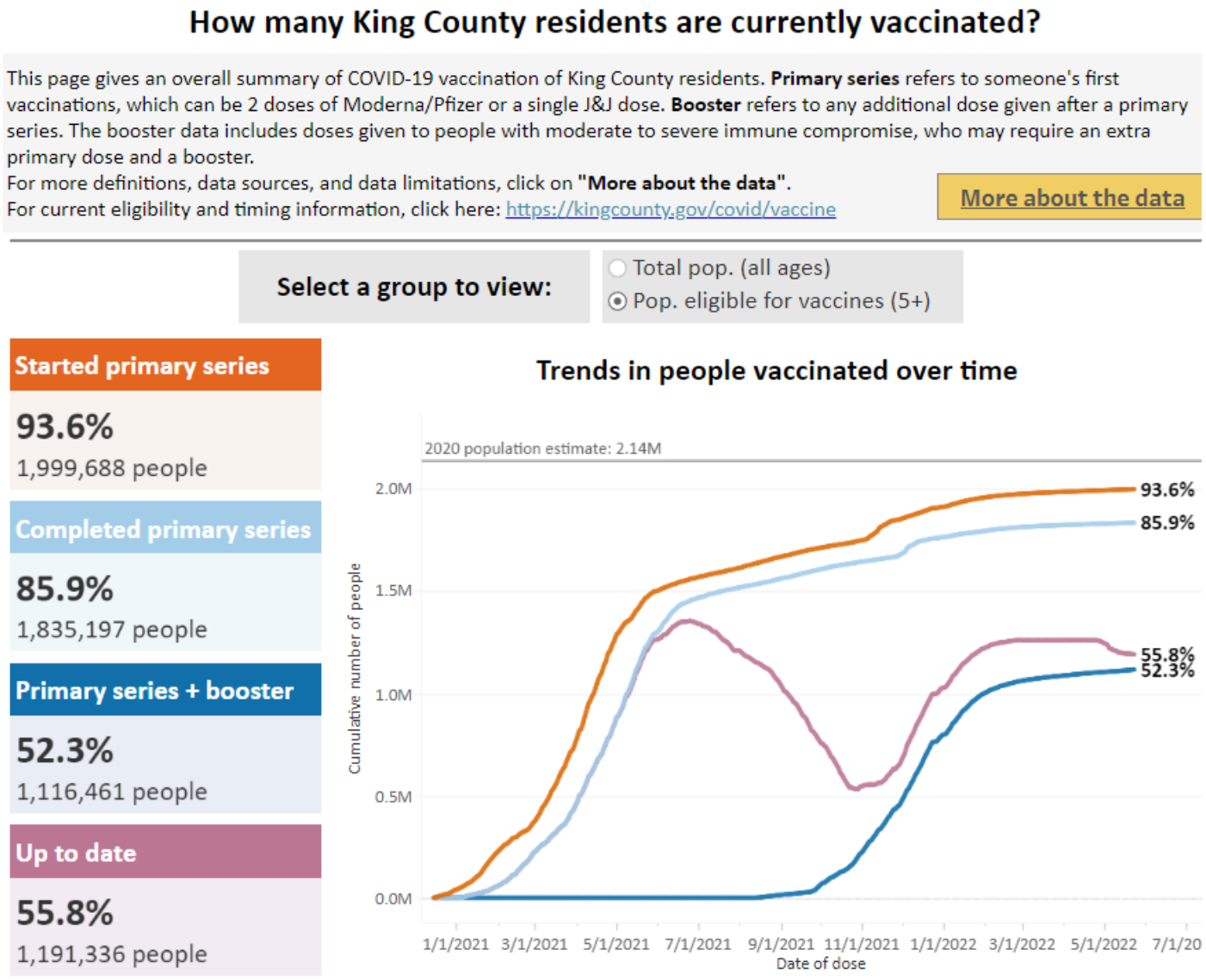

Image 10: Seattle & King County COVID-19 Vaccination Rates

NATIONAL COVID-19 PANDEMIC INCIDENT SUMMARY

Overview

In December 2019, health officials in Wuhan, a metropolitan city in the Hubei Province of the People's Republic of China, identified cases of an unknown viral pneumonia.[411] Symptoms manifested most commonly in the upper respiratory system and included fever, dry cough, and trouble breathing. As cases began to cluster, the World Health Organization (WHO) launched an investigation which confirmed the existence of a novel coronavirus now known as SARS-CoV-2. The virus causes a disease now known by the global community as COVID-19 (**Co**rona**vi**rus **D**isease – 20**19**). As China instituted public health measures to contain the virus, officials found evidence of communal spread in surrounding countries. On January 30, 2020, the WHO declared a Public Health Emergency of International Concern. Countries implemented travel restrictions, stay-at-home orders, and controlled screenings for the virus. By February 4, 2020, the U.S. would also declare a Public Health Emergency.[412] And, by March 11, 2020, the WHO would declare COVID-19 a pandemic; this would be preceded by the U.S. declaring COVID-19 a national emergency on March 13, 2020.

As of January 31, 2022, which is the considered the end of the operational period being recorded in this report, there were 394,108,167 confirmed cases of COVID-19 worldwide, with the highest numbers of confirmed cases in the United States, India, and Brazil.[413] COVID-19 presents several key challenges for responders across sectors, including an extended incubation period between infection and the development of symptoms, and asymptomatic carriers that may present no symptoms at all. The extended incubation period of the virus and lack of initial testing capability contributed to initial spread of the disease. By the fall of 2020, U.S. pharmaceutical companies and medical researchers were conducting clinical trials for potential COVID-19 vaccines. In December 2020, the U.S. Food and Drug Administration issued emergency use authorization for two COVID-19 vaccines (Pfizer-BioNTech and Moderna).[414]

Leaders in public health, public service, public safety, education, and other sectors continue to implement multidisciplinary approaches and ongoing collaborative strategies to address the virus. They often sacrifice their own health and safety to ensure the well-being of the public during the ongoing global pandemic.

[411] World Health Organization. *Timeline of WHO's Response to COVID-19.* Accessed July 30 2020. https://www.who.int/news-room/detail/29-06-2020-covidtimeline
[412] Federal Register. *Determination of Public Health Emergency*. Accessed June 15 2022. https://www.federalregister.gov/documents/2020/02/07/2020-02496/determination-of-public-health-emergency
[413] World Health Organization. *WHO Coronavirus (COVID-19) Dashboard.* Accessed June 15 2022. https://covid19.who.int/
[414] U.S. Food and Drug Administration. COVID-19 Vaccines. https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines

Initial Challenges in the United States

As of January 31, 2022, there were a total of 75,921,493 confirmed cases of COVID-19 in the United States. Of those cases, 900,931 deaths have occurred.[415] While at the time of writing (May 2022), transmission rates have decreased, the number of vaccinated and/or boosted adults continues to rise, and public health officials are generally beginning to consolidate COVID-19 response and recovery operations within steady-state operations to account for a new normal, there were many initial challenges when responding to COVID-19.

Initial challenges to responding to COVID-19 in the U.S. as a whole were synonymous with the initial challenges to responding to COVID-19 in Washington and PHSKC. As indicated in the State and Local Overview section of the report, the first U.S. COVID-19 case was confirmed in Washington on January 21, 2020 and the outbreak in the Life Care LTCF marked what was one of the first possible instances of U.S. community spread on February 28, 2020.[416]

Physical distancing was identified as one of the most effective tools to reduce the spread of COVID-19. Without public health interventions, the virus can spread easily and sustainably between people. Research points to the virus spreading primarily through respiratory droplets when an infected person coughs, sneezes, or talks. These droplets can reach up to 6 feet and aerosolized viral particles can remain suspended in the air for long periods of time, spreading the infection. People may also be infected with the virus but may not display any symptoms. These "asymptomatic carriers," without knowing they have the disease, may spread COVID-19 when in close contact with other people. [417] The White House initially introduced an effort to stop the spread in 15 days through a nationwide recommendation to implement social distancing.[418]

The nationwide recommendation of social distancing was not equivalent to mandatory public lockdowns or curfews, however. As such, many states, including Washington, as well as local jurisdictions implemented stricter stay-at-home orders focused on educating the public on physical distancing to reduce both the overall number of infections and the number of cases occurring at once. This concept, known as "flattening the epidemic curve," helped prevent hospitals from becoming overwhelmed.

Hospitals and healthcare facilities continue to serve on the frontlines of this global pandemic. Their employees work tirelessly during this unprecedented public health crisis to serve their communities, all while potentially exposing themselves to an invisible enemy. Their only protection against exposure is access to a supply of PPE, which includes face masks, face shields, medical gowns, and other protective gear. The increased demand for resources including PPE, ventilators, antiseptics, and cleaning supplies, by the healthcare system, first responders, and the general public, caused a worldwide shortage of supplies during initial response to COVID-19. This impact was especially felt in the United States. The PPE supplies in the Strategic National Stockpile

[415] World Health Organization. *WHO Coronavirus (COVID-19) Dashboard.* Accessed June 15 2022. https://covid19.who.int/
[416] Centers for Disease Control. *CDC Announces Additional COVID-19 Presumptive Positive Cases*. Accessed June 15 2022. https://www.cdc.gov/media/releases/2020/s0228-additional-COVID-19-cases.html
[417] Centers for Disease Control. *How to Protect Yourself and Others.* Accessed August 7 2021. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention-H.pdf
[418] White House. *15 Days to Slow the Spread*. Accessed June 15 2022. https://trumpwhitehouse.archives.gov/articles/15-days-slow-spread/

were approximately 90% depleted by April 2020, after distributing equipment to state and local governments.[419] The United States experienced a shortage of ventilators in hospitals hardest hit by the disease in the early months of response. FEMA led the federal response for PPE requests, distributing N95 respirators, surgical masks, face shields, surgical gowns, and gloves to 53 states and territories. Additionally, the President of the United States used the Defense Production Act to boost the acquisition of N95 masks and the production of ventilators. Companies such as Ford Motor Company and General Motors also pivoted from their regular activities to manufacture critically needed resources including face shields and ventilators.[420]

State and local health departments also expanded efforts to increase contact tracing of COVID-19 cases. Contract tracing, a public health strategy to identify and isolate people exposed to an infection, is used to contain the spread of infectious disease. Internationally, countries such as China and South Korea were among the first to be impacted by the virus and benefitted from ramping up contact tracing efforts to contain its spread. In the United States, state governments dedicated significant amounts of staff and resources toward expanding contact tracing efforts, including partnerships with university centers and local health departments.

The United States also experienced challenges when expanding testing for COVID-19. The initial test the CDC provided to state and local health departments did not work correctly, forcing the CDC to send out new tests. State governors across the country reported a shortage of availability for COVID-19 test kits and the reagents needed for those kits to work. Through May of 2020, demand for COVID-19 tests would still far outpace the supply due to shortages of reagents, swabs, and various collection devices impacting test manufacturers and the U.S. getting a 'slow start' to COVID-19 testing due to only diagnostic test makers being initially allowed to develop COVID-19 tests (a policy that would later expand).[421] This lapse in testing early on in the pandemic enabled exponential growth of cases.

Many states experienced a resurgence of COVID-19 cases in the early summer months of 2020. While some states were able to make significant progress to bring down their case numbers from the summer surge, others continued to see high numbers of daily new cases into the fall of 2020. This presented an ongoing dilemma for economic relief initiatives. Public leaders were tasked with finding balance between economic recovery efforts and the social distancing strategies that reduce the risk of increasing COVID-19 spread. As the fall of 2020 continued, public health officials braced for the arrival of the COVID-19 vaccine, which would mark a pivotal shift in COVID-19 response and recovery activities.

Continued Response in the United States - Vaccination

Prior to the outbreak of the global pandemic, there was already ongoing research conducted on other coronaviruses, which allowed scientists all over the world to work together and develop a vaccine within the

[419] Department of Health and Human Services. Public Health Emergency. Accessed August 5, 2020. https://www.phe.gov/emergency/events/COVID19/SNS/Pages/FAQ.aspx#sns-depleted

[420] Ford Motor Company. Personal Protection Equipment Product Information. http://corporate.ford.com/social-impact/coronavirus/ppe.html

General Motors. General Motors Commitment. https://www.gm.com/our-stories/commitment/face-masks-covid-production.html

[421] Modern Healthcare. *COVID-19 Testing Problems Started Early, U.S. Still Playing from Behind*. Accessed June 15, 2022. https://www.modernhealthcare.com/technology/covid-19-testing-problems-started-early-us-still-playing-behind

span of a year.[422] To reach the point at which vaccinations could be safely distributed in the U.S., the vaccines needed to undergo three phases of clinical trials that followed rigorous guidelines set by the Food and Drug Administration (FDA). The vaccine studies were rapidly completed due to many individuals volunteering to participate as well as the partnerships between Operation Warp Speed (OWS) and other organizations, such as the CDC.

One of the most significant cornerstones in the United States' response to COVID-19 was the development, authorization, and deployment of COVID-19 vaccines. The clinical trial data released in November of 2020 showed that Pfizer's and Moderna's COVID-19 vaccines were 95% and 94.5% effective at preventing COVID-19 disease, respectively.[423] Following the release of the clinical trial data in November of 2020, the Advisory Committee on Immunization Practices (ACIP) issued interim recommendations in early December to federal, state, and local jurisdictions advising them that demand would exceed COVID-19 vaccine supply during the initial vaccination rollout, and therefore healthcare personnel and residents of long-term care facilities should be offered the vaccine in the initial Phase 1a of vaccination.[424] While not binding, most states generally followed this guidance for the recommendations that they provided relating to Phase 1a of vaccination.

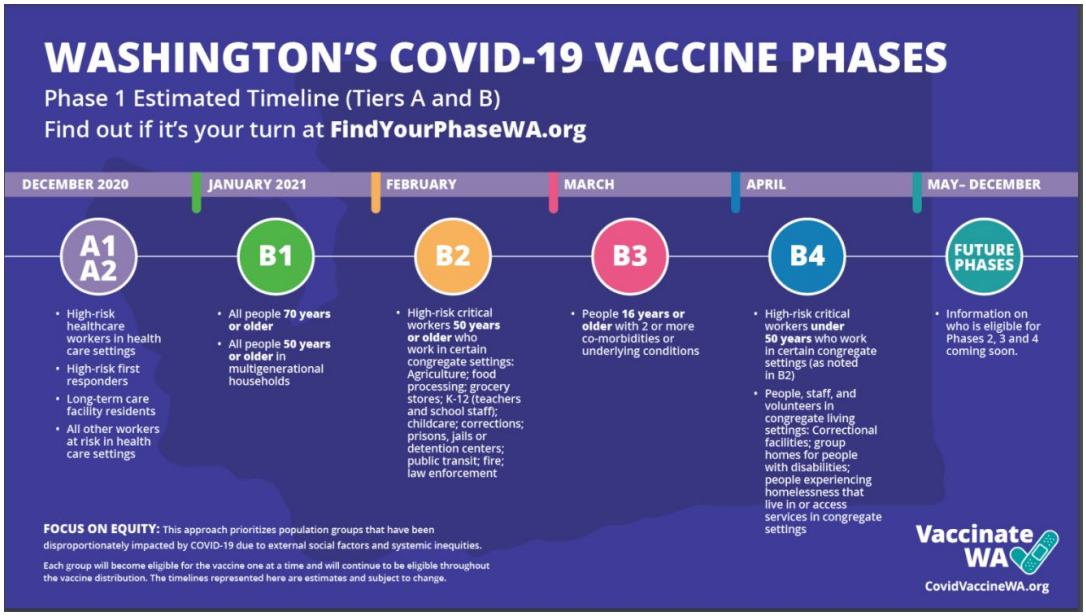

Image 11: Washington's COVID-19 Phases (https://doh.wa.gov/sites/default/files/legacy/Documents/1600/coronavirus//VaccinationPhasesInfographic.pdf)

[422] Medical News Today. *How did we develop a COVID-19 vaccine so quickly?*. Accessed June 17, 2021. https://www.medicalnewstoday.com/articles/how-did-we-develop-a-covid-19-vaccine-so-quickly
[423] Pfizer, *Pfizer and BioNTech Conclude Phase 3 Study of COVID-19 Vaccine Candidate, Meeting All Primary Efficacy Endpoints*. https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-conclude-phase-3-study-covid-19-vaccine.
[424] Moderna, *Moderna's COVID-19 Vaccine Candidate Meets its Primary Efficacy Endpoint in the First Interim Analysis of the Phase 3 Cove Study*. https://investors.modernatx.com/news/news-details/2020/Modernas-COVID-19-Vaccine-Candidate-Meets-its-Primary-Efficacy-Endpoint-in-the-First-Interim-Analysis-of-the-Phase-3-COVE-Study-11-16-2020/default.aspx./.

The FDA issued an Emergency Use Authorization (EUA) for the Pfizer vaccine on December 11, 2020, the Moderna vaccine on December 18, 2020, and the Janssen vaccine on February 27, 2021.[425] By December 14, 2020, shortly after Pfizer's EUA, the first American outside of a clinical trial had received a COVID-19 vaccine.[426] Subsequently, on December 22, 2020,[427] additional phases of vaccination outlined by the ACIP including Phase 1b for frontline essential workers and individuals 75 years or older, and Phase 1c for individuals 65 to 74 years or older or those 16 to 64 years with high-risk conditions, and essential workers not in Phase 1b. States and counties across the country, however, took different approaches to vaccination based on the vaccination plans that they had developed.

Extensive challenges managing the vaccination tiers and the associated distribution of the vaccine emerged in Washington and throughout the country. As demand for the vaccine exceeded supply well into the spring of 2021 and guidance from both federal and state authorities was constantly changing, county health officials had to rapidly pivot and decide whether to adopt new recommendations or pursue their original vaccination plans. Subsequently, the public expressed frustration as not only were they also impacted by the changing guidance relating to vaccination tiers, but they also faced challenges registering for vaccines and getting appointments.[428] Washington specifically took a measured approach to expanding vaccine eligibility as the state sought to ensure that risk and equity remained at the forefront of its rollout and leaders publicly disagreed on the balance between equitable distribution and expanding eligibility.[429]

Amidst continued struggles with vaccination, individuals across the country continued to be infected with COVID-19. Though both daily case counts and hospitalizations generally declined from February 2021 to mid-July of 2021, health officials continued to balance testing operations, contact tracing, updating guidance relating to isolation, quarantine, and masking, communicating with healthcare facilities, schools, community-based organizations, and other partners, and vaccination. Vaccination efforts included both the actual act of coordinating and administering vaccinations as well as developing public messaging to communicate the importance of being vaccinated against COVID-19. Developing communications strategies and addressing access and hesitancy barriers to vaccination became a larger challenge once supply of the vaccine exceeded the demand for it in late April and early May of 2021. The EUA of the Pfizer vaccine that allowed it to be

[425] Food and Drug Administration, *FDA Takes Key Action in Fight Against COVID-19 By Issuing Emergency Use Authorization for First COVID-19 Vaccine*. https://www.fda.gov/news-events/press-announcements/fda-takes-key-action-fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19.
[426] The Washington Post, *First Coronavirus Vaccine Shots Given Outside Trial in U.S.* https://www.washingtonpost.com/nation/2020/12/14/first-covid-vaccines-new-york/.
[427] Centers for Disease Control and Prevention, *The Advisory Committee on Immunization Practices' Updated Interim Recommendation for Allocation of COVID-19 Vaccine – United States 2020.* https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm.
[428] AARP, *How to Navigate the Confusing COVID-19 Vaccine Rollout*. https://www.aarp.org/health/conditions-treatments/info-2021/vaccine-distribution.html
[429] Seattle Times. *Why Washington's Rollout of COVID-19 Vaccine Eligibility Has Been Slower Than in Some Other States*. https://www.seattletimes.com/seattle-news/health/why-washingtons-rollout-of-covid-vaccine-eligibility-has-been-slower-than-other-states/

administered for adolescents who are between 12 and 15 years old on May 10, 2021 did provide an additional boost and demand, and also contributed to rising vaccination rates across the United States.[430]

Though the development of vaccines and declining case counts, hospitalizations, and fatalities gave hope to a "return to normal," the Delta variant was declared a variant of concern by the CDC on June 16, 2021.[431] By August 3, 2021, it was estimated to account for approximately 93% of cases in the United States during the last two weeks of July.[432] The Delta variant brought challenges to healthcare and public health officials across the United States as it is highly transmissible and led to an overwhelming increase in hospitalizations in many states, particularly those with a high percentage of unvaccinated individuals. In response, the CDC updated its masking guidance, including for fully vaccinated individuals, on July 27, 2021 as breakthrough infections were emerging.[433] And though data at the time suggested that two doses of the COVID-19 vaccines were generally effective in preventing the Delta variant, the CDC authorized an additional COVID-19 vaccine dose for immunocompromised individuals on August 12, 2021.[434] As a result of expanding eligibility and studies finding a declining efficacy in vaccinations six months post-second dose, there continued to be changes to vaccination guidance with booster shots for those 65 years and older or those 18 years and older who have underlying medical conditions or are frontline workers then being authorized on October 21, 2021.[435]

The FDA also authorized the Pfizer vaccine for children between 5 and 11 years old on October 29, 2021 and later expanded booster eligibility to all individuals 18 years and older on in November 2021.[436] Additionally, in November 2021, pediatric COVID-19 vaccines, specifically the Pfizer vaccine, were recommended for children ages 5 to 11 years old. An increase in COVID-19 cases during the fourth wave of infection in the United States was fueled by the Delta variant and generally peaked in mid-September of 2021.

After declining daily COVID-19 case counts following the Delta variant's peak, public health officials would then be impacted by its greatest challenge yet, the Omicron variant. The Omicron variant, which was designated as a variant of concern by the World Health Organization (WHO) on November 26, 2021, brought unprecedented case numbers, hospitalizations, and deaths across the United States, particularly between December and February 2022. The Omicron variant multiplies around 70 times faster than the Delta variant

[430] Food and Drug Administration, *FDA Authorizes Pfizer-BioNTech COVID-19 Vaccine for Emergency Use in Adolescents in Another Important Action in Fight Against Pandemic*, https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-pfizer-biontech-covid-19-vaccine-emergency-use.
[431] WebMD, *Delta Variant from India a "Variant of Concern."* https://www.webmd.com/lung/news/20210616/delta-variant-of-concern
[432] Centers for Disease Control and Prevention, *COVID-19 Data Tracker*. https://covid.cdc.gov/covid-data-tracker/#variant-proportions
[433] CNN, *CDC Changes Mask Guidance in Response to Threat of Delta Variant of COVID-19*. https://www.cnn.com/2021/07/27/politics/cdc-mask-guidance/index.html.
[434] Food and Drug Administration, *FDA Authorizes Additional Doses for Certain Immunocompromised Individuals*. https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-additional-vaccine-dose-certain-immunocompromised.
[435] Centers for Disease Control, *CDC Expands Eligibility for COVID-19 Booster Shots*. https://www.cdc.gov/media/releases/2021/p1021-covid-booster.html.
[436] Food and Drug Administration, *FDA Authorizes Pfizer-BioNTech COVID-19 Vaccine for Emergency Use in Children 5 Through 11 Years of Age*. https://www.fda.gov/news-events/press-announcements/fda-authorizes-pfizer-biontech-covid-19-vaccine-emergency-use-children-5-through-11-years-age.

but has been found to be less severe in terms of symptoms. A peak of 807,897 new daily COVID-19 cases in the U.S. was recorded on January 22, 2022. The emergence of the Omicron variant caused public health officials to encounter many of the challenges they experienced during initial COVID-19 response in early 2020 as well as some experienced during the Delta variant, including COVID-19 testing demand that exceeded supply and an influx of hospitalizations. These challenges were only exacerbated by an exhausted public health workforce as well as a public that was resistant to ongoing restrictions. At time of writing (May 2022), the 7-day moving average of daily new cases was 84,778 and nearly 100% of the lineages of cases continue to be Omicron or its sub lineages (B.1.1.529, BA.1, BA.2, BA.3, BA.4, and BA.5), though new daily COVID-19 case counts have stabilized at a level far lower than the peak in mid-January.

Inequity in the Context of national COVID-19 response

The COVID-19 pandemic spotlighted and exacerbated health inequities that were already present in the U.S. As described throughout the report, PHSKC, its partners, and the broader State of Washington took steps to mitigate the impacts of COVID-19 on individuals and communities disproportionately impacted by COVID-19, as attributable to structural racism and social and economic vulnerabilities, to varying levels of success. On a broader scale, however, the COVID-19 response as well as COVID-19 outcomes paint a harsh picture of how health inequity contributed to significant racial and ethnic disparities in COVID-19 cases, hospitalizations, and deaths across the U.S.

Though this report covers an operational period ending January 31, 2022, data available at time of writing (June 2022) from the CDC[437] emphasizes stark differences between risks of COVID-19 infection, hospitalization, and death by race/ethnicity in the U.S. These trends have been evident since public health officials have been able to classify COVID-19 surveillance, hospitalization, and mortality data on race and ethnicity in spring 2020. Particularly, the American Indian or Alaska Native, Black, and Hispanic communities in the U.S. have experienced a disproportionate burden of COVID-19 cases, hospitalizations, and deaths as compared to White and Asian people. Data outlined in the table below has been adjusted for age to account for age distribution differing by racial or ethnic group.

[437] CDC. *Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity*. Access June 15, 2022. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

Table 8: COVID-19 Rate Ratios by Ethnicity

COVID-19 Rate Ratios Compared to People who are White, Non-Hispanic	American Indian or Alaska Native	Asian	Black	Hispanic
Cases	1.6X	0.7X	1.1X	1.5X
Hospitalization	3.0X	0.8X	2.3X	2.2X
Death	2.1X	0.8X	1.7X	1.8X

While these numbers show quantifiable outcomes in terms of cases, hospitalization, and death across racial and ethnic groups, public health officials across the U.S. have identified both quantitative and qualitative factors that have contributed to this disparity. Social determinants of health and the impacts on these due to historical and institutionalized discrimination have all contributed to people of color being disproportionately impacted by COVID-19. For instance:

- Chronic Medical Conditions: Factors contributing to inadequate access to or unequal medical care for racial and ethnic minorities can be linked to these populations facing higher numbers of chronic medical comorbidities[438] which have been associated with poorer outcomes among those infected with COVID-19.

- Workplace factors: Racial and ethnic minorities disproportionately work in settings that are considered essential, such as factories, grocery stores, public transportation, and healthcare facilities. Particularly during initial COVID-19 response, this contributed to disproportions in exposure to the public as an 'essential worker.' For example, 16,233 workers in meat and poultry processing in the U.S. were infected with COVID-19 from April to May 2020, and 87% of the infected workers were racial and ethnic minorities.[439]

- Location and Residence: Racial and ethnic minorities have been found to be more likely to live in multi-generational homes[440] as well as in crowded cities.[441] Facing more crowded living conditions impacts COVID-19 prevention strategies such as isolation and quarantine and increases the chance of exposure particularly when living with an essential worker or frequently utilizing public transportation.

[438] American College of Cardiology. *Racial Disparities in Hypertension Prevalence and Management: A Crisis Control*? Accessed June 16, 2022. https://www.acc.org/latest-in-cardiology/articles/2020/04/06/08/53/racial-disparities-in-hypertension-prevalence-and-management
[439] CDC. *Increased Risk Factors for Exposure*. Accessed June 15, 2022. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/increased-risk-exposure.html
[440] Pew Research. *A Record of 64 Million Americans Live in Multigenerational Households*. Accessed June 16, 2022. https://www.pewresearch.org/fact-tank/2018/04/05/a-record-64-million-americans-live-in-multigenerational-households/.
[441] Brookings. *2020 Census: Big Cities Grew and Became More Diverse*. Accessed June 16, 2022. https://www.brookings.edu/research/2020-census-big-cities-grew-and-became-more-diverse-especially-among-their-youth/.

- Incarceration: People living in incarceration experienced higher likelihoods of being exposed to COVID-19, lack of access to testing, vaccinations, and healthcare. Congregate living spaces and lack of quality care contributed to higher COVID-19 case rates and outbreaks of disease.

- Access to healthcare: Despite some progress being made from previous years, a February 2022 report by HHS demonstrates that disparities in the unsured rate and the affordability of healthcare between Black and White Americans persists.[442] A June 2020 report also showed higher unemployment rates for Black and Latino individuals than White and Asian individuals, a troubling trend considering that approximately half of the U.S. population receives employment-based health insurance .[443] The combination of these factors contributed to a scenario where racial and ethnic minority populations were more likely to initiate care later in the course of COVID-19 illness, correlating with poorer outcomes.[444]

- Barriers to Testing: In some of the largest segregated cities in the U.S. such as Chicago, New York City, Houston, and Los Angeles, neighborhoods that house a greater percentage of racial and ethnic minorities were found to have fewer COVID-19 testing sites.[445]

- Distrust of Healthcare Systems and Government: There is a long history of racism and mistreatment by medical professionals toward minorities that has manifested in both known instances such as the Tuskegee Syphilis Study[446] as well sentiment through polls that suggest inequitable health care treatment from health care providers.[447] This distrust initially fueled vaccine hesitancy[448] but disparities between vaccination rates or Black, Hispanic, and White people have since narrowed.[449]

The pandemic also spotlighted and exacerbated social and economic inequities that were already present in the U.S. A report from the Poor People's Campaign showed that people residing in poorer counties died from COVID-19 at a rate twice that of people living in richer counties, and that during the deadliest phases of the

[442] HHS. *New HHS Report Highlights 40 Percent Decline in Uninsured Rate Among Black Americans Since Implementation of the Affordable Care Act*. Accessed June 15, 2022. https://www.hhs.gov/about/news/2022/02/23/new-hhs-report-highlights-40-percent-decline-in-uninsured-rate-among-black-americans-since-implementation-affordable-care-act.html
[443] National Academy of Social Insurance. *The Impact of the COVID-19 Pandemic on Access to Health Care.* Accessed June 16, 2022. https://www.nasi.org/research/medicare-health-policy/the-impact-of-the-covid-19-pandemic-on-access-to-health-care/
[444] Jama Network. *Racial and Ethnic Health Disparities Related to COVID-19*. Accessed June 16, 2022. https://jamanetwork.com/journals/jama/fullarticle/2775687
[445] American Journal of Public Health. *Racial/Ethnic Segregation and Access to COVID-19 Testing: Spatial Distribution of COVID-19 Testing Sites in the Four Largest Segregated Cities in the United States.* Accessed June 16, 2022. https://ajph.aphapublications.org/doi/10.2105/AJPH.2021.306558
[446] CDC. *The Tuskegee Timeline*. Accessed June 16, 2022. https://www.cdc.gov/tuskegee/timeline.htm
[447] Andscape. *New Poll Shows Black Americans Put Far Less Trust in Doctors and Hospitals Than White People*. Accessed June 16, 2022. https://andscape.com/features/new-poll-shows-black-americans-put-far-less-trust-in-doctors-and-hospitals-than-white-people/
[448] Stanford Medicine. *How Misinformation, Medical Mistrust Fuel Vaccine Hesitancy*. Accessed June 16, 2020. https://med.stanford.edu/news/all-news/2021/09/infodemic-covid-19.html
[449] KFF. *Latest Data on COVID-19 Vaccinations By Race/Ethnicity*. Accessed June 16, 2022. https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-by-race-ethnicity/

pandemic, this disparity in death rate widened even more.450 Speaking to the intersectionality between racial identify and class, the report acknowledges that "if poverty were experienced equally by each racial group, it would be expected that poorest counties [that experienced disparities in COVID-19 death rates compared to wealthier counties] would be made up of approximately 10% of each racial group. However, these poorest counties are home to nearly 27% of all Indigenous people in the US, and 15% of all Black people, 13% of all Hispanic people, 9% of all white people, and 2% of all Asian people."

Another community disproportionately impacted by COVID-19 includes people with disabilities. Some challenges that people with disabilities have faced include lack of access to food deliveries, COVID-19 testing, and the internet, lack of accessible messaging (i.e., guidance in American Sign Language), postponement and cancellation of medical treatment and rehabilitation, unsafe conditions in health facilities and congregate living, closures of in-person learning limiting access to learning, etc.[451] Results of such challenges include but are not limited to adults with physical disabilities being overrepresented in terms of COVID-19-related hospitalizations, adults with existing mental health disorders experiencing substantial pandemic-related changes in eating and sleeping, loss of community mobility and participation for adults with autism spectrum disorder, and individuals who are deaf, hard of hearing, or Deaf-blind experiencing communications barriers, particularly if working remotely.[452] The impacts of COVID-19 on people with disabilities cannot be underscored, and the Biden Administration announced steps being undertaken to address the needs of individuals with disabilities in the face of COVID-19 impacts in February 2022. [453]

It is undeniable that the COVID-19 pandemic has highlighted health inequities across the U.S., amongst different racial and ethnic minorities, income levels, and abilities. And while the outcomes described above serve as a display of how these inequities can glaringly manifest in the context of a global pandemic, they have forced policy makers, health care officials, and public health officials across the U.S. to confront what have been longstanding disparities that are ultimately rooted in racism and discrimination. As such, we acknowledge a few steps that have been taken on a nationwide basis in an attempt to address health disparities:

- In April 2021, CDC recognized racism as a threat to the public's health and "noted it would lead in efforts to confront systems and policies that have resulted in the generational injustice that has given rise to racial and ethnic health inequities.[454]

[450]A Poor People's Campaign. *A Poor People's Pandemic Report: Mapping the Intersections of Poverty, Race, and COVID-19*. Accessed June 16, 2022. https://www.poorpeoplescampaign.org/wp-content/uploads/2022/04/ExecutiveSummary_7.pdf
[451] The Lancet. *Triple Jeopardy: Disabled People and the COVID-19 Pandemic*. Accessed June 16, 2022. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00625-5/fulltext
[452] Administration for Community Living. *COVID-19 Response.* Accessed June 16, 2022. https://acl.gov/sites/default/files/COVID19/ACL_Research_ImpactC19-PWD.pdf
[453] The White House. *Administration Announces New Actions to Address the Needs of People with Disabilities and Older Adults in Response to and Recovery from COVID-19.* Accessed June 16, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/24/fact-sheet-administration-announces-new-actions-to-address-the-needs-of-people-with-disabilities-and-older-adults-in-response-to-and-recovery-from-covid-19/
[454] KFF. *Disparities in Health and Health Care: 5 Key Questions and Answers*. Accessed May 11, 2021. https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

- In March 2021, the National Institute of Health (NIH) launched an effort called UNITE in order to address structural racism in biomedical research.[455]
- An Executive Order was issued in January 2021 to convene a COVID-19 Health Equity Task Force within HHS. [456]
- The American Rescue Plan Act reserved $10 billion in funds to trickle down to SLTT public health departments for the establishment of community vaccination centers and mobile vaccination units for populations hardest-hit and highest-risk for COVID-19.[457] This included investing in Community Health Centers specifically to expand COVID-19 testing, vaccination, and treatment access.

In addition to actions taken at the federal level, some state, local, tribal, and territorial public health programs have found success working in partnerships with community-based organizations, private organizations, and health care providers to address inequities that have manifested during COVID-19 response and recovery. Actions taken have included steps such as using CARES Act funds to provide transportation, home-delivered food, medications, COVID-19 supplies, and financial relief, training community health workers, launching campaigns to address inequities through culturally appropriate exposure notifications and increased testing capacity, engaging historically marginalized communities in building vaccination plans, convening task forces on equity to support ongoing COVID-19 response, and more.[458] With equity not bearing a significant public role in federal COVID-19 response until January 2021, multiple state and local agencies can be applauded for developing innovative policies to address emerging needs and trends.

In sum, COVID-19 brings substantial lessons learned for health policy makers at multiple levels of government on how social determinants of health can profoundly contribute to inequities in infectious disease-related morbidity and mortality.

[455] NIH. *Ending Structural Racism*. Accessed June 16, 2022. https://www.nih.gov/ending-structural-racism/unite
[456] The White House. *Executive Order on Ensuring an Equitable Pandemic Response and Recovery*. Accessed June 16, 2022. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-ensuring-an-equitable-pandemic-response-and-recovery/
[457] KFF. *What's In the American Rescue Plan for COVID-19 Vaccine and Other Public Health Efforts*. Accessed June 16, 2022. https://www.kff.org/policy-watch/whats-in-the-american-rescue-plan-for-covid-19-vaccine-and-other-public-health-efforts/
[458] Health Affairs. *Pandemic-Driven Health Policies To Address Social Needs and Health Equity.* Accessed June 16, 2022. https://www.healthaffairs.org/do/10.1377/hpb20220210.360906/

LOCAL AND STATE TIMELINE

Table 9: Local and State Timeline

JURISDICTIONAL LEVEL	DATE	MILESTONES
International and Federal	Dec. 2019 – Jan. 2020	CDC issues an official Health Advisory to state and local health departments and providers regarding international 'viral pneumonia' with first cases noted in Wuhan, People's Republic of China. First epidemiological alert issued on novel coronavirus with recommendations covering international travelers, infection prevention and control measures and laboratory testing.
Federal	1/21/20	CDC confirms first US COVID-19 case in the state of Washington.
Local	1/21/20	PHSKC activates the HMAC at Level 2 - Enhanced Operations (Partial HMAC Activation).
State	1/22/20	The State of Washington activates its SEOC.
Local	1/24/20	PHSKC elevates its HMAC to Level 1 - Full HMAC Activation.
Local	1/31/20	CDC funnels flights from China to select US airports including SeaTac and for enhanced screening of traveler's potential quarantine by local public health jurisdictions including PHSKC
State	1/26/20	CDC has the only lab in the country that can test samples and is overwhelmed. WA State PH lab develops capability and begins testing COVID-19 samples
Local	2/7/20	PHSKC launches new resources to help address stigma and discrimination that can be exacerbated during global outbreaks.
Local	2/27/20	First positive case of COVID-19 recorded in King County
Local	2/28/20	First COVID-19 case identified at Lifecare, Long Term Care Facility
Local	2/29/20	King County Emergency Operations Center (EOC) activated at Enhanced Level
State	2/29/20	Washington State declares COVID-19 State of Emergency.

JURISDICTIONAL LEVEL	DATE	MILESTONES
		Governor Inslee directs all state agencies to use resources necessary to prepare and respond to the crisis
Local	3/1/20	Proclamation of Emergency is signed in King County, enabling "extraordinary measures" to fight the COVID-19 outbreak including waiving procurement protocols, authorizing overtime for employees, and purchasing an area motel to isolate and quarantine patients.
Local	3/3/20	King County opens Novel Coronavirus Call Center, activated and staffed by PHSKC
Local	3/4/20	Large employers in area (Microsoft and Amazon) mandate telecommuting
Local	3/9/20	All area colleges move to online courses through September 2021
Local	3/11/20	State and Local Health Officer limits large gatherings to less than 250
State	3/16/20	Statewide proclamation limiting and Local Health Officer orders gatherings to less than 50 people; state and local prohibition of onsite consumption of food or beverages until phased reopening completed in May 2020
State	3/17/20	K-12 schools closed statewide for in person learning
Federal	3/18/20	Families First Coronavirus Response Act signed into law, provides paid sick leave, tax credits, and free COVID-19 testing; expands food assistance and unemployment benefits; and increases Medicaid funding.
State	3/18/20	Ratepayer Assistance and Preservation of Essential Services proclamation ensures that energy, electric, telecommunications, and water utilities cannot disconnect or refuse to reconnect services
State	3/18/20	Family Emergency Assistance Program/FEAP provides Disaster Cash Assistance through July 2020 and expands this order to include individuals without children
Local	3/19/20	First COVID-19 testing site opens for first responders in King County

JURISDICTIONAL LEVEL	DATE	MILESTONES
Local	3/20/20	Kent Isolation and Quarantine site opens
State	3/23/20	Governor Inslee announced a "Stay Home, Stay Healthy" order, implementing mandatory telecommuting for all employees who are not First Responders or Mission-Critical.
State	3/24/20	State proclamation that expands telehealth services, testing coverage to include provider visits for all respiratory illness and drive-up testing without copays
Local	3/25/20	King County launches Stand Together, Stay Apart campaign
Local	3/25/20	PHSKC launches public data dashboards with daily updates of local COVID-19 cases and deaths
State	3/25/20	Stay Home, Stay Healthy Order through 4 May 2020 bans all gatherings for social, spiritual, recreational activities and all businesses except essential.
Federal	3/27/20	Coronavirus Aid, Relief, and Economic Security Act (CARES, Act) signed into law, including one-time cash payments. Increased unemployment benefits, creation of the Paycheck Protection Program, additional funding for state and local governments.
Local	3/27/20	CDC issues COVID-19 prevention guidance in Morbidity and Mortality Weekly Report for Long Term Care (LTC) Facilities based off Public Health - Seattle & King County findings and transparency with their first LTC outbreak.
Local	3/27/20	Aurora Isolation and Quarantine site opens
Local	3/29/20	Issaquah Isolation and Quarantine site opens
Federal	3/30/20	Stay at home guidelines are extended by President Trump until April 30.
Local	4/1/20	PHSKC/HMAC Community Well-Being Group support begins to focus on behavior health impacts of the outbreak.
Local	4/2/20	King County announces plan to reduce capacity at shelters by moving nearly 400 people to hotel rooms

JURISDICTIONAL LEVEL	DATE	MILESTONES
Local	4/10/20	PHSKC starts releasing preliminary data of COVID-19 cases by race/ethnicity
Local	4/28/20	COVID-19 public education campaign videos have been released in 24 languages
Local	5/18/20	King County directive to wear face coverings while in public goes into effect
Local	6/2/20	Phase 1 Safe Start - Stay Healthy King County Reopening - allows limited operation of restaurants, retail and personal services
State	6/5/20	Statewide implementation of "Washington Listens," an emotional health support program to reach those most affected by the stress of the outbreak. $2.2 million designated for this program with a call center and 120 counselors or team leaders available for support. $2M grant also issued for support to those with substance abuse and mental health disorders
Federal	6/10/20	There are 2 million confirmed cases of COVID-19 in the US.
Local	6/10/20	New free testing sites open in south King County bringing the total number of free testing sites in south Seattle and south King County to 10, with 18 free testing sites overall in King County.
Local	6/11/20	King County declared racism a public health crisis, recognizing that racism is an underlying root cause of the disproportionate impacts of the COVID-19 pandemic on communities of color, and committing to implementing a racially equitable response to this crisis, centering on community.
Local	6/19/20	Phase 2 Safe Start - Stay Healthy King County Reopening - allows gatherings of 5 or fewer people and allows restaurants, retailers and other businesses to reopen.
State	6/26/20	Secretary of Health mandates face coverings through 3/11/2022 for all people above the age of 2 or with a medical condition that prohibits the use of the mask.
Local	7/3/20	Safe Start for Taverns and Restaurants (SSTAR) program

JURISDICTIONAL LEVEL	DATE	MILESTONES
		begins educational outreach and enforcement of Safe Start requirements for operating restaurants, bars, and taverns.
State	7/9/20	State expands eligibility of the Family Emergency Assistance Program through 6/30/2021
Federal	8/24/20	The CDC restricts its testing recommendations to only symptomatic individuals who have been exposed to the virus.
Local	8/31/20	Two new free drive-thru COVID-19 test sites announced in Renton and Auburn
Local	9/1/20	Individual Eviction and Rental Assistance granted through December 2020
Local	10/6/20	Tukwila testing site open
Local	10/13/20	Federal Way test site opens
State	11/16/20	State rolls back its phased reopening plan until 1/22/2021 to slow the spread of rapidly increasing COVID-19 cases, hospitalizations and deaths before health systems become overloaded
Local	11/20/20	Test site opens at Highline College to expand testing capacity in south King County as case numbers increase
Federal	12/2/20	CDC announces that those who have been exposed to someone with COVID-19 can quarantine for ten days without a COVID-19 test if they have no symptoms or seven days if they have no symptoms and a negative test result.
Local	12/10/20	Test site opens in Enumclaw to expand testing access in southeast King County
State	12/11/20	State issues first vaccine through tiered approach for high-risk health care workers; high risk first responders and long-term care facility residents
Local	12/15/20	Bellevue College test site opens, bringing the first free high-volume test site to King County's Eastside.

JURISDICTIONAL LEVEL	DATE	MILESTONES
Local	12/18/20	King County begins vaccinating high-risk workers in health care settings, patients and staff of long-term care facilities, and high risk first responders (EMTs, paramedics, and fire fighters)
Local	1/1/2021	In collaboration with PHSKC and dozens of local hospitals, many hundreds of EMS personnel staffed mass vaccination sites and mobile vaccination vehicles.
State	1/11/21	State declares "Healthy Washington - Roadmap to Recovery" that outlines recovery plan and metrics that will be monitored in each region to transition phases
Federal	1/21/21	The Biden administration publishes its national COVID-19 response strategy. It Includes a data-driven response to the pandemic and expanded access to care and treatment; policy directives on the domestic goal of 100 million vaccinations in 100 days and strengthening the global response;
State	1/28/21	State expands vaccine eligibility to all individuals 65 and older
Federal	1/30/21	Required mask mandate for travelers into, within, and out of the United States on airplanes, ships, ferries, trains, subways, buses, taxis, and ride shares.
Local	2/1/21	Two mass vaccination sites for COVID-19 opened in South King County
Local	3/2/21	500,000 vaccines administered in King County
State	3/2/21	State expands eligibility for vaccine to educator and care givers
Federal	3/11/21	American Rescue Plan Act signed into law. Among other actions, the law provides a boost to unemployment benefits through September; expands the child tax credit, rental payment assistance, and funds for COVID-19 vaccine distribution and testing; and directs money to state, local, and tribal governments and to schools.
Local	3/11/21	First cases of unique and highly transmissible COVID-19 variants (United Kingdom and South African variants)

JURISDICTIONAL LEVEL	DATE	MILESTONES
		detected in King County
Federal	3/18/21	White House declares COVID-19 outbreak a National Emergency
State	3/22/21	Governor Inslee announces that the state will enter phase 3 in a county-by-county evaluation process versus a regional decision. He lifts ban on in person spectators for professional and high school sports
Local	4/7/21	1 million vaccines administered in King County
Federal	4/15/21	The Pfizer-BioNTech COVID-19 vaccine is authorized for age 16+ and Moderna and J&J COVID-19 vaccines are authorized for age 18+.
Local	4/26/21	Public Health - Seattle & King County releases COVID-19 principles for equitable vaccine delivery
Federal	4/28/21	CDC releases assessment that states that "fully vaccinated adults 65 years and older were 94% less likely to be hospitalized with COVID-19 than people of the same age who were not vaccinated."
Local	5/13/21	Vaccines are available for ages 12+ in King County
Local	6/30/21	King County eases COVID-19 restrictions to prepare for reopening of Washington State (Vaccinated people have the option to go maskless indoors)
State	7/1/21	State proclaims through "Washington Ready" that face covering, movement and occupancy restrictions can be modified through 8/13/2021
Local	7/24/21	The delta variant accounts for 56% of positive cases sequenced in King County.
State	8/9/21	State requires Vaccine for employees in all higher education institutions, most childcare, early learning providers, K-12 educators, school staff, coaches, bus drivers, school volunteers and any others working in school facilities as a condition of employment. Effort is ongoing.
State	8/23/21	Statewide Mask Mandate expanded to include vaccinated

JURISDICTIONAL LEVEL	DATE	MILESTONES
		individuals in indoor settings through 3/11/2022
Local	9/8/21	COVID-19 -19 Case Investigation and Contact Tracing transitioned from PHSKC to Washington Department of Health
Local	9/16/21	Vaccination Verification Order ensuring that all patrons 12 years and older are required to have proof of vaccination to attend all indoor events with a capacity of 12 people or more and all outdoor events with 500 or more people
State	9/21/21	Pfizer booster eligibility expanded to those older than 65 years, younger adults with risk of severe COVID-19 or high risk of exposure - ongoing
State	10/18/21	Vaccine Requirement for all employee, on site contractors and volunteers at public and private K-12 schools, public and private 2–4-year institutions of higher learning and all early learning and childcare programs. Colleges and Universities are allowed to reopen upon compliance with Proclamation 21-14.1
State	10/22/21	Booster Eligibility expanded statewide to those 18+ who received J&J > 2 months ago, or Pfizer/Moderna > 6 months at a higher risk of severe COVID-19 or high risk of exposure
State	11/3/21-11/22/21	Eligibility for Pfizer Vaccine includes children 5-11; Booster Eligibility expanded statewide to those 18+ Pfizer/Moderna > 6 months ago
Local	12/4/21	Public Health – Seattle & King County confirmation of the first case of the Omicron variant of COVID-19 in King County
State	12/9/21	Booster Eligibility expanded statewide to those 16-17 who have received Pfizer/Moderna > 6 months ago
State	1/3/22 - 1/22/22	Booster Eligibility expanded statewide to those 12-15 who have received Pfizer/Moderna > 6 months ago; Booster Eligibility changed from 6 months to 5 months; Washington "Say Yes! COVID-19 Home Test" Program launched allowing residents to order 2 COVID-19 tests per

JURISDICTIONAL LEVEL	DATE	MILESTONES
		month
Local	3/1/22	King County Vaccination Verification Order ends
State	3/11/22	King County Mask Directive is lifted for all venues and gatherings

ACRONYMS

A&I	Analytics and Informatics
AAR	After Action Report
AC/RC	Alternate Care / Recovery Center
ACS	Alternate Care Site
ADA	Americans with Disabilities Act
ALF	Assisted Living Facilities
APDE	Assessment, Policy Development, and Evaluation
BIPOC	Black, Indigenous, People of Color
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CHS	Community Health Services
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare and Medicaid Services
COOP	Continuity of Operations Plans
COVID-19	Coronavirus Disease – 2019
CSB	Customer Service Bureau
DAJD	Adult and Juvenile Detention
DOH	Washington State Department of Health
DHHS	Department of Health & Human Services
DOC	Department Operations Center
EAP	Employee Assistance Program
EHD	Environmental Health Services
EMSA	Emergency Medical Services Authority
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ERT	Equity Response Team
EUA	Emergency Use Authorization
ESF	Emergency Services Function
FAST	Field Assessment Support and Technical Assistance
FBO	Faith-Based Organization
FBOD	Finance and Business Operations Division
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
HAI	Hospital Associated Infection
HAR	Household Assistance Request
HCC	Healthcare Coalition
HEART	Homeless Health Emergency Action and Response Teams
HHS	U.S. Department of Health and Human Services
HMAC	Health and Medical Area Command
HPI	Healthy Places Index

HR	Human Resources
I&Q	Isolation and Quarantine
IAP	Incident Action Plans
ICS	Incident Command System
IT	Information Technology
JHS	Jail Health Services
JIS	Joint Information System
KCIT	King County Information Technology
LTCF	Long- Term Care Facility
MEO	Medical Examiner's Office
MHCC	Medical and Health Coordination Center
MHOAC	Medical Health Operational Area Coordinator
MOU/MOA	Memorandum of Understanding/Agreement
MYTEP	Multi-Year Training and Exercise Program
NIMS	National Incident Management System
OEM	Office of Emergency Management
OWS	Operation Warp Speed
PAPR	Powered Air Purifying Respirator
PARCAG	Pandemic and Racism Community Advisory Group
PHN	Public Health Nurse
PHSKC	Public Health - Seattle & King County
PHRC	Public Health Reserve Corps
PICC	Public Information Contact Center
PIO	Public Information Officer
PPE	Personal Protective Equipment
RR	Resource Request
SEOC	State Emergency Operations Center
SNF	Skilled Nursing Facilities
SOP	Standard Operating Procedure
SSTAR	Safe Start for Taverns and Restaurants
SWIQ	Stipend for Workers in Isolation and Quarantine
ULTF	Ultra-low Temperature Freezer
WASCLA	Washington State Coalition for Language Access
WDRS	Washington Disease Reporting System
WIC	Women, Infants, and Children

King County

Dow Constantine
King County Executive
401 Fifth Avenue, Suite 800
Seattle, WA 98104-1818
206-263-9600 Fax 206-296-0194
TTY Relay: 711
www.kingcounty.gov

December 27, 2023

The Honorable Dave Upthegrove
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember Upthegrove:

In response to Motion 15650, this letter transmits an updated Pandemic Influenza Response Plan report and a proposed Motion that, if enacted, would acknowledge receipt of the report.

As required, the enclosed report includes a new pandemic response plan that expands on past Pandemic Influenza Response Plans and uses lessons learned from the COVID-19 pandemic. This report responds to the Motion by identifying critical infrastructure gaps and offering recommendations on how to fill these gaps. The new pandemic influenza response plan is now called the King County Biological Incident Response Annex, which is more comprehensive than past influenza pandemic response plans. With this broader name, the plan addresses responses to other viruses in addition to influenza, other natural causes of outbreaks, and human-caused biological incidents or outbreaks. “Annex” is an emergency preparedness term that refers to an operational plan.

As required, the enclosed report was drafted by Public Health – Seattle & King County (PHSKC) in coordination with the King County Office of Emergency Management. The new plan addresses each pandemic phase identified by the Centers for Disease Control and Prevention. The plan includes a description of the responsibilities of governmental and nongovernmental agencies, including the Washington State Governor, the State Secretary of Health, the King County Executive, the King County Board of Health, the Local Health Officer, Public Health – Seattle & King County, and healthcare system organizations in the region.

Since February 2020, there have been almost 600,000 cases, close to 18,000 hospitalizations, and over 3,600 deaths from COVID-19 in King County. As substantial as these numbers and losses are, King County experienced one of the lowest death rates due to COVID-19 among large metropolitan areas in the U.S. The burdens of COVID-19, however, were not borne evenly across the population. Throughout the country, the virus had disproportionate impacts on the elderly, people with weakened immune systems, those with pre-existing chronic medical

conditions and disabilities, and those in communities of color. In King County, American Indian/Alaskan Native, Black, Hispanic, and Native Hawaiian/Pacific Islander residents endured substantially higher rates of COVID-19 cases, hospitalizations, and deaths than did Asian and white residents.

The report identifies critical infrastructure and resources that were lacking or insufficient during the COVID-19 response. These include gaps in disability access, limited language translation and interpretation, limited racial and ethnic diversity among PHSKC staff and volunteers, and service gaps resulting from staffing demands that exceeded available capacity. The report also identifies the infrastructure and resources that are currently insufficient to respond to future pandemics. The report outlines barriers to acquiring or developing this infrastructure and closes with recommendations for how to fill these gaps.

King County faces barriers to acquiring needed infrastructure for emergency responses. These include: limited staffing and funding levels, lack of flexibility in hiring and retention processes, a funding cycle that goes up and down in response to emergencies, a lack of bridge funding between funding cycles, and limited racial and ethnic diversity among staff and volunteers.

The report outlines recommendations for how to fill these incident response gaps, including:

1. Build and deepen community trust through relationships and communication;
2. Enact equity strategies to tailor actions and information to better serve specific communities, including Black, Indigenous, other people of color, people with disabilities, and residents living in less resourced locations;
3. Improve emergency response operations by using standard processes and coordination methods, and
4. Add workforce flexibility to allow staffing to align with pandemic surges.

The recommendations in the report are based on interviews with over 150 PHSKC staff and key partners who participated in the COVID-19 response from 2020 through 2022. In addition, community partners made recommendations in four virtual townhall meetings, which offered Communication Access Real-time Translation (CART) and live interpretation in multiple languages.

Thank you for your consideration of the report and proposed Motion. If your staff have questions, please contact Dr. Faisal Khan, Director, Public Health – Seattle & King County, at 206-477-6246.

Sincerely,

for

Dow Constantine
King County Executive

Enclosure

cc: King County Councilmembers

ATTN: Stephanie Cirkovich, Chief of Staff
Melani Hay, Clerk of the Council
Karan Gill, Chief of Staff, Office of the Executive
Penny Lipsou, Council Relations Director, Office of the Executive
Dr. Faisal Khan, Director, Public Health – Seattle & King County
Hikari Tamura, Deputy Director, Public Health – Seattle & King County
Lorraine Patterson-Harris, Director, Department of Executive Services
Brendan McCluskey, Director, King County Office of Emergency Management

King County

Metropolitan King County Council
Health, Housing, and Human Services Committee

STAFF REPORT

Agenda Item:	6	**Name:**	Miranda Leskinen
Proposed No.:	2024-0228.2	**Date:**	March 4, 2025

SUBJECT

A motion acknowledging receipt of the 2023 Best Starts for Kids (BSK) annual report.

SUMMARY

The BSK 2023 Annual Report, the second annual report for the 2022-2027 levy period, provides information on BSK financial investments made in 2023, as well as BSK performance measures and outcomes. In 2023, the report indicates that Best Starts for Kids invested more than $129 million in the community, completed 12 competitive RFP processes, partnered with 336 community-based organizations operating 591 programs (including 187 new programs) to reach 151,919 children, young people, families, and community members across King County.

The report also links to an updated data dashboard on the Best Starts for Kids website.[1] The dashboard provides additional measures for Best Starts for Kids programs, customizable data views, and greater geographic and financial detail.

BSK annual reports must be provided to the Council on levy implementation throughout the 2022-2027 levy period. These reports are due no later than July 15 each year from 2023 through 2028 and reflect levy implementation for the prior calendar year.

Proposed Motion 2024-0228 is dually referred to the Regional Policy Committee (nonmandatorily) and then to the Health and Human Services Committee. The Regional Policy Committee was briefed on the report on July 31, 2024 (2024-B0094), and passed the motion, as amended to correct a typo in the proposed motion, on September 3, 2024.

Staff analysis has determined that the 2023 report meets the requirements for BSK annual reporting in Ordinance 19267.

BACKGROUND

[B] Best Starts for Kids dashboard - King County, Washington

Best Starts for Kids. Best Starts for Kids (BSK) is a levy-funded initiative in King County that is aimed at supporting the healthy development of children and youth, families, and communities across the county through strategic investments in promotion, prevention and early intervention programs and services. The inaugural six-year BSK Levy (approved by voters in November 2015) expired at the end of 2021.

2022-2027 BSK Levy. In April 2021, the King County Council approved Ordinance 19267, which placed a Best Starts for Kids (BSK) six-year renewal levy proposition on the ballot. King County voters approved the 2022-2027 BSK levy on August 3, 2021.

The 2022-2027 levy entails a first-year levy rate of $0.19 per $1,000 of assessed value in 2022 with a three percent annual limit (growth) factor. Based on the March 2024 revenue forecast, the renewal levy is expected to generate approximately $910.4 million over the six-year levy period.

Levy Investment Requirements. Ordinance 19267 directs that levy proceeds shall be used to:

- Promote improved health and well-being outcomes of children and youth, as well as the families and the communities in which they live;
- Prevent and intervene early on negative outcomes;
- Reduce inequities in outcomes for children and youth in the county; and
- Strengthen, improve, better coordinate, integrate, and encourage innovation in health and human services systems and the agencies, organizations, and groups addressing the needs of children and youth, their families, and their communities.

In the levy's first year (2022), after accounting for attributable election costs, 22.5 percent of first-year levy proceeds are to be allocated toward the Youth and Family Homelessness Prevention Initiative (YFHPI), a new affordable child care program, a new child care workforce demonstration project, and continuing technical assistance and capacity building programs. Allocated levy proceeds may be used to plan, provide, fund, administer, measure performance, and evaluate these programs.

In the subsequent levy years (2023-2027), it is broadly directed that the amount to be distributed to these programs be allocated so that the six-year levy investment for these purposes totals at least $240 million including $1 million annually for a grant program to support capacity building and developing infrastructure in areas lacking services/services infrastructure.[2]

Remaining levy proceeds are to be disbursed as follows to plan, provide, and administer the following:

- 50 percent for Investing Early strategies (ages 0-5)
- 37 percent for Sustain the Gain strategies (age 5 or older)
- 8 percent for Communities of Opportunity
- 5 percent for performance measurement, evaluation, and data collection; CYAB stipends; and pro-rationing mitigation (if authorized by ordinance) for applicable local metropolitan parks, fire, and public hospital districts.

[2] The capacity building support grant program, per Ordinance 19267, must include support for development of new organizations and expansion of existing organizations.

The renewal levy will also invest up to $50 million (subject to levy revenue projections[3]) to establish a new capital grants program for facility/building repairs and expansion and to support the construction of new buildings/facilities that will serve children and youth.

Implementation Plan. Ordinance 19267 required the Executive to transmit to the Council an implementation plan for the 2022-2027 BSK levy to govern the expenditure of levy proceeds. The plan, as required, details the strategies and programs to be funded and outcomes to be achieved with the use of the levy's proceeds and includes a framework to measure the performance of levy strategies in achieving their outcomes. Council adopted the implementation plan, as amended, in November 2021.

Results-Based Accountability. As with the initial BSK levy, the renewal levy will continue to evaluate its results beginning with Results Based Accountability (RBA) and supplement RBA with additional evaluation activities. Altogether, the implementation plan indicates the evaluation framework will utilize population indicators[4], performance measurement[5] and in-depth evaluation[6].

Levy Oversight. Levy oversight, like for the initial BSK levy, is provided by the Children and Youth Advisory Board (CYAB) and the Communities of Opportunity-Best Starts for Kids Levy Advisory Board.

Annual Reporting. Annual reports will be delivered digitally, with a notification letter transmitted to the King County Council when the report is ready for review. These reports, due no later than July 15 each year from 2023 through 2028, will cover levy expenditures, services, and outcomes for the levy for the prior calendar year and provide performance data for Investing Early, Sustain the Gain, COO, YFHPI, Child Care, Capital Grants, and Technical Assistance and Capacity Building investments. As indicated in the levy implementation plan, ZIP code-level geographic detail required by Ordinance 19267 will be phased into reports beginning with the 2022 BSK Annual Report.[7]

Annual reporting for the levy will also describe any changes made to strategy-level investments during the reporting period, as well as indicate whether strategy-level investments are expected to change for the subsequent reporting period or remain the same.

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[3] If total projected levy proceeds exceed $822 million, the excess (up to $50 million) would fund the capital grants program. Consequently, Ordinance 19267 directs that funding for this grant program would be subject to reduction prior to other levy program funding in the event total projected levy proceeds were to fall below $822 million.

[4] Population indicators use population-level measures to identify needs, understand baseline conditions, and track trends over time. BSK strategies intend to contribute to population-level results over the long term.

[5] Performance measures are regular measurement of program outcomes to assess how well a levy investment or strategy is working. BSK is accountable for performance of the levy's strategies.

[6] Additional, in-depth evaluation activities are expected to complement performance measurement to further learning during the renewal levy in some program areas.

[7] Including total expenditures of levy proceeds by program area by ZIP code in King County and the number of individuals receiving levy-funded services by program area by ZIP code in King County of where the individuals reside at the time of service.

The levy's advisory boards, in accordance with the implementation plan, will consult on, and review the annual reports.

Additionally, the levy's implementation plan indicates that BSK, no later than 2027, will report on the levy's performance and outcomes in conjunction with the performance and outcomes for the Mental Illness and Drug Dependency Behavioral Health Sales Tax Fund (MIDD) and the Veterans, Seniors and Human Services Levy (VSHSL), including whether the investments from these programs are achieving desired county population-level results or impacts monitored as part of the consolidated reporting dashboard for DCHS-administered human services.

ANALYSIS

The 2022-2027 BSK Implementation Plan, consistent with Ordinance 19267, outlines requirements related to the transmittal timelines, stakeholder involvement and contents of Best Starts for Kids (BSK) annual reports. The following subsections evaluate whether the 2023 BSK Annual Report is consistent with annual reporting requirements for the levy. In sum, staff analysis has determined that the 2023 report meets the requirements for BSK annual reporting.

Transmittal Timeline. BSK annual reports are due no later than July 15 each year. The Executive transmitted the 2023 BSK Annual Report on July 15, 2024, thereby meeting this requirement.

Content Requirements. BSK annual reports must describe the programs funded and outcomes for the children, youth, families, and young adults served. Specifically, annual reports are to include:

- Annual information on levy expenditures, services, and outcomes;
- Total expenditures of levy proceeds by program area by ZIP Code in King County, with partial data to be available in the report completed in 2024 and additional data available in each subsequent report;
- The number of individuals receiving levy-funded services by program area by ZIP Code of where the individuals reside at the time of service, with partial data to be available in the first annual report in 2023 and additional data available in each subsequent report; and
- Description of any changes made, and any anticipated changes, to strategy-level investments.

Description of any changes made to strategy-level investments. In 2023, Best Starts for Kids made no changes to planed strategy-level investments. The annual report notes that any underspend in a strategy or investment area's prior annual budget that was legislatively carried forward into 2023 and future years is allocated within the same strategies and investment areas to maintain the level of commitments outlined in the levy's implementation plan.

Review by Advisory Boards. According to the Executive, the CYAB and COO-AB members received a draft copy of the annual report in May 2024 and the final report reflects their input and feedback.

BSK 2023 Annual Report Highlights. In 2023, Best Starts for Kids invested more than $129 million in the community, completed 12 competitive RFP processes, partnered with 336 community-based organizations operating 591 programs to reach 151,919 children, young people, families, and community members across King County. Of note, the formatting for summarizing levy strategy highlights is updated for the 2023 annual report around the following five key themes that shaped BSK programming and results in 2023:

- Meeting families' needs
- Prioritizing well-being and mental health
- Cultivating opportunities for children and young people
- Strengthening the workforce
- Building community power and capacity

Table 1 provides a summary of 2023 levy expenditures, excerpted from the annual report, organized by levy investment area. Please note that the amounts shown in the '2023 Budgeted' column include approximately $16 million in 2022 commitments that were not spent in 2022 due to implementation and strategy design of new initiatives. Most of these are in the Child Care and Capital Projects investment areas, which are new for the 2022-2027 Best Starts levy.

Also of note, the annual report indicates that 2023 funds are on track to be fully committed in 2024. Capital Projects anticipates having funds allocated in contracts by the end of 2024, but some funds may need to be expended later subject to project complexity. In addition, the annual report notes that Child Care Wage Boost Pilot implementation was delayed by start-up staffing timelines and a change in community partner in Q3 of 2023, which necessitated a re-procurement. However, full implementation of the pilot is anticipated in 2024.

Table 1. BSK 2023 Expenditure by Investment Area

Investment Area	2023 Budgeted	2023 Expenditures
Child Care	$34,764,300	$30,890,272
Youth and Family Homelessness Prevention Initiative	$4,934,290	$4,774,967
Technical Assistance and Capacity Building	$2,424,120	$2,197,463
Subtotal *(per Ord 19267 subsection 4.D)*	$42,122,710	$37,862,703
Investing Early (Prenatal to 5)	$47,552,860	$45,855,095
Sustain the Gain (5 to 24)	$35,427,922	$34,044,586
Communities of Opportunity	$7,737,003	$6,736,765
Data and Evaluation	$4,931,858	$4,446,479
Capital Projects	$9,885,000	$204,803
Total 2023 Expenditures	**$147,657,352**	**$129,150,430**

Figures 1 through 3 (also excerpted from the annual report) summarize geographic distributions of BSK participants (Figure 1) and levy expenditures (Figures 2 and 3) by

ZIP Code. Please note that data for individual ZIP Codes are available in Appendix E to the annual report and on the BSK online dashboard.

Figure 1. Best Starts Services Participation in 2023

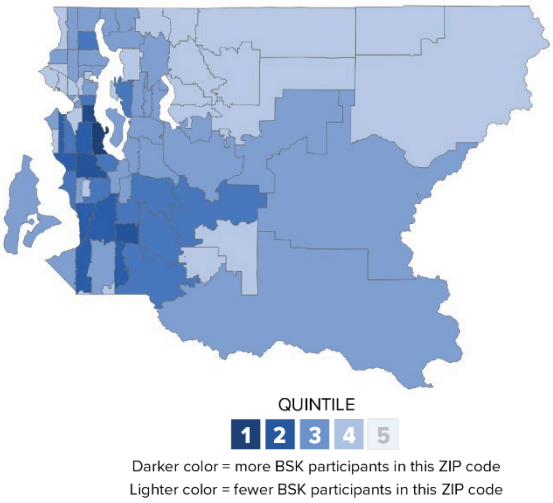


Figure 2. Best Starts Expenditures by ZIP Code in 2023 (by where participants reside)

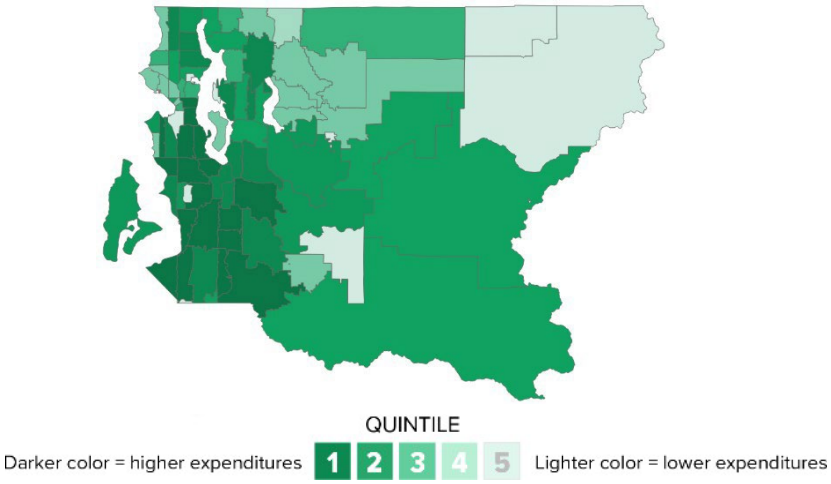
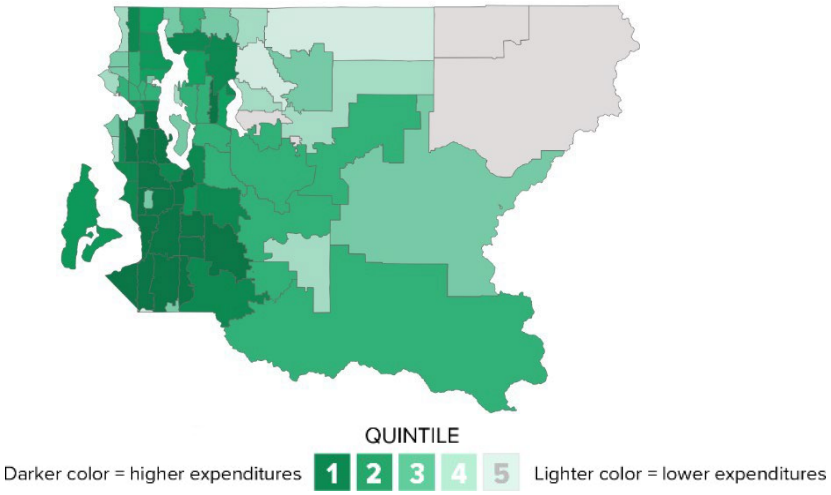


Figure 3. Best Starts Expenditures by ZIP Code in 2023 (by where office-based services are located)



Data and Evaluation. BSK evaluators, noted in the annual report, summarized quantitative and qualitative data from performance measures and semiannual narrative reports from funded community partners to capture the levy's work in 2023. Additionally, staff also gathered feedback throughout the year and shared themes focusing on where partners needed support and how BSK is already addressing them. The report further notes that such findings inform how BSK is working towards investing and will continue to invest in partners in 2023 and onward.

The report also links to an updated data dashboard on the Best Starts for Kids website.[8] The dashboard provides additional measures for Best Starts for Kids programs, customizable data views, and greater geographic and financial detail. Additionally, the report includes a link to its webpage that includes the published results of more in-depth evaluations completed by third-party, independent evaluators and community partners.[9] Additionally, key findings from evaluation reports completed in 2023 are included in the annual report itself.

INVITED

- Dr. Jamalia Jones, BSK Co-Lead, DCHS
- Jessica Tollenaar Cafferty, BSK Co-Lead, PHSKC

ATTACHMENTS

1. Proposed Motion 2024-0228.2
   a. 2023 BSK Annual report
2. Transmittal letter

[B]Best Starts for Kids dashboard - King County, Washington
[9] Best Starts for Kids Reports - King County.

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Motion

Proposed No. 2024-0228.2 **Sponsors** von Reichbauer and Mosqueda

A MOTION acknowledging receipt of the second annual report on the second Best Starts for Kids initiative, in accordance with Ordinance 19354.

WHEREAS, King County voters approved the best starts for kids levy in 2015 to fund prevention and early intervention strategies to improve the health and well-being of children, youth, families and communities, and

WHEREAS, Ordinance 19267, providing for the submission of a renewed best starts for kids levy to the qualified electors of King County, was adopted by the metropolitan King County council on April 20, 2021, and signed by the executive on April 30, 2021, and

WHEREAS, Ordinance 19267, King County voters approved King County Proposition No. 1 on August 3, 2021, authorizing a six-year renewal of the Best Starts for Kids levy to plan, provide, administer, and evaluate promotion, prevention, and early interventions and capital investments for King County children, youth, families and communities, and

WHEREAS, in accordance with Ordinance 19267, the executive transmitted to the council for review and adoption an implementation plan that identified the strategies to be funded, outcomes to be achieved, and framework to measure the performance of levy strategies, and

WHEREAS, Ordinance 19354 adopted the Best Starts for Kids Implementation Plan, dated October 13, 2021, and

WHEREAS, Ordinance 19267 and Ordinance 19354 require an annual report on levy expenditures, services, and outcomes to be transmitted to the council, with the first report due by July 15, 2023, and additional yearly reports to be transmitted no later than July 15 of each year through 2027, and

WHEREAS, the second annual report on the second Best Starts for Kids initiative, entitled 2023 Best Starts for Kids Annual Report, is submitted by the executive;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

The receipt of the second annual report on the second Best Starts for Kids

initiative, entitled 2023 Best Starts for Kids Annual Report, Attachment A to this motion, in accordance with Ordinance 19354, is hereby acknowledged.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Rod Dembowski, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Dow Constantine, County Executive

Attachments: A. 2023 Best Starts for Kids Annual Report, July 15, 2024

2023 Best Starts for Kids Annual Report

July 15, 2024

King County

Contents

Executive Summary

Overview

The Best Starts for Kids 2023 Annual Report summarizes the activities of the Best Starts for Kids initiative in 2023 and fulfills the reporting requirements in Ordinance 19354 and the Best Starts for Kids Implementation Plan.[1] [2]

Background

Best Starts for Kids (Best Starts) is King County's community-driven initiative to support every baby born and child raised in King County to be happy, healthy, safe, and thriving. This annual report celebrates the second year of the second levy, reflecting Best Starts' value of centering equity and community strengths. This year's report presents Best Starts' work organized by themes rather than by investment areas to highlight the collective impact of Best Starts and community partners' work. The report offers quantitative and qualitative data from performance measures and narrative reports, along with evaluation findings. Community partners' feedback is included. Best Starts staff, the Department of Community and Human Services (DCHS), Public Health – Seattle & King County (PHSKC), the Children and Youth Advisory Board, Communities of Opportunity-Best Starts Advisory Board (COO Governance Group), and Initiative Sponsors, in partnership with Cardea Services, have all reviewed the report to ensure alignment, input, and accountability across Best Starts.

Report Requirements

A. Best Starts for Kids Implementation and Outcomes in 2023

In 2023, Best Starts and community partners expanded their reach and achieved positive outcomes for King County families across age groups, races, ethnicities, geography, and cultures. In 2023, Best Starts partnered with 336 community-based organizations operating 591 programs to directly serve 151,919 children, young people, families, and community members across King County.[3]

Outcomes from Best Starts strategies are organized into five themes: Meeting Families' Needs, Prioritizing Well-being and Mental Health, Cultivating Opportunities for Children and Young People, Strengthening the Workforce, and Building Community Power and Capacity. For each theme, this report includes supporting quantitative and qualitative findings from evaluation data and partner reporting. Some examples of Best Starts 2023 outcomes are:

- 94 percent of households who received support from Youth Family Homelessness Prevention Initiative stayed housed within one year of exit.
- 57 percent of youth leaders who participated in the Community Well-being Initiative reported increased leadership skills.
- 81 percent of assessed participants in Youth Development programs increased connections or built healthy relationships.

[1] Ordinance 19354

[2] 2022 – 2027 Best Starts for Kids Implementation Plan

[3] Best Starts funded programs also reached 222,562 people through programs that included drop-in services or screenings, 1,243 people in workforce training programs, and 198,130 people through social media engagement.

- 81 percent of participants in Workforce Development workshops reported they could apply something they learned to their work.
- Communities of Opportunity Systems and Policy Change partners developed 1,006 resident leaders.

B. Geographic Distribution of Best Starts for Kids Services

Best Starts reaches children, young people, families, and caregivers across King County. ZIP Codes where the highest number of Best Starts participants reside typically have more young people, lower opportunity, or both.[4] For more detailed information on Best Starts' reach, see Appendix E ZIP Code Data Book, starting on page 32.

C. Best Starts for Kids Fiscal Information

In 2023, Best Starts expended more than $129 million. Two new investment areas, Child Care and Capital Projects, launched in the 2022-2027 levy and have taken more time to implement than anticipated. As of this report date, the Capital Projects investment has awarded 2022 funds through competitive procurement and the 2023 funds are on track to be fully committed in 2024. The delay in the Child Care Wage Boost Pilot implementation resulted from delays in start-up staffing timelines and a change in community partner in Q3 of 2023, which necessitated a re-procurement. Wage Boost's 2023 funds will be used for full implementation including distribution of funds to child care workers in 2024.

The Best Starts fiscal table detailing expenditures by investment area and strategy is online in the Best Starts for Kids Data Dashboard. A summary fiscal table at the investment area level is provided in section IV.C of this report.

D. Investment Changes

Best Starts made no changes to planned strategy-level investments in 2023 or for future years. Underspend in a strategy or investment area's prior annual budget that was legislatively carried forward into 2023 and future years is allocated within the same strategies and investment areas to maintain the level of commitments outlined in the Best Starts implementation plan.

E. Feedback from Grantees and Providers

In 2023, Best Starts' community partners across strategies shared a desire for role clarity between King County staff and community providers, and clarity on King County processes and systems. Partners also requested more in-person opportunities to share resources and knowledge or best practices, build community, and develop strong relationships and connections. In response to community feedback, Best Starts created, co-hosted, and scheduled more virtual and in-person meetings with partners on a consistent basis, so that staff and providers could connect and engage deeply with one another. Best Starts is also continually improving the Request for Proposal (RFP) and contracting processes to make it easier for organizations to access funds and successfully meet expectations and contract deliverables.

[4] Child Opportunity Index (COI) 2.0 Zip Code Data, February 2023

F. Best Starts for Kids Data and Evaluation

To complement Best Starts' performance measurement, narrative reporting, and data capacity building across programs, Best Starts funds in-depth evaluation for select strategies and investment areas. Key findings from 2023 in-depth evaluation reports are found in section F.

Additional Information Available on the Best Starts for Kids Dashboard

Best Starts evaluates all strategies and programs and maintains an interactive data dashboard. This report integrates data highlights. Readers can explore data further by going to the Best Starts for Kids Data Dashboard. The dashboard:

- Provides detailed information on Best Starts' geographic reach within King County
- Provides customizable views of data by individual strategies and their programs
- Shares more detailed fiscal data, including for individual strategies

G. Children and Youth Advisory Board and Communities of Opportunity Governance Group Consultation

Members of the King County Children and Youth Advisory Board and the Communities of Opportunity Governance Group reviewed a draft of this report in May 2024, in recognition of these bodies' advisory roles for Best Starts as described in KCC 2A.300.510 and KCC 2A.300.521.[5]

Conclusion/Next Actions

In 2023, Best Starts invested in 187 new programs operated by 136 organizations, expanding reach and creating positive impacts to provide King County's children with the best start in life. Best Starts built on accomplishments across eight investment areas. The five key themes in this report summarize the holistic nature of Best Starts strategies.

Best Starts' approach provides opportunities for healthy development that proactively focus on prevention and early intervention, coupled with promotion and systems and policy change across ages and lifespans. With the interconnected nature of community, children, and families, Best Starts seeks to create change through immediate individual impact as well as sustainable systemic impact.

In 2024, Best Starts plans to continue re-procurement processes for several strategies that will refresh its work with current partners and create opportunities for new partners to join through re-procurement processes. Best Starts will also begin to evaluate the impacts of several of its innovative approaches to address community needs.

Through partnerships in every part of the region, Best Starts catalyzes strong starts with comprehensive prenatal well-being through early childhood supports, sustaining these gains as young people progress

[5] KCC 2A.300.510 and KCC 2A.300.521

to adulthood, and strengthening communities' voices and power to influence decisions that affect them. Best Starts will continue to lead with racial equity and community wisdom, staying true to the pillars of promotion, prevention, early intervention, and systems and policy change.

Background

Best Starts for Kids Overview

Best Starts for Kids is King County's community-driven initiative to support every baby born and child raised in King County to be happy, healthy, safe, and thriving. Best Starts is committed to racial equity and justice and strives to ensure that neither ZIP Code nor family income constrain people from pursuing lives of promise and possibility, while advancing equity in systems and policies that affect families across King County. Best Starts and community partners center and value the experiences and voices of Black, Indigenous, and People of Color (BIPOC) in their projects and programs to bolster historically underserved and underrepresented communities.[6] Best Starts' holistic approach aims to support young people in achieving their fullest potential and growing successful relationships with self, family, caregivers, teachers, providers, and community.

Community partners use Best Starts funding to strengthen relationships and programs and respond to community needs. When families and communities have what they need to give their kids the best possible start:

- **Babies** are born healthy with the foundation for a happy, healthy life.
- **Young people** have equitable opportunities to be safe, healthy, and thriving.
- **Communities** offer safe and welcoming environments for their young people.

Best Starts works toward this vision by working with community partners in these investment areas, described in the 2022-2027 Best Starts for Kids Implementation Plan:[7]

- **Child Care (CC):** Offers subsidies for families so that more families can afford this essential service and investments in the child care workforce so that workers are well-compensated and supported.
- **Investing Early (IE):** Builds a robust system of programs for pregnant people, babies, young children, and their families and caregivers, meeting them where they are — at home, in the community, and wherever children receive care.
- **Sustain the Gain (SG):** Provides school- and community-based opportunities for young people to enhance their social-emotional development and mental well-being, and connect with peers and supportive adults in and out of school.

[6] Best Starts and partners acknowledge that not all communities represented in this report identify with Black, Indigenous, and People of Color (BIPOC) as a meaningful identifier or lived experience. Where possible, Best Starts identifies people and communities how they identify themselves (such as Black and Brown children, students of color, communities of color and so on), but encourages holistic interpretations of this term used throughout the report.

[7] 2022 – 2027 Best Starts for Kids Implementation Plan

- **Youth and Family Homelessness Prevention Initiative (YFHPI):** Provids concrete resources and case management to prevent families and young people from losing stable housing.
- **Communities of Opportunity (COO):** Builds community power to create equitable conditions in housing, health, economic opportunity, and community connections.[8]
- **Capital Projects (CP):** Improves and creates physical community spaces to equitably expand access to high-quality programs and services for children, young people, and families.
- **Technical Assistance and Capacity Building (TACB):** Offering assistance to community organizations to apply for Best Starts funding and strengthening funded partners' organizations and programs.

Best Starts for Kids Approach

Best Starts produces positive outcomes for children through the principles of promotion, prevention, early intervention, and policy and systems change (Figure 2). Promotion continues to be a cornerstone for Best Starts strategies, followed by prevention and early intervention. Best Starts also focuses on policy and systems change to work toward longer-term, multigenerational impacts. By providing comprehensive opportunities for children, young people, families, and caregivers, Best Starts catalyzes strong starts in early childhood and sustains those gains as children progress to adulthood and community life.

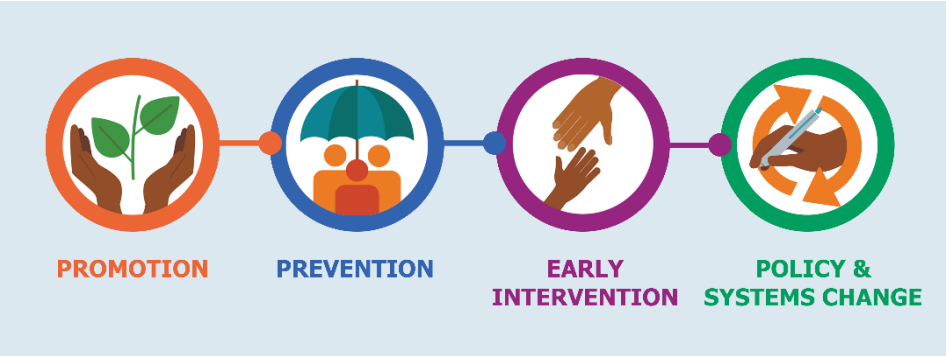


Figure 1. Best Starts for Kids Principles

Founded in community, Best Starts commits to learning alongside partners, experimenting with new, innovative approaches, and growing with partners to expand reach and impact.

Department Overview

DCHS and PHSKC share an important vision grounded in the King County Strategic Plan that all King County residents achieve optimal health and well-being and that communities thrive.[9] Best Starts funds equitable and comprehensive programs that span infancy through young adulthood. DCHS and PHSKC jointly administer the Best Starts initiative to realize this vision. Various divisions throughout these two departments manage the Best Starts strategies.

[8] Community power is the ability of communities most impacted by inequities to work together to set agendas, shift public discourse, increase opportunities for community ownership, and advance meaningful change.
[9] The King County Council approved the King County Strategic Plan by Ordinance 16897 in 2010, and adopted the corresponding vision, mission, guiding principles, goals, and priorities by Motion 14317 in 2015.

DCHS envisions a welcoming community that is racially just, where the field of human services exists to undo and mitigate systemically inequitable structures. The Department, along with a network of community providers and partners, plays a leading role in creating and coordinating the region's human services infrastructure. DCHS stewards the revenue from the Veterans, Seniors, and Human Services Levy (VSHSL), Best Starts for Kids (Best Starts) levy, the MIDD behavioral health sales tax fund (MIDD), the Crisis Care Centers (CCC) levy, the Health Through Housing sales tax, and the Puget Sound Taxpayer Accountability Account (PSTAA), along with other state and federally-directed revenues.[10, 11, 12, 13]

PHSKC envisions health, well-being, and racial equity, every day and for everyone in King County. The department works to promote and improve the health and well-being of all people in King County by leading with racial equity and changing systems and structures that impact health. PHSKC protects the public from threats to their health, promotes better health, and helps ensure people have accessible, quality health care.[14]

Key Historical Context and Current Conditions

This report showcases how Best Starts and community partners work in collaboration to address immediate and pressing concerns in King County, including basic needs, mental health, and workforce development, to ensure all babies, children, and families can grow to be healthy and thrive. Best Starts and community partners understand the importance of adapting to communities and their evolving needs.

Grounded in the value of building on community strengths, Best Starts and community partners identified five key themes featured in this report that integrate strategies across investment areas. This integrated presentation of strategies demonstrates the holistic nature of Best Starts, as it was designed from the beginning to give kids and families opportunities to prosper. Best Starts has always been rooted in racial equity and reliant on community wisdom and expertise to know what is essential for them. From Best Starts' inception, community has been at the table to design what types of programs to fund and how to address what matters to them the most.

As the cost of living increases in the area, families struggle to make ends meet.[15] Overstretched and under-compensated as wages do not keep up with rising costs, families must make hard decisions about where to spend their resources. Best Starts approaches this issue at an individual level by working with partners to get tangible goods to families, and from a systemic perspective through strategies that seek to increase non-profit and child care workers' salaries, enhance access to employment opportunities for young people, and provide skill and professional development resources.

[10] Best Starts for Kids Levy
[11] The MIDD behavioral health sales tax fund is also referred to as the Mental Illness and Drug Dependency fund.
[12] Health Through Housing sales tax
[13] Puget Sound Taxpayer Accountability Account
[14] Public Health Seattle King County Strategic Plan
[15] Workforce Development Council of Seattle-King County. Overlooked and Undercounted: Struggling to Make Ends Meet in Washington State

King County continues to face enduring impacts from the COVID-19 pandemic that impact the overall community. Among these are the mental health needs of young people.[16] Best Starts works with community partners to support individual and collective well-being, including youth mental health. Partners provide caregivers tools to develop secure attachments with the young children in their lives and to create a pathway to establish a more diverse workforce in the mental health field to meet the needs of all children. Best Starts' focus on promotion brings more youth development programming into the community where young people can flourish and feel prepared in planning for their future.

This year's report highlights Best Starts and community partners' focus on providing services to families navigating continuously rising costs of living, strengthening the child care workforce, and uplifting young people by addressing mental health concerns.

Legislative History, Policy Goals, and Annual Reporting Requirement

In 2015, King County voters approved the first Best Starts for Kids levy to fund strategies that improve the health and well-being of children, young people, families, and communities. After passage of Ordinance 19267 six years later, King County voters approved King County Proposition No. 1 to renew the Best Starts for Kids levy through 2027.[17] In accordance with Ordinance 19267, the Executive transmitted to the Council for review and adoption an implementation plan that identified the strategies for funding, outcomes for achieving, and frameworks to measure the performance of levy strategies. Ordinance 19354 adopted the Best Starts for Kids Implementation Plan.[18] Ordinance 19267 and Ordinance 19354 require an annual report on levy expenditures, services, and outcomes to the Council by July 15 of each year.

Report Methodology

Best Starts and community partners work together to gather data and feedback regularly. Best Starts evaluators summarized quantitative and qualitative data from performance measures and semiannual narrative reports from funded community partners to capture Best Starts' work in 2023. Best Starts staff also gathered feedback continuously throughout the year and shared themes focusing on where partners needed support and how Best Starts is already addressing them. Findings inform how Best Starts is working towards investing and will continue to invest in partners in 2023 and beyond. Best Starts staff contracted Cardea Services and created this report in collaboration, using these performance measures and narrative reports.

This report summarizes these results. A comprehensive look at the data is available at the Best Starts for Kids Data Dashboard, with detailed geographic data also provided in Appendix E. For detailed partner feedback by strategy, please see Appendix D.

[16] In Their Own Words Young People Describe the Impact of COVID 19
[17] Ordinance 19267
[18] Ordinance 19354

Report Requirements

This annual report summarizes the activities of the Best Starts for Kids initiative through the end of 2023 and fulfills the reporting requirements in Ordinance 19267, Ordinance 19354, and the Best Starts for Kids Implementation Plan 2022 – 2027.[19,20] [21] Specifically, this document includes summaries of the accomplishments and effectiveness of the expenditure of Best Starts for Kids levy in 2023, and financial information and the distribution of participants and expenditures by ZIP Code and investment area. In addition, t contains customizable data views and greater geographic and financial detail, organized by section and investment area.Best Starts for Kids Data Dashboard contains customizable data views and greater geographic and financial detail, organized by section and investment area.

A. Best Starts for Kids Key Themes and Outcomes in 2023

Best Starts for Kids Key Themes

Best Starts invests in eight areas, including Child Care, Investing Early, Sustain the Gain, Youth and Family Homelessness Prevention Initiative, Communities of Opportunity, Capital Projects, Technical Assistance and Capacity Building, and Data and Evaluation. Across these investment areas, five key themes shaped Best Starts programming and results in 2023:

- **Meeting Families' Needs** to support families in feeling safe and stable.
- **Prioritizing Well-being and Mental Health** to support the family unit and the whole community.
- **Cultivating Opportunities for Children and Young People** to support their goals in education and employment.
- **Strengthening the Workforce** to support a sustainable, robust, skilled, and well-compensated workforce to meet the needs of babies, children, and families.
- **Building Community Power and Capacity** to support equitable systems change and organizational infrastructure.

Best Starts Outcomes

2023 represents nearly full implementation of Best Starts strategies. In 2023, Best Starts partnered with 336 community-based organizations operating 591 programs to reach more than 221,000 children, young people, families, and community members across King County. Strategies that procured funds in 2022 started to see impact of those programs, and the data dashboard began to be populated with information demonstrating services reaching the community. Best Starts ran 12 RFP processes in 2023, which resulted in 187 new programs and welcomed 136 organizations to the Best Starts family. The new investment areas of Child Care and Capital Projects have operated on extended timelines while continuing to deepen their strategy development in partnership with community. Full implementation will ensure families with young children can get subsidies for child care, providers' needs are integrated into program design, and to provide for healthy and safe buildings where children can learn, grow, and explore.

[19] Ordinance 19267
[20] Ordinance 19354
[21] Best Starts for Kids Implementation Plan, p. 58

This report contains examples of Best Starts' positive impact on young people, families, and communities in concrete and systemic ways. As Best Starts moves into the middle years of the second levy, it continues to improve systems inside and outside the County, especially by breaking down barriers to accessing public funds. For example, Best Starts is striving to make RFPs simpler to understand with questions that are straightforward, examining the County's insurance requirements for partners, and ensuring Best Starts practices are equitable and hold community in the center.

Meeting Families' Needs

Figure 2. Family at Center for Human Services, Kaleidoscope Play & Learn Group

Best Starts Strategies for Meeting Families' Needs

- Child Care Subsidy (CC)
- Community-Based Parenting Supports (IE)
- Help Me Grow (IE)
- Home-Based Services (IE)
- Parent Child Health Services (IE)
- Positive Family Connections (SG)
- Youth Family Homelessness Prevention Initiative (YFHPI)

The seven Best Starts strategies above contribute to outcomes related to meeting families' needs by providing concrete supports, services, and resources across the age spectrum. Some of these are direct services that keep families and young people housed or expand access to care they need, and some focus on developing integrated networks of programs to serve families. Knowing where to turn to for resources can help alleviate day-to-day stressors. For example, in 2023:

- 98 percent of primary caregivers who received Child Care Subsidy reported less financial stress.
- 94 percent of households who received support from Youth Family Homelessness Prevention Initiative stayed housed within one year of exit.
- 99 percent of clients served through Maternity Support Services and Infant Case Management had infants with a healthy birth weight.

The wide variety of services provided to families through Best Starts funding is essential to build a stable foundation that benefits the entire community. These Best Starts programs are connecting families to tangible supports and culturally rooted services, boosting families' knowledge of parenting and child development, and increasing social connection.

Connecting families to tangible supports and culturally rooted services

Best Starts' Help Me Grow program partners with local community organizations to connect families and caregivers with young children to what they need, when and how they need it, making **10,240 connections to support for 1,530 parents and caregivers** in 2023.[22]

In 2023, Best Starts transitioned its contract for administration of the Child Care Subsidy program from Scholar Fund to Brightspark Early Learning Services to ensure high quality services for families.[23] Best Starts successfully preserved enrollment for all families in the subsidy program during and after the transition. The Child Care Subsidy, which partnered with five community-based organizations, helped 1,334 families afford the cost of child care for 2,064 children.

> *"Our team goes to great lengths to try to meet every single baby item request honoring the family's culture, wishes, and hopes for their baby. This looks like spending extra time sorting through donations to make sure we can pass them on to a family with confidence… or dropping diapers off at a family's door when they are in urgent need and they don't have access to transportation... The breadth and depth of our tangible baby item support is astonishing and would not be possible without the care and heart that our team pours into their work."*
>
> – Stacey Silver, Family Connector Lead, Open Arms Perinatal Services

The 2023 geographic distribution of the Best Starts for Kids Child Care Subsidy dollars reflected initial projections based on where eligible families are concentrated in the County. About 60 percent of eligible families reside in the southern region of the County, while approximately two thirds of children receiving Best Starts subsidy live in South King County. In 2023, **95 percent of primary caregivers who received the subsidy experienced a positive change in career or education** through their new capacity to pursue career goals or advancement.

Best Starts' Youth and Family Homelessness Prevention Initiative engages families and connects them to case management and flexible financial assistance programs to reduce imminent risk of housing loss. **In 2023, 94 percent of households remained housed within one year of exit.** However, the initiative "is more than just rental assistance," shares Taylor Brown, a Best Starts Case Manager at POCAAN. "We provide life skills, an ear to listen when there is nobody else, accountability, and a safe space to learn and grow. We help to foster growth, improvement, and success in our families."[24]

[22] Best Starts Strategy One-Pagers
[23] Best Starts Strategy One-Pagers
[24] Best Starts Strategy One-Pagers

Now in its second year, Best Starts' Parent Child Health Services' Family Ways program leads with racial equity, supporting pregnant people, parenting families, and children up to age 5 to promote family health and wellness.[25] Family Ways works one-on-one with clients on family-identified priorities which cover a wide range of topics from obtaining rental assistance, to addressing picky eating at family mealtimes, and even just listening to families. Focus populations include American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and U.S. born Black/African American. All services are culturally rooted, participant-centered, and strengths-based with peer community specialists representing the communities served as well as a skilled clinical team which includes a public health nurse, social worker, and registered dietician. In 2023, **Best Starts reached 178 participants** through the Family Ways program**.**

> *"We believe our successes and high client satisfaction are because of our flexible yet structured approach to services and the trust we build with clients. We are committed to our vision and program core components but customize our services to clients...We are able to meet clients at locations convenient for them such as their home or library, reducing barriers and no-show / cancellation rates."*
>
> – Katie Hess, Program Manager, Public Health—Seattle & King County

Boosting families' knowledge of parenting and child development

Best Starts' Home-Based Services offers relationship-based support by trained Home Visitors for expecting families and families of children birth to age 5 years. In 2023, **3,272 caregivers participated in 86,893 visits** using nationally implemented or community-designed models, building their knowledge of parenting and child development**.**[26]

[25] Family Ways Website
[26] Best Starts Strategy One-Pagers

Through an array of programs, Community-Based Parenting Supports provides community-centered, peer-based services to strengthen protective factors, mitigate risk, and increase health, safety, and social-emotional well-being of pregnant people, parents, and caregivers of children birth to age 5.[27] In the community-based Lactation and Perinatal Support Services Program, **all 271 participants reported increased knowledge and skills** because of the culturally relevant educational services in 2023.[28]

> *"Families were able to connect with one another, sharing their experiences and asking one another questions. Positive relationships quickly blossomed between parents/caregivers and our staff, and these communal meals were certainly a factor in each participant reporting that they felt an increase in social connections thanks to attending [our program]. We are so grateful that these families trusted us, that they were able to find community amongst one another, and that they will all be returning in February to take part in level two of the program."*
>
> — Community-Based Parenting Supports partner

Increasing social connection

Best Starts' Positive Family Connections strategy focuses on strengthening and building positive relationships between children and young people ages five to 24, their families, and their caregivers through services including intergenerational healing circles, kinship care support groups, and educational workshops for families about child and youth development.[29] In 2023, the strategy enrolled **1,895 parents and caregivers and 1,055 young people. Ninety-nine percent of parents and caregivers and 97 percent of young people reported increased connection** to peers, family, culture, or community.

Prioritizing Well-being and Mental Health

Figure 3. Participants at the Infant Early Childhood Mental Health Certificate Program Kickoff

Best Starts Strategies for Prioritizing Well-being and Mental Health

- Community Well-being Initiative (SG)
- Child and Adolescent Immunizations (SG)
- Early Support for Infants and Toddlers (IE)
- Systems Building for Infant and Early Childhood Mental Health (IE)
- Liberation and Healing (SG)
- Parent Child Health Services (IE)
- School-Based Screening and Brief Intervention and for Referral to Treatment/Services (SG)
- School-Based Health Centers (SG)
- Universal Developmental Screening (IE)

[27] Best Starts Strategy One-Pagers
[28] Best Starts Strategy One-Pagers
[29] Best Starts Strategy One-Pagers

A focus on holistic well-being including mental health at all stages of life has been a cornerstone of the Best Starts initiative. The nine Best Starts strategies above contribute to outcomes related to prioritizing well-being and mental health while celebrating cultural roots and strengths by working to undo the tangible impacts of racism; meeting physical health, mental health, and developmental needs; and increasing understanding and awareness of physical and mental health. For example, in 2023:

- 65 percent of families who received a referral through the Universal Developmental Screening Family Centered Developmental Programs went on to establish a service connection.
- 57 percent of youth leaders who participated in the Community Well-being Initiative reported increased leadership skills.
- 99 percent of scholars served through the Liberation and Healing from Systemic Racism programs were in progress to meet or met their relationship goal.

Working to undo the tangible impacts of racism

Best Starts Parent Child Health Services' Infant Mortality Prevention Network supports community collaboration to eliminate racial disparities in infant deaths and improve birth outcomes within the communities experiencing the highest rates of infant mortality.[30] [31] In 2023, the Network **provided 3,180 services** within the communities experiencing the highest rates of infant mortality. **Among 122 pregnant patients with birth outcomes observed, 94 percent had healthy birth outcomes**, meaning babies were neither miscarried, premature, nor had low birth weight.[32]

Best Starts' Liberation and Healing partners with communities most impacted by systemic racism to co-create opportunities for scholars to participate in a wide range of programs. [33] The activities, ranging from the arts to exposure to the natural world, are designed to create a culturally responsive education system that aids young people's healing and sparks new interests. In 2023, **94 percent of families who received a basic needs referral through Liberation and Healing's TRACE partners were able to meet a basic need** such as securing housing, accessing

> *"Seeing scholars literally experience liberation and healing by gaining confidence in their abilities to create compelling, entertaining, and inspirational stories on screen is truly an honor. The scholars say they feel empowered, confident, and assured they can learn the fundamentals of filmmaking, take these skills, build on them, and eventually produce entertaining content that uplifts, brings joy, entertains, and inspires Black and Brown communities."*
>
> — Dr. Anita M. Cal, CEO/President, Kreative Collective L.L.C.

[30] Best Starts for Kids Blog
[31] Public Health – Seattle & King County, 2024/2025 Community Health Needs Assessment
[32] The term "healthy birth outcomes" refers to births that were neither premature nor low-birth weight.
[33] Best Starts Strategy One-Pagers

food, or accessing medical services which allowed families in crisis to move towards healing.[34]

Meeting physical health, mental health, and developmental needs

Best Starts' Universal Developmental Screening strategy provides information, training, tools, and connections among providers to ensure all King County children receive or have access to culturally appropriate, high quality developmental screening.[35] In 2023, Best Starts partners **directly screened 1,801 children for developmental progress**, **making 2,095 connections to needed services**.

> *"We are intentionally modeling new habits, attitudes, beliefs, and expectations…We know that there is a powerful parallel process involved in this work, so that the fundamental goals of a positive parent-child dyad are reflected all the way up through service providers, leadership members, supervisors/directors, and the CEO."*
>
> – Laura Anderson, ESIT Program Director, Children's Therapy Center

One such service is Early Support for Infants and Toddlers, which promotes equitable outcomes for families with children birth to age three who have developmental delays or disabilities.[36] In 2023, the Early Support for Infants and Toddlers (ESIT) program **served 6,720 children, 76 percent of whom made progress in their social-emotional development**.

School-Based Health Centers (SBHCs) meet young people where they are: in school. In clinics across King County, young people can access high quality, culturally relevant medical care, mental health care, and, in some cases, dental care.[37] In 2023, **4,459 students enrolled in school-based health center programs**. As Marlen Mendez, a Health Center Administrator at Sea Mar, shared, "Over the last month, [a student] had been to the ER three times. The SBHC provider was able to communicate and reassure him in Spanish and ordered an MRI and a referral to neurology…The provider offered [the student] the option of therapy and medication to manage [his] anxiety. He chose both options, something that the visits to the ER never addressed or offered."

> *"At my school, we utilized the universal screening. Through this process, I met a 7th grade student who screened in with a yellow flag. He was struggling with self-worth. With support from parents, we were able to connect him to individual counseling. This student has made gains emotionally and socially over the school year. This student is more involved in school, improved grades and appears much happier at school. SBIRT helped identify this student for support."*
>
> – Renee Damerow, Middle School Counselor, Kent School District

Best Starts' School-Based Screening and Brief Intervention and for Referral to Treatment/Services (SB:SBIRT) **screened 10,151 middle and 3,186 high school students for behavioral health needs**.[38] About four in ten students

[34] TRACE is an enhanced trauma-specific response to eligible children, young people, and family members who have experienced an adverse community event and/or are experiencing trauma as a result of childhood experiences.
[35] Best Starts Strategy One-Pagers
[36] Best Starts Strategy One-Pagers
[37] Best Starts Strategy One-Pagers
[38] Best Starts Strategy One-Pagers

in middle and high school identified new needs through SBIRT. Staff connected more than half of the students who received services to prevent suicide in young people, promote social and emotional health, and prevent substance use.[39]

Increasing understanding and awareness of physical and mental health

Best Starts' Child and Adolescent Immunizations activities increase vaccine awareness and knowledge, vaccine demand and referral to care, and engagement with health topics through youth-designed games, t-shirts, and stickers that promote vaccinations in a fun, relatable way.[40] The Child and Adolescent Immunizations strategy also works to foster growth and amplify voices of youth health advocates. As Marina Martinez, a Program Manager at the Washington Chapter of the American Academy of Pediatrics shared, "The WA-CHIP [Washington Child Health Improvement Partnership] Team is proud to have **impacted over 13,800 children and adolescents in King County. Missed opportunities to vaccinate children decreased by 19.9 percent and missed opportunities to vaccinate teens decreased by 13.5 percent.**"

The Community Well-Being Initiative builds community capacity to share resources and deliver culturally relevant programming on emotional health and well-being to reduce stigma associated with mental health topics and to reinforce compassion, connection, and care in communities.[41] In 2023, this initiative **held 468 community outreach activities and program events and 120 trainings with young leaders, community members, and providers. 100 percent of young people reported increased understanding of mental health and well-being after participating in the program.**

Promoting positive relationships between families and service providers

Best Starts' Systems Building for Infant and Early Childhood Mental Health focuses on improving social and emotional outcomes of young children birth to age five through training and reflective practice approaches for providers. [42] [43] These offerings strengthen the ability of caregivers and providers to support children to form close relationships with adults and peers. In 2023**, 257 providers participated in 37 workshops** in which **94 percent of participants** reported they **could apply something they learned to their work.** In addition, **519 providers participated in 696 reflective practice sessions** in which **85 percent of participants reported increased capacity to reflect on their work**.

[39] A yellow flag, mentioned in the quote by Renee Damerow, is known as a Tier 2 concern when a student has a response on the screening tool that indicates they may benefit from a brief intervention within the next two weeks.

[40] Best Starts Strategy One-Pagers

[41] Best Starts Strategy One-Pagers

[42] The term "reflective practice" is an approach that centers connecting the head, heart, and the hands in all aspects of caregiving, giving providers the ability the stop and reflect about how work is being done, how policies are created, and families are being served.

[43] Best Starts Strategy One-Pagers

Cultivating Opportunities for Children and Young People

Figure 4. Youth and Staff at the Spring Youth Showcase with Launch, Coyote Central, Double Dutch Divas, and SPIN

Best Starts Strategies for Cultivating Opportunities for Children and Young People

- Expanded Learning (SG)
- School-to-Work (SG)
- Stopping the School-to-Prison Pipeline (SG)
- Transitions to Adulthood (SG)
- Youth Development (SG)

These five Best Starts strategies cultivate opportunities for children and young people by investing in programming that creates positive spaces for young people when they are not in school or work. These programs build young people's strength and resilience to address stigma and racism and promote social and emotional well-being, interpersonal connections, and positive identity development. By supporting young people through mentorship, cultural connection and celebration, exploration of nature, and job training skills, programs provide opportunities for young people to learn and develop skills so they can actively plan for and look forward to their future and avoid legal system involvement. For example, in 2023:

- 80 percent of youth participating in Expanded Learning gained new skills.
- 61 percent of young people participating in the Stopping the School-to-Prison Pipeline made progress toward their educational goals.
- 81 percent of assessed participants in Youth Development programs increased connections or built healthy relationships.

Building young people's strength and resilience to address stigma and racism

Best Starts' Transitions to Adulthood supports young people ages 16 to 24 to meet their education and employment goals who may not otherwise have opportunities due to stigma and racism.[44] Reengaging in secondary education and helping them navigate the post-secondary systems such as applying for financial aid, paying for college books, and training in trades are some of the ways young people get the necessary tools to establish stability and security in their lives. In 2023, **720 young people participated in employment, education, or behavioral health programming on an ongoing basis**. According to assessments of individualized goal plans, **74 percent of young people** enrolled in behavioral health programming **improved their behavioral health.**

> *"One client was struggling with multiple panic attacks a week due to social anxiety and family-related trauma. Their treatment goals for counseling sessions were to reduce panic attacks and build stronger communication with parents. The clinician was able to use talk therapy and evidenced-based treatment to support the client in processing their feelings and better understand their trauma response...Sessions were reduced to every other week upon improved parental relationship and diminished recurrence of panic attacks. The client is now able to better focus on their academics and is on track for graduation."*
>
> – Bonnie Wang, Director, Asian Counseling and Referral Service

Stopping the School-to-Prison Pipeline invests in direct service programs to support young people ages 12 to 24 who, due to systemic and institutional racism, are more likely to be excluded from higher education and employment and pushed into the legal system.[45] Program staff build relationships with young people, provide guidance, and connect them to internships and employment with the guide of a navigator that advances economic and educational success. In 2023, **755 young people enrolled** and **98 percent participated in new activities focused on nurturing a positive sense of cultural identity**. As Sarah Sense-Wilson, Chair/Volunteer at Urban Native Education Alliance, said, "We traveled to local reservations and to Washington, D.C. with 14 youth for an intensive educational experience covering the National Museum of the American Indian, Department of Interior, the Center for Native American Youth. These cultural, leadership, and civic engagement experiences promote confidence, self-esteem, tribal values, and positive identity."

Best Starts' School-to-Work program provides critical supportive employment services such as practicing job tasks and talent assessments prior to employment and help with system navigation in partnership with an employment coach for young people with intellectual and developmental disabilities (I/DD) so they can obtain and maintain employment prior to exiting high school.[46] Nationally, individuals with I/DD face significant barriers participating in the workforce, on top of barriers like stigma and racism, experiencing employment rates of only 19 to 21 percent over the past decade.[47] Despite continuing impacts of the COVID pandemic, including contractor staffing shortages, the School-to-Work Program **served 330 students in 2023 and assisted 34 percent of students exiting school to reach employment within six months after their exit from high school**.

[44] Best Starts Strategy One-Pagers
[45] Best Starts Strategy One-Pagers
[46] Best Starts Blog
[47] StateData: The National Report on Employment Services and Outcomes through 2019

"We have come to understand the budget crisis that the school districts are facing this year and its implications for equity, especially for newcomer students. The equity problems stemming from this have activated our youth to respond by giving statements at school board meetings advocating for BIPOC representation among teaching staff, sensitivity trainings and inclusion of Asian American history in school curricula. The students wrote a public letter about what they need for mental health in our community and submitted petitions with 129 signatures, advocating for anti-racist curricula in their school districts."

– Joann Kim, former Family Youth Program Manager, Korean Community Services Center

Promoting social-emotional well-being, interpersonal connections, and positive identity development

Best Starts' Youth Development partners with community-based organizations to support mentoring, leadership, and healthy relationships. Programs include activities that help youth overcome toxic stress caused by family dysfunction, hip hop classes to reach youth, and opportunities for trans and gender diverse youth to engage with area leaders and connect with mentors and adults with similar lived experiences.[48] In 2023, Best Starts' partners **enrolled 5,594 young people, and 95 percent of assessed participants developed a positive identity**.

Best Starts' Expanded Learning provides high-quality after school and summer programming for young people ages 5 to 13 through academic enrichment, cultural and social development activities, physical activity and health promotion, arts education, and leadership development.[49] In 2023, Best Starts' **partners served 7,466 young people, and 89 percent of young people built social emotional learning skills**.

[48] Best Starts Strategy One-Pagers
[49] Best Starts Strategy One-Pagers

Strengthening the Workforce

Figure 5. Prenatal-to-Five Partners Showcasing Their Services at the Innovation Supports Partner Gathering

Best Starts Strategies for Strengthening the Workforce

- Child Care Health Consultation (IE)
- Child Care Wage Boost Pilot (CC)
- Innovation Supports (IE)
- Technical Assistance and Capacity Building (TACB)
- Workforce Development (IE)

Best Starts' work is accomplished through a strong network of community-based organizations and the dedicated people who work for them. Best Starts invests in strengthening the workforce through provider, program, and organizational capacity, and by providing practical support in early care and education. This includes funding organizations at levels that support livable wages, offering opportunities for workforce training, and paying for essential business tools. By investing in organizations' infrastructure and workforce, community-based organizations build the foundation they need to be strong and sustainable. For example, in 2023:

- 81 percent of participants in Workforce Development workshops reported they could apply something they learned to their work.
- 100 percent of providers served by Child Care Health Consultation teams reported increased knowledge of community resources or other consultation topics.
- 81 percent of Technical Assistance recipients' staff learned new skills.

Strengthening provider, program, and organizational capacity

Best Starts' Workforce Development strategy provides workshops, peer learning, and other professional development opportunities to build the knowledge and skills of early childhood practitioners in healthy child development, racial equity, and infant and early childhood mental health.[50] As an Ages and Stages Questionnaire (ASQ) training participant shared in an anonymous survey, "This training equips me to better support caregivers in recognizing developmental milestones, fostering an inclusive environment, and tailoring strategies that honor the diverse and unique needs of each infant and toddler in their care." In 2023, **374 providers in King County's early childhood workforce attended learning opportunities** funded by the Workforce Development strategy, and **90 percent of participants reported confidence in their abilities** to apply learnings to their work.

[50] Best Starts Strategy One-Pagers

Best Starts' Innovation Supports strategy leverages the creativity and expertise of community to design, develop, and lead innovative programs and interventions that serve children birth to age five and their families.[51] In 2023, Innovation Supports **built program capacity** through workshops, partner convenings, and individualized program assistance provided to **93 participants.** The success of increasing program capacity is evident as **100 percent of participants reported they felt prepared to implement their programs using their Innovation Supports materials.**

> *"As Innovation Supports Team providers, we were able to connect very closely with the partner organizations that we served this year, and this was especially the case for newly developing organizations we worked with who were newer to the Best Starts funding landscape. For these organizations, we were able to share valuable insights throughout the IDEAS Impact Design Framework process that not only supported them to develop their program materials (contract deliverables), but also support them in feeling confident in how to best navigate the Best Starts system, to share their stories of their work and to feel prepared to launch their programs into implementation."*
>
> – Colleen Alabi, Deputy Director, Mother Africa

Best Starts' Technical Assistance and Capacity Building offers applicants for Best Starts funding culturally responsive assistance with proposal development through consultation services provided by a diverse cohort of consultants, including proficiency in several languages, that is free to all organizations interested in applying for funding.[52] The strategy also assists funded Best Starts partners in building and or strengthening their organizational infrastructure for long-term stability and sustainability**.** In 2023, Best Starts **connected 104 community organizations to capacity building services, providing more than 8,800 hours of support**. **Eighty-five percent of capacity building recipients' staff, board, or volunteers were more effective in their work** after receiving capacity building.[53] For example, organizations that received brand and marketing consultation reached more community members who could benefit from their services.

Providing practical support in early care and education

Best Starts' Child Care Health Consultation is a collaborative partnership between a trusted child care health consultant and families, caregivers, and child care providers to promote the optimal physical and emotional health, safety, and development of children in their care. [54] Karen Snowden, an Infant and Early Childhood Mental Health Clinician at Navos, said, "Our team recognizes that effective consultation work can only occur in the context of relationships and have prioritized opportunities to build relationships with providers and community partners. Through these efforts, our team has developed a complex and rich understanding of the strengths, stressors, and challenges facing childcare providers in our community, and we were able to design a program and create materials that are responsive to these needs." In 2023, Child Care Health Consultation teams served **475 child care providers**. **Ninety-nine percent of providers reported increased ability to support growth and development of the children** in their care.

[51] Best Starts Strategy One-Pagers
[52] Best Starts Strategy One-Pagers
[53] Capacity Building Services
[54] Best Starts Strategy One-Pagers

Best Starts' Child Care Wage Boost Pilot invests in the child care workforce by providing a wage boost to child care workers. [55,56] This pilot aims to counteract the systemic inequities perpetuated by industry-wide low wages for child care workers and will evaluate the wage boost's impact on child care workers' well-being and retention in the workplace. **In 2023, Best Starts reprocured the funds to identify a group of three organizations with the skills and knowledge needed to effectively deliver the project.** These organizations are Aidkit, Inc., The Imagine Institute, and Uncommon Bridges. During this year, initial implementation planning continued to create frameworks for program design and selection and prioritization of participants, based in part on wage boost programs around the country, and the creation of communication and outreach plans. Wage boost partners also convened focus groups with child care workers to inform the design of the pilot, which is set to launch in summer of 2024.

Building Community Power[57]

Figure 6. Indian American Community Services Lead and Toxics Product Testing Event

Best Starts Strategies for Building Community Power

- Capital Projects (CP)
- Communities of Opportunity (COO)
- Healthy and Safe Environments (SG)
- Lead and Toxics (IE)

Vibrant, powerful communities are essential for the growth and success of young people and families, and leaning into community members' deep expertise informs and drives King County to healthier and equitable communities.[58] These Best Starts strategies contribute to outcomes that build community power to make improvements in policies and systems by investing in community ideas, capacity, and infrastructure to address risks and maximize opportunities to create safer environments. For example, in 2023, Communities of Opportunity Systems and Policy Change partners developed 1,006 resident leaders and Healthy and Safe Environments partners changed or improved 17 environments such as high schools, community centers and afterschool clubs. In one program, 100 percent of staff surveyed by Lead and Toxics partners reported increased knowledge on blood testing process and resources available to families.

[55] The Child Care Wage Boost Pilot was formerly known as the Child Care Workforce Demonstration Project.
[56] Best Starts Strategy One-Pagers
[57] Community power is the ability of communities most impacted by inequities to work together to set agendas, shift public discourse, increase opportunities for community ownership, and advance meaningful change.
[58] Communities of Opportunity Evaluation

Building and strengthening community power for decision-making and policy and systems change

Best Starts' Communities of Opportunity works through their Systems and Policy Change, Learning Community, and Place-Based and Cultural Community Partnership strategies to increase equitable conditions in housing, health, and economic opportunities through partner-led programs.[59]

- Communities of Opportunity's Systems and Policy Change strategy supports community-engaged and community-led efforts to transform systems and policies, increasing the readiness and ability of groups to inform, improve, and guide the implementation of systems and policies. For example, in 2023, **the Doulas For All Coalition partnership** made significant progress in a long-term and historic collaborative effort, **working with other community-based organizations, elected officials, government agencies, and others to change Washington state policy around securing Medicaid coverage for birth doula services for the first time in state history**.
- Through the Learning Community strategy, Communities of Opportunity builds community leadership and power through learning and supporting capacity-building resources, funding to pilot community-led, innovative models, and strengthening relationships and networks. In 2023, **295 people participated in Learning Community convenings, making new relationships or critical connections in progress building toward structural equity, including policy and/or systems change**.
- The Place-Based and Cultural Community Partnerships strategy realizes the power of community partnerships in neighborhoods and cultural communities to advance better health, safe and affordable housing, economic opportunity, and stronger community connections for residents. In 2023, **COO invested in the establishment and continuation of more than 20 community-rooted organizations and coalitions** working on issues such as guaranteed basic income, Crisis Care Center Levy opportunities, Bipartisan Military Mental Health Taskforce, Seattle-Tacoma International Airport's environmental impact, and digital equity for Washington's Native communities.

Creating safer and more equitable environments

Best Starts Capital Projects provides the funds to create safe, equitable physical spaces through contracts for building repairs, renovations, and new construction or expansion to improve access to high-quality programs and services for low-income children, young people, and families, prioritizing BIPOC and rural communities, and communities without access to similar facilities.[60] A new strategy added in the 2022-2027 Best Starts levy, 12 projects have already been funded to address critical health and safety repair projects in early learning facilities and child care, community, and recreation centers. In fall 2024, new construction projects as well as major renovations such as building acquisition, façade repair, and shell buildout are expected to be ready to break ground. Community members have responded positively to Best Starts' reduction of barriers for community partners seeking these funds by providing technical assistance for construction activities, creating a less complex contracting structure, and offering flexibility in payment structures.

[59] Communities of Opportunity Website
[60] Best Starts Strategy One-Pagers

Best Starts' Healthy and Safe Environments helps partners and organizations address community inequities by transforming systems, environments, and policies.[61] In 2023, Healthy and Safe Environments **partners engaged over 1,900 young people in activities** and **impacted 39,899 people.** For example**,** a teen advisory council implemented new programs in community clubs to raise awareness about mental health and evaluated how to take those programs to scale. They impacted how a youth-serving system talks about mental health to children, addressing stigma and breaking down barriers to treatment.

> *"Multiple community members have appreciated the value add of the lead talks and testing events that were held in various locations and formats... These members have now become vocal ambassadors of the lead toxicity program and raise awareness amongst other community members by spreading the word and talking to them individually. There has been a cascading effect in the community, due to the education and awareness brought about by these events."*
>
> – Kavitha Ramakrishnan, Early Childhood Facilitator, Indian American Community Services

The Lead and Toxics Program works to create healthier communities by building on the leadership within communities of color working towards environmental justice through activities such as hosting product testing events and participation on the Lead (Pb) Action Group some of whom provided testimony on the lead in cookware bill.[62] Children are particularly vulnerable to the effects of pollution, toxic substances, and unhealthy living conditions. In 2023, **364 community members attended 21 product testing projects hosted by community partners**. At the events, 18 percent of items that families with young children brought from home for testing had high lead levels. The program encouraged families to replace lead-identified products with safer alternatives and stop using them. All families received education on how to reduce the risk of lead exposure if replacing the item was a barrier. Data, such as referenced above, from these events supported policy changes at the state level including two new laws that reduce the amount of lead allowable in cookware and cosmetics sold in Washington.[63, 64]

B. Where Best Starts Serves: The Geographic Distribution of Best Starts Services

Best Starts works toward eliminating regional, racial, and economic disparities in King County and addressing the systems that create these disparities.[65] Best Starts works upstream to promote positive, healthy outcomes for young people and their families. In centering racial equity and justice, Best Starts' distribution of investments aligns with areas where the youth population is greatest and opportunities are lowest.[66] This level of demand is demonstrated by darker shades of color in the Figure 7 below.

[61] Best Starts Strategy One-Pagers
[62] Best Starts Strategy One-Pagers
[63] State of Washington Department of Ecology
[64] Research by Hazardous Waste Management Program in King County drives historic state law banning sale of lead-contaminated cookware
[65] Best Starts for Kids Implementation Plan
[66] Child Opportunity Index (COI) 2.0 Zip Code Data, February 2023

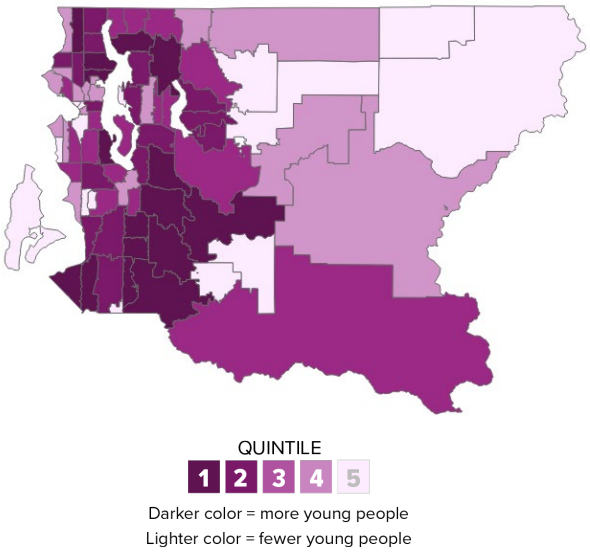
Youth Population Density and Young People's Needs in King County

The maps in Figure 7 demonstrate the different levels of youth population density and opportunities within King County. The Population density map demonstrates which areas of King County have higher concentrations of young people (ages 0 to 24 years). The Child Opportunity Levels map shows which areas of King County have low opportunity, defined by the Child Opportunity Index (COI).[67] High-opportunity ZIP Codes (lighter color) have more quality schools, parks and playgrounds, clean air, access to healthy food, health care, and safe housing. Low opportunity ZIP Codes (darker color) have fewer of these resources. These maps each provide an important lens on community need for investment within King County.

Figure 7. Population Density and Child Opportunity Levels in King County

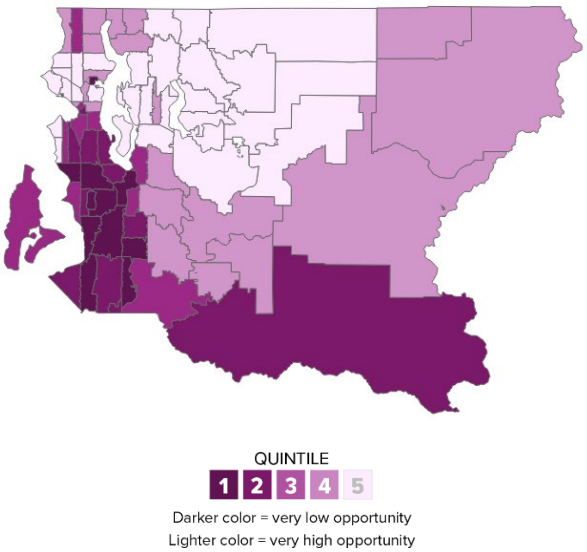
Population density (ages 24 and under)[68]

ZIP Codes with high number of young people include central, west, east, and north King County, though the highest numbers are in south King County.



Child Opportunity levels[69]

ZIP Codes with lowest opportunity according to the COI are mostly located in South Seattle and South King County



Geographic Distribution of Best Starts Participants and Expenditures in King County

The geographic distributions of Best Starts participants and expenditures, with two different methods of calculating Best Starts' expenditures by ZIP Code, are shown in Figures 8 and 9. Participant numbers and expenditures for individual ZIP codes are available in Appendix E and at the Best Starts for Kids Dashboard.

[67] Child Opportunity Index (COI) 2.0 Zip Code Data, February 2023

[68] Washington State Population Interim Estimates (PIE), December 2022. See also this details tab.

[69] Child Opportunity Index (COI) 2.0 Zip Code Data, February 2023

Figure 8. Best Starts Participants in 2023

Best Starts Participants

Best Starts reaches across King County. ZIP Codes with the most participants typically have more young people, lower opportunity, or both.

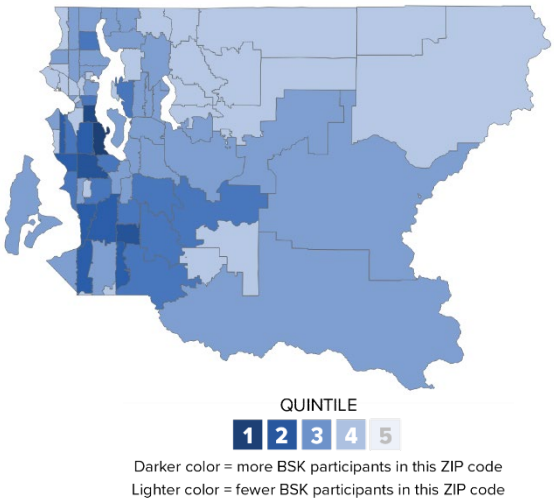


Figure 9. Best Starts Expenditures by ZIP Code in 2023

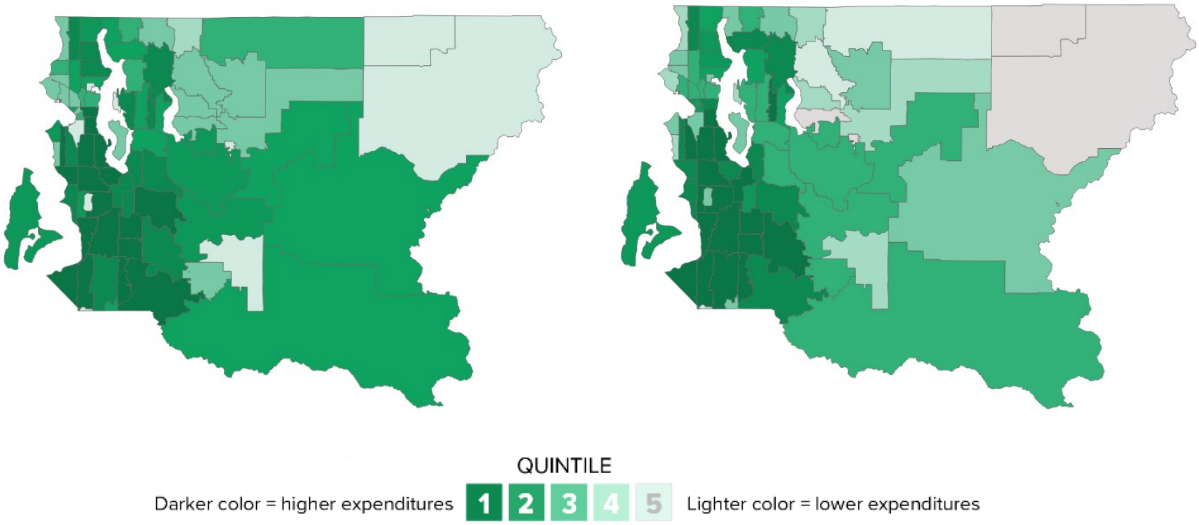
Best Starts Expenditures by Zip Code in 2023

Expenditures by where participants live

Best Starts spends more in ZIP Codes with more young people and lower access to opportunity.

Expenditures by where office-based services are located

Not all services take place at a physical office location, and expenditures for services that are office-based reach most of King County. The ZIP Codes with a higher density of young people and lower Child Opportunity Levels generally have higher expenditures by where office-based services are located



C. Best Starts for Kids Fiscal Information

The renewal of the Best Starts for Kids Levy in 2021 means Best Starts will invest more than $880 million throughout 2022–2027 to support children, young people, families, and communities across King County. In 2023, Best Starts expended more than $129 million.

The annual reported budget shown below is higher than the adopted implementation plan budget because it includes legislatively approved carry forward from Best Starts' 2022 budget.[70] Child Care and Capital Projects are two new investment areas launched in the 2022-2027 levy that have taken more time to launch than originally planned. Funding set aside for Capital Projects in 2022 has now been awarded through competitive procurement, but these funds will not be fully spent until construction on the awarded projects are completed. Similarly, 2023 funds are on track to be fully committed in 2024. Capital Projects anticipates having funds allocated in contracts by the end of 2024, but because of the complex nature of construction projects some funds may be expended later. In addition, the Child Care Wage Boost Pilot implementation was delayed by start-up staffing timelines and a change in community partner in Q3 of 2023, which necessitated a re-procurement. Full implementation of the pilot is anticipated in 2024.

The Best Starts fiscal table detailing expenditures by investment area and strategy, as well as maps detailing expenditures by ZIP Code, can be viewed online in the Best Starts for Kids Dashboard. A summary fiscal table at the investment area level is provided below.

Figure 10. 2023 Best Starts for Kids Expenditures by Investment Area

2023 Best Starts for Kids Expenditures by Investment Area		
Investment Area	**2023 Budgeted[71]**	**2023 Expenditures**
Child Care	$34,764,300	$30,890,272
Youth and Family Homelessness Prevention Initiative	$4,934,290	$4,774,967
Technical Assistance and Capacity Building	$2,424,120	$2,197,463
Subtotal *(per Ord 19267 subsection 4.D)*	$42,122,710	$37,862,703
Investing Early (Prenatal to 5)	$47,552,860	$45,855,095
Sustain the Gain (5 to 24)	$35,427,922	$34,044,586
Communities of Opportunity	$7,737,003	$6,736,765
Data and Evaluation	$4,931,858	$4,446,479
Capital Projects	$9,885,000	$204,803
Total 2023 Expenditures	**$147,657,352**	**$129,150,430[72]**

[70] Ordinance 19633

[71] Budgeted amounts shown for 2023 include approximately $16 million in 2022 commitments that were not spent in 2022 due to implementation and strategy design of new initiatives. Most of these are in the Child Care and Capital Projects investment areas, which were new in the 2022-2027 Best Starts levy.

[72] Remaining 2023 funds are reserved to meet contract commitments within the investment area strategies.

D. Investment Changes

Best Starts made no changes to planned strategy-level investments in 2023 or future years. Underspend in a strategy or investment area's prior annual budget that was carried forward into 2023 and future years continues to be allocated within the same strategies and investment areas to maintain the overall funding commitments outlined in the Best Starts for Kids Implementation Plan.

E. Feedback from Partners

Best Starts is grateful for lessons learned from community partners in 2023 and ongoing learning in partnership with community. As outlined in the Best Starts Implementation plan, Best Starts seeks feedback from partners proactively through surveys or semi-annual reports, and partners also give feedback informally during monthly check-in calls or partner convenings.[73]

In 2023, Best Starts' partners shared a desire for clearer descriptions of King County staff roles so that organizations are clear about where to turn to get their questions answered, along with clearer explanations of King County systems and processes. They wanted more opportunities for sharing knowledge to better understand, access, and raise awareness of resources, tools, and skills. Partners reflected a need for more in-person community-building opportunities and opportunities for training to deepen professional skills. Partners expressed that they want more organized gatherings and retreats to support and promote engagement between families and communities and to provide professional development opportunities to program staff.

In response, each strategy meets with all newly funded partners as a group to welcome them to King County, introduce them to key King County staff from other divisions such as finance and compliance, and explain at a high level what to expect over the course of their contract with the County. Best Starts also provides live and recorded trainings about the process of site visits and the financial documentation and systems requirements.

To support community and relationship building and promote opportunities for training and reflective learning, Best Starts created, cohosted, and scheduled virtual and in-person meetings with partners more frequently. This has allowed staff and providers opportunities to share information, connect about a certain topic, or learn from other experts in the field. Best Starts conducted a data walk to engage program partners in performance measure data reflection, dissemination, and community building. Best Starts also supported knowledge sharing and professional development opportunities to encourage access to continued opportunities for learning.

Feedback from partners for individual Best Starts strategies is summarized in Appendix D.

[73] Best Starts for Kid Implementation Plan, pg. 88.

F. Best Starts for Kids Data and Evaluation

Data Dashboard

Best Starts Data and Evaluation Team collaborates with partners to gather useful performance data and analyze that data for learning and reflection. Newly available 2023 performance measure data for all Best Starts strategies and programs is presented in detail on the Best Starts for Kids Data Dashboard. The Data Dashboard answers key questions on each tab including who Best Starts served, the results of the work, qualitative learnings, Best Starts' reach geographically, how Best Starts changes systems, and Best Starts investment areas. Additionally, the Resources and notes tab navigates users to in-depth evaluation reports, background references, and Best Starts population indicators. Best Starts population indicators are presented through interactive visualizations and reflect the most current data about community strengths and needs, including new results from the 2023 Best Starts for Kids Health Survey.[74] Indicators are presented along with the Communities Count Health Equity Timeline to document local historical and structural context that contributes to the conditions measured.[75] Best Starts strategies focus on contributing to long-term, county-wide positive changes, understanding that systemic factors within and beyond King County influence population data.

In-Depth Evaluation and Continuous Improvement

To complement Best Starts performance measurement and data capacity building across programs, Best Starts funds in-depth evaluation for select strategies and investment areas to answer specific learning questions. Best Starts maintains a full library of evaluation and technical reports on the King County website.[76] Below are key findings from in-depth evaluation reports Best Starts completed in 2023.

Child Care Health Consultation (CCHC) Evaluation Final Report—May 2023[77]

A three-year evaluation of CCHC showed consistent demand for health consultation from King County child care providers of all types, with an average of 1,000 consultations per quarter from 2019-2022. The pandemic highlighted consultants' ability to quickly adapt service delivery modes and respond to the shifting needs of child care providers. CCHC services demonstrated positive outcomes for child care providers across modes and settings in which consultation and child care are provided in the following areas of impact:

- Learning new developmentally appropriate ways to interact with children and support their behavior
- Implementing new nutrition practices
- Increasing capacity to support children with special needs
- Improving interpersonal relationships with children and families
- Gaining additional referral resources
- Receiving personal health and wellness support

[74] Best Starts for Kids Website
[75] Communities Count Health Equity Timeline
[76] Evaluation and Technical Reports
[77] Child Care Health Consultation (CCHC) Evaluation Final Report

Understanding the Reach of School-to-Work – August 2023[78]

The School-to-Work strategy connects students with developmental disabilities to employment services while they are in high school transition programs, investing in supports that reduce barriers to employment and promote success. This report details the reach of School-to-Work throughout King County, finding enrollment rate disparities by school district, support needs, and race and ethnicity. As a direct result of this report, School-to-Work staff are now providing additional outreach and support for communities that enroll at lower rates to ensure a more equitable reach of the program.

Strategic Vision for the Child Care Health Consultation System in King County —December 2023[79]

Upon completion of the final CCHC evaluation report, Best Starts funded a strategic visioning process led by an external evaluator and advisory group. The findings of this work directly shape the continuous improvement of the strategy over the remainder of the levy by sharpening the focus on the following four system components:

1. Build relationships between all child care health consultants and child care providers
2. Create strong connections and relationships among child care health consultants
3. Strengthen the child care health consultant workforce
4. Build supportive, co-designed systems for monitoring and evaluation

Culturally Responsive Measurement Tool – Protective Factors (CRMT-PF) —December 2023[80]

The Culturally Responsive Measurement Tool – Protective Factors (CRMT-PF) is a multilingual survey with 22 questions measuring five protective factors: family resilience, knowledge of parenting and child development, social supports, concrete support, and caregiver/practitioner relationships. In 2023, King County partnered with The Capacity Collective, community-based early learning service providers, and families to conduct a rigorous community validation process and implementation evaluation. The survey tool was adapted based on community feedback and the CRMT-PF is now available in Spanish, Simplified Chinese, and English. The tool, a final report, translated executive summaries, and other associated resources are free for the public to use.[81]

G. Children and Youth Advisory Board Consultation and the Communities of Opportunity Governance Group Review

Members of the King County Children and Youth Advisory Board and the Communities of Opportunity Governance Group reviewed a draft of the 2024 annual report in May 2024, in recognition of these bodies' advisory roles for Best Starts as described in KCC 2A.300.510 and KCC 2A.300.521.[82]

Conclusion and Next Actions

In 2023, Best Starts invested in 187 new programs operated by 136 organizations, expanding reach and creating positive impacts to provide King County's children with the best start in life. Best Starts built on

[78] Understanding the Reach of School-to-Work
[79] Strategic Vision for the Child Care Health Consultation System in King County
[80] Culturally Responsive Measurement Tool – Protective Factors (CRMT-PF)
[81] Culturally Responsive Measurement Tool
[82] KCC 2A.300.510 and KCC 2A.300.521

accomplishments across eight investment areas. The five key themes in this report summarize the holistic nature of the Best Starts strategies:

- Meeting Families' Needs
- Prioritizing Well-being and Mental Health
- Cultivating Opportunities for Children and Young People
- Strengthening the Workforce
- Building Community Power and Capacity

Best Starts' approach provides opportunities for healthy development that proactively focus on prevention and early intervention, coupled with promotion and systems and policy change across ages and lifespans. For example, mental health is strengthened by improving a baby's essential first relationships and through continued support all the way through young adulthood. Also, the non-profit and child care workforce can been bolstered through individual training and professional development as well as systemwide changes in pay scale and benefits. With the interconnected nature of community, children, and families, Best Starts seeks to create change through immediate individual impact as well as sustainable systemic impact.

In 2024, Best Starts plans to continue re-procurement processes for several strategies that will refresh its work with current partners and create opportunities for new partners to be funded. Best Starts will also begin to evaluate the impacts of several of its innovative approaches to address community needs. Among these, Best Starts is currently conducting in depth evaluations of Technical Assistance and Capacity Building and the Child Care Wage Boost Pilot. Best Starts plans to release results of these evaluations and use them to shape strategies and priorities in the future.

Through partnerships in every part of the region, Best Starts catalyzes strong starts with comprehensive prenatal well-being through early childhood supports, sustains these gains as young people progress to adulthood, and strengthens communities' voices and power to influence decisions that affect them. In 2024, Best Starts will continue to lead with racial equity and community wisdom, staying true to the pillars of promotion, prevention, early intervention, and systems and policy change. To ensure that services and programming progress, and new areas of investments begin to take shape, Best Starts continues to strive to offer positive, uplifting opportunities for all so that King County's children have access to a path to lifelong health and well-being and the region's communities can thrive.

Appendix A Reporting Elements Table and Best Starts for Kids Online Reporting Guide

Figure 11. Reporting Elements Table and Best Starts for Kids Online Reporting Guide

Reporting Element Language	Source	See Section(s) of This Report	See Also Best Starts Online Dashboard Tab(s)
The annual report on levy expenditures, services, and outcomes shall include:	Ordinance 19267 Ordinance 19354 Best Starts for Kids Implementation Plan 2022-2027, p. 85	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023 • Report Requirements Subsection C: Best Starts for Kids Fiscal Information	• Who do we serve? • What are our results? • What are we learning? • Where do we reach? • What do we invest in?
Total expenditures of levy proceeds by program area by ZIP Code in King County	Ordinance 19267 Ordinance 19354	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023 • Report Requirements Subsection C: Best Starts for Kids Fiscal Information	• Where do we reach?
The number of individuals receiving levy-funded services by program area by ZIP Code in King County of where the individuals reside at the time of service	Ordinance 19267 Ordinance 19354	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023 • Report Requirements Subsection C: Best Starts for Kids Fiscal Information	• Where do we reach?

Reporting Element Language	Source	See Section(s) of This Report	See Also Best Starts Online Dashboard Tab(s)
King County shall require collection of this ZIP Code information from all service contractors who receive moneys from the Best Starts for Kids levy for contracts executed after December 31, 2021. King County shall work with contractors providing services to individuals and families to develop the capacity to collect and report the information to the county. The annual report shall include this ZIP Code information in addition to any other ways the report may visually provide the information.	Ordinance 19354	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023 • Report Requirements Subsection C: Financial Information	• Where do we reach?
These Best Starts Annual Reports will provide data for Investing Early, Sustain the Gain, COO, YFHPI, child care, and technical assistance strategies, and the capital grants program.	Best Starts for Kids Implementation Plan 2022-2027, p. 85	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023 • Report Requirements Subsection C: Financial Information	• Who do we serve? • What are our results? • What are we learning? • Where do we reach? • What do we invest in?

Reporting Element Language	Source	See Section(s) of This Report	See Also Best Starts Online Dashboard Tab(s)
Best Starts will also develop and pilot a methodology beginning in 2022 for reporting program expenditures by ZIP Code based on available data or modeling. This methodology will need to account for expenditures for programs that are provided virtually, programs that do not operate from a single service location like home-based services, and systems-change work that has impacts in communities larger than a single ZIP Code.	Best Starts for Kids Implementation Plan 2022-2027, p. 87	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023 • Report Requirements Subsection C: Best Starts for Kids Fiscal Information	• Where do we reach? Resources and notes
ZIP Code data will be reported using maps or other visualizations to aid interpretation of the data.	Best Starts for Kids Implementation Plan 2022-2027, p. 86	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023 • Report Requirements Subsection C: Best Starts for Kids Fiscal Information	• Where do we reach?
Detailed performance measures are anticipated to be available online through interactive dashboards that provide transparency by making timely data available and easier to explore.	Best Starts for Kids Implementation Plan 2022-2027, p. 85	N/A	• What are our results?

Reporting Element Language	Source	See Section(s) of This Report	See Also Best Starts Online Dashboard Tab(s)
Annual reporting for the levy will also describe any changes made to strategy-level investments during the reporting period in order to best utilize levy resources, as well as indicate whether strategy-level investments are expected to change for the subsequent reporting period or remain the same.	Best Starts for Kids Implementation Plan 2022-2027, p. 86	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023	N/A
Best Starts' performance measurement analyses will also solicit feedback from grantees and levy-funded service providers regarding recommendations for achieving improvements in services delivery and strategy-level outcomes. Feedback received will be included in the annual reporting for the levy, beginning with the annual report for calendar year 2022.	Best Starts for Kids Implementation Plan 2022-2027, p. 86	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023	N/A
Annual reporting for the levy will include the evaluation findings, including when appropriate an assessment of the program's effectiveness in achieving stated goals and intended outcomes.	Best Starts for Kids Implementation Plan 2022-2027, p. 87	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023	N/A
This section shall prevail in the event of a conflict between the language in this section and language contained in Attachment A to this ordinance.	Ordinance 19354	N/A	N/A

Reporting Element Language	Source	See Section(s) of This Report	See Also Best Starts Online Dashboard Tab(s)
The [Children and Youth Advisory] board shall… Consult on and review annual reports to the council and community that demonstrate transparency regarding the expenditure of levy proceeds and the effectiveness of the Best Starts for Kids children and youth strategies in meeting the goals and outcomes established in Ordinance 19267.	K.C.C. 2A.300.510.E.4	• Report Requirement Subsection G: Children and Youth Advisory Board Consultation and the Communities of Opportunity Governance Group	N/A
The Children and Youth Advisory Board and the COO Governance Group will consult on, and review, the respective portion of annual reports on Best Starts programming for which they have been charged with oversight.	Best Starts for Kids Implementation Plan 2022-2027, p. 86	• Report Requirement Subsection G: Children and Youth Advisory Board Consultation and the Communities of Opportunity Governance Group	N/A
By late 2020, DCHS anticipates being able to make available maps and/or data summaries showing the distribution of BSK, MIDD, and VSHSL human services by service participant zip code, with high-level summaries included in the initiatives' annual reports.	Human Services Geographic Equity Plan December 2019, p. 57	• Report Requirements Subsection B: Best Starts for Kids Implementation and Outcomes in 2023 • Report Requirements Subsection C: Best Starts for Kids Fiscal Information	• Where do we reach?

Appendix B: Best Starts for Kids Strategies Funded in 2023

Figure 12. Best Starts for Kids Strategies Funded in 2023

Investment Area	Strategy Name
Child Care	Child Care Subsidy Program Child Care Wage Boost Pilot[83]
Investing Early	Child Care Health Consultation (CCHC) Community-Based Parenting Supports (CBPS) Early Support for Infants and Toddlers (ESIT) Environmental Supports: Lead and Toxics Help Me Grow Home-Based Services Innovation Supports Parent and Child Health Services[84] Systems Building for Infant and Early Childhood Mental Health Universal Developmental Screening Workforce Development
Sustain the Gain	Child and Adolescent Immunizations Expanded Learning Healthy and Safe Environments Liberation and Healing Positive Family Connections SB:SBIRT School-Based Screening and Brief Intervention and for Referral to Treatment/Services School-Based Health Centers Stopping the School-to-Prison Pipeline (SSPP)

[83] Formerly known as Child Care Workforce Demonstration Project
[84] Formerly known as Maternal and Child Health Services

Investment Area	Strategy Name
	Transitions to Adulthood Youth Development
Youth and Family Homelessness Prevention Initiative (YFHPI)	Youth and Family Homelessness Prevention
Communities of Opportunity (COO)	Learning Community Place-based and Cultural Communities Systems and Policy Change
Capital Projects	Capital Projects
Technical Assistance and Capacity Building	Technical Assistance and Capacity Building
Data and Evaluation	Data and Evaluation

Appendix C: Partner Feedback by Strategy

Best Starts recognizes that investing in community organizations goes beyond the initial award, and requires ongoing partnership, shared and continuous learning, mutual accountability, and supporting the organization with capacity building to ensure organizational stability and sustainability. Best Starts values receiving feedback from partners to continue centering community needs in realizing *their* vision for *their* communities, in order to build a thriving King County. Figure 13 outlines examples of feedback received in 2023 and Best Starts' actions to respond by strategy. Best Starts Program Manages collect feedback continuously throughout the year and shared themes focusing on where partners needed support and how Best Starts is already addressing and plans to continue building on that feedback to meet partner and community needs. These findings inform how Best Starts is working towards investing and will continue to invest in partners in 2023 and beyond. For a comprehensive look at the data, please see the Best Starts for Kids Data Dashboard.

Note: Some Best Starts strategies fund programs directly executed by internal King County staff. They do not have external partners and are not represented on this table.

Figure 13. Partner Feedback by Strategy

Strategy	Partner Feedback Received in 2023	Best Starts' Response to Partner Feedback
Investment Area: Child Care		
Child Care Subsidy	Subsidy partners offered suggestions for enhancements in clients' application experience and improvement in procedures and strategies to improve language access and non-internet based options for families to access program application technical support.	Best Starts is integrating this feedback into the implementation of the Subsidy program in partnership with its new program administrator, BrightSpark Early Learning Services. The focus for program improvements for 2024 include, language access enhancements, provider payment efficiency, program data management, client customer service and communication, and relationship building with the child care provider community.
Child Care Wage Boost Pilot	Partners requested a flat wage boost for the life of the project.	Best Starts is integrating this feedback into planning for the Wage Boost Pilot that will launch

Strategy	Partner Feedback Received in 2023	Best Starts' Response to Partner Feedback
		summer 2024, attempting to reach the desired wage increase if the budget allows.
Investment Area: Investing Early		
Child Care Health Consultation	Partners suggested having a reflective learning space in a case-based learning format.	Best Starts is partnering with the Northwest Center for Public Health Practice's IMPACT team to facilitate monthly Reflective Case Consultation sessions for CCHC service delivery partners, where consultants learn from real cases that others have consulted on and share tools and ideas with one another.
Community-Based Parenting Supports	Partners expressed feeling blindsided by the site visits and audit requirements.	Best Starts launched a new Best Starts Orientation that collaborated and included the Compliance, Finance, and Evaluation Teams.
Early Support for Infants and Toddlers	Partners requested recording meetings to support language access. Recording allows people to review information more than once, which can help with processing the information.	Best Starts is exploring recording community meetings and posting them online; considering the right balance between recording and free and open discussion.
Environmental Supports: Lead and Toxics	Partners expressed a need to increase budgets and scopes of work in 2024 to allow each organization to pursue projects specific to their community's needs.	Best Starts is having each organization add focused projects of their choosing for their 2024 scope of work and increased their budgets through underspend in other areas to incorporate this new work.
Help Me Grow	Partners expressed a need for in-person resource sharing and learning from one another.	Best Starts is co-hosting rotating, in-person meetings with partners at funded community-based organizations. The intention is to build community for shared learning and ongoing collaboration.

Strategy	Partner Feedback Received in 2023	Best Starts' Response to Partner Feedback
Home-Based Services	Partners expressed a need to address high costs of living, especially to increase staff compensation.	Best Starts works to ensure partner award levels include annual cost of living increases throughout the duration of each contract. Partners will receive additional funds, if available, to address this gap.
Innovation Supports	Partners expressed a desire for more opportunities to connect with each other and engage with other organizations throughout the design and development phase.	Best Starts is leading two virtual shared learning partner convenings and planning and hosting an in-person Prenatal-to-5 Innovation Supports Partner Gathering, inviting the larger Best Starts for Kids' Prenatal-to-5 community, along with piloting an in-person workshop series, increasing sharing across partners.
Systems Building for Infant and Early Childhood Mental Health	Partners expressed a need to offer training opportunities on weekends.	Best Starts is scheduling several options on Saturdays to meet the need of child care providers.
Universal Developmental Screening	Partners expressed a need for guidance and support to pilot the Parent Champions work.	Best Starts is partnering with Innovation Support Team capacity builders, trained in program development tools, to guide partners through thoughtful visioning and program planning activities like story boarding, practice profile, and theory of change.
Workforce Development	Partners expressed a desire to improve community outreach, recommending engaging the community in-person.	Best Starts is attending and setting up tables at several local conferences pertaining to the Prenatal to Five Workforce to make in-person connections and share Workforce Development flyers, along with planning and scheduling more in-person meetings and collaborative activities with community-based organization partners.
Investment Area: Sustain the Gain		

Strategy	Partner Feedback Received in 2023	Best Starts' Response to Partner Feedback
Child and Adolescent Immunizations	Partners requested to shift the model to shorten overall cohort length to improve accessibility for clinics and expand access to overburdened and under resourced healthcare partners and reach a greater number of clinics across King County.	Best Starts is adjusting curriculum length to accommodate two improvement partnership cohorts, expanding reach to more of the highest need clinics in King County.
Expanded Learning	Partners shared a need for additional time with each other focused on collaborative planning and reflection.	Best Starts is hiring a Partnership Manager who assists Place-based Collaborative partners in strengthening practices and growing capacity in partnership building through technical assistance.
Healthy and Safe Environments	Partners shared that the contracting process was cumbersome, given the quick turnaround for work plans and performance measurement plans soon after contract execution and project implementation.	Best Starts is providing comprehensive support and guidance for work plan and performance measurement plan development in one-on-one meetings for the first and second drafts of these documents.
Liberation and Healing	Partners shared a need for clarity in relationships between the funded Subject Matter Experts (SMEs) and Organization Leads (OLs) in relation to accessing scholars for program purposes.	Best Starts is meeting monthly as an executive team that includes the OLs and SMEs to create space to deepen relationships and bring clarity to the collective work.
Positive Family Connections	Partners expressed a desire to have a strategy retreat where they can gather and learn topics that would support staff professional development with family engagement.	Best Starts is planning for a strategy retreat for Positive Family Connections partners in 2024.

Strategy	Partner Feedback Received in 2023	Best Starts' Response to Partner Feedback
School-Based Screening and Brief Intervention and for Referral to Treatment/Services	Partners requested better documentation about meeting notes and decision making within the district workgroups and learning collaboratives.	Best Starts is sending out agendas for meetings ahead of time and taking more detailed meeting notes that are then shared out with the partners.
School-Based Health Centers	Partners expressed interest in understanding evaluation of collective impact and how data collection efforts come together to support the collective work.	Best Starts planned December 2023's meeting to focus on collective impact and evaluation practices.
Stopping the School-to-Prison Pipeline	Partners expressed a need for access to more funding, along with continued support through transitions in the funding process, including the step of offboarding as a Best Starts partner and working to secure private funds as organizations prepare for the unforeseen future.	Best Starts is initiating monthly one-on-one check-ins with each provider to have a private space where they would be able to share more openly than the monthly Provider meeting spaces that were more public.
Transitions to Adulthood	Partners expressed feeling worried that they cannot continue the levels of service that they have in the past without an increase in budget.	Best Starts is examining how to best support organizations in the budget making process to plan for inflation and wage increases over the life of the contract.
Transitions to Adulthood: School to Work	Partners shared that online orientations and "meet & greets" were helpful in educating students and families about the program, navigating system services, and connecting to School-to-Work Services.	Best Starts is adding more events for 2023-2024. Best Starts will plan more language specific orientations and provide language support for King County's community Employment First outreach efforts to engage younger students.
Youth Development	Partners requested an interactive map of their programs and services	Best Starts' Youth Development team is discussing with the Evaluation Team and are working on developing interactive maps of partners' programs and services.

Strategy	Partner Feedback Received in 2023	Best Starts' Response to Partner Feedback
Investment Area: Youth and Family Homelessness Prevention Initiative		
Youth and Family Homelessness Prevention Initiative	Partners expressed that having case managers serve as the primary referral source for rental assistance, screen households, and gather documentation was labor and time intensive.	Best Starts is moving all pre-screening and assessments to the rental assistance agencies in August of 2023, asking case managers only to send an email asking for support.
Investment Area: Communities of Opportunity		
Communities of Opportunity	Partners expressed interest in connecting across sectors, projects, community partners, and system changers.	Best Starts has created Communities of Practice across the COO strategies for partners to network, strategize, learn, and develop skills for building stronger partnerships through self-guided and facilitated activities.
Learning Community	Partners expressed their interest in more opportunities to convene together across sectors, projects, and communities, and to connect to funders and systems change makers.	In addition to the two All-Partner Convenings in 2023, the Learning Community also supported additional convenings of community partners around shared strategies, collaborations and plans that aligned groups, activities and opportunities.
Place-Based and Cultural Community Partnerships	Partners expressed that building a coalition takes more planning time than individual organization work. Some, especially newer ones, suggest dedicating the first 6+ months of the contract to planning. This allows more time to build relationships and infrastructure for successful implementation of strategies.	Best Start Program Managers were flexible and accommodating to partner needs. They adjusted work plans and provided ample time for coordination. Program Managers strengthened partnerships by meeting in person and working with Learning Community strategy to address needs.
Systems and Policy Change	Partners shared that systems change work takes years, and it is unreasonable to expect immediate change and community level impacts over the course of a two-year grant cycle.	For the 2023-2024 cycle Best Starts Program Managers were open to re-funding previously funded partners to continue their previously supported work. Best Starts Program Managers also continued the commitment to share

Strategy	Partner Feedback Received in 2023	Best Starts' Response to Partner Feedback
		partners' success stories and encouraged COO's Governance Group to explore potential new partners.
Investment Area: Capital Projects		
Capital Projects	Partners suggested that Best Starts' Capital Projects put extra focus on outreach for this new funding source to ensure receiving applications from all regions and that Best Starts provides even stronger geographic dispersion of funding.	Best Starts is proactively doing in-person outreach, hosting in-person open houses in every region of the County ahead of the second RFP release of 2023.
Investment Area: Technical Assistance and Capacity Building		
Technical Assistance and Capacity Building	Best Starts partners expressed a need for more training and support, particularly regarding budget development and financial management.	Best Starts offered trainings to funded partners designed to increase understanding of nonprofit fiscal best practices, organizational legal issues, contract language, school/nonprofit partnerships, data management skills, and program budget development.

Appendix D: Community Partner List

Best Starts is grateful to our community partners for the compassion, wisdom, and expertise they share with King County communities. Best Starts encourages collaboration and partnership between organizations. While this list reflects the primary agencies that held contracts with Best Starts in 2023, many additional partners carry out the work in collaboration with these organizations.

A 4 Apple Learning Center
A Sacred Passing
A Supportive Community for All (SCFA)
- Empower Youth Network
- Encompass Northwest

Abubakr Islamic Center of WA
Adaptive and Inclusive Movement Initiative
Afghan Health Initiative
African American Leadership Forum
African Community Housing & Development
Africatown Community Land Trust
After-School All-Stars
alterNative Consulting
Amara
AMT Up 3D
ANEW - Apprenticeship & Nontraditional Employment for Women
API Chaya
Arts Corps
ArtsEd Washington
Asian Counseling and Referral Service
Atlantic Street Center
Attemla Consulting, LLC
AtWork! Washington
Auburn School District
Babies of Homelessness
BDS Planning & Urban Design
Bike Works
Birth to Three Developmental Center
Black Star Line African Centered Family Educational Collective
BLKBRY, LLC
Boyer Children's Clinic
Boys & Girls Clubs of Bellevue
Boys & Girls Clubs of King County
BRAVE
Bridges - Seattle Alternative Peer Group
Bridging Cultural Gaps (BCG)
BrightSpark Early Learning Services/Child Care Resources
Build 2 Lead
Bulle Consulting
Byrd Barr Place
Cardea Services

Casa Latina
Cascade Middle School
Cascadia Consulting Group
Catholic Community Services
Celebrating Roots
Center for Human Services
Center for Indigenous Midwifery
Cham Refugees Community
Chief Seattle Club
- Seattle Indian Health Board
- United Indians of All Tribes Foundation
Childhaven
Children's Therapy Center
ChildStrive
Chinatown-International District Worker and Organizing Center
- Massage Parlor Outreach Project (MPOP)
- Chinatown International District Coalition
- Puget Sound Sage
Chinese Information and Service Center
CHOOSE 180
City of Shoreline
City of Tukwila
Cloudbreak Collective
Collective Justice Project
Communities In Schools of Greater King County
Communities of Rooted Brilliance (CRB)
Communities Rise
Community for Youth (CfY)
Community Network Council
Community Roots Housing
Comunidad Latina de Vashon
- Latino Community Fund of Washington
Congolese Integration Network
Construyendo Juntos Consulting
Contacto Consulting
Creative Justice
Crescent Collaborative
- Africatown Community Land Trust
- Byrd Barr Place
- Community Roots Housing
- First Hill Improvement Association
- Friends of Little Saigon
- Seattle Chinatown International District Preservation and Development Authority (SCIDpda)
Crux Consulting Consortium
Cultivate South Park
DANCE This Productions
Dare2Be Project
Denise Louie Education Center
Diaspora Family Healing Network
Dicentra Consulting
Dick Scobee Elementary
Disability Rights Washington
Dispute Resolution Center of King County

Divine Alternatives for Dads Services (DADS)
East African Community Services
Eastside for All
Educate to Liberate Consulting
Education for All Youth Program
El Centro de la Raza
Empower Next Generations
Empower Youth Network
Empowering Youth and Families Outreach
Encompass Northwest
ENSO Employment Services
Enumclaw School District
Equity in Education Coalition
Eritrean Association in Greater Seattle
Fair Work Center
Faith Finance Center
Families of Color Seattle (FOCS)
FamilyWorks
Federal Way Public Schools
FEEST
Food Empowerment Education & Sustainability (FEEST)
Filipino Community of Seattle
First Five Years & Beyond
First Hill Improvement Association
ForFortyTwo
    - Glover Empower Mentoring
Freedom Project
Friends of Little Saigon
Friends of Youth
FW Black Collective
Geeking Out Kids of Color
Generosity on the Go
Global Perinatal Services
Global to Local
Glover Empower Mentoring
Got Green
Gwen's Guidance
Hayaan, LLC
Headwater People Consulting
HealthPoint
Hearing Speech & Deaf Center
Heart & Hustle Academy
Highline College
Highline Public Schools
Hip Hop Is Green
HopeCentral
Horn of Africa Services
    - Oromia Center in Washington
    - Somali Community Services of Seattle
Housing Development Consortium
Hummingbird Indigenous Family Services
Illuminate Evaluation Services
Immigrant Women's Community Center
Inclusive Data LLC

Indian American Community Services (IACS)
- Muslim Community Network Association
- Eastside for All
- Housing Development Consortium

Institute for Community Leadership

InterCultural Children & Family Services

International Community Health Services (ICHS)

Iraqi Community Center of Washington

JSOL STUDIOS LLC

Kandelia

KBTC Public Television at Bates Tech

Kennedy Catholic High School

Kent Community Development Collaborative
- Community Network Council
- Communities In Schools of Kent
- Communities of Rooted Brilliance (CRB)
- Mother Africa

Kent School District

Kent Youth and Family Services

Khalsa Gurmat Center

Kids & Paper

Kids Co.

KidsQuest Children's Museum

KidVantage

Kiks for Cool Kids

Kindering

King County Equity Now

King County Medical Society

King County Play Equity Coalition - Seattle Parks Foundation

King County Sexual Assault Resource Center

Korean Community Service Center

Kreative Collective, LLC

Lambert House

Laney Brackett

Latino Community Fund of Washington

Launch Learning/Community Day School Association

Legacy P.O.W.E.R. Council
- Build2Lead
- Federal Way Public Schools
- King County Public Health Department
- Leadership Tomorrow
- Livia Behavioral Health Services
- Momentum Belonging Group
- Morehouse School and Medicine
- UW Medicine Physicians Clinic
- Virginia Mason Franciscan Health

Listen and Talk

Living Well Kent

Look2Justice

Manos Unidas International

Mary's Place

Mercer Island School District

Mother Africa

Multimedia Resources and Training Institute (MMRTI)

Muslim American Youth Foundation

Muslim Community Network Association
Muslimahs Against Abuse Center
Navos
Neighborcare Health
Neighborhood House
New Americans Alliance for Policy and Research
- Horn of Africa Services
- Iraqi Community Center of Washington
- Partners in Employment
- Somali Community Services of Seattle

New Economy Project
New Horizons
NISO Programs
No Limits Therapeutics Services
Northshore School District
Northshore Youth and Family Services
Northwest Center
Northwest Education Access
Northwest Film Forum
Northwest School for Deaf and Hard-of-Hearing Children
Not This Time!
Open Arms Perinatal Services
Open Doors for Multicultural Families
Oromia Community Center in Washington
Pacific Islander Health Board of Washington
Para Los Niños
Partner in Employment (PIE)
Partners For Educational Reform and Student Success (PERSS)
People of Color Against AIDS Network (POCAAN)
Perinatal Support Washington
Pollock+Partners
Potlatch Fund
Praisealujah Discipleship
Praxis Institute for Early Childhood Education
Primm ABC Child Care Center
Pro Se Potential
Provail
Puget Sound Educational Service District
Puget Sound Personnel
Puget Sound Sage
Queer Power Alliance
Rainier Athletes
Rainier Beach Action Coalition (RBAC)
Rainier Valley Midwives
Reclaiming Our Greatness
Refugee Immigrant Community Health (R.I.C.H.) Program
- Cham Refugees Community
- Omar Bin Al-Khattab Islamic Center
- Somali Cultural Center

Refugee Women's Alliance (ReWA)
reimagine collective
Renton School District (RSD)

Resilient in Sustaining Empowerment (RISE)
Restore Assemble Produce (RAP)
RHL Consulting
Riverton Park United Methodist Church
Rooted in Vibrant Communities (RVC) Seattle
Rooted in Vibrant Communities/First Five Years & Beyond (?)
Ryther
SAILS Washington, Inc.
Sama Praxis
SanArte Healing & Cultura Clinic
Sarah Derstadt
Scholar Fund
School's Out Washington
Sea Mar Community Health Center
Sea Potential
SeaTac Airport Community Coalition (STACC) 4 Justice
- Beacon Hill Council
- 350 Aviation
- El Centro De La Raza
- King County Int'l Airport Community Coalition
- Quiet Skies Puget Sound

Seattle CARES Mentoring Movement
Seattle Children's Hospital
Seattle Chinatown International District Preservation and Development Authority (SCIDpda)
Seattle Foundation
Seattle Housing Authority
Seattle Indian Health Board
Seattle Neighborhood Group
Seattle Parks and Recreation
Seattle Public Schools
SG Education Consulting
SKCAC Industries & Employment Services
Skykomish School District
Skyway Coalition
Snoqualmie Valley Human Services Coalition
- A Supportive Community for All
- Acres of Diamonds
- Empower Youth Network
- Encompass NW
- Holy Innocents Food Pantry
- Helping Hands
- Hopelink
- Huntington Learning Center
- Mt. Si Senior Center
- Mamma's Hands
- Reclaim
- Snoqualmie Valley Food Bank
- Sno-Valley Senior Center
- Tolt Congregational UCC Community Connections Program
- Snoqualmie Valley YMCA
- SVA Church

Snoqualmie Valley School District
Society of St. Vincent de Paul
Solid Ground

Somali Childcare Providers Association/Somali Women and Child Care Association
Somali Community Services of Seattle (SCSS)
Somali Health Board
South End Stories
South King County LGBTQIA+ Collaborative
- Queer Power Alliance (formerly known as LGBTQ Allyship)
- Entre Hermanos
- POCAAN
South Seattle Women's Health Foundation
Southeast Youth & Family Services
Southwest Youth & Family Services
Speak With Purpose
St. Stephen Housing Association
Start Early Washington
Statewide Poverty Action Network
STEM Paths Innovation Network
Stemtac Foundation
Student & Family Support Program
Student Connection
Sunrise Services, Inc.
Supported Solution, LLC
Surge Reproductive Justice
- Families of Color Seattle (FOCS)
Sustainable Seattle
Tahoma School District
Team Read
Technology Access Foundation (TAF)
Tenants Union of Washington State
Teniel Sabin Education & Consulting
The 4C Coalition
The Arc of King County
The Breakfast Group
The Bureau of Fearless Ideas
The Burien Collaborative
- Lake Burien Presbyterian Church
- Alimentando al Pueblo
- BLK Berry
- Southwest Youth and Family Services
- YES! Foundation
The Capacity Collective
The Children's Center at Burke Gilman Gardens
The Church Council of Greater Seattle
The Community Cafe Collaborative
The Garage, A Teen Cafe
The Good Foot Arts Collective
The Mockingbird Society
The People's Institute for Survival and Beyond
The Profitable Nonprofit
The Silent Task Force
The South End Ultimate Program
The Urban Food Systems Program
The Urban Institute
The Vera Project

Therapeutic Health Services
Tilth Alliance
Together We Heal
- Collective Justice
- Freedom Project
Tollo Social Purpose Corporation
Total Accounting Tax & Payroll LLC
Trafton International Consulting Group, LLC
TransFamilies
Treehouse
Trillium Employment Services
Tubman Center for Health & Freedom
Tukwila School District
Ubumwe Women Association
Umoja P.E.A.C.E. Center
United Communities of Laos
United Indians of All Tribes Foundation
United Way of King County
University of Washington
University of Washington - Haring Center
University of Washington - SMART Center
Unleash the Brilliance
Urban ArtWorks
Urban Impact Community Health Center
Urban League of Metropolitan Seattle
Urban Native Education Alliance (UNEA)
UTOPIA (United Territories of Pacific Islanders Alliance) Washington
Vadis
Valley Cities Counseling
Vashon Island School District
Vashon Youth & Family Services
Vietnamese Family Autism Advisory Board
Villa Comunitaria
Voices of Tomorrow
Wa Na Wari
- Africatown Community Land Trust
- King County Equity Now
WAPI Community Services
Wasat
Washington Chapter of the American Academy of Pediatrics
Washington Immigrant Solidarity Network
Washington Poison Center
Washington West African Center
We are Victorious Youth
WestEd
WestSide Baby
Wheellab
White Center Community Development Association (WCCDA)
- Community Roots Housing
- FEEST
- Healthpoint

- Southwest Youth and Family Services
- YES Foundation

White Center Food Bank
Wonderland Child & Family Services
Workathon LLC
Worth a Shot
YES! Foundation
YMCA of Greater Seattle
Young Women Empowered
Your Pretty Perfect LLC
Youth Development Executives of King County (YDEKC)
YouthCare
YWCA Seattle | King | Snohomish

Appendix E: Best Starts for Kids ZIP Code Reporting Data Book

Best Starts' ZIP Code data on participants and expenditures is available in table format in Figures 14, 15, and 16.

Fiscal data in Figures 15 and 16 do not fully capture how Best Starts for Kids investments benefit residents within each ZIP Code because not all strategies and programs enroll individual participants (such as Evaluation, Capital Projects, and Technical Assistance and Capacity Building), some participants choose not to provide their ZIP Codes, and not all Best Starts investments are attributable or divisible among individual participants or ZIP Codes (such as costs to manage and administer programs, and costs for programs to report performance). In addition, attribution of expenditures based on office location in Figure 6 does not capture mobile or virtual service delivery.

For interactive views of Best Starts' ZIP Code data on people served and expenditures, please visit the "Where do we reach?" tab of the Best Starts for Kids Data Dashboard.

Zip Code Data Table Notes:

- Investment areas that do not enroll individual participants, including Communities of Opportunity, Capital Projects, and Technical Assistance and Capacity Building, do not collect data on participants' ZIP Code of residence.
- Participant data is expressed as "Fewer than 5" when there are fewer than 5 participants in a ZIP Code to protect privacy. In ZIP Codes where this suppression applies for one investment area, total numbers of participants across all investment areas are expressed as a narrow range so that the suppressed number cannot be recalculated from the other available data, also to protect privacy.
- Participant counts will not sum to the overall number of people reached by Best Starts because of missing and unknown data. Not all participants choose to provide their ZIP Codes.
- Rounding of expenditures data to the nearest $1,000 accounts for variations in program models, locations, and services provided over time within each strategy.
- Expenditures by where service participants live, shown in Figure 15, will not sum to the overall Best Starts expenditures because not all strategies enroll individual participants and not all expenditures are on services (such as Evaluation, Capital Projects, and Technical Assistance and Capacity Building), and because County costs to manage and administer programs are not readily attributable or divisible among individual participants or ZIP Codes.
- Expenditures by where office-based services are located, shown in Figure 16, will not sum to the overall Best Starts expenditures because not all strategies provide office-based services and not all expenditures are on services (such as Evaluation, Capital Projects, and Technical Assistance and Capacity Building), and because County costs to manage and administer programs are not readily attributable or divisible among individual participants or ZIP Codes.
- Expenditures by investment area may not add to total expenditures in the ZIP Code due to rounding.

Figure 14. 2023 Number of Best Starts Participants by Investment Area by ZIP Code

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98001	38	1,264	377	69	1,748
98002	108	3,504	916	168	4,696
98003	154	3,480	371	218	4,223
98004	Fewer than 5	2,015	301	0	2,316 - 2,320
98005	9	683	94	5	791
98006	15	603	163	11	792
98007	30	1,354	512	13	1,909
98008	11	805	152	Fewer than 5	968 - 972
98009	0	11	15	0	26
98010	8	90	63	0	161
98011	7	534	369	8	918
98012	0	18	97	0	115
98013	0	5	0	0	5
98014	0	172	78	0	250
98019	Fewer than 5	273	97	0	370 - 374
98020	0	0	13	0	13
98021	0	18	249	0	267
98022	12	673	163	16	864
98023	59	1,299	446	91	1,895
98024	0	93	87	0	180
98025	0	5	5	0	10
98026	0	6	13	0	19
98027	8	1,213	134	Fewer than 5	1,355 - 1,359
98028	6	928	384	8	1,326
98029	22	662	112	31	827

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98030	88	6,134	730	192	7,144
98031	160	2,641	811	128	3,740
98032	104	4,193	654	177	5,128
98033	11	334	56	13	414
98034	12	876	126	18	1,032
98035	0	25	Fewer than 5	0	25 - 29
98036	0	9	13	0	22
98037	0	Fewer than 5	8	0	8 - 12
98038	17	1,533	1,408	28	2,986
98039	0	5	10	0	15
98040	Fewer than 5	252	330	0	582 - 586
98042	39	2,516	490	53	3,098
98043	0	5	11	0	16
98045	Fewer than 5	477	215	0	692 - 696
98047	29	216	118	8	371
98048	0	Fewer than 5	0	0	0 - 4
98050	0	0	Fewer than 5	Fewer than 5	5
98051	Fewer than 5	18	80	0	98 - 102
98052	25	1,121	267	30	1,443
98053	6	163	43	7	219
98055	38	622	257	47	964
98056	18	1,553	193	36	1,800
98057	19	508	557	36	1,120
98058	114	1,885	496	55	2,550
98059	24	1,032	334	10	1,400
98062	0	0	Fewer than 5	0	0 - 4
98063	0	Fewer than 5	5	0	5 - 9

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98064	0	Fewer than 5	Fewer than 5	0	5
98065	Fewer than 5	560	331	17	908 - 912
98068	0	Fewer than 5	0	0	0 - 4
98070	9	778	519	0	1,306
98071	0	Fewer than 5	Fewer than 5	0	6
98072	Fewer than 5	149	213	Fewer than 5	369
98074	Fewer than 5	150	39	10	199 - 203
98075	5	161	26	0	192
98077	Fewer than 5	56	152	0	208 - 212
98082	0	0	Fewer than 5	0	0 - 4
98083	0	Fewer than 5	0	0	0 - 4
98087	0	7	8	0	15
98092	36	3,043	840	56	3,975
98093	0	5	5	0	10
98101	0	128	125	0	253
98102	Fewer than 5	206	166	6	378 - 382
98103	10	788	428	0	1,226
98104	Fewer than 5	414	297	6	717 - 721
98105	20	313	410	6	749
98106	50	2,272	580	13	2,915
98107	Fewer than 5	163	194	0	357 - 361
98108	21	4,366	576	15	4,978
98109	6	150	87	Fewer than 5	243 - 247
98110	0	0	5	0	5
98111	0	Fewer than 5	16	Fewer than 5	18
98112	Fewer than 5	347	320	7	674 - 678
98113	0	Fewer than 5	12	0	12 - 16

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98114	0	5	9	0	14
98115	15	549	1,218	6	1,788
98116	6	245	669	Fewer than 5	920 - 924
98117	Fewer than 5	293	524	0	817 - 821
98118	80	9,986	1,814	101	11,981
98119	5	129	85	0	219
98121	Fewer than 5	339	688	Fewer than 5	1,030
98122	24	2,620	739	11	3,394
98125	32	2,276	532	10	2,850
98126	45	4,634	755	29	5,463
98133	35	1,152	587	21	1,795
98134	0	Fewer than 5	21	0	21 - 25
98136	0	59	160	0	219
98138	0	Fewer than 5	Fewer than 5	0	2
98144	60	8,728	747	12	9,547
98145	0	Fewer than 5	0	0	0 - 4
98146	160	3,915	1,221	26	5,322
98148	20	450	393	31	894
98155	28	562	123	Fewer than 5	713 - 717
98158	0	7	Fewer than 5	0	7 - 11
98160	0	0	Fewer than 5	0	0 - 4
98164	0	Fewer than 5	Fewer than 5	0	2
98165	0	0	Fewer than 5	0	0 - 4
98166	36	1,662	545	9	2,252
98168	97	4,995	1,397	106	6,595
98177	Fewer than 5	160	139	Fewer than 5	304
98178	94	2,125	1,172	76	3,467

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98188	96	2,108	848	133	3,185
98189	0	Fewer than 5	0	0	0 - 4
98195	0	120	Fewer than 5	0	120 - 124
98198	72	3,500	729	126	4,427
98199	Fewer than 5	81	81	0	162 - 166
98201	0	9	Fewer than 5	0	9 - 13
98203	0	7	6	0	13
98204	0	6	5	0	11
98208	0	11	12	0	23
98223	0	Fewer than 5	Fewer than 5	0	3
98224	0	0	Fewer than 5	0	0 - 4
98251	0	Fewer than 5	0	0	0 - 4
98252	0	0	Fewer than 5	0	0 - 4
98258	0	Fewer than 5	Fewer than 5	0	7
98270	0	Fewer than 5	Fewer than 5	0	7
98271	0	0	Fewer than 5	0	0 - 4
98272	0	Fewer than 5	10	0	10 - 14
98275	0	Fewer than 5	9	0	9 - 13
98288	0	9	Fewer than 5	0	9 - 13
98290	0	0	Fewer than 5	0	0 - 4
98294	0	0	Fewer than 5	0	0 - 4
98296	0	0	6	0	6
98310	0	0	Fewer than 5	0	0 - 4
98312	0	Fewer than 5	Fewer than 5	0	3
98321	0	0	5	0	5
98328	0	0	Fewer than 5	0	0 - 4
98329	0	0	Fewer than 5	0	0 - 4

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98332	0	Fewer than 5	Fewer than 5	0	3
98338	0	Fewer than 5	Fewer than 5	0	2
98346	0	0	Fewer than 5	0	0 - 4
98354	0	11	5	0	16
98366	0	0	5	0	5
98367	0	Fewer than 5	Fewer than 5	0	3
98371	0	Fewer than 5	Fewer than 5	0	6
98372	0	0	Fewer than 5	0	0 - 4
98373	0	Fewer than 5	5	0	5 - 9
98374	0	Fewer than 5	8	0	8 - 12
98375	0	Fewer than 5	8	0	8 - 12
98386	0	0	Fewer than 5	0	0 - 4
98387	0	0	6	0	6
98390	0	Fewer than 5	6	0	6 - 10
98391	0	Fewer than 5	11	0	11 - 15
98396	0	0	Fewer than 5	0	0 - 4
98402	0	Fewer than 5	0	0	0 - 4
98403	0	0	Fewer than 5	0	0 - 4
98404	0	Fewer than 5	10	0	10 - 14
98405	0	7	Fewer than 5	0	7 - 11
98406	0	Fewer than 5	0	0	0 - 4
98408	0	Fewer than 5	Fewer than 5	0	5
98409	0	Fewer than 5	8	0	8 - 12
98416	0	0	Fewer than 5	0	0 - 4
98418	0	Fewer than 5	Fewer than 5	0	3
98422	0	Fewer than 5	9	0	9 - 13

Fiscal data in this table do not fully capture how Best Starts investments benefit residents within each ZIP Code because not all strategies and programs enroll individual participants (such as Evaluation, Capital Projects, and Technical Assistance and Capacity Building), some participants choose not to provide their ZIP Codes, and not all Best Starts investments are attributable or divisible among individual participants or ZIP Codes (such as costs to manage and administer programs, and costs for programs to report performance).

Figure 15. 2023 Expenditures by Best Starts Investment Area by ZIP Code, based on Where Participants Live

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98001	$500,000	$638,000	$508,000	$121,000	$1,767,000
98002	$1,421,000	$1,567,000	$812,000	$295,000	$4,096,000
98003	$2,027,000	$1,375,000	$603,000	$383,000	$4,388,000
98004	$53,000	$801,000	$165,000	$0	$1,018,000
98005	$118,000	$299,000	$114,000	$9,000	$541,000
98006	$197,000	$261,000	$195,000	$19,000	$673,000
98007	$395,000	$441,000	$549,000	$23,000	$1,408,000
98008	$145,000	$323,000	$173,000	$7,000	$648,000
98009	$0	$1,000	$31,000	$0	$32,000
98010	$105,000	$48,000	$25,000	$0	$179,000
98011	$92,000	$231,000	$126,000	$14,000	$464,000
98012	$0	$9,000	$43,000	$0	$52,000
98013	$0	$6,000	$0	$0	$6,000
98014	$0	$91,000	$82,000	$0	$173,000
98019	$13,000	$156,000	$125,000	$0	$294,000
98020	$0	$0	$11,000	$0	$11,000
98021	$0	$19,000	$69,000	$0	$88,000
98022	$158,000	$323,000	$40,000	$28,000	$549,000
98023	$776,000	$663,000	$781,000	$160,000	$2,380,000
98024	$0	$61,000	$46,000	$0	$107,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98025	$0	$7,000	$9,000	$0	$16,000
98026	$0	$4,000	$15,000	$0	$18,000
98027	$105,000	$602,000	$134,000	$7,000	$848,000
98028	$79,000	$402,000	$140,000	$14,000	$634,000
98029	$290,000	$308,000	$129,000	$54,000	$781,000
98030	$1,158,000	$1,589,000	$716,000	$337,000	$3,800,000
98031	$2,105,000	$1,178,000	$656,000	$225,000	$4,165,000
98032	$1,369,000	$1,376,000	$651,000	$311,000	$3,706,000
98033	$145,000	$148,000	$78,000	$23,000	$393,000
98034	$158,000	$351,000	$169,000	$32,000	$710,000
98035	$0	$12,000	$1,000	$0	$14,000
98036	$0	$10,000	$12,000	$0	$21,000
98037	$0	Less than $1,000	$11,000	$0	$12,000
98038	$224,000	$261,000	$329,000	$49,000	$863,000
98039	$0	$3,000	$15,000	$0	$18,000
98040	$13,000	$123,000	$81,000	$0	$217,000
98042	$513,000	$783,000	$326,000	$93,000	$1,716,000
98043	$0	Less than $1,000	$11,000	$0	$12,000
98045	$13,000	$367,000	$125,000	$0	$506,000
98047	$382,000	$110,000	$36,000	$14,000	$541,000
98048	$0	Less than $1,000	$0	$0	Less than $1,000
98050	$0	$0	$2,000	$5,000	$7,000
98051	$13,000	$7,000	$22,000	$0	$43,000
98052	$329,000	$381,000	$266,000	$53,000	$1,029,000
98053	$79,000	$63,000	$28,000	$12,000	$182,000
98055	$500,000	$289,000	$312,000	$82,000	$1,183,000
98056	$237,000	$456,000	$266,000	$63,000	$1,023,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98057	$250,000	$180,000	$568,000	$63,000	$1,061,000
98058	$1,500,000	$876,000	$443,000	$97,000	$2,916,000
98059	$316,000	$456,000	$365,000	$18,000	$1,155,000
98062	$0	$0	Less than $1,000	$0	Less than $1,000
98063	$0	$2,000	$7,000	$0	$9,000
98064	$0	$1,000	Less than $1,000	$0	$1,000
98065	$53,000	$388,000	$188,000	$30,000	$659,000
98068	$0	$3,000	$0	$0	$3,000
98070	$118,000	$327,000	$526,000	$0	$971,000
98071	$0	$2,000	$3,000	$0	$6,000
98072	$39,000	$77,000	$66,000	$7,000	$189,000
98074	$26,000	$109,000	$48,000	$18,000	$200,000
98075	$66,000	$98,000	$46,000	$0	$209,000
98077	$13,000	$32,000	$30,000	$0	$75,000
98082	$0	$0	$6,000	$0	$6,000
98083	$0	$2,000	$0	$0	$2,000
98087	$0	Less than $1,000	$5,000	$0	$5,000
98092	$474,000	$1,287,000	$459,000	$98,000	$2,319,000
98093	$0	$4,000	$4,000	$0	$8,000
98101	$0	$72,000	$172,000	$0	$244,000
98102	$26,000	$65,000	$161,000	$11,000	$263,000
98103	$132,000	$198,000	$213,000	$0	$542,000
98104	$39,000	$143,000	$299,000	$11,000	$492,000
98105	$263,000	$151,000	$309,000	$11,000	$733,000
98106	$658,000	$457,000	$674,000	$23,000	$1,811,000
98107	$39,000	$56,000	$79,000	$0	$174,000
98108	$276,000	$1,336,000	$668,000	$26,000	$2,307,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98109	$79,000	$66,000	$53,000	$4,000	$201,000
98110	$0	$0	$8,000	$0	$8,000
98111	$0	Less than $1,000	$33,000	$2,000	$35,000
98112	$13,000	$57,000	$253,000	$12,000	$335,000
98113	$0	$1,000	$25,000	$0	$26,000
98114	$0	$6,000	$17,000	$0	$23,000
98115	$197,000	$251,000	$844,000	$11,000	$1,303,000
98116	$79,000	$82,000	$597,000	$4,000	$761,000
98117	$26,000	$150,000	$176,000	$0	$352,000
98118	$1,053,000	$1,825,000	$2,387,000	$177,000	$5,442,000
98119	$66,000	$72,000	$62,000	$0	$200,000
98121	$26,000	$96,000	$509,000	$2,000	$634,000
98122	$316,000	$911,000	$800,000	$19,000	$2,047,000
98125	$421,000	$551,000	$395,000	$18,000	$1,385,000
98126	$592,000	$655,000	$810,000	$51,000	$2,109,000
98133	$461,000	$410,000	$619,000	$37,000	$1,526,000
98134	$0	$1,000	$40,000	$0	$41,000
98136	$0	$33,000	$79,000	$0	$112,000
98138	$0	Less than $1,000	Less than $1,000	$0	Less than $1,000
98144	$790,000	$871,000	$756,000	$21,000	$2,437,000
98145	$0	Less than $1,000	$0	$0	Less than $1,000
98146	$2,105,000	$787,000	$762,000	$46,000	$3,699,000
98148	$263,000	$204,000	$325,000	$54,000	$846,000
98155	$368,000	$226,000	$178,000	$7,000	$779,000
98158	$0	$1,000	Less than $1,000	$0	$2,000
98160	$0	$0	$2,000	$0	$2,000
98164	$0	Less than $1,000	$3,000	$0	$3,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98165	$0	$0	$4,000	$0	$4,000
98166	$474,000	$288,000	$295,000	$16,000	$1,072,000
98168	$1,276,000	$985,000	$932,000	$186,000	$3,380,000
98177	$26,000	$73,000	$87,000	$5,000	$192,000
98178	$1,237,000	$603,000	$1,231,000	$133,000	$3,204,000
98188	$1,263,000	$794,000	$550,000	$233,000	$2,840,000
98189	$0	$2,000	$0	$0	$2,000
98195	$0	$11,000	$6,000	$0	$17,000
98198	$947,000	$1,596,000	$487,000	$221,000	$3,252,000
98199	$13,000	$44,000	$78,000	$0	$135,000
98201	$0	$13,000	$3,000	$0	$15,000
98203	$0	Less than $1,000	$7,000	$0	$7,000
98204	$0	Less than $1,000	$8,000	$0	$8,000
98208	$0	$6,000	$12,000	$0	$18,000
98223	$0	Less than $1,000	Less than $1,000	$0	Less than $1,000
98224	$0	$0	Less than $1,000	$0	Less than $1,000
98251	$0	Less than $1,000	$0	$0	Less than $1,000
98252	$0	$0	Less than $1,000	$0	Less than $1,000
98258	$0	Less than $1,000	$2,000	$0	$2,000
98270	$0	$3,000	$2,000	$0	$5,000
98271	$0	$0	Less than $1,000	$0	Less than $1,000
98272	$0	Less than $1,000	$9,000	$0	$9,000
98275	$0	Less than $1,000	$8,000	$0	$8,000
98288	$0	$7,000	Less than $1,000	$0	$7,000
98290	$0	$0	$3,000	$0	$3,000
98294	$0	$0	$2,000	$0	$2,000
98296	$0	$0	$2,000	$0	$2,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98310	$0	$0	$2,000	$0	$2,000
98312	$0	Less than $1,000	Less than $1,000	$0	Less than $1,000
98321	$0	$0	Less than $1,000	$0	Less than $1,000
98328	$0	$0	Less than $1,000	$0	Less than $1,000
98329	$0	$0	$3,000	$0	$3,000
98332	$0	Less than $1,000	Less than $1,000	$0	Less than $1,000
98338	$0	Less than $1,000	Less than $1,000	$0	Less than $1,000
98346	$0	$0	$3,000	$0	$3,000
98354	$0	$4,000	$2,000	$0	$6,000
98366	$0	$0	$2,000	$0	$2,000
98367	$0	Less than $1,000	Less than $1,000	$0	Less than $1,000
98371	$0	$3,000	$3,000	$0	$6,000
98372	$0	$0	$1,000	$0	$1,000
98373	$0	Less than $1,000	$2,000	$0	$3,000
98374	$0	$1,000	$5,000	$0	$6,000
98375	$0	$1,000	$2,000	$0	$4,000
98386	$0	$0	Less than $1,000	$0	Less than $1,000
98387	$0	$0	$2,000	$0	$2,000
98390	$0	Less than $1,000	$5,000	$0	$5,000
98391	$0	Less than $1,000	$4,000	$0	$4,000
98396	$0	$0	Less than $1,000	$0	Less than $1,000
98402	$0	Less than $1,000	$0	$0	Less than $1,000
98403	$0	$0	$1,000	$0	$1,000
98404	$0	Less than $1,000	$2,000	$0	$3,000
98405	$0	$1,000	$2,000	$0	$3,000
98406	$0	Less than $1,000	$0	$0	Less than $1,000
98408	$0	Less than $1,000	$3,000	$0	$3,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98409	$0	Less than $1,000	$2,000	$0	$2,000
98416	$0	$0	Less than $1,000	$0	Less than $1,000
98418	$0	Less than $1,000	$3,000	$0	$3,000
98422	$0	$3,000	$3,000	$0	$6,000

Fiscal data in this table do not fully capture how Best Starts investments benefit residents within each ZIP Code because not all strategies and programs enroll individual participants (such as Evaluation, Capital Projects, and Technical Assistance and Capacity Building), some participants choose not to provide their ZIP Codes, and not all Best Starts investments are attributable or divisible among individual participants or ZIP Codes (such as costs to manage and administer programs, and costs for programs to report performance).

Figure 16. 2023 Expenditures by Best Starts Investment Area by ZIP Code, based on Where Office-based Services are Located

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98001	$1,137,000	$585,000	$555,000	$0	$2,276,000
98002	$651,000	$1,552,000	$811,000	$147,000	$3,161,000
98003	$1,421,000	$1,740,000	$589,000	$147,000	$3,897,000
98004	$239,000	$69,000	$34,000	$0	$342,000
98005	$127,000	$0	$205,000	$0	$332,000
98006	$157,000	$0	$167,000	$147,000	$471,000
98007	$666,000	$1,191,000	$1,087,000	$147,000	$3,090,000
98008	$284,000	$260,000	$167,000	$0	$711,000
98009	$0	$63,000	$100,000	$0	$163,000
98010	$15,000	$237,000	$0	$0	$252,000
98011	$97,000	$174,000	$84,000	$0	$355,000
98012	$7,000	$0	$34,000	$0	$41,000
98014	$0	$63,000	$100,000	$0	$163,000
98015	$0	$0	$100,000	$0	$100,000
98019	$0	$0	$34,000	$0	$34,000
98021	$0	$0	$84,000	$0	$84,000
98022	$180,000	$237,000	$34,000	$0	$450,000
98023	$965,000	$1,006,000	$556,000	$0	$2,528,000
98024	$0	$0	$51,000	$0	$51,000
98026	$135,000	$69,000	$0	$0	$204,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98027	$232,000	$63,000	$133,000	$0	$428,000
98028	$30,000	$69,000	$84,000	$0	$183,000
98029	$75,000	$191,000	$0	$0	$266,000
98030	$1,204,000	$1,914,000	$931,000	$293,000	$4,342,000
98031	$1,496,000	$698,000	$444,000	$0	$2,638,000
98032	$1,421,000	$2,512,000	$1,565,000	$440,000	$5,938,000
98033	$52,000	$428,000	$34,000	$0	$514,000
98034	$165,000	$737,000	$397,000	$0	$1,299,000
98036	$82,000	$0	$0	$0	$82,000
98037	$30,000	$0	$0	$0	$30,000
98038	$232,000	$69,000	$163,000	$0	$464,000
98039	$0	$0	$90,000	$0	$90,000
98040	$67,000	$0	$129,000	$0	$196,000
98042	$1,122,000	$872,000	$213,000	$147,000	$2,354,000
98043	$7,000	$0	$121,000	$0	$129,000
98045	$0	$147,000	$84,000	$0	$231,000
98047	$232,000	$0	$0	$0	$232,000
98051	$0	$0	$51,000	$0	$51,000
98052	$307,000	$470,000	$134,000	$147,000	$1,058,000
98053	$22,000	$0	$0	$0	$22,000
98054	$0	$69,000	$0	$0	$69,000
98055	$621,000	$111,000	$219,000	$0	$951,000
98056	$187,000	$796,000	$281,000	$0	$1,264,000
98057	$299,000	$1,330,000	$759,000	$293,000	$2,682,000
98058	$658,000	$258,000	$315,000	$0	$1,231,000
98059	$367,000	$0	$124,000	$0	$490,000
98065	$15,000	$390,000	$84,000	$0	$489,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98068	$67,000	$0	$0	$0	$67,000
98070	$135,000	$317,000	$531,000	$0	$983,000
98072	$105,000	$0	$84,000	$0	$189,000
98074	$52,000	$0	$34,000	$0	$86,000
98077	$0	$0	$51,000	$0	$51,000
98087	$0	$0	$121,000	$0	$121,000
98092	$613,000	$692,000	$320,000	$0	$1,625,000
98101	$52,000	$119,000	$221,000	$147,000	$539,000
98102	$120,000	$0	$155,000	$0	$275,000
98103	$30,000	$0	$295,000	$0	$325,000
98104	$329,000	$329,000	$292,000	$0	$950,000
98105	$292,000	$56,000	$155,000	$0	$503,000
98106	$733,000	$997,000	$535,000	$0	$2,264,000
98107	$52,000	$0	$79,000	$0	$131,000
98108	$995,000	$806,000	$1,757,000	$147,000	$3,705,000
98109	$67,000	$243,000	$166,000	$0	$476,000
98112	$15,000	$208,000	$150,000	$0	$373,000
98113	$0	$0	$34,000	$0	$34,000
98114	$0	$0	$0	$147,000	$147,000
98115	$269,000	$451,000	$250,000	$0	$970,000
98116	$0	$0	$217,000	$0	$217,000
98117	$0	$0	$174,000	$0	$174,000
98118	$965,000	$2,429,000	$2,112,000	$147,000	$5,653,000
98119	$30,000	$111,000	$327,000	$0	$468,000
98121	$0	$953,000	$34,000	$0	$987,000
98122	$142,000	$491,000	$993,000	$0	$1,626,000
98125	$359,000	$126,000	$441,000	$0	$926,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98126	$711,000	$17,000	$333,000	$0	$1,061,000
98133	$232,000	$911,000	$605,000	$0	$1,747,000
98134	$15,000	$63,000	$34,000	$0	$112,000
98136	$30,000	$0	$45,000	$0	$75,000
98144	$741,000	$3,162,000	$889,000	$147,000	$4,939,000
98146	$718,000	$577,000	$542,000	$147,000	$1,984,000
98148	$935,000	$514,000	$708,000	$147,000	$2,304,000
98155	$217,000	$300,000	$112,000	$0	$629,000
98158	$0	$0	$121,000	$0	$121,000
98166	$681,000	$543,000	$512,000	$147,000	$1,883,000
98168	$1,990,000	$845,000	$987,000	$147,000	$3,969,000
98177	$0	$0	$79,000	$0	$79,000
98178	$598,000	$374,000	$509,000	$0	$1,482,000
98188	$1,489,000	$1,021,000	$1,127,000	$587,000	$4,224,000
98195	$0	$174,000	$0	$0	$174,000
98198	$928,000	$1,373,000	$858,000	$293,000	$3,452,000
98199	$37,000	$0	$45,000	$0	$82,000
98204	$15,000	$0	$0	$0	$15,000
98208	$45,000	$174,000	$0	$0	$219,000
98271	$15,000	$0	$0	$0	$15,000
98290	$30,000	$0	$0	$0	$30,000
98354	$15,000	$0	$0	$0	$15,000
98372	$15,000	$0	$0	$0	$15,000
98374	$7,000	$0	$0	$0	$7,000
98387	$60,000	$0	$0	$0	$60,000
98404	$22,000	$0	$132,000	$0	$155,000
98405	$15,000	$0	$0	$0	$15,000

ZIP Code	Child Care	Investing Early	Sustain the Gain	Youth and Family Homelessness Prevention	Total
98407	$0	$174,000	$0	$0	$174,000
98421	$0	$0	$34,000	$0	$34,000
98422	$90,000	$0	$0	$0	$90,000
98424	$0	$0	$34,000	$0	$34,000
98444	$0	$0	$132,000	$0	$132,000
98446	$0	$0	$34,000	$0	$34,000
98499	$0	$0	$56,000	$0	$56,000
98580	$0	$0	$34,000	$0	$34,000

King County

Dow Constantine
King County Executive
401 Fifth Avenue, Suite 800
Seattle, WA 98104-1818
206-263-9600 Fax 206-296-0194
TTY Relay: 711
www.kingcounty.gov

July 15, 2024

The Honorable Dave Upthegrove
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember Upthegrove:

I am proud to transmit the 2023 Best Starts for Kids (BSK) Annual Report as required by Ordinance 19354, and an accompanying proposed Motion that would, if enacted, acknowledge receipt of the report. This is the second annual report for the second BSK levy (2022-2027).

This report reflects the accomplishments of funded partners and shares data that highlights community's success in making positive changes for individuals and the community. The report organizes around five themes, representing impact, learnings, and integration of BSK work across strategies. These themes are:

- Meeting Families' Needs
- Prioritizing Well-being and Mental Health
- Cultivating Opportunities for Children and Young People
- Strengthening the Workforce
- Building Community Power and Capacity

From its inception, BSK has reflected both community wisdom and research about what we know babies, young people, and families need to have the best opportunity to be happy, healthy, safe, and thriving. As described in this report's themes, BSK addresses these issues holistically. It serves children and young people across the age span of prenatal to young adulthood and provides direct services as well as supporting policy and system changes.

In 2023, BSK partnered with 336 community-based organizations operating 591 programs to reach 151,919 children, young people, families, and community members across King County. In 2023, the BSK team released 12 request for proposals which resulted in 187 new programs run by 136 community partners. The new investment areas of Child Care and Capital Projects continued their development in partnership with community, so that families with young

children can get subsidies for childcare, and to provide for healthy and safe buildings where children can learn, grow, and explore.

The 2023 BSK Annual Report links to an updated data dashboard on the BSK website. The Best Starts for Kids Data Dashboard provides additional measures for BSK programs, customizable data views, and greater geographic and financial detail.

As required, the annual report provides information about expenditures, services, and outcomes for BSK activities, including geographic data by ZIP code consistent with Ordinance 19354. In addition, the report includes recommendations from providers for service improvements as well as in-depth evaluations Best Starts for Kids completed in 2023.

The King County Council directed the Children and Youth Advisory Board (CYAB) members provide input on the BSK annual report. CYAB members and the Communities of Opportunity Advisory Board members received a draft copy of the 2023 Annual Report in May 2024. The final report reflects their input and feedback.

Thank you for your review of this report and your consideration of the proposed Motion, and for your strong support for children, young people, and families across King County. If your staff have any questions, please contact Kelly Rider, Acting Director, Department of Community and Human Services, at 206-263-5780.

Sincerely,

for

Dow Constantine
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff
Melani Pedroza, Clerk of the Council
Shannon Braddock, Deputy County Executive, Office of the Executive
Karan Gill, Chief of Staff, Office of the Executive
Penny Lipsou, Council Relations Director, Office of the Executive
Kelly Rider, Acting Director, Department of Community and Human Services
Faisal Khan, Director, Public Health – Seattle & King County

King County

Metropolitan King County Council
Local Services and Land Use Committee

STAFF REPORT

Agenda Item:	7	**Name:**	Olivia Brey
Proposed No.:	2025-0030	**Date:**	March 5, 2025

SUBJECT

Proposed Ordinance 2025-0030 would approve the 2025-2029 King County Consortium Consolidated Housing and Community Development Plan.

SUMMARY

King County, through the Department of Community and Human Services (DCHS), serves as the lead entity in administering federal block grants for the purpose of affordable housing, housing stability, and community development through a Consortium model permitted by the U.S. Department of Housing and Urban Development (HUD). The Consolidated Plan is required to help jurisdictions assess their affordable housing and community development needs and market conditions within their geographic area to guide the investment of HUD funds. The funding sources that the Consolidated Plan contemplates are the Community Development Block Grant, Emergency Solutions Grants, and HOME Investment Partnerships Program. The King County Consortium includes membership types that plan for and implement projects and programs from these funding sources.

The proposed 2025-2029 Consolidated Plan would set three goals: 1) increase affordable housing; 2) prevent and mitigate homelessness; and 3) enhance community and economic development. The proposal would also set projected outcomes and projected grant spending allocations within each goal, the progress of which will be tracked through annual reports submitted to HUD.

It is anticipated that HUD will be sending grants in April 2025. HUD requires that King County adopt the proposed Consolidated Plan by that time to remain in good standing as a grant recipient with HUD. Proposed Ordinance 2025-0030 should be adopted by April 2025 in order to secure the funding.

BACKGROUND

The U.S. Department of Housing and Urban Development (HUD) requires the development of a Consolidated Plan every three to five years for jurisdictions that receive funding from one or more of the following programs: the Community Development Block Grant (CDBG), the HOME Investment Partnership Program

(HOME), and the Emergency Solutions Grant (ESG). King County and various jurisdictions within it receive funding from all three sources, so the Consolidated Plan must comport with the HUD requirements for each of the three entitlement programs.

HUD allows for jurisdictions to form consortia in order to plan for and implement projects and programs resulting from these entitlements.[1] King County, through the Department of Community and Human Services (DCHS), serves as the lead entity for the King County Consortium[2] (the Consortium), which is an urban county consortium. As the lead entity, the County is responsible for monitoring subrecipients, managing the public engagement process and preparing the Consolidated Plan and other required reports, including the Consolidated Annual Performance and Evaluation Report (CAPER) and annual Action Plans, both of which articulate progress towards the goals of the Plan. The various forms of membership within the Consortium are described later in this staff report. The King County Consortium also utilizes the consortium-model in planning for and distributing state-allocated document recording fees for affordable housing.

The Consolidated Plan follows a template provided by HUD, with specific sections and questions within each section provided.

Funding sources. There are three federal funding sources related to affordable housing and community development that the Consolidated Plan contemplates. Each funding source has specific program goals and requirements, as described below:

- *Community Development Block Grant (CDBG):*[3] The CDBG is a federal formula grant designed to address community development needs that are specific to the funded jurisdiction. Over a one- to three-year period[4], at least 70% of a jurisdiction's or consortium's funds must be used to benefit low- and moderate-income individuals and households. Eligible projects include constructing public facilities, rehabilitating of residential and non-residential structures, and aiding businesses to support job creation. In general, constructing new housing is not an eligible use of these funds.
- *HOME Investment Partnership Program (HOME):*[5] The HOME Program is a federal formula grant designed to create and promote affordable housing for low-income households. Allowable uses for these funds are broad in order to provide flexibility within participating jurisdictions but include building affordable housing for rent or ownership, providing rental assistance to low-income individuals, and providing rehabilitation assistance for homeowners.
- *Emergency Solutions Grant (ESG):*[6] Before adoption of the HEARTH Act[7], this was called the Emergency Shelter Grant, though the program experienced a shift

[1] https://files.hudexchange.info/resources/documents/notice-cpd-13-002-procedures-for-designation-of-consortia.pdf
[2] Ordinance 15571 formally authorized the consortia partnership in King County, though the model had been used prior to adoption of that ordinance in 2006.
[3] https://www.hudexchange.info/programs/cdbg-entitlement/
[4] The grantee may select the time period between 1 and 3 years.
[5] https://www.hud.gov/program_offices/comm_planning/affordablehousing/programs/home/
[6] https://www.hudexchange.info/programs/esg/esg-requirements/
[7] https://www.hudexchange.info/homelessness-assistance/hearth-act/

in focus at the same time as it was renamed. The ESG is a federal formula grant intended to help individuals and families regain stability in permanent housing after experiencing a housing crisis or homelessness. Eligible uses include street outreach, emergency shelter, homelessness prevention, rapid rehousing, and the Homeless Management Information System (HMIS). The ESG also requires recipients to consult with the geography's Continuum of Care in determining how to allocate the funds.

King County Consortium Membership. Membership types within the Consortium fall into three categories:

1. Cities that partner with King County for both CDBG and HOME funds;
2. Joint Agreement Cities, which are cities that qualify for their own CDBG funds but choose to partner with King County in a regional housing and community development program - these cities retain a portion of their CDBG funds and contribute a portion to the Consortium; and
3. HOME-only cities, which are cities that receive their own CDBG funds directly from HUD.

The City of Seattle prepares their own consolidated plan and only participates in the King County Consortium for the administration and allocation of regional fund sources that are available for use in the City of Seattle. The two County jurisdictions not belonging to the Consortium are the cities of Milton and Seattle.

Below is a table outlining membership in each category.

Table 1. Consortium Membership

Membership Type	City Members	
Cities that partner for both CDBG and HOME Funds	• Algona • Beaux Arts • Black Diamond • Bothell • Carnation • Clyde Hill • Covington • Des Moines • Duvall • Enumclaw • Hunts Point • Issaquah • Kenmore • Lake Forest Park	• Maple Valley • Medina • Mercer Island • Newcastle • Normandy Park • North Bend • Pacific • Sammamish • Sea Tac • Skykomish • Snoqualmie • Tukwila • Woodinville • Yarrow Point
Joint Agreement Cities	• Burien • Kirkland	

	• Redmond • Renton • Shoreline
HOME-Only Cities	• Auburn • Bellevue • Federal Way • Kent

Joint Recommendations Committee. The Joint Recommendations Committee (JRC) is an interjurisdictional advisory body that provides funding recommendations and advice on guidelines and procedures for the Consortium. The Interlocal Agreements that created the Consortium included language forming the committee and the committee is now codified in King County Code (K.C.C.) 24.13.020.[8] In addition to making funding recommendations for CDBG, HOME, and ESG funds, the JRC reviews and recommends the Consolidated Plan, advises the County Executive on state and federal legislative priorities, and advises the Consortium and County Executive on programs under the Consortium's jurisdiction.

The JRC is composed of three representatives appointed by the King County Executive and eight representatives of participating jurisdictions. The City of Seattle participates only in JRC meetings regarding regional funding sources that are available for use in their jurisdiction, primarily Regional Affordable Housing Program dollars.

Table 2 outlines the current composition of the JRC.

Table 2. Composition of the JRC

Membership Type	Jurisdiction/Representative
King County	1) Jim Chan, *Division Director, Department of Local Services* 2) Danielle De Clerq, *Deputy Director, Department of Local Services* 3) Sunaree Marshall, *Acting Division Director, Housing and Community Development*
Participating Jurisdiction[9]	1) Elizabeth Porter, *Covington Councilmember* 2) Amy McHenry, *Duvall Councilmember* 3) Karen Howe, *Sammamish Mayor* 4) Anyah Zupancic, *Burien Human Services Coordinator* 5) Carol Helland, *Redmond Director of Planning and Community Development* 6) Merina Hanson, *Kent Human Services Manager* 7) Sabrina Velarde, *Bellevue Housing Stability*

[8] K.C.C. 24.13

[9] There is has been vacancy from the city representatives from the Regular CDBG Consortium. The Sound Cities Association is anticipated to meet in February 2025 to identify the four members who will serve on the JRC in 2025.

	Program Coordinator
City of Seattle[10]	1) Rosey Zhou, *Seattle Rental Housing Program Manager*

2020-2024 Consolidated Plan. The 2020-2024 Consolidated Plan was adopted by the King County Council on October 23, 2019.[11] Development of that Plan followed a similar structure to that of the proposed update and identified actions the Consortium would take in the years following. The goals, like those in the proposed update, were focused on affordable housing, homelessness, and community and economic development.

The 2020-2024 Consolidated Plan predated the development of the King County Regional Homelessness Authority (KCRHA), which was established through Ordinance 19039 in December 2019.[12] The staff report for the 2020-2024 Consolidated Plan indicates that, upon establishment, funding would be allocated to KCRHA as a sub-grantee, to use for homeless purposes that are allowable under ESG and CDBG regulations.

The 2020-2024 Consolidated Plan was developed well before the COVID-19 pandemic, which impacted the ability to meet some of the anticipated outcomes. The Consortium exceeded goals related to Rental Units Constructed, Rental Units Rehabilitated, Emergency Overnight Shelter, Public Facilities/Infrastructure and Businesses Assisted. Housing repair projects experienced delays due to supply chain shortages, contractor shortages, and agency staff turnover. Additional details regarding the evaluation of how funds were used to carry out the goals and objectives in the Consolidated Plan can be found in the Consolidated Annual Performance and Evaluation Report (CAPER), which HUD requires King County to submit annually.[13]

ANALYSIS

The draft Consolidated Plan follows the template provided by HUD, which includes an Executive Summary, a description of the process for developing the Consolidated Plan, a Needs Assessment, a Housing Market Analysis, and a Strategic Plan with outcomes identified. According to Executive staff, HUD requires all sections of the template to be included in the document, including narratives and tables.

The Process. To develop the 2025-2029 Consolidated Plan, the Consortium sought input from 45 interested parties through virtual consultation sessions and an online survey. Both engagement methods indicated the highest need is affordable housing options. Conversations with interested parties also highlighted the need for public services for people experiencing behavioral health issues, food insecurity, and limited transportation options.

[10] The City of Seattle participates in the King County Consortium only for only for the administration and allocation of the Regional Affordable Housing Program (RAHP).
[11] King County - File #: 2019-0405
[12] King County - File #: 2019-0478
[13] King County DCHS Housing and Community Development Division Reports and Data, https://kingcounty.gov/en/dept/dchs/human-social-services/housing-homeless-services/housing-policy-data/plans-reports

The Consortium also compared the goals of the Strategic Plan with local and regional planning efforts and consulted with public entities within King County and statewide.

The development process included citizen engagement through a community survey, public comment periods, and public hearings. The community survey was shared through websites and local partner organizations. It was available in 12 languages and accepted responses for approximately one month. A total of 120 responses were received regarding housing and community development needs. No comments were received during the public comment periods and public hearings.

Needs Assessment. The HUD template requires a needs assessment for the following categories: housing needs, homeless needs, non-homelessness special needs, and non-housing community development needs. An analysis of existing public housing solutions is also part of the assessment.

The housing needs assessment includes information on the number of households within Consortium jurisdictions with housing problems, as defined by HUD[14]. The identified housing problems are:

1) Substandard housing: units lacking complete plumbing or kitchen facilities;
2) Overcrowded: households in which there is more than one person per room;
3) Severe overcrowding; households in which there are more than 1.5 people per room;
4) Housing cost burden: households that spend more than 30 percent of their income on housing costs;
5) Severe housing cost burden: households that spend more than 50 percent of their income on housing costs.

The 2016-2020 data indicate that 34 percent of households within the Consortium experienced at least one housing problem. Housing problems are shown to be more common for renters than for owners; 49 percent of renters experienced at least one housing problem, whereas this figure was 25 percent for owners. The most common housing problem, for both renters and owners, was the cost burden.

While all demographics experience housing cost burden, Pacific Islander, Black or African American, elderly, and small family households are overrepresented in the data. Elderly households experience severe cost burden at the greatest percentage in all income categories.

The King County Housing Authority (KCHA) and the Renton Housing Authority (RHA) serve low-income residents living in the Consortium with housing assistance. The combined portfolio of these organizations include: 2,416 public housing units, 2,729 project-based vouchers, and 12,705 tenant-based vouchers. There are additional special purpose vouchers for veterans' affairs supportive housing, family unification program, and people with disabilities. KCHA's voucher waitlist includes 1,350 people seeking housing assistance and the public housing waitlist includes more than 22,000

[14] https://www.huduser.gov/portal/datasets/cp/CHAS/bg_chas.html

households and is temporarily closed. RHA does not maintain a public housing waitlist and they are not accepting new applications for vouchers.

The homeless needs assessment uses information from the 2023 Point in Time (PIT) count, conducted by KCRHA, as well as the HMIS data. In 2023, there were 2,248 people experiencing homelessness that were residing in a shelter in the Consortium. KCRHA was not able to differentiate the Consortium data from the PIT data on unsheltered homelessness, so the estimates used in this section represent unsheltered homelessness for all of King County, including Seattle. There were 14,149 people experiencing homelessness on a given night in 2023 across King County. Of these individuals, 6,464 were sheltered (46 percent) and 7,685 were unsheltered (54 percent).

Market Analysis. The market analysis includes a study of the general housing market, public and assisted housing, homeless facilities and services, special needs facilities, and other community development.

The data from the market analysis indicate that the current availability of housing units does not meet the needs of the population. The Consortium will need an additional 196,627 units by 2044 to meet projected demand and over 60 percent of the units need to be affordable to households earning less than 80 percent area median income (AMI).

Between 2012 and 2022, across all of King County, median home value increased 96 percent and median contract rent increased by 86 percent. Within the Consortium, only 29 percent of rental units are affordable to households earning less than 50 percent AMI, lending to the cost burden discussion in the needs assessment. Additionally, a portion (39 percent) of the people living in units affordable to households earning less than 30 percent AMI have incomes above that, indicating that there is a mismatch between income categories of occupants and the income to afford the units.

Strategic Plan. The Consortium intends to further the following primary goals:

- *Goal 1 – Increase Affordable Housing***:** The Consortium will work to preserve and expand the supply of affordable housing by funding activities such as developing new rental and homeowner housing units, preserving existing rental units, and providing housing repairs for income-eligible homeowners and renters. The Consortium will plan for and support fair housing strategies and initiatives designed to affirmatively further fair housing choice, increase access to housing and housing programs, and reduce discrimination towards protected classes.
- *Goal 2 – Prevent and Mitigate Homelessness:* The Consortium will support public service activities that prevent homelessness and reduce the number of households experiencing homelessness by funding activities such as rapid rehousing, emergency shelter, diversion, and housing stability programs. The Consortium will engage in planning, activities, and initiatives to reduce homelessness in collaboration with the King County Regional Homelessness Authority (KCRHA), Washington State, and local jurisdictions.
- *Goal 3 – Enhance Community and Economic Development:* The Consortium will support investments across the County in low-income communities to promote access to thriving, connected, and inclusive communities by funding activities

such as infrastructure improvements, sidewalks, community center rehabilitation, economic development, microenterprise programs, and other non-housing public services.

The goals identified above have not changed significantly from the previous Consolidated Plan, though the proposed update has added new language and added information to explain the Consortium's role in advancing the goals. For example, Goal 2 of the 2025-2029 Consolidated Plan identifies the Consortium's intention to support activities that prevent homelessness through specific activities like rapid re-housing, emergency shelters, and others.

Goal outcomes. The proposed Consolidated Plan includes outcomes the Consortium hopes to achieve throughout the life of the Plan and how much funding will be allocated to each goal, as determined by the Consortium. Table 3 shows a summary of the funding allocations and anticipated goal outcomes. The progress towards the goals and outcomes will be tracked through the CAPER and Action Plan submittals.

Table 3. Goals of the Plan

Goal	Funding[15]	Goal Outcomes
Increase Affordable Housing	CDBG: $7,125,000 HOME: $17,000,000	1) Rental units constructed: 40 2) Rental units rehabilitated: 10 3) Homeowner housing units added: 20 4) Homeowner housing units rehabilitated: 715
Prevent and Mitigate Homelessness	CDBG: $4,275,000 ESG: $1,375,000	1) People assisted by emergency overnight shelter: 5,000 2) People assisted by homeless prevention: 1,250 3) Households assisted by homelessness diversion: 5,000
Enhance Community and Economic Development	CDBG: $17,100,000	1) People assisted by public facilities / infrastructure activities (other than low- and moderate- income housing): 125,000 2) Businesses assisted: 600 3) People assisted by public service activities other than low- / moderate-income housing: 2,000

According to Executive staff, the goal outcomes are based on the previous five-year average of persons or households served. They only reflect the federally funded units and do not include the units leveraged by other funds.

A discontinuity was found between the values of the goal outcomes in the Executive Summary of the Consolidated Plan and the table in the body of the plan,

[15] The values reflect the total estimated values for annual entitlement amounts, as well as approximately $3,000,000 in program income generated by CDBG and HOME activities.

Table 58. The correct values are shown in Table 3 of this report. Executive staff have agreed to address the erroneous values before the submission to HUD.

Analysis of Impediments to Fair Housing Choice. HUD requires grant recipients to conduct an Analysis of Impediments to Fair Housing Choice (AI) in order to maintain their obligations to "affirmatively further fair housing."[16] The AI includes information on the potential impediments within a given jurisdiction and assesses prior and current actions that further fair housing.

At the time of this staff report, the AI had not been finalized. According to Executive staff, it is expected to be transmitted mid-March and does not require Council action.

Timing Considerations. In order to promptly secure funding from HUD, the Consolidated Plan needs to be adopted and ready to submit. DCHS expects to receive the grants from HUD as soon as April 2025 and must submit the Consolidated Plan within 60 days of receiving the annual amounts. This means that Proposed Ordinance 2025-0030 should be passed out of the Health, Housing, and Human Services Committee at the March 4, 2025, meeting to be acted on in Full Council on March 18, 2025, or March 25, 2018, to avoid an issue with receiving block grant funding.

INVITED

- Kristin Pula, Acting Deputy Director, Housing and Community Development Division, Department of Community and Human Services

ATTACHMENTS

1. Proposed Ordinance 2025-0030
2. Transmittal Letter
3. Fiscal Note

[16] Title VIII of the Civil Rights Act of 1968, 42 U.S.C. 3608 and Executive Order 12892.

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Ordinance

Proposed No. 2025-0030.1 **Sponsors** Mosqueda

AN ORDINANCE approving the King County Consortium Consolidated Plan for 2025-2029.

STATEMENT OF FACTS:

1. King County is the official applicant and grantee to the United States Department of Housing and Urban Development ("HUD") for Community Development Block Grant, HOME Investment Partnerships Program, and Emergency Solutions Grant on behalf of King County and a consortium of cities and towns in the county, except for the city of Seattle, which receives its own HUD moneys, and the city of Milton.

2. The county is responsible to the federal government for activities undertaken with those moneys by the King County Consortium.

3. Federal regulations, 24 C.F.R. Part 91, require King County to adopt a three- to five-year consolidated plan that: identifies housing and community development needs; identifies resources and key partnerships; and establishes objectives and strategies to provide decent affordable housing and a suitable living environment for very-low- to moderate-income residents within the consortium territory of the county.

4. The King County Consortium's current Consolidated Plan for 2020-2024 provides a comprehensive affordable housing and community

development policy and planning document to guide King County administration of federal housing, homeless, and community development moneys.

5. The interjurisdictional Joint Recommendations Committee of the King County Consortium member cities participated in the development of the updated Consolidated Plan for 2025-2029, has approved the plan, and recommends it for approval by the King County council.

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

SECTION 1. The King County Consortium Consolidated Plan for 2025-2029 is approved in substantially the form of Attachment A to this ordinance.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Rod Dembowski, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Dow Constantine, County Executive

Attachments: A. 2025-2029 King County Consortium Consolidated Plan

King County Consortium 2025-2029 Consolidated Plan

January 2025

King County

Table of Contents

Executive Summary

ES-05 Executive Summary – 24 CFR 91.200(c), 91.220(b)

Introduction

Each year, King County, Washington, receives federal funding from the U.S. Department of Housing and Urban Development (HUD) to support affordable housing and community development programs that primarily benefit low- and moderate-income people. HUD generally defines “low- and moderate-income” as income that is at or below 80 percent area median income (AMI). HUD calculates AMI for communities across the country each fiscal year and establishes specific income limits for households based on household size. These income limits determine eligibility for various HUD-funded programs. This funding comes from the Community Development Block Grant (CDBG), HOME Investment Partnerships Program (HOME), and Emergency Solutions Grants (ESG) Program. In order to receive this funding, King County develops a Consolidated Plan every five years to outline the County’s funding strategy over the next five federal fiscal years. The Consolidated Plan incorporates information gathered through data analysis and consultation with a range of voices in the community, including County residents, low- and moderate-income people, and organizations that work with or have specific knowledge of the needs facing low- and moderate-income communities. The Plan uses this information to identify the County’s current housing and community development needs and outline the specific goals and expected outcomes for the use of CDBG, HOME, and ESG funds.

Each of the federal grant programs included in this Consolidated Plan (CDBG, HOME, and ESG) has its own unique requirements, uses, and jurisdictional boundaries. In order to qualify for and coordinate investment for HOME funding, King County partners with other local jurisdictions to form the King County HOME Consortium (Consortium). The Consortium is an inter-jurisdictional partnership with nearly all the cities and unincorporated areas in the County, including Algona, Auburn, Beaux Arts Village, Bellevue, Black Diamond, Bothell, Burien, Carnation, Clyde Hill, Covington, Des Moines, Duvall, Enumclaw, Federal Way, Hunts Point, Issaquah, Kenmore, Kent, Kirkland, Lake Forest Park, Maple Valley, Medina, Mercer Island, Newcastle, Normandy Park, North Bend, Pacific, Redmond, Renton, Sammamish, SeaTac, Shoreline, Skykomish, Snoqualmie, Tukwila, unincorporated King County, Woodinville, and Yarrow Point. The Consortium does not include the cities of Seattle and Milton.

Joint Agreement Cities are the cities — including Redmond, Renton, Shoreline, Kirkland, and Burien — that have a joint agreement with King County for CDBG and HOME funds. The joint agreement cities qualify for their own CDBG funds but choose to partner in a regional housing and community development program. They retain a portion of the CDBG funds to allocate to city projects and contribute a portion of funds to consortium-wide programs and administration.

Though Auburn, Bellevue, Federal Way, and Kent are part of the HOME Consortium, each of these four cities receives its own annual CDBG allocation from HUD and develops a separate Consolidated Plan to guide the use of these funds in their

communities. This Consolidated Plan informs the use of King County's CDBG and ESG allocations as well as the Consortium's HOME allocation. Figure 1 shows the boundaries for Auburn, Bellevue, Federal Way, and Kent, as well as the rest of the Consortium in blue.

The Joint Recommendations Committee (JRC) is an inter-jurisdictional body that provides specific funding recommendations and advice on guidelines and procedures for King County and the Consortium member cities on a wide range of housing and community development issues. The JRC is created through the interlocal cooperation agreements that form the CDBG Consortium, the HOME Consortium, and the RAHP Consortium. King County Code Title 24, Chapter 24.13 codifies the creation of the JRC.

The JRC is comprised of three King County representatives appointed by the King County Executive and eight representatives of cities outside the City of Seattle that participate in the King County Consortium. The City of Seattle participates in the JRC for some meetings regarding regional fund sources that are available for use in the City of Seattle. JRC meetings are open to the public. Some meetings are designated for gathering public testimony and are specifically advertised as such. King County’s Housing and Community Development (HCD) Division staffs the JRC and prepares and presents reports and recommendations for funding awards and procedures that guide HCD programs.

King County’s Community Development Program Manager is the CDBG lead who works closely with the jurisdiction cities. The County’s Housing Finance Program Manager is the HOME lead who works closely with the HOME Consortium.

Figure 1: King County Consortium Boundary Map

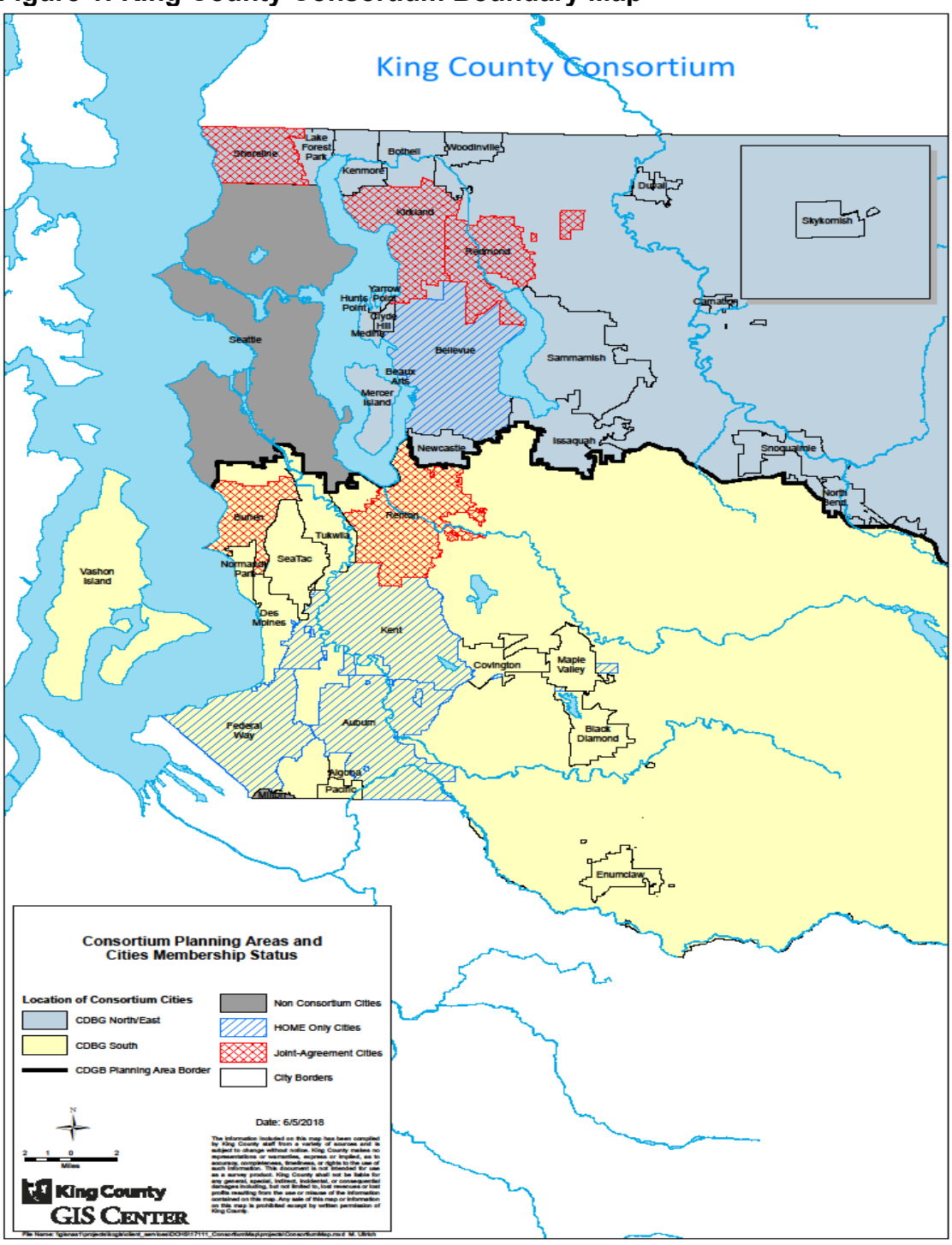


Figure 1 represents the King County Consortium boundaries and member jurisdictions listed in the preceding section. Note the City of Seattle prepares their own Consolidated Plan.

Summary of the objectives and outcomes identified in the plan

King County anticipates receiving the following annual grant amounts over the five-year period of the Consolidated Plan for program years 2025-2029.

- CDBG: $5,300,000
- HOME: $3,200,000
- ESG: $275,000

King County, along with the Consortium, intends to use these funds to further three primary goals.

Goal One **Increase Affordable Housing:** The Consortium will work to preserve and expand the supply of affordable housing by funding activities such as developing new rental and homeowner housing units, preserving existing rental units, and providing housing repairs for income-eligible homeowners and renters. The Consortium will plan for and support fair housing strategies and initiatives designed to affirmatively further fair housing choice, increase access to housing and housing programs, and reduce discrimination towards protected classes.

Goal Two **Prevent and Mitigate Homelessness:** The Consortium will support public service activities that prevent homelessness and reduce the number of households experiencing homelessness by funding activities such as rapid rehousing, emergency shelter, diversion, and housing stability programs. The Consortium will engage in planning, activities, and initiatives to reduce homelessness in collaboration with the King County Regional Homelessness Authority (KCRHA), Washington State, and local jurisdictions.

Goal Three **Enhance Community and Economic Development:** The Consortium will support investments across the County in low-income communities to promote access to thriving, connected, and inclusive communities by funding activities such as infrastructure improvements, sidewalks, community center rehabilitation, economic development, microenterprise programs, and other non-housing public services.

The Strategic Plan section of the Consolidated Plan provides more information on the Consortium's goals, objectives, and specific strategies designed to make progress toward those goals. The Consortium estimated the anticipated outcomes listed in the Strategic Plan using funding projections for CDBG, HOME, and ESG funds for the next five years. If funding values change significantly during the five-year period, the Consortium may amend the anticipated outcomes with the Joint Recommendations Committee (JRC).

During the five-year period, the Consortium estimates the following anticipated outcomes for each goal using the goal outcome indicators provided by HUD:

Increase Affordable Housing	Prevent and Mitigate Homelessness	Enhance Community and Economic Development
• **42** Rental Units Constructed • **10** Rental Units Rehabilitated • **18** Homeowner Housing Units Added • **715** Homeowner Housing Units Rehabilitated	• **1,500** People Assisted by Emergency Overnight Shelter • **1,250** People Assisted by Homelessness Prevention • **5,000** Households Assisted by Homelessness Diversion	• **125,000** People Assisted by Public Facilities/ Infrastructure Activities (Other Than Low- and Moderate-Income Housing) • **600** Businesses Assisted • **2,000** People Assisted by Public Service activities other than Low/Moderate-income Housing

Overview

Evaluation of past performance

An evaluation of the Consortium's past performance in meeting the objectives included in the 2020-2024 Consolidated Plan would be incomplete without recognizing the role of the COVID-19 pandemic on planned activities and programs. The Consortium developed the last Consolidated Plan in 2019, well before the coronavirus reached the U.S. and forced communities across the country to adapt to the public health crisis.

The Consortium's 2020-2024 Consolidated Plan outlined primary goals that were substantively similar to this plan's three primary goals. The Consortium exceeded goals related to Rental Units Constructed, Rental Units Rehabilitated, Emergency Overnight Shelter, Public Facilities/Infrastructure and Businesses Assisted. However, due to several factors, the Consortium did not meet some of its originally anticipated outcomes. Particularly for housing repair projects, factors such as supply chain shortages, a shortage of contractors, and agency staff turnover contributed to project delays. As described in more detail in the Strategic Plan, due to these challenges, some of which continue to impact Consortium programs, the Consortium is taking a more conservative approach in estimating its expected outcomes for the 2025-2029 Consolidated Plan period.

Summary of citizen participation process and consultation process

The Consortium followed the requirements for public participation outlined in the King County Consortium's Citizen Participation Plan, which specifies the Consortium's process for broadening and encouraging public participation in the development of the Consolidated Plan. The Consortium used various methods to comply with the Citizen Participation Plan. First, the Consortium developed and distributed an online community survey to gather input from the general public, as well as the specific groups mentioned in the Citizen Participation Plan. This included working with partner agencies to provide the option for residents to submit hard-copy versions of the community survey and

offering the community survey in 12 different languages to encourage participation of people with diverse language backgrounds.. Secondly, the Consortium organized and facilitated two public comment periods and one public hearing to offer opportunities for the public to provide feedback on the draft Consolidated Plan prior to submission to HUD.

In addition to the public participation process, the Consortium consulted with stakeholders and partners from agencies, organizations, and other groups that work directly with and/or have knowledge of the needs of low- and moderate-income people and communities in King County. Overall, the Consortium gathered input from 45 unique organizations in the development of the Consolidated Plan.

Summary of public comments

There were no public comments.

Summary of comments or views not accepted and the reasons for not accepting them

There were no public comments.

The Process

PR-05 Lead & Responsible Agencies - 91.200(b)

Describe the agency or entity responsible for preparing the Consolidated Plan and those responsible for administration of each grant program and funding source.

As the lead entity of the Consortium, King County's Department of Community and Human Services' Housing and Community Development Division led the development of this Consolidated Plan, which outlines the County's strategy for its CDBG and ESG allocations and the strategy for the Consortium's HOME allocation over the next five years. The Housing and Community Development Division administers the County's CDBG and ESG allocations and the Consortium's HOME allocation on behalf of its members.

The following are the agencies/entities responsible for preparing the Consolidated Plan and those responsible for administration of each grant program and funding source.

Table 1: Responsible Agencies

Agency Role	Name	Department/Agency
CDBG Administrator	King County	King County Department of Community and Human Services, Housing and Community Development Division
HOME Administrator	King County	King County Department of Community and Human Services, Housing and Community Development Division
ESG Administrator	King County	King County Department of Community and Human Services, Housing and Community Development Division

Consolidated Plan Public Contact Information

The following contact information is for members of the public to reach each entitlement community in the Consortium. King County is the contact for the Consortium's Consolidated Plan and HOME program as well as the County's CDBG and ESG programs. Auburn, Bellevue, Federal Way, and Kent have separate contacts for their CDBG programs and individual Consolidated Plans.

King County

Laurie Wells
King County Department of Community and Human Services' Housing and Community Development Division
lauwells@kingcounty.gov
206-263-8341

Auburn	Jeff Tate City of Auburn Department of Community Development Jtate@auburnwa.gov 253-804-5036
Bellevue	Donna Adair City of Bellevue Parks & Community Services Department, Human Services Division dadair@bellevuewa.gov 425-452-4069
Federal Way	Kim Bachrach City of Federal Way Community Services Division kim.bachrach@cityoffederalway.com 253-835- 2654
Kent	Brittany Gaines City of Kent Parks, Recreation, and Community Services, Human Services BGaines@kentwa.gov 253-856-5076

PR-10 Consultation - 91.100, 91.110, 91.200(b), 91.300(b), 91.215(l) and 91.315(l)

Introduction

The Consortium routinely coordinates with partner agencies and organizations in the administration, implementation, and evaluation of CDBG, HOME, and ESG-funded programs to meet the Consortium's Consolidated Plan goals and objectives. Part of this process involves ongoing communication with partners on funded programs and activities as well as consulting partners and other stakeholders in the development of the five-year Consolidated Plan to outline broader funding strategies. In the development of the 2025-2029 Consolidated Plan, the Consortium sought input from partners and stakeholders through virtual consultation sessions and an online stakeholder survey. This input, combined with information from data analysis, contributed to the Consortium's funding strategy for the next five years.

The Consortium consulted with 45 unique organizations in the development of the Consortium Consolidated Plan. Through virtual consultation sessions with partners including the King County Housing Authority, A Regional Coalition for Housing (ARCH), and multiple agencies across county government, stakeholders noted the continued need for a variety of affordable housing options to meet the current needs of low- and moderate-income people as well meet future projected need in the years to come. In addition, stakeholders noted the need for public services to assist people experiencing challenges such as mental health conditions, substance abuse disorder, food insecurity, and limited transportation options.

In addition to the consultation sessions, the Consortium distributed an online stakeholder survey from December 15, 2023, to February 1, 2024, which received 29 responses from stakeholders. The survey asked respondents to indicate how they would prioritize funding across various topic areas, such as affordable housing, economic development, and public infrastructure. The survey tool calculated an average weighted score based on respondents' prioritization of the topic areas. The average weighted score for each topic area provides a clear ranking of the topics, with higher scores indicating that respondents prioritized a given topic more. The survey results indicated that respondents prioritized affordable housing the most (7.10), followed by housing, shelter, and services for people experiencing homelessness (6.45), public services (5.14), special needs accommodation (4.69), economic development (3.41), fair housing (3.31), public facilities (3.07), and public infrastructure (2.83). Input from the stakeholder survey aligns with other information summarized throughout the Consolidated Plan highlighting the continued need for additional affordable housing opportunities particularly for low- and moderate-income people.

Provide a concise summary of the jurisdiction's activities to enhance coordination between public and assisted housing providers and private and governmental health, mental health and service agencies (91.215(l)).

As an inter-jurisdictional partnership that includes 38 members, the Consortium routinely engages with regional and local partners including government agencies,

housing providers, health providers, and service providers to address the housing, health, and service needs of the region. Over the past several years, the Consortium has worked with the following partners amongst others:

- Washington State Housing Finance Commission
- Washington State Department of Commerce
- A Regional Coalition for Housing (ARCH)
- King County Housing Authority
- Renton Housing Authority
- Seattle Housing Authority
- King County Regional Homelessness Authority
- Affordable Housing Committee
- Nonprofit housing and service providers
- Housing Development Consortium of Seattle-King County
- Public Health-Seattle & King County
- Human Services Planners for North, East and South King County
- Divisions within King County's Department of Community and Human Services such as Behavioral Health and Recovery; Adult Services; Children, Youth and Young Adults; and Developmental Disabilities and Early Childhood Supports.

Coordination with partner organizations, agencies, and entities is ongoing throughout the program year and, together with official stakeholder and public meetings, informs all programs and recommendations brought forth to the JRC.

Describe coordination with the Continuum of Care and efforts to address the needs of homeless persons (particularly chronically homeless individuals and families, families with children, veterans, and unaccompanied youth) and persons at risk of homelessness.

The KCRHA is the lead entity responsible for coordinating the homelessness response system in Seattle and King County and serves as the local Continuum of Care (CoC) Lead. KCRHA began operations in 2021 with the goal of solidifying a unified coordinated homeless housing, shelter, and services system that incorporates equity and social justice principles as well as the perspectives of people with lived experience with homelessness.

The Consortium routinely collaborates with KCRHA and other partner agencies and organizations to support a variety of long-standing programs that provide housing, shelter, and supportive services for people experiencing homelessness and those at risk of homelessness in King County. Through multiple County-funded programs, the County provides services to children, youth and young adults, seniors, survivors of domestic violence, persons with developmental disabilities, people experiencing homelessness, and veterans. King County funds permanent supportive housing projects to meet the housing and service needs of people experiencing chronic homelessness. The Consortium and other funders for KCRHA also fund supportive services that help meet the immediate needs of people experiencing homelessness as well as prevent episodes of homelessness. Services such as employment and education resources, the King County Veterans Program, assistance to residents with developmental disabilities

and their families, and the Child Welfare Early Learning Partnership provide low-income individuals and households with vital resources and community support networks to enhance stability. The County's Behavioral Health and Recovery Division (BHRD) provides direct services for crisis outreach, mental health client services, and outreach and triage on the streets for people incapacitated by alcohol or drugs. In addition, the County's Youth and Family Homeless Prevention Initiative (YFHPI) helps prevent homelessness by offering families at risk of eviction needed supports such as case management, flexible financial assistance, and rental assistance to maintain housing stability. One of the YFHPI's key eligibility factors is people who have experienced prior episodes of homelessness. Keep King County Housed also provides homeless prevention rental assistance.

The Consortium also continues to prioritize a variety of housing projects that help meet the needs of different segments of the population. For example, the Consortium has funded projects to develop homeless housing and system-connected housing through the Housing Finance Program's annual Affordable Housing Capital Projects request for proposals (RFP) process. Projects that provide housing for people experiencing homelessness reflect Housing First principles and must use the Coordinated Entry system. In addition, projects that provide system-connected housing serve individuals and households with involvement in another system such as criminal justice, in-patient medical, or behavioral health.

Describe consultation with the Continuum(s) of Care that serves the jurisdiction's area in determining how to allocate ESG funds, develop performance standards and evaluate outcomes, and develop funding, policies and procedures for the administration of HMIS.

KCRHA manages the CoC which is centered on Housing First principles and incorporates a racial equity framework to the coordinated regional homelessness response system. The Consortium works with KCRHA and partner organizations to achieve the ambitious goal of Functional Zero, defined as a system where homelessness is avoidable, and there are immediate options for someone who is experiencing homelessness to return to housing within 20 days.

Consultation with CoC: In the development of the Consolidated Plan, KCRHA provided input and data for the data tables and prompts throughout the Consolidated Plan. KCRHA and the Consortium also routinely collaborate during recurring meetings to plan, manage, and evaluate progress across County-funded programs.

Allocation of ESG Funds: King County routinely consults with member jurisdictions, stakeholders, members of the public, and the JRC to allocate ESG funds. Historically King County announced funding awards on a competitive basis through biannual funding applications that incorporate multiple fund sources, are advertised publicly, and conducted through King County Procurement. Going forward, procurement for the emergency housing response system will be managed through KCRHA. King County and KCRHA will work together to revise ESG procurement policies and procedures as needed.

Performance Standards and Evaluation of Outcomes: KCRHA's website includes links to various CoC policies and procedures for Coordinated Entry (CE), Homeless Management Information System (HMIS), governance, and system performance. The website also offers training manuals, resources, and guidance for partner organizations to adhere to the CoC's standards and policies. KCRHA has various boards and committees to guide its work: the Seattle King County CoC Board (also referred to as the Advisory Committee) leads the CoC and carries out the mandatory functions outlined by HUD; the Implementation Board provides goal setting and oversight for the CoC; and the Governing Committee provides high-level guidance and oversight, approves the budget, and reviews performance. CoC boards and committees host recurring meetings that are open to the public. Performance standards for projects regardless of fund source are developed by KCRHA, recommended by the System Performance Committee, and approved by the CoC Board. Performance against standards is part of ongoing contract management and monitoring. In addition, prior performance is a consideration in all procurements.

Funding, Policies, and Procedures for HMIS: HMIS is funded with HUD CoC dollars along with local and state dollars. In 2022, the management of HMIS transferred from King County to KCRHA as the CoC underwent internal restructuring. KCRHA's System Performance Committee supports data collection and evaluation efforts for the CoC to assess and inform progress in ending homelessness in King County. KCRHA publishes its HMIS policies, procedures, and guidance online to support system users in adhering to the CoC's requirements and standards.

Describe agencies, groups, organizations, and others who participated in the process and describe the jurisdiction's consultations with housing, social service agencies, and other entities.

Table 2 lists all the agencies and organizations that provided input in the development of the Consolidated Plan. The Consortium sought input from all the required organization types for the Consolidated Plan through virtual consultation sessions and an online stakeholder survey. Overall, the Consortium gathered input from 45 unique organizations. At least one agency or organization from each of the required organization types provided input in the consultation process for the Consolidated Plan.

Table 2: Organizations Consulted in the Development of the Consolidated Plan

#	Organization	Organization Type	Section of Plan Addressed by Consultation	Method of Consultation	Anticipated Outcome of Consultation and/or Areas for Improved Coordination
1	4 Tomorrow	• Civic Leader • Services – Homeless • Services – Fair Housing	• Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Fair Housing Strategy.
2	A Regional Coalition for Housing (ARCH)	• Housing • Regional Organization • Civic Leader	• Needs Assessment • Market Analysis • Anti-Poverty Strategy • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
3	African Community Housing and Development	• Housing • Services – Elderly • Services – Homeless • Services – Employment • Services – Fair Housing • Regional Organization • Civic Leader	• Needs Assessment • Homeless Needs – Families with Children • Homeless Needs – Unaccompanied Youth • Homelessness Strategy • Economic Development • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
4	Africans on the Eastside	• Services – Education • Civic Leader • Neighborhood Organization	• Needs Assessment • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
5	Central Puget Sound Regional Transit Authority (Sound Transit)	• Regional Organization • Planning Organization	• Non-Homeless Special Needs • Market Analysis	• Survey	Provided input to develop the Consortium's Consolidated Plan.

#	Organization	Organization Type	Section of Plan Addressed by Consultation	Method of Consultation	Anticipated Outcome of Consultation and/or Areas for Improved Coordination
		• Services – Public Transportation	• Economic Development • Anti-Poverty Strategy		
6	Chief Seattle Club	• Housing • Services – Homeless • Services – Health • Services – Employment	• Needs Assessment • Homelessness Strategy • Economic Development • Anti-Poverty Strategy • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
7	City of Burien, WA	• Government – Local	• Needs Assessment • Homelessness Strategy	• Survey	Provided input to develop the Consortium's Consolidated Plan.
8	City of Carnation, WA	• Government – Local	• Needs Assessment • Market Analysis • Economic Development	• Survey	Provided input to develop the Consortium's Consolidated Plan.
9	City of Duval, WA	• Government – Local	• Needs Assessment • Market Analysis	• Survey	Provided input to develop the Consortium's Consolidated Plan.
10	City of North Bend, WA	• Government – Local	• Needs Assessment • Homelessness Strategy • Market Analysis • Economic Development	• Survey	Provided input to develop the Consortium's Consolidated Plan.
11	City of Redmond, WA	• Government – Local	• Needs Assessment • Homelessness Strategy • Market Analysis	• Survey	Provided input to develop the Consortium's Consolidated Plan.
12	City of Renton, WA	• Government – Local	• Needs Assessment • Market Analysis	• Survey	Provided input to develop the

#	Organization	Organization Type	Section of Plan Addressed by Consultation	Method of Consultation	Anticipated Outcome of Consultation and/or Areas for Improved Coordination
					Consortium's Consolidated Plan.
13	City of SeaTac, WA	• Government – Local	• Needs Assessment • Market Analysis	• Survey	Provided input to develop the Consortium's Consolidated Plan.
14	Eastside for All	• Civic Leader • Neighborhood Organization	• Needs Assessment • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
15	Eastside Legal Assistance	• Services – Domestic Violence • Services – Fair Housing	• Needs Assessment • Non-Homeless Special Needs • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
16	El Centro de la Raza	• Housing • Services – Children • Services – Education • Services – Employment	• Needs Assessment • Market Analysis • Anti-Poverty Strategy • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
17	Enumclaw School District (642)	• Services – Education	• Needs Assessment	• Survey	Provided input to develop the Consortium's Consolidated Plan.
18	Habitat for Humanity of Seattle and King & Kittitas Counties	• Housing • Regional Organization	• Needs Assessment • Market Analysis • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's

#	Organization	Organization Type	Section of Plan Addressed by Consultation	Method of Consultation	Anticipated Outcome of Consultation and/or Areas for Improved Coordination
					Consolidated Plan and Fair Housing Strategy.
19	Highline College	• Services – Education	• Needs Assessment	• Survey	Provided input to develop the Consortium's Consolidated Plan.
20	Indian American Community Services	• Housing • Services – Children • Services – Elderly • Services – Employment • Services – Fair Housing • Civic Leader	• Needs Assessment • Market Analysis • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
21	King County Bar Association Housing Justice Project	• Services – Fair Housing	• Needs Assessment • Non-Homeless Special Needs • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
22	King County Behavioral Health and Recovery Division	• Services – Disabilities • Services – Health • Health Agency • Government – County • Grantee Department	• Needs Assessment • Non-Homeless Special Needs • Market Analysis	• Survey	Provided input to develop the Consortium's Consolidated Plan.
23	King County Best Starts for Kids	• Services – Children • Government – County • Grantee Department	• Needs Assessment • Market Analysis • Anti-Poverty Strategy	• Survey	Provided input to develop the Consortium's Consolidated Plan.

#	Organization	Organization Type	Section of Plan Addressed by Consultation	Method of Consultation	Anticipated Outcome of Consultation and/or Areas for Improved Coordination
24	King County Department of Community and Human Services Adult Services Division	• Services – Elderly • Government – County • Regional Organization • Planning Organization • Other – Veterans • Grantee Department	• Needs Assessment • Non-Homeless Special Needs • Anti-Poverty Strategy	• Survey	Provided input to develop the Consortium's Consolidated Plan.
25	King County Department of Community and Human Services Homelessness and Community Development Program	• Housing • Government – County • Regional Organization • Grantee Department	• Needs Assessment • Homelessness Strategy • Anti-Poverty Strategy	• Survey	Provided input to develop the Consortium's Consolidated Plan.
26	King County Department of Community Development and Human Services Emergency Management Operations	• Agency Managing Flood Prone Areas • Emergency Management Agency • Government – County • Regional Organization • Grantee Department	• Needs Assessment • Market Analysis	• Survey	Provided input to develop the Consortium's Consolidated Plan.
27	King County Housing Authority	• Housing • PHA • Fair Housing	• Needs Assessment • Public Housing Needs • Non-Homeless Special Needs • Market Analysis • Anti-Poverty Strategy • Fair Housing Strategy	• Interview • Survey	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.

#	Organization	Organization Type	Section of Plan Addressed by Consultation	Method of Consultation	Anticipated Outcome of Consultation and/or Areas for Improved Coordination
28	King County Metro Transit Department	• Government – County • Regional Organization • Planning Organization • Other – Public Transportation • Grantee Department	• Non-Homeless Special Needs • Economic Development	• Survey	Provided input to develop the Consortium's Consolidated Plan.
29	King County Puget Sound Taxpayer Accountability Account (PSTAA)	• Government – County • Regional Organization • Grantee Department	• Needs Assessment	• Survey	Provided input to develop the Consortium's Consolidated Plan.
30	King County Regional Homelessness Authority	• Housing • CoC • Services – Domestic Violence • Services – Homeless • Regional Organization	• Needs Assessment • Homeless Needs – Chronically Homeless • Homeless Needs – Families with Children • Homeless Needs – Veterans • Homeless Needs – Unaccompanied Youth • Homelessness Strategy • Market Analysis • Anti-Poverty Strategy	• Email • Data Request	Provided input to develop the Consortium's Consolidated Plan.
31	Open Doors for Multicultural Families	• Services – Children • Services – Elderly • Services – Disabilities • Services – Narrowing the Digital Divide • Services – Education • Civic Leader	• Needs Assessment • Non-Homeless Special Needs • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
32	Queer Power Alliance	• Services – Education • Civic Leader	• Needs Assessment • Anti-Poverty Strategy	• Interview	Provided input to develop the

#	Organization	Organization Type	Section of Plan Addressed by Consultation	Method of Consultation	Anticipated Outcome of Consultation and/or Areas for Improved Coordination
			• Fair Housing Strategy		Consortium's Consolidated Plan and Fair Housing Strategy.
33	Rainier Valley Leadership Academy (1082)	• Services – Children • Services – Education	• Needs Assessment • Economic Development • Anti-Poverty Strategy	• Survey	Provided input to develop the Consortium's Consolidated Plan.
34	Renton Housing Authority	• Housing • PHA • Services – Elderly • Services – Disabilities • Services – Homeless • Services – Employment • Services – Fair Housing	• Needs Assessment • Public Housing Needs • Market Analysis • Anti-Poverty Strategy • Fair Housing Strategy	• Survey	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
35	Renton School District (413)	• Services – Children • Services – Education	• Needs Assessment	• Survey	Provided input to develop the Consortium's Consolidated Plan.
36	Seattle-King County Advisory Council on Aging and Disability Services	• Services – Elderly • Services – Disabilities • Government – County • Regional Organization • Planning Organization	• Needs Assessment • Non-Homeless Special Needs	• Survey	Provided input to develop the Consortium's Consolidated Plan.
37	Shoreline School District (349)	• Services – Children • Services – Education	• Needs Assessment	• Survey	Provided input to develop the Consortium's Consolidated Plan.

#	Organization	Organization Type	Section of Plan Addressed by Consultation	Method of Consultation	Anticipated Outcome of Consultation and/or Areas for Improved Coordination
38	Skyway Coalition	• Housing • Civic Leader • Neighborhood Organization	• Needs Assessment • Market Analysis • Anti-Poverty Strategy • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
39	South King Housing and Homelessness Partners (SKHHP)	• Regional Organization • Planning Organization	• Needs Assessment • Homeless Needs – Chronically Homeless • Homeless Needs – Families with Children • Homeless Needs – Veterans • Homeless Needs – Unaccompanied Youth • Homelessness Strategy • Anti-Poverty Strategy • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
40	Tahoma School District (582)	• Services – Children • Services – Education	• Needs Assessment • Homelessness Strategy • Anti-Poverty Strategy	• Survey	Provided input to develop the Consortium's Consolidated Plan.
41	Tenants Union of Washington State	• Services – Employment • Services – Fair Housing • Regional Organization • Planning Organization • Civic Leader	• Needs Assessment • Market Analysis • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
42	Transit Riders Union	• Services – Education • Regional Organization	• Needs Assessment	• Interview	Provided input to develop the

#	Organization	Organization Type	Section of Plan Addressed by Consultation	Method of Consultation	Anticipated Outcome of Consultation and/or Areas for Improved Coordination
		• Planning Organization • Civic Leader	• Non-Homeless Special Needs • Market Analysis • Anti-Poverty Strategy • Fair Housing Strategy		Consortium's Consolidated Plan and Fair Housing Strategy.
43	Washington Multifamily Housing Association	• Services – Education • Regional Organization • Planning Organization	• Needs Assessment • Market Analysis • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
44	Windermere Real Estate	• Housing • Business Leader	• Market Analysis • Fair Housing Strategy	• Interview	Provided input to develop the Consortium's Consolidated Plan and Fair Housing Strategy.
45	YMCA (Y Social Impact Center)	• Housing • Services – Children • Services – Homeless • Services – Employment • Regional Organization • Civic Leader	• Needs Assessment • Homeless Needs – Unaccompanied Youth • Homelessness Strategy • Anti-Poverty Strategy	• Survey	Provided input to develop the Consortium's Consolidated Plan.

Identify any agency types not consulted and provide rationale for not consulting.

The Consortium did not exclude any agencies or organizations in the consultation process for the Consolidated Plan. The Consortium encouraged all organization types to participate in the consultation process and provide input for the Consolidated Plan.

Describe other local, regional, state, or federal planning efforts considered when preparing the Consolidated Plan.

The Consortium considered multiple local and regional planning efforts while developing the Consolidated Plan which are listed in Table 3.

Table 3: Other local, regional, state, and/or federal planning efforts considered when preparing the Consolidated Plan

Name of Plan	Lead Organization	How do the goals of your Strategic Plan overlap with the goals of each plan?
2021 King County Countywide Planning Policies	King County, WA	The Countywide Planning Policies identify and establish the policy goals for all King County jurisdictions' comprehensive plans and long-range affordable housing goals. The goals in the Consortium's Consolidated Plan align with the goals in the Countywide Planning Policies.
Best Starts for Kids Implementation Plan: 2022-2027	King County, WA	The Best Starts for Kids Implementation Plan outlines the County's plans for investment in Best Starts for Kids levy funds to support children and youth services. The goals in the Consortium's Consolidated Plan align with the goals in the Best Starts for Kids Implementation Plan.
FY 2024 King County Housing Authority Moving to Work (MTW) Plan	King County Housing Authority	The King County Housing Authority's (KCHA's) 2024 MTW Plan outlines KCHA's goals, strategies, and planned activities for the upcoming fiscal year. The goals in the Consortium's Consolidated Plan align with the goals in KCHA's 2024 MTW Plan.
King County 2020 Strategic Climate Action Plan	King County, WA	King County's 2020 Strategic Climate Action Plan outlines the guiding principles, strategic framework, and recommendations for mitigating climate change. The goals in the Consortium's Consolidated Plan align with the goals in the Strategic Climate Action Plan.
King County 2024 update to the Comprehensive Plan	King County, WA	King County's 2024 update to the King County Comprehensive Plan (King County Comprehensive Plan) provides data and information to guide the growth and development over the next 20 years. The goals in the Consortium's Consolidated Plan

Name of Plan	Lead Organization	How do the goals of your Strategic Plan overlap with the goals of each plan?
		align with the information included in the King County Comprehensive Plan.
King County Crisis Care Centers Levy Implementation Plan 2024-2032	King County, WA	The Crisis Care Centers Levy Implementation Plan outlines King County's action steps for the upcoming years in implementing levy programs. The goals and information included in the Implementation Plan align with the goals and strategies in the Consortium's Consolidated Plan.
King County Extreme Heat Mitigation Strategy	King County, WA	The Extreme Heat Mitigation Strategy outlines recommendations to address the effects of extreme heat including energy-efficient housing, prioritizing green space, and redesigning of the built landscape. The goals in the Consortium's Consolidated Plan align with the information included in the Extreme Heat Mitigation Strategy.
King County Initial Health through Housing Implementation Plan 2022-2028	King County, WA	The Initial Health Through Housing Implementation Plan outlines King County's action steps for the upcoming years in implementing the program. The goals and information included in the Implementation Plan align with the goals and strategies in the Consortium's Consolidated Plan.
King County Metro Strategic Plan for Public Transportation 2021-2031	King County, WA	The King County Metro Strategic Plan for Public Transportation outlines the objectives, strategies, and recommendations for creating a safer, more equitable transportation landscape in King County. The information in the Strategic Plan for Public Transportation aligns with the information included in the Consortium's Consolidated Plan.
King County Regional Hazard Mitigation Plan 2020-2025	King County, WA	King County's Regional Hazard Mitigation Plan includes recommendations to promote equity and social justice in preparation for natural and human-made disasters. The information in the Consolidated Plan aligns with the information included in the Regional Hazard Mitigation Plan.
King County Regional Homelessness Authority 5-Year	King County Regional Homelessness Authority	KCRHA's 5-Year Plan outlines the authority's goals and strategies to reduce homelessness in King County. The goals in KCRHA's 5-Year Plan align with the goals in the Consortium's Consolidated Plan.

Name of Plan	Lead Organization	How do the goals of your Strategic Plan overlap with the goals of each plan?
Plan (2023-2028)		
King County Road Services Division: Americans with Disabilities Act Transition Plan	King County, WA	The King County Road Services Division's ADA Transition Plan outlines steps for removing barriers to accessibility, such as non-compliant sidewalks, curbs, and obstacles. The goals in the Consortium's Consolidated Plan align with the information included in the ADA Transition Plan.
King County Strategic Plan	King County, WA	The King County's Office of Performance, Strategy and Budget's Strategic Plan outlines a common vision, mission, and guiding principles for King County government including goals and objectives across topics such as economic vitality, safety and justice, affordable housing, health and human services, and efficient and accountable government. The goals in the Consortium's Consolidated Plan align with the goals outlined in the King County Strategic Plan.
King County Veterans, Seniors, and Human Services Levy Implementation Plan (2024-2029)	King County, WA	The King County Veterans, Seniors, and Human Services Levy Implementation Plan outlines the County's strategy for using levy funds to achieve outcomes related to healthy living, housing stability, financial stability, social engagement, and service system access for veterans and military servicemembers and their respective families, seniors and their caregivers, and vulnerable populations. The goals in the Consortium's Consolidated Plan align with the goals in the Veterans, Seniors, and Human Services Levy Implementation Plan.
Puget Sound Regional Council 2022-2026 Regional Economic Strategy	Puget Sound Regional Council	The Regional Economic Strategy outlines the strategic framework for King, Kitsap, Pierce, and Snohomish Counties. The goals in the Regional Economic Strategy align with the goals in the Consortium's Consolidated Plan.
Puget Sound Regional Council Regional Housing Strategy	Puget Sound Regional Council	The Regional Housing Strategy outlines the regional supply and demand for affordable housing and outlines local and regional actions to preserve, improve, and expand the housing stock in the region. The goals in the

Name of Plan	Lead Organization	How do the goals of your Strategic Plan overlap with the goals of each plan?
		Consortium's Consolidated Plan align with the goals in the Regional Housing Strategy.
Renton Housing Authority 5-Year PHA Plan (2022-2026)	Renton Housing Authority	The Renton Housing Authority Five-Year PHA Plan outlines the PHA's goals and planned activities for the upcoming five years. The goals in the Consortium's Consolidated Plan align with the goals in the Renton Housing Authority's Five-Year PHA Plan.
Seattle-King County Workforce Innovation and Opportunity Act (WIOA) Local Plan 2024-2028	Workforce Development Council of Seattle-King County	The Seattle-King County WIOA Local Plan outlines the Workforce Development Council's goals and strategies to support regional workforce development to foster economic growth, empower individuals, and promote resilient and thriving communities. The goals in the Consortium's Consolidated Plan align with the goals in the Seattle-King County WIOA Local Plan.
Skyway-West Hill and North Highline Anti-Displacement Strategies Report	King County, WA	The Skyway-West Hill and North Highline Anti-Displacement Strategies Report outlines the recommendations for actionable anti-displacement strategies for the Skyway-West Hill and North Highline Communities. The goals in the Consortium's Consolidated Plan align with the goals and strategies in the Anti-Displacement Strategies Report.

Describe cooperation and coordination with other public entities, including the state and any adjacent units of general local government, in the implementation of the Consolidated Plan (91.215(l)).

In the development and review of the Consolidated Plan, the Consortium consulted with numerous public entities including working closely with the other member jurisdictions of the Consortium. During the consultation process, the Consortium gathered input from these public entities:

- A Regional Coalition for Housing (ARCH)
- Public Health – Seattle & King County
- King County Department of Community and Human Services Behavioral Health and Recovery Division
- King County Department of Community and Human Services Developmental Disabilities and Early Childhood Supports Division
- King County Department of Community and Human Services, Adult Services Division

- King County Department of Community and Human Services Children, Youth and Young Adults Division
- King County Best Starts for Kids Children and Youth Advisory Board
- King County Veterans, Seniors, and Human Services Levy Advisory Board
- King County Regional Homelessness Authority
- King County Veterans Program
- City of Auburn
- City of Bellevue
- City of Federal Way
- City of Kent
- City of Renton
- City of Shoreline
- City of Kirkland
- City of Burien
- City of Seattle
- Sound Cities Association
- Washington State Department of Social and Health Services
- Washington State Department of Veterans Affairs
- Washington State Department of Commerce
- Washington State Housing Finance Commission.

In the implementation of the Consolidated Plan, the Consortium often coordinates with many of these same public entities. For example, the Consortium's interlocal agreement structure establishes specific requirements for implementation which the County and Consortium members continue to uphold.

PR-15 Citizen Participation - 91.105, 91.115, 91.200(c) and 91.300(c)

Summary of citizen participation process and efforts made to broaden citizen participation

In the development of the Consolidated Plan, the Consortium outlined a public participation strategy that aligns with the King County Consortium's Citizen Participation Plan. The Citizen Participation Plan outlines the requirements guiding public participation for the Consolidated Plan and states that the Consortium must provide citizens and stakeholders with information and the opportunity to give meaningful input in the development of the Consolidated Plan. This process must include outreach to low- and moderate-income people, people living in predominantly low- and moderate-income neighborhoods (defined as areas where more than 50 percent of the population have household incomes at or below 80 percent AMI), people of color, non-English and limited English-speaking people, people with a disability, and people experiencing homelessness.

The Consortium used several methods to broaden public participation in the development of the Consolidated Plan. The Consortium developed a community survey to gather input from the general public as well as the specific groups mentioned in the Citizen Participation Plan. The community survey accepted responses from March 19 to April 18, 2024 online. The Consortium published the community survey link on its social media platforms and the Housing and Community Development Division's webpage on King County's website. The Consortium also coordinated with local partner organizations that work closely with people in one or more of the subpopulations listed in the Citizen Participation Plan to encourage survey responses from a wide range of voices in the community. The online version of the community survey was available in 12 languages, including English, Spanish, Vietnamese, Russian, Somali, Simplified Chinese, Traditional Chinese, Korean, Ukrainian, Amharic, Punjabi, and Khmer.

The Consortium also facilitated two 30-day public comment periods and one public hearing to gather public input on the draft Consolidated Plan. The Consortium followed the requirements specified in its Citizen Participation Plan regarding ensuring access to, providing adequate notice of, and encouraging participation in the public comment periods and public hearing. The first public comment period occurred from July 1 to August 12, 2024, and the second public comment period occurred from November 1 to November 30, 2024. County staff provided a presentation summarizing the Consolidated Plan to the JRC and responded to questions as part of the public hearing held on July 25, 2024.

Summarize citizen participation process and how it impacted goal setting.

Overall, 120 members of the public responded to the Consortium's community survey and provided input on the housing and community development needs in their communities. There were no public comments during the public comment periods or the public hearing.

Table 4: Citizen Participation Outreach

#	Method of Outreach	Target of Outreach	Summary of response/attendance	Summary of comments received	Summary of comments not accepted and why
1	Consortium Consolidated Plan Community Survey	• Non-targeted/broad community • Minorities • Non-English-speaking persons • Persons with disabilities • Other (specific groups included in the Citizen Participation Plan)	The Consortium received 120 responses to the community survey from March 19 to April 18, 2024.	Members of the community provided input on the housing and community development needs and priorities in the communities where they live.	The Consortium accepted all community survey responses.
2	First Public Comment Period for the Consortium Consolidated Plan Newspaper Ad	• Non-targeted/broad community	Posting of the draft 2025-2029 Consolidated Plan was available for public review between July 1, 2024 and August 12, 2024	There were no public comments.	There were no public comments.
	Public Hearing for the Consortium Consolidated Plan	• Non-targeted/broad community	A public meeting was held on July 25, 2024.	There were no public comments.	There were no public comments.
3	Second Public Comment Period for the Consortium Consolidated Plan	• Non-targeted/broad community	Posting of the draft 2025-2029 Consolidated Plan was available for public review between December 1, 2024 and December 31, 2024	There were no public comments.	There were no public comments.

4	Public Comment Period for the 2025 Annual Action Plan	• Non-targeted/broad community	Posting of the draft 2025 Annual Action Plan was available for public review between December 1, 2024 and December 31, 2024	There were no public comments.	There were no public comments.
5	Public Hearing for the draft 2025 Annual Action Plan	• Non-targeted/broad community	A public meeting was held on September 26, 2024.	There were no public comments.	There were no public comments.
6	Public Hearing 2024 CAPER	• Non-targeted/broad community	Posting of draft 2024 CAPER was available for public review between March 7-March 28, 2025. A public meeting was held on March 27, 2025.	There were no public comments.	There were no public comments.

Needs Assessment

NA-05 Overview

The Needs Assessment of the Consolidated Plan summarizes key housing and community development trends impacting the Consortium. Through analysis of federal, state, and local datasets as well as information gathered through interviews with community partners, a stakeholder survey, and a community survey, the Consortium identified several major housing and human service needs of low- and moderate-income people in the jurisdiction. The needs identified in this section helped to inform the Strategic Plan, which outlines how the Consortium will use its CDBG, HOME, and ESG funds over the next five years.

The Consolidated Plan utilizes two primary data sources: data from the U.S. Census Bureau's American Community Survey (ACS) and custom tabulations of ACS data called the Comprehensive Housing Affordability Strategy (CHAS) data. The Consortium analyzed the 2016–2020 five-year CHAS estimates, 2018–2022 ACS five-year estimates, and information from other available sources such as local reports, plans, and studies, dashboards, and datasets to better understand current trends impacting the region. The Consortium also facilitated consultation sessions with partner agencies and organizations, distributed an online stakeholder survey, and gathered input from the public through a community survey to hear directly from residents.

HUD's fiscal year 2024 income limits for King County, which is part of the Seattle-Bellevue, WA HUD Metro FMR Area, provides context for different income categories referred to throughout the Consolidated Plan (Table 5). In fiscal year 2024, HUD's median family income for King County is $147,400.

Table 5: 2024 HUD Income Limits for the Seattle-Bellevue, WA Metro Area (King County)

Income Category	Household Size							
	1	2	3	4	5	6	7	8
Extremely Low-income (0-30% AMI)	$31,650	$36,200	$40,700	$45,200	$48,850	$52,450	$56,050	$59,700
Low-income (30-50% AMI)	$52,700	$60,250	$67,800	$75,350	$81,400	$87,450	$93,400	$99,450
Moderate-income (50-80% AMI)	$77,700	$88,800	$99,900	$110,950	$119,850	$128,750	$137,600	$146,500

Data Source: HUD Income Limits, 2024.

Key Themes from the Needs Assessment

Through qualitative and quantitative data analysis, the Consortium identified several major trends impacting the region. Of note, the data analysis points to housing affordability as a continued concern in the Consortium. Rising housing costs and a lack of affordable units have caused many low- and moderate-income households to become cost-burdened or severely cost-burdened. While households of all demographics experience housing cost burden and severe housing cost burden, the data indicates that Pacific Islander, Black or African American, elderly, and small family households are overrepresented in the data. The data analysis also identified five racially or ethnically concentrated areas of poverty (R/ECAPs) in the Consortium, three of which received that designation in the last 10 years. Point-in-Time (PIT) count data from the CoC indicates that among the total population experiencing homelessness, 20 percent experienced chronic homelessness and 54 percent were adult-only households. Finally, surveys, consultation sessions, and a review of existing plans, reports, and studies indicate that mental health and substance abuse disorder services, street and sidewalk improvements, accessibility improvements for people with disabilities, parks and recreational facilities, and community centers are high non-housing community development needs for the Consortium.

NA-10 Housing Needs Assessment - 24 CFR 91.405, 24 CFR 91.205 (a,b,c)

Summary of Housing Needs

The Housing Needs Assessment uses ACS and CHAS data as well as other information to explore the characteristics of the 36 percent of households in the Consortium that are considered low- to moderate-income (0-80 percent AMI). Within the Consortium's low- to moderate-income population, housing cost burden and severe housing cost burden are the most prevalent housing problems, particularly among households earning less than 30 percent AMI. People who are elderly, or 62 years or older as defined by HUD, owner households and small family renter households experience the highest percentage of severe cost burden by tenure, respectively. In addition, the Consortium analyzed several factors that can contribute to housing instability and homelessness, such as living in a single-person household, living with a disability, and being a victim of domestic violence, dating violence, sexual assault, or stalking. Of note, median incomes for single-person households and households where one member is living with a disability are significantly lower than those for the Consortium as a whole, which speaks to a need for housing assistance for those populations.

ACS data provides insight on the change in the Consortium's population, number of households, and median household incomes from 2012 to 2022. Table 6 provides a high-level overview of the demographic change from 2012 to 2022 and indicates that the Consortium's population — King County's population outside of Seattle and Milton — grew by 14 percent (190,471 people) over the 10-year period while the number of households grew by 12 percent (59,340 households). During this same period, the median income for all of King County increased by 63 percent from $71,175 in 2012 to $116,340 by 2022.

Table 6: Housing Needs Assessment Demographics

Demographics	Base Year: 2012	Most Recent Year: 2022	% Change
Population	1,320,754	1,511,225	14%
Households	508,075	567,876	12%
Median Income*	$71,175	$116,340	63%

* Median income estimates are countywide whereas population and household estimates are just for the Consortium.
Data Source: ACS 2008-2012 (Base Year), ACS 2018-2022 (Most Recent Year).

Population growth plays a key role in local demand for housing. From 2012 to 2019, the yearly growth rate averaged 1.4 percent. However, in 2020 the growth rate fell to 0.8 percent. It then increased sharply in 2021 to 2.1 percent and decreased sharply in 2022 to 0.3 percent.

King County's Comprehensive Plan provides additional insight into population trends and notes that the countywide population steadily increased between 2000 and 2020, with most growth taking place in incorporated areas. During this same period, the population of the County's unincorporated areas decreased by 29.5 percent, largely as

a result of the annexation of unincorporated areas into cities. Population projections from Washington's Office of Financial Management estimate that King County's population will continue to increase over the next 25 years, with low projections estimating a six percent increase, moderate projections estimating a 24 percent increase, and high projections estimating a 54 percent increase from 2025 to 2050.

In addition to exploring population trends, data from the ACS and CHAS provides information on household income and housing affordability in the Consortium.

Fifty-four percent of all households in the Consortium earned more than 100 percent AMI, or $116,340 in 2020. The remaining income categories see an even distribution among households. The least common income category, though not by a large margin, was households earning 80-100 percent of AMI, comprising 10 percent of all households.

Table 7 presents a breakdown of the types of households in the Consortium by income category in 2020. The most common type of household was small family households, or those with 2-4 members as defined by HUD, which comprised 47 percent of total households, followed by households containing at least one-person age 62 to 74 years of age which comprised 21 percent of households.

Table 7: Total Households Table

	0-30% AMI	30-50% AMI	50-80% AMI	80-100% AMI	>100% AMI
Total Households	67,685	63,225	67,355	56,210	297,810
Small Family Households defined as two-four members	19,671	21,115	26,080	22,850	169,725
Large Family Households defined as five or more members	4,570	6,465	6,316	5,616	24,201
Household contains at least one person 62-74 years of age defined as elderly	15,805	13,431	15,635	12,726	59,140
Household contains at least one-person age 75 or older defined as frail elderly	12,505	11,670	8,996	5,095	16,466
Households with one or more children 6 years old or younger	10,101	11,741	11,530	9,530	50,586

Data Source: 2016-2020 CHAS.

More recent ACS data for King County indicates that median household income was $116,340 in 2022. When disaggregated by tenure, median renter household income was $79,624, while median owner household income was $151,858. The share of households by annual household income by tenure shows that 68 percent of owner households, but just 38 percent of renters have income of $100,000 or more. Forty-nine percent of renter households have incomes between $20,000 and $99,999, while just 29 percent of owner households have incomes within that range.

The data also demonstrates the wide range in median income by community. Communities such as Yarrow Point, Hunts Point, Clyde Hill, and Beaux Arts Village had median incomes of $250,000 or more in 2022, in contrast to Skykomish, Tukwila, and SeaTac which had median incomes below $80,000.

Housing Needs Summary Tables

The following tables explore the number of households in the Consortium experiencing specific types of housing problems that are captured in CHAS data, which include the following definitions.

- **Substandard housing:** Units lacking complete plumbing or kitchen facilities.
- **Overcrowded:** Households in which there is more than one person per room (and none of the above problems).
- **Severe overcrowding:** Households in which there are more than 1.5 people per room (and none of the above problems).
- **Housing cost burden:** Households that spend more than 30 percent of their income on housing costs.
- **Severe housing cost burden:** Households that spend more than 50 percent of their income on housing costs.

Table 8 outlines the number of households experiencing a housing problem by tenure across the Consortium in 2020. Of the housing problems identified in the table, the most common issues for renter and owner households were cost burden (spending more than 30 percent of income on housing costs) and severe cost burden (spending more than 50 percent of income on housing costs). For renter households, 39,710 households were cost-burdened, and 36,025 households were severely cost-burdened in 2020. For owner households, these figures were 50,375 and 30,845, respectively.

For both renter and owner households, the data indicates that severe housing cost burden was more prevalent in households earning 0-30 percent of AMI. In 2020, 23,975 renters and 15,045 owners earning less than 30 percent of AMI paid more than 50 percent of their income on housing costs. Renters in the 30-50 percent AMI income category and owners in the 50-80 percent AMI income category report the most instances of cost burden, at 14,790 and 12,220 households, respectively.

Table 8: Households with Housing Problems by Tenure and Income

Number of Households	Renter						Owner					
	0-30% AMI	30-50% AMI	50-80% AMI	80-100% AMI	Over 100% AMI	Total	0-30% AMI	30-50% AMI	50-80% AMI	80-100% AMI	Over 100% AMI	Total
Substandard Housing Lack complete plumbing or kitchen facilities	1,530	775	520	251	581	3,655	240	150	120	75	460	1,045
Severely Overcrowded Over 1.51 people per room (and complete kitchen/plumbing)	1,320	1,230	955	630	2,095	6,235	95	146	280	125	480	1,131
Overcrowded 1.01-1.5 people per room (and none of the above problems)	2,805	2,370	1,921	1,195	2,196	10,485	465	695	870	655	1,931	4,616
Severe Housing Cost Burden Housing cost burden greater than 50% of income (and none of the above problems)	23,975	9,725	1,640	470	205	36,025	15,045	7,610	4,236	1,740	2,215	30,845
Housing Cost Burden Housing cost burden greater than 30% of income (and none	4,835	14,790	12,080	5,120	2,890	39,710	4,440	8,570	12,220	9,280	15,865	50,375

Number of Households	Renter						Owner					
	0-30% AMI	30-50% AMI	50-80% AMI	80-100% AMI	Over 100% AMI	Total	0-30% AMI	30-50% AMI	50-80% AMI	80-100% AMI	Over 100% AMI	Total
of the above problems)												
Housing cost burden not computed (and none of the above housing problems)	2,365	0	0	0	0	2,365	1,895	0	0	0	0	1,895
Has none of the above housing problems	6,030	5,400	13,325	15,525	61,845	102,120	2,650	11,745	19,180	21,165	207,045	261,780

Data Source: 2016-2020 CHAS.

Table 9 presents the number of households with severe housing problems in the Consortium in 2020. The data indicates that 26 percent of renters and 11 percent of owners earning below 100 percent AMI experienced one or more of the four severe housing problems. For both renters and owners, households earning between 0-30 percent AMI experienced one or more of the four severe housing problems the most out of all income categories.

Table 9: Households with Severe Housing Problems by Tenure and Income

Number of Households	Renter						Owner					
	0-30% AMI	30-50% AMI	50-80% AMI	80-100% AMI	Over 100% of AMI	Total	0-30% AMI	30-50% AMI	50-80% AMI	80-100% AMI	Over 100% of AMI	Total
Has one or more of the four severe housing problems	29,630	14,100	5,040	2,546	10,175	103,410	15,850	8,610	5,506	2,590	7,700	55,200
Has none of the four severe housing problems	13,235	20,185	25,405	20,645	141,050	288,305	8,985	20,315	31,405	30,430	331,295	453,150

Data Source: 2016-2020 CHAS.

Table 10 shows the number of cost-burdened renter and owner households that earned less than 80 percent AMI in 2020. Overall, small families comprised the greatest share (39 percent) of cost-burdened renters, and elderly households comprised the greatest share of cost-burdened owners (43 percent). In households earning 0-30 percent AMI, elderly households were the most represented group with 36 percent of renters and 65 percent of owners experiencing cost burden.

Table 10: Cost Burden Greater Than 30%

Number of Households	Renter				Owner			
	0-30% AMI	30-50% AMI	50-80% AMI	Total Under 80% of AMI	0-30% AMI	30-50% AMI	50-80% AMI	Total Under 80% of AMI
Small Related	1,760	7,070	5,045	13,875	831	2,625	5,400	8,856
Large Related	720	2,180	785	3,685	210	1,135	1,310	2,655
Elderly	2,085	2,220	1,886	6,191	2,950	4,355	3,805	11,110
Other	1,155	5,600	5,410	12,165	550	745	2,025	3,320
Total need by income	5,720	17,070	13,126	35,916	4,541	8,860	12,540	25,941

Data Source: 2016-2020 CHAS.

Table 11 shows the number of severely cost-burdened renter and owner households that earned less than 80 percent AMI in 2020. Overall, small families comprised the greatest share (34 percent) of severely cost-burdened renters, followed closely by other households (33 percent). For owners, elderly households comprised the greatest share of severely cost-burdened households across all income categories (48 percent in total).

Table 11: Cost Burden Greater Than 50%

	Renter				Owner			
Number of Households	0-30% AMI	30-50% AMI	50-80% AMI	Total Under 80% of AMI	0-30% AMI	30-50% AMI	50-80% AMI	Total Under 80% of AMI
Small Related	9,610	3,665	385	13,660	4,275	2,455	1,545	8,275
Large Related	2,280	555	30	2,865	775	510	170	1,455
Elderly	7,265	2,560	906	10,731	7,885	3,500	1,911	13,296
Other	9,021	3,655	541	13,217	2,495	1,286	640	4,421
Total need by income	28,176	10,435	1,862	40,473	15,430	7,751	4,266	27,447

Data Source: 2016-2020 CHAS.

To better understand recent housing cost burden for owners and renters, the Consortium analyzed 2022 ACS data that explored housing costs as a percentage of income for all households. The data indicates a noticeable disparity by tenure. Renters make up the greatest portion of both cost-burdened and severely cost-burdened households at 24 percent and 22 percent, respectively. The cost burden status of owners varies depending on whether the household has a mortgage. Owners with a mortgage comprise 18 percent of cost-burdened households and 11 percent of severely cost-burdened households, while the figures for owners without a mortgage are eight percent and seven percent, respectively.

Table 12 shows the number of crowded households that earn less than 100 percent AMI by household type and income category. Households are considered crowded when there are more people living in the household than there are rooms. In total 12,602 renter households and 3,401 owner households were crowded in 2020. Across all income categories, single-family households comprised the majority of crowded households for renters and owners. For renters, 81 percent of crowded households were single families and 79 percent of owner households experiencing crowding were single families. Single families earning 0-30 percent AMI experienced crowding the most, comprising 90 percent of renter and 87 percent of owner crowding instances in that income category.

Table 12: Crowded Households

Number of Households	Renter					Owner				
	0-30% AMI	30-50% AMI	50-80% AMI	80-100% AMI	Total	0-30% AMI	30-50% AMI	50-80% AMI	80-100% AMI	Total
Single family households	3,835	3,235	1,891	1,276	10,237	505	656	995	545	2,701
Multiple, unrelated family households	235	200	705	305	1,445	75	175	170	235	655
Other, non-family households	175	170	295	280	920	0	10	35	0	45
Total need by income	4,245	3,605	2,891	1,861	12,602	580	841	1,200	780	3,401

Data Source: 2016-2020 CHAS.

Table 13 outlines the number of renter and owner households earning less than 80 percent AMI with one or more children aged six or younger by housing structure age. Housing units constructed prior to 1978 pose a potentially higher risk of containing lead-based paint since it was not until 1978 that the federal government banned the use of lead-based paint in residential dwellings. While current HUD habitability standards require inspections for units constructed prior to 1978 that will be occupied by households with children aged six years old or younger, lead poisoning remains a serious health risk for young children.

The data also indicates that 9,535 renter and 5,362 owner households earning less than 80 percent AMI with young children lived in a structure built prior to 1980 in 2020. For renter households earning 0-30 percent AMI, 43 percent of households lived in structures built before 1980 while this figure was 47 percent for owner households. The percentage of renters and owners earning 50-80 percent AMI living in structures built prior to 1980 is 38 percent and 49 percent, respectively. Although CHAS data do not identify housing units requiring lead hazard remediation, the data do indicate that many lower income households with young children reside in older housing stock, which increases the risk of exposure to lead-based paint.

Table 13: Households with Children Under Age Six by Tenure and Income

Number of Households	Renter				Owner			
	0-30% AMI	30-50% AMI	50-80% AMI	Total	0-30% AMI	30-50% AMI	50-80% AMI	Total
Households with Children Present	7,985	8,095	6,260	22,340	2,116	3,646	5,270	11,032

Data Source: 2016-2020 CHAS.

Describe the number and type of single person households in need of housing assistance.

In 2022, there were 137,772 single-person households in the Consortium, comprising 24 percent of total households. Of these single-person households, 49,775 (36 percent) were seniors aged 65 or older living by themselves.

According to 2022 ACS data, 2,558 single-person households lived below the federal poverty line comprising 13 percent of all households in the Consortium living below the poverty line. Of these single-person households, 73 percent of occupants were female, and 27 percent were male. In King County, a single-person household earned approximately $76,281 in 2022, while family households earned, on average, $146,321. This disparity in median income between single and multiple person households, coupled with climbing housing costs in the Consortium indicate that fewer individuals may be able to afford living by themselves, especially those with lower incomes.

Estimate the number and type of families in need of housing assistance who are disabled or victims of domestic violence, dating violence, sexual assault, and stalking.

In 2022, 152,211 individuals in the Consortium lived with a disability. This amounts to approximately 10 percent of the Consortium's population. In general, people with disabilities have a lower median income and higher poverty rate compared to individuals without a disability. In 2022, the median income for individuals without a disability was $64,388. The median income for individuals living with a disability was $40,434, which is over $20,000 less than individuals without a disability. The poverty rate for individuals without a disability was 6.9 percent in 2022. The poverty rate for individuals with a disability in 2022 was 18.4 percent, which is almost triple the poverty rate for individuals without a disability.

While data regarding the number of people in the Consortium who are victims of domestic violence, dating violence, sexual assault, and stalking is not readily available, Seattle & King County Public Health Department's Domestic Violence and Child Abuse Demographic Data Dashboard provides insight into the demographics of people experiencing domestic violence. Over the month of May 2023, when the data was last updated, 36.7 out of every 10,000 emergency department visits in the County included

cases involving domestic violence. The dashboard also records information on National Domestic Violence Hotline Contacts. Out of calls received from October 2019 to March 2023, 12.3 percent of callers (or 1,468 people) requested shelter assistance, which was the third most common request. In addition, 2.8 percent of callers (or 337 people) requested transitional housing support and 4.9 percent of callers (or 1,340 people) reported housing as a circumstance or detail related to domestic violence, which was the second most common circumstance. Finally, the primary barrier identified to obtaining services was finances, accounting for 8.3 percent of all callers.

Additionally, data from the King County Prosecuting Attorney's Office Data Dashboard provides information on felony referrals and cases filed into the King County Superior Court. The data indicate that in 2023 there were, on average, more than 1,000 domestic violence, sexual assault, and child abuse cases open in King County. Open cases increased significantly during 2020 and 2021 to a peak of 1,309 open cases in February 2021 and have slowly declined over the past few years to 804 open cases in January 2024. In 2023, law enforcement made 1,608 referrals for potential domestic violence felony cases and 1,181 referrals for potential sexual assault and child abuse cases.

What are the most common housing problems?

CHAS data provides information on four housing problems: 1) housing units lacking complete kitchen facilities, 2) housing units lacking complete plumbing facilities, 3) overcrowded households, and 4) cost-burdened households. The data further differentiates between overcrowded (more than one person per room) and severely overcrowded (more than 1.5 people per room) households as well as households that are cost-burdened (paying over 30 percent of income on housing costs) and severely cost-burdened (paying over 50 percent of income on housing costs). CHAS considers a household as having a housing problem if it has one or more of the four problems.

2020 CHAS data for the Consortium indicates that 34 percent of households experienced at least one housing problem. Renters experienced housing problems at a higher rate than owners with 49 percent of renters experiencing at least one housing problem, whereas this figure was 25 percent for owners. The most common housing problem for both renters and owners was cost burden and severe cost burden. Specifically, 20 percent of renters experienced cost burden and 18 percent experienced severe cost burden. For owners, these figures were nine percent and 14 percent, respectively. When disaggregated by tenure, 67 percent of renters and 49 percent of owners that were severely cost-burdened had incomes below 30 percent AMI while 68 percent of renters and 41 percent of owners experiencing cost burden were low to moderate-income households.

Are any populations/household types more affected than others by these problems?

Regarding severely cost-burdened owners, elderly households experience severe cost burden at the greatest percentage in all income categories. The most notable disparity exists for extremely low-income households, where 51 percent of all severely cost-burdened households were elderly. For severely cost-burdened renters, there exists

less disparity between small, large, elderly, and other family types, except for moderate-income households, in which 49 percent of severely cost-burdened renters are elderly.

Extremely low- and low-income cost-burdened owner households see similar trends. Sixty-five percent of extremely low-income and 49 percent of low-income households experiencing cost burden are elderly. Again, for cost-burdened renters, less disparities exist, however, small families make up the largest share of cost-burdened renters across all income categories.

Describe the characteristics and needs of low-income individuals and families with children (especially extremely low-income) who are currently housed but are at imminent risk of either residing in shelters or becoming unsheltered 91.205(c)/91.305(c)). Also discuss the needs of formerly homeless families and individuals who are receiving rapid re-housing assistance and are nearing the termination of that assistance.

In 2020, there were 10,101 extremely low-income households and 11,741 low-income households containing at least one child aged six years old and younger. Low-income and cost-burdened households are at higher risk of housing instability. According to the 2023 PIT count there were 7,685 unsheltered people living in King County (including Seattle). This figure accounts for 54 percent of the total population experiencing homelessness.

The rapid re-housing program assists families experiencing homelessness in achieving housing stability. In 2022, the County and the KCRHA had 1,082 rapid rehousing beds available to individuals and families. The rapid rehousing (RRH) program is designed to provide short-term services to move individuals from homelessness to housing stability. Increasingly, households need longer stays to reach housing stability, and those who are nearing the termination of RRH assistance frequently need a combination of increased income and some level of housing subsidy. According to KCRHA's Rapid Rehousing Performance Data, as of June 2023, 70 percent of people who enrolled in rapid rehousing are permanently housed and just three percent of people return to homelessness.

Other County programs assist low-income families by preventing homelessness. This includes the Best Start for Kids Youth and Family Homelessness Prevention Initiative (YFHPI) which, among other projects, has provided financial assistance and case management to families at risk of homelessness. In 2022, the program supported 3,386 youth and family households and prevented homelessness in 95 percent of cases. Keep King County Housed is a new program providing homeless prevention rental assistance. Among those at imminent risk of homelessness, the Veterans, Seniors, and Human Services Levy's (VSHSL) Housing Stability Program provided emergency short-term financial assistance to 1,558 households across the County. Similarly, the County's VSHSL reported providing housing counseling and foreclosure prevention, alternative dispute resolution, and legal aid to a total of 4,618 people between 2018 to 2021. Various County programs underscore the continued need for financial assistance, housing and shelter assistance, and human services to prevent households from losing their housing or experiencing homelessness.

If a jurisdiction provides estimates of the at-risk population(s), it should also include a description of the operational definition of the at-risk group and the methodology used to generate the estimates.

The Consortium uses the definition of "at risk of homelessness' defined in the ESG Program Interim Rule and the CoC Program Interim Rule. In general, individuals and families are considered at-risk of homelessness if the following applies for the individual or household:

1. Has an annual income below 30 percent of the median family income for the area as determined by HUD.
2. Does not have sufficient resources or support networks to prevent them from moving into an emergency shelter.
3. Meets one of the following conditions:
    a. Has moved due to economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance.
    b. Is living in the home of another because of economic hardship.
    c. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance.
    d. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by Federal, State, or local government programs for low-income individuals.
    e. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 persons reside per room, as defined by the U.S. Census Bureau.
    f. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution).
    g. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.

Specify particular housing characteristics that have been linked with instability and an increased risk of homelessness.

In the development of the Consortium's Analysis of Impediments to Fair Housing Choice (AI Report), service providers described how the high cost of living is the greatest barrier to housing stability in King County. Stakeholders also noted that the cost of rent, even for affordable housing units, and the cost of deposits are barriers to housing for multiple populations, including low-income renters, immigrants and refugees, and individuals identifying as Black, Indigenous, and other people of color (BIPOC).

In addition, in the Consortium's stakeholder survey for the Consolidated Plan, one question asked respondents to describe factors that increase the risk of someone becoming homeless. Several respondents mentioned that factors such as the lack of affordable housing options, high cost of living in King County, and insufficient incomes

contribute to an increased risk of homelessness particularly for low-income people. For those who have lost their jobs, have poor credit, have a past eviction, or have experienced a medical emergency, these events can push an individual or household into homelessness if they lack the social supports and financial resources to remain housed. Lastly, respondents noted that specific subpopulations with whom they work such as single parents with children, immigrants and refugees with limited English proficiency, people with mental health challenges or substance abuse disorders, those with a history with the criminal justice system, and victims of domestic violence, may face unique challenges that can increase the risk of becoming homeless.

NA-15 Disproportionately Greater Need: Housing Problems - 91.405, 91.205 (b)(2)

Assess the need of any racial or ethnic group that has disproportionately greater needs in comparison to the needs of that category of need as a whole.

Introduction

HUD defines a disproportionately greater housing need when a racial or ethnic group experiences housing problems at a rate over 10 percentage points that of the corresponding income level as a whole. The tables below summarize the percentage of each racial/ethnic group experiencing housing problems.

The four housing problems captured in CHAS data include the following:

1. Housing unit lacks complete kitchen facilities.
2. Housing unit lacks complete plumbing facilities.
3. Household is overcrowded (more than one person per room).
4. Household spends over 30 percent of income on housing costs (i.e., cost burden).

0-30% AMI

Table 14 provides a breakdown of extremely low-income households experiencing one or more housing problems by race and ethnicity in the Consortium. In 2020, 81 percent of all households earning less than 30 percent AMI had at least one housing problem. When disaggregated by race and ethnicity, no specific group was disproportionately affected; however, the data indicates that Hispanic, Pacific Islander, and Black/African American households experienced one or more housing problems at a greater rate than the total jurisdiction. Specifically, 88 percent of Hispanic households, 86 percent of Pacific islander households, and 85 percent of Black/African American households earning under 30 percent AMI experienced at least one housing problem, which is seven, six, and four percentage points above the jurisdiction as a whole.

Table 14: Disproportionally Greater Need 0 - 30% AMI

Housing Problems	One or More Housing Problems	No Housing Problems or No Income	Total Households	Percent with a Housing Problem
Jurisdiction as a whole	54,745	12,945	67,690	81%
White alone, non-Hispanic	29,635	7,775	37,410	79%
Black or African American alone, non-Hispanic	6,440	1,120	7,560	85%
Asian alone, non-Hispanic	7,916	2,205	10,121	78%

Housing Problems	One or More Housing Problems	No Housing Problems or No Income	Total Households	Percent with a Housing Problem
American Indian or Alaska Native alone, non-Hispanic	685	171	856	80%
Pacific Islander alone, non-Hispanic	535	84	619	86%
Hispanic, any race	6,420	880	7,300	88%

Data Source: 2016-2020 CHAS.

30-50% AMI

Table 15 depicts the number of low-income (30-50 percent AMI) households who experienced one or more housing problems by race and ethnicity in the Consortium. In 2020, 73 percent of all households earning between 30-50 percent AMI had at least one housing problem. When disaggregated by race and ethnicity, the data indicate that all categories besides White alone were overrepresented. Pacific Islander households were disproportionally impacted, experiencing one or more housing problems at a rate 18 percentage points about the jurisdiction as a whole.

Table 15: Disproportionally Greater Need 30 - 50% AMI

Housing Problems	One or More Housing Problems	No Housing Problems or No Income	Total Households	Percent with a Housing Problem
Jurisdiction as a whole	46,075	17,145	63,220	73%
White alone, non-Hispanic	25,420	11,410	36,830	69%
Black or African American alone, non-Hispanic	5,056	1,185	6,241	81%
Asian alone, non-Hispanic	5,485	1,940	7,425	74%
American Indian or Alaska Native alone, non-Hispanic	350	85	435	80%
Pacific Islander alone, non-Hispanic	740	74	814	91%
Hispanic, any race	6,900	1,991	8,891	78%

Data Source: 2016-2020 CHAS.

50-80% AMI

Table 16 presents the number of moderate-income (50-80 percent AMI), who experienced one or more housing problems by race and ethnicity in the Consortium. In

2020, 52 percent of all households earning between 50-80 percent AMI had at least one housing problem. The variations between race and ethnicity categories are less pronounced in this income category, with four of the categories being just one or two percentage points away from the jurisdiction as whole.

Table 16: Disproportionally Greater Need 50 - 80% AMI

Housing Problems	One or More Housing Problems	No Housing Problems or No Income	Total Households	Percent with a Housing Problem
Jurisdiction as a whole	34,845	32,505	67,350	52%
White alone, non-Hispanic	20,845	20,130	40,975	51%
Black or African American alone, non-Hispanic	2,540	2,510	5,050	50%
Asian alone, non-Hispanic	5,475	3,925	9,400	58%
American Indian or Alaska Native alone, non-Hispanic	130	165	295	44%
Pacific Islander alone, non-Hispanic	406	390	796	51%
Hispanic, any race	4,070	3,931	8,001	51%

Data Source: 2016-2020 CHAS.

80-100% AMI

Table 17 illustrates the number of households with incomes between 80-100 percent AMI who experienced one or more housing problems by race and ethnicity in the Consortium. In 2020, 35 percent of all households in this income range had a least one housing problem, which is the lowest percentage across all income categories. There is some variation between the percentages of households earning between 80-100 percent AMI who experienced at least one housing problem by race and ethnicity; however, no single group appeared to be disproportionally impacted.

Table 17: Disproportionally Greater Need 80 - 100% AMI

Housing Problems	One or More Housing Problems	No Housing Problems or No Income	Total Households	Percent with a Housing Problem
Jurisdiction as a whole	19,530	36,690	56,220	35%
White alone, non-Hispanic	12,080	23,380	35,460	34%

Housing Problems	One or More Housing Problems	No Housing Problems or No Income	Total Households	Percent with a Housing Problem
Black or African American alone, non-Hispanic	1,200	2,175	3,375	36%
Asian alone, non-Hispanic	3,275	5,041	8,316	39%
American Indian or Alaska Native alone, non-Hispanic	25	295	320	8%
Pacific Islander alone, non-Hispanic	190	370	560	34%
Hispanic, any race	1,680	3,670	5,350	31%

Data Source: 2016-2020 CHAS.

Discussion

In regard to the prevalence of housing problems both by income category and race/ethnicity, it is apparent that disparities exist across both categories. The total percentage of households experiencing one or more housing problems decreases significantly as income increases. Eighty-one percent of total households earning under 30 percent AMI experienced at least one housing problem, while that figure was just 35 percent for households earning between 80-100 percent AMI. In each income category, there were variations in the share of households experiencing housing issues across race and ethnicity categories. One instance of disproportionate impact was identified: low-income Pacific Islander households, who experienced at least one housing problem at a rate 18 percentage points above the jurisdiction as a whole. In general, Black/African American households were the most overrepresented group across all income categories, experiencing housing problems at a greater percentage than the total jurisdiction in three out of four income categories.

NA-20 Disproportionately Greater Need: Severe Housing Problems - 91.405, 91.205 (b)(2)

Assess the need of any racial or ethnic group that has disproportionately greater needs in comparison to the needs of that category of need as a whole.

Introduction

HUD defines a disproportionately greater housing need when a racial or ethnic group experiences housing problems at a rate over 10 percentage points than that of the corresponding income level as a whole. The tables below summarize the percentage of each racial/ethnic group experiencing housing problems by AMI levels. For this analysis, AMI is comparable to AMI.

The four severe housing problems captured in CHAS data include the following:

1. Housing unit lacks complete kitchen facilities.
2. Housing unit lacks complete plumbing facilities.
3. Household is severely overcrowded (more than 1.5 persons per room).
4. Household spends over 50 percent of income on housing costs (i.e., severe housing cost burden).

0-30% AMI

Table 18 depicts the number of extremely low-income, earning under 30 percent AMI, households experiencing one or more severe housing problems. In 2020, 67 percent of all households in this income category had at least one housing problem. When disaggregated by race and ethnicity, Pacific Islander, Hispanic, and Black/African American households are overrepresented. Pacific Islander households earning less than 30 percent AMI are disproportionally impacted, experiencing severe housing problems 14 percentage points above the total jurisdiction. For Hispanic and Black/African American households, the data indicates that these households experience severe housing problems at eight and five percentage points about the total jurisdiction, respectively.

Table 18: Disproportionally Greater Need – Severe Housing Problems - 0 - 30% AMI

Severe Housing Problems	One or More Severe Housing Problems	No Severe Housing Problems or No Income	Total Households	Percent with a Severe Housing Problem
Jurisdiction as a whole	45,480	22,220	67,700	67%
White alone, non-Hispanic	24,455	12,960	37,415	65%
Black or African American alone, non-Hispanic	5,425	2,140	7,565	72%

Severe Housing Problems	One or More Severe Housing Problems	No Severe Housing Problems or No Income	Total Households	Percent with a Severe Housing Problem
Asian alone, non-Hispanic	6,360	3,756	10,116	63%
American Indian or Alaska Native alone, non-Hispanic	555	295	850	65%
Pacific Islander alone, non-Hispanic	500	114	614	81%
Hispanic, any race	5,500	1,801	7,301	75%

Data Source: 2016-2020 CHAS.

30-50% AMI

Table 19 depicts low-income households earning between 30-50 percent AMI, who experienced severe housing problems by race and ethnicity. In 2020, 36 percent of all households in this income category experienced at least one severe housing problem. Disaggregation by race and ethnicity shows that Hispanic, Pacific Islander and Asian households are slightly overrepresented, experiencing severe housing problems at two (Hispanic and Asian households) or three (Pacific Islander households) percentage points about the total jurisdiction. American Indian or Alaska Native households are disproportionally impacted, with 52 percent of households experiencing at least one housing problem, which is 16 percentage points higher than the jurisdiction as a whole.

Table 19: Disproportionally Greater Need– Severe Housing Problems - 30 - 50% AMI

Severe Housing Problems	One or More Severe Housing Problems	No Severe Housing Problems or No Income	Total Households	Percent with a Severe Housing Problem
Jurisdiction as a whole	22,710	40,500	63,210	36%
White alone, non-Hispanic	12,910	23,915	36,825	35%
Black or African American alone, non-Hispanic	2,261	3,980	6,241	36%
Asian alone, non-Hispanic	2,805	4,620	7,425	38%
American Indian or Alaska Native alone, non-Hispanic	225	210	435	52%

Pacific Islander alone, non-Hispanic	314	495	809	39%
Hispanic, any race	3,370	5,526	8,896	38%

Data Source: 2016-2020 CHAS.

50-80% AMI

Table 20 depicts moderate-income households earning between 50-80 percent AMI, who experienced at least one severe housing problem by race and ethnicity in the Consortium. In 2020, 16 percent of the total moderate-income population experienced at least one severe housing problem. When disaggregated by race, American Indian or Alaskan Native, Asian, Pacific Islander, and Hispanic households are overrepresented. Pacific Islander households are disproportionally impacted, experiencing severe housing problems at a rate 12 percentage points higher than the jurisdiction as a whole.

Table 20: Disproportionally Greater Need– Severe Housing Problems - 50 - 80% AMI

Severe Housing Problems	One or More Severe Housing Problems	No Severe Housing Problems or No Income	Total Households	Percent with a Severe Housing Problem
Jurisdiction as a whole	10,546	56,810	67,356	16%
White alone, non-Hispanic	5,581	35,390	40,971	14%
Black or African American alone, non-Hispanic	705	4,355	5,060	14%
Asian alone, non-Hispanic	2,145	7,255	9,400	23%
American Indian or Alaska Native alone, non-Hispanic	55	240	295	19%
Pacific Islander alone, non-Hispanic	220	575	795	28%
Hispanic, any race	1,470	6,531	8,001	18%

Data Source: 2016-2020 CHAS.

80-100% AMI

Table 21 shows households earning between 80-100 percent AMI who experience at least one severe housing problem by race and ethnicity in the Consortium. In 2020, ninepercent of all households earning between 80-100 percent AMI experienced at least one severe housing problem. When disaggregated by race and ethnicity, Hispanic and Pacific Islander households are overrepresented by six percentage points, each. Asian and Black or African American households are slightly overrepresented by three percentage points and one percentage point respectively.

Table 21: Disproportionally Greater Need– Severe Housing Problems - 80 - 100% AMI

Severe Housing Problems	One or More Severe Housing Problems	No Severe Housing Problems or No Income	Total Households	Percent with a Severe Housing Problem
Jurisdiction as a whole	5,136	51,075	56,211	9%
White alone, non-Hispanic	2,585	32,870	35,455	7%
Black or African American alone, non-Hispanic	340	3,045	3,385	10%
Asian alone, non-Hispanic	1,005	7,311	8,316	12%
American Indian or Alaska Native alone, non-Hispanic	4	310	314	1%
Pacific Islander alone, non-Hispanic	85	481	566	15%
Hispanic, any race	806	4,540	5,346	15%

Data Source: 2016-2020 CHAS.

Discussion

In regard to severe housing problems, there exists disparities by income and race/ethnicity. The percentage of households experiencing one or more severe housing problems decreases significantly as income increases. Sixty-seven percent of total households earning less than 30 percent AMI experience at least one severe housing problem, while that figure is just nine percent for households earning between 80-100 percent AMI. In each income category, there were variations in the share of households experiencing housing problems by race and ethnicity. The Consortium identified three instances of disproportionate impact: extremely low-income Pacific Island households, low-income American Indian or Native Alaskan households, and moderate-income Pacific Islander households. In general, Pacific Islander and Hispanic households were the two most overrepresented groups across all income categories, experiencing severe housing problems at a greater percentage than the total jurisdiction in all four income categories.

NA-25 Disproportionately Greater Need: Housing Cost Burdens - 91.405, 91.205 (b)(2)

Assess the need of any racial or ethnic group that has disproportionately greater needs in comparison to the needs of that category of need as a whole.

Introduction

HUD defines a disproportionately greater housing need when a racial or ethnic group experiences housing problems at a rate over 10 percentage points than that of the corresponding income level as a whole. HUD also considers a household to be cost-burdened when it spends over 30 percent of income on housing costs while severe housing cost burden occurs when a household spends over half its income on housing costs.

Housing Cost Burden

Table 22 outlines the percentage of households at different housing cost burden levels by race and ethnicity. In 2020, 67 percent of households in the Consortium spent less than 30 percent of their incomes on housing costs, meaning they are not cost-burdened. Seventeen percent of households spent between 30-50 percent of their income on housing costs, meaning they are cost-burdened. Thirteen percent of households are severely cost-burdened, meaning they spend over 50 percent of their income on housing expenses. Finally, there were 4,433 households with negative income or whose cost burden status could not be computed. In total, this means that the majority of households in the Consortium are not cost-burdened. However, nearly one third (30 percent) of total households experience some form of cost burden.

When disaggregated by race and ethnicity, noticeable variations emerge. White and Asian households experienced cost burden and severe cost burden at slightly lower rates than the jurisdiction as a whole. Households belonging to the other race and ethnic categories experienced both cost burden and severe cost burden at higher rates than the total population. The data indicates that Pacific Islander households are disproportionally affected among households paying 30-50 percent of their income on housing costs while Black/African American households are disproportionally affected among households paying over 50 percent of their income on housing costs.

Table 22: Housing Cost Burden by Race and Ethnicity

Housing Cost Burden	Less than 30%	Share Less than 30%	30-50%	Share 30-50%	Greater than 50%	Share Greater than 50%	Not Computed
Jurisdiction as a whole	370,916	67%	93,693	17%	71,329	13%	4,433
White	249,690	71%	56,885	16%	43,295	12%	2,420
Black / African American	16,290	52%	7,645	24%	7,200	23%	235

Housing Cost Burden	Less than 30%	Share Less than 30%	30-50%	Share 30-50%	Greater than 50%	Share Greater than 50%	Not Computed
Asian	69,610	72%	15,105	16%	10,125	11%	1,235
American Indian, Alaska Native	1,651	62%	470	18%	555	21%	8
Pacific Islander	2,290	58%	1,071	27%	529	13%	40
Hispanic	25,675	60%	10,072	23%	6,935	16%	330
Other	14,550	63%	4,180	18%	3,945	17%	255

Data Source: 2016-2020 CHAS.

To supplement the CHAS analysis on cost-burdened households, the Consortium explored more recent ACS data. The data demonstrates that while the poverty rate for the Consortium was eight percent, the poverty rate for people among different races and ethnicities varies. White and Asian populations had the lowest poverty rates at six percent each while American Indian and Alaska Native and Black/African American populations experienced the highest poverty rates at 17 percent and 16 percent, respectively. These rates are nine percentage points and eight percentage points above the poverty rate for the Consortium's total population.

NA-30 Disproportionately Greater Need: Discussion - 91.205 (b)(2)

Are there any income categories in which a racial or ethnic group has disproportionately greater need than the needs of that income category as a whole?

The Consortium's analysis of housing problems identified six cases of disproportionately greater need by race and ethnicity. The analysis found that Pacific Islander households earning less than 30 percent AMI and Pacific Islander households earning 50-80 percent AMI were disproportionately impacted by severe housing problems; Pacific Islander households earning 30-50 percent AMI were disproportionately impacted by housing problems; and Pacific Islander households as a group disproportionately experienced housing cost burden. In addition, American Indian/Alaska Native households earning 30-50 percent AMI were disproportionately impacted by severe housing problems. Lastly, the analysis found that Black/African American households as a group disproportionately experienced severe housing cost burden.

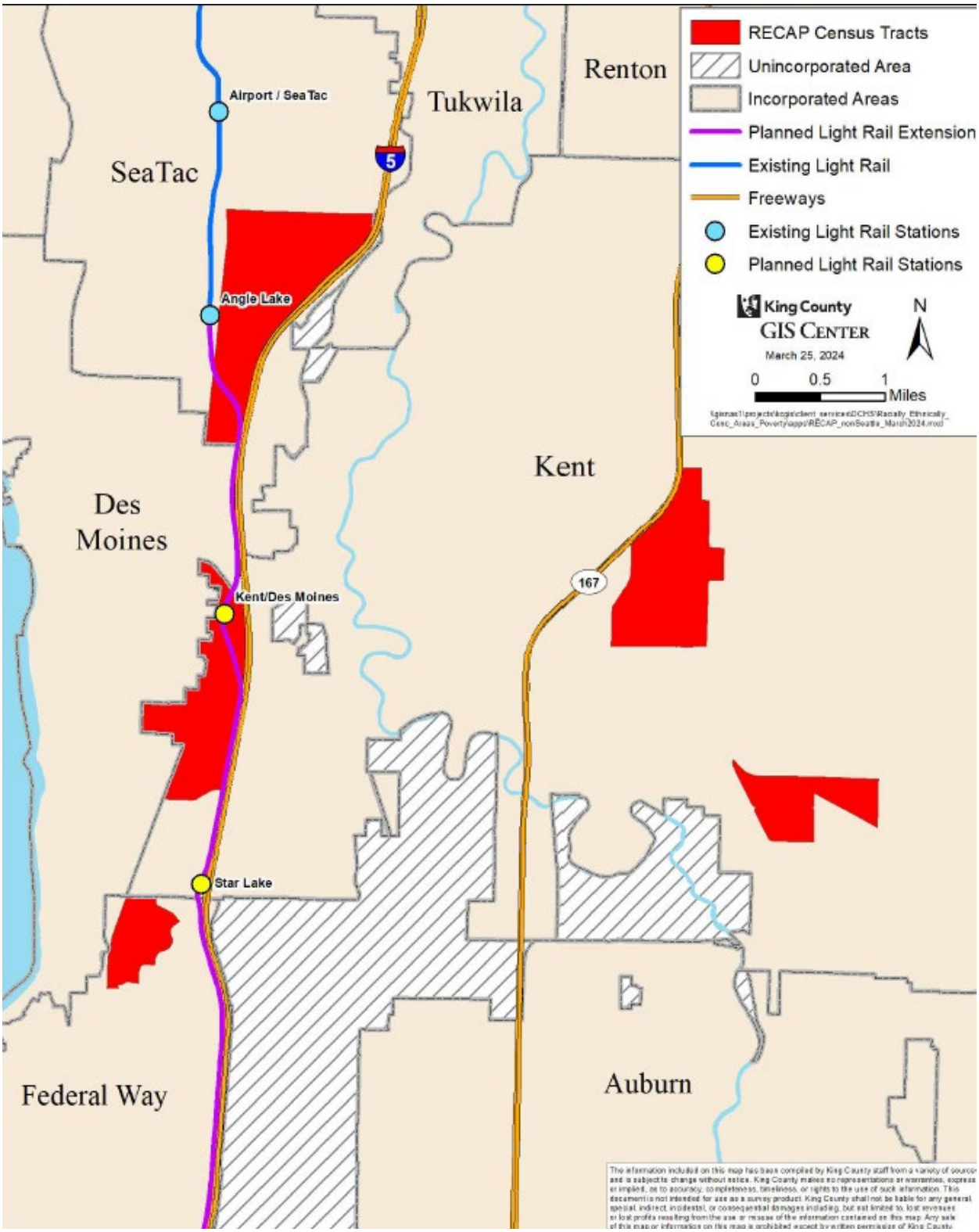
If they have needs not identified above, what are those needs?

The CHAS analysis identified needs for the racial and ethnic groups described above. Other sections of the Needs Assessment and Market Analysis of the Consortium's Consolidated Plan outline other needs not identified in this section.

Are any of those racial or ethnic groups located in specific areas or neighborhoods in your community?

According to the HUD R/ECAPs mapping tool, which uses 2017-2021 ACS data, there are several census tracts located in King County that qualify as racially or ethnically concentrated areas of poverty (R/ECAPs). Five R/ECAPs exist within the boundaries of the Consortium. All of them are located in South King County and are either adjacent or in close proximity to a major highway (Figure 2). Kent has three R/ECAPs and SeaTac and Federal Way both have one.

Figure 2: R/ECAPs in King County



Data Source: HUD Racially or Ethnically Concentrated Areas of Poverty.

In Kent, two of the R/ECAPs are in the East Hill neighborhood. The Consortium's previous analysis of census tracts in the area found that the community has a larger population of people identifying as BIPOC than the County average with 37 percent of the population identifying as White, 20 percent as Black or African American, 21 percent as some other race, and 17 percent as two or more races. About 18.5 percent of residents in the East Hill R/ECAP live below the poverty line, which is over double the poverty rate in King County and more than 1.4 times the poverty rate in Kent. The area also houses a large foreign-born population (44.2 percent of residents) since a local resettlement organization helps connect immigrants and refugees to a handful of apartment complexes in the area for housing. A previous version of the HUD R/ECAPs mapping tool, which uses 2009-2013 ACS data, also showed a R/ECAP in the East Hill area. While the boundaries are slightly different, the similarities between the two figures demonstrate a persistence of need in East Kent.

The Consortium's three other R/ECAPs do not appear in the 2009-2013 version of the HUD mapping tool, which indicates they are less than ten years old. These census tracks are located in the western part of South King County near I-5.

The 2009-2013 version of the HUD mapping tool includes a R/ECAP located in the Duwamish Valley that covered parts of Seattle, Burien, Tukwila, and unincorporated King County. In the most recent version of the mapping tool, the boundaries of that R/ECAP have shifted slightly north and are now located in Seattle. While this R/ECAP is no longer part of the Consortium, its continued presence in that region speaks to a persistence of need in unincorporated King County.

NA-35 Public Housing - 91.405, 91.205 (b)

Introduction

The King County Housing Authority (KCHA) and the Renton Housing Authority (RHA) serve low-income residents living in the Consortium with housing assistance. KCHA serves people living in King County outside the cities of Seattle and Renton. RHA serves residents of Renton. Each housing authority aims to provide decent, safe, and sanitary housing to low-income people in the community and outlines its specific goals and strategies through separate planning processes.

In its FY 2024 Moving to Work Annual Plan, KCHA outlined the following strategic goals:

- Continue to strengthen the physical, operational, financial, and environmental sustainability of KCHA's portfolio of affordable housing units.
- Increase the region's supply of housing affordable to households earning less than 30 percent AMI by developing new housing, preserving existing housing, and expanding the size and reach of rental subsidy programs.
- Advance racial equity and social justice within KCHA and in King County through the implementation and ongoing evaluation of KCHA's equity, diversity, inclusion, and belonging strategy.
- Affirmatively further the policies and purposes of the Fair Housing Act and provide greater geographic choice for low-income households including residents with disabilities, elderly residents with mobility impairments, and families with children to provide access to neighborhoods with high-performing schools and convenient access to support services, transit, health services, and employment.
- Coordinate closely with the behavioral health care and homeless systems to increase the supply of supportive housing for people experiencing chronic homelessness or who have special needs, to significantly decrease homelessness throughout King County.
- Engage in the revitalization of King County's low-income neighborhoods by focusing on housing and other services, amenities, institutions, and partnerships that empower strong, healthy communities and prevent displacement of existing community members.
- Work with King County government, regional transit agencies, and suburban cities to support sustainable and equitable regional development by integrating new and preserving existing affordable housing in regional growth corridors aligned with mass transit investments.
- Expand and deepen partnerships with residents, local school districts, Head Start programs, after-school program providers, public health departments, community colleges, and the philanthropic community with the goal of improving educational and life outcomes for the children and families served.
- Promote greater economic independence for families and individuals living in subsidized housing by addressing barriers to employment and facilitating access to training and education programs, with the goal of enabling moves to market-rate housing opportunities.

- Continue to develop institutional capacities and operational efficiencies to make the most effective use of limited federal resources, and provide high quality service to residents, communities, and partners.
- Continue to reduce KCHA's environmental footprint through energy and water conservation, renewable energy generation, waste stream diversion, green procurement policies, waste reduction, and fleet management practices.
- Develop KCHA capacity as a learning organization that uses data, research, and evaluation to assess housing access, outcomes, and equity, and to drive decisions that shape policies and programs.

Similarly, in its most recent Five-Year PHA Plan, RHA states that its mission is to provide quality affordable housing and improve and expand its affordable housing portfolio through renovation, land acquisition, and construction of new units. RHA also plans to explore new partnerships to expand resident programs.

The following section outlines the number of public housing units and vouchers in use at both PHAs as well as data on the characteristics of current public housing residents and voucher recipients.

Total Units and Vouchers in Use

KCHA manages a portfolio of 2,416 public housing units, 2,426 project-based vouchers, and 11,819 tenant-based vouchers while RHA manages 303 project-based vouchers and 886 tenant-based vouchers. Table 23 provides the combined number of units and vouchers currently in use for the housing authorities.

Among special purpose vouchers, KCHA administers 826 vouchers and RHA administers 15 vouchers under the HUD-Veterans Affairs Supportive Housing (HUD-VASH) program which offers rental assistance paired with case management and supportive service to eligible veterans experiencing homelessness. In addition, KCHA offers 1,962 vouchers and RHA offers 30 vouchers for people with disabilities through the Non-Elderly Disabled, Mainstream One-Year, Mainstream Five-Year, or Nursing Home Transition programs. KCHA also manages 449 vouchers under the Family Unification Program which provides rental assistance to eligible families with inadequate housing and eligible youth exiting foster care who are homeless or at imminent risk of homelessness. Lastly, KCHA administers 839 and RHA administers 66 Emergency Housing Vouchers which provide rental assistance to vulnerable populations including individuals and families who are homeless; individuals and families at-risk of homelessness; people fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking; and people who were recently homeless or have a high risk of housing instability.

Table 23: Public Housing by Program Type

Program Type									
	Certificate	Mod-Rehab	Public Housing	Vouchers					
				Total	Project - based	Tenant -based	Special Purpose Voucher		
							Veterans Affairs Supportive Housing	Family Unification Program	Disabled *
# of units and vouchers in use	N/A	N/A	2,416	15,434	2,729	12,705	841	449	1,992

**Includes Non-Elderly Disabled, Mainstream One-Year, Mainstream Five-year, and Nursing Home Transition.*
Data Source: 2023 PHA data.

Characteristics of Residents

Table 24 provides information on the individuals and households currently residing in public housing or utilizing a rental assistance voucher from KCHA and RHA. On average, the income for assisted households residing in public housing is $16,625 and $21,235 for households using a voucher, both of which are below 30 percent AMI for King County. In addition, while the average length of stay for public housing residents is 8.5 years, the average length of stay for households residing in units with a project-based voucher is 3.7 years and 8.8 years for people with tenant-based vouchers. The data also indicates that a significant number of public housing residents and voucher holders are over the age of 62 and members of households with at least one person with a disability.

Table 25 provides demographic information on program participants by race while Table 26 provides information by ethnicity. The data indicates that among the individuals residing in public housing, 54 percent identify as White, 21 percent identify as Black/African American, 19 percent identify as Asian, five percent identify as American Indian or Alaska Native, one percent identify as Pacific Islander, and one percent identify as another race. There was a similar distribution among people residing in a unit subsidized with a project-based voucher. Among tenant-based voucher recipients, 44 percent of people identify as Black/African American, 43 percent identify as White, five percent identify as Asian, four percent identify as another race, two percent identify as American Indian or Alaska Native, and one percent identify as Pacific Islander. The majority of beneficiaries are not Hispanic.

Table 24: Characteristics of Public Housing Residents by Program Type

Program Type								
	Certificate	Mod-Rehab	Public Housing	Vouchers				
				Total	Project -based	Tenant - based	Special Purpose Voucher	
							Veterans Affairs Supportive Housing	Family Unification Program
Average Annual Income	N/A	N/A	$16,625	$21,235	$19,876	$22,594	$18,643	$18,116
Average Length of Stay in Years	N/A	N/A	8.5	6.2	3.7	8.8	4.0	8.0
Average Household Size	N/A	N/A	1.8	2.3	2.0	2.5	1.4	2.9
# Homeless at Admission	N/A	N/A	20	1,088	178	910	952	508
# of Elderly Program Participants (>62)	N/A	N/A	1,523	5,243	927	4,316	432	27
# of Disabled Families	N/A	N/A	644	7,085	747	6,338	397	136
# of Families requesting accessibility features	N/A	N/A	315	373	N/A	373	N/A	N/A
# of HIV/AIDS program participants	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# of DV victims	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Data Source: 2023 PHA data.

Table 25: Race of Public Housing Residents by Program Type

Program Type									
Race	Certificate	Mod-Rehab	Public Housing	Vouchers					
				Total	Project-based	Tenant-based	Special Purpose Voucher		
							Veterans Affairs Supportive Housing	Family Unification Program	Disabled *
White	N/A	N/A	1,423	7,145	1,375	5,770	534	235	1,371
Black/African American	N/A	N/A	555	6,602	730	5,872	362	185	667
Asian	N/A	N/A	498	1,047	328	719	8	18	87
American Indian/Alaska Native	N/A	N/A	26	272	40	232	29	21	49
Pacific Islander	N/A	N/A	26	325	53	272	17	17	27
Other	N/A	N/A	124	648	137	511	32	32	92

**Includes Non-Elderly Disabled, Mainstream One-Year, Mainstream Five-year, and Nursing Home Transition.*
Data Source: 2023 PHA data.

Table 26: Ethnicity of Public Housing Residents by Program Type

Program Type									
Ethnicity	Certificate	Mod-Rehab	Public Housing	Vouchers					
				Total	Project - based	Tenant - based	Special Purpose Voucher		
							Veterans Affairs Supportive Housing	Family Unification Program	Disabled *
Hispanic	N/A	N/A	177	1,042	253	789	41	65	128
Not Hispanic	N/A	N/A	2,481	14,998	2,411	12,587	941	443	2,165

**Includes Non-Elderly Disabled, Mainstream One-Year, Mainstream Five-year, and Nursing Home Transition.*
Data Source: 2023 PHA data.

Section 504 Needs Assessment: Describe the needs of public housing tenants and applicants on the waiting list for accessible units.

KCHA's HCV waitlist currently includes 1,350 people seeking housing assistance. The waitlist is partially open, and the housing authority is currently only accepting targeted voucher referrals. In comparison, KCHA's public housing waiting lists include more than 22,000 households and are temporarily closed as of December 15, 2023. Since the closure of the waiting lists, KCHA is reviewing and refining the agency's waiting list policies and procedures and transitioning to new housing-management software. Following the software conversion, the public housing waiting lists will reopen.

KCHA does not maintain a separate waiting list for accessible units. However, public housing tenants and applicants have similar needs for accessible units as other households that receive housing assistance from the housing authority.

RHA does not manage public housing units and therefore does not maintain a public housing waiting list; however, the housing authority has a single application process for all subsidized units. The housing authority is currently not accepting new applications. RHA works with people residing in units subsidized by project-based vouchers and recipients of tenant-based vouchers that request accommodation by offering exit vouchers and/or working with people to transfer them to units that better meet their needs.

What are the number and type of families on the waiting lists for public housing and section 8 tenant-based rental assistance? Based on the information above, and any other information available to the jurisdiction, what are the most immediate needs of residents of public housing and Housing Choice voucher holders? How do these needs compare to the housing needs of the population at large?

KCHA manages several waiting lists for people looking for housing assistance. When KCHA opened its Housing Choice vouchers (Section 8) waitlist in 2020, the agency received 20,321 applications for housing assistance. Of these households, 4,443 were elderly households, 7,946 were disabled households, and 7,932 were non-elderly/disabled households. Roughly half of applicant households included one or more children. Compared to the agency's Section 8 waitlist from 2017, there was a 54 percent increase in the number of elderly households on the waiting list.

KCHA also manages regional waiting lists for public housing. The Northeast regional waitlist currently has 4,674 applicants, of which 1,078 are elderly. The Southeast regional waitlist currently has 6,441 applicants, of which 1,419 are elderly and the Southwest regional waitlist currently has 6,870 applicants, of which 1,542 are elderly. Lastly, KCHA has a property/site-specific waitlist for public housing that currently has 10,030 unique applicants. The average wait time on KCHA's public housing waiting list is over five years.

The large number of applicants across KCHA's waiting lists demonstrates the significant need for affordable housing opportunities across King County. In its efforts to meet the community's needs and address the escalating local homelessness crisis, KCHA works

to develop and acquire additional affordable housing units and implement innovative solutions to help low-income individuals and households achieve long-term self-sufficiency.

Relative to the population at large, KCHA serves some of the region's lowest income residents. Across the agency's housing programs, 81 percent of enrolled households earn less than 30 percent AMI and have a median income of $13,266. Public housing residents are more likely to experience high stress levels, have limited access to health care, and experience more barriers to employment compared to the population at large. To better understand the relationship between subsidized housing and health, KCHA partnered with the Seattle Housing Authority and Public Health – Seattle and King County (PHSKC) to form the Data Across Sectors of Health and Housing (DASHH) partnership. The partnership connected housing and Medicaid data to explore the intersection of housing and healthcare utilization. One of the key findings was that PHA residents were more likely to receive care for chronic conditions, such as hypertension and diabetes, than non-PHA Medicaid recipients. In addition, the data indicated that the rates of service utilization for depression and other mental health concerns were higher for PHA residents than for individuals that did not receive PHA housing assistance.

RHA continues to pursue new development opportunities and access to supportive services for its residents. Recent development projects highlight the need for affordable housing for low-income seniors as well as supportive services such as food assistance and case management.

NA-40 Homeless Needs Assessment - 91.405, 91.205 (c)

Introduction

KCRHA is the lead entity for the Seattle/King County CoC (WA-500) and the homelessness emergency response for the region. KCRHA's mission is to significantly decrease homelessness throughout the County, while centering the principles of equity and social justice, and incorporating the voices of people with lived experience into the homelessness response system.

KCRHA publishes various dashboards, reports, and plans on its website that provide the public with detailed information on the people and households served and the performance of the homelessness response system. The NA-40 Homeless Needs Assessment includes data for the Consortium except for estimates on unsheltered homelessness from the 2023 PIT which cover the entire County. KCRHA was not able to provide 2023 PIT data for the Consortium on unsheltered homelessness, so the estimates included in this section represent unsheltered homelessness for all of King County.

CoC Data Sources
HUD requires CoCs to collect data on program enrollment, client demographics, and overall system performance. One source of information on people experiencing homelessness is the Point In Time (PIT) count, which is an annual census of the number of sheltered and unsheltered people experiencing homelessness on a single night in January. While conducting the PIT count, CoCs also count the inventory and utilization of shelter beds for people experiencing homelessness for the Housing Inventory Count (HIC). Together, PIT and HIC data provide a useful snapshot of people experiencing homelessness and the utilization of available resources on a given day.

Another useful source of CoC data is HMIS which CoCs use to record client-level data and information on the utilization of housing, shelter, and services for individuals and families experiencing homelessness. Whereas PIT data provides a snapshot of needs on a given day, HMIS data provides information on people experiencing homelessness and resources over time.

Definition of Homelessness
CoCs use a specific definition of "homeless" which determines whether someone is eligible to receive CoC-funded housing, shelter, and services. An individual or family is considered homeless if they fall into at least one of the following categories:

1. **Literally Homeless:** The individual or family lacks a fixed, regular, and adequate nighttime residence. For example, they live in a place not meant for human habitation such as a car, park, or public place.
2. **At Imminent Risk of Homelessness:** The individual or family will imminently lose their primary nighttime residence, does not have another residence identified, and does not have the resources or support networks to find permanent housing.
3. **Is Fleeing or Attempting to Flee Domestic Violence:** The individual or family who is experiencing trauma or a lack of safety related to, or fleeing or attempting

to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, traumatic, or life-threatening conditions related to the violence against the individual or a family member in the individual's or family's current housing situation, including where the health and safety of children are jeopardized.

Consortium Homeless Needs Assessment

The 2023 PIT data provides a snapshot of the nature and extent of people experiencing homelessness in the Consortium on a given day. In 2023, there were 2,248 people experiencing homelessness that were residing in a shelter in the Consortium on the day of the PIT count. KCRHA was unable to provide 2023 PIT data on unsheltered homelessness in the Consortium, so Table 27 includes 2023 PIT data for people experiencing unsheltered homelessness for the entire county.

HMIS data estimates the number of people experiencing homelessness over an entire year. The 2022 HMIS data indicates that 17,669 people experienced homelessness over the course of the year in the Consortium and that most people were members of adult only households (54 percent). There were 3,588 people experiencing chronic homelessness which represents 20 percent of all people experiencing homelessness in the Consortium in 2022. Lastly, the HMIS data indicates that many people experiencing homelessness in the Consortium were homeless for over a year and that the average length of time spent homeless varied by subpopulation. For example, people living with HIV/AIDS spent an average of 306 days homeless while chronically homeless individuals spent an average of 633 days homeless.

It should be noted that while KCRHA and the Consortium go to great lengths to quantify the experience of homelessness in King County. The PIT does not cover every place in the County, and households may deny or hide their homeless status. To mitigate this, KCRHA continues to consult those with lived experience of homelessness and to refine its methodology for enumeration.

Table 27: Homeless Needs Assessment

Population	Estimate the number of persons experiencing homelessness on a given night (2023 PIT)		Estimate the number experiencing homelessness each year (2022 HMIS)	Estimate the number becoming homeless each year (2022 HMIS)	Estimate the number exiting homelessness each year (2022 HMIS)	Estimate the number of days persons experience homelessness (2022 HMIS)
	Unsheltered	Sheltered				
Persons in households with adults and children	415	1,475	7,945	2,653	2,858	402
Persons in households with only children	415	30	212	48	39	478
Persons in households with only adults	6,017	659	9,512	1,770	1,628	526
Chronically homeless individuals	2,954	135	3,588	243	452	633
Chronically homeless families	169	26	396	56	120	629
Veterans	607	42	1,214	238	430	459
Unaccompanied youth	778	246	2,527	595	503	437
Persons living with HIV/AIDS	0	0	14	2	4	306

Data Source: Unsheltered counts include 2023 PIT data for the entire County (including Seattle and Milton); sheltered counts include 2023 PIT data for just the Consortium; and the remaining columns include 2022 HMIS data for just the Consortium.

If data is not available for the categories "number of persons becoming and exiting homelessness each year," and "number of days that persons experience homelessness," describe these categories for each homeless population type (including chronically homeless individuals and families, families with children, veterans and their families, and unaccompanied youth).

The 2022 HMIS data for the Consortium provides estimates for the number of people becoming homeless and exiting homelessness over the year by subpopulation. The data indicates that chronically homeless individuals experienced the greatest net decrease between the number of people becoming homeless (243) and the number exiting homelessness (452) over the course of the year. Note that the data indicates how many people entered or exited homelessness and does not deduct for a person entering or exiting more than once during the year. KCRHA's website includes detailed dashboards on performance metrics for programs across the entire County.

Estimate the number and type of families in need of housing assistance for families with children and the families of veterans.

The 2023 PIT data indicates that there were 1,475 people in families (households with adults and children) that resided in a shelter on the night of the PIT count and 2022 HMIS data indicates that 7,945 people in families experienced homelessness during the entire year. In 2022, there were also 2,653 people in families becoming homeless and 2,858 exiting homelessness. While it is unknown how many of these people in families exited to permanent destinations over the year, the high number of people in families becoming homeless during the year signals that a significant number of households with children need housing assistance to prevent them from becoming homeless.

The 2023 PIT data also shows that there were 42 veterans experiencing sheltered homelessness in the Consortium. In 2022, 1,214 veterans experienced homelessness. When comparing the number of veterans becoming homeless to the number of veterans exiting homelessness, there was a net decrease of 192 people.

Nature and Extent of Homelessness
Describe the Nature and Extent of Homelessness by Racial and Ethnic Group.

2023 PIT data provides information on the race and ethnicity of people experiencing homelessness. In the Consortium, 581 people experiencing sheltered homelessness identified as Black/African American (34 percent of the total sheltered population) and 576 people identified as White (33.7 percent of the total sheltered population). At the County level, 43 percent of people experiencing sheltered homelessness were White and 35 percent identified as Black/African American. Among people experiencing unsheltered homelessness, 51 percent identified as White, 17 percent identified as multiracial, 16 percent identified as Black/African American, and 11 percent identified as American Indian/Alaska Native. Among people experiencing sheltered homelessness in the Consortium, 26 percent of people identified as White, and 26 percent identified as Black/African American.

Describe the Nature and Extent of Unsheltered and Sheltered Homelessness.

There were 14,149 people experiencing homelessness on a given night in 2023 across King County. Of these individuals, 6,464 were sheltered (46 percent) and 7,685 were unsheltered (54 percent). The data also indicates that 35 percent of people experiencing sheltered homelessness in King County were located in the Consortium. Among those experiencing sheltered homelessness in the Consortium, 576 identified as White, 581 identified as Black/African American, 166 identified as Pacific Islander, 43 identified as American Indian/Alaska Native, 32 identified as Asian, and 159 identified as multiracial. 370 people experiencing sheltered homelessness in the Consortium identified as Hispanic.

NA-45 Non-Homeless Special Needs Assessment - 91.405, 91.205 (b,d)

Introduction

Special needs populations include people who may not be experiencing homelessness but require housing and supportive services. People with special needs include seniors, people with disabilities, and people with substance abuse disorders. For many, those with special needs can have lower incomes and face challenges in finding and securing affordable housing opportunities. The NA-45 Non-Homeless Special Needs Assessment describes the housing and service needs of the following special needs populations as defined by HUD:

- **Elderly:** defined as aged 62 and older.
- **Frail elderly:** defined as an elderly person who requires assistance with three or more activities of daily living such as bathing, walking, and performing light housework. CHAS data considers an individual aged 75 and over as frail elderly.
- **Persons with disabilities:** defined as those with mental, physical, and/or developmental disabilities.
- **Persons with substance abuse disorders:** defined as the recurrent use of alcohol and/or drugs which causes significant impairment such as health problems, disability, and the failure to meet major responsibilities at work, school, or home.
- **Victims of gender-based violence:** defined as persons fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or human trafficking.
- **Persons with HIV/AIDS:** defined as people living with HIV/AIDS and their families.
- **Veterans:** defined as any person who has served at least one day in the military with any discharge type.

Numerous federal laws and regulations exist to safeguard access to and inclusion of persons with special needs in programs that offer housing and services to communities. As a recipient of HUD funding, the Consortium must comply with requirements outlined under Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act of 1988, the Architectural Barriers Act of 1968, the 2022 reauthorization of the Violence Against Women Act (VAWA), and the Housing for Older Persons Act of 1995. Other King County programs may use other definitions to define elderly or seniors.

The following section describes the housing and service needs facing the Consortium's special needs populations.

Describe the characteristics of special needs populations in your community.

Elderly and Frail Elderly

In 2022, 18 percent of people in the Consortium were considered elderly or over the age of 62. Six percent of the population was aged 75 or older, or frail elderly. ASC data also shows that in 2022, seven percent of people aged 65 years or older in the Consortium lived below the poverty line which represents about 13 percent of all people in the

Consortium living below the poverty line. CHAS data from 2020 indicates that elderly households struggle with cost burden. Significantly, 65 percent of extremely low-income homeowners and 36 percent of extremely low-income renters that experienced cost burden were elderly households. These figures are 51 percent and 26 percent respectively for severely cost-burdened households.

Persons with Disabilities

Approximately 10 percent of people living in the Consortium have a disability. The two most common disability types are ambulatory (affecting 46 percent of the disabled population) and cognitive (affecting 41 percent of the disabled population). In terms of age, disabilities affect the population relatively evenly; 34 percent of people with disabilities are between ages 35 and 64, while 33 percent of the disabled population is aged 65 years or older.

People living with disabilities in King County see reduced median earnings and an increased risk of poverty. In 2022, the average income for individuals without a disability was $64,388 but was just $40,434 for those living with a disability. The poverty rate for people living with a disability is nearly triple (18.4 percent) the poverty rate of people living without a disability (6.9 percent).

Persons with a Mental Illness

Persons with a mental illness need crisis services mental health treatment, substance use disorder treatment, plus programs to help people with behavioral health challenges avoid jail, hospital visits. The Crisis Care Centers Initiative will create a countywide network of crisis care centers, the stabilization of mental health residential treatment and a well-supported behavioral health workforce. This network of crisis care centers will provide much needed resources such as someone to contact, respond, a safe place to go and someone to follow up. People with mental health issues need walk-in behavioral health care access and the potential for short-term stays to help stabilize.

Persons with Substance Abuse Disorder

Data on substance abuse disorder in the Consortium is not readily available however, Seattle and King County Public Health Department Overdose Deaths Data Dashboard provides insight into the characteristics of this population. In 2023, there were 1,322 drug and alcohol poisoning deaths in King County. Of these deaths, 60.3 percent were attributed to opioids and stimulants. Since 2013, deaths related to the use of fentanyl and methamphetamine have increased significantly. In 2023, there were 1,078 overdose deaths in which fentanyl was present. In 2023, 24 percent of overdose deaths occurred among people living in a location not meant for human habitation or in an emergency shelter which represents a 50 percent increase from 2022. In addition, 19 percent of overdose deaths occurred among people living in subsidized housing, eitherprovided by the government or a social service agency which represents a 44 percent increase from the previous year.

The dashboard also indicates that the number of non-fatal opioid overdoses has increased over the past four years from 3,003 instances in 2020 to 8,341 instances in 2024. According to the MIDD (Mental Illness and Drug Dependency) 2023 Summary

Report, in 2023 the program assisted 24,342 people experiencing a mental health crisis or substance abuse disorder. Lastly, data from the 2023 PIT count conducted by KCRHA found that 12 percent of individuals experiencing homelessness reported having a substance abuse disorder.

Victims of Gender-Based Violence

Data on the prevalence of domestic violence, dating violence, sexual assault, stalking, and human trafficking is oftentimes limited to law enforcement data on criminal offenses. Available data from the King County Prosecuting Attorney's Office Data Dashboard provides information on felony referrals and cases filed to the King County Superior Court. The data indicate that in 2023 there were on average over 1,000 domestic violence, sexual assault, and child abuse cases open in King County each month. In 2023, law enforcement made 1,608 referrals for potential domestic violence felony cases and 1,181 referrals for potential sexual assault and child abuse cases. In addition, from March to May 2023, the dashboard classified 19,224 emergency department visits as suspected cases of domestic violence.

Persons Living with HIV/AIDS

King County and Seattle's Public Health Department estimates that about 200 to 300 people in King County become infected with HIV each year. In total, 7,200 to 8,000 people residing in King County live with HIV/AIDS, however, the County estimates that anywhere from six to 10 percent of people who have HIV are unaware, which means the total could be higher. In addition, the King County Health Department notes that African Americans, African immigrants, Latinos, injection drug users, and members of the LGBTQ+ community experience disproportionate rates of HIV infections.

Veterans

ACS data from 2022 indicates that there are 65,750 veterans living in the Consortium, which accounts for 5.6 percent of the population. Among Consortium veterans, 49 percent are aged 65 years or older, 27 percent have a disability, and five percent live below the federal poverty line.

What are the housing and supportive service needs of these populations and how are these needs determined?

Elderly and Frail Elderly

Call logs from 2-1-1 provide insight into the service needs for elderly residents in the Consortium. In 2022, 52.6 percent of callers asking about home repair and maintenance programs were aged 60 years or older. In addition, approximately 30 percent of callers asking about ride services and transportation assistance were aged 60 years or older.

As noted in King County's Comprehensive Plan, Appendix B, seniors in the County may face challenges due to rising housing costs. Many seniors have fixed incomes, which can make securing new housing or repairing and modifying existing housing a challenge. In community sessions held for the King County Comprehensive Plan in January 2023, community members noted that there is a growing number of seniors in the County experiencing homelessness due to the constraints of fixed income.

Communities in the Skyway-West Hill and North Highline areas advocated for more affordable, family-sized housing units and culturally specific housing units for seniors during outreach conducted for the 2021 Anti-Displacement Strategies Report. In addition, consultations for the draft 2024 AI with the King County Older Adults and Healthy Aging Unit, speak to the need for more behavioral support services and care within affordable senior housing buildings, housing repair programs, and support for manufactured housing communities.

Lastly, program outcomes from the King County Department of Community and Human Services' VSHSL provides information on the number of seniors served through various housing and human services programs across King County. In 2021, the levy provided more than 2,000 seniors with health promotion programming, of whom 71 percent reported improvements to their health and wellness. During the same year, the levy also served more than 29,000 seniors across 39 senior centers and served 670 seniors through senior virtual villages which are social engagement programs that promote belonging and interpersonal connections among subpopulations experiencing isolation. In addition, the levy has supported home-visits to 197 seniors since 2020 to provide behavioral health and human services. An August 2022 assessment report on the levy offered recommendations for a renewed levy in coming years and proposed that the levy continue to explore the role of senior virtual villages in helping seniors age in place and continue support for seniors and their caregivers.

Veterans

King County's VSHSL also provides information on the number of veterans and their families served through various housing and human services programs which provides insight into the continuing housing and service needs of this population. Veterans' programs funded by the levy serve over 2,000 veterans, service members, and their families every year with wraparound services. Between 2019 and 2021, veterans' programs provided housing navigation and stabilization services such as documentation services and housing search assistance to enable more than 300 veterans experiencing homelessness to find housing. In addition, between 2018 and 2021, the VSHSL provided housing counseling and foreclosure prevention, alternative dispute resolution, and legal aid to 432 people who were either veterans, military service members, or a family member. Levy-funded programs also provided emergency short-term financial assistance to 229 veteran households to prevent households from becoming homeless. Lastly, the levy supports an average of 278 veterans and 34 military family members annually through counseling to provide targeted behavior health support to veterans and their families struggling with military trauma, post-traumatic stress disorder, and reintegration issues. These services fill capacity gaps in federal Veterans Administration (VA) behavioral health services for veterans and provide specific counseling support for veteran families that the VA does not provide.

Lastly, during the consultation process for the Consortium's Consolidated Plan, stakeholders described the housing needs of elderly veterans across the County. Specifically, they described the need for affordable housing with a higher AMI threshold to accommodate elderly veterans on a fixed income who also receive VA benefits.

Persons with Disabilities

As called out in King County's Comprehensive Plan Appendix B, people living with disabilities often face challenges in searching, securing, and relocating to affordable housing that accommodates their needs and/or is near supportive services. Community feedback gathered for the 2023 Developmental Disabilities Legislative Committee of King County indicates that there is less housing available in rural areas for those living with intellectual and developmental disabilities. In addition, community members noted that some landlords in King County are uncooperative in providing accommodations for rental units, further exacerbating the need for affordable and accessible housing. In particular, a 2023 interview with a representative from African Community Housing and Development speaks to the increased uncertainty of immigrant and refugee populations living with disabilities. They note that some immigrants do not file fair housing complaints out of fear of landlord retaliation or simply not knowing their rights.

County interviews with the King County Developmental Disability and Early Childhood Supports Division also identified a need in King County for affordable, family-sized rental units with appropriate accommodations for families with at least one individual living with a disability. Lastly, consultations with service providers from the County's 2024 AI speak to the need for downpayment assistance to increase homeownership among those living with disabilities and who are on fixed incomes.

Persons with Substance Abuse Disorder

Interviews conducted during the 2022 PIT helped inform the service needs of those with substance abuse disorder. Individuals spoke of the challenges in navigating the health care system and accessing supportive services while experiencing housing instability and homelessness. This speaks to an increased need for supportive housing and wraparound services for those with substance abuse disorders in these settings.

In April 2023, King County voters approved the Crisis Care Centers Levy, a nine-year property tax levy to fund the creation of five county crisis care centers to improve residential treatment capacity and support the behavioral health workforce. King County established the levy in response to critical gaps in the crisis service system that offered few options for immediate care for people in crisis. The 2024-2032 Crisis Care Center Levy Implementation Plan notes unmet needs for people living with mental health and substance use conditions in King County. The report notes that in 2022, among people enrolled in Medicaid in King County, about 45,000 people or 51 percent of adults with an identified mental health need did not receive treatment. In addition, significant inequalities in service access and utilization exist among people identifying as BIPOC. The levy's five crisis care centers will serve as facilities to divert people from emergency departments or law enforcement in favor of receiving trauma-informed, recovery-oriented care in a specialized setting. The levy also aims to address recent shortages in residential treatment facilities and staff capacity. The report notes that from 2018 to 2023, King County lost 115 residential treatment beds due to the lack of resources for capital maintenance and facility improvements. The remaining 240 beds are insufficient to meet current needs.

Victims of Gender-Based Violence

Data from the National Domestic Violence Hotline for King County provides insight on the barriers that survivors of domestic violence face in securing stable and affordable housing. Among calls to the hotline from October 2019 to March 2023, 12.3 percent of callers (or 1,468 people) requested shelter assistance, which was the third most common request and 2.8 percent of callers (or 337 people) requested transitional housing support. In addition, 4.9 percent of callers (or 1,340 people) reported housing as a circumstance or detail related to domestic violence, which was the second most common circumstance. Finally, the primary barrier identified to obtaining services was finances, accounting for 8.3 percent of all callers.

In addition to the National Domestic Violence Hotline, King County launched a 24-hour countywide domestic violence hotline, DVHopeline, in 2021. From 2021 to 2022, the DVHopeline received more than 16,000 calls. The multi-lingual, multi-modal hotline provides immediate and confidential advocacy to survivors. Although the hotline can quickly connect people in crisis to advocates, the hotline's ability to refer people to housing, health, legal, financial, and counseling services is hindered because programs across the County are operating at maximum capacity. Gender-based violence providers were already stretched thin prior to the pandemic, but COVID-19 exacerbated these capacity challenges, indicating need for additional support for providers to serve the community.

Through the VSHSL, King County funds multiple other gender-based violence programs that work to prevent violence and offer crisis and short- and medium-term support for survivors including case management, mobile advocacy programs, and culturally specific services. In an August 2022 assessment of the VSHSL, the County notes that public funding continues to be inadequate to address the community's needs: "Because of its prevalence and impact, domestic violence is a major cause and contributor to demand for other human service supports funded by the [VSHSL], and marginalized communities are often the most impacted by lack of services." The report goes on to recommend for the sustained and expanded investment of gender-based violence services particularly for mobile advocacy and continued exploration into programs to address the root causes of gender-based violence.

Persons Living with HIV/AIDS

According to a 2023 HIV/AIDS Epidemiology Report and Community Profile of King County and Washington State, racial and ethnic disparities exist among those living with HIV/AIDS in the County. The study estimates that 16.5 percent of American Indian or Alaska Native, 11.7 percent of Black or African American, and 10.1 percent of Hispanic or Latin American people living with HIV/AIDS experience homelessness in King County, which is higher than the averages for the County as a whole. The report also found that 15 percent of people diagnosed with HIV/AIDS in 2022 experienced homelessness or housing instability, which is a slight increase from the previous year at 13 percent but is far lower than its peak in 2018 at 27 percent. Of those diagnosed in 2022, Black or African American individuals experienced homelessness at the highest rate. The report emphasizes that housing instability can hinder a person's ability to access and engage in critical medical care for people living with HIV/AIDS.

If the Participating Jurisdiction will establish a preference for a HOME Tenant Based Rental Assistance (TBRA) activity for persons with a specific category of disabilities (e.g., persons with HIV/AIDS or chronic mental illness), describe their unmet need for housing and services needed to narrow the gap in benefits and services received by such persons. (See 24 CFR 92.209(c)(2) (ii)).

This is not applicable since the Consortium does not use HOME funds for TBRA.

NA-50 Non-Housing Community Development Needs - 91.415, 91.215 (f)

The Consortium identified the jurisdiction's non-housing community development needs by analyzing information gathered through several methods including the following:

- 2025-2029 Consortium Consolidated Plan stakeholder survey
- 2025-2029 Consortium Consolidated Plan community survey
- 2023 King County Department of Local Services survey of community needs in the County's unincorporated areas
- consultation sessions with organizations, agencies, and partners working with low- and moderate-income people in the community
- data on calls for assistance to 2-1-1 from people in a zip code located in the Consortium
- analysis of federal, state, and local data sources and existing plans, studies, and reports.

Multiple sources of information provided insight into the non-housing community development needs in the region, but the stakeholder survey, community survey, and consultation sessions gathered input specifically for the Consortium's Consolidated Plan.

Describe the jurisdiction's need for Public Facilities. How were these needs determined?

Stakeholder Survey Responses

The stakeholder survey provided insight into the need for public facilities in the Consortium. Thirteen respondents answered questions on the need for a variety of public facility activities in the Consortium. Sixty-nine percent of respondents indicated a need for community centers for specific groups (such as seniors or youth) and 38 percent selected parks and recreational facilities; however, when asked to prioritize among activities, the average-weighted score indicates that respondents ranked the need for parks and recreational facilities (9.80) higher than the need for community centers (9.44).

The Department of Local Services Survey Responses

The Department of Local Services community survey of residents in unincorporated King County asked respondents about the most important policy areas in their communities. Although most issues included in the environment, farmland, parks, and open spaces policy area are generally ineligible activities for the Consortium's CDBG, HOME, or ESG funds, one issue — recreation and community programs — may be eligible for CDBG funds. The survey found that 60 out of 318 residents (or 19 percent) indicated that recreation and community programs was the most important issue for their community. Furthermore, 21 of these residents lived or worked in East Renton Plateau and 10 lived or worked in Skyway-West Hill which indicates that these areas may have high needs for recreation and community programs.

Community Survey Responses
When asked to rate the level of need for different activity categories in the community where they live, respondents of the community survey seemed divided about the level of need for public facilities. Specifically, 33 percent of respondents indicated a high level of need, 32 percent indicated a medium level of need, and 30 percent indicated a low level of need. The survey then asked respondents to pick three public facilities activities that are most needed, and 68 percent selected improvements to facilities for people with special needs, 65 percent chose improvements to facilities for people experiencing homelessness, and 62 percent selected improvements to nonprofit buildings that serve low- and moderate-income people.

Describe the jurisdiction's need for Public Improvements. How were these needs determined?

Stakeholder Survey Responses
The stakeholder survey provided insight into the need for public infrastructure and improvements in the Consortium. Thirteen respondents of the stakeholder survey provided input on the most needed infrastructure activities in their communities. Seventy-seven percent of respondents selected street and sidewalk improvements, 69 percent selected accessibility improvements, 54 percent selected broadband internet access services, and 46 percent selected sewer infrastructure improvements. When asked to rank the most needed activities, the average-weighted score indicates that the most needed activity was a tie between street and sidewalk improvements (10.60) and water infrastructure improvements (10.60), followed by accessibility improvements (10.56), clearance and demolition of buildings/structures (10.00), and flood and drainage improvements (9.67).

The Department of Local Services Survey Responses
The Department of Local Services community survey highlighted the need for activities related to public transportation and roads in the County's unincorporated areas. Across a variety of policy areas, 22 percent of respondents indicated that public transportation and roads was the most important policy area for their community. Furthermore, 98 of 521 respondents (19 percent) that responded to additional questions on public transportation and roads indicated that roadway pedestrian infrastructure and safety was the most important issue for their community. Residents also indicated issues related to transit service and options which suggests that existing transit options in unincorporated areas may not be adequately meeting the needs of communities.

Community Survey Responses
When asked to rate the level of need for different activity categories in the community where they live, 44 percent of respondents of the community survey indicated a medium level of need for public infrastructure improvements while 29 percent indicated a high level of need and 23 percent indicated a low level of need. The survey then asked respondents to pick three infrastructure activities that are most needed, and 61 percent selected street and sidewalk improvements, 48 percent chose broadband internet access improvements, and 41 percent selected traffic lights/signs and public safety improvements.

Describe the jurisdiction's need for Public Services. How were these needs determined?

Stakeholder Survey Responses
Twenty-one respondents of the stakeholder survey provided input on the public service needs in the Consortium. The survey listed a variety of eligible public services and asked respondents to indicate which activities are needed the most. Eighty-six percent of respondents selected mental health services, 81 percent selected food assistance, 76 percent selected childcare services, 67 percent transportation services, and 67 percent selected substance abuse disorder treatment services. The average-weighted score, which the survey tool calculates based on how survey respondents prioritized the need for each topic, indicates that the top five most needed activities are substance abuse disorder treatment services (19.42), followed by mental health services (18.88), childcare services (18.40), senior services (17.58), and services for people with disabilities (17.00).

The Department of Local Services Survey Responses
The Department of Local Services community survey underscored the need for a variety of public services in the County's unincorporated areas. Among residents that responded to questions about health and human service issues in their community, 95 respondents (or 35 percent) indicated that housing and health services for people experiencing homelessness was the most important issue for their community. Of these residents, 23 live or work in East Renton Plateau, 16 live or work in North Highline/White Center, 14 live or work on Vashon-Maury Island, and 13 live or work in Southeast King County.

In the realm of youth and childhood services, 78 out of 155 residents (or 50 percent) indicated that youth programs and services were the most important issue in their communities. Many residents commented on the need for community centers that offer programs for children and youth for recreation, childcare, and skill-building. Others spoke of the need for childcare assistance to support working families and described the need for daycare centers for young children, particularly ones that accept government childcare subsidies. Some residents spoke of the need for after school programming to not only provide safe spaces for children but offer services such as mental health care, tutoring, job readiness, support for immigrant children, and more.

Community Survey Responses
When asked to rate the level of need for different activity categories in the community where they live, 64 percent of respondents of the community survey indicated a high level of need for public services, 27 percent indicated a medium need, and five percent indicated a low level of need. The survey then asked respondents to pick five public services that are most needed, and 60 percent selected mental health services, 47 percent selected services for people experiencing homelessness, 47 percent selected substance use disorder treatment services, 38 percent selected services for victims of violence (including domestic violence, sexual assault, stalking, dating violence, and human trafficking), and 35 percent selected youth programs and services.

Consultation Input
The Consortium conducted three consultation sessions with housing providers and developers and stakeholders highlighted the need for public services. The Director of Housing at a shelter and affordable housing organization emphasized the need for mental and physical health, substance abuse disorder, and senior services as critical components in ensuring stable housing for their clients. In addition, a Veterans Administrator at King County spoke to the need for dedicated veteran's service providers, particularly those who can help veterans navigate and apply for VA benefits.

Data Analysis
The Consortium also analyzed publicly available data from 2-1-1 Washington from people calling for assistance from a zip code located in the Consortium. Between December 28, 2022, and December 27, 2023, there were 101,114 calls for assistance. The data does not indicate how many unique callers requested assistance during this period; however, the greatest share of calls to 2-1-1 were related to housing and shelter (32,811 calls or 32.4 percent). While the publicly available data does not provide information on the income of the caller, the call volume across different categories provides insight into the types of services that Consortium residents may need.

The top non-housing call categories included Government and Legal (11,662 calls or 11.3 percent), Utilities (11,430 calls or 11.3 percent), Other (11,415 calls or 11.3 percent), and Food (10,736 calls or 10.6 percent). Each category includes various sub-categories that provide further insight into the service needs of people living in the Consortium. Among calls for Government and Legal assistance, there were 3,961 calls related to housing law. For calls related to Utilities, 6,148 were for assistance with electric utilities and 800 were for water, sewer, and garbage services. Among calls for Food assistance, 5,611 calls were for help buying food and 2,611 were for food pantries and food banks. Other notable sub-categories related to public services include: 1,142 calls for medical expense assistance, 1,122 calls for nursing homes and adult care services, 1,097 calls for crisis intervention and suicide assistance, 1,866 calls for financial assistance related to a disaster, and 3,131 calls for ride services such as senior transportation.

Market Analysis

MA-05 Overview

The Market Analysis of the Consolidated Plan includes quantitative data analysis, supplemented with information gathered through consultation sessions and surveys, to identify the housing market, economic, and community development factors impacting low- and moderate-income people and communities in the Consortium. The key themes identified in this section help to inform the Strategic Plan, which outlines how the Consortium will use its CDBG, HOME, and ESG funds over the next five years.

Similar to the Needs Assessment, the Market Analysis utilizes two primary data sources: data from the 2018-2022 ACS and 2016-2020 CHAS. This section also summarizes information from other existing reports, studies, and plans as well as input from the stakeholder survey, community survey, and consultation sessions to better understand recent trends impacting the region.

Key Trends Identified in the Market Analysis

Overall, the cost of living remains a significant concern for low- and moderate-income households in the Consortium. Particularly in the post-COVID period, stakeholders and Consortium residents noted large increases in monthly rents. The median rent in King County increased 86 percent between 2012 and 2022. In 2022, the median rent was $1,813 per month. Over half of Consortium renter households spent more than $2,000 on rent each month that year. Despite local and regional efforts to add to the affordable housing stock, the current availability still does not meet the needs of the population. Data summarized in the Market Analysis suggests that the greatest need for affordable housing units is for households earning less than 30 percent AMI. To mitigate the effects of cost burden and help meet the needs of the community, the County supports an array of programs, many of which are funded through levies. Lastly, the County, along with other local and regional partners, promotes economic and workforce development initiatives to expand opportunities.

MA-10 Housing Market Analysis: Number of Housing Units - 91.410, 91.210(a)&(b)(2)

Introduction

For years, government agencies, partner organizations, advocates, and residents of King County have voiced concerns over the lack of affordable housing in the region. Housing affordability is a complex phenomenon influenced by a variety of individual and regional level factors that contribute to the local supply and demand for housing. The Housing Market Analysis of the Consolidated Plan explores recent data on both supply and demand characteristics of the Consortium's housing market including the number, types, size, cost, and quality of housing units as well as projected demand for additional housing units.

To establish a shared and consistent framework for growth management planning — including planning for future housing need — King County established the Countywide Planning Policies to align planning efforts for all jurisdictions in the County in accordance with the Revised Code of Washington (RCW) 36.70A.210. The Countywide Planning Policies implement the regional growth plan, VISION 2050, which aims to provide high quality services, amenities, and resources for residents in the decades to come.

For the Consolidated Plan, the Countywide Planning Policies provide useful information on the future projected housing need by jurisdiction in the Consortium. Together with ACS and CHAS data, this information provides valuable insight into the context and environment in which the Consortium administers its housing and community development programs.

Existing Residential Housing Supply

2022 ACS data on the number, types, and size of existing residential housing units provides information on the Consortium's current housing stock. Table 28 provides data on the number of residential units by property type which includes both occupied and unoccupied units. The data indicates that among the 597,146 residential units in the Consortium, the majority are detached, single-family homes (60 percent). The second most common property type is properties with 20 or more units (15 percent) followed by properties with five to 19 units (13 percent).

Table 28: Residential Properties by Unit Number

Property Type	Number	Percent
1-unit detached structure	356,813	60%
1-unit, attached structure	28,424	5%
2-4 units	33,410	6%
5-19 units	75,075	13%
20 or more units	88,949	15%
Mobile Home, boat, RV, van, etc.	14,475	2%
Total	597,146	100%

Data Source: 2018-2022 ACS.

Data on the number of housing units by bedroom size and tenure indicates that in general, a larger share of owner-occupied housing units have three or more bedrooms compared to renter-occupied units. Overall, there are 567,876 occupied housing units in the Consortium and 63 percent are owner-occupied and 37 percent are renter-occupied. Among owner-occupied units, 83 percent contain three or more bedrooms while this figure is 25 percent for renter-occupied units.

Table 29: Unit Size by Tenure

	Owners		Renters		Total	
	Number	%	Number	%	Number	%
No bedroom	1,415	1%	17,653	9%	19,068	4%
1 bedroom	7,714	2%	57,459	28%	65,173	12%
2 bedrooms	51,074	14%	79,750	38%	130,824	23%
3 or more bedrooms	299,495	83%	53,316	25%	352,811	62%
Total	359,698	100%	208,178	100%	567,876	100%

Data Source: 2018-2022 ACS.

Describe the number and targeting (income level/type of family served) of units assisted with federal, state, and local programs.

The King County Regional Affordable Housing Dashboard provides information on the number of assisted housing units in production in the county. From 2019 to 2021, 3,417 income-restricted units at or below 50 percent AMI were created of which 1,734 of these units are targeted to extremely low-income households (0-30 percent AMI).

In addition, the King County Income-Restricted Housing Database provides information on the County's assisted housing inventory. As of 2021, there were 31,336 total assisted units of which 2,952 (nine percent) were affordable to households under 30 percent AMI, 6,661 (21 percent) were affordable to households between 30-50 percent AMI, 21,245 (68 percent) were affordable to households between 50-80 percent AMI, and 20 units (0.1 percent) were affordable to households between 80-100 percent AMI. Information on the number of assisted units by targeted subpopulation is not readily available from the database. However, data from the Washington State Housing Finance Commission indicates that about 69 percent of assisted units in King County are targeted. The most commonly targeted population is the elderly (37 percent), followed by units for people with a disability (17 percent), and then large households (10 percent).

Lastly, the County database indicates that housing developers created 1,211 income-restricted units affordable to households with incomes at or below 50 percent AMI from 2019-2021 in the Consortium. Kirkland saw the greatest increase in new units at 408, while many areas in the Consortium, such as unincorporated King County, did not see any new assisted units during this period.

Provide an assessment of units expected to be lost from the affordable housing inventory for any reason, such as expiration of Section 8 contracts.

The Washington State Housing Finance Commission's Affordable Housing Data Portal provides insight into the number of assisted units in the Consortium with subsidy restriction expiration date data. The Data Portal defines the subsidy expiration date as the date that the unit's income and rent restrictions expire according to the regulatory agreement. The data indicates that a few hundred units may be lost to the private market over the next few years if property owners and public funders take no action to preserve unit affordability. Most assisted units in the Consortium that are included in the state database have subsidy expiration dates in the coming two to four decades.

Of the estimated 2,366 assisted units in the Consortium that have subsidy expiration dates by 2040, 508 units are targeted to the elderly, 63 are targeted to large households, and 207 are targeted to people with a disability. Regarding the income affordability of these 2,366 assisted units, 1,810 units (77 percent) are affordable to households earning 60 percent AMI.

Does the availability of housing units meet the needs of the population?

The current availability of housing units does not meet the needs of the population. The King County Countywide Planning Policies offers a recent estimate of the additional housing units needed in order to meet projected demand in the decades to come. The 2021 the Washington State Department of Commerce calculated the number of additional housing units needed by income category for each jurisdiction in the County based on the 2019 housing supply and projected number of housing units needed by 2044. In 2019, there were 591,957 housing units in the Consortium — excluding emergency shelter units — and the Consortium will need an estimated total of 788,584 units by 2044 in order to meet projected demand. The Consortium therefore will need an additional 196,627 housing units by 2044.

The data indicates that to meet projected demand, the Consortium needs 124,308 new housing units affordable to households earning less than 80 percent AMI. The need is greatest for units that are affordable to the lowest income households. The income category with the greatest need for housing units is households earning less than 30 percent AMI that are not permanent supportive housing.

Describe the need for specific types of housing.

As described in greater detail in MA-15, there is a need for housing affordable to households with incomes at or below 50 percent AMI as demonstrated by a significant number of households renting units unaffordable to their income category.

MA-15 Housing Market Analysis: Cost of Housing - 91.410, 91.210(a)

Introduction

While household housing costs vary across communities in the Consortium, overall, 26 percent of Consortium households spend $3,000 or more on monthly housing costs. As with concerns over the supply and demand for housing in King County, housing affordability is a well-known concern that has worsened over time. Increasing housing costs, as well as the increased cost of other necessities including food, childcare, and transportation, place considerable financial pressure on households across the Consortium, particularly those with lower incomes.

2022 ACS data provides additional insight into the housing costs for renter and owner households in King County and the Consortium. Table 30 provides a snapshot of the change in the median home value and contract rent from 2012 to 2022 in King County and indicates that over this 10-year period, the median home value increased 96 percent while median contract rent increased 86 percent.

Table 30: Cost of Housing in King County

	Base Year: 2012	Most Recent Year: 2022	% Change
Median Home Value	$388,700	$761,500	96%
Median Contract Rent	$976	$1,813	86%

Data Source: 2008-2012 ACS (Base Year), 2018-2022 ACS (Most Recent Year). *Data is for all of King County.

The single largest annual increase in median home values occurred from 2021 to 2022 where median home values increased by 17 percent. In 2022, median housing costs for King County homeowners with a mortgage were $2,999, while this figure was $1,010 for owners without a mortgage.

Contract rent is the estimated monthly rent agreed to or contracted for a rental unit while gross rent is the contract rent plus the estimated average monthly cost of utilities including electricity, gas, water and sewer, and fuels such as oil, coal, or kerosene that are paid for by the renter. The data indicates that over the 10-year period, median gross rents increased by 77 percent in comparison to median contract rents which increased by 86 percent. Table 31 provides data on the number of renter households by contract rent bracket in the Consortium. In 2022, 54 percent of renters in the Consortium spent $2,000 or more on contract rent.

Table 31: Rent Paid in the Consortium

Rent Paid	Number	Percent
Less than $500	17,706	3%
$500-999	58,539	10%
$1,000-1,499	82,585	15%
$1,500-1,999	98,328	17%
$2,000 or more	305,678	54%
Total	562,836	100%

Data Source: 2018-2022 ACS. *Data represents contract rent in the Consortium.

In regard to monthly housing costs, which can include the cost of rent, mortgage payments, insurance, and utilities, 33 percent of owner households spent $3,000 or more on monthly housing costs in 2022 while this figure was 13 percent among renter households. Among renter households, the most common cost category was $1,500 to $1,999 for monthly housing costs. This range applied to 28 percent of renter households.

Table 32 provides 2020 CHAS data on the number of housing units that are affordable to households at different income brackets in the Consortium. Predictably, the number of affordable housing units increases as the income category increases. For renter households, only 10 percent of total units are affordable to those earning less than 30 percent AMI. For homeowners, 84 percent of units are affordable to those earning over 80 percent of AMI and only 15 percent of units are affordable to households earning less than 80 percent AMI.

Table 32: Housing Affordability in the Consortium

Number of Units Affordable to Households Earning	Renter	Owner	Total
Less than 30% AMI	19,220	N/A	19,220
30-50% AMI	39,575	25,436	65,011
50-80% AMI	71,500	29,617	101,117
Over 80% AMI	70,321	296,631	366,952
Total	200,616	351,684	552,300

Data Source: 2016-2020 CHAS.

Among rental units affordable to households earning less than 30 percent AMI, 61 percent of households occupying these units have incomes below 30 percent AMI while the remaining 39 percent of households occupying these units have incomes above 30 percent AMI. The data indicates that for rental units affordable to various income categories, there is a mismatch between the income category of occupant households and the income needed to afford the units.

Lastly, Table 33 provides the HUD Fair Market Rents (FMRs) for various unit sizes in King County. FMRs are used to determine payment standard amounts for various HUD housing programs and generally represent the estimated cost to rent a moderately-priced dwelling unit in a local housing market.

Table 33: HUD Fair Market Rent and HOME Rents

Monthly Rent	Efficiency (no bedroom)	1 Bedroom	2 Bedroom	3 Bedroom	4 Bedroom
Fair Market Rent	$2,211	$2,269	$2,645	$3,510	$4,080
High HOME Rent	$1,735	$1,860	$2,234	$2,573	$2,850
Low HOME Rent	$1,317	$1,411	$1,695	$1,959	$2,186

Data Source: 2024 HUD FMR and HOME Rents.

Is there sufficient housing for households at all income levels?

There is not sufficient housing for households at all income levels but particularly for households earning less than 80 percent AMI. 2020 CHAS data indicates that only 29 percent of rental units are affordable to households earning less than 50 percent AMI and only 15 percent of owner units are affordable to households earning less than 50 percent AMI. With fewer units affordable to lower-income households, lower income households are more likely to occupy housing that is unaffordable to them and contribute a larger share of household income towards housing costs. Data provided throughout the Needs Assessment of the Consolidated Plan indicates high percentages of rental and owner households that are cost-burdened and severely cost-burdened. Similarly, data from the 2021 Countywide Planning Policies summarized in MA-10 Housing Market Analysis indicates that the Consortium needs additional housing units at all income levels in order to meet projected housing demand by 2044.

Throughout the consultation process in the development of the Consolidated Plan, stakeholders and members of the community noted the need for a variety of affordable housing options for low- and moderate-income renters and homeowners.

How is affordability of housing likely to change considering changes to home values and/or rents?

Housing costs for both renter and owner households have increased significantly over the past ten years in the Consortium and will likely continue to increase. While the Consortium continues to work with partner organizations and agencies to develop, preserve, and expand housing opportunities, housing affordability will likely continue to be a pressing issue in the years to come.

How do HOME rents and HUD FMRs compare to area median rent? How might this impact your strategy to produce or preserve affordable housing?

Table 33 presents the HUD FMRs and HOME rents for King County and indicates that the FMRs are noticeably higher than the high and low HOME rents for units of different sizes. A challenge with FMRs and HOME rents is that these amounts often do not keep pace with changes in rents, particularly for tight rental markets such as those in King County. The Zillow Observed Rent Index (ZORI) provides data on the typical observed market rate rent for a given region for multifamily residences. The data indicates that there is a wide range in average rents by jurisdiction over time. As of January 2024, the average rent in Bellevue was $2,509, while this figure was $2,221 countywide, $1,939 in Auburn, $1,879 in Kent, and $1,850 in Federal Way. Given the monthly fluctuation of

rents in Zillow data, HUD FMRs and HOME rents may be insufficient for households to afford decent units depending on where they live and the volatility of the local rental market.

When it comes to the Consortium's strategy for preserving and producing affordable housing units, insufficient FMRs and HOME rents can require deeper levels of housing subsidy to support lower income households in remaining stably housed.

MA-20 Housing Market Analysis: Condition of Housing - 91.410, 91.210(a)

Introduction

To assess housing condition, the Consortium analyzed 2022 ACS data which captures information on housing units with at least one of the following conditions:

1) lacks complete plumbing facilities
2) lacks complete kitchen facilities
3) more than one person per room
4) monthly housing costs exceed 30 percent of household income.

Describe the jurisdiction's definition for "substandard condition" and "substandard condition but suitable for rehabilitation."

- **Standard Condition:** A standard housing unit meets HUD Housing Quality Standards and state and local codes. This includes plumbing and adequate kitchen facilities.
- **Substandard Condition:** A substandard housing unit does not meet state and local building, fire, health, or safety codes; presents health and safety issues to occupants; and rehabilitation is not structurally and financially feasible.
- **Substandard condition but suitable for rehabilitation:** A substandard unit that is suitable for rehabilitation is in poor condition, but it is both structurally and financially feasible to rehabilitate the unit.

Table 34 illustrates the number of owner- and renter-occupied housing units with varying numbers of housing conditions. Among owner- and renter-occupied housing units, most units have no selected housing conditions. Twenty-four percent of owner-occupied units have one selected housing condition while 44 percent of renter-occupied units have one condition. Less than one percent of owner-occupied units have two conditions while this figure is five percent for renter-occupied units.

Table 34: Condition of Units

Condition of Units	Owner-Occupied		Renter-Occupied	
	Number	Percent	Number	Percent
With one selected Condition	87,212	24.2%	91,444	44%
With two selected Conditions	1,647	0.5%	9,888	5%
With three selected Conditions	122	0%	426	0%
With four selected Conditions	0	0%	23	0%
No selected Conditions	270,717	75.3%	106,397	51%
Total	359,698	100%	208,178	100%

Data Source: 2018-2022 ACS.

Table 35 presents the age of residential units of renter- and owner-occupied housing. Renter- and owner-occupied housing follow similar patterns when it comes to the age of the dwelling. In 2022, 54.8 percent of owner-occupied units were built after 1980, while 57.7 percent of renter-occupied units were built after 1980.

Table 35: Year Unit Built

Year Unit Built	Owner-Occupied		Renter-Occupied	
	Number	Percent	Number	Percent
2000 or later	82,204	22.9%	58,393	24.8%
1980-1999	114,722	31.9%	72,192	32.9%
1950-1979	138,664	38.6%	67,365	36.3%
Before 1950	24,108	6.7%	10,228	6%
Total	359,698	100%	208,178	100%

Data Source: 2018-2022 ACS.

2020 CHAS data provides additional information on units built prior to 1980 occupied by households with at least one child aged six years or younger present. The data indicates that in 2020, 40 percent of owner-occupied housing and 47 percent of renter-occupied housing units were constructed prior to 1980, which suggests there could be a risk of lead-based paint. Of these housing units, approximately 8 percent have children under the age of six present in the home.

Table 36: Risk of Lead-Based Paint Hazard

Risk of Lead-Based Paint Hazard	Owner-Occupied		Renter-Occupied	
	Number	Percent	Number	Percent
Total Number of Units Built Before 1980	80,746	40%	164,949	47%
Housing Units built before 1980 with children under age six present	15,230	8%	22,878	7%

Data Source: 2016-2020 CHAS.

Vacant Units

In 2022, there were 29,270 vacant units in the Consortium which include a variety of unoccupied housing units. Among these vacant units 8,847 (or 30 percent) are for rent, 2,543 (or nine percent) are rented but not occupied, 2,394 (or eight percent) are for sale only, 1,828 (or six percent) are owned but not occupied, 4,378 (or 15 percent) are for seasonal, recreational, or occasional use, 32 (or 0.1 percent) are set aside for migrant workers, and the remaining 9,248 (or 32 percent) are classified as vacant for another reason. Specific information on the number and condition of abandoned vacant, bank-owned, and abandoned bank-owned properties is not readily available, however, the Consortium does not have a significant number of abandoned or vacant units. A HUD Comprehensive Housing Market Analysis for the Seattle-Bellevue metro area notes that the rate of housing units with delinquent mortgages at risk of foreclosure and real estate owned properties in the region is at 0.4 percent, while this figure is 1.1 percent nationally. The region's rate has been consistently lower than the national rate since 2000.

Describe the need for owner and rental rehabilitation based on the condition of the jurisdiction's housing.

Available ACS data indicates that 87,212 (or 24 percent) of owner-occupied and 91,444 (or 44 percent) of renter-occupied housing units in the Consortium have one selected

housing condition. Since ACS data considers housing cost burden as a selected condition, and the Needs Assessment identified a significant number of cost-burdened households in the Consortium, many of the housing units with one selected condition are likely occupied by cost-burdened households and may not necessarily require rehabilitation. It is more likely that the housing units with two, three, or four selected conditions contain physical or structural concerns in need of repair or rehabilitation.

Estimate the number of housing units within the jurisdiction that are occupied by low- or moderate-income families that contain lead-based paint hazards (91.205(e), 91.405).

CHAS data also provides an estimate for the number of housing units constructed prior to 1980 that are occupied by households with young children. In the Consortium, there are 98,502 low- and moderate-income households that live in a unit constructed prior to 1980. Of these households, 14,897 include at least one child aged six years or younger. Although housing units built prior to 1980 are not necessarily in need of lead-based paint remediation, the age of the housing unit and presence of young children indicates there is a possible risk of lead-based paint exposure. Lower income households with young children that reside in units with lead-based paint hazard may be less able to afford remediation services.

MA-25 Public and Assisted Housing - 91.410, 91.210(b)

Introduction

KCHA and RHA provide a variety of affordable housing opportunities to some of the Consortium's lowest income households. In its FY 2024 MTW Plan, KCHA notes that the agency aims to pursue various funding opportunities, subsidies, and partnerships to expand housing assistance. Examples include acquiring additional special purpose vouchers, pursuing property acquisition and new development opportunities, activating banked public housing subsidies, utilizing project-based rental assistance to increase permanent supportive housing, over-leasing the HCV program, and more. In its FY 2024 Annual Plan, RHA describes the agency's continued efforts to expand affordable housing opportunities through its partnership with the Homestead Community Land Trust and continuation of the agency's redevelopment plan to replace antiquated housing units to improve housing opportunities for residents.

Currently, KCHA manages a portfolio of 2,416 public housing units, 2,426 project-based vouchers, and 11,819 tenant-based vouchers while RHA manages 303 project-based vouchers and 886 tenant-based vouchers. Table 37 outlines the total number of units and vouchers available at the housing authorities by program type.

Table 37: Total Number of Units by Program Type

Program Type									
	Certificate	Mod-Rehab	Public Housing	Vouchers					
				Total	Project-based	Tenant-based	Special Purpose Voucher		
							Veterans Affairs Supportive Housing	Family Unification Program	Disabled *
# of units/vouchers available	N/A	N/A	2,416	15,434	2,729	12,705	841	449	1,992
# of accessible units	N/A	N/A	119	N/A	N/A	N/A	N/A	N/A	N/A

*Includes Non-Elderly Disabled, Mainstream One-Year, Mainstream Five-year, and Nursing Home Transition
Data Source: 2023 PHA data.

Describe the supply of public housing developments.

KCHA currently manages 2,416 public housing units and notes in its FY 2024 MTW Plan that the agency plans to add 36 additional public housing units to its inventory in the upcoming fiscal year. These units are located at Illahee Apartments in Bellevue and include 22 studio/one-bedroom units and 14 two-bedroom units. Currently, KCHA has not determined whether the units will be targeted to a specific population. The FY 2024 MTW Plan also indicates that KCHA does not plan to remove any public housing units from the agency's inventory over the next fiscal year. Lastly, KCHA intends for 195 vouchers to be newly project-based over the next fiscal year.

Describe the number and physical condition of public housing units in the jurisdiction, including those that are participating in an approved Public Housing Agency Plan.

KCHA provided recent data on the public housing inspection scores for 40 KCHA public housing developments Table 38). HUD requires that public housing developments be assessed to ensure that housing is decent, safe, sanitary, and in good repair. Developments can receive a maximum score of 100 from an inspection, with higher scores indicating that a property better meets HUD's housing quality and inspection requirements. Among KCHA's public housing developments, properties received an average inspection score of 91 and a median score of 94. The lowest-scoring development received a score of 59 and the highest-scoring development received a score of 99. There were three scores that were outliers and received scores under 73. Compared to publicly available inspection score data from 2021, KCHA's average public housing score is higher than the average inspection score of 86 for all public housing developments located in King County.

Table 38: KCHA Public Housing Development Inspection Scores

Public Housing Development	Inspection Score
Salmon Creek	86
Eastbridge	59
Island Crest	94
Houghton	85
Westminster	84
Kirkland Place	95
Forest Glen	97
Mardi Gras	91
Park Royal	89
Casa Madrona	94
Burndale Homes	92
Northridge I & Northridge II	96
College Place & Eastside Terrace	99
Cedar Grove	72
Firwood Circle	86
Lake House & Briarwood	91
Zephyr	94
Sixth Place	72

Public Housing Development	Inspection Score
Northlake House	97
Southridge House	98
Vantage Point	94
Paramount House	80
Casa Juanita	92
Plaza Seventeen	75
Yardley Arms & Munro Manor	99
Boulevard Manor	94
Cascade Homes	99
Fairwind	94
Shelcor	99
Northwood	89
Hillsview	94
Nia	97
Northwood Square	99
Seola Crossing	90
Wayland Arms & Gustaves Manor	99
Valli Kee	94
Ballinger Homes	86
Burien Park	99
Riverton Terrace Sr. & Pacific Court & Brittany Park	99
Brookside	88

Data Source: 2023 KCHA data.

Describe the restoration and revitalization needs of public housing units in the jurisdiction.

KCHA continues to improve housing quality and the physical condition of its public housing units through the agency's recapitalization efforts and investments to extend the life expectancy of its housing stock while also considering the environmental impact of restoration and development activities. KCHA routinely makes capital upgrades to extend the useful life of its properties. For example, as part of the agency's unit upgrade program, in 2024 KCHA's in-house workforce will perform renovations to approximately 135 units to extend the useful life by 20 years. As the impacts of climate change become more apparent, KCHA has sought to improve its properties while also reducing dependency on fossil fuels and resource consumption. In FY 2024, KCHA plans to continue its recapitalization efforts and invest $16.5 million in MTW working capital toward upgrading the agency's federal housing inventory. This investment will provide upgrades to improve housing quality, lower maintenance costs, and reduce energy consumption in the long-term.

Describe the public housing agency's strategy for improving the living environment of low- and moderate-income families residing in public housing.

To further its mission of transforming lives through housing, KCHA works with community partners to provide supportive services to its residents. The agency's Neighborhood Early Learning Connectors program provides a community-based model for families with young children to form networks and share resources with other

households and support early childhood development. KCHA also provides a robust resident services department that works individually with residents to increase household stability and provide resources to assist residents in meeting their basic needs. The agency’s resident services department also includes workforce development programs that help adults improve job readiness and financial literacy. The department also provides nutritious food to households and increasingly partners with local healthcare delivery systems to support residents' overall health. Lastly, KCHA aims to develop properties with sufficient access to available transit and supportive services in the community.

MA-30 Homeless Facilities and Services - 91.410, 91.210(c)

Introduction

As explained in NA-40 Homeless Needs Assessment, the Seattle/King County CoC provides housing, shelter, and supportive services to people experiencing homelessness in King County and is led by KCRHA. KCRHA publishes various dashboards, reports, and plans on its website that provide the public with detailed information on the people and households served and the performance of the homelessness response system. The MA-30 Homeless Facilities and Services section includes data on the number of beds and units available in the Consortium.

CoC Housing and Shelter Terms
The following section uses specific terms to refer to housing and shelter for people experiencing homelessness including:

- **Emergency shelter:** Temporary shelter for people experiencing homelessness. Emergency shelter is typically provided for a limited period of time such as 90 days.
- **Permanent supportive housing:** Permanent housing paired with supportive services to assist chronically homeless individuals and families. HUD defines "chronically homeless" as an individual with a disability who lives in a place not meant for human habitation, a shelter, or an institutional care facility. Chronically homeless individuals must have been living in any of these situations for at least 12 months or on four separate occasions over the past three years.
- **Rapid rehousing:** A form of permanent housing that provides short-term or medium-term rental subsidy and supportive services to quickly move people experiencing homelessness into permanent housing.
- **Transitional housing:** Temporary housing with supportive services to help people transition from homelessness to permanent housing. Transitional housing is usually provided for anywhere between two weeks and 24 months.
- **Other permanent housing:** Includes other forms of permanent housing that are not considered permanent supportive housing or rapid rehousing. Includes housing only as well as housing with supportive services.

Facilities Targeted to People Experiencing Homelessness

Table 39 provides data on the number of beds and units available to various subpopulations by program type across the Consortium. There are 1,554 emergency shelter beds, 849 transitional housing beds, and 1,868 permanent supportive housing beds in the Consortium. Most emergency shelter and transitional housing beds are designated for families (households with adults and children) and households with only adults while more permanent supportive housing beds are set aside for adult-only households, chronically homeless individuals, and veterans. In addition to the beds listed in Table 39, there are 298 rapid rehousing beds and 3,004 other permanent housing beds to house people experiencing homelessness in the Consortium.

Table 40 provides additional information on the types of units and beds in the Consortium's inventory. This table indicates that there are beds and units designated for victims of domestic violence including 85 emergency shelter beds, 57 rapid rehousing beds, 35 transitional housing beds, and 18 other permanent housing beds.

Table 39: Facilities Targeted to People Experiencing Homelessness

Subpopulation	Emergency Shelter Beds		Transitional Housing Beds	Permanent Supportive Housing Beds	
	Year-Round Beds (Current & New)	Voucher, Seasonal, and Overflow Beds	Current & New	Current & New	Under Development
Households with Adult(s) and Child(ren)	899	0	686	110	0
Households with Only Adults	635	0	153	304	0
Chronically Homeless Households	0	0	0	243	0
Veterans	4	0	6	1,211	0
Unaccompanied Youth	16	0	4	0	0
Total Beds Available	1,554	0	849	1,848	0

Data Source: 2023 HIC.

Table 40: Current Unit and Bed Inventory

Beds and Units in Inventory	For Adults and Children		For Adults Only		For Children Only		Veterans	Victims of Domestic Violence
	# Beds	# Units	# Beds	# Units	# Beds	# Units	# Beds	# Beds
Emergency Shelter	817	259	632	635	16	16	4	85
Transitional Housing	651	234	153	153	4	4	6	35
Permanent Supportive Housing	222	186	435	304	0	0	1,211	0
Rapid Rehousing	158	78	82	84	0	0	1	57
Other Permanent Housing	909	315	2,077	2,077	0	0	0	18

Data Source: 2023 HIC.

Describe mainstream services, such as health, mental health, and employment services to the extent those services are used to complement services targeted to homeless persons.

KCRHA and partner agencies, organizations, and service providers work to coordinate mainstream services with those targeted to assist people experiencing homelessness. KCRHA's Five Year Plan describes how people experiencing unsheltered homelessness, poverty, substance use, and violent victimization often face barriers to accessing healthcare such as being unable to access facilities, being unavailable during office hours, and facing stigma surrounding their circumstances. Such barriers can prevent people from accessing medical and mental health treatment. To address these challenges, partners work together to make system-to-system connections between the homelessness response system, behavioral health system, public health, hospital, and healthcare systems, and educational system. Examples include:

- The Crisis Response Program deploys Crisis Responder Mental Health Professionals with police to serve the community in North and East King County to better serve people experiencing a behavioral health crisis.
- The Law Enforcement Assisted Diversion program brings the homelessness response system, criminal-legal system, and healthcare system together to provide case management, pathways to housing, alternatives to incarceration, and healthcare access.
- Medical Respite programs aim to prevent people who are unhoused and have complex or acute medical needs from being discharged to homelessness or shelters that are unable to provide sufficient care.

List and describe services and facilities that meet the needs of homeless persons, particularly chronically homeless individuals and families, families with children, veterans and their families, and unaccompanied youth. If the services and facilities are listed on screen SP-40 Institutional Delivery Structure or screen MA-35 Special Needs Facilities and Services, describe how these facilities and services specifically address the needs of these populations.

Tables 41-45 list the number of beds and units for emergency shelter, transitional housing, rapid rehousing, permanent supportive housing, and other permanent housing by organization and subpopulation designation in the Consortium. There are designated units for families, adult-only households, child-only households, youth, veterans, chronically homeless individuals, and victims of domestic violence.

Table 41: Emergency Shelter Bed/Unit Inventory in the Consortium

Organization	Households with Children		Adult-Only Beds	Child-Only Beds	Veteran Beds	Youth Beds	Chronic Homeless Beds	Domestic Violence Beds	Year-Round Beds
	# Beds	# Units							
Auburn Food Bank			55						55
Catholic Community Services (King County)	72	20	53						125
Congregations for the Homeless			154						154
Domestic Abuse Women's Network (DAWN)	27	10	3					30	30
Friends of Youth			15	16		15			31
FUSION	87	29							87
Hopelink	65	19							65
Hospitality House			9						9
Lake City Partners Ending Homelessness			60						60
Lifewire	55	10							55
Mamma's Hands	16	4							16
Mary's Place	410	113							410
Multiservice Center (MSC)	64	15							64
Renton Ecumenical Association of Churches (REACH)	35	9							35

Organization	Households with Children		Adult-Only Beds	Child-Only Beds	Veteran Beds	Youth Beds	Chronic Homeless Beds	Domestic Violence Beds	Year-Round Beds
	# Beds	# Units							
Snoqualmie Valley Shelter Services	6	3	23						29
The Sophia Way			21						21
YMCA of Greater Seattle			12			12			12

Data Source: 2023 HIC for projects with a geocode located in the Consortium. *Beds/units could be designated for more than one subpopulation. Some bed/unit data may not be included to protect client confidentiality.

Table 42: Transitional Housing Bed/Unit Inventory in the Consortium

Organization	Households with Children		Adult-Only Beds	Child-Only Beds	Veteran Beds	Youth Beds	Chronic Homeless Beds	Domestic Violence Beds	Year-Round Beds
	# Beds	# Units							
Acres of Diamonds	58	36	1						59
Attain Housing (formerly KITH)	134	34							134
Catholic Community Services (King County)			12						12
Congregations for the Homeless			18						18
Friends of Youth	37	9	4	4		41			45
FUSION	61	16							61
Hopelink	166	56							166
Lifewire	35	10						35	35
Lighthouse	8	2							8

Organization	Households with Children		Adult-Only Beds	Child-Only Beds	Veteran Beds	Youth Beds	Chronic Homeless Beds	Domestic Violence Beds	Year-Round Beds
	# Beds	# Units							
Multiservice Center (MSC)			6		6				6
St Stephen Housing Association	86	20							86
Vision House	138	41							138
YMCA of Greater Seattle			8			8			8

Data Source: 2023 HIC for projects with a geocode located in the Consortium. *Beds/units could be designated for more than one subpopulation. Some bed/unit data may not be included to protect client confidentiality.

Table 43: Rapid Rehousing Bed/Unit Inventory in the Consortium

Organization	Households with Children		Adult-Only Beds	Child-Only Beds	Veteran Beds	Youth Beds	Chronic Homeless Beds	Domestic Violence Beds	Year-Round Beds
	# Beds	# Units							
African Community Housing & Development			2						2
Friends of Youth	8	3	9			8			17
Integration Family Services (IFS)									0
Lifewire	45	17	2			10		47	47
Reclaiming our Greatness	4	1	8			1			12
Solid Ground	12	4						12	12
YouthCare			8			7			8
YWCA of Seattle, King and Snohomish Counties - King County	36	13	4		1			40	40

Data Source: 2023 HIC for projects with a geocode located in the Consortium. *Beds/units could be designated for more than one subpopulation. Some bed/unit data may not be included to protect client confidentiality.

Table 44: Permanent Supportive Housing Bed/Unit Inventory in the Consortium

Organization	Households with Children		Adult-Only Beds	Child-Only Beds	Veteran Beds	Youth Beds	Chronic Homeless Beds	Domestic Violence Beds	Year-Round Beds
	# Beds	# Units							
Compass Housing Alliance	55	16	33		33		44		88
Congregations for the Homeless			69						69
Imagine Housing	11	4	23		21				34
King County Housing Authority	295	89	616		616				911
King County Veterans Program	32	9	102		102				134
Low Income Housing Institute (LIHI)			7		7				7
Multiservice Center (MSC)	25	6	42		42				67
Sound Mental Health			53						53
The Sophia Way			38						38
Valley Cities Counseling and Consultation	87	30	38		24		36		125
YMCA of Greater Seattle			15			15			15
YWCA of Seattle, King and Snohomish Counties - King County	98	32					68		98

Data Source: 2023 HIC for projects with a geocode located in the Consortium. *Beds/units could be designated for more than one subpopulation. Some bed/unit data may not be included to protect client confidentiality.

Table 45: Other Permanent Housing Bed/Unit Inventory in the Consortium

Organization	Households with Children		Adult-Only Beds	Child-Only Beds	Veteran Beds	Youth Beds	Chronic Homeless Beds	Domestic Violence Beds	Year-Round Beds
	# Beds	# Units							
Attain Housing (formerly KITH)	8	3							8
Catholic Community Services (King County)			10						10
Domestic Abuse Women's Network (DAWN)	18	6						18	18
Friends of Youth	26	16				26			26
Hopelink	129	43							129
Imagine Housing	164	38	50						214
King County Housing Authority	30	10	782						812
Multiservice Center (MSC)			15						15
Renton Housing Authority	10	3	782						792

Data Source: 2023 HIC for projects with a geocode located in the Consortium. *Beds/units could be designated for more than one subpopulation. Some bed/unit data may not be included to protect client confidentiality.

MA-35 Special Needs Facilities and Services - 91.410, 91.210(d)

Introduction

Special needs populations include, but are not limited to, persons who have a mental illness or disability, have a physical or self-care disability, persons with substance abuse disorder, those living with HIV/AIDS, and seniors.

Including the elderly, frail elderly, persons with disabilities (mental, physical, developmental), persons with alcohol or other drug addictions, persons with HIV/AIDS and their families, public housing residents, and any other categories the jurisdiction may specify, describe their supportive housing needs.

Elderly and Frail Elderly
Since 2006, the King County Veterans, Seniors, and Human Services Levy (VSHSL) has funded a wide range of programs that connect seniors, veterans, military service members, and their families with affordable housing, employment, behavioral health treatment, and other services. The VSHSL promotes housing stability among seniors and veterans by supporting the building, preservation, and operation of affordable housing and housing navigation centers. In addition, the VSHSL funds organizations providing culturally and regionally specific services to seniors, such as Asian Counseling and Referral Services and El Centro de La Raza. Finally, the levy funds senior centers, health organizations, and other non-housing projections to enhance the lives of seniors.

King County's Health Through Housing Initiative, which aims to end chronic homelessness, also provides housing and supportive services to seniors. In 2023, the program assisted 459 people aged 50 and older.

Persons with Disabilities
King County funds a variety of programs to help persons with disabilities find and maintain affordable housing that meets their needs. As of 2024, King County has 6,266 units of permanent supportive housing available to individuals with disabilities or substance abuse disorders, according to the 2024 Housing Needs Assessment. As of 2022, 1,366 of these units are funded through the Health Through Housing Initiative which targets people experiencing chronic homelessness and includes those with disabilities, behavioral health conditions, and chronic illnesses.

In addition, the King County Integrated Care Network (KCICN) provides supportive and subsidized housing for people with mental illness and the King County Developmental Disabilities Division works to refer individuals with developmental disabilities to affordable housing and prevent homelessness. The Consortium also funds non-profit organizations, including The Arc of King County, that work to provide housing navigation and housing opportunities for individuals with disabilities.

Persons with a Mental Illness
Persons with a mental illness need crisis services, mental health treatment, substance use disorder treatment, and programs to help people with behavioral health challenges avoid jail or hospital visits. The Crisis Care Centers Initiative will create a countywide

network of crisis care centers, stabilize mental health residential treatment access and provide for a well-supported behavioral health workforce. This network of crisis care centers will provide much needed resources such as someone to contact, respond, a safe place to go and someone to follow up. People experiencing mental health crises may need walk-in behavioral health care access and the potential for short-term stays to stabilize.

Persons with Substance Abuse Disorder
The County's permanent supportive housing units are available to individuals with disabilities and those with substance abuse disorders, with housing first and harm reduction central to our approach. People experiencing chronic homelessness, including those with substance use disorders, are among those prioritized for housing in our coordinated entry system. To help connect people with substance abuse disorder to supportive housing, King County Housing Finance team consults with the DCHS Behavioral Health and Recovery Division regarding housing opportunities. In addition, a 2022 Sub-Regional Analysis of Homelessness in King County found that most housing providers utilize external referrals for substance abuse disorder services. Approximately five housing providers have onsite substance abuse services, while a few housing providers have no ability to provide or refer people with substance abuse disorder to specialized services.

Finally, King County's MIDD (Mental Illness and Drug Dependency) Behavioral Health Sales Tax supports programs that provide for crisis diversion, early intervention, and system improvement for those experiencing a mental health condition or a substance abuse disorder. Recovery supports are a core component of MIDD services, which includes stable housing, homelessness prevention, employment and community reentry services, and peer-based recovery supports.

Persons with HIV/AIDS
The Seattle Human Services Department is the regional coordinator for Housing Opportunities for Persons With AIDS (HOPWA) funds in King County. The agency is in the fourth year of implementing the End the HIV Epidemic initiative which supports community-based organizations that provide housing case management and allocates HOPWA-funded housing assistance. The Initiative focuses on cross-collaboration with housing, mental health, and substance abuse services.

Public Health – Seattle & King County also receives Ryan White funds, which are used, in part, to fund organizations with housing programs such as Lifelong and Bailey Boushay House. In fiscal year 2022, the Ryan White program funded 14,832 transitional and emergency bed nights to serve people in King, Island and Snohomish Counties.

Public Housing Residents
As stated in NA-35, KCHA and RHA serve low-income residents living in the Consortium with housing assistance. KCHA serves people living in King County outside the cities of Seattle while RHA serves residents of Renton. KCHA manages a portfolio of 2,416 public housing units, 2,426 project-based vouchers, and 11,819 tenant-based vouchers while RHA manages 303 project-based vouchers and 886 tenant-based vouchers. The data also indicates that a significant number of public housing residents

and voucher holders are over the age of 62 and members of households with at least one person with a disability.

Describe programs for ensuring that persons returning from mental and physical health institutions receive appropriate supportive housing.

People with medical conditions, particularly people experiencing housing instability or homelessness often need access to care and a safe place to recover after leaving the hospital. KCRHA's Five Year Plan notes that experiencing homelessness can create and exacerbate physical, mental, and behavioral health conditions, and many who experience homelessness have complex medical needs. For those with medical conditions, recuperative housing or medical respite programs. KCRHA currently partners with medical respite programs to prevent people who are unhoused and have complex or acute medical needs from being discharged to homelessness or shelters that are unable to provide sufficient care. In addition, the Health Through Housing Initiative provides permanent supportive housing and wraparound services for individuals experiencing chronic homelessness which includes people who have been incarcerated in the past five years or involuntarily committed at any time, in addition to having a disability, behavioral health condition, or chronic illness. Lastly, the MIDD (Mental Illness and Drug Dependency) Behavioral Health Sales tax provides recovery and reentry services for those experiencing crisis. Programming includes stable housing services for people experiencing homelessness, employment support services, peer-based recovery supports, and community reentry services after incarceration. These programs have helped decrease emergency department visits, reduced substance abuse, and reduced adult jail bookings long-term.

Specify the activities that the jurisdiction plans to undertake during the next year to address the housing and supportive services needs identified in accordance with 91.215(e) with respect to persons who are not homeless but have other special needs. Link to one-year goals. 91.315(e).

King County's Housing Finance Program includes special needs units in each funding year awards. These units are under a contractual requirement for a 50-year term. In addition, King County publishes an annual RFP that provides funding for operating support, rental assistance, and supportive services linked to non-time limited housing and services (permanent supportive housing) for people moving from homelessness. In 2024, King County will award $12 million worth of funding through that RFP.

King County works with housing funders, mainstream service systems, such as the developmental disabilities, substance use disorder, and mental health systems, and with housing referral information and advocacy organizations to plan for community-based housing options for persons with special needs.

MA-40 Barriers to Affordable Housing - 91.410, 91.210(e)

Describe any negative effects of public policies on affordable housing and residential investment.

Member jurisdictions of the Consortium engage in ongoing efforts to advance public policy to increase the supply of affordable housing for County residents. Challenges to affordable housing and residential investment in the Consortium include:

- The need for affordable housing opportunities outpaces the current ability of the Consortium and partner organizations to develop new units.
- The cost and coordination of supporting ongoing operating and service costs across a growing portfolio of permanent supportive housing units.
- Rapidly escalating rents, particularly in the private market, create housing instability.
- Residents feel displacement pressures as they move further from jobs and transportation to seek lower housing costs, which increases transportation costs for households.
- Following the end of pandemic-era rental assistance programs and protections, rents in many communities significantly increased and placed financial strain on households across the County.
- Past zoning practices create barriers to multi-family zoning and townhomes.

MA-45 Non-Housing Community Development Assets - 91.410, 91.210(f)

Introduction

In determining priorities for the allocation of CDBG funds, the Consortium recognizes the need to foster a competitive local economy that expands economic opportunities for current and future residents. The MA-45 Non-Housing Community Development Assets section of the Consolidated Plan summarizes data trends related to employment and the workforce including labor force participation, educational attainment, and workforce skills training and development efforts in the County.

King County is home to a diverse economy noted for its robust technology, information, and professional services hubs in cities like Seattle and Bellevue as well as its sizeable aerospace, aviation, and manufacturing industries. Multiple Fortune 500 companies, including Microsoft and Amazon, are headquartered in the County. While the region is characterized by a highly educated workforce and strong economy, region-level data often obscures the financial difficulties of many lower-income people trying to get by in a high-cost market. As a result, several public agencies and local planning organizations in King County and the broader region are pursuing economic and workforce development initiatives geared towards equitably expanding opportunities and access for lower income people and historically marginalized communities while promoting continued economic growth.

Economic Development Market Analysis

Table 46: Business Activity in the Consortium

Business by Sector	Workers		Jobs	
	Number	Percent	Number	Percent
Agriculture, Mining, Oil & Gas Extraction	2,558	0%	1,693	0%
Arts, Entertainment, Accommodations	30,883	6%	54,546	8%
Construction	34,492	6%	48,225	7%
Education and Health Care Services	90,287	16%	135,769	19%
Finance, Insurance, and Real Estate	36,686	7%	38,769	6%
Information	20,649	4%	94,131	13%
Manufacturing	63,673	12%	63,329	9%
Other Services	17,525	3%	20,429	3%
Professional, Scientific, Management Services	124,887	23%	65,982	9%
Public Administration	18,912	3%	16,899	2%
Retail Trade	60,498	11%	83,111	12%
Transportation and Warehousing	33,322	6%	41,375	6%
Wholesale Trade	17,267	3%	40,454	6%
Total	551,639	100%	704,712	100%

Data Source: 2017-2021 ACS (Workers), 2021 Longitudinal Employer-Household Dynamics (Jobs)

Table 47: Labor Force

Total Population in the Civilian Labor Force	821,041
Civilian Employed Population 16 years and over	572,036
Unemployment Rate	4.5%
Unemployment Rate for Ages 16-24	11.9%
Unemployment Rate for Ages 25-65	3.8%

Data Source: 2018-2022 ACS.

Table 48: Occupations by Sector

Occupations by Sector	Number of People
Management, business, and financial	402,219
Farming, fisheries, and forestry occupations	2,050
Service	111,123
Sales and office	136,806
Construction, extraction, maintenance, and repair	47,297
Production, transportation, and material moving	81,969

Data Source: 2018-2022 ACS.

Table 49: Travel Time

Travel Time	Number	Percent
< 30 Minutes	319,618	52%
30-59 Minutes	225,323	37%
60 or More Minutes	65,463	11%
Total	610,404	100%

Data Source: 2018-2022 ACS.

Table 50: Educational Attainment by Employment Status (Population Aged 25 and over)

Educational Attainment	In Labor Force		Not in Labor Force
	Civilian Employed	Unemployed	
Less than high school graduate	58,852	2,625	16,752
High school graduate (includes equivalency)	140,708	6,084	34,552
Some college or Associate's degree	221,459	8,347	44,253
Bachelor's degree or higher	429,874	10,213	62,748

Data Source: 2018-2022 ACS.

Table 51: Educational Attainment by Age

	Age				
	18–24 years	25–34 years	35–44 years	45–65 years	65+ years
Less than 9th grade	1,568	4,537	8,047	15,768	9,466
9th to 12th grade, no diploma	15,164	8,252	8,733	13,515	7,324
High school graduate, GED, or alternative	33,746	38,837	34,662	67,209	42,395
Some college, no degree	30,939	38,674	33,808	73,600	45,801
Associate's degree	9,268	18,600	20,169	36,608	16,982
Bachelor's degree	16,773	73,806	71,035	113,443	52,851
Graduate or professional degree	1,403	43,276	56,802	71,512	36,277

Data Source: 2018-2022 ACS.

Table 52: Median Earnings in the Past 12 Months

Educational Attainment	Median Earnings in the Past 12 Months
Less than high school graduate	$36,510
High school graduate (includes equivalency)	$44,236
Some college or Associate’s degree	$52,272
Bachelor’s degree	$87,204
Graduate or professional degree	$116,347

Data Source: 2018-2022 ACS.

Based on the Business Activity table above, what are the major employment sectors within your jurisdiction?

According to 2021 ACS data, the highest percentage of workers are employed in the Professional, Scientific, and Management Services sector. Twenty-three percent of Consortium workers are employed in this sector, whereas just nine percent of jobs in the Consortium are in this sector. Another notable sector in the Consortium includes Education and Health Care Services, which comprises 16 percent of workers and 19 percent of jobs. The Seattle-Bellevue metropolitan area serves as a major employment center for the region, so large discrepancies between the number of workers and jobs in the Consortium are likely due to removing data for Seattle from the estimates in the Business Activity table. During the consultation process for the Consolidated Plan, stakeholders noted that due to high housing costs in Seattle, many people who work in the city look for less expensive housing options elsewhere in King County.

2021 ACS and LEHD data align with other information on the economic characteristics of the region. King County is home to a cluster of information, technology, and professional services companies and as noted by the King County Office of Economic and Financial Analysis, eight Fortune 500 companies are headquartered in the County, including Amazon and Starbucks in Seattle. Three Fortune 500 companies are located in the Consortium including Costco in Issaquah, Microsoft in Redmond, and Paccar in Bellevue. In addition, Boeing Commercial Airplanes is headquartered in Renton. In addition, there is a strong

industrial and manufacturing sector in the Consortium. Kent, in particular, has strong historical ties to manufacturing and according to the Kent Valley Economic Development Corporation, Kent Valley is home to more than 12,000 businesses and over 50,000 manufacturing jobs, 31,200 of which are in the aerospace or outer-space industry. The Office of Economic and Financial Analysis reports that King County's industry composition is similar to peer counties such as Cook County, Illinois, and Maricopa County, Arizona.

In addition to ACS data, the U.S. Census Bureau's 2021 Longitudinal Worker-Household Dynamics (LEHD) data provides insight into the labor and commuting patterns in King County. For people who are employed in King County, 23 percent live in Seattle. Seattle is also the place where most people (39 percent) who live in King County work.

2021 LEHD data also provides insight into the people who are employed in King County but live outside the County and the people who live in King County but are employed outside the County. Among all workers employed in King County, 835,365 (64 percent) also live in the County while the remaining 36 percent live outside of the County. Conversely, 154,266 (16 percent) employed people live in King County but leave the County for work.

Describe the workforce and infrastructure needs of the business community.

The Workforce Development Council of Seattle – King County (WDC) is a nonprofit grant-making organization with the goal of furthering workforce development efforts that empower individuals, foster economic growth, and ensure resilient and thriving communities. In the organization's 2024 Workforce Innovation and Opportunity Act (WIOA) Local Plan, WDC provides data and information on the regional economy, quality of jobs, and workforce development needs across different sectors and industries. The plan describes the current and future job needs of the economy and notes that in 2023 Seattle and King County's three most in-demand sectors and occupations were: (1) professional, scientific, and technical services, (2) health care and social assistance, and (3) information. The main components of the information sector are the publishing industries, including software publishing, and both traditional publishing and publishing exclusively on the internet; the motion picture and sound recording industries; the broadcasting industries, including traditional broadcasting and those broadcasting exclusively over the internet; the telecommunications industries; Web search portals, data processing industries, and the information services industries. In the coming years, however, employment projections highlight that the following sectors will add the most jobs to the economy:

- management of companies and enterprises (41,859 jobs, 48 percent growth)
- professional, scientific, and technical services (18,729 jobs, 12 percent growth)
- information (12,038 jobs, nine percent growth)
- health care and social assistance (10,238 jobs, six percent growth)
- transportation and warehousing (7,752 jobs, 12 percent growth)
- accommodation and food service (6,042 jobs, six percent growth).

Notably, the plan indicates that among sectors projected to lose jobs are retail trade (29,696 jobs, 28 percent loss) and manufacturing (2,811 jobs, three percent loss).

In an assessment of the skills, knowledge, and qualification needs for in-demand sectors in the region, WDC indicates that the Seattle-King County labor market largely is in need of skills and certifications required by Healthcare and Information occupations. WDC notes

that skills currently in demand should not be analyzed in isolation since they represent a snapshot of needs in time and do not capture the rapidly changing structure of work and skills, for example, related to the automation of jobs or changes due to renewable energy.

Describe any major changes that may have an economic impact, such as planned local or regional public or private sector investments or initiatives that have affected or may affect job and business growth opportunities during the planning period. Describe any needs for workforce development, business support or infrastructure these changes may create.

WDC's WIOA Local Plan also includes the organization's six priority opportunity sectors for Seattle-King County. At the regional level, WDC identifies construction, healthcare, information technology, manufacturing, maritime, and retail trade as their six priority opportunity sectors for workforce development based on an evaluation multiple criteria for each sector including the following:

- size and presence in the regional economy
- post-pandemic job recovery and growth prospects
- wages and benefits
- education and training requirements
- career pathways
- workplace safety
- sector engagement, commitment, and readiness (e.g., industry associations, engaged unions, etc.).

For each of the six opportunity sectors, the plan describes WDC's strategies to support regional and local initiatives to address workforce development needs and mitigate disparities and challenges in accessing well-paying jobs. For example, for the construction sector, WDC notes that a collaboration of public agencies including Seattle, King County, the Port of Seattle, Seattle Public Schools, and Washington State Department are working to expand access to well-paying construction jobs while addressing race and gender-based disparities. For the manufacturing sector, despite the projected loss of jobs in upcoming years, production occupations in the sector are expected to generate nearly 16,000 total job openings annually due to replacement needs. And while specific manufacturing occupations such as assembly and fabrication are expected to decline, occupations related to software development, testing, computer systems, and other fields are likely to increase. Given that the sector offers a range of well-paying jobs that are accessible to people with varying levels of educational attainment, WDC and the Pacific Northwest Aerospace Alliance are exploring strategies for broadening access to manufacturing jobs.

At the county-level, the 2021 King County Countywide Planning Policies provide a framework for the County's planned economic development in which, "growth in King County occurs in a compact, centers-focused pattern that uses land and infrastructure efficiently, connects people to opportunity, and protects rural and natural resources lands." In line with these policies, the County is focused on investments to create a sufficient number of jobs and housing opportunities across urban growth centers to support businesses and infrastructure changes. In doing so, the Countywide Planning Policies also emphasize support for middle-wage jobs and protections for historically marginalized groups

such as people identifying as BIPOC and LGBTQ+ residents throughout development activities.

How do the skills and education of the current workforce correspond to employment opportunities in the jurisdiction?

ACS data from 2022 indicates that among the population aged 25-64 in the Consortium, 51 percent of people have obtained a Bachelor's degree or higher which is slightly lower than the same figure for King County (57 percent). Among Consortium residents with this level of education, 97 percent of individuals in the labor force are employed.

Multiple sources note that the region is one of the most educated in the country and this can be attributed to highly educated individuals moving to King County from out of state or other countries for employment opportunities. This aligns with 2022 ACS data which indicates that 72 percent of people who moved to King County from out of state or abroad within the past year had a Bachelor's degree or higher while 60 percent of people who moved within King County over the past year had a Bachelor's degree or higher. When excluding Seattle and Milton, 65 percent of people who moved to the Consortium from out of state or abroad had a Bachelor's degree or higher while 52 percent of people who moved within the Consortium had a Bachelor's degree or higher.

In addition, a HUD Comprehensive Housing Market Analysis for the Seattle-Bellevue metropolitan area noted that in 2022, international net in-migration to the area increased as a result of easing COVID effects and policies and rapid hiring in the technology industry. At the same time, domestic net out-migration to the area decreased due to rising interest rates, Big Tech companies announcing return-to-office policies, and easing housing market conditions. Over the past few years, most people who moved to the Seattle metro area from elsewhere in the U.S. came from California markets and the Portland, Oregon metro area. Most people who left the Seattle metro area relocated to lower-cost markets elsewhere in the state of Washington.

While the region is characterized by a highly educated workforce and strong economy, region-level data often obscures the financial difficulties of many lower-income people trying to get by in a high-cost market. A 2021 report developed for WDC by the University of Washington summarized the disparity between higher-income and lower-income households in King County:

> *"In 2021, two parents and a preschooler [in King County] need $90,727 per year to cover their basic needs in East King County and $84,478 in Seattle. The top occupation in the Seattle-Tacoma-Bellevue Metropolitan Statistical Area (MSA) is software developer with median annual earnings of $151,960 in 2021. However, the second two most common occupations in this region are fast food and counter workers and retails salespersons who have median annual earnings of $33,960 and $34,980 respectively. The wage stratification between fast food and counter workers, as well as retail salespersons, in comparison to software developers, underscores the disparity in households' ability to navigate escalating inflation and growing costs. While some households are better equipped to handle these challenges, others face an increased risk of economic hardships."*

The report also explored the geographic variation in what it terms the “inadequacy rate,” or the percentage of households in a given area whose earnings fail to match the rising cost of basic needs. The report calculated a “self-sufficiency standard” for different areas that represents the needed income to cover basic needs for expenses including housing, childcare, food, transportation, healthcare, and more for that given area. The data indicates that the area including Federal Way, Des Moines, and Vashon Island has the highest share of households (38 percent) whose incomes are below the self-sufficiency standard. In contrast, the area including Sammamish, Issaquah, Mercer Island, and Newcastle has the lowest share of households (12 percent) whose incomes are below the standard.

Describe any current workforce training initiatives, including those supported by Workforce Investment Boards, community colleges and other organizations. Describe how these efforts will support the jurisdiction's Consolidated Plan.

Numerous organizations, public agencies, and groups collaborate within King County and the broader region on economic and workforce development initiatives. WDC partners with the Puget Sound Regional Council (PSRC), the Metropolitan Seattle Chamber of Commerce, and the Greater Seattle Partners. WDC’s WIOA Local Plan noted that regional partners have recently coordinated plans for economic and workforce development on topics including cultivating local talent, aligning talent with economic needs and opportunities, addressing inequalities in access to opportunities, reviewing public policy strategies, and considering growth and/or reforms in training and credentialing. The plan notes that the regional partnership aims to bring about meaningful systemic change.

In addition, King County’s Office of Economic Opportunity and Creative Economy works to promote equitable, regional economic development, growth, and recovery. The Office partners with WDC on the County’s regional workforce development strategy, which strives to expand career pathways for adults and youth through demand-driven workforce and training programs. WDC funds programs for adults, dislocated workers, and youth.

The Career Launchpad program through King County’s Children, Youth, and Young Adults Division also provides career navigation, job opportunities, and advancement skill building to 16- to 24-year-olds in the County. The program is available in multiple locations across the County.

At a broader regional level, PSRC serves as the federally designated economic development district for King, Kitsap, Pierce, and Snohomish Counties and established the 2022-2026 Regional Economic Strategy that includes 160 detailed implementation activities for promoting equitable economic growth. The Strategy describes a variety of workforce development activities to expand education and workforce training programs that target the needs of regional employers. Examples include expanding pre-apprenticeship training for recognized and new pre-apprenticeship programs, supporting apprenticeship development for small and mid-sized firms, expanding efforts to equitably recruit students into workforce training programs, and providing benefits and wraparound supports to improve access to educational resources.

Does your jurisdiction participate in a Comprehensive Economic Development Strategy (CEDS)? If so, what economic development initiatives are you undertaking that may be coordinated with the Consolidated Plan? If not, describe other local/regional plans or initiatives that impact economic growth.

PSRC established a 2022-2026 Regional Economic Strategy to serve as the framework for regional planning and collaboration between King, Kitsap, Pierce, and Snohomish Counties. The Strategy serves as the Comprehensive Economic Development Strategy (CEDS) for the central Puget Sound region and the Central Puget Sound Economic Development District updates the Strategy every five years. The Strategy aims to build regional workforce capacity, guide economic growth and resiliency, and align with other regional planning efforts.

The 2022-2026 Strategy outlines three main goals to guide the region's economic development: (1) Expanding Economic Opportunity, (2) Maintaining Global Competitiveness, and (3) Sustaining Quality of Life. The Strategy outlines 23 broad strategies encompassing 160 detailed implementation activities that include existing and future efforts to work towards each goal and include the following types of initiatives:

- **Expanding Economic Opportunity:** incorporate equity into all initiatives, provide childcare, promote jobs across various types of communities, and expand broadband access throughout the region.
- **Maintaining Global Competitiveness:** foster business recovery from the impacts of the pandemic and promote industry resilience through diversification.
- **Sustaining Quality of Life:** preserve and expand affordable housing options across the region and align with transportation and job-creation investments, address chronic homelessness, and promote the health and wellbeing of residents and communities across the region.

The goals and initiatives outlined in the Consortium's Consolidated Plan align with the overarching goals and many of the broad strategies included in the Regional Economic Strategy including encouraging economic growth across all parts of the region, ensuring a diversity of housing stock that is affordable and connected to jobs, and making the region a healthy place to live, work, and play for all residents.

MA-50 Needs and Market Analysis Discussion

Are there areas where households with multiple housing problems are concentrated? (include a definition of "concentration")

The Consortium has identified Skyway-West Hill and North Highline as areas where households with multiple housing problems are concentrated. The Consortium identified these areas using input from the consultation and public participation process as well as reviewing data on HUD-identified R/ECAPs. R/ECAPs are census tracts in which the population is majority non-White and has a poverty rate greater than 40 percent or three or more times the average tract poverty rate of the metropolitan area, whichever threshold is lower. In this context, areas with a concentration of households experiencing multiple housing problems can include areas that qualify as R/ECAPs or areas identified through the consultation and public participation process as having high numbers of households living in units in need of rehabilitation or households experiencing housing cost burden. Skyway-West Hill and North Highline are located in unincorporated King County. Sixty-four percent of Skyway-West Hill's population includes people identifying as BIPOC, while this figure is 54 percent for North Highline. Both neighborhoods have higher percentages of residents that are foreign born, multilingual, or have limited English proficiency relative to King County as a whole. Median household incomes are much lower in both areas compared to those for the County and both areas have witnessed sharp annual increases in rent contributing to housing cost burden.

Are there any areas in the jurisdiction where racial or ethnic minorities or low-income families are concentrated? (include a definition of "concentration")

The Consortium has identified South Park, in unincorporated King County, and the City of Kent as areas where racial or ethnic minorities and/or low-income families are concentrated. In addition, there are five census tracts in the Consortium that are designated HUD R/ECAPs; three are located in Kent, one in SeaTac, and one in Federal Way. The Consortium identified these areas using input from the consultation and public participation process as well as reviewing data on HUD-identified R/ECAPs. In this context, areas with a concentration of racial or ethnic minorities or low-income families can include areas that qualify as R/ECAPs or areas identified through the consultation and public participation process as having high numbers of low-income households or people of color. More information on these R/ECAPs is provided in the Needs Assessment.

What are the characteristics of the market in these areas/neighborhoods?

For many areas across King County with concentrations of low-income households and people of color, communities are increasingly facing rising housing costs and greater competition for available housing units. Some of these areas have historically included naturally occurring affordable housing, however, population growth in the region and high demand for housing units has contributed to the displacement of lower income households. Displacement occurs when households must involuntarily move as a result of factors like housing market forces, disinvestment in communities of color, redevelopment projects, and new investments. For those forced to relocate, there can be lasting adverse impacts on health, education, earnings, and cultural connections.

Are there any community assets in these areas/neighborhoods?

Several of these areas have strong ties to communities of faith, public school identification and pride, and multiple generations of families living in the area. In addition, there are multiple active community-based organizations based in these areas such as White Center CDA and the Skyway Coalition.

Are there other strategic opportunities in any of these areas?

The Consortium is beginning an affordable homeownership project using the land trust model in Skyway. King County recently selected Homestead Community Land Trust for the venture, which will be a 14-acre site.

MA-60 Broadband Needs of Housing Occupied by Low- and Moderate-Income Households - 91.210(a)(4), 91.310(a)(2)

Describe the need for broadband wiring and connections for households, including low- and moderate-income households and neighborhoods.

While 95 percent of households in the Consortium have access to broadband internet, four percent, or 21,188 households, have no internet access. Households without internet do not have equal access to resources such as those provided by government agencies, schools, and employers. King County's 2020 Broadband Access Study found that low- and moderate-income households are more likely to lack internet access. Eighty percent of households earning less than $25,000 annually in King County have access to Internet services, compared to 96 percent of the total County population.

A 2024 Broadband and Digital Equity Report conducted by the King County Department of Information Technology (KCIT) identified broadband needs in rural (defined as a territory that does not meeting the criteria to be an urban area) and urban (defined as a territory that includes at least 2,000 housing units or has a population of at least 5,000 people), King County. In rural areas, the report identified the need for fiber infrastructure construction for areas without existing broadband connectivity. According to the report, providing fiber infrastructure would be cost prohibitive in approximately 29 percent of rural King County, and satellite technology would be required instead. For urban King County, the report highlights needed upgrades and extensions to existing infrastructure.

The 2024 KCIT report also describes how KCIT issued a request for information (RFI) in March 2023 for project proposals to enhance broadband connectivity to unserved and underserved areas in King County. In response to the RFI, private internet service providers began identifying projects to improve connectivity to more than 6,500 locations by leveraging over $21M in private investment. KCIT plans to continue to identify potential project locations, working closely with internet service providers to enhance broadband connectivity throughout King County.

Other strategies to increase broadband access in unserved areas include King County supporting internet service providers in applying for federal ReConnect grants, developing public-private partnerships for rural infrastructure development, and developing a "dig once" policy. Infrastructure investment is necessary to reach unserved households, however, direct broadband support programs are necessary to reach underserved households. King County offers an Affordable Connectivity Program to provide low-income households $30-$75 monthly broadband subsidy to offset costs. The County conducted a broad outreach strategy to raise awareness about the program to low-income households and areas. Lastly, KCIT is also exploring strategies to expand broadband access to unserved areas, provide free broadband services to residents, and supplement County fiber services to public housing buildings by providing private sector mobile service to residents.

Describe the need for increased competition by having more than one broadband Internet service provider serve the jurisdiction.

King County has multiple broadband internet service providers, with no area having access to less than three broadband providers. Available technologies include ADSL, Cable, Fiber,

Fixed Wireless, and Satellite. In addition, King County has several non-cellular broadband providers including Century Link, Comcast, Frontier, Xfinity, and Wave.

MA-65 Hazard Mitigation - 91.210(a)(5), 91.310(a)(3)

Describe the jurisdiction's increased natural hazard risks associated with climate change.

King County works closely with partners on emergency plans and protocols in the event of natural disasters. The County attributes some of these events to climate change and recognizes that increased atmospheric Greenhouse Gasses (GHGs) are linked to increased severity and frequency of natural disasters and extreme weather events. The 2020 Strategic Climate Action Plan (SCAP) outlines the increased risk of flooding and wildfires as well as the associated impacts of low winter snowpack, hotter summers, and heavy rain events.

Communities within King County face differing impacts based on their location, demographics, and preparedness. The 2020 SCAP has placed an emphasis on equity in its strategy to ensure that low access and high-risk communities are equally prepared for annual climate events such as severe droughts, extreme heat, wildfire conditions/smoke events, and low snowpack. It has also laid out a strategy for unpredictable natural disasters such as floods and severe snow events. Besides the inherent danger of these storms, snow, rain, and wind bring long-term recovery costs in the millions of dollars to housing and related infrastructure.

Describe the vulnerability to these risks of housing occupied by low- and moderate-income households based on an analysis of data, findings, and methods.

Common natural hazards in King County include flooding events and snowstorms. As the impacts of climate change become more apparent, King County anticipates an increase in the prevalence of other hazards such as extreme heat, smoke, and wildfire events that pose public health and safety risks particularly to low- and moderate-income people. Notable weather events include record snowstorms in February 2019 and February 2021. An extreme heat event in June 2021 also took the lives of 20 King County residents. King County experiences annual summer smoke events and low air quality resulting from droughts and wildfires throughout the region.

To better assist vulnerable communities, King County created an Environmental Exposure Index based on proxies of opportunity, higher pollution exposure, existing inequities, and lower health and economic wellbeing indicators. High exposure communities are often concentrated in South King County and partially in rural communities. High exposure communities will likely feel the impacts of climate change induced hazards more often and severely than low exposure communities. King County operates an emergency coordination center and established protocols to coordinate emergency response among municipal partners in the event of an emergency. This includes providing additional shelter beds in the event of severe weather situations or emergencies. In addition, King County's Post Disaster Interim Emergency Housing Plan outlines the County's housing response for communities in unincorporated King County following an emergency.

The SCAP outlines the County's five-year framework for mitigating the impacts of climate change while uploading equity, engaging with communities, and reducing health disparities. The 2020 SCAP builds upon the progress from the 2015 SCAP targets and outcomes which include the following:

- launched the Frontline Community Climate Partnerships program

- contributed to an 11 percent reduction in emissions per capita over the last decade
- increased total transit ridership by 14 million annual trips from 2015 to 2019
- transitioned transit fleets to clean energy
- focused more than 98.5 percent of new residential development in urban areas
- launched the Land Conservation Initiative to accelerate efforts to permanently protect open space lands, farmlands, forestlands, urban green spaces, and trails
- created a partnership that planted one million trees throughout King County
- supported a 50 percent increase in green building certifications from 2015 to 2019
- implemented the King County-Cities Climate Collaboration (K4C)
- led efforts of cities representing 80 percent of King County residents to advance transformational state energy policies
- advanced the Local Food Initiative, supporting local farmers and making access to locally grown, nutritious food more equitable
- strengthened and Developed adaptation strategies to address sea level rise
- launched the Puget Sound Climate Preparedness Collaborative, to improve the climate preparedness of the entire Puget Sound Region.

Strategic Plan

SP-05 Overview

The Strategic Plan section of the Consolidated Plan outlines the Consortium's goals, objectives, and specific strategies to work towards those goals and objectives over the next five federal fiscal years. Most of the strategies have output goals based on the funding projected to be available for the five-year period of the Consolidated Plan. If funding changes significantly during the five-year period of the Consolidated Plan, the Consortium may amend the output goals through its JRC.

An important consideration for this Strategic Plan is the impact the COVID-19 pandemic had, and continues to have, on the County and partner agencies, organizations, and groups. The retirement of baby boomers has significantly impacted the available workforce and jurisdictions across the County continue to experience staffing shortages. Nonprofit partners also report significant employee turnover due to burnout, adverse mental health impacts, and insufficient pay to afford living expenses. Finally, the pandemic drastically changed the way many County programs operate, for example, by prompting the County to move towards funding non-congregate shelters to provide more space for clients. Other factors such as supply chain issues, a concrete strike, and a shortage of labor and contractors, have delayed many County-funded construction projects. Given these factors, the Consortium is taking a conservative approach to estimating the anticipated outcomes for CDBG, HOME, and ESG-funded activities for the upcoming five years of the 2025-2029 Consolidated Plan.

Priorities

King County invests in the following priorities: projects that predominantly serve households at or below 60 percent AMI; mixed-income projects that serve a portion of households at or below 30 percent AMI; projects that include homeless households and vulnerable populations; projects that embrace evidence-based best practices; projects that are located and designed thoughtfully, considering connectivity, health and access to transit; and projects that reduce their screening barriers for tenants.

All programs and projects reflect values of equity and social justice, including equitable development principles. For example, projects should avoid or minimize displacement of existing affordable housing or community assets such as small businesses or cultural institutions. When impacts are anticipated, community engagement and mitigation actions should be included. Housing projects that require a Certificate of Consistency with the Consolidated Plan should be consistent with other goals in the Consolidated Plan.

The Consortium's desired outcomes for each goal are impacted by many factors, especially the growing economy, the health of other federal programs, such as the Section 8 program, Low-Income Housing Tax Credits, and other federal, state, and local funding streams that King County does not control and that are far beyond the capability of the Consortium's strategies to accomplish alone. For that reason, it is particularly important to work across sectors toward shared outcomes that will help all partners make progress toward shared goals. Annual output goals for each of the strategies in this plan are dependent upon the continuation of the applicable fund sources.

SP-10 Geographic Priorities - 91.415, 91.215(a)(1)

Introduction

King County allocates CDBG and HOME funds throughout the region. KCRHA allocates ESG funds throughout the region.

CDBG and ESG

Allocations for CDBG and ESG funds are based upon the percentage of low-and-moderate-income populations in the North/East and South sub-regions. The North/East sub-region includes the cities and towns of Beaux Arts Village, Bellevue, Bothell (King County portion), Lake Forest Park, Medina, Mercer Island, Newcastle, North Bend, Shoreline, Skykomish, Snoqualmie, Sammamish, Issaquah, Kenmore, and unincorporated King County.

The South sub-region includes the cities and towns of Algona, Auburn, Black Diamond, Burien, Covington, Des Moines, Federal Way, Kent, Maple Valley, Normandy Park, Pacific, Renton, SeaTac, Tukwila, Vashon-Maury Island, and unincorporated King County.

HOME

King County's Housing Finance Program awards HOME funds through a competitive process and distributes funds to the members of the HOME Consortium, which includes King County and the cities of Auburn, Bellevue, Kent, and Federal Way, in addition to the CDBG and ESG cities listed in the Executive Summary of this plan.

General Allocation Priorities

Describe the basis for allocating investments geographically within the jurisdiction.

The Consortium allocates funds to address strategies under the three overarching goal areas: 1) Increase Affordable Housing; 2) Prevent and Mitigate Homelessness; and 3) Enhance Community and Economic Development. Investments are distributed throughout the County, and guidelines adopted by the Consortium balance investments geographically over time. Allocation guidelines are determined through use of low- and moderate-income population data, and other data, as applicable.

King County also considers other local plans and initiatives in making allocation decisions, such as plans regarding climate change, transit-oriented development, equity and social justice, the KCRHA 5-year Plan, the Best Starts for Kids Implementation Plan, the Veterans, Seniors, and Human Services Levy Implementation Plan, the Crisis Care Centers Levy Implementation Plan, and the Health Through Housing Initiative.

In 2024, King County adopted the King County Comprehensive Plan, which has key goals of establishing vibrant, thriving, healthy, and sustainable communities. The King County Comprehensive Plan aligns with the Washington State Growth Management Act, VISION 2050's Multicounty Planning Policies, and the King County Countywide Planning Policies regarding establishing and implementing clear goals for affordable housing. The KCCP includes broad funding priorities for affordable housing. The King County Comprehensive Plan promotes affordable housing for all county residents through support for adequate funding, zoning, and regional cooperation to create new and diverse housing choices in communities throughout the county. As part of this work, King County adopted zoning

ordinances for urban unincorporated King County to expand missing middle housing zoning and reduce barriers to emergency shelter and permanent supportive housing, such as reducing parking requirements for these housing types.

Transit Oriented Development

The Consortium will prioritize investments in affordable housing and eligible community development projects near high-capacity transit, including high-capacity bus routes, bus rapid transit, and light rail. Future light rail lines will be completed in the next planning period serving East King County, North King County, and South King County, continuing with additional new routes to serve the region. King County's Department of Community and Human Services works with King County Metro and Sound Transit to identify publicly owned land that may be developed for affordable and mixed-use housing within a half mile walkshed of high-capacity or frequent transit, including bus rapid transit.

Communities of Opportunity

The Communities of Opportunity initiative in King County invests in strategies that build power for community-based organizations to advance structural change toward equity. Current awardees include organizations such as the Seattle Indian Health Board, Look 2 Justice, Horn of Africa Services, FEEST and Disability Rights Washington. In addition to funding from Communities of Opportunity, the White Center Community Development Association and the White Center HUB project received $450,000 in CDBG funding and $757,194 in HOME funding. Community of Opportunity partners are working to advance policies that support community priorities, integrate equity into policies, and expand representation of cultural communities.

SP-25 Priority Needs - 91.415, 91.215(a)(2)

Introduction

The sort order column in the Priority Needs table simply identifies the order of the priority need in the table and does not signify the rank or importance of the priority.

Table 53: Priority Needs

1	**Priority Need Name**	Affordable Housing
	Priority Level	High
	Population	• Extremely Low-income • Low-income • Moderate-income • Large Families • Families with Children • Elderly and Frail Elderly • Public Housing Residents • Chronically Homeless Individuals • People with Mental Illness • People with Chronic Substance Abuse Disorders • Veterans • Survivors of Domestic Violence • Unaccompanied Youth • People with Physical Disabilities • People with Alcohol or Other Addictions
	Geographic Areas Affected	Countywide and potential Neighborhood Revitalization Strategy Areas
	Associated Goals	Increase Affordable Housing
	Description	The Consortium will work to preserve and expand the supply of affordable housing by funding activities such as the development of new affordable rental and homeownership units, preserving existing rental units, and providing housing repair for income eligible homeowners and renters. The Consortium will plan for and support fair housing strategies and initiatives designed to affirmatively further fair housing choice, increase access to housing and housing programs, and reduce discrimination towards protected classes.
	Basis for Relative Priority	The information analyzed and summarized in the Needs Assessment and Market Analysis underscores the need for additional affordable housing units for lower income households across the Consortium. The 2021 King County Countywide Planning Policies estimates that communities in the Consortium will need an additional 196,627 housing units by 2044. Among these additional needed units, the Consortium needs 124,308

		new housing units that are affordable to households earning less than 80 percent AMI. Other concerns such as the high percentage of low- and moderate-income households experiencing housing cost burden and the need for homeowner housing repair contribute to significant needs for affordable housing options and assistance programs in the Consortium.
2	**Priority Need Name**	Homelessness
	Priority Level	High
	Population	• Extremely Low-income and Low-income • Large Families • Families with Children • Elderly and Frail Elderly • Public Housing Residents • Rural Residents • Chronically Homeless Individuals • People with Mental Illness • People with Chronic Substance Abuse Disorders • Veterans • Survivors of Domestic Violence • Unaccompanied Youth • People with Mental Disabilities • People with Physical Disabilities • People with Developmental Disabilities • People with Alcohol or Other Addictions • Non-housing Community Development
	Geographic Areas Affected	Countywide and potential Neighborhood Revitalization Strategy Areas
	Associated Goals	Prevent and Mitigate Homelessness
	Description	The Consortium will support public service activities that prevent homelessness and reduce the number of households experiencing homelessness by funding activities such as rapid re-housing, emergency shelters, diversion, and housing stability programs. The Consortium will engage in planning and other activities and initiatives to reduce homelessness in collaboration with the KCRHA, Washington State, and local jurisdictions.
	Basis for Relative Priority	2022 HMIS data indicates that 17,669 people experienced homelessness over the course of the year in the Consortium and that many people experiencing homelessness in the Consortium were homeless for over a year. The nature and extent of homelessness in the region has prompted the Consortium and its partners to continue to fund programs and services to meet the needs of this population while preventing others from experiencing episodes of homelessness.

3	**Priority Need Name**	Community and Economic Development
	Priority Level	High
	Population	• Extremely Low-income • Low-income • Moderate-income • Large Families • Families with Children • Elderly and Frail Elderly • Rural Residents • Chronically Homeless Individuals • People with Mentally Illness • People with Chronic Substance Abuse Disorders • Veterans • Survivors of Domestic Violence • Unaccompanied Youth • People with Mental Disabilities • People with Physical Disabilities • People with Developmental Disabilities • People with Alcohol or Other Addictions • Non-housing Community Development
	Geographic Areas Affected	Consortium-wide, North/East sub-region, South sub-region, and potential Neighborhood Revitalization Strategy Areas
	Associated Goals	Enhance Community and Economic Development
	Description	The Consortium will support investments across the county in low-income communities to promote access to thriving, connected, and inclusive communities by funding activities such as infrastructure improvement, sidewalks, community center rehabilitation, economic development, microenterprise programs, and other non-housing public services.
	Basis for Relative Priority	While King County and the surrounding region is characterized by a highly educated workforce and strong economy, region-level data often obscures the financial difficulties of many lower-income people trying to get by in a high-cost market. For many lower income people and communities in the Consortium, income inequality and lack of investment have contributed to high needs for public services—including food, childcare, and transportation assistance—as well as high needs for community and economic development activities such as community centers, public infrastructure improvements, and job training/workforce development programs.

SP-30 Influence of Market Conditions - 91.415, 91.215(b)

Introduction

The Seattle-Bellevue metropolitan area is a high-cost housing market characterized by low rental vacancy rates and high demand for housing units. Considerable economic growth over time has contributed to income inequality in the region, many lower-income households experiencing cost burden and severe cost burden, and a shortage in housing units for different income levels. Other market conditions, including insufficient incomes to afford the cost of living, increased competition for housing due to population growth, and high interest rates pose significant challenges not only for low- and moderate-income people, but the public agencies, organizations, and groups operating programs to serve them. Table 54 outlines various market characteristics that influence affordable housing programs and summarizes the Consortium's efforts to address or mitigate these challenges.

Table 54: Influence of Market Conditions

Affordable Housing Type	Market Characteristics that will influence the use of funds available for housing type
Tenant Based Rental Assistance (TBRA)	In its FY 2024 MTW Plan, KCHA notes how factors including increased population growth in King County, low vacancy rates, and rising rents have increased the competition for affordable rental units, particularly among lower-income renters. For people trying to use a tenant-based voucher and those with barriers to housing stability — such as criminal histories, eviction histories, and low credit scores — securing a rental unit in the private market can be a significant challenge. KCHA continues to use a variety of methods to ameliorate some of these barriers including: • Establishing contracts with nonprofits to provide housing search assistance. • Maintaining housing navigators at KCHA to assist voucher recipients. • Monitoring a ZIP code-based payment standard system to track changes in market rents and adjust payment standards semi-annually. • Conducting landlord outreach and retention efforts. • Establishing expedited inspection processes. • Providing security deposit assistance and flexible assistance funds to mitigate financial leasing barriers for people with special purpose vouchers.
TBRA for Non-Homeless Special Needs	Many of the same market constraints — including low rental vacancy rates and increased competition for rental units — that impact tenant-based rental assistance programs also impact rental assistance for special needs populations including seniors, victims of gender-based violence, and people with disabilities. During the consultation process for the Consolidated Plan, stakeholders

Affordable Housing Type	Market Characteristics that will influence the use of funds available for housing type
	noted that seniors living on a fixed income are often unable to afford their portion of rent despite subsidies.
New Unit Production	A HUD Comprehensive Housing Market Analysis of the Seattle-Bellevue metro area notes that construction activity of rental housing units increased significantly in 2021 and 2022 during a period when the region's population growth slowed due to the continued impact of the pandemic. The current level of rental construction has decreased to pre-pandemic levels in response to eased apartment market conditions. While supply chain issues caused by the pandemic have eased, local builders indicate that the lack of labor is an ongoing issue. While the construction of market-rate rental housing may not necessarily reflect the construction of affordable housing units, similar market challenges including land constraints, high construction costs, high interest rates, and lack of labor are market conditions also noted by stakeholders in the Consortium. Other notable challenges specific to affordable housing production include: • The declining value of federal funding for housing development. • The gap in funding from all sources (including local, state, federal, philanthropic, tax credits, and private debt) to adequately meet current affordable housing production needs. • The lack of affordable housing developers and contractors. • Infrastructure capacity limitations. • Displacement and the risk of displacement of low- and moderate-income people from their communities due to new affordable housing production.
Rehabilitation	King County currently funds programs that offer resources for housing repair and rehabilitation such as the Housing Repair Program which provides grants and no-interest loans for housing repair services to low-income homeowners and special needs renters in most parts of King County. Funding can support repairs including roof replacement, installing a new septic system, repairs in response to emergency conditions, health and safety repairs, and major building preservation issues within single-family owner-occupied homes. In recent years, there continues to be a high demand for housing unit rehabilitation and repair assistance, particularly for senior homeowners living on fixed incomes that are unable to maintain their units themselves. Among the affordable housing stock, housing providers in the Consortium note the need for investment in repairs and long-term strategies to maintain assisted units. In its 2024 MTW Plan, KCHA

Affordable Housing Type	Market Characteristics that will influence the use of funds available for housing type
	notes plans to continue the agency's recapitalization efforts and invest $16.5 million in MTW working capital to upgrade its federal housing stock. The investments will address needed repairs, improve housing quality, reduce maintenance costs and energy consumption, and extend the life expectancy of housing units.
Acquisition, including preservation	In its 2024 MTW Plan, KCHA notes the agency's strategy to add to the region's supply of affordable housing by acquiring and preserving units. The agency continues to use MTW resources to preserve affordable housing at risk of market-rate redevelopment and create additional affordable housing opportunities in partnership with the state and local jurisdictions. KCHA also looks for opportunities to purchase small- to medium-sized apartment complexes and utilize banked public housing subsidies. The agency's partnerships with major regional technology companies have enabled the acquisition and preservation of over 2,000 units of non-subsidized housing over the past several years. KCHA leverages available MTW flexibilities in order to find innovative strategies to acquire and preserve affordable housing units.

SP-35 Anticipated Resources - 91.420(b), 91.215(a)(4), 91.220(c)(1,2)

Introduction

The Consortium receives three federal entitlement grants on an annual basis. These federal funds include: (1) CDBG in the approximate annual amount of $5,300,000; (2) HOME in the approximate annual amount of $3,200,000; and (3) ESG in the approximate annual amount of $275,000. These three resources are listed in Table 55. Other federal, state, and local funds are listed below.

Like the federal formula grants, other resources come with restrictions and regulatory requirements regarding allowed uses. Some, such as Low-Income Housing Tax Credits (LIHTC) and CoC funds, are secured through competitive applications and are not listed. Some of the following list of funds, such as the Regional Affordable Housing Program (RAHP), provide leverage annually for federal dollars:

- Consolidated Homeless Grant: $ 5,156,168
- Housing and Essential Needs: $26,129,304
- King County Document Recording Fee: $8,966,946
- MIDD (Mental Illness and Drug Dependency) local behavioral health sales tax: $7,984,705
- King County Veterans and Human Services Levy: $8,587,161
- Regional Affordable Housing Program: $1,326,097
  Transit Oriented Development: $56,000,000 for 2025. Any future Transit Oriented Development funding would be determined in future King County budgets.

Table 55: Anticipated Resources

Program	Source of Funds	Uses of Funds	Expected Amount Available Year 1				Expected Amount Available Remainder of Con Plan ($)	Narrative Description
			Annual Allocation	Program Income	Prior Year Resources	Total for Year One		
CDBG	Federal HUD	• Community Facilities • Public Improvements • Public Services • Economic Development • Housing • Administration • Planning	$5,300,000	$400,000	$0	$5,700,000	$22,800,000	Resources anticipated based upon 2024 entitlement.
HOME	Federal HUD	• Permanent housing for rental and homeownership • Housing Repair • Administration	$3,200,000	$200,000	$0	$3,400,000	$13,600,000	Resources anticipated based upon 2024 entitlement.
ESG	Federal HUD	• Homeless Prevention • Emergency Housing • Administration	$275,000	$0	$0	$275,000	$1,100,000	Resources anticipated based upon 2024 entitlement.
Total Federal Grant Resources			$8,775,000	$600,000	$0	$8,935,000	$37,500,000	

Explain how federal funds will leverage those additional resources (private, state and local funds), including a description of how matching requirements will be satisfied.

Federal funds leverage private, state, and local funds. The sources of matching funds for housing funded with HOME are the RAHP funds and the Veterans, Seniors, and Human Services Levy (VSHSL) capital funds. The RAHP funds are a dedicated, state-adopted housing resource (a document recording fee surcharge) administered by King County and targeted to the creation of affordable housing. The VSHSL capital funds are local dollars targeted to housing development projects that serve veterans, seniors, and other vulnerable populations. Owner contributions provide the source of match for the HOME-funded, ownership occupied rehabilitation activities. The RAHP funds provide the primary source of match for ESG projects.

If appropriate, describe publicly owned land or property located within the jurisdiction that may be used to address the needs identified in the plan.

The King County Facilities Management Division, working with the landholding King County departments, assesses if King County-held properties are needed to provide essential public services. If the property is not needed for essential services, the Facilities Management Division will issue a Notice of Surplus Property (Notice). The Department of Community and Human Services reviews the Notice and determines if the property would be suitable for affordable housing. In June, the Facilities Management Division issues an annual report regarding all Notices in the past year.

In 2023, King County worked with Skyway community members in designing a Request for Proposal (RFP) for the right to negotiate directly with the County for potential development of affordable housing at Brooks Village, a 14.3-acre parcel of undeveloped land owned by King County. In early 2024, King County selected Homestead Community Land Trust (CLT), in partnership with Skyway Coalition, to directly negotiate with King County to assess the viability of the Brooks Village site for affordable housing. If the pre-development assessments show favorable results, the organizations propose to develop up to 57 permanently affordable homeownership units serving households at 50-80 percent AMI on the developable land at Brooks Village.

In addition to the King County surplus property program, a number of partner jurisdictions and Sound Transit have similar programs to make land available for affordable housing, through either donation or a long-term lease at favorable terms.

SP-40 Institutional Delivery Structure - 91.415, 91.215(k)

Explain the institutional structure through which the jurisdiction will carry out its consolidated plan including private industry, non-profit organizations, and public institutions.

This section of the Consolidated Plan summarizes information gathered through multiple local and regional reports and strategic plans, as well as input from the consultation process, on the institutional delivery structure in the Consortium. The institutional delivery structure includes the entities that will carry out the objectives outlined in the Strategic Plan for CDBG, HOME, and ESG funds. There are numerous other entities in the region — such as ARCH, the Housing Development Consortium of Seattle-King County, PSRC, Seattle King County Coalition on Homelessness, South King Housing and Homelessness Partners, and the Washington Low Income Housing Alliance — that collaborate to meet the housing, homelessness, and community development needs through other resources and planning processes.

Table 57: Institutional Delivery Structure

Responsible Entity	Responsible Entity Type	Role	Geographic Area Served
King County DCHS – Housing, and Community Development Division	Government	King County is the lead for the Consortium and staffs the Regional JRC.	King County, WA
Regional Joint Recommendations Committee (JRC)	Governmental inter-jurisdictional body	The JRC provides funding recommendations and advice on guidelines and procedures for King County and its Consortium partners.	King County CDBG, HOME, and RAHP Consortium
King County Regional Homelessness Authority (KCRHA)	Government, CoC	KCRHA is the CoC and lead for homelessness initiatives in King County.	King County CDBG and ESG Consortium
King County Housing Authority	Government, PHA	KCHA is the PHA for most of the Consortium and provides housing opportunities for low-income people.	King County outside the Cities of Seattle and Renton, WA.
Renton Housing Authority	Government, PHA	RHA is the PHA for the city of Renton and provides housing opportunities for low-income people.	City of Renton, WA

Responsible Entity	Responsible Entity Type	Role	Geographic Area Served
City of Auburn	Government	The city administers the CDBG program for the city of Auburn.	City of Auburn, WA
City of Bellevue	Government	The city administers the CDBG program for the city of Bellevue.	City of Bellevue, WA
City of Federal Way	Government	The city administers the CDBG program for the city of Federal Way.	City of Federal Way, WA
City of Kent	Government	The city administers the CDBG program for the city of Kent.	City of Kent, WA
City of Burien	Government	The city is a Joint Agreement City member of the CDBG Consortium.	City of Burien, WA
City of Kirkland	Government	The city is a Joint Agreement City member of the CDBG Consortium.	City of Kirkland, WA
City of Redmond	Government	The city is a Joint Agreement City member of the CDBG Consortium.	City of Redmond, WA
City of Renton	Government	The city is a Joint Agreement City member of the CDBG Consortium.	City of Renton, WA
City of Shoreline	Government	The city is a Joint Agreement City member of the CDBG Consortium.	City of Shoreline, WA

Assess the strengths and gaps in the institutional delivery system.

The Consortium works closely with public and private funders to maximize program delivery and leverage other resources to extend the reach of its CDBG, HOME, and ESG funds. Among these other resources are Low-Income Housing Tax Credits, PHA-provided Section 8 and HUD-VASH (HUD-Veterans Affairs Supportive Housing) vouchers, private foundation funds, and local jurisdiction resources.

The following strengths, challenges, and gaps summarize key themes from existing King County plans, studies, and reports related to the Consortium's institutional delivery

structure. The following lists are not exhaustive but focus on factors related to the Consolidated Plan.

Strengths

- A strong, well-balanced economy that is home to several major industry centers.
- A countywide infrastructure for inter-jurisdictional coordination, planning, and recommendations for programming.
- Multiple state and local funding sources to support and supplement federally funded housing, homelessness, community development, and human services programs.
- Strong local and regional partnerships, collaborations, and initiatives that include public agencies, nonprofits, businesses, and other entities working together to advance positive and equitable change.

Challenges

- An expensive area that contributes to the high cost of living for residents as well as high costs for public agencies, nonprofits, and other entities to provide affordable housing, community development activities, and human services.
- High current unmet housing needs, particularly for lower income households, and high projected housing needs by 2044.
- Severely limited federal, state, and local resources to meet the growing regional housing need.
- Displacement and the risk of displacement for lower income communities due to gentrification and, in some cases, affordable housing and community development initiatives.
- Limited capacity among housing and human service providers to keep up with growing community needs.
- Disparities in access to available human services and a need for culturally and linguistically appropriate access and services.

Identified Gaps

- Expanded anti-displacement policies and programs for areas with rapidly increasing housing and land costs.
- Better support for community-based organizations in securing land and securing sites for homeownership projects.
- Additional resources to ensure that housing and service providers are offered livable wages given the high cost of living in King County.
- Additional funding from a variety of sources to meet current and projected housing needs.
- Additional funding and support to address administrative cost burdens.
- Implementation of equitable development strategies including sustained and flexible funding, technical assistance, and cross-sector partnerships.
- Investment in programs that provide fair housing, education, enforcement, and testing in King County.

Discuss the availability of services targeted to homeless persons and persons with HIV and mainstream services.

The Consortium includes CDBG entitlement cities and Joint Agreement cities that, through the Interlocal Cooperation Agreement process, direct human services funding to services for homeless populations and homelessness prevention. The Joint Agreement cities make independent funding decisions regarding the use of CDBG human service funding. While the Consortium serves people living with HIV/AIDS through existing human services, the Consortium does not have CDBG, HOME, or ESG-funded services specifically targeted to this population. The City of Seattle receives annual federal funding under the Housing Opportunities for Persons With AIDS (HOPWA) program which can fund a variety of housing and human services for people living with HIV/AIDS and their families. Seattle's Consolidated Plan outlines the specific goals, priorities, and uses of its HOPWA funds which provides more information on targeted services for this population available to people in the Consortium.

Table 57: Homeless Prevention Services Summary

Homelessness Prevention Services	Available in the Community	Targeted to the Homeless	Targeted to People with HIV
Homelessness Prevention Services			
Counseling/Advocacy	X	X	
Legal Assistance	X	X	
Mortgage Assistance	X		
Rental Assistance	X	X	
Utilities Assistance	X		
Landlord Mediation/Mitigation	X	X	
Street Outreach Services			
Law Enforcement	X	X	
Mobile Clinics	X	X	
Other Street Outreach Services	X	X	
Supportive Services			
Alcohol & Drug Abuse	X	X	
Childcare	X	X	
Education	X	X	
Employment and Employment Training	X	X	

Homelessness Prevention Services	Available in the Community	Targeted to the Homeless	Targeted to People with HIV
Healthcare	X	X	
HIV/AIDS	X	X	
Life Skills	X	X	
Mental Health Counseling	X	X	
Transportation	X	X	

Describe how the service delivery system including, but not limited to, the services listed above meet the needs of homeless persons (particularly chronically homeless individuals and families, families with children, veterans and their families, and unaccompanied youth).

KCRHA is responsible for the homelessness crisis response system for King County. The KCRHA 5-Year Plan states this overarching priority. “One Goal: Bring unsheltered people inside – in a way that meets their needs – as swiftly as possible.” Seven initial actions strategies include: 1) Increase shelters and emergency housing capacity, 2) expand medical recuperation and high-acuity programs, 3) pilot cash transfer programs for youth and young adults and families, 4) bring diversion programming up to scale, 5) change severe weather to seasonal shelter services, 6) pay fair wages, and 7) invest in system capacity.

KCRHA operates the region’s coordinated entry system to ensure that people experiencing homelessness have equitable access to housing resources and housing navigation support to help them secure permanent housing. Regional Access Points located in Seattle, South King County, North King County, and East King County provide an entry point to coordinated entry. Regional Access Points operate both on a walk-in and an appointment basis. Veterans experiencing homelessness can schedule an appointment for a coordinated entry evaluation by calling a Regional Access point or the Washington State Department of Veterans Affairs. Additionally, veterans can also get connected to housing resources and services through Operation: WelcomeOneHome. Young adults who are imminently at risk of homelessness within 14 days are also eligible for coordinated entry. Four additional access locations operate to serve young adults. Domestic Violence housing resources provide a parallel system of coordinated entry for survivors of domestic violence, distinct from the main King County coordinated entry system.

Providing supportive housing for people experiencing chronic homelessness creates a foundation of stability that makes it possible to address other needs. The Health through Housing Initiative accelerates King County's response to chronic homelessness by acquiring and preserving existing single-room properties such as hotels to provide emergency and permanent supportive housing for people experiencing chronic homelessness. By year-end 2023, HTH permanently secured a total of 1,358 supportive housing units. In 2023 alone, King County opened approximately 76 units, funded the operation of an additional 65 units, and continued operation of units which it opened in

2021 and 2022. In addition to property acquisitions, much of 2023's focus was expanding health-supportive services at HTH locations and cultivating new partnerships and agreements with cities and direct service organizations. Health Through Housing will open two more permanent supportive housing projects in 2024.

Describe the strengths and gaps of the service delivery system for special needs population and persons experiencing homelessness, including, but not limited to, the services listed above.

Strengths of the service delivery system include the following:

- regional approach to addressing homelessness
- a new program, the Health Through Housing Initiative, which repurposes hotels into permanent supportive and/or emergency housing
- local elected officials and staff in government, foundations, and nonprofits that are active at the national level, and provide regional leadership
- strong coordination with the Veteran's Administration
- strong ties to private foundations and philanthropic organizations such as United Way of King County, the Bill and Melinda Gates Foundation, the Seattle Foundation, and the Raikes Foundation
- three strong public housing authorities working in collaboration with the public funders
- recent approval of the Crisis Care Centers initiative by the voters of the King County that will provide new regional resources for behavioral health care.

Gaps of the service delivery system include the following:

- shrinking federal funds
- increasing numbers of unstably housed families and individuals due to the rising cost of rental housing
- unserved or underserved persons with serious behavioral health conditions and a shortage of behavioral health beds
- unserved or underserved persons involved with the justice system.

Provide a summary of the strategy for overcoming gaps in the institutional structure and service delivery system for carrying out a strategy to address priority needs.

In 2023, King County adopted amendments to the King County Countywide Planning Policies that established specific countywide and jurisdictional affordable housing needs by income level and for emergency housing that all jurisdictions would be responsible for planning for and accommodating in their comprehensive plan updates in 2024. The Countywide Planning Policies provide a framework within which all jurisdictions are called upon to plan for a range of affordable housing choices within neighborhoods that promote health, well-being, diversity, and access to opportunities for employment, recreation, social interaction and cohesion, active transportation (walking, biking, and public transit) and education. The Countywide Planning Policies also established an accountability framework for meeting these needs, which includes a housing-focused review of draft comprehensive plans, annual monitoring and reporting, and a check-in

and adjustment period to address significant shortfalls in planning for and accommodating need five years after plan adoption.

In 2024, King County adopted the King County Comprehensive Plan, which includes key goals of establishing vibrant, thriving, healthy, and sustainable communities. The King County Comprehensive Plan aligns with the Washington State Growth Management Act, VISION 2050's Multicounty Planning Policies, and the King County Countywide Planning Policies regarding establishing and implementing clear goals for affordable housing. To align with the Washington State Growth Management Act, the King County Comprehensive Plan promotes affordable housing for all county residents through support for adequate funding, zoning, and regional cooperation to create new and diverse housing choices in communities throughout the County. As part of this work, King County adopted zoning ordinances for urban unincorporated King County to expand missing middle housing zoning and reduce barriers to emergency shelter and permanent supportive housing, such as reducing parking requirements for these housing types.

SP-45 Goals - 91.415, 91.215(a)(4)

Introduction

The Consortium identified the following three goals to guide its CDBG, ESG, and HOME funding over the next five years:

Goal One: **Increase Affordable Housing:** The Consortium will work to preserve and expand the supply of affordable housing by funding activities such as the development of new affordable rental and homeownership units, preserving existing rental units, and providing housing repair for income eligible homeowners and renters. The Consortium will plan for and support fair housing strategies and initiatives designed to affirmatively further fair housing choice, increase access to housing and housing programs, and reduce discrimination towards protected classes.

Goal Two: **Prevent and Mitigate Homelessness:** The Consortium will support public service activities that prevent homelessness and reduce the number of households experiencing homelessness by funding activities such as rapid re-housing, emergency shelters, diversion, and housing stability programs. The Consortium will engage in planning and other activities and initiatives to reduce homelessness in collaboration with the King County Regional Homelessness Authority (KCRHA), Washington State, and local jurisdictions.

Goal Three: **Enhance Community and Economic Development:** The Consortium will support investments across the county in low-income communities to promote access to thriving, connected, and inclusive communities by funding activities such as infrastructure improvement, sidewalks, community center rehabilitation, economic development, microenterprise programs, and other non-housing public services.

The following tables provide additional information for each of the Consortium's goals including the estimated funding amounts, measures using HUD's specific goal outcome indicators, and goal descriptions. The tables summarize the priorities and anticipated outcomes for each goal over the five-year period.

Table 58: Goals Summary

Sort Order	Goal Name	Start Year	End Year	Category	Geographic Area	Needs Addressed	Funding	Goal Outcome Indicator
1	Increase Affordable Housing	2025	2029	Affordable Housing Homeless Non-Homeless Special Needs Public Housing	• Consortium-wide • North/East Sub-Region • South Sub-Region • Skyway • White Center • SeaTac/Tukwila • Kent • Vashon-Maury Island • Rural Snoqualmie Valley	Affordable Housing Homelessness	CDBG: $7,125,000 HOME: $17,000,000	Rental units constructed: **40** Household Housing Units Rental units rehabilitated: **10** Household Housing Units Homeowner Housing Added: **20** Household Housing Units Homeowner Housing Rehabilitated: **715** Household Housing Units
2	Prevent and Mitigate Homelessness	2025	2029	Homeless Affordable Housing	• Consortium-wide • North/East Sub-Region • South Sub-Region • Skyway • White Center • SeaTac/Tukwila • Kent • Vashon-Maury Island	Homelessness	CDBG: $4,275,000 ESG: $1,375,000	Overnight Homeless Shelter: **5,000** Persons Assisted Homelessness Prevention: **1,250** Persons Assisted

Sort Order	Goal Name	Start Year	End Year	Category	Geographic Area	Needs Addressed	Funding	Goal Outcome Indicator
					• Rural Snoqualmie Valley			Other (Homelessness Diversion): **5,000** Households Assisted
3	Enhance Community and Economic Development	2025	2029	Non-Homeless Special Needs Non-Housing Community Development	• Consortium-wide • North/East Sub-Region • South Sub-Region • Skyway • White Center • SeaTac/Tukwila • Kent • Vashon-Maury Island • Rural Snoqualmie Valley	Community and Economic Development	CDBG: $17,100,000	Public Facility or Infrastructure Activities Other Than Low- and Moderate-Income Housing: **125,000** Persons Assisted Businesses Assisted: **600** Businesses Public Services Other Than Low- and Moderate-Income Housing: 2,000 Persons Assisted

Goal Descriptions

1	**Goal Name**	**Increase Affordable Housing**
	Goal Description	The Consortium will work to preserve and expand the supply of affordable housing by funding activities such as the development of new affordable rental and homeownership units, preserving existing rental units, and providing housing repair for income eligible homeowners and renters. The Consortium will plan for and support fair housing strategies and initiatives designed to affirmatively further fair housing choice, increase access to housing and housing programs, and reduce discrimination towards protected classes.
2	**Goal Name**	**Prevent and Mitigate Homelessness**
	Goal Description	The Consortium will support public service activities that prevent homelessness and reduce the number of households experiencing homelessness by funding activities such as rapid re-housing, emergency shelters, diversion, and housing stability programs. The Consortium will engage in planning and other activities and initiatives to reduce homelessness in collaboration with KCRHA, Washington State, and local jurisdictions.
3	**Goal Name**	**Enhance Community and Economic Development**
	Goal Description	The Consortium will support investments across the County in low-income communities to promote access to thriving, connected, and inclusive communities by funding activities such as infrastructure improvement, sidewalks, community center rehabilitation, economic development, microenterprise programs, and other non-housing public services.

Estimate the number of extremely low-income, low-income, and moderate-income families to whom the jurisdiction will provide affordable housing as defined by HOME 91.315(b)(2).

Table 59 outlines the estimated number of households the Consortium expects to serve in one program year based on the number of housing units that the Consortium anticipates subsidizing with HOME funds.

Table 59: Estimates Number of HOME-Assisted Households

Housing Type	Units
Permanent Housing	8
Homeownership	4
Total	**12**
Income Level	**Units**
Affordable to 0%-30% of Area Median Income	4

Affordable to 31%-50% of Area Median Income	7
Affordable to 51%-80% of Area Median Income	1
Total	**12**

SP-50 Public Housing Accessibility and Involvement - 91.415, 91.215(c)

Describe the need to increase the number of accessible units (if required by a Section 504 Voluntary Compliance Agreement).

Both KCHA and RHA have met their Section 504 requirements.

Describe activities to increase resident involvement.

KCHA has a number of programs that aim to encourage self-sufficiency among recipients of subsidized housing assistance, including its Family Self-Sufficiency program, on-site workforce development training, and rent policies that allow residents to earn additional money before seeing an immediate change in their rent. Another initiative to increase resident involvement is through the Neighborhood Early Learning Connector program which employs public housing residents as staff and supports them in delivering services to eligible families with young children, in an effort to promote engagement with other families in public housing. KCHA also offers an opportunity for resident involvement through its Resident Advisory Committee which is comprised of KCHA residents living throughout the County who provide feedback on KCHA's policies and procedures. In addition, KCHA operates five manufactured housing communities, and both of its HOPE VI projects in White Center have included development of new market-rate homeownership. KCHA is working to identify partnerships, policies, and programs that could contribute to greater homeownership opportunities for low-income households across the region.

Is the public housing agency designated as troubled under 24 CFR part 902? If so, what is the plan to remove the 'troubled' designation?

KCHA is not designated as troubled. However, RHA is a troubled PHA. King County continues to monitor RHA's progress in working toward its FY 2022 Section Eight Management Assessment Program (SEMAP) Corrective Action Plan. As of April 2024, RHA plans to complete all the required actions outlined in its SEMAP Corrective Action Plan by June 30, 2024, and to regain its high performing status by the end of the year. The City of Renton has met with RHA staff and offered support to the agency to address its troubled designation. The city also noted that it plans to meet with RHA quarterly in the coming months.

SP-55 Strategic Plan Barriers to Affordable Housing - 91.415, 91.215(h)

Describe the barriers to affordable housing.

The King County Comprehensive Plan Housing Needs Assessment (Appendix B)identifies barriers to affordable housing that fall into four broad categories.

Zoning Barriers

- Zoning that supports single family housing and limits multi-family housing limits the types of housing developments, and
- Development codes that pose barriers to developing permanent supportive and emergency housing by creating logistical and financial challenges to increasing the supply of both types of housing.

Funding Shortfalls

- Affordable housing in the 0-50 percent AMI range requires public investment in the development phase (capital financing). In addition, some affordable housing developments may require ongoing operating or rental subsidies.
- Homeownership programs serving households with incomes between 50-80 percent AMI require additional development and, potentially, down payment assistance support, and
- Permanent supportive housing requires both substantial public investments in the development phase (capital financing) and ongoing funding for supportive services and operations.

Community-Driven Development

- A shortage of flexible funds or dedicated funds for advancing community-driven development for communities at risk of displacement exacerbates the risk of displacement, and
- Community-based organizations are at a disadvantage in securing sites for development.

Fair Housing

- Extremely low- and low-income renters are disproportionately members of a protected class, as noted in the AI Report. The AI Report also notes specific concerns related to housing access issues for households requiring deep levels of housing subsidy including:
    - The lack of tenant protections in many jurisdictions, minimal enforcement of existing tenant protections, and up-front requirements on renters create barriers to obtaining housing.
    - The lack of a relocation assistance program for low-income renters increases housing instability particularly for households impacted by the sale or redevelopment of rental units. The displacement of members of a protected class, such as people identifying as BIPOC, could represent a fair housing issue in communities.

Discuss the strategy to remove or ameliorate the barriers to affordable housing.

Strategies King County utilizes to remove barriers to affordable housing include the following activities: 1) increase housing choice through reducing screening criteria and other barriers to people securing and maintaining housing and by investing in rental assistance and eviction prevention, 2) increase funding for affordable housing development and preservation, 3) increase funding for operating and supportive services in housing for people who have experienced homelessness, 4) streamline permitting processes, 5) reduce development code barriers to the development of permanent supportive housing, emergency housing, middle housing and accessory dwelling units, 6) invest in communities at risk of both residential and commercial displacement, and 7) research methods to assist in community-driven development for permanently affordable homeownership programs.

SP-60 Homelessness Strategy - 91.415, 91.215(d)

Describe how the jurisdiction's strategic plan goals contribute to:

Reaching out to homeless people (especially unsheltered persons) and assessing their individual needs.

Outreach to people experiencing homelessness is an important component of King County's efforts to end homelessness. Numerous long-standing programs focus on individuals with behavioral health conditions, including PATH (Projects for Assistance in Transition from Homelessness), HOST (Homeless Outreach Stabilization and Transition) - Mental Health and Substance Use Disorder, PACT (Program for Assertive Community Treatment), Veteran Services, Scope (Seattle Community Outreach Program & Engagement), ETS (Evergreen Treatment Services) REACH, Pioneer Square Client Engagement, City Hall, Burien and Sound Transit outreach teams, Recovery Navigator Teams, LEAD (Law Enforcement Assisted Diversion) and the Emergency Services Patrol. South King County has its own mobile medical outreach team and outreach teams with nurses and mental health staff that are part of the Healthcare for the Homeless Network operating in six cities across the County.

Workers provide outreach to people experiencing homelessness who identify as LGBTQ+ and at-risk youth. They are responsible for identifying people experiencing unsheltered homelessness in neighborhoods through direct street outreach activities. Outreach workers administer assessment tools, facilitate placement into emergency short-term shelter and permanent housing programs, and connect people to social services. Outreach focused on individuals sleeping overnight in vehicles is active in east and south King County.

Vehicle outreach workers directly connect with people living in vehicles and RVs to provide stabilization services and pathways to permanent housing. In addition, Kids Plus works with families on the streets, in tent cities, or car camps countywide. King County's Veteran Families program also offers outreach targeted to veterans and operates federally funded veterans' supportive services. Many of these teams take advantage of existing meal programs to make contact with individuals or families in a non-threatening environment. Washington State has a Right of Way Safety Initiative and Encampment Resolution Program that is designed to provide outreach and shelter to households living unsheltered in state highway rights of way. KCRHA began implementation of this initiative in King County in 2023 and will continue throughout the next Consolidated Plan.

Addressing the emergency and transitional housing needs of homeless people.

The Consortium utilizes CDBG and ESG resources for emergency shelter and rapid rehousing. KCRHA is the lead entity responsible for the homelessness emergency response in King County.

Helping homeless persons (especially chronically homeless individuals and families, families with children, veterans and their families, and unaccompanied youth) make the transition to permanent housing and independent living,

including shortening the period of time that individuals and families experience homelessness, facilitating access for homeless individuals and families to affordable housing units, and preventing individuals and families who were recently homeless from becoming homeless again.

KCRHA coordinates the homelessness crisis response system in King County and in its 5-Year Plan states that the organization's overarching priority is, "One Goal: Bring unsheltered people inside – in a way that meets their needs – as swiftly as possible."

Three key components of KCRHA's 5-Year Plan include coordinating funding and policy, improving system-wide efficiency, effectiveness, and accountability, and investing in programs with proven outcomes. Seven initial actions strategies include: (1) increasing shelters and emergency housing capacity, (2) expanding medical recuperation and high-acuity programs, (3) piloting cash transfer programs for youth, young adults, and families, (4) bringing diversion programming up to scale, (5) changing severe weather to seasonal shelter services, (6) paying fair wages, and (7) investing in system capacity.

KCRHA works toward a more effective and efficient system. This includes determining how to prioritize people who are experiencing homelessness while furthering racial equity, developing effective and culturally sensitive outreach, overcoming barriers to people obtaining housing, and reducing screening and other barriers identified in serving people.

KCRHA's efforts to assist homeless youth in transitioning to housing stability are centered in a system of youth navigation and rapid rehousing which includes behavioral health and legal support. King County's Youth and Family Homeless Prevention Initiative is designed to offer families at risk of eviction the support they need to maintain their homes with case management and flexible financial assistance or rent only. Along with ongoing coordinated entry work, Housing Connectors work directly with private market and nonprofit housing providers to create a bridge that connects private property owners and managers to those most in need of housing. They use a housing platform to share information about low barrier vacant units and renters who receive ongoing support.

HOME Program regulations at 24 CFR 92.253(d) require that persons assisted in housing funded through the HOME Program be selected from a waiting list in chronological order. However, the waiting list process for HOME-funded units may defer to the process allowed by other federal regulations (e.g., HUD CoC Program). In addition, the HOME Program regulations also allow projects that do not receive funding from a federal program that limits eligibility to a particular segment of the population to also have a limitation or preference for persons with disability who need services offered at the project in accordance with regulations at 24 CFR 92.253(d)(3)(ii).

King County has established the following limitations and preferences for HOME-funded Permanent Supportive Housing (PSH) projects serving homeless families (including individuals):

- If the project receives funding from a federal program that limits eligibility to a particular segment of the population (e.g., CoC Program funding),
    - Eligibility is limited by the federal program's funding limitations.
- If the project does not receive federal funding that limits eligibility, King County sets a preference for:
    - Households (including individuals) with disabilities that significantly interfere with their ability to obtain and maintain housing, and
    - Families who are unable to maintain housing without appropriate supportive services.

For all HOME-funded PSH projects meeting the above local preference, the HOME Program requirement for affirmatively marketing and selecting persons from a wait list in chronological order is superseded by the countywide Coordinated Entry (CE) system to fill program vacancies, in accordance with CE Policies and Operations. However, the HOME-funded PSH project also maintain a waitlist to allow for external fills, where the housing provider decides who to select for the resource and coordinates their enrollment, move-in, and placement in housing outside of the CE case conferencing process and prioritization, as aligned with CE Policies and for those persons who decline assessment through the CE system.

Helping low-income individuals and families avoid becoming homeless, especially extremely low-income individuals and families who are likely to become homeless after being discharged from a publicly funded institution or system of care, or who are receiving assistance from public and private agencies that address housing, health, social services, employment, education, or youth needs.

King County funds programs and services to assist the most vulnerable members of the community, including programs for children, youth and young adults, seniors, survivors of domestic violence, persons with developmental disabilities, and veterans returning home and rebuilding their lives. Services provided include employment and education resources, the King County Veterans Program, assistance to residents with developmental disabilities and their families, and the Child Welfare Early Learning Partnership. King County's Behavioral Health and Recovery Division (BHRD) provides direct services for crisis outreach and investigation for involuntary commitment, community-based behavioral health treatment services, and outreach and triage on the streets for people incapacitated by alcohol or drugs. BHRD has identified that there is a high need for more beds to serve people who have been discharged from publicly funded institutions to prevent discharges to homelessness.

The Youth and Family Homeless Prevention Initiative (YFHPI) is designed to offer families at risk of eviction the support they need to maintain their homes with case management and flexible financial assistance or rent only. As a continuation of COVID relief-funded rental assistance, Keep King County Housed provides eviction prevention rent assistance.

County-funded homeless housing projects reflect Housing First principles with a focus on moving people experiencing homelessness into housing as quickly as possible. Homeless housing projects must use the Coordinated Entry system. King County also supports system-connected housing projects which serve individuals or households in which a member is involved in existing systems such as the criminal justice system or in-patient medical or behavioral health systems.

SP-65 Lead-based Paint Hazards - 91.415, 91.215(i)

Describe actions to address lead-based paint hazards and increase access to housing without lead-based paint hazards.

King County participated in the statewide lead task force that was responsible for developing Washington State's lead-based paint legislation that went into effect in 2004. Since then, King County has participated in many networking groups of home repair service providers discussing home repair issues including lead hazards and lead-based paint legislation.

The King County Housing Repair Program, which coordinates the Consortium's home repair programs for existing housing owned by low- and moderate-income households, conducts lead hazard reduction work in-house. Six staff are currently Washington State certified risk assessors and conduct paint inspections and/or risk assessments as needed on homes built before 1978 that are eligible for repair program funding. If lead hazard reduction is required for a given home repair project, the program incorporates the hazard reduction service into the scope of the project. Housing Repair Program staff members monitor the lead hazard reduction work and perform clearance inspections when required.

The King County Housing Finance Program, which administers the capital contracts for affordable rental and ownership housing projects for the Consortium, requires all projects to comply with lead paint requirements.

How are the actions listed above related to the extent of lead poisoning and hazards?

The actions and procedures of the King County Housing Repair Program and Housing Finance Program ensure a consistent and systematic approach for addressing lead hazards and remediation when working on homes and apartment buildings.

How are the actions listed above integrated into housing policies and procedures?

The King County Housing Repair Program is a Washington State certified and accredited program able to teach the Renovate, Repair and Paint curriculum. This curriculum was designed by the Washington Department of Commerce for training licensed and bonded contractors and their employees to establish lead safe work practices. In addition, the County's Housing Finance Program has established contract protocols that include a due diligence item requiring a Phase I Environmental Site Assessment and, if needed, a follow up Phase II Environmental Review. Both the Housing Repair and Housing Finance Programs also follow the HUD protocols for housing repairs and/or major renovations for units built before 1978.

SP-70 Anti-Poverty Strategy - 91.415, 91.215(j)

Describe the jurisdiction's goals, programs, and policies for reducing the number of poverty-level families.

King County's Strategic Plan outlines the vision, mission, and guiding principles across County programs and creates an overarching framework prioritizing safety and justice, mobility, economic vitality, accessible and affordable housing, health environment, health and human services, and an efficient, accountable government. Central to these goals is meeting the needs of lower-income communities including individuals and families living in poverty.

How are the jurisdiction's poverty-reducing goals, programs, and policies coordinated with the affordable housing strategy described in the Consolidated Plan?

As described in detail throughout the Consolidated Plan, King County funds a number of affordable housing, homeless, and human services programs that serve families, children, youth and young adults, adults, and special needs populations. Below are examples of a few of these programs.

Best Starts for Kids Levy
King County voters initially approved BSK in 2015 and renewed the levy in 2021. The latest renewal will raise an estimated $800 million through 2027. BSK funds support programs for pregnant people and childhood and youth development, including childhood and family homelessness prevention. When BSK revenues exceed $822 million, approximately $50 million in funding can support building repairs, renovations, new construction and expansion to improve access to high quality programs for low-income families and children as well as people identifying as BIPOC. BSK capital funding can support a variety of projects including those for housing.

Veterans, Seniors, and Human Services Levy
VSHSL supports seniors and caregivers, veterans, active service members, and their families, as well as other vulnerable populations in areas including employment, housing, and health. King County voters first approved VSHSL in 2005 and recently renewed the levy for the fourth time in 2023. VSHSL funding invests in 10 strategies to meet the housing needs of VSHSL populations, including housing stability programs, permanent housing development for projects that serve VSHSL populations, navigation centers, housing counseling, alternative dispute resolution services to represent tenants for eviction prevention services, and other housing stability activities.

MIDD (Mental Illness and Drug Dependency) Behavioral Health Sales Tax
The MIDD Behavioral Health Sales Tax levies a countywide 0.1 percent sales tax to fund programs and services to address behavioral health conditions for King County residents. Funds raised by this tax are invested in various programs, some of which are linked to homelessness response and housing stability programs. For example, the Housing Supportive Services program combines funding and resources with other government agencies to serve adults experiencing chronic homelessness who have difficulty maintaining housing due to their behavioral health needs.

Communities of Opportunity

The Communities of Opportunity initiative aims to create greater health, social, economic, and racial equity in King County so that all people have the opportunity to thrive and prosper. Its specific initiatives are tied together through a broad, results-based framework to move the region towards a system that is primarily preventative rather than crisis-oriented. Communities of Opportunity identifies policy and system issues across different levels of government and works across sectors to implement changes.

SP-80 Monitoring - 91.230

Describe the standards and procedures that the jurisdiction will use to monitor activities carried out in furtherance of the plan and will use to ensure long-term compliance with requirements of the programs involved, including minority business outreach and the comprehensive planning requirements.

King County (as an entitlement grantee, Urban County, and Consortium lead agency) is responsible for monitoring its subrecipients to ensure compliance with all applicable federal requirements at 24 CFR 570, 24 CFR 576, and 24 CFR 92 for individual project goals, and CDBG and HOME program requirements. King County selects subrecipients for the CDBG and HOME program and executes contracts for all funded activities that meet the applicable program and federal requirements. KCRHA selects subrecipients for ESG program activities, executes contracts for all funded activities, and is also responsible for monitoring selected subrecipients.

The County monitors contracts for compliance with the specific program requirements applicable to the project including general management, performance goals, financial management, data collection, reporting, eligibility determinations, environmental review, non-discrimination, minority business outreach, fair housing, affirmative marketing, lead-based paint, acquisition and relocation, housing inspections, and labor standards compliance.

King County includes language in all contracts related to Small Contractors and Suppliers (SCS) and Minority and Women-Owned Business Enterprises. The County encourages contractors to utilize small businesses, including SCS and minority-owned and women-owned business enterprises certified by the Washington State Office of Minority and Women's Business Enterprises in County contracts. The County also encourages contractors to use voluntary practices to promote open competitive opportunities for small businesses, including SCS firms and minority-owned and women-owned business enterprises.

CDBG Monitoring

Annually, King County HCD Community Development staff review the timeliness of CDBG expenditures, stay within spending caps, and spend the required percentage of CDBG funds on activities benefiting low- to moderate-income households. For construction projects, all projects require a pre-construction conference where the general contractor, agency representative, and project engineers are instructed on labor compliance requirements and receive information on how the County will monitor projects. The conference also includes Section 3 requirements and reporting expectations.

HOME Monitoring

Public funders use a joint inspection tool, based on the HUD Real Estate Assessment Center Physical Assessment Sub-system for HOME monitoring. As of March 2024, the County has adopted the new National Standards for the Physical Inspection of Real Estate (NSPIRE). Visits to properties are currently coordinated between funders to minimize the burden of multiple visits to the same property and tenants over the course of a year. King County completed 60 inspections from June 2023 through October 2023.

King County continues to work with the Washington State Housing Finance Commission, State of Washington Department of Commerce, and the City of Seattle in using the Web-Based Annual Reporting System (WBARS). The County uses WBARS reports to monitor compliance with the HOME requirements in each project's contract.

Appendix A: King County Consortium 2025-2029 Citizen Participation Plan

Citizen Participation Plan

Table of Contents

King County Consortium Citizen Participation Plan

I. Introduction

The King County Consortium's (Consortium) Citizen Participation Plan sets forth the policies and procedures for citizen participation in the process to receive and administer federal funds for the Community Development Block Grant (CDBG), HOME Investment Partnership Program (HOME), and the Emergency Solutions Grant (ESG) programs. The Citizen Participation Plan is required by the U.S. Department of Housing and Urban Development (HUD). As the lead entity for the Consortium, the King County Department of Community and Human Services (DCHS) assumes responsibility for the planning, preparation, day-to-day activities, and submission of the Consortium's Consolidated Plan, Annual Action Plans, Analysis of Impediments to Fair Housing Choice, and Consolidated Annual Performance Evaluation Report (CAPER) for the CDBG, HOME and ESG programs.

II. Purpose

On February 5, 1988, the President signed into law the Housing and Community Development Act of 1987, which among other things, requires jurisdictions to develop and follow a Citizen Participation Plan. This plan is intended to encourage citizens to participate in the Consolidated Planning process and it outlines the procedures for approval of the Consolidated Plan and the Annual Action Plan, for addressing concerns and complaints and for making amendments to the Consolidated Plan. The Citizen Participation Plan guides outreach for community development, housing, and emergency shelter activities under the CDBG, HOME, and ESG programs. The relevant regulations are listed below.

Code of Federal Regulations for Citizen Participation:
24 CFR Part 91.105 Local Governments Citizen Participation
24 CFR Part 91.100 Local Governments Consultation
24 CFR Part 91.401 Home Consortia

III. Participation

The Consortium is required to adopt a Citizen Participation Plan (CPP) that sets forth policies and procedures for Citizen Participation (24CFR 91.105 (a)(1). Citizens and stakeholders, including the Continuum of Care and Public Housing Authorities will be provided with information and the opportunity to give meaningful input to the consolidated planning process. This includes outreach to low- and moderate-income persons, persons living in predominately low- and moderate-income neighborhoods (defined as areas where more than 50 percent of the population has household incomes at or below 80 percent of the King County area median income), persons of color, non-English and limited English-speaking persons, persons with a disability, and people experiencing homelessness.

Consolidated Plan (24 CFR 91.200)
The Consolidated Plan guides the use of federal CDBG, ESG, and HOME funds for a five-year period. It describes the amount of assistance, priorities, range of activities, and estimated amount that will benefit low- and moderate-income people. The Consolidated Plan is a strategic plan, designed to help local jurisdictions assess their affordable housing and community development needs, market conditions, and make data-driven investment decisions. The consolidated planning process serves as the framework for a communitywide dialogue to identify housing and community development priorities that align and focus funding from the entitlement programs for CDBG, ESG and HOME.

Annual Action Plan (24 CFR 91.220)
The Annual Action Plan implements the Consolidated Plan for each program year. The Annual Action Plan is a concise summary of the actions, activities, and specific federal resources that the Consortium and Joint Agreement Cities will undertake in the program year to address the priority needs and specific goals identified in the Consolidated Plan. The program year begins January 1 and ends December 31.

Consolidated Annual Performance Evaluation Report – CAPER (24 CFR 91.520)
The CAPER reports on the accomplishments and progress toward Consolidated Plan goals undertaken and completed in the Consortium and Joint Agreement Cities in the previous program year. King County submits the CAPER to HUD on March 31 each year.

Analysis of Impediments to Fair Housing Choice (AI Report)
Every five years, the Consortium conducts a countywide AI Report. Annual progress and work towards the fair housing goals in the AI Report are reported annually in the CAPER. The duty to affirmatively further fair housing means taking meaningful actions, in addition to combating discrimination, that overcome patterns of segregation and foster inclusive communities free from barriers that restrict access to opportunity based on protected characteristics. Specifically, affirmatively furthering fair housing means taking meaningful actions that, taken together, address significant disparities in housing needs and in access to opportunity, replacing segregated living patterns with truly integrated and balanced living patterns, transforming racially or ethnically concentrated areas of poverty into areas of opportunity, and fostering and maintaining compliance with civil rights and fair housing laws. The Consortium shall ensure an AI is informed by meaningful community participation, identifies fair housing issues and factors contributing to fair housing issues. As part of the community participation process, the Consortium shall conduct outreach to members of protected class groups and underserved communities, such as populations who have historically experienced exclusion and lack of access to opportunity, including racial and ethnic minorities, Limited English proficient (LEP) persons, and persons with disabilities.

A. Public Hearings

Public hearings will be held at least twice per year at key stages of the grants administration process to obtain the public's views and to provide the public with responses to their questions and comments. Public hearings will be offered both in person and via Zoom or Teams. The Consortium will hold an additional public hearing prior to King County Council adopting the Consolidated Plan.

B. Public Notice

Citizens must be given adequate notice of all hearings and public meetings through the local or regional newspaper, posting on the DCHS webpage and direct notification to stakeholders. Adequate notice is defined as 15 calendar days. For public meetings and hearings, notice shall indicate the date, time, location, purpose of the meeting, and information about the issues to be discussed.

C. Comment Period

The following table lists the comment periods for plans and reports referenced in the Citizen Participation Plan. Free copies of any plan or report will be provided to citizens and groups that request it by contacting HCD staff. King County submits the Consolidated Plan and the first Annual Action Plan to HUD at the same time. However, the approval process for the Consolidated Plan, including public comment, occurs separately from the Annual Action Plan.

Document	Comment Period
Consolidated Plan	30 calendar days
Annual Action Plan	30 calendar days
Substantial Amendment to Consolidated	30 calendar days
Substantial Amendment to Annual Action Plan	30 calendar days
Analysis of Impediments to Fair Housing Choice	30 calendar days
Citizen Participation Plan	30 calendar days
Minor Amendment to Consolidated & Annual Action Plan	15 calendar days
Consolidated Annual Performance Evaluation Report (CAPER)	15 calendar days

D. Access to Meetings

Meetings and forums will be held in accessible locations to ensure that architectural barriers do not preclude the attendance of people who have a disability. In addition, accommodations will be made, upon request, for attendees who have hearing or visual challenges.

E. Language Access

The Consortium shall take reasonable steps to provide language assistance to ensure meaningful access to participation by non-English speaking and limited English proficient residents of the Community. This will include making accommodations for translation and interpretation services and meeting materials available in the appropriate language.

IV. Structure for the Administration of CDBG, HOME and ESG Funds

A. King County Consortium

The Consortium is an interjurisdictional partnership of King County and the cities and towns of King County, with the exception of Seattle and Milton.

Home Cities: The cities of Auburn, Bellevue, Kent, and Federal Way received entitlement status and participate in the Consortium for the use of HOME funds. These cities receive their own CDBG entitlement funds and prepare separate Citizen Participation Plans, but the Consortium retains responsibilities for the HOME funds.

Joint Agreement Cities: The cities of Burien, Kirkland, Redmond, Renton, and Shoreline have deferred separate entitlement status for CDBG funds from HUD and participate in the Consortium. The Joint Agreement Cities contribute a portion of their CDBG funds to consortium-wide activities, however they make funding awards at their jurisdictional level regarding their portion of the funds.

Partner Cities: The 28 Partner Cities and Unincorporated King County participate in the Consortium through membership in the Interlocal Cooperation Agreement (ICA). This agreement guides the allocation of the CDBG, HOME, and ESG funds.

HOME Jurisdictions				
Auburn	Bellevue	Federal Way	Kent	
Joint Agreement Cities CDBG				
Burien	Kirkland	Redmond	Renton	Shoreline
Partner Cities & Unincorporated King County				
Algona	Black Diamond	Beaux Arts	Bothell	Carnation
Clyde Hill	Covington	Des Moines	Duvall	Enumclaw
Hunts Point	Issaquah	Kenmore	Lake Forest Park	Maple Valley
Medina	Mercer Island	Newcastle	Normandy Park	North Bend
Pacific	Sammamish	SeaTac	Skykomish	Snoqualmie
Tukwila	Woodinville	Yarrow Point	unincorporated King County	

B. Joint Recommendations Committee

The CDBG/ESG/HOME/HOME Consortium is guided by an interjurisdictional Joint Recommendations Committee (JRC). The JRC recommends the allocation of CDBG, ESG, and HOME funds to specific projects, and advises on guidelines and procedures for King County and the Consortium partners. The JRC consists of eight cities' representatives and three County representatives. Four city representatives from the Regular CDBG Consortium, two city representatives from the Joint Agreement cities and two city representatives from the HOME-only cities. The County Council is the body that approves the Consortium's Interlocal Cooperative Agreements for signature by the King County Executive and approves each new or updated five-year Consortium Consolidated Plan.

V. Amendments to the Consolidated and Annual Action Plans

A. Amendments to the Consolidated Plan

1. Revisions to the Consolidated Plan
   Revisions are edits, updates or corrections that do not alter the activities, purpose or intended beneficiaries of any of the strategies adopted in the Strategic Plan section. Revisions do not meet threshold criteria for amendments and do not require public notice.

2. Minor Amendments to the Consolidated Plan
   Minor Amendments are those which: 1) alter the annual accomplishment goals and/or the long-term goals of the major strategies in the strategic plan, or 2) add or amend a neighborhood revitalization strategy for a specific neighborhood located in a geographic area of the King County CDBG Consortium. Minor amendments require public notice and an opportunity for the public to comment for 15 days and recommended by the JRC.

3. Substantial Amendments to the Consolidated Plan
   a. Substantial amendments are those which: 1) alter the activities, purpose or intended beneficiaries of a strategy identified in the Strategic Plan section of the Consolidated Plan; or 2) add or delete a strategy in the Strategic Plan section.
   b. Substantial amendments will not require King County Council action but will require public notice and an opportunity for the public to comment for 30 days prior to the date set for a Consortium JRC meeting to take action on the substantial change(s) to the Consolidated Plan.
   c. All comments that are submitted, either orally or in writing during the comment period, shall be considered in any substantial amendment to the Consolidated Plan. A summary of public comments made and how they influenced the amendment, as well as the reasoning for comments that were rejected and did not influence the amendment, will be attached to the substantial amendment.

B. Modifications to the Approved Annual Action Plan

After the Annual Action Plan is submitted to HUD, modifications to the Annual Action Plan fall into three categories and follow the processes described below.

1. Revisions are minor changes that do not meet threshold criteria for amendments and do not require public notice.

2. Minor Amendments to the Annual Action Plan
   a. A change in the amount of any single source of federal funds awarded to a project of more than 50 percent.
   b. A change in an eligible activity, a change in the purpose of an activity, or scope of an activity such that the estimated number of intended beneficiaries are impacted by 50 percent or more, or a change in the intended beneficiaries of an activity.
   c. The cancellation or addition of a project or activity.

d. Will be published and available for public comment in the regional and/or local newspaper for at least 15 days before it is implemented. The Minor Amendment will be reviewed and recommended by the JRC or approved by a Joint Agreement City, whichever body initially awarded the funds.

e. Changes to the Joint Agreement Cities' CDBG projects that will require a minor amendment shall be adopted by their City Councils through a consent agenda or regular Council meeting. The Joint Agreement Cities shall provide King County with supporting documentation for the amendment which includes public notice, meeting minutes, and comments for inclusion in the Annual Action Plan. All comments that are submitted, either orally or in writing, during the comment period shall be considered in any amendment.

3. Substantial Amendment to the approved Annual Action Plan
   a. A change in the amount of CDBG, HOME, or ESG funds allocated by more than 35 percent of the annual entitlement for that fund source.

   b. Must be reviewed and recommended by the JRC or approved by the Joint Agreement City of its pass-through portion of the entitlement, whichever body initially awarded the funds.

   c. Will be published and available for public comment in the regional and/or local newspaper for at least 30 days before implementation. The Substantial Amendment will be reviewed and recommended by the JRC or approved by a Joint Agreement City.

   d. Changes to the Joint Agreement Cities' CDBG projects that will require a Substantial Amendment shall be adopted by their City Councils through a consent agenda or regular Council meeting. The Joint Agreement Cities shall provide King County with supporting documentation for the amendment which includes public notice, meeting minutes, and comments for inclusion in the Annual Action Plan. All comments that are submitted, either orally or in writing, during the comment period shall be considered in any amendment.

Contingency Plan in the Event of an Emergency or Disaster

In the event of an emergency or disaster that presents a serious and immediate threat to the health and welfare of our citizens, the noticing requirements for public comment on plans or amendments may be reduced to five calendar days, or as required by state and federal guidelines. Any reprogramming of funds in the event of such an emergency will require review by the Joint Recommendations Committee. Documents may not be available for review in-person, but will otherwise be made available.

VI. Availability of Funds to Meet Objectives of the Consolidated Plan

Funding opportunities and awards are posted on the HCD webpage at the link below.

https://www.kingcounty.gov/hcdfunding

A. CDBG non-housing capital funds available through the Consortium are announced via a notice posted on the HCD website and emailed to interested parties and stakeholders every spring. Pre-applications are generally due in April and full applications are generally due in June. Award decisions are made in collaboration with jurisdiction staff on the CDBG Review Panel. The JRC makes final funding recommendations.

B. Joint Agreement Cities conduct separate application processes to award their cities CDBG capital and human services funds, with those processes generally starting in the spring. Awards of Joint City CDBG funds are approved through their city councils. Once awarded, Joint City capital funded projects are contracted and implemented by King County HCD staff, whereas human services contracts are administered directly by Joint City staff.

C. King County HCD administers the HOME funds. Allocation decisions are made in collaboration with the cities in the HOME Consortium. The JRC makes final funding recommendations. Funds available for affordable housing projects are announced through the HCD and King County Procurement websites, with applications generally due in September.

D. King County HCD administers ESG funds, with the King County Regional Homelessness Authority (KCRHA) responsible for procurement and contracting. KCRHA conducts a procurement process for homeless housing programs and services approximately every two years. Awards are generally multi-year. The JRC makes final funding recommendations. Consultation and coordination concerning ESG funds occurs through the regional Continuum of Care prior to the JRC's review and recommendations.

VII. Pre-applications and Technical Assistance to Applicants for Capital Funds

A. Each spring, King County conducts CDBG pre-application conferences to provide technical assistance to potential applicants for funds. The conferences provide information about federal requirements, local priorities, and application instructions. Technical assistance may be provided to individual applicants upon request prior to an application being submitted.

B. The Housing Finance Program conducts pre-application meetings every spring/summer. A notification is sent out to a broad distribution list and agencies are invited to meet with the Housing Finance Program to discuss potential projects prior to an RFP being posted.

C. The Housing Repair Program conducts an open loan intake process all year. Potential applicants are informed about the program requirements through an intake protocol during a telephone information session. The Housing Repair Program manager participates in numerous public outreach efforts year-round.

VIII. Anti-Displacement and Relocation

Applicants are encouraged to propose projects that avoid or minimize commercial and residential displacement. Projects that include or that will include federal funding (HOME and CDBG) and will acquire, demolish, or rehabilitate structures that have residential or commercial tenants in place, must follow the federal relocation requirements of the Uniform Relocation Act (URA) and the Real Property Acquisitions Regulations of for Federal and Federally Assisted Programs, as well as the Barney Frank Amendment, Section 104(d), if applicable.

IX. Access to Records

Records relevant to the consolidated planning process are available for the preceding five years.

X. Complaints

To facilitate the planning engagement process the Consortium will provide a substantive written response to address written concerns and complaints received regarding the draft Consolidated Plan, draft Amendments to the Consolidated Plane, the draft Annual Action Plan and the draft CAPER within 15 working days.

XI. King County Program Managers

King County Housing & Community Development Contacts	
Capital Programs Manager	Kristin Pula kpula@kingcounty.gov 206-263-7911
Consolidated Plan, Annual Action Plan, and CAPER	Laurie Wells lauwells@kingcounty.gov 206-263-8341
Community Development/CDBG Manager	Laurie Wells lauwells@kingcounty.gov 206-263-8341
Housing Finance/HOME Manager	Tina Ilvonen tilvonen@kingcounty.gov 206-263-8491
Housing Repair Manager	Clark Fulmer clark.fulmer@kingcounty.gov 206-263-9087
Homeless Housing/ESG Manager	Martha Sassorossi msassoro@kingcounty.gov 206-263-0217

Sign language and communication material
in alternate formats can be arranged
given sufficient notice by calling:
206-263-9062 or TTY: 711 (Relay service)

King County

Dow Constantine
King County Executive
401 Fifth Avenue, Suite 800
Seattle, WA 98104-1818
206-263-9600 Fax 206-296-0194
TTY Relay: 711
www.kingcounty.gov

January 16, 2025

The Honorable Girmay Zahilay
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember Zahilay:

This letter transmits the 2025-2029 King County Consortium Consolidated Plan (Consolidated Plan), and a proposed Ordinance that, if enacted, would approve the plan. The Consolidated Plan is a requirement of the U.S. Department of Housing and Urban Development (HUD), through which the King County Consortium (Consortium) receives an annual entitlement, or formula grant.

This HUD grant comes from the following federal sources: Community Development Block Grant (CDBG), the HOME Investment Partnerships Program (HOME), and the Emergency Solutions Grant (ESG). King County and the Consortium anticipate receiving grant amounts from CDBG, HOME, and ESG, totaling approximately $8,775,000 per year during the five-year period of the Consolidated Plan for program years 2025-2029. Council action to approve this plan during the first quarter of 2025 will enable King County to access this year's funds as soon as HUD makes them available.

The Department of Community and Human Services (DCHS) prepared the Consolidated Plan on behalf of the King County Consortium, a partnership that includes all jurisdictions within the county except for the cities of Seattle and Milton. The cities of Auburn, Bellevue, Kent, and Federal Way participate in the Consortium only for the use of HOME funds for affordable housing. These four cities receive their own CDBG entitlement and have separate Consolidated Plans to guide the investment of those funds.

As described in the Consolidated Plan, the King County Consortium intends to use these federal grant funds to further three overarching goals: increasing affordable housing, preventing and mitigating homelessness, and enhancing community and economic development to primarily benefit low- and moderate- income people.

In the development of the Consolidated Plan, the King County Consortium consulted with partners from 45 organizations that work directly with and/or have knowledge of the needs of low- and moderate-income people in King County. Survey results identifying respondents' funding priorities played a pivotal role in shaping how to prioritize the King County Consortium's funding strategy for the next five years.

Thank you for your consideration of the proposed Ordinance to approve the Consolidated Plan. This important legislation serves King County's residents through its strategies for creating affordable housing, including housing for individuals and families experiencing homelessness, and new community and economic development projects to ensure access to thriving, connected, and inclusive communities.

If your staff have any questions, please to contact Kelly Rider**,** Director, King County Department of Community and Human Services, at 206-263-5780.

Sincerely,

for

Dow Constantine
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff, King County Council
Melani Hay, Clerk of the Council
Karan Gill, Chief of Staff, Office of the Executive
Penny Lipsou, Council Relations Director, Office of the Executive
Kelly Rider, Director, Department of Community and Human Services

2025 FISCAL NOTE

Ordinance/Motion:	Ordinance
Title:	An Ordinance Relating to the Adoption of the King County Consortium Consolidated Plan for 2025-2029.
Affected Agency and/or Agencies:	Department of Community and Human Services
Note Prepared By:	Melissa Aguilar
Date Prepared:	6/24/2024
Note Reviewed By:	Florence Nabagenyi
Date Reviewed:	6/24/2024

Description of request:

This fiscal note is related to the transmittal of a proposed Ordinance that, if enacted, would approve the King County Consortium 2025-2029 Consolidated Plan (Consolidated Plan). Council adoption of a Consolidated Plan is required by the U.S. Department of Housing and Urban Development (HUD) as a part of the County's federally assisted housing and community development planning process. The Consolidated Plan provides guidance for the annual allocation of federal housing and community development funds (Community Development Block Grant (CDBG), HOME Investment Partnerships (HOME), Emergency Solutions Grant (ESG) that come to King County for the King County CDBG and HOME Consortia in approximately the amounts shown below. This updated Consolidated Plan will guide the allocation of annually appropriated funds for the years 2025-2029. The summary information below aligns with the 2025 Adopted Budget for the Housing and Community Development (HCD) Fund. Actual revenue will depend on annual federal appropriations.

Revenue to:

Agency	Fund Code	Revenue Source	2025	2026-2027	2028-2029
Housing and Community Development Division	000002460	Federal Grants	8,775,000	17,550,000	17,550,000
TOTAL			**8,775,000**	**17,550,000**	**17,550,000**

Expenditures from:

Agency	Fund Code	Department	2025	2026-2027	2028-2029
Housing and Community Development Division	000002460	DCHS	8,775,000	17,550,000	17,550,000
TOTAL			**8,775,000**	**17,550,000**	**17,550,000**

Expenditures by Categories

			2025	2026-2027	2028-2029
Salaries and Benefits	000002460	DCHS	1,322,203	1,376,413	1,376,413
Contracts with community agencies and surburban cities	000002460	DCHS	7,408,077	16,128,867	16,128,867
Other (supplies & intracounty service	000002460	DCHS	44,720	44,720	44,720
TOTAL			**8,775,000**	**17,550,000**	**17,550,000**

Does this legislation require a budget supplemental? Yes/No

Notes and Assumptions:

2025-2029 estimates assume stable levels of federal funding

The contracts with community agencies and cities are for a range of projects from housing to public infrastructure to social service agencies' capital improvements and operating funds. The funds are allocated by the individual cities according to the adopted interlocal cooperation agreement, or by the county through recommendations of the inter-jurisdictional Joint Recommendations Committee.

King County

Health, Housing, and Human Services Committee

March 4, 2025 Meeting

Agenda Item No. 8
Briefing No. 2025-B0028

DESC and DCHS Joint Briefing: Expansion of Mobile Crisis Teams and System

Materials for this item will be available before the meeting.

King County

Metropolitan King County Council
Health, Housing, and Human Services Committee

STAFF REPORT

Agenda Item:	9	**Name:**	Sam Porter
Proposed No.:	2025-B0027	**Date:**	March 4, 2025

SUBJECT

A briefing on the Health, Housing, and Human Services Committee's 2025 anticipated work items.

BACKGROUND

Health, Housing, and Human Services Committee Jurisdiction. As set forth in the King County Council's January 2025 organizational motion[1], the Health, Housing, and Human Services Committee (3HS) considers and makes recommendations on policies relating to 3HS programs, including those related to:

- Health services provided to the community by county agencies and branches;
- Public health programs, including those related to the protection, promotion,
- and provision functions of the department of public health, including the structure of the
- Public health centers; and
- Human services programs, including review of human services-related
- Levies, and human services programs relating to housing services and programs.

In the areas within the committee's purview, the Council's organizational motion also specifies that the committee tracks state and federal legislative action and develops recommendations on policy direction for the county budget.

King County Health, Housing, and Human Services Agencies.

Department of Community and Human Services (DCHS). King County's DCHS operates services and programs for behavioral health treatment, affordable housing, childcare resources, education and employment for youth and young adults, veterans

[1] Motion 16726
Organization of the Metropolitan King County Council covering Motions through 16747
https://cdn.kingcounty.gov/-/media/king-county/depts/council/clerk-of-the-council/2025_organizational_compilation_02-04-25_final.pdf?rev=ed6adbe32a49418d998d5ec97990579b&hash=832E93EBFB4771FCD1BDF5ADB99EF7FD_late

services, senior supports, and inclusive resources for people with intellectual and developmental disabilities. DCHS Divisions include the Behavioral Health and Recovery Division, Housing and Community Development Division, Developmental Disabilities and Early Childhood Supports Division as well as key initiatives, including Best Starts for Kids, Health Through Housing, MIDD Behavioral Health Sales Tax Fund, and the Veterans, Seniors, and Human Services Levy. *(Council Analysts: Sam Porter, Miranda Leskinen, April Sanders, Olivia Brey)*

Public Health—Seattle & King County (PHSKC). Public Health—Seattle & King County operates services and programs related to health and well-being for people in King County. This includes operating public health clinics across King County that provide sexual health services, pregnancy and infant support services, child-parent health programs, school-based health clinics, dental clinics, and drug-user health clinics. PHSKC divisions include Medic One/Emergency Medical Services, Environmental Health, Jail Health Services, the Medical Examiner's Office, and Safety and Injury Prevention. *(Council Analysts: Sam Porter, Olivia Brey)*

Health, Housing, and Human Services Committee Anticipated Work Items.

2025 Budget Provisos. The Council included in its adopted 2025 Annual Budget[2] five provisos (Attachment 1) on topics that fall within the jurisdiction of the Health, Housing, and Human Services Committee. Table 1 below summarizes the provisos and identifies the due dates and the Council analyst. Also note that for some of the provisos, withheld funds will be released upon transmittal and do not require Council passage of a motion.

Table 1. Health, Housing, and Human Services Committee Anticipated Provisos

Subject	Funds to be Released by Motion or on Transmittal	Council Analyst	Due Date in 2025
DCHS briefing on a plan to improve processing times for grant moneys for housing providers and payment for contracted services performed by human service providers	Release upon transmittal	N/A	March 31
JHS Two reports and a letter on postrelease jail health services plans	Release upon transmittal	N/A	May 30 November 1 December 31
Housing and Community Development briefing on a plan to update and consolidate housing funding policies	Release upon transmittal	N/A	June 25
PSB encampment resolution program funding options report	Release upon transmittal	N/A	June 30
DAJD report on the status of safety improvements at adult detention facilities	Release by passage of motion	Sam Porter	July 1

[2] Ordinance 19861

Other Anticipated Legislation. Council staff received a list from Executive staff of other planned legislation seen in Table 2 below.

Table 2. Other 3HS Committee Anticipated Legislation Not Yet Transmitted

Subject	Council Analyst	Estimated Transmittal Date
DCHS Minimum Administrative Costs Motion and Report	April Sanders	May 31
HTH Annual Report and Motion*	April Sanders	June 15
BSK Annual Report and Motion*	Sam Porter	July 12
MIDD Annual Report and Motion*	Sam Porter	August 1
VSHSL Annual Report and Motion*	Miranda Leskinen	August 1
CCC Annual Report and Motion*	Sam Porter	August 15
SKHHP Budget, Workplan and Motion	April Sanders	September 1
ARCH Budget, Workplan and Motion	April Sanders	September 1

* These annual report motions are dual referrals to RPC. Historically RPC hears the legislation first before being taken up in 3HS.

Briefings. In addition to considering legislation, the committee may wish to plan briefings on various topics related to the committee's jurisdiction.

ATTACHMENTS

1. 2025 Health, Housing, and Human Services Committee Provisos

COMMUNITY AND HUMAN SERVICES ADMINISTRATION

BRIEFING ONLY: Plan to Improve Processing Times for Housing Grant Providers and Contracted Human Service Providers: Due 3/31/2025

Of this appropriation, $100,000 shall not be expended or encumbered until the executive provides a briefing to the health, housing, and human services committee, or its successor, on a plan to improve processing times for all awards of grant moneys for housing providers and payment for contracted services performed by human service providers within the department of community and human services. The plan shall include, but not be limited to:

A. Potential actions that could result in decreasing the time between grant invoicing and payment distribution to housing providers and payment for contracted services performed by human service providers to a total of four weeks, including, but not limited to, actions the department of community and human services, the office of performance, strategy, and budget, or the council could take to increase award processing efficiencies; and

B. Potential needs for additional financial or personnel resources to support these actions.

The executive should provide the briefing to the health, housing, and human services committee or its successor, by March 31, 2025.

JAIL HEALTH SERVICES

REPORT/LETTER ONLY: Report on Postrelease Jail Health Services Plans: First report due: 5/30/2025 Follow up letter due: 11/1/2025 Second report due: 12/31/2025

Of this appropriation, $100,000 shall not be expended or encumbered until the executive transmits two reports and a letter on postrelease jail health services plans. Moneys restricted by this proviso shall be released as follow: $50,000 after receipt of the first report; and $50,000 after receipt of the letter.

A. The first report shall be a plan to address the needs of jail residents using medication for a substance use disorder as they transition from prerelease to postrelease treatment, which shall include, but not be limited to:

1. A comparison of the services provided and administrative framework of at least three different care models, including, but not limited to: (1) the status quo; (2) a program administered according to the requirements and coverage of Washington's Medicaid demonstration waiver Reentry Demonstration Initiative; and (3) a program operated by a third party private contractor providing prerelease services and a seamless transition to postrelease services through a clinic network with prescribing authority;

2. A discussion of the patient experience under each care model, including how soon after release patients would be connected to care providers and services and whether care would continue for at least thirty days postrelease; and

3. An evaluation of the likely effectiveness of each care model, including consideration of the effectiveness of similar models administered at other detention facilities in Washington state.

B. The letter shall be an update on the status of the report required by section C. of this proviso.

C. The second report shall be a plan to address the needs of other vulnerable jail residents as they transition from prerelease to postrelease services, which shall include, but not be limited to:

1. Consideration of how transitional and postrelease services could be expanded to serve jail residents who are likely to experience homelessness, have a disability, have a physical or mental illness, have experienced domestic violence, may need violence interruption interventions, or are in other vulnerable populations; and

2. Discussion of the timeframe and resources needed to implement such an expansion of transitional and postrelease services.

The executive should electronically file the first report by this proviso by May 30, 2025, the letter no later than November 1, 2025, and the second report no later than December 31, 2025, with the clerk of the council, who shall retain an electronic copy and provide an electronic copy to all councilmembers, the council chief of staff, and the lead staff for the health and human services committee or its successor.

HOUSING AND COMMUNITY DEVELOPMENT

BRIEFING ONLY: Plan to Update and Consolidate Housing Funding Policies: Due 6/25/2025

Of this appropriation, $150,000 shall not be expended or encumbered until the executive provides a briefing to the council's health, housing, and human services committee, or its successor, on a plan to update and consolidate housing funding policies, with the intent to transmit effectuating legislation to the council adopting such policies in 2026.

The briefing shall outline policies and priorities that the department of community and human services will utilize in the funding of affordable housing projects, including program priorities, eligibility requirements, financing terms, and other guidelines for housing programs administered by the department of community and human services, including, but not limited to: transit-oriented development; operating, rental assistance program, and services; health through housing; the regional affordable housing program; HOME Investment Partnership Program; and housing programs supported by document recording fees, short-term lodging revenues, and HOME American Rescue Plan revenue. Further, those policies and priorities shall inform the administration of procurement processes, the selection process of awardees, and the distribution of moneys.

Development of the briefing shall be done in consultation with council policy staff, housing providers, and other external partners. The briefing should include a plan for the executive to regularly transmit legislation proposing new or amended housing funding policies.

The briefing should consider the following objectives in development of policies and priorities:

A. Homelessness and extremely low-income housing, which are projects that expand the number of permanently supportive housing units, particularly for chronically homeless households;

B. Providing a mix of affordable rental housing, which are projects that serve a range of households, family sizes to promote housing opportunity and choice throughout the county;

C. Equitable community driven affordable housing development, which are projects that mitigate displacement pressures and ensure that historically marginalized communities have access to affordable housing investments, including projects with community-serving ground floor uses, including childcare, early learning facilities, eldercare, or care for individuals with disabilities, and projects with sponsors who have the experience to effectively address the needs of underserved communities including communities recently displaced or at high risk of displacement, and other communities historically excluded from equitable access to housing;

D. Acquisition and preservation, which are acquisition of land and buildings to promote community ownership, and preservation of existing affordable housing;

E. Transit-oriented development, which is projects that promote the geographic distribution of transit-oriented development funding;

F. Homeownership development, which is projects that expand the capacity of homeownership opportunities to King County residents; and

G. Labor standards, which are projects that utilize best practices and advance strong labor standards in construction and operations, and that support inflationary increases for human service providers.

The executive should brief the health, housing, and human services committee, or its successor, by June 25, 2025.

OFFICE OF PERFORMANCE, STRATEGY, AND BUDGET

PLAN ONLY: An Encampment Resolution Program Funding Options Report: Due 6/30/2025

Of this appropriation, $50,000 shall not be expended or encumbered until the executive transmits an encampment resolution program funding options report.

The report shall explore how money sources in existing county budgets could be used to support an encampment resolution program, including, but not limited to, money sources within the department of community and human services, the department of natural resources and parks, the road services division, and the water and land resources division, that could be directed towards removing encampments in a way that is both humane and effective.

The executive shall electronically file the plan by June 30, 2025, with the clerk of the council, who shall retain an electronic copy and provide an electronic copy to all councilmembers, the council chief of staff, and the lead staff for the health, housing, and human services committee or its successor.

ENVIRONMENTAL HEALTH

REPORT AND MOTION: Report on Streamlining and Improving Food Business Permit Process to Reduce Barriers: Due 7/1/2025

Of this appropriation, $100,000 shall not be expended or encumbered until the executive transmits a report on streamlining and otherwise improving the food business permitting process to reduce barriers for small food businesses seeking permits, and a motion that should acknowledge receipt of the report, and a motion acknowledging receipt of the report is passed by

the council. The motion should reference the subject matter, the proviso's ordinance, ordinance section, and proviso number in both the title and body of the motion.

The report shall include, but not be limited to:

A. Description of current food business permitting processes;

B. Data on current food business permitting timelines;

C. Options for streamlining and otherwise improving the food business permitting process to reduce barriers for small food businesses seeking permits, including resources necessary for or barriers to implementing each option;

D. A recommendation on whether to implement each option required in subsection C. of this proviso;

E. A workplan, including, but not limited to, a timeline of key milestones for implementing each option recommended in accordance with subsection D. of this proviso.

The executive should electronically file the report and a motion required by this proviso by July 1, 2025, with the clerk of the council, who shall retain an electronic copy and provide an electronic copy to all councilmembers, the council chief of staff, and the lead staff for the health and human services committee or its successor.