WSALPHO

WASHINGTON STATE ASSOCIATION OF LOCAL PUBLIC HEALTH OFFICIALS

WASHINGTON STATE
BOARD OF HEALTH
Working for a safer and healthier Washington since 1889

A Plan to Rebuild and Modernize Washington's Public Health System

December 2016

ACKNOWLEDGEMENTS

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"Recognizing the financial challenges faced by the public health system, which comprises state and local entities, and the impact that those financial challenges have had on the system's ability to deliver essential public health services throughout the state, the legislature directs the department and local public health jurisdictions, within amounts appropriated in this section, to provide a proposal outlining a plan for implementing Foundational Public Health Services statewide to modernize, streamline, and fund a twenty-first century public health system in Washington state. Current fees that support the work of public health should be reviewed, and the proposal should identify those fees that are not currently supplying adequate revenue to maintain compliance or enforcement. The first report regarding the proposal is due to the appropriate committees of the legislature no later than December 1, 2016, and subsequent reports shall be submitted biennially, thereafter"

Washington State 2016 Supplemental Budget,
ESHB 2376, Section 219(24) Page 147, Lines 6-21

To the Washington State Legislature,

As directed by a proviso in the 2016 supplemental state budget, we are pleased to bring you this proposal for rebuilding, modernizing and funding a 21st century public health system.

Protecting the public's health is one of the state's fundamental responsibilities. However, the public health system has become woefully inadequate and is now unable to meet its basic responsibilities to protect the health and safety of people in Washington State. Public health leaders from the Department of Health (DOH), the State Board of Health (SBOH), and local health jurisdictions (LHJs) represented by the Washington State Association of Local Public Health Officials (WSALPHO) have been working together for over five years to develop a plan for rebuilding, modernizing and funding the public health system. We stand together in our commitment to move this work forward in order to protect and improve the health of the people of Washington.

This report explains the problem and the proposed solution that has been developed over the past five years of collaborative work. We provide you, the legislature, with this multi-year plan to implement rebuild, modernize and fund a 21st century public health system, and we look forward to working with you to make it a reality.

The Public Health Improvement Partnership (PHIP) was established over 20 years ago in response to RCW 43.70.520 and 43.70.580, and has served as a national model for public health collaboration. Our current work together to rebuild, modernize and fund the public health system is the next iteration of our collaborative partnership and, as such, this report also serves as the biennial Public Health Improvement Plan report.

The proviso also directed us to provide additional information about the adequacy of fees that support public health. If funded, one of the next steps in modernizing the public health system includes a statewide assessment of capacity, costs and funding to be conducted in the next two years. Information on fees will be a part of this comprehensive assessment and will be included in the next biennial report in the fall of 2018.

As this report was being finalized, the Governor's budget for 2017 – 2019 was released. The budget contains $23.9M as a down payment to begin the rebuilding and modernization of the public health system. We are very grateful for Governor Inslee's support in this very difficult budget environment and appreciate his commitment to public health.

Sincerely,

John Wiesman
Secretary of Health,
Washington State

Michelle Davis
Executive Director,
State Board of Health

Dorene Hersh
Immediate Past President,
WSALPHO

December 16, 2016

December 16, 2016

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EXECUTIVE SUMMARY

The Problem Statement

Washington's governmental public health system (public health system) has a critical and unique public safety role that is focused on protecting and improving the health of families and communities. According to state law, RCW 43.70.512, protecting the public's health is a fundamental responsibility of the state.

After a century of effectively preventing illness and premature death and increasing the length and quality of life in Washington communities, the public health system has become woefully inadequate due to the combined challenges of:

Today's children are in danger of becoming the first generation in American history to live shorter, less healthy lives than their parents. [i]

A change in the nature of preventable disease. The people of Washington State are at increased risk from new infectious diseases that can spread rapidly across the world –such as Ebola and Zika. Old diseases, once thought to be largely controlled, are returning such as measles and mumps. Tuberculosis continues to be a challenge as there are now cases that are resistant to multiple drugs costing the public health system tens of thousands of dollars to treat. We continue to see alarming disparities in life expectancies based on socioeconomic status, race and ethnicity, which could be reduced by taking action to prevent chronic diseases.

Increasing demand for public health services. Increasingly, our residents suffer from chronic diseases that diminish their quality of life and lead to early death. In Washington, we have seen an increase in the rates of adult and childhood obesity, a contributing factor to many chronic diseases, and crises related to the opioid addiction epidemic. Additionally, tobacco use continues to be the most preventable cause of death in the state. Add a population growth of about 12% between 2006 and 2016 and local health department staffing cuts of as much as 50% in many jurisdictions, and you have service demands that far exceed existing capacity. [ii]

Diminished funding for core public health services. State and county budgets have been significantly impacted by the Great Recession and tax-limiting measures, making it difficult to generate the funds needed to meet their obligations to fund core public health services. In addition, there is wide variation in public health funding and services across the state leaving some communities at greater risk than others.

The public health system is funded by the federal, state and local government as well as user fees which can have restrictions that limit the ability to provide core services and support critical infrastructure.

- Federal grants can only be used for very specific services and don't provide funding to cover infrastructure and the core public health services needed in every community.
- User fees can only be used to fund the specific service for which they were collected.

- Funds from state and local government pay for core public health services and basic infrastructure for the system but are currently not sufficient to meet the needs.

The Solution

Modernize and Adequately Fund the Public Health System

Since 2004 the legislature has been engaged with public health in examining and trying to fix this problem. Over the years, and demonstrated through various committees and reports, there has been consistent agreement that public health needs more funding to deliver core services but the problems remain.

In the past five years, a new collaborative effort has been underway. Leaders from local and state public health, Tribes, elected officials, state policy experts, professional organizations, and advocacy groups have come together to create a **new vision** to rebuild, modernize and fund a 21st century public health system in Washington.

Our Vision

1. There is a limited statewide set of core public health services, called Foundational Public Health Services (FPHS), that government is responsible for providing.
2. Core public health services are funded through dedicated revenues that are predictable, reliable and sustainable, and responsive to changes in demand and cost over time. A major tenet of this part of the vision is that these services would be funded through a combination of state funds, state and local fees, and when available and sustainable, federal grants.
3. Governmental public health services are delivered in ways that maximize the efficiency and effectiveness of the overall system.
4. Governmental public health activities are tracked and performance is evaluated using evidence-based measures.
5. Local revenue generating options are provided to address locally driven priorities that are targeted to specific community problems.

This ambitious vision will modernize Washington's public health system and will improve the health and lives of all Washingtonians. We are proposing more than just increased funding for public health; modernization also includes:

- Defining which core services are needed in every community
- Restructuring how the public health system is funded
- Implementing new service delivery models across multiple jurisdictions
- Modernizing and improving our use of technology

Given the magnitude of the current challenges and the transformative nature of the vision, modernizing Washington's public health system will be a phased, multi-year effort.

Policy and Budget Actions for 2017 – 2019 Biennium

- Propose legislation to define core services that need to be available in every community and establish the framework for implementing new ways of delivering core services across multiple jurisdictions.
- In a very difficult budget year, Governor Inslee has prioritized investing in public health by proposing a $23.9M immediate investment in foundational public health services towards an initial down payment request of $60M. This initial investment recognizes a much larger need of $312M to $344M (preliminary estimate) but is a significant step to stabilize the crumbling system and fill the most critical gaps in core public health services

  The Governor's initial investment of $23.9M will help restore key functions that have already been lost, improve public health's ability to respond to the threat of communicable diseases and continue the modernization of the public health system.

  Specifically, the funds will support:

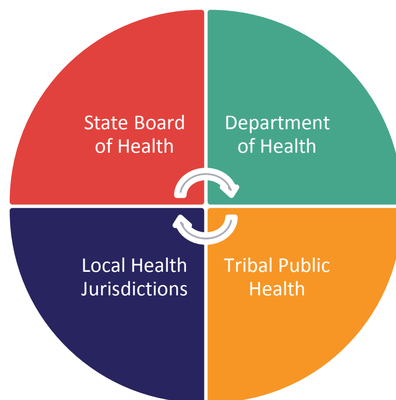
  - The most critical **LOCAL** gaps in core communicable disease programs and capabilities.
  - Specific **STATEWIDE** gaps in core high-priority programs and capabilities.
  - Development and implementation of shared service models to maximize resources.
  - Continued implementation of the Public Health Modernization plan.
  - An assessment of the current capacity of each of the 35 local health jurisdictions to describe the full system gaps and identify the cost of providing the limited set of core public health services statewide.

Washington is not alone in facing these new public health challenges, and is a national leader in this critical and exciting work to rebuild, modernize and fund our public health system. The US Department of Health and Human Services is encouraging public health modernization as "Public Health 3.0," which describes how public health needs to adapt to meet 21st century challenges and calls for a major investment in the public health system. [iii]

PUBLIC HEALTH IS ESSENTIAL

Washington's public health system has a critical and unique public safety role focused on protecting and improving the health of families and communities. This is primarily accomplished through monitoring and controlling of communicable diseases; preventing the spread of disease from one person or place to another; promoting healthy lifestyles; giving all children a healthy start on life; preventing chronic disease (e.g. diabetes, heart disease, cancer, stroke, etc.); ensuring safe water and food; preventing injuries; and ensuring safe and quality healthcare. According to state law, RCW 43.70.512, protecting the public's health is a fundamental responsibility of the state.

Exhibit 1. Governmental Public Health in Washington



Source: Department of Health, 2016.

As shown in Exhibit 1, the governmental public health system in Washington is made up of:

- Washington State Department of Health (DOH);
- State Board of Health (SBOH);
- 35 local health jurisdictions (LHJs) governed by their local Boards of Health; and,
- Sovereign tribal nations of Washington.

Public health works to eliminate or reduce disease risks and prevent illness for whole groups of people or communities (called population health) – in contrast to the medical care system, which focuses primarily on treating individuals after they become sick or injured (called individual healthcare or medical care). Both are needed for health and must work together. Each has an important and unique role to play. Both are necessary and neither is sufficient alone.

The impacts of the Great Recession, changing population health challenges and the Affordable Care Act all require the public health system to change how we do our work.

Public health has a role in bridging the chasm between the healthcare delivery system and the community, improving health outside clinic walls to reduce the need for and cost of healthcare and giving everyone a chance to live a healthy and productive life.

THE PROBLEM

After a century of effectively preventing illness and premature death and increasing the length and quality of life in Washington communities, the public health system now faces the combined challenges of:

- A change in the nature of preventable disease;
- Increasing demand for core public health services; and,
- Diminished and inequitable funding for core public health services.

These combined challenges result in a growing risk to the public that has reached a crisis level.

The cumulative effect of new complex disease threats, costly and preventable chronic diseases and injuries, and the increasing need to ensure that all children have a healthy start in life, as well as several other factors, threatens to produce lower life expectancies among today's children than among their parents – something that has never before happened in United States history. [ii]

The Changing Nature of Preventable Disease

Global travel and trade have increased exposure to new diseases which now spread faster than ever. We have recently experienced this as the public health system worked to prepare the healthcare system to quickly identify and control the spread of Ebola. We were fortunate not to see any actual cases of Ebola, but outbreaks will happen again, as well as outbreaks of other diseases that are equally dangerous.

PROTECTING OUR COMMUNITIES FROM DANGEROUS DISEASES

During the 2014 international Ebola crisis, state and local public health staff worked with emergency medical systems, hospitals, funeral homes, waste management companies and others to plan and coordinate how to transport and care for an individual who might have Ebola. In addition:

- 339 people who returned to Washington from Ebola impacted countries were each checked daily for 21 days, by local public health staff to monitor for any signs of the disease.
- The state Public Health Laboratories had to prepare for new tests with infectious agents and tested three samples.
- State and local public health staff developed and communicated guidance to the healthcare system for screening and treatment of individuals who might have Ebola. Guidance often changed daily.

HEALTHCARE ASSOCIATED INFECTIONS

The impact of Healthcare Associated Infections is placing new demands on an already stretched public health system. Tracking and investigation of these complex infections is more important than ever. Most recently, outbreaks of Legionnaires' disease and infections from endoscopes at healthcare facilities have caused preventable deaths and generated significant public and media interest. Additional resources are needed to further strengthen connections between public health and healthcare to prevent these diseases.

The Seattle Times — Health

Ice machine, sinks linked to Legionnaires' cases at UW Medical Center

Some old diseases, once thought to be largely controlled, are returning and in some cases are even more difficult and expensive to treat than before.

LATENT TUBERCULOSIS (TB)

Latent TB means a person is infected with *Mycobacterium tuberculosis*, but the patient does not have active (contagious) tuberculosis. The US Prevention Services Task Force recommends high-risk individuals be screened and treated for latent TB by the primary care system.

In King County, more than 100,000 people have latent TB. [iv] One in 10 of these cases will become contagious, leaving the region vulnerable to the spread of disease. [iv] The public health system needs to reach out to healthcare providers to share information about screening for latent TB and encourage individuals to be tested. Without new funding, King County could be dealing with up to 10,000 cases of active TB that could have been prevented.

SIGNIFICANT INCREASE IN SYPHILIS

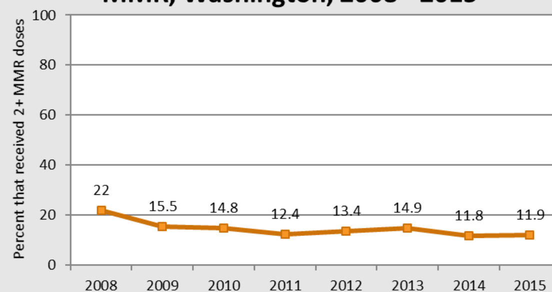
Syphilis cases in King County more have more than doubled over the last decade. [v] **As of October 2016, the number of syphilis cases occurring in heterosexuals in King County increased by 78% from 2015, with a 130% increase seen specifically in women.** [v] Syphilis can cause severe and even fatal infections in infants born to infected mothers; cases involving women require intensive public health intervention to minimize the risk of congenital syphilis. Based on national practice, Public Health – Seattle & King County (PHSKC) attempts to investigate each syphilis case to ensure that the infected person and their sex partners receive curative treatment. However, resources to perform complete investigations are limited, hampering PHSKC's efforts to stop the spread of syphilis among individuals and to assure community health.

THE RETURN OF MEASLES

In the spring of 2015, a Clallam County woman died from pneumonia due to measles, a disease thought to be effectively eradicated in the United States through vaccinations. **In 2015, 11.9% of Washington teens (ages 13-17 years) did not have the two recommended doses of MMR (measles, mumps and rubella) vaccine.** When this number goes above 5%, the community is at risk of uncontrolled spread of measles. [vi]

Because our community immunity is weakened, it is likely that measles and other "eradicated" diseases will return. There were 43 cases of measles in our state in 2014-15. We usually expect to see between zero and five cases per year. Addressing this returning threat will require additional public health system resources.

Percentage of teens ages 13-17 years who have not received 2+ doses of MMR, Washington, 2008 - 2015



Source: Department of Health, 2016.

Increasing Number of People Suffering from Chronic Diseases

We continue to see alarming disparities in life expectancies based on socioeconomic status, race and ethnicity, which could be addressed by taking action to prevent chronic diseases. There are increasing numbers of people suffering from chronic diseases in our state. The public health system has a unique role to monitor the causes of chronic diseases and work with partners to implement evidence-based strategies that work at the systems level to eliminate or reduce risk factors, giving everyone a chance to live a long, healthy life.

- In Washington, we have seen increases in the rates of adult and childhood obesity, a contributing factor to many chronic diseases.
- We have a crisis related to the opioid addiction epidemic.
- Tobacco use continues to be the most preventable cause of death in the state.
- Poor health is associated with a lower quality of life and contributes to decreased worker productivity and rising healthcare costs for businesses, individuals and government.

DEATH BY OPIOID OVERDOSE

Washington State is currently experiencing an opioid abuse and overdose crisis involving prescription opioids and heroin. [vii] **Approximately 700 individuals die each year from opioid overdose with an increasing proportion of those deaths involving heroin.** [vii] As overdoses have surpassed traffic crashes as a top cause of accidental death, [vii] this work represents a new demand on the system.[vii]

Preventing or delaying the onset of chronic disease is in everyone's best interest. The public health system lacks the capacity to implement proven and cost-effective strategies to address these problems.

TOBACCO USE IS THE MOST PREVENTABLE CAUSE OF DEATH IN WASHINGTON STATE

Between 2008 and 2016, state funding for tobacco prevention declined precipitously from $27.1M to $2.3M annually, essentially eliminating any effective tobacco program. [viii]

The declines in smoking rates have plateaued, and smoking rates for some populations and preventable deaths from tobacco use are still high. There is a significant disparity in tobacco usage rates across race, ethnicity, education level, sexual orientation and socioeconomic status.

In Washington, about 16% of adults smoke, but the rate varies greatly among different populations.

- An American Indian or Alaskan Native person is twice as likely to smoke cigarettes as a non-Hispanic white person;[ix]
- A person who makes less than $35,000 per year is three times more likely to smoke cigarettes than a person who makes over $75,000 per year;[ix]
- A person with a high school diploma or less education is four times more likely to smoke cigarettes than a college graduate;[ix]
- A lesbian, gay, or bisexual person is twice as likely to smoke cigarettes as a heterosexual person;[ix]
- A person living with a disability is twice as likely to smoke cigarettes as a person without a disability.[ix]

Investing in tobacco prevention programs can result in increased savings for individuals, insurers, employers, and local, state and federal government. [x]

There has been a dramatic increase in youth use of nicotine products, including vapor products, in Washington state. Youth reporting use of all nicotine products combined jumped 67% among 10th graders between 2012 and 2014, according to the 2014 Healthy Youth Survey. Tobacco companies spend over $88 million a year on marketing in Washington. [xi]

UNDERSTANDING LEAD POISONING IN OUR CHILDREN

A 2014 capacity survey showed that only 44% of LHJs were able to respond to elevated levels of lead greater than 5 mcg/dL (recommended action level) in children. **Over 12% of LHJs did not have the capacity to respond to any elevated blood lead results in children**.

Because LHJs do not have the foundational capacity to investigate all elevated blood levels, our children are being continuously exposed unnecessarily to lead, leaving them at risk of lifelong impacts.

Increasing Demand for Information

In today's world, we all expect immediate access to information and data. The public expects the same in order to make good decisions and stay healthy. Policy makers, healthcare providers, public health and public safety need this too. This requires developing data systems that can exchange data electronically with hospitals, labs and healthcare providers in real-time; using standardized platforms for data systems to reduce costs; making data available so others can efficiently use it; and partnering with others to make data and health information available through apps in mobile technology.

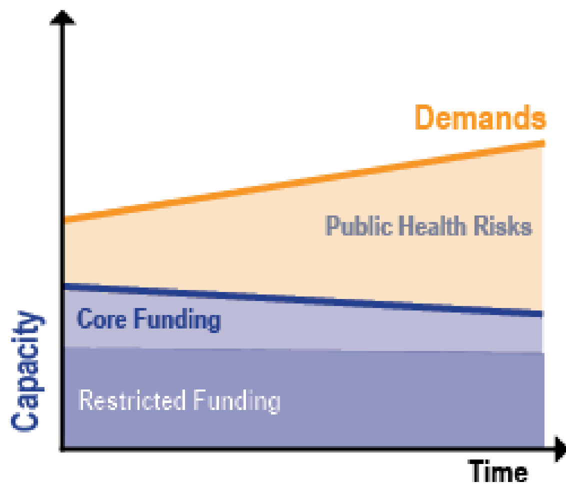
There are growing demands on the public health system for real-time data and to be a reliable partner with others in collecting, protecting, analyzing, sharing and linking data at a time when most public health data systems are old, slow, and often unable to meet current demands. The existing data systems were built using a patchwork of grants that have long since gone away.

Today, communicating about health and what people, communities and organizations can do to protect themselves and each other requires more effort. Making information widely accessible and available via the internet, social media, traditional media and other modalities, and for people of different abilities (i.e. limited vision or hearing), languages and cultures is an important and resource-intensive part of public health.

Diminished and Inequitable Funding for Core Public Health

In Washington, funding public health is a shared responsibility of state and local government. State and local funds are used for basic infrastructure of the system (facilities, fiscal services, information technology, communications, etc.), core public health services not covered by categorical grants or fees, and priorities designated by state or local government.

Exhibit 2. Increasing demand and diminishing core funding is resulting in growing risk to the public



Source: BERK Consulting, 2016.

Over the years, state and county budgets have been significantly impacted by tax-limiting measures (e.g. repeal of the Motor Vehicle Excise Tax [MVET] in 2000 related to I-695 and the 1% property tax limit in 2001 related to I-747), making it difficult to raise funds to meet obligations and fund core public health services. This has resulted in a consistent trend of increased dependence on categorical grants and fees to fund the public health system and diminishing capacity to provide core services that prevent disease and improve health.

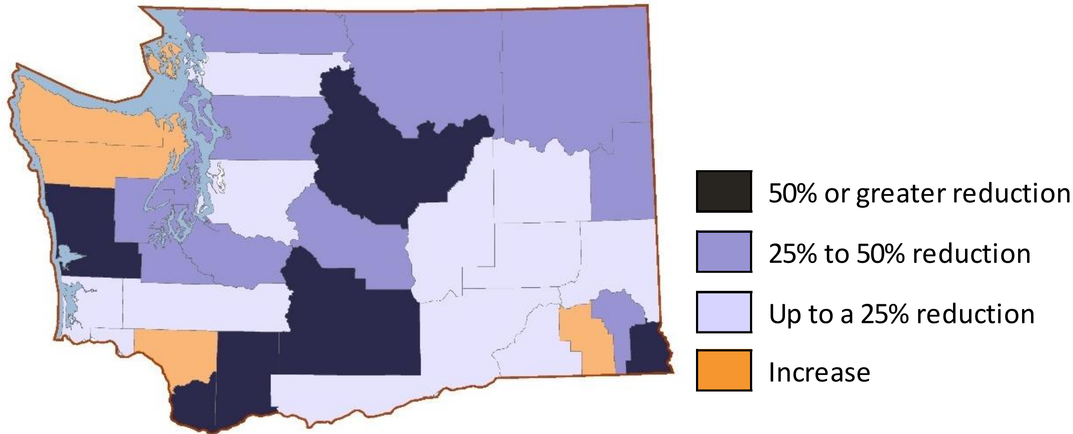
"Restricted" funds (categorical grants, fees and "dedicated" funds) are important in funding specific programs and services. However, without an ability to provide the core public health services that support these activities, the grants and fees cannot be used to most effectively and efficiently improve the health of the public.

Local funding issues are severe. In 2014, overall statewide per capita spending by LHJs was $52.93, a reduction of $7.49 (12.4%) since 2005 in inflation-adjusted dollars.

And not everyone is equally impacted. In Washington, public health funding and service levels vary significantly depending on where you live. More work is needed to understand the level of investments specifically in the core public health services and how and why needs and cost vary regionally.

Exhibit 3 shows the percentage change in per capita spending for each LHJ in Washington from 2005 to 2014.

Exhibit 3. 2005 to 2014 Percentage Change in LHJ Per Capita Spending



Source: Washington State Department of Health BARS Data Reports, and BERK Consulting, 2016.

County Level

- Only four LHJs show an increase in per capita funding from 2005 to 2014 when adjusted for inflation.
- All other LHJs show a decrease in per capita spending. Six LHJs show a decrease in per capita spending of 50% or more when adjusted for inflation.

Population Level

- Almost 97% of Washingtonians live in LHJs that have received a decrease in public health funding from 2005 to 2014.
- Over 13% of Washingtonians live in LHJs that have received a 50% or higher decrease in funding from 2005 to 2014.

Disparities in local public health spending likely contribute to the disparities in health outcomes.

While these problems have been years in the making, the current level of public risk is unacceptable and has reached a breaking point. Public health officials can no longer ensure policy makers or the public of its ability to protect the public's health as they expect.

Every day increases the risk. The time to act is now – to begin addressing this problem and reducing the risk to public health and safety.

THE SOLUTION

A New Vision for Public Health in Washington State

As the saying goes "An ounce of prevention is worth a pound of cure"—investing in prevention is an effective way to improve health. Containing the growing health burden and economic impact of preventable diseases in Washington **requires a strong public health approach**. The public health system can reduce preventable illnesses and deaths through prevention programs—promoting positive changes in behavior and giving everyone a chance to live a healthy life.

Protecting the public's health is one of the state's fundamental responsibilities according to RCW 43.70.512. For more than a decade, the legislature has been engaged with public health in examining and trying to fix the problem. Over the years of various committees and reports, there has been consistent agreement that public health needs more funding to deliver core services but the problems remain. See ***Appendix B*** for a summary of these past efforts.

AN OUNCE OF
PREVENTION
IS WORTH A POUND OF **CURE**

Preventable infectious diseases cost the country more than $120 billion annually – and that cost is exponentially compounded when new diseases emerge. [xii]

A 2012 study found that for every $1 previously invested, $5 in tobacco-related hospitalization costs were saved. Funding tobacco prevention and control is an investment in Washington State's health and economic future. [xiii]

A study evaluating the economic impact of the 2009 US childhood immunization schedule estimated that routine immunization of children born during that year will prevent approximately 42,000 early deaths and 20 million cases of disease. [xiv]

Over the past five years, leaders from local and state public health, tribes, elected officials, state policy experts, professional organizations and advocacy groups have come together to create a new vision for the governmental public health services in Washington. They recommended that:

- State funding for public health should ensure that the cost of core public health services is covered in every community.
- The core services should be funded with statutorily directed revenues placed in a dedicated account.
- Allocation determinations should be a collaborative process between state and local stakeholders.
- A robust accountability structure that aligns with the core services framework should be collaboratively developed by state and local stakeholders to ensure accountability and return on investment.
- Tribes, with support from the Department of Health, should convene a process to define how the core services funding and delivery framework will apply to tribal public health, and

how tribal public health, the Department of Health and local health jurisdictions can work together to serve all people in Washington.

- Local spending on services provided to meet local priorities should be incentivized.

There has been significant work accomplished to achieve the new vision. We have:

- Defined a limited set of core public health services that need to be present in every community.
- Estimated the cost of providing the core services statewide.
- Developed a set of principles to guide the implementation of the new vision.
- Developed a modernization plan to create a system that uses multi-jurisdictional service agreements to maximize efficiency and effectiveness in the delivery of core public health services.
- Submitted a budget request to fill the most critical gaps in core public health services as a short term solution until the final system proposal is completed and presented to the legislature in fall of 2018.

NATIONAL EFFORTS - PUBLIC HEALTH MODERNIZATION

The challenges facing Washington's public health system are not unique to the state. Washington, along with a select group of other states, is helping to develop and demonstrate concepts and frameworks for modernizing public health that can be used nationwide. The US Department of Health and Human Services is encouraging public health modernization as "Public Health 3.0," which calls for major investment in public health, emphasizing cross-sectoral environmental, policy and systems-level actions that directly affect the social determinants of health and advance health equity. [xv] Public Health 3.0 is not yet an implementable framework but rather a nascent concept supported by five recommendations:

1. Strong Leadership and Workforce
2. Strategic Partnerships
3. Flexible and Sustainable Funding
4. Timely and Locally Relevant Data, Metrics and Analytics
5. Foundational Infrastructure

Washington's groundbreaking work is being used by several states that are working to implement initiatives supporting Public Health 3.0 and is being leveraged across the nation.

Implementing a Modernized Public Health System in Washington

To achieve this new vision, we need to do more than just increase funding for governmental public health; we also need to rebuild and modernize the public health system. The plan for modernizing the public health system is organized around **five guiding principles**:

1. There should be a limited statewide set of core public health services that the government is responsible for providing.
2. Core public health services should be funded through dedicated revenues that are predictable, reliable, sustainable and responsive to changes in demand and cost over time.
3. Governmental public health services should be delivered in ways that maximize the efficiency and effectiveness of the overall system.
4. Governmental public health activities should be tracked and performance evaluated using evidence-based measures.
5. Local revenue-generating options should be provided to address locally driven priorities that are targeted to specific community problems.

Each of these guiding principles reflects the best thinking of people with decades of experience and different values and priorities, but all with a common goal of improving the health of all Washingtonians.

The following sections provide additional detail about each of the guiding principles.

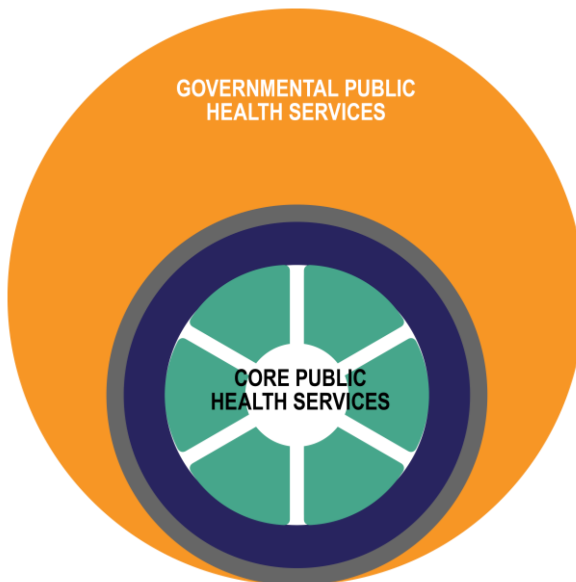
1. There should be a limited statewide set of core public health services that the government is responsible for providing.

The first guiding principle is a focus on efficiently delivering a consistent and uniform set of core public health services statewide that were developed using the following criteria:

- Basic responsibility of government;
- Population-based prevention services or individual interventions that have significant population health implications; or are
- Mandated by the state.

These core services are a subset of the essential work of the public health system, as shown in Exhibit 4, and are called **Foundational Public Health Services (FPHS)** because they provide the foundation to support the work of the broader public health system and community partners.

Exhibit 4. FPHS' Role in Public Health and Health



Source: BERK Consulting, 2016.

This foundation is a limited set of core capabilities and services that must be present in every community in order to efficiently and effectively protect all people in Washington.

When one part of the public health system is unable to provide the core communicable disease services, it leaves all communities vulnerable to disease outbreaks such as measles, pertussis and foodborne illness that could have been contained if the whole system was functioning as designed.

A summary of these definitions is on the following page. These definitions will continue to be refined, and it is expected that they will evolve over time. See ***Appendix B*** for the full definitions.

FOUNDATIONAL PUBLIC HEALTH SERVICES:
A Summary of Washington's "Core" Governmental Public Health Services

Foundational Programs are governmental public health programs needed in every community for the public health system to work well in protecting people's health.

- **Control of Communicable Disease and Other Notifiable Conditions:** Control disease through surveillance; outbreak investigation; identification and control of causes; prevention (including immunizations when applicable); follow up on important notifiable conditions; and education.
- **Chronic Disease and Injury Prevention:** Reduce statewide and community rates of chronic disease and injury through multi-faceted prevention programs that address health disparities; educate and promote positive changes in behavior, policy, systems and environment.
- **Environmental Public Health:** Prevent exposures to environmental health hazards and support healthier built and natural environments; this includes enforcing environmental public health regulations.
- **Maternal/ Child/Family Health:** Help children and families achieve the highest attainable standard of physical, mental and social health through education, support and evidence-based interventions across the lifespan, including those that address health disparities.
- **Access/Linkage with Medical, Oral, and Behavioral Health Care Services[1]:** Work as an active partner with medical, oral and behavioral healthcare[1] in efforts to improve healthcare quality, reduce healthcare costs and improve population health, including efforts to address health disparities.
- **Vital Records:** Maintain accurate records and data about vital events such as births and deaths, in accordance with state law.

Foundational Capabilities are the knowledge, skill, ability and systems infrastructure necessary to support effective and efficient governmental public health services.

- **Assessment:** Collect and use data to identify community health problems and health disparities to guide public health planning and decision making.
- **Public Health Emergency Management:** Help communities plan for and respond to disasters or emergencies in accordance with national and state guidelines.
- **Communication:** Create and implement communication plans to inform stakeholders about public health services and issues and to promote positive change.
- **Policy Development and Support:** Develop evidence-based and emerging public health policy recommendations that promote health and reduce health disparities.
- **Community Partnership Development:** Mobilize community partnerships to identify and solve health problems including the reduction of health disparities.
- **Business Competencies:** Demonstrate competency in (1) leadership; (2) accountability and quality assurance; (3) quality improvement; (4) information technology; (5) human resources; (6) fiscal management; (7) facilities and operations; and (8) legal services and analysis.

2. Core public health services should be funded through dedicated revenues that are predictable, reliable, sustainable and responsive to changes in demand and cost over time.

The second guiding principle is to identify funding sources that are predictable and reliable over time, and that increase with cost drivers such as population growth and inflation. There are several tenets of this guiding principle, including:

- According to RCW 43.70.512, the state is primarily responsible for ensuring that core governmental public health services are provided statewide. As such, these services should be funded through a combination of state funds, state and local fees and, where available and sustainable, federal grants.
- Due to the critical role that core governmental public health services play in protecting and promoting community health in Washington, state funding for this purpose should be statutorily dedicated to a new FPHS Fund that would be restricted to ensuring statewide provision of these services. The allocation of these funds will be based on a new funding allocation method to be developed by DOH and LHJs (subject to legislative action.)
- Given the overall decline in public health spending over the past decade and the significant demands on the system for all essential public health services, new funding targeted for FPHS should not supplant existing state and local funding, which should remain in the public health system to fund local and state priorities.
- Realignment of state and local funding to support the new vision should be phased to minimize disruptions in existing programs.
- To promote continued local investment in the public health system, opportunities to incentivize funding of locally driven priorities (that are not considered FPHS but vital to the health of local communities) should be considered including, but not limited to, the establishment of local match requirements to receive full core governmental public health services funding.

PRELIMINARY ESTIMATED COST OF PROVIDING CORE SERVICES

Initial cost estimates for providing core services statewide (based on the FPHS model) are approximately $906 million per biennium. After removing current state funding for DOH core services (including fee revenue collected by DOH for statewide core services), state flexible funding for LHJs, and estimated local fee income for local core services, there is an estimated $312 million per biennium resource need for full implementation of FPHS statewide.

There is $31.7 million per biennium in grant funding currently supporting core services which could be at risk depending on future grant funding availability and priorities. This funding is considered "insecure." As a result, long-term funding needs could range from a low of $312 million to $344 million a biennium in 2016 dollars.

Estimated Cost to Fully Implement FPHS	**$ 905.2 M**
Less Current FPHS Funding	
Local fees	($ 141.7 M)
State flexible funds to LHJs	($ 74.0 M)
State funds to DOH and fees	($ 377.0 M)
Net Funding Need	**$ 312.5 M**
Insecure Funding (Grants)	
LHJs	$ 28.1 M
DOH	$ 3.6 M
Potential Insecure FPHS Funding	**$ 31.7 M**
Potential Range of FPHS Funding Needs	**$ 312 M to $ 344 M**

These are preliminary estimates based on incomplete information about local needs and current spending. A major work element in 2017 is to develop a comprehensive statewide assessment of current capacity and future needs.

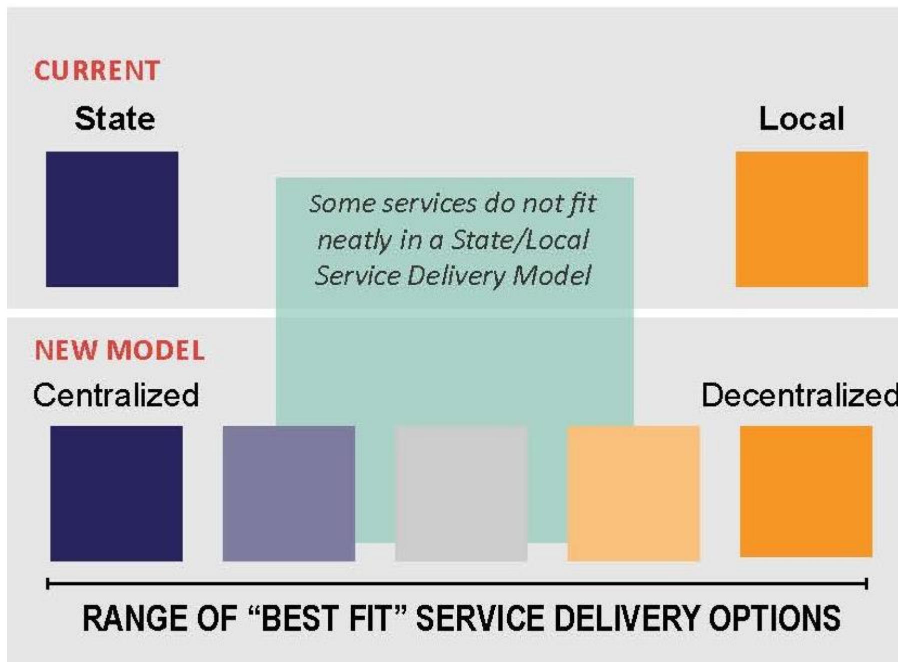
3. Governmental public health services should be delivered in ways that maximize the efficiency and effectiveness of the overall system.

A critical element of the vision is to develop strategies to improve the overall capacity, efficiency and effectiveness of the governmental public health system by redesigning the service delivery model. **New investments are needed to move this work forward.**

Currently, there are a number of public health services that are formally centralized at the state level. In addition, there are formal and informal arrangements for shared services between LHJs, or between DOH and LHJs, that have taken place for reasons that have included a lack of resources, urgent responses to outbreaks and a need to collaborate on certain program areas such as emergency preparedness. With budget reductions, much has been done to leverage scarce resources, but the system lacks the capacity to develop and implement innovative strategies that could do more.

Public health services do not necessarily fit neatly into the current state/local delivery model, where DOH and LHJs have separate but related responsibilities. There are services that lend themselves to a delivery model that looks more like a continuum. This is illustrated in Exhibit 5.

Exhibit 5. Service Delivery Concepts



Source: BERK Consulting, 2016.

To maximize return on investment and ensure that the FPHS are available statewide, DOH and LHJs must identify strategies that would make service delivery through cross-jurisdictional sharing (collaborations between LHJs) and cross-jurisdictional delivery methods (services provided by one LHJ on behalf of others) more intentional and formalized.

As cross-jurisdictional sharing agreements are implemented, it is expected that increased capacity, access to specialized expertise, access to important local knowledge and contacts and the ability to re-direct people and resources (known as surge capacity) when needed in emergencies will be more available statewide. This will create a more effective, responsive and cost-effective public health system because of the ability to leverage capacity across political boundaries instead of funding every entity to provide all FPHS.

These strategies will maximize the overall efficiency of governmental public health services by leveraging specialized expertise or investments in technology, which do not need to be physically located in every community. Services that require a significant degree of local knowledge or benefit from a local presence will still be delivered at the local level.

TRAUMA CARE SYSTEM SHARED SERVICES MODEL

The different trauma levels (I, II, III, IV) refer to the resources available at trauma centers throughout the country. Not every trauma center offers services for every level of trauma. If a patient in a small city in a rural part of Washington needs a trauma service that is not offered at their local trauma center, they will be assessed, and then transported to the appropriate level trauma center.

Our service delivery initiatives focus on creating and evaluating a similar approach to delivering cross-jurisdictional services. Smaller LHJs may not have the capacity to provide every service or respond to every crisis. Creating a cross-jurisdictional service model in which certain specialized services are provided by one LHJ or multiple LHJs in their area or throughout the state will provide opportunities for more specialized service availability and better response.

4. Governmental public health activities should be tracked and performance evaluated using evidence-based measures.

The fourth guiding principle is that there must be a robust accountability structure to ensure accountability and an appropriate return on investment. Accountability will be focused on ensuring the funding is used for the intended purpose and to measure the efficiency and effectiveness of the governmental public health system in achieving targeted health results.

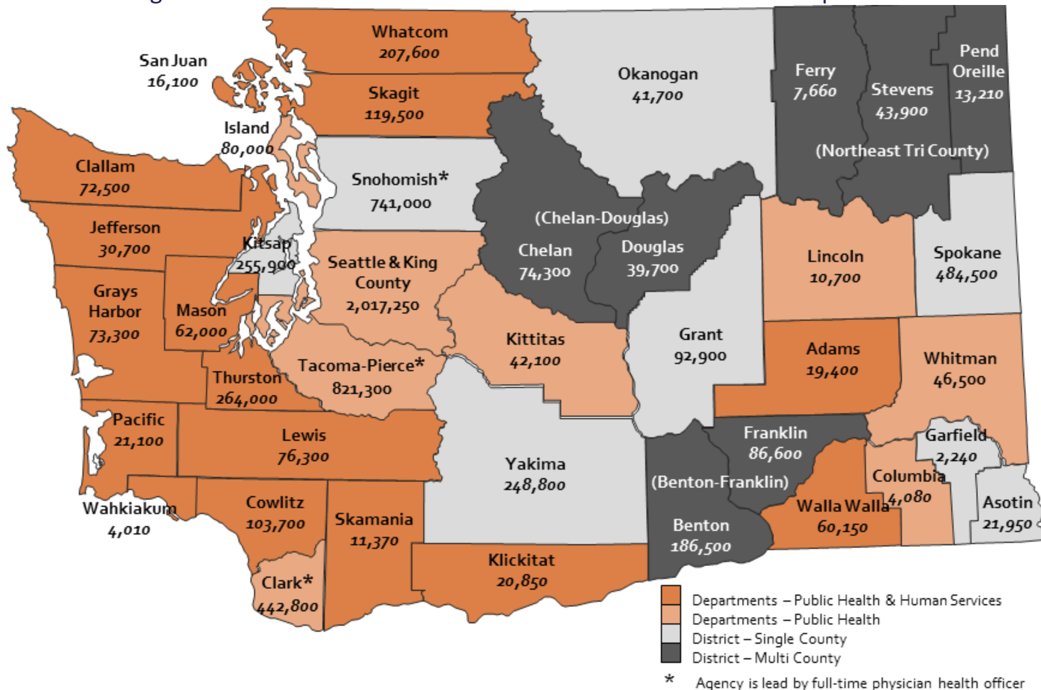
5. Funding locally driven priorities that are targeted to specific community problems.

There are many public health services that vary according to state and local priorities. The 2014 FPHS Policy Workgroup recommended the following principles to guide the funding of essential public health services that are targeted towards those specific local priorities that are not needed in every community:

a) Services provided at the discretion of the local jurisdictions to meet local priorities should be **funded with locally identified funding** such as grants, categorical federal and state funding (where available), and locally generated taxes and fees.

b) To promote continued local investment in the public health system, consider opportunities to **incentivize funding of local priorities** including local options to raise revenue for public health.

Exhibit 6: Washington State Local Health Jurisdictions and 2014 Service Area Populations



Source: Office of Financial Management, 2014, and Department of Health, 2016.

IMPLEMENTATION PLAN

Rebuilding and Modernizing Our Public Health System

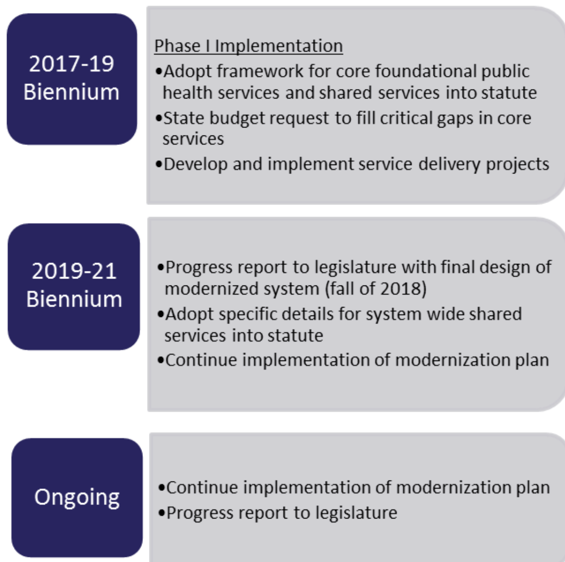
Washington's public health system is at a critical juncture—demand for governmental public health services is increasing and, given current trends, will continue to increase faster than the public health system's capacity.

While the public health system has long been underfunded, the gap between demand and capacity is widening, increasing the public health risks faced by communities to unacceptable levels.

However, the public health system has a clear vision for the future—a modernized public health system that will provide a core set of foundational public health services statewide; be adequately funded; maximize opportunities for enhanced capacity, efficiency and effectiveness through new service delivery models; be highly accountable; and have appropriate local funding mechanisms to enable communities across the state to identify and fund their specific priorities.

This vision for a modernized system will help protect and improve health statewide—and it's crucial we take the first step to realizing it now.

Exhibit 7. Implementation Plan



Source: BERK Consulting, 2016.

Given the magnitude of the current challenges and the transformative nature of the vision, modernizing Washington's public health system will necessarily be a phased, multi-year effort. Steps for the first phase, to occur over the coming 2017-2019 biennium, are well defined.

Exhibit 7 shows the expected milestones for the next two biennia.

2017 – 2019 PHASE 1 IMPLEMENTATION

Policy - Amend RCW 43.70

- Add definitions of governmental public health system and FPHS.
- Codify the concept of a dedicated account for FPHS in the DOH budget with no overhead assigned to it.
- Include the requirement for a 2018 report that will contain the final design and cost for modernizing the governmental public health system.

Funding Request to Stabilize Public Health System, Implement Service Delivery Projects and Continue Implementation of Modernization Plan

A $60M request for an immediate investment in the state and local public health system was submitted for the 2017 – 2019 budget. The request was for a **down payment** on the larger need of $312M to $344M (preliminary estimate) to stabilize the crumbling system and fill the most critical gaps in core public health services that support the entire governmental public health system in Washington.

In a very difficult budget year, Governor Inslee's budget prioritizes public health by containing an immediate investment of $23.9M that will help restore key functions that have already been lost, improve public health's ability to respond to the threat of communicable diseases and continue the modernization of the public health system.

The full, Phase 1 Implementation request included:

1. Increase state funds for public health that would be allocated to LHJs to immediately address the most critical **LOCAL** gaps in the communicable disease and chronic disease FPHS priorities.
2. Increase state funds for public health that would address specific **STATEWIDE** FPHS gaps in high-priority programs and capabilities.
3. Appropriate state funds to implement new service delivery models.
4. Appropriate funds to continue implementation of Public Health Modernization plan.

Local Funding ($50M for the biennium)

While each LHJ has different gaps, this funding will help raise the bar across the state in these areas **but will still fall short of fully funding the FPHS** that only government can provide.

However, this funding will increase the overall capacity of the local public health system to provide the core public health services that provide the greatest threat to the health of Washingtonians detailed below:

- **Communicable Disease Monitoring and Prevention.** Managing the threat of disease through monitoring, investigating outbreaks, identifying causes and preventing more cases.
- **Chronic Disease and Injury Prevention.** Containing the growing health burden and economic impact of preventable diseases in Washington that requires a public health approach. We

need to reduce statewide and community rates of chronic disease through prevention programs, promoting positive changes in behavior and giving everyone a chance to live a healthy life.

This local funding infusion is intended to be a **short-term strategy** to address immediate needs, while the comprehensive plan to modernize the governmental public health system and secure reliable funding is fully implemented.

For funding received in the 2017-2019 biennium, LHJs, in partnership with DOH, have discussed various new funding distribution models. It is anticipated that the funds, if appropriated by the legislature, will flow through a dedicated FPHS account in the DOH budget. There is consensus to use the distribution model included in ***Appendix C*** as an interim method pending allocation recommendations expected in the 2018 FPHS report. Local Boards of Health should retain the discretion to allocate the funds they receive as needed to address the most critical gaps in communicable and chronic disease programs and capabilities. DOH would assure that the funds are used for the designated FPHS and compile whatever data beyond the current financial reporting system is needed to document this.

DOH-System Funding ($4M for the biennium)

This funding would allow DOH to fill the most critical gaps in core public health services that support the entire governmental public health system in Washington, particularly in the areas of communicable disease and managing exposures to health hazards. This includes funds for laboratory services, disease investigation and data systems for which the entire public health system depends.

Implement New Service Delivery Models ($4M for the biennium)

This budget request is to develop and implement two initiatives specifically designed to test different service delivery options similar to the state trauma care model. The goal is to allow multiple jurisdictions to share staff and services without the need for someone to be physically present in every LHJ to provide every FPHS.

The initiatives will test different structures/elements to support this work, including: number of LHJs in each collaborative; types of shared services; policy development; funding method; management structure; location of staff; expertise of staff; resource allocation; levels of support needed to meet the demands; contracting strategies; customer satisfaction; and communication methods. New frameworks are expected to:

- Maximize overall cost efficiency of governmental public health services where there are opportunities to leverage specialized expertise or investments in technology which do not need to be physically located in every community.
- Maximize the overall cost effectiveness of governmental public health services by leveraging the current strengths and capacity of the state/local governance model. Services that require a significant degree of local knowledge or benefit from a local presence will be delivered at the local level.

- Build on the existing core strengths of the state/local delivery model by assigning responsibility for new or expanded services where there are opportunities to leverage current capacity and expertise for the benefit of the entire public health system. Examples to be evaluated include, but are not limited to, the following:
    - Locate services best delivered in a decentralized way broadly across all LHJs.
    - Locate a particular function or expertise within a single LHJ that would provide services on behalf of other identified jurisdictions.
    - Locate a particular function or expertise within DOH or a selected LHJ that would provide services statewide.
    - Locate additional capacity within the DOH or a LHJ to support individual LHJs in delivering FPHS. Available capacity and resources could be in the form of:
        - Staff resources to provide technical assistance for specific programs or capabilities.
        - Rapid response teams to support local communicable disease or environmental public health outbreaks.
        - Information technology access and technical support.

The successful models will be incorporated into the Public Health Modernization Plan, and future funding allocations for FPHS will be based on shared delivery models where practical. This is expected to result in increased capacity, efficiency and effectiveness in the future.

Continued Implementation of the Modernization Plan ($2M for the biennium)

This funding will allow the public health system to continue to advance Public Health Modernization implementation. This will include:

- **Statewide Evaluation of FPHS.** DOH and LHJs will update the 2013 evaluation of FPHS to reflect current capacity and resource needs at DOH and every LHJ in the state.
- **Accountability.** To ensure that FPHS are available statewide and provided in a cost-effective and quality way, there must be a robust accountability system that aligns with the FPHS framework to ensure accountability and an appropriate return on investment. The accountability system will be collaboratively developed by the DOH and LHJs, with appropriate consultation with other stakeholders.
- **Funding Allocation.** DOH and LHJs will develop a funding allocation model to distribute funds deposited in the state FPHS account beginning with allocations received in the 2019-2021 biennium.
- **Operational Guidelines for Implementing FPHS.** DOH and LHJs will develop more detailed operational guidelines for FPHS implementation.
- **Report due fall of 2018 to the legislature.**

NEXT STEPS

This plan outlines an ambitious vision for transforming Washington's public health system to improve the health and lives of all Washingtonians. **To achieve this new vision, we need to do more than just increase funding for governmental public health; we also need to rebuild and modernize the governmental public health system.**

Doing so will necessitate a phased, multi-year effort to rebuild and modernize the public health system. Steps for the first phase, occurring over the 2017-2019 biennium, have been thoroughly articulated in this plan. The first phase funds additional work to detail the following phases. An update to this plan will be provided in a report to the legislature in fall of 2018.

APPENDIX A

Past and Present Efforts to Solve the Governmental Public Health Crisis in Washington

For more than a decade, efforts by public health professionals and the legislature to ensure that the public health system fully meets its responsibilities have repeatedly identified similar issues (e.g., lack of core flexible funds, wide variation in public health spending across the state, need for additional and dedicated funds and identification of core public health services and priorities). Over the years of various committees and reports, there has been consistent agreement that public health needs more funding to deliver core services. There has been good intent and some action—but the overall result is that problems remain.

These efforts included:

- **2004** – Public health developed a cost model to estimate the cost of delivering public health services in compliance with public health standards**.** Key findings included:
    - A $400M per year gap for LHJs and a $150M per year gap for DOH.
- **2005 – 2006** – The legislature passed EHCR 4410 that created the **Joint Select Committee (JSC) on Public Health Funding.** In 2006, at the request of the JSC, public health developed the report *Creating a Stronger Public Health System: Statewide Priorities for Action* that identified spending priorities for additional new funds to the local/state public health system at different annual funding levels of $200M per year, $100M per year, and $50M per year. Top two priorities included: communicable disease and chronic disease prevention.
- **2006** – Public health developed two white papers *Financing Local Public Health in Washington State: Challenges & Choices* and *Financing Public Health in Seattle-King County* that explored the public health funding structure and adequacy. Key findings included:
    - Wide variation in spending and public health services across the state.
    - A $400M per year funding need for LHJs.
- **2006** – The **Joint Legislative Audit and Review Committee (JLARC)** completed a review of Washington's public health system. Key findings included:
    - Washington's public health system is funded through a complex mix of federal, state and local funds, including permits and user fees. Many of the state and federal funds may only be used for specific programs or services.
    - State and local public health agencies currently are not meeting the minimum standards, and officials from these agencies do not expect to be able to do so without an investment of additional resources.
    - Wide variation in public health expenditures (both in total and per person) and in local jurisdictions' ability to meet the minimum public health standards.

- **2007** – The *Blue Ribbon Commission on Health Care Cost and Access* recommended strengthening the public health system with the specific action of "invest in public health funding strategies that are accountable for improved health outcomes, based on the recommendations of the Joint Select Committee on Public Health Financing." Also stating that "a strong public health system, with its statewide focus on prevention and health promotion, can keep us all healthier, reducing the need and demand for costly medical treatment. This allows available treatment dollars to be spread further."
- **2007** – The legislature directed public health (E2SSB 593) to define the priorities and measures for new funds and define core public health services of statewide significance. The state budget included a proviso for **$20M per biennium of new funds to LHJs**. Public health defines the **priorities for the new funds as communicable disease and chronic disease prevention** and implemented performance reporting on these.
- **2009**—The funds gained in 2007 were reduced to $16M per biennium as part of statewide funding reductions due to the recession.
- **2011**—The funds gained in 2007 and reduced in 2009 were further reduced to $10M per biennium as part of statewide funding reduction due to the recession.
- **2013**—The remaining $10M were combined with two other funding streams and were renamed County Public Health Assistance funds and distributed directly to LHJs.

These efforts consistently identified the need but yielded limited new investment or change.

In 2010, concern that the erosion of public health funding was at a crisis point, and threatening the most critical public health services, led to the formation of the Reshaping Government Public Health Workgroup which published *An Agenda for Change, October 2010.* [xvi] The Agenda for Change posited that to address the dual challenges being faced by governmental public health in Washington, changes in the demands on the system and severe restrictions in capacity to respond to those demands, the entire governmental public health system needed to be reimagined.

In 2012, a workgroup made up of state and local governmental public health experts was formed to develop a long-term strategy to ensure the effectiveness and sustainability of the governmental public health system. Building on the work of the Institute of Medicine report, *For the Public's Health: Investing in a Healthier Future,* the workgroup identified a "minimum package of services" needed everywhere to support population health anywhere and went on to develop the Foundational Public Health Services (FPHS) model as a viable framework for Washington's reimagined governmental public health system. [xvii]

Foundational Public Health Services includes both cross-cutting foundational capabilities and programs needed everywhere in order for the system to work anywhere. The Foundational Public Health Services support all other "additional important services" which may be needed and available in specific areas and are determined within each community.

An initial feasibility assessment to understand the cost of implementation was conducted, the preliminary results of which were published in *Foundational Public Health Services Preliminary*

Cost Estimation, September 2013. [xviii] Final results of that effort were published in the *Foundational Public Health Services Final Technical Report, September 2014.* [xix]. The results of the 2014 Policy Workgroup were published in *Foundational Public Health Services, A New Vision for Washington State, January 2015.* [xx].

APPENDIX B

Foundational Public Health Services Definitions

Foundational Capabilities

A. **Assessment (Surveillance and Epidemiology)**. The foundational definition of this capability includes:

1. Ability to collect sufficient statewide data to develop and maintain electronic information systems to guide public health planning and decision making at the state and local level. Foundational data includes Behavioral Risk Factor Surveillance Survey (BRFSS), Healthy Youth Survey (HYS) and vital statistics and foundational information systems including PHIMS, PHRED, CHARS, and CHAT. (state function only)
2. Ability to access, analyze and use data from a minimum of eight specific information sources, including (1) US Census data, (2) vital statistics, (3) notifiable condition data, (4) certain clinical administrative data sets including hospital discharge, (5) BRFSS, (6) HYS, (7) basic community and environmental health indicators, and (8) local and state chart of accounts.
3. Ability to prioritize and respond to information and data requests and to translate data into information and reports that are valid, statistically accurate and readable by the intended audiences.
4. Ability to conduct a basic community and statewide health assessment and identify health priorities arising from that assessment, including analysis of health disparities and the social determinants of health.

B. **Emergency Preparedness (All Hazards)**. The foundational definition of this capability includes:

1. Ability to develop and rehearse response strategies and plans, in accordance with national and state guidelines, to address natural or manmade disasters and emergencies, including special protection of vulnerable populations.
2. Ability to lead the Emergency Support Function 8 – Public Health & Medical for the county, region, jurisdiction and state.
3. Ability to activate public health emergency response personnel in the event of a public health crisis; coordinate with federal, state, and county emergency managers and other first responders; and operate within, and as necessary lead, the incident management system.
4. Promote community preparedness by communicating with the public in advance of an emergency about steps that can be taken before, during, or after a disaster.

C. **Communication**. The foundational definition of this capability includes:

1. Ability to maintain ongoing relations with local and statewide media, including the abilities to write a press release, conduct a press conference, and use electronic communication tools to interact with the media.
2. Ability to develop and implement a communication strategy, in accordance with Public Health Accreditation Board Standards, to increase visibility of a specific public health issue and communicate risk. This includes the ability to provide information on health risks, healthy behaviors and disease prevention in culturally and linguistically appropriate formats for the various communities served, including use of electronic communication tools.

D. **Policy Development and Support**. The foundational definition of this capability includes:

1. Ability to develop basic public health policy recommendations. These policies must be evidence-based, or, if innovative/promising, must include evaluation plans.
2. Ability to work with partners and policy makers to enact policies that are evidence-based (or are innovative/promising and include evaluation plans) and that address the social determinants of health and health disparities.
3. Ability to utilize cost benefit information to develop an efficient and cost-effective action plan to respond to the priorities identified in a community and/or statewide health assessment.

E. **Community Partnership Development**. The foundational definition of this capability includes:

1. Ability to create and maintain relations with important partners, including health-related national, statewide and community-based organizations; community groups or organizations representing populations experiencing health disparities; key private businesses and healthcare organizations; and key federal, tribal, state, and local government agencies and leaders.
2. Ability to strategically select and articulate governmental public health roles in programmatic and policy activities and coordinate with these partners.

F. **Business Competencies**. The foundational definition of this capability includes:

1. Leadership. Ability to lead internal and external stakeholders to consensus and action planning (adaptive leadership) and to serve as the public face of governmental public health in the community.
2. Accountability and Quality Assurance Services. Ability to uphold business standards and accountability in accordance with federal, state, and local laws and policies and to assure compliance with national and Public Health Accreditation Board Standards.
3. Quality Improvement. Ability to continuously improve processes, including plan-do-study-act cycles.

4. Information Technology Services. Ability to maintain and access electronic health information to support the public health agency's operations and analyze health data. Ability to support, maintain, and use communication technology.
5. Human Resources Services. Ability to develop and maintain a competent workforce, including recruitment, retention and succession planning functions; training; and performance review and accountability.
6. Fiscal Management, Contract, and Procurement Services. Ability to comply with federal, state, and local standards and policies.
7. Facilities and Operations. Ability to procure, maintain, and manage safe facilities and efficient operations.
8. Legal Services and Analysis. Ability to access and appropriately use legal services in planning and implementing public health initiatives.

Foundational Programs

G. **Control of Communicable Disease and Other Notifiable Conditions.** The foundational definition of this program includes:

1. Provide timely, statewide, locally relevant and accurate information statewide and to communities on communicable disease and other notifiable conditions and their control.
2. Promote immunization through education of the public and through collaboration with schools, healthcare providers and other community partners.
3. Identify statewide and local community assets for the control of communicable diseases and other notifiable conditions, develop and implement a prioritized control plan addressing important communicable diseases and other notifiable conditions such as influenza and hepatitis, seek resources for and advocate for high priority policy and other control initiatives regarding communicable diseases and other notifiable condition.
4. Ability to receive laboratory reports and other identifiable data; conduct disease investigations, including contact notification; and recognize, identify, and respond to cases and outbreaks/clusters of communicable diseases and other notifiable conditions in accordance with national, state, and local mandates and guidelines.
5. Assure the availability of partner notification services for newly diagnosed cases of syphilis, gonorrhea, and HIV according to Centers for Disease Control and Prevention (CDC) guidelines.
6. Assure the appropriate treatment of individuals who have active tuberculosis, including the provision of directly-observed therapy according to CDC guidelines.
7. Assure availability of public health laboratory services for disease investigations and response, and reference and confirmatory testing related to communicable diseases and notifiable conditions.

8. Coordinate and integrate additional important control programs and services regarding communicable disease and other notifiable conditions.

H. **Chronic Disease and Injury Prevention**. The foundational definition of this program includes:

1. Provide timely, statewide, and locally relevant and accurate information statewide and to communities on chronic disease (including behavioral health[1]) and injury prevention.
2. Identify statewide and local chronic disease (including behavioral health[1]) and injury prevention community assets, develop and implement a prioritized prevention plan, seek resources for and advocate for high priority policy initiatives.
3. Reduce statewide and community rates of tobacco use through programs that conform to standards set by Washington laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand smoke exposure. Contribute to a reduction in statewide and community rates of alcohol and other drug use by working with partners at the state and local level to identify (1) evidence-based population-based interventions or (2) innovative/promising population-based interventions with valid evaluation studies; and collaborate with partners in generating funding for these interventions.
4. Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized program of best and emerging practices aligned with national and state guidelines for healthy eating and active living.
5. Coordinate and integrate additional important chronic disease and injury prevention programs and services.

I. **Environmental Public Health.** The foundational definition of this program includes:

1. Provide timely, statewide, and locally relevant and accurate information statewide and to communities on environmental public health issues and health impacts from common environmental or toxic exposures.
2. Identify statewide and local community environmental public health assets and partners, and develop and implement a prioritized prevention plan to protect the public's health by preventing and reducing exposures to health hazards in the environment, seek resources for and advocate for high priority policy initiatives.
3. Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, water recreation, drinking water, and liquid and solid waste streams in accordance with federal, state, and local laws and regulations.
4. Identify and address priority notifiable zoonotic conditions (e.g. those transmitted by birds, insects, rodents, etc.), air-borne conditions, and other public health threats related to environmental hazards.
5. Protect the population from unnecessary radiation exposure in accordance with federal, state, and local laws and regulations. (state function only)

6. Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes (e.g. consideration of housing, urban development, recreational facilities, and transportation).
7. Coordinate and integrate additional important environmental public health programs and services.

J. **Maternal/Child/Family Health**. The foundational definition of this program includes:

1. Provide timely, statewide, and locally relevant and accurate information statewide and to communities on emerging and ongoing maternal child health trends, taking into account the importance of Adverse Childhood Experiences (ACEs) and health disparities.
2. Assure mandated newborn screening done by the state public health lab to test every infant born in Washington to detect and prevent the developmental impairments and life-threatening illnesses associated with congenital disorders that are specified by the State Board of Health. (state function only)
3. Identify, disseminate and promote emerging and evidence-based information about early interventions in the prenatal and early childhood period that optimize lifelong health and social-emotional development.
4. Identify local maternal and child health community assets, develop a prioritized prevention plan using life course expertise and an understanding of health disparities, seek resources for and advocate for high priority policy initiatives.
5. Coordinate and integrate additional important maternal, child, and family health programs and services.

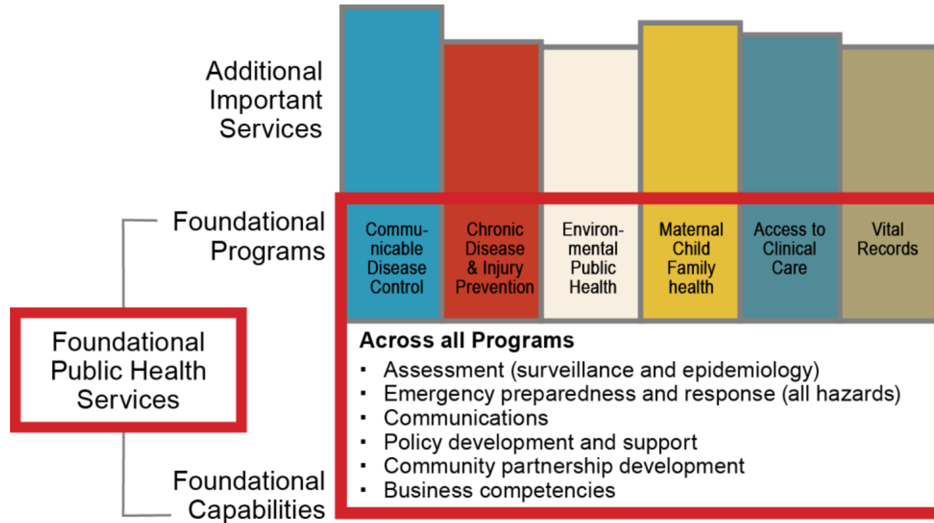
K. **Access/Linkage with Medical, Oral, and Behavioral[1] Health Care Services.** The foundational definition of this program includes:

1. Provide accurate timely, statewide, and locally relevant information statewide and to communities on the medical, oral, and behavioral[1] healthcare system.
2. Participate actively in local, regional and state level collaborative efforts regarding medical, oral and behavioral[1] systems planning to improve healthcare quality and effectiveness, reduce healthcare costs and improve population health.
3. In concert with national, statewide, and local healthcare providers and groups, develop and implement prioritized plans for assuring access to specific clinical services of public health importance such as family planning, key services for pregnant women and their infants (i.e. maternity support, WIC), and STD and HIV testing and treatment; seek resource for and advocate for high priority policy initiatives.
4. Improve patient safety through inspection and licensing of healthcare facilities and licensing, monitoring and discipline of healthcare providers. (state function only)
5. Coordinate and integrate with additional important medical, oral and behavioral health programs and services.

L. **Vital Records**. The foundational definition of this program includes:

1. In compliance with state law and in concert with national, state and local groups, assure a system of vital records. (state function only)
2. Provide certified birth and death certificates in compliance with state law and rule.

Exhibit 1B. Washington Foundational Public Health Services Model



Source: Department of Health, 2016 and BERK, 2016.

APPENDIX C

2017 – 2019 Biennium Local Funding Allocation

The funding received in the 2017-2019 biennium is proposed to be allocated to Local Health Jurisdictions (LHJs) using a different funding allocation method than is currently being used.

The proposed allocation is based on the following assumptions:

1. The initial funding request is an interim funding infusion which recognizes that a new funding allocation formula is yet to be developed.
2. The current allocation of Public Health County Assistance Funding is a mix of outdated allocation methods for several sources of funding.
3. The current allocation results in a wide range of state flexible funding on a per-capita basis.

New funding would be allocated through a two-tier per capita funding distribution formula that:

- Calculates an average statewide per-capita value for the recommended LHJ funding level.
- Establishes a single per capital funding level for the largest 25 LHJs by population based on applying a factor of 95-98% of the statewide average.
- Calculates a small LHJ per-capita value using the remaining funding divided by the population of the smallest 10 LHJs.

A conceptual funding allocation based on this allocation methodology is below.

Exhibit 1C. Conceptual Funding Allocation Scenarios

Total New Investment	$25,000,000	
Per-capita (statewide)	$3.49	
Small LHJ cutoff (population)	25,000	
Small LHJ new $ add-on	$7.22	per capita
Non-small LHJ's factor	98.0%	of statewide per cap
Non-small LHJ new $ add-on	$3.42	per capita

OBSERVATIONS ON THIS SCENARIO

A 68.8% increase in LHJ funding raises the median LHJ distribution by 92.3%

The smallest LHJ increase is 17.2%, the largest 122.3% and the median increase is 83.5%

	Current Distribution		Distributional Impact				
	Funding	Per Cap	New $	% Chg	LHJ % Inc.	Total	Per Cap
Lowest	$93,154	$2.79	$16,029	17.2%	17.2%	$109,183	$6.21
Highest	$12,685,521	$41.98	$7,233,622	57.0%	122.3%	$19,919,143	$49.20
Median	$263,134	$4.72	$243,004	92.3%	83.5%	$508,331	$8.14
Statewide	$36,356,001	$5.07	$25,000,000	68.8%		$61,356,001	$8.56

LHJ	OFM Population (April 1, 2015)	County Public Health Assistance (FY 2015)	Current State Flexible $ Per Capita	New Funding Per Capita Add-on	Allocation of New Funding	LHJ % Inc. over FY2015	TOTAL Funding (Current + New$)	Total per Capita Funding (w/ New$)
Garfield	2,219	$93,154	$41.98	$7.22	$16,029	17.2%	$109,183	$49.20
Columbia	3,944	$119,991	$30.42	$7.22	$28,489	23.7%	$148,480	$37.65
Wahkiakum	4,042	$93,181	$23.05	$7.22	$29,197	31.3%	$122,378	$30.28
Lincoln	10,321	$113,917	$11.04	$7.22	$74,552	65.4%	$188,469	$18.26
Skamania	11,339	$111,327	$9.82	$7.22	$81,905	73.6%	$193,232	$17.04
Pacific	20,848	$169,075	$8.11	$7.22	$150,592	89.1%	$319,667	$15.33
San Juan	16,252	$126,569	$7.79	$7.22	$117,394	92.8%	$243,963	$15.01
Klickitat	21,026	$153,784	$7.31	$7.22	$151,878	98.8%	$305,662	$14.54
Asotin	22,105	$159,890	$7.23	$7.22	$159,672	99.9%	$319,562	$14.46
Adams	19,254	$121,213	$6.30	$7.22	$139,078	114.7%	$260,291	$13.52
Seattle-King	2,117,125	$12,685,521	$5.99	$3.42	$7,233,622	57.0%	$19,919,143	$9.41
Jefferson	30,466	$184,080	$6.04	$3.42	$104,094	56.5%	$288,174	$9.46
Spokane	490,945	$2,877,318	$5.86	$3.42	$1,677,421	58.3%	$4,554,739	$9.28
Benton Franklin	279,116	$1,614,337	$5.78	$3.42	$953,661	59.1%	$2,567,998	$9.20
Whatcom	212,284	$1,214,301	$5.72	$3.42	$725,315	59.7%	$1,939,616	$9.14
Tacoma-Pierce	843,954	$4,143,169	$4.91	$3.42	$2,883,554	69.6%	$7,026,723	$8.33
Walla Walla	60,338	$302,173	$5.01	$3.42	$206,158	68.2%	$508,331	$8.42
Kittitas	43,269	$198,979	$4.60	$3.42	$147,838	74.3%	$346,817	$8.02
Cowlitz	103,468	$477,981	$4.62	$3.42	$353,521	74.0%	$831,502	$8.04
Snohomish	772,501	$3,433,291	$4.44	$3.42	$2,639,419	76.9%	$6,072,710	$7.86
Grays Harbor	71,122	$335,666	$4.72	$3.42	$243,004	72.4%	$578,670	$8.14
Yakima	248,830	$1,052,482	$4.23	$3.42	$850,182	80.8%	$1,902,664	$7.65
Okanogan	41,516	$169,882	$4.09	$3.42	$141,849	83.5%	$311,731	$7.51
Whitman	48,177	$189,355	$3.93	$3.42	$164,607	86.9%	$353,962	$7.35
Clallam	73,486	$291,401	$3.97	$3.42	$251,081	86.2%	$542,482	$7.38
Thurston	269,536	$1,046,897	$3.88	$3.42	$920,929	88.0%	$1,967,826	$7.30
Clark	459,495	$1,767,341	$3.85	$3.42	$1,569,965	88.8%	$3,337,306	$7.26
Kitsap	260,131	$997,476	$3.83	$3.42	$888,795	89.1%	$1,886,271	$7.25
NE Tri-County	64,731	$249,303	$3.85	$3.42	$221,168	88.7%	$470,471	$7.27
Skagit	121,846	$449,745	$3.69	$3.42	$416,314	92.6%	$866,059	$7.11
Mason	61,023	$227,448	$3.73	$3.42	$208,498	91.7%	$435,946	$7.14
Chelan Douglas	116,178	$399,634	$3.44	$3.42	$396,948	99.3%	$796,582	$6.86
Lewis	75,882	$263,134	$3.47	$3.42	$259,268	98.5%	$522,402	$6.88
Grant	93,259	$297,762	$3.19	$3.42	$318,640	107.0%	$616,402	$6.61
Island	80,593	$225,224	$2.79	$3.42	$275,364	122.3%	$500,588	$6.21
TOTAL	**7,170,621**	**$36,356,001**	**$5.07**	**$3.49**	**$25,000,000**		**$61,356,001**	**$8.56**

Source: WSALPHO, 2016 and BERK Consulting, 2016.

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[1] **Definitions Note:** In these definitions, Behavioral Health Care includes mental health and chemical dependency.

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