Public Health – Seattle & King County

Equity Response Annex

ESF 8 PLAN RESPONSE ANNEX

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Version 7.0
Next Update: TBD

Public Health
Seattle & King County

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Contents

Record of Changes

Description of Change	Date Change was Made
• Annex Creation • Review of statistics, attachments, language translation tiers, and formatting changes	October 2012
• Updated statistics • Replaced the "vulnerable population" terminology with "groups impacted by inequities" (GII), updated population categories to include People of color as a group impacted by inequities, and incorporated language of RCW 38.52.070 • Consolidated ICS functions under Operations, developed roles and function of an Equity Officer and the integration of equity monitoring within each Operations Section Branch to reflect updated HMAC structure • Revised to reflect functional structure of 2020-2021 COVID-19 equity response and lessons learned, and engaged the annex in community review processes by Equity Response Team and Community Navigators	March 2016 – March 2021
• Updated statistics • Incorporated feedback from community review processes by Equity Response Team and Community Navigators Team • Modified GII table • Reformatted to align overall annex structure with that of other functional annexes • Replaced Reference Documents with new tools • Reviewed for ADA accessibility of document	March 2023

INTRODUCTION

Purpose

The *Equity Response Annex* (Annex) for Public Health – Seattle & King County (Public Health) describes how the department may establish and implement equity-driven incident objectives and strategies during an emergency response. The annex outlines the functional structure of response processes and approaches to carry out community-informed response operations during emergencies to support community health and address health disparities.

Scope

This Annex can be referenced by Public Health leadership and staff to ensure that Populations Impacted by Inequity (PII) receive equitable access to resources, services, and health, medical, and mortuary information during emergencies. Public Health defines PII as *individuals, groups, or communities who experience institutional, structural, and systemic discrimination, bias, and racism in access to opportunity and to resources on a daily basis*. This daily lived experience of inequity puts individuals, groups, or communities at greater risk of experiencing additional inequities during emergency incidents.

Planning constraints

This Annex was developed under nonemergency conditions and includes Public Health's general procedures for integrating equity into Public Health's Health and Medical Area Command (HMAC). When activated, HMAC serves as Public Health's single coordination point for emergency response and follows a formal incident action planning process consistent with the National Incident Management System (NIMS). The role of HMAC is further defined in the Emergency Support Function (ESF) 8 Annex to King County's Comprehensive Emergency Management Plan.

This Annex describes how NIMS concepts, including overall incident command and control and incident action planning for each response operational period, can be modified and adapted by HMAC to better elevate and evaluate equity concerns and share power between HMAC responders and the community. However, health inequities experienced by communities in King County are multifaceted and institutionalized, and it is not possible to precisely account for the unique considerations of all PII ahead of future emergencies. This Annex should be considered a starting point for how to manage and respond to emergencies using equity-based approaches, and Public Health leadership and staff who adapt or implement this Annex should maintain flexibility for action and innovation to meet community needs during an emergency.

OVERVIEW OF KING COUNTY COMMUNITIES AND EQUITY IN PUBLIC HEALTH EMERGENCY PREPAREDNESS

Demographic Overview of King County Communities

Public Health works to protect and improve the health and well-being of all people in King County. The department serves a resident population of nearly 2.2 million people in an environment of great diversity and scale. For example, over 100 languages are spoken in King County, and immigrants and refugees make up more than 20% of the population. King County is also home to three of the most diverse zip codes and school districts in the nation, where a majority of the population are Black, Indigenous, and people of color (BIPOC).

Understanding the demographic composition of King County is a first step to ensuring that public health emergency preparedness activities and plans center communities. Community-centered preparedness is essential to ensuring that PII are appropriately and efficiently reached with health and safety information and receive response services during, before, and after a response.. Population and demographic data for King County is found in the table below.[1] This data should be considered with the following assumptions:

1. The context of historical misuse, censorship, and barriers to participation are deeply ingrained in the U.S. Census. It is likely that the following data on race, sexual orientation, and gender identity significantly undercounts the actual populations present. This is especially salient for American Indian and Alaskan Native groups.
2. King County does not currently have disaggregated data reflecting communities of disabled populations. Additionally, many people may not identify as having a disability even though they

[1] Data Complied by American Community Survey; 2020 and Data USA

may have an impairment or condition that would qualify them under the ADA. The data for disabled communities below only reflects adult populations.

3. Self-identifying race and ethnicity responses can be difficult for small communities and may make data interpretation difficult or prone to assumption. For example, Indigenous Latin American communities may respond to the Native American option but are rarely considered in policy decisions that use this data.
4. Many colonized languages (languages of colonized peoples) are not disaggregated (e.g., "Pacific Island Languages"), making it difficult to form policy decisions or target resources. This data should not be used as a substitute but a partner to community engagement.
5. The census traditionally has treated sex as binary — male or female — and omits asking about gender identity or sexual orientation. This significantly constrains the representation of all sexual orientations and gender identities, and masks transgender, non-binary, genderfluid, two-spirit, bisexual, lesbian, and gay identities.

Total King County Population: 2,252,305 residents (2021 Estimates)		
2021 ACS Age		
19 and under	493,891 residents	22% of population
20 – 24	127,914 residents	5.7% of population
25 – 44	767,774 residents	34.1% of population
45 – 64	553,391 residents	24.5% of population
65-74	189,413 residents	8.4% of population
75 and over	119,922 residents	5.4% of population
2021 ACS Sex		
Male	913,295 residents	50.6% of population
Female	893,162 residents	49.4% of population
2021 ACS Race and Ethnicity		
Non-Hispanic White	1,229,496 residents	54.6% of population
Black or African American	149,726 residents	6.6% of population
American Indian and Alaska Native	14,721 residents	0.7% of population
Asian	455,423 residents	20.2% of population
Native Hawaiian and Other Pacific Islander	15,351	0.7% of population
Hispanic or Latino	231,744 residents	10.3% of population
Two or more race	244,525 residents	10.90% of population
Population Trend by Place of Birth, 2021		
Local-born	1,690,228 residents	75% of population
Foreign-born	562,077 residents	25% of population

Language Representation, 2021		
Speaks Other Language (5 years and older)	626,071 residents	29.5% of population
Limited English Proficiency	907,761 residents	40% of population
Major Languages Spoken at Home in King County, 2021		
English only	1,495,030 residents	70.1% of population
Spanish	134,859 residents	6.3% of population
Chinese (incl. Mandarin, Cantonese)	54,129 residents	4.4% of population
Vietnamese	17,048 residents	1.8% of population
Somali, Amharic (2018 estimate)	37,200 residents	1.8% of population
Tagalog	14,036 residents	1.1% of population
Korean	10,531 residents	1.1% of population
French, Haitian, Cajun	8,792 residents	.7% of population
German	7,068 residents	.4% of population
Hindi, Punjabi (2021 estimate)	39,580 residents	1.7% of population
Russian, Polish, other Slavic language	29,332 residents	1.5% of population
Arabic	7,963 residents	.6% of population
Japanese (2021 estimate)	11,410 residents	0.9% of population
Ukrainian (2021 estimate)	11,508 residents	0.6% of population
Other Asian and Pacific Island Languages (e.g., Samoan)	36,526 residents	3.4% of population
American Sign Language[2] (2019 estimate)	Estimated 45,000 residents	2% of population
Disability Data, 2020		
King County Overall	313,280 residents	18.4% of population
Non-Hispanic White	60,776 residents	19.4% of population
Black or African American	83,959 residents	26.8% of population
American Indian and Alaska Native	102,442 residents	32.7% of population
Asian	24,122 residents	7.7% of population
Native Hawaiian and Other Pacific Islander	72,680 residents	23.2% of population
Hispanic or Latino	69,234 residents	22.1% of population

[2] Gallaudet University estimates that about 2-4 out of 1000 people are functionally deaf, hence the percentage per population is about 2-4%. This estimate uses 2% in calculations since that gives an approximate estimation on ASL fluency among deaf and deafblind populations. Gallaudet demographics report: https://www.gallaudet.edu/office-of-international-affairs/demographics/deaf-employment-reports/

Two or more race	62,342 residents	19.9% of population

Racism is a public health crisis

On June 11, 2020, King County government, including Public Health, declared that racism is a public health crisis. Racism 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. Structural racism is a root cause of several health disparities, manifesting through laws and policies that create barriers to equitable and high-quality care.

The COVID-19 pandemic further drew back the curtain on the impact of structural racism in the American healthcare system. Through June 12, 2022, King County had 2,850 deaths (0.6% of positive cases) attributed to COVID-19. Age-adjusted death rates of confirmed cases were 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) compared to White residents (106 per 100,000).

When understanding the impacts racism has on the health of communities, it is vital to recognize that racism often manifests in an intersectional manner, i.e., racism does not occur in a vacuum, but intersects with other forms of discrimination, including discrimination based on ability, socioeconomic status, sexuality, or place of birth. For example, the COVID-19 pandemic has shown that people with disabilities experience unique impacts due to a lack of appropriate data on these communities as well as barriers to accessing information, testing, and vaccination that result in greater disparities during a response. As recovery efforts from COVID-19 continue, historically marginalized populations continue to face greater challenges due to racism and its intersections with other forms of discrimination.

Equity in Public Health Emergency Preparedness

Recognizing the layering of discrimination in our healthcare institutions is necessary for effective public health emergency response. In addition to individual acts of discrimination, structural racism invades systems of power, informing decision-making and furthering health inequity. Such systems of power in emergency responses include the Incident Command System (ICS), and while Public Health cannot abandon using these systems altogether given state and federal requirements, it can honor its commitment to addressing racism by actively incorporating equity into overall incident command structure and incident action planning for each response operational period.

The Community Engagement for Public Health Emergency Preparedness (PHEP) Guide (included as a Reference Document) is a tool that Public Health is utilizing to inform preparedness activities and response planning through a community-centered approach. The guide includes information on PII in King County, several approaches to engage with community in PHEP activities and plan development, and recommendations for incorporating equity in the incident command structure. The guide also includes an Equity Impact Review tool that may be used before or during a response to support equity-led decision making and prioritize PII in response efforts.

Additionally, Public Health relies on data from the Washington Tracking Network to identify social vulnerability to hazards across the county. This data source includes social vulnerability indices that

come from the Centers for Disease Control and Prevention Social Vulnerability Index – a measurement approach that uses 16 United States census variables to help local health departments identify communities that may need support before, during, or after disasters. Through the use of the aforementioned tools and data sources, and by way of the response structure and operations outlined in the next section, Public Health plans to demonstrate its commitment to incorporating equity in a meaningful and sustainable way in the incident command structure.

OPERATIONALIZING EQUITY IN EMERGENCY RESPONSE

During an emergency, Public Health will respond in a manner that is consistent with the National Response Framework (NRF) and the guiding principles of the National Incident Management System as mandated in RCW 38.52.070. Public Health will collaborate with local partner agencies and community-based organizations during emergencies to stabilize the incident, ensure community-centered response operations, and sustain public health services. In addition, Public Health will use the Incident Command System (ICS), which is a standardized incident management approach, to coordinate emergency response operations.

During an emergency response, Public Health has critical primary functions that are:

- Coordinate public health and medical emergency operations
- Coordinate and manage Emergency Support Function 8 resources
- Maintain situational awareness of health outcomes and healthcare system
- Communicate effectively with response and community partners
- Effectively staff and mobilize response workforce personnel
- Ensure equity and social justice is embedded in and implemented through operations

To further ensure that equitable and community-centered practices are embedded in the ICS, Public Health will establish equity-focused roles and teams within the response structure. For example, the role of Equity Officer will serve to lead equity-based decision making and support the creation of Branches and Groups that are focused on community engagement and outreach.

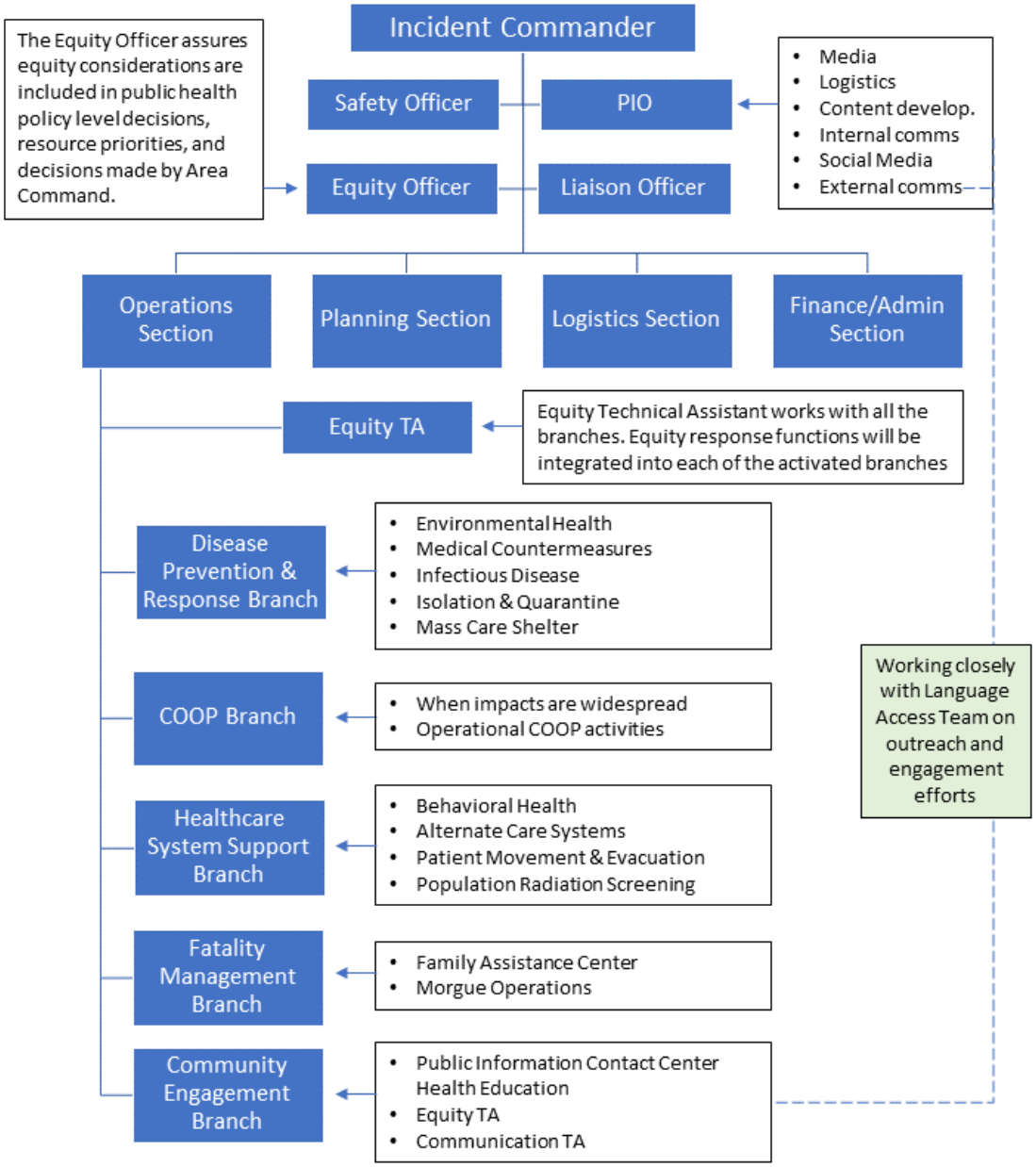
Incident Command Structure

The Incident Command System is a standardized organization structure that allows agencies to work together using common terminology and operating procedures during an emergency response. Public Health, under the legal authority of the Local Health Officer will establish and lead the Health and Medical Area Command (HMAC) incident command structure during emergencies and public health incidents. HMAC positions will be adjusted depending on incident type, hazard type, complexity, and legal responsibilities and authorities. HMAC serves as the coordination point for public health and medical services response within Seattle and King County and sets the strategy, objectives and priorities for health and medical emergency response.

Departmental ICS & HMAC Integration

The HMAC command structure is inclusive and complementary to the incident command systems and leadership structures utilized by response partners to manage organization-specific incidents and activities. Public Health will activate HMAC to establish overall health and medical response and recovery objectives, coordinate incident information with ESF 8 agencies, and manage the acquisition and use of medical resources. The below organization chart outlines the ICS structure for HMAC. Public

Health has created the Equity Officer and Equity Technical Advisor positions to fit within the ICS organizational structure. This model uses the Operations section as an example of how Technical Advisors may be placed when Branches and support the organization of the Operations Section.



Roles and Responsibilities

Public Health's Workforce Mobilization Annex further defines the processes for identifying and deploying HMAC response staff in a manner that is consistent with King County policies, collective bargaining agreements, and emergency worker regulations. Communication methods, translation, and interpretation procedures for notifying response teams, and procedures for maintaining updated response team rosters can also be found in Public Health's Workforce Mobilization Annex. Public Health may incorporate an expanding scale of equity-focused positions into the HMAC structure as it moves through response operations. The equity-focused roles and groups may include the following:

Equity Officer

The Equity Officer is a Command Staff position and reports directly to the Incident Commander. Public Health staff that are Equity Response Team (ERT) members may fill the Equity Officer and/or Equity Technical Advisor positions in HMAC. The Equity Officer's primary responsibility is to ensure equity-led decision making and practices are incorporated in HMAC management functions, response priorities, and policies. The Equity Officer is involved in reviewing emergency services eligibility criteria and identifying where response operations could be better aligned to serve PII. The Equity Officer works closely with the Language Access Team to support with translations and consultation of health and safety messaging. Additional duties falling under the scope of the Equity Officer are included in the full job aid in Appendix.

Equity Technical Advisor(s)

The Equity Technical Advisor's primary responsibility is to facilitate connections, feedback, and two-way communication with other Groups in the Operations Section to ensure equity considerations are incorporated in response strategies. This responsibility is primarily carried out in the Tactics Meeting during the Planning Cycle (shown below) but may also include regular check-ins or other planning meetings that will be organized by the Equity Officer. Use of the Equity Impact Review Tool may support the Equity Technical Advisor's contributions to the development of incident objectives and components of the Incident Action Plan.

Equity Response Team

The Equity Response Team (ERT) is considered a quasi-external body that is connected to the HMAC structure through the Equity Officer. It is comprised of both community members and staff who hold diverse subject matter expertise and lived experiences. The team's primary responsibilities are to discuss and provide guidance on equity concerns, review response plans, tools, and documents, and regularly meet with relevant response groups and community partners. The ERT also conducts deep-dive case studies on specific response operations to analyze equity impacts and consider whether response operations are community-informed.

Public Health staff that are ERT members typically fill the Equity Officer and/or Equity Technical Advisor positions. If no staff ERT members are available to serve in these positions, other staffing sources may be considered. Staffing this role should include consideration of a hiring process for high level or long-term responses but may also be satisfied by deploying Public Health employees to serve in HMAC. There should be a temporary job reclassification to Command Staff pay grade or identification of alternate payment and compensation mechanisms to allow the Equity Officer to serve to their fullest ability. In addition, a compensation mechanism should be assessed among HMAC Command Staff for

appropriately compensating community member representatives to serve in ERT roles to their fullest ability.

ERT members may not be actively serving in HMAC if certain members of the ERT choose not to respond during an incident. ERT members that are not serving in HMAC will be kept apprised of the incident response each operational period via briefings and shared folders or documents. In addition, they may be asked to meet with the Equity Officer and/or Equity Technical Advisor periodically or regularly to leverage team members' unique perspectives and inform incident response decisions. ERT members will be provided with the appropriate tools and resources to support their roles during a response.

Disability Justice Technical Advisor

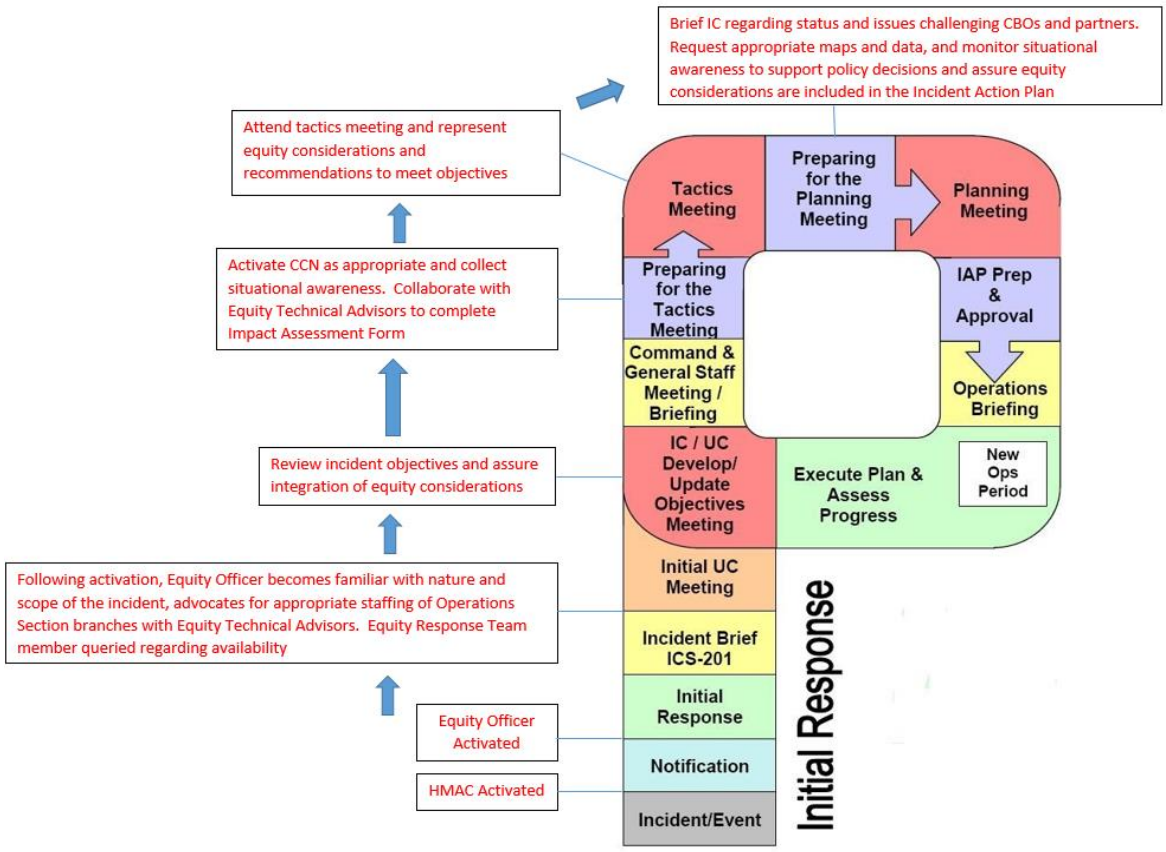
The Disability Justice Technical Advisor reports to the Equity Officer, and the role is placed within the Operations Section alongside the Equity Technical Advisor. This role works and liaises with the disability and racial equity community and other community partners. The Disability Justice Technical Advisor provides cross departmental technical assistance to advance disability equity issues related to social determinants of health impacting the disability community during a response. In addition, this role would serve to provide consultation on an action plan to implement Americans with Disability Act (ADA) compliance and accessibility in Public Health's response activities.

HMAC Community Engagement Branch

The Community Engagement Branch coordinates community outreach and engagement opportunities during a response. The Branch will comprise of different groups focused on community engagement, outreach, and ensuring that response operations are community-centered and informed. The teams within this Branch collaborate closely with the Communications team, Public Information Officer, and other Branches/Groups within the Operations Section. The activities implemented by this Branch will build on existing outreach mechanisms and established relationships within Public Health, while focusing on identifying and reaching PII that have been most negatively impacted by the emergency.

Incident Action Planning

Public Health uses a formal planning cycle to manage incidents. This cycle includes meetings and associated products to develop an Incident Action Plan (IAP) that ensures operational progress throughout a response. The IAP formally documents incident goals known as operational period objectives or incident objectives that inform response activities and outline the overall response strategy. The figure below ("The Planning P") shows how the Equity Officer and Equity Technical Advisor positions are incorporated into each step Public Health takes when managing an incident. The sequence of meetings, work periods, and briefings that comprise the incident action planning cycle may be repeated depending on the length of the incident and the number of operational periods.



Equity in Response Subject Matter Experts

In addition to the established equity-focused roles described above, incident action planning and management rely strongly on external organizations and individuals to provide information and subject matter expertise on incident objectives and associated response operations. The following approaches for community engagement and/or equity review have been taken from the Community Engagement for Public Health Emergency Preparedness (PHEP) Guide (included as Reference Document) and serve as a starting point for community engagement:

- Convening a consulting group of community leaders, such as the Equity Response Team, Pandemic and Racism Community Advisory Group (PARCAG), Community Health boards, and Community Navigators to discuss response operations and decision-making.
- Communicating directly with leadership and program managers of community and faith-based organization whose work focuses on the most impacted communities during a disaster.
- Developing and implementing surveys for community partners to share feedback during or after a response regarding their experiences or involvement at a Public Health site.
- On-the-ground field observation of barriers, questions, and complaints during response operations.
- Ensuring adequate representation from and outreach to various disability communities and their perspectives on policies for making decisions about resource distribution, information sharing, and funding opportunities.

The Incident Commander, HMAC Operations Section leadership, Equity Officer, and Equity Technical Advisor may leverage community partnerships to inform the development of the IAP and incorporate partners into response strategies. Through creating incident objectives that center communities' greatest needs and including community partners in operations such as community engagement and outreach, Public Health can ensure that information and resources are reaching communities of PII that are at-risk or most negatively impacted by health emergencies. Partnerships include but are not limited to the following:

- **Community Health Boards (CHBs) and the Community Health Board Coalition (CHBC):** The CHBC is comprised of 14 individual CHBs representing historically marginalized communities in King County, all of whom experience high levels of health disparities on a daily basis. CHBs are trusted entities in their communities. Language and cultural groups that can be reached by the CHBC and CHBs include:
    - African American
    - African Leaders
    - Afro Descendant and Indigenous
    - Cham
    - Congolese
    - Eritrean (Tigrinya)
    - Ethiopian (Amharic)
    - Filipinx
    - Iraqi/Arab (Arabic)
    - Khmer
    - Latinx (Spanish)
    - Pacific Islander
    - Somali
    - Vietnamese
- **Public Health Reserve Corps (PHRC):** The PHRC is made up of medical and non-medical volunteers who support Public Health in meeting the needs of affected communities during an incident. To respond with cultural appropriateness to PII and underserved persons, the PHRC includes volunteers who are multilingual. Multilingual PHRC volunteers may be available to assist in interpreting alerts and warnings for limited English-speaking communities. PHRC volunteers may also be able to provide on the ground outreach.
- On the ground outreach through **Community Based Organizations and Faith-based Organizations** is effective when there is a need to rapidly disseminate information and resources in specific geographic areas or neighborhoods with limited English-speaking communities. Providing appropriately translated information, and distributing information to grocery stores, restaurants, gathering centers and other locations that have a high level of pedestrian traffic is recommended.
- **Community Health Services Division:** Public Health Nurses, Health Educators and Medical Interpreters who works in Public Health Clinics could assist in outreach efforts including delivering presentations and providing interpretation services to communities.

Equity-based Communications in Response

In addition to leveraging existing partnerships, Public Health relies on communication with community-based organizations and leaders that serve PII to provide operational updates and establish a communication mechanism to both inform IAP development and include partners in response activities. Examples of the communication mechanisms that Public Health relies on to achieve those purposes are:

- **Office of Equity and Community Partnerships:** Sharing situational awareness information at Office of Equity and Community Partnerships (OECP) meetings that include staff from various teams and groups that may have response roles within HMAC as well as those who do not. Working closely with the Public Health Language Access Team to ensure that information regarding the emergency and response activities is translated and interpreted up to 30 languages. In addition, OECP staff may be able to support with equity and cultural

appropriateness reviews of in-language documents, public communications, and community outreach activities.

- Public Health's **Community Communication Network (CCN)** is a partnership between Public Health, community-based organizations, and community leaders. The function of the CCN is to ensure essential health-related information reaches PII during emergencies by using established communications channels to disseminate messages. All emails to the CCN should be sent from ccn@kingcounty.gov or from the Gov Delivery communications platform.
- **Seattle Office of Emergency Management (OEM)** maintains Alert Seattle, the City of Seattle's official emergency alert and warning system. This system can send alerts to the public via text message, email, voice message and social media (Facebook and Twitter). Alerts can be sent out city-wide to everyone who has opted-in to the system, or to a specific area or neighborhood for localized incidents. Alert Seattle can currently only send out messages in English.
- King County OEM maintains **Alert King County**, King County's official emergency alert and warning system. They also maintain the **Trusted Partner Network**, a partnership with individual community leaders who may be able to provide translation assistance and are able to quickly spread messages within their social networks.
- Public Health's Risk Communications Response Annex includes additional guidance for alerts and warnings for PII, external communications procedures to center community needs in messaging, language access standards and processes, and distributing messaging through community partners and community and multilingual media.

While Public Health relies on communication with community-based organizations and leaders that serve PII to help inform the incident planning cycle, it is important to consider and plan for the following incident circumstances that may hinder communications, especially in a large-scale incident:

- Public Health, community-based organizations, and/or leaders may not have immediate access to functioning telecommunication systems including telephone and Internet access.
- Public health responders, community-based organizations, and/or leaders may be unwell or otherwise unable to respond to communications
- Public Health responders do not have the appropriate language resources (including ASL) to reach all communities in a timely manner. In addition, communication may not meet a variety of access needs, screen reader accessibility of written digital information, etc.
- Public Health relies on data to drive resource allocation, relief programs, and communications. However, if data is not yet available on impacts it may result in misdirected or failed operations. Another consideration is that available data may not be intersectional in relation to race, income, geography, disability, etc.

Overview of Incorporating Equity in Incident Action Planning and Response Operations

During a response and HMAC activation, the Incident Commander and Operations Section leadership may utilize the established structures and processes outlined in the sections above along with the Equity Impact Review Tool and Community Engagement for PHEP Guide to ensure that incident objectives incorporate equity and operational decision-making, and response strategies are equity-focused and informed by community. Examples of all-hazards equity-based incident objectives that may be adapted to the context of the emergency or that support with this process are included as Reference Documents to this Annex. Below is a non-exhaustive list of approaches for conducting effective, community-centered incident action planning and subsequent response activities.

- When resources are scarce during a response, Public Health will reference Crisis Standards of Care protocols that will be used for making urgent allocation decisions in a disaster. These protocols cannot be expected to remedy historic and structural inequity, but also should not exacerbate underlying disparities. Resource allocation for community-based interventions (such as vaccination clinics and testing sites) should be weighted to ensure equitable access to resources for communities according to their risk of illness and mortality, including access to transportation, personal protective equipment (PPE), diagnostics, safe disability accessible spaces for quarantine, and treatment for those who become ill. Public and private partnerships will be needed to work through structural inequity, trust, and access to care issues prior to an incident.
- When community partners receive resources, it is essential that language services interpreters selected for response activities are aware of different regional dialects and consider the reach of their information to marginalized communities. Community outreach teams or navigators should additionally be equipped to support persons with disabilities and connect them to appropriate services. There will need to be larger systemic supports in place for this effort to reach *everyone* and ensure health and safety during a response. The Equity Impact Review tool included as a Reference Document to this Annex may serve as decision-making support.
- All written and visual materials that will be shared with communities must be screen reader accessible when posted online, have high color contrast, and be written in a way that is easy to understand. For printed materials, large print and braille options should be available ASAP. (Any video materials should have audio description for the visually impaired, especially if there is important information that is only portrayed visually).
- Ensure that data is being collected on community outreach efforts through HMAC, including collection of anonymized data from community on needs, barriers, and experiences accessing and utilizing response services. Partner with the Public Health Language Access Team to ensure that communications, data collection mechanisms, and all forms of outreach are translated into the appropriate languages and that interpretation is available as needed.

ANNEX MAINTENANCE

Review and revision

This Annex will be reviewed yearly. The revision process will include outreach to relevant Public Health divisions and programs represented in the Annex to ensure their response activities and services are documented accurately.

Following any exercises or actual emergency responses, Public Health will seek feedback on the response from HMAC responders, Public Health divisions and programs involved in the response, impacted communities, and key partners across the county. Based on this feedback, this 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 the review and updating process for this annex:

- Office of Equity and Community Partnerships, including but not limited to the following groups:

    - Community Navigators Team
    - Equity Response Team
    - Pandemic and Racism Community Advisory Group
- Public Health divisions and programs
- King County Office of Emergency Management
- City of Seattle Office of Emergency Management
- Emergency management representatives from local jurisdictions

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 Equity Response Annex may be integrated into the IPP to ensure key capabilities are exercised and relevant training developed.

ANNEX REFERENCE DOCUMENTS

- EqRef 1: Community Engagement for Public Health Emergency Preparedness Guide
- EqRef 2: Equity Impact Review Tool
- EqRef 3: Equity Officer Job Aid
- EqRef 4: Emergency Response Bill of Rights
- EqRef 5: All-Hazards Equity-based Incident Objectives
- EqRef 6: Community Communications Network Protocol