American Indian Health Commission for Washington State

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Tribe-Local Health Jurisdiction Mutual Aid Agreements in Washington State

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American Indian Health Commission for Washington State

TRIBE-LOCAL HEALTH JURISDICTION MUTUAL AID AGREEMENTS IN WASHINGTON STATE

I. OVERVIEW OF MUTUAL AID AGREEMENTS

Local health jurisdictions and tribes are the first to experience a public health emergency or incident, and most likely, the first to respond. Even with their great authority to commandeer resources, no local health jurisdiction or tribal government has the capacity to respond to every public health incident or emergency that may occur within its jurisdiction. Most governments at one time or another will rely on another government to share resources such as supplies, equipment, personnel, expertise or information. This sharing of resources is referred to as "Mutual Aid." Developing mutual aid relationships and agreements helps facilitate coordination and cooperation between governments during public health incidents or emergencies, such as measles outbreaks or foodborne illness outbreaks.

A Mutual Aid Agreement provides the legal mechanisms for jurisdictions to share resources. While parties to a signed mutual aid agreement are not obligated to provide or receive aid, the agreement is intended as a useful resource should an incident require it. In addition to the mutual aid agreement, it is useful to have a mutual aid planning guide for operational staff to execute responses in a manner that is consistent with their executed agreements.

National Standards for Mutual Aid Agreements. In 2004, the United States Department of Homeland Security created the National Incident Management System (NIMS), a national standardized approach to a broad spectrum of potential incidents, hazards and impacts regardless of size, location, or complexity. An underlying concept of NIMS is that, most often, local jurisdictions manage incidents.[1] According to NIMS, mutual aid agreements play a key role in a local emergency response: "In the vast majority of incidents, local resources and local mutual aid agreements and assistance agreements will provide the first line of emergency management and incident response."[2] NIMS recommends mutual aid agreements include provisions that address issues such as: reimbursement; worker's compensation; liability immunity; and licensure.[3] Other important legal issues included in mutual aid agreements include control of resources and dispute resolution.

Washington State Standards for Intrastate Mutual Aid Agreements. Many states, including Washington, specifically authorize mutual aid agreements. The Washington Intrastate Mutual Aid System (WAMAS), created

[1] U.S. Dept. of Homeland Security. National Incident Management System (December 2008), p. 12.

[2] U.S. Dept. of Homeland Security. National Incident Management System (December 2008), p. 12.

[3] U.S. Dept. of Homeland Security. National Incident Management System (December 2008), p. 18.

in 2011 under RCW 38.56, provides for mutual assistance in an emergency among political subdivisions and federally recognized Indian tribes that choose to participate as member jurisdictions. WAMAS establishes guidelines to Washington political subdivisions and to tribes for addressing worker's compensation, dispute resolution, immunity, licensure, and control of resources. The statute specifically states WAMAS is not intended to preclude political subdivisions and tribes from entering into or participating in other mutual aid agreements or systems.[4] WAMAS does not address issues specific to tribal jurisdictions.

Benefits of a Mutual Aid Agreement. Executing a Mutual Aid Agreement helps a government fulfill its duty to protect the lives, health and welfare of its people from threats caused by attack or extraordinary natural hazards. Such an agreement provides several benefits including:

i. Facilitates faster and more organized access to resources from other jurisdictions in time of need.

ii. Reduces legal disputes that may occur after a joint response to an incident or emergency. When jurisdictions do not agree ahead of time on issues such as reimbursement or liability, disputes or legal actions may occur.

iii. Improves the ability for an impacted government to receive reimbursement from the Federal Emergency Management Agency (FEMA) and Washington State for allowable costs incurred by their jurisdiction and partner jurisdictions who provide assistance in responding to an event.

iv. Affords an opportunity for governments to better understand each jurisdiction's system of government and build relationships. It also provides a tool for regional partners to regularly exercise emergency response practices and strengthen the region's capacity to respond and recover from incidents and emergencies.

v. Supports cross-jurisdictional sharing of assets, resources and expertise, which is especially valuable in the current climate of insufficient funding for public health.

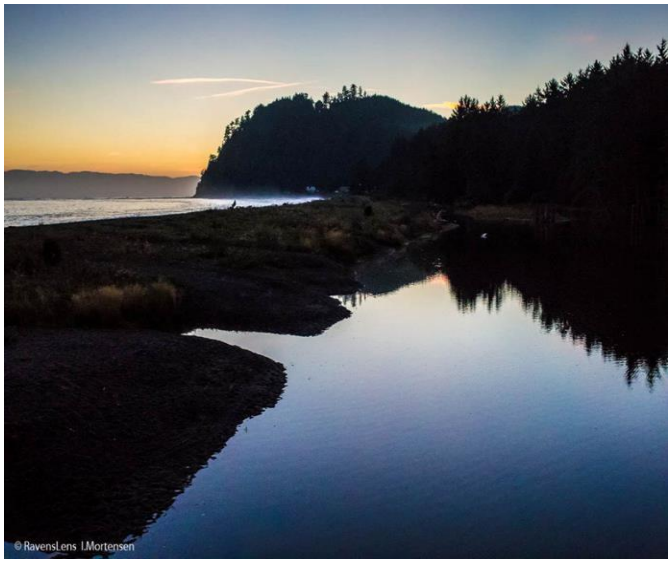
vi. Provides established guidelines and legal mechanisms for jurisdictions who do not have a public health officer to temporarily grant authority to another jurisdiction's health officer.

vii. Provides established guidelines and legal mechanisms for jurisdictions who do not have a public health code that is appropriate to responding to a specific public health emergency to temporarily adopt another jurisdiction's code.

[4] RCW 38.56.

II. MUTUAL AID AGREEMENTS BETWEEN TRIBES AND LOCAL HEALTH JURISDICTIONS IN WASHINGTON STATE

To delineate the role and importance of the public health system in protecting and improving the safety and health of all Washington residents, and to create funding mechanisms to support this system, the Washington State legislature approved RCW 43.70.520 in 1993 and RCW 43.70.580 in 1995. In these, Washington's decentralized governmental public health system is defined as one that includes tribal, state and local public health agencies.



Shortly after these legislative milestones, Clallam County, under the leadership of Thomas Locke, MD, (the County's Health Officer) initiated efforts to establish an interlocal agreement between the County and the four tribes within the County's geographical borders: Jamestown S'Klallam Tribe, Lower Elwha Klallam Tribe, Makah Nation, and Quileute Tribe. Although significant effort was invested, the initiative came to a halt when the various jurisdictions' attorneys tried to develop an agreement that would satisfactorily address the five governments' concerns.

Years later, the September 11, 2001 terrorist attacks generated interest throughout the United States in developing and strengthening local capacity to prevent and respond to natural and man-made disasters. At that time, the American Indian Health Commission for Washington State (Commission) began exploring ways to support the development of cross-jurisdictional agreements between tribes and non-tribal jurisdictions in Washington to strengthen emergency response capacity, support cross-jurisdictional sharing of resources and achieve other benefits.

In 2008, in response to continued and growing interest in achieving a regional agreement, Washington State's Emergency Management Division provided funds to support a renewed effort. Dr. Tom Locke was Health Officer for Clallam and Jefferson Counties, and Dr. Scott Lindquist was Health Officer for the Bremerton-Kitsap County Health District. These three local health jurisdictions represent Washington State's Public Health Emergency Planning Region 2 (of 9 regions.) Concurrently, Dr. Locke and Dr. Lindquist were also serving as part-time primary care providers for two of the seven tribes in the region.

The first step in the effort to execute an agreement was for Dr. Locke and Dr. Lindquist to meet with tribal councils and county commissioners in the region. After securing leadership approval, the efforts proceeded with creating a workgroup and holding a series of meetings to develop a draft agreement. This work was facilitated by project-funded attorney, Susan Ferguson, and attended by county staff, tribal staff, and public health officials. By January 2010, all ten partner jurisdictions had signed the agreement. Finally, the partners developed an operational document, completed by December 2010.

Over time, other regions in Washington State requested the Commission for assistance in crafting their own regional agreements. Also, Region 2 tribal and local health staff who had opportunities to work with the original operational document expressed a desire to rewrite it and make it more "user-friendly."

III. 2017 AMERICAN INDIAN HEALTH COMMISSION MUTUAL AID AGREEMENT PROJECT

In fall of 2016, The American Indian Health Commission (Commission) applied for and obtained funding from the Washington State Department of Health to facilitate the development of Mutual Aid Agreements for Regions 1 and 3 and Operational Guides for Regions 1, 2 and 3. Although the goal is for all regions in the state to have the opportunity to develop their own cross-jurisdictional agreements, available funding was not sufficient to provide support for all of Washington State's regions. Regions 1 and 3 were selected because there are more tribes within the geographical boundaries of these two regions than in other regions.

A. PROJECT OBJECTIVES

Objective 1: Revise and improve Region 2's Operational Plan document

Objective 2: Facilitate a collaborative process for tribes and local health jurisdictions in Regions 1 and 3 to develop Mutual Aid Agreements and Mutual Aid Guides

B. PROJECT ACTIVITIES

i. **Outreach and Engagement.** AIHC reached out to key contacts at every jurisdiction via phone and email to announce the project and invite their participation in the project. The outreach was designed to maximize inclusion, asking the key contacts to participate in the project activities and to invite others in their jurisdiction who should also be included. Key contacts who were invited to participate and maintain informed included:

a. Tribes.

- Tribal Chairs
- AIHC Delegates
- Health Directors
- Health Officers
- Medical Directors
- Clinic Managers
- Public Health Emergency Coordinators
- Emergency Managers
- Tribal Attorneys

b. Local Health Jurisdictions.

- Public Health Officers
- Health Department Administrators/Directors
- Local Emergency Response Coordinators
- Healthcare Coalition Coordinators
- Attorneys

ii. **Communication and Coordination.** Throughout the process, project participants and other key representatives of partner jurisdictions received continuous updates via telephone calls and emails.

iii. **Beginning Drafts.** The Commission developed beginning drafts of a Mutual Aid Agreement and a Mutual Aid Guide. The drafts were created drawing from the Olympic Tribal-Public Health Mutual Aid Agreement, the Washington Intrastate Mutual Aid System (WAMAS), the national Emergency Management Assistance Compact (EMAC), and other identified existing agreements and best practices.

iv. **Regional Workshops.** The Commission originally designed the project to consist of one in-person kickoff meeting for each region, followed by webinar workshops for each region to tailor the documents to its unique needs. All three regions expressed great value in meeting with partners face to face, and requested all meetings to be held in person. Additionally, for Region 1, two of five meetings were held both in person and available for participation via webinar.

A total of 11 in-person meetings were held: Region 1 – five meetings, Region 2 – three meetings, Region 3 – three meetings. Two of the meetings were specific for attorney participants, although some operational staff also attended.

The workshops served to strengthen relationships across jurisdictions, increase knowledge of regional capacity, and collaboratively develop operational guidance for cross-jurisdictional responses.

v. **Coordination of Agreement Language.** The Commission communicated and coordinated with twenty-one attorneys from both counties and tribes to compile all parties' edits to the draft mutual aid language.

C. PARTICIPATION BY REGION

i. **Region 2.** Six of the seven tribes in the region and all three counties participated in project meetings and document development. The one tribe that did not participate has very limited staff and resources, but greatly values being party to the agreement. Three in-person meetings were held.

Participation Breakdown:
Tribes – Operational Staff: 13
Counties – Operational Staff: 8

ii. **Region 1**. Every tribe (of 8 tribes) and every county (of 5 counties) in the region participated in project meetings and document development.

Participation Breakdown:
Tribes – Operational Staff: 21
Counties – Operational Staff: 13
Tribes – Attorneys: 13
Counties – Attorneys: 2

iii. **Region 3**. Every tribe (of 7 tribes) and every county (of 5 counties) in the region participated in project meetings and document development.

Participation Breakdown:
Tribes – Operational Staff: 16
Counties – Operational Staff: 15
Tribes – Attorneys: 5
Counties – Attorneys: 3

D. PROJECT PRODUCTS AND PROCESS OUTCOMES

a. Mutual Aid Operational Guide

Process

The Commission developed a draft Mutual Aid Operational Guide (MAG) to serve as a starting point for the regions to work with. The draft MAG was designed to serve as a tool that supports implementing the provisions of the Mutual Aid Agreement. Guiding principles for the draft MAG included:

a. The Guide should be consistent with NIMS and ICS.

b. The Guide should be consistent with the region's Mutual Aid Agreement.

c. The Guide should be useful and provide clear guidance to anyone who may be in the position of operationalizing a response at 2:00am, even if it is the first time they see the MAA and/or the MAG.

d. The Guide should be exercised and updated annually.

e. Where appropriate, the Guide should be consistent with WAMAS.

Project participants in each region engaged in reviewing the entire document. During each region's series of in-person workshops, participants learned about the components of the MAA and MAG, and the legal and operational principles that must work in harmony to achieve a successful response. Participants suggested edits to both format and content of the MAG. These suggestions were incorporated in the document and reviewed in subsequent in-person workshops.

Region 1 conducted a tabletop to exercise the MAG and the Tribal-Public Health Mutual Aid Request Form, drafted and facilitated by Mark Raaka, Emergency Response Specialist for the Whatcom County Health Department.

Each region approved a final version of the Mutual Aid Guide at their region's final in-person meeting. At present, the version approved by all regions is identical. Also, all regions agree to the concept that the MAGs must be "living documents", to be updated and enhanced on an ongoing basis.

Product

The MAG contains several checklists to be completed by all parties. The checklists provide a step-by-step approach to assist the Requesting Party and Responding Party(ies) in completing a Tribal-Public Health Mutual Aid Request Form to execute the Mutual Aid process and taking actions to work effectively across jurisdictions in responding to an incident. Part One of the Mutual Aid Guide is a checklist that establishes important steps for ALL parties to complete prior to a public health incident. Part Two provides a checklist for the Requesting Party and Responding Party to complete at the time a public incident or emergency occurs.

The MAG's checklists are designed to be in a somewhat logical order. However, each incident and each Party's processes are unique, so actions may need to be completed in a different order, some actions not completed, and/or additional actions not listed on the checklists may need to be completed. Many items will need to be worked on simultaneously. Although the MAG is quite thorough, the nature of each incident will determine which of the steps included in the MAG should be completed, and whether additional steps that are not part of the MAG should also be taken.

The MAG includes steps to take in the following major areas.

a. Preparation. Steps each party should complete on or before executing the Mutual Aid Agreement;

b. Invoking Assistance and Responding to a Request for Assistance. Steps a Requesting Party and Responding Party(ies) should complete to request assistance and to offer assistance in response to an incident;

c. Deployment and Coordination. Steps a Requesting Party and Responding Party(ies) should complete to ensure a well-coordinated deployment of resources from the Responding Party to the Requesting Party and effective operation control during a response to an incident;

d. Demobilization. Steps a Requesting Party and Responding Party(ies) should complete to ensure an organized process for returning personnel, equipment and material to a Responding Party's jurisdiction; and

e. Reimbursement. Steps a Requesting Party and Responding Party(ies) should complete to ensure parties can pursue reimbursement from federal and/or state resources, and if necessary, from other parties to the Agreement.

b.Tribal-Public Health Mutual Aid Request Form

Process

The Commission developed a draft Tribal-Public Health Mutual Aid Request Form to serve as a starting point for the regions to work with. The draft Form was designed to serve as a tool to document a Requesting Party's request for assistance and a Responding Party's offer or declination to assist. Guiding principles for the draft MAG included:

a. Where appropriate, the Form should be consistent with the WAMAS request form;

b. The Form must not be a barrier to a timely response;

Project participants in each region engaged in reviewing the Form. Participants suggested edits to both format and content of the Form. These suggestions were incorporated in the document and reviewed in subsequent in-person workshops, until the final draft was achieved.

Product

Each region approved a final version of their Tribal-Public Health Mutual Aid Request Form at their region's final in-person meeting. At present, the final version approved by all regions is identical.

c. Model Mutual Aid Agreement

Process

Attorney engagement differed from operational staff engagement. Contact information for Local Health Jurisdiction (LHJ) attorneys was not directly available to the Commission. The Commission requested LHJ key contacts to invite LHJ attorneys to participate in project activities and to share project documents for LHJ attorneys' legal review at each Kickoff Meeting and in subsequent meetings. As the project progressed, the Commission was able to obtain contact information for some of the LHJ attorneys, but not all. Communication with some LHJ attorneys was achieved only with an operational staff person as intermediary. The draft mutual aid agreement was first distributed to county and tribal attorneys and other partner jurisdiction representatives in March 2017. Some tribal attorneys attended several of the in-person workshops. In Region 1, two LHJ attorneys attended a couple of attorney-specific workshops to discuss the draft MAA.

The Commission's attorney, Heather Erb, reached out via telephone and email to attorneys individually to request feedback on the draft. The first draft provided strong protections for sovereign immunity to the tribes but also established a process for reimbursement and dispute resolution. The Commission examined existing mutual aid agreements from states that, similar to tribes, enforce their sovereign immunity and do not allow for indemnification in their mutual aid agreements. In the first draft, tribes would only waive sovereign immunity for purposes of enforcement of an arbitration award as it relates to the reimbursement provision of the agreement. In order to remain consistent with tribes' desire to keep their sovereign immunity, the agreement did not include an indemnification provision. The majority of tribes expressed a willingness to adopt this version of the agreement.

Early on, counties raised strong concerns regarding the initial draft, specifically in regard to the liability provision, the lack of an indemnification provision, and the narrow waiver of sovereign immunity. Counties reasoned that if their responding personnel would be under the operational control of a tribe requesting assistance, their personnel and the counties should receive broad protection from suit. In addition, counties argued that they are constrained to agreeing to such provisions by their membership in the statewide county risk pool. Several county attorneys worked together to coordinate their suggested changes. As a result of the counties' requests and input, a significantly revised agreement was proposed to the tribes. The counties' proposed changes included:

a. More consistent language with Washington's intrastate mutual aid legislation found in RCW 38.56;

b. Broad waiver of Sovereign immunity;

c. Requirement for requesting parties to have a five (5) million-dollar insurance policy;

d. Requirement for requesting parties to name responding parties as additional insureds;

e. Broad indemnification provision;

f. The removal of tribal court for venue in exchange for federal court first, and if no jurisdiction in federal court, then state court; and

g. The removal of tribal law for governing law in exchange for federal law, and if no applicable federal law, then state law.

Product

The final draft mutual aid agreement was sent to all tribes and local health jurisdictions in Regions 1 and 3. Although all jurisdictions are currently moving the final agreement through their individual governments' approval processes, several partners have already stated the intent to sign the agreement. The Commission will continue to advocate and support execution of the Region 1 and Region 3 MAAs. The Commission will seek additional funding for these efforts and to provide the same opportunity to the remaining regions in the state.

d. Regional Online Password-Protected Mutual Aid Document Share Sites

Process

The Commission developed draft online password-protected document share sites for project participants to review and provide feedback. Project participants in each region engaged in reviewing the draft share sites. Participants suggested edits to both format and content of the share sites. These suggestions were incorporated in the web site design and reviewed in subsequent in-person workshops.

Product

Each region approved a final version of their region's online document share site. The Commission will maintain the three regional document share sites. Each party to the agreements is responsible for submitting the information they choose to share. Document share site content includes:

a. Signed Mutual Aid Agreement
b. Mutual Aid Guide
c. Tribal-Public Health Mutual Aid Request Form
d. Mutual Aid Guide Operational Forms
e. ICS Forms
f. Model Tribal Public Health Codes
g. For Tribal Partners
    i. Mutual Aid Request Contacts
    ii. Public Health Emergency Laws and Codes
    iii. Comprehensive Emergency Management Plan
    iv. Pandemic Influenza Plan
    v. Reservation Map
    vi. Tribal Campus Map
    vii. Available Resources and Estimated Costs Inventory

h. For LHJ Partners
   i. Mutual Aid Request Contacts
   ii. Public Health Jurisdiction Resolution
   iii. Public Health Department/County Services Campus Map
   iv. Available Resources and Estimated Costs Inventory

IV. LESSONS LEARNED

The six-month long project created many newly established relationships and an important framework for operationalizing mutual aid between tribes and local health jurisdictions. During this period, the Commission identified the following best practices for on-going development of mutual aid agreements and their implementation:

a. Involve all attorneys early and often with emphasis on individual outreach to better address the needs of individual county and tribal clients;

b. Engage the insurers for both the counties and the tribes. Ensure that they receive copies of the draft mutual aid agreement. Identify any possible concerns regarding the liability and indemnification provisions;

c. Educate all participants early on that both counties and tribes will have to "give up" something in the negotiation process to reach common ground. Counties and tribes have very different rules and policies regarding immunity and liability;

d. Provide more time to develop and execute agreements with complex issues among multiple jurisdictions. Region 2's Olympic Tribal-Public Health Mutual Aid Agreement required over three years to accomplish. Although having a beginning document that has been reviewed and vetted by the 15 tribes and 10 LHJs in Regions 1 and 3 will facilitate efforts in Washington's remaining Public Health Emergency Planning Regions, efforts to work with other regions will require a time period longer than six months to assure time for review and approval in tribal council and health board meetings; and

e. Work closely with the Department of Health tribal liaison and have them in attendance at all meetings if possible.

V. NEXT STEPS

In furtherance of the accomplishments achieved under the Mutual Aid Project, the Commission will:

- **a.** Continue to advocate and support execution of the Region 1 and Region 3 MAAs, and will seek additional funding for these efforts;
- **b.** Continue to maintain the three regions' document share sites;
- **c.** Seek additional funding to facilitate a process in Washington State's remaining Public Health Emergency Planning regions to execute Tribal-Local Health Jurisdiction mutual aid agreements;
- **d.** Seek additional funding to facilitate exercises and other efforts to strengthen cross-jurisdiction collaboration and mutual aid between tribes and local health jurisdictions; and
- **e.** Participate, along with tribes and local health jurisdictions, in the Mutual Aid Recognition and Signing Ceremony with Washington Secretary of Health, John Wiesman.