

Report to the Legislature

# Foundational Public Health Services:

Progress Toward  
Full Funding and  
Implementation,  
Transformation and  
Better Health

**October 2020**

RCW 43.70.515 (3)



Prepared by  
Office of the Secretary  
Foundational Public Health Services



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## Executive Summary

Protecting the public's health across the state is a fundamental responsibility of the state and is accomplished through the governmental public health system. (RCW 43.70.512) Currently, the governmental public health system is struggling to provide the most basic, core public health services necessary to adequately protect and promote the health of all Washingtonians. As the COVID-19 pandemic has made clear, this makes all Washingtonians vulnerable to communicable diseases, environmental health threats, preventable chronic diseases, and avoidable unhealthy births and childhoods. The results of a deteriorating public health system are increased and avoidable health care costs, reduced productivity in our economy, and needless suffering from preventable disease and death. Many are mandated in state law.

Modest investments into the governmental public health system have been made over the past decade by the federal and state government. These funds are critical to help address the crisis of the moment, but they have been inadequate in that they are time limited and targeted only to the specific and urgent need. They do not provide funding for ongoing core public health services. Adequate, dedicated, and stable funding for core public health services is key to healthy people, communities and the economy.

Public health leaders in Washington have led the nation in diligently collaborating to define a limited statewide set of core public health services, called Foundational Public Health Services (FPHS). These FPHS are a) unique services provided only or primarily by government everywhere, b) services that must be everywhere for them to work anywhere and c) are services that communities, businesses and individuals depend on.

Through cooperation and collaboration, testing and evaluating, increased use of technology and new service delivery models the governmental public health system is transforming to better serve the people of Washington. System transformation aims to a) make the best use of local presence, knowledge, and expertise combined with subject matter expertise and technology; b) in the most effective, efficient and equitable manner possible for the people of Washington; c) with the funds available.

By investing in FPHS over the past two biennia, the legislature has begun addressing the chronic underfunding and resulting detrimental effects on people, communities, and the state's economy. This is a step in the right direction, and more is needed to protect the public's health and the state's economy.

After the initial investment in 2017-2019, there is a small but measurable increase in the system's capacity to deliver FPHS and indicators of better health. In the current biennium, the \$28 million FPHS investment and short-term COVID funding have increased system capacity. However, because nearly all resources are focused on the pandemic, at the expense of other core public health services, indicators are showing the impact of this shift in declining immunization rates and rising rates of communicable diseases other than COVID, drug overdoses, and suicide, as just a few examples.

Going forward, it is critical for the state to provide adequate, dedicated, stable funding for full implementation of FPHS statewide that keeps pace with inflation and demand for services.

# Introduction

## Background

Washington's governmental public health system is comprised of:

- Washington State Department of Health (DOH)
- State Board of Health (SBOH)
- 35 local health jurisdictions (LHJs) – represented in this work by the Washington State Association of Local Public Health Officials (WSALPHO)
- 29 sovereign tribal governments and two urban Indian health programs – the American Indian Health Commission (AIHC) participates in this work on their behalf

The broader public health system is larger and includes other government organizations at the local, state, and federal level, and partners, such as healthcare systems and community-based organizations. To move the needle on important health issues, the public's health depends on all of these partners.

The governmental public health system is struggling to provide the most basic, core public health services necessary to adequately protect and promote the health of all Washingtonians. As the COVID-19 pandemic has made clear, this makes all Washingtonians vulnerable to communicable diseases (both new and old), environmental health threats, preventable chronic diseases (diabetes, heart disease, stroke, and cancer), and avoidable unhealthy births and childhoods. The results of a deteriorating public health system are increased and avoidable health care costs, reduced productivity in our economy, and needless suffering from preventable disease and death.

A lack of stable and ongoing funding for core public health services has been a challenge. Sufficient and stable funding that keeps up with increasing demand due to growing population, resurgent and new health threats, and increasing costs of maintaining current business is essential to keep people and the economy healthy. A lack of stable funding means that the public health system is barely able to address an emergent crisis and leaves no resources to focus on prevention or preparedness.

Historically, small, brief infusions of funds into the governmental public health system have been made over the past decade by the federal and state government. The current infusion of funds related to the COVID-19 response and economic recovery are current examples. These funds are a critical help to address the crisis of the moment, but they have been inadequate in that they are time limited and targeted only to the specific and urgent need. They do not provide funding for ongoing core public health services.

Adequate, dedicated, and stable funding for core public health services is key to healthy people, communities and the economy.

Leaders of the governmental public health system in Washington have defined a limited statewide set of core public health services, called Foundational Public Health Services (FPHS). FPHS are unique services, provided only or primarily by government and that communities, businesses and individuals depend. Like other public infrastructure, FPHS are services that need to be everywhere for them to work anywhere. Many are mandated in state law.

For these FPHS to be available everywhere in Washington, the governmental public health system must be fully funded and transformed to provide these services in the most effective, efficient and equitable manner possible.

FPHS principles and objectives are:

1. Adopt a limited statewide set of core public health services, called Foundational Public Health Services (FPHS). FPHS are a defined, basic set of capabilities and programs that the government is responsible for providing and must be present in every community to efficiently and effectively protect all people in Washington. (DONE)
2. Fund FPHS primarily through state funds and fees that are predictable, sustainable and responsive to changes in both demand and cost. (IN PROCESS)
3. Provide and use local revenue-generating options to address local public health priorities. (IN PROCESS in some local jurisdictions)
4. Deliver FPHS in ways that maximize efficiency and effectiveness and are standardized, measured, tracked, and evaluated. (IN PROCESS)
5. Complete a tribally-lead process, with support from the Department of Health, to define how the Foundational Public Health 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. (IN PROCESS)
6. Allocate resources through a collaborative process between state, local, and tribal governmental public health system partners. (ONGOING)

The FPHS Steering Committee, which includes representation and co-chairs from the four parts of the governmental public health system, is using a collaborative process to develop each funding request to the Governor and legislature and to allocate resources that are appropriated. In partnership with the Governor and legislature, the governmental public health system in Washington State is pursuing a long-term, phased, multi-biennia, building block approach to full funding and implementation of FPHS across the state.

## The Public Health Vision

A responsive and viable governmental public health system that supports healthy and economically vital communities across Washington.

## Second Substitute House Bill 1496

In 2019, the Washington State Legislature passed Second Substitute House Bill 1496 (2SHB 1496) (Chapter 14, Laws of 2019). This bill defined the public health system as well as the core public health services, called Foundational Public Health Services (FPHS). It also provided that any FPHS funding allocations appropriated to the Office of Financial Management must be jointly certified by specific public health stakeholders in consultation with federally recognized tribes. By October 1, 2020, the Department of Health shall report on the work underway to fully fund and transform Washington's governmental public health system.

This report fulfills the mandate in 2SHB 1496, which directs the Department of Health, in partnership with sovereign tribal nations, local health jurisdictions, and the state board of health, to report on:

- Service delivery models, and a plan for further implementation of successful models;
- Changes in capacity of the governmental public health system; and
- Progress made to improve health outcomes.

This report builds on the [2018 FPHS Report to the Legislature](#) and other related reports. See the appendix for associated reports and materials.





**Figure 2: \$225 million more per year is needed.** These funds will fully implement FPHS so they are available everywhere in Washington. With a population of 7.5 million, that is the equivalent of about \$30 per person, per year.

■ Additional funds needed  
■ Estimated annual spending\*  
 \*Berk (2018). Washington State Public Health Transformation Assessment Report

## Progress toward Full Funding of FPHS

In the 2017-2019 biennium, the legislature made the first initial investment in FPHS with \$12 million of one-time funding. In the 2018 supplemental budget, \$3 million of one-time funding was additionally appropriated to Public Health – Seattle-King County (PHSKC) for communicable disease efforts. Together, the \$15 million were focused on communicable disease and allocated as follows: \$12 million to LHJS, \$2 million to DOH, and \$1 million for new service delivery models.

For the 2019-2021 biennium, DOH submitted a decision package on behalf of the governmental public health system. That decision package started with the most critical, fund first FPHS: communicable disease, environmental health, assessment (epidemiology, disease surveillance, and community health assessment) and the other capabilities that support them because:

- Stopping and preventing the spread of disease, from one person to another and from the environment to people, has immediate and long-term impact on individuals, communities, the healthcare system, schools, workplaces, business, and tourism.
- The control and prevention of communicable disease and environmental threats to human health are so core to the health and safety of people and business that much of it has been codified in state laws and regulations for decades. Yet it is largely unfunded.
- Collecting, analyzing, sharing and using data is essential to individuals and communities for making decisions and to public health leaders, policy makers, and stakeholders to measure the impact of programs, services, and policy choices.

The 2019-2021 budget request for the most critical, fund first FPHS totaled \$295M/biennium. The legislature appropriated \$28 million.

DOH again submitted a decision package on behalf of the governmental public health system for the 2021-2023 biennium. This proposal continues to seek funding for these critical, fund first FPHS that remain unfunded.

Progress toward full funding of FPHS is illustrated in dark orange on the following exhibit.



**Figure 3: Investments incrementally support progress toward full funding of FPHS.** About 6% of the funds needed have been provided. Additional funds needed to make these core public health services available everywhere are displayed in light orange.

■ Additional funds needed  
■ Investment  
■ Estimated annual spending\*

\*Berk (2018). Washington State Public Health Transformation Assessment Report

## Progress toward System Transformation

In the 2017-2019 biennium, a portion of the funds appropriated by the legislature were invested in testing and evaluating new service delivery models. These models focused on sharing staff, expertise and technology across local jurisdictions to deliver specific FPHS in assessment and communicable disease. They included:

**Tuberculosis (TB) expertise and surge capacity** – This model focuses on assuring that people across the state who have active TB receive the same level of expertise and standard of care and that communities have resources for disease investigation and outbreak management, when and where it is needed. Public Health – Seattle-King County (PHSKC) provides all LHJs with access to expert clinicians for consultation and case management. PHSKC also provides consultation for contact tracing and staff, “boots-on-the-ground,” to assist LHJ in conducting the contact tracing and TB testing at no charge to the LHJs.

**Communicable disease data and web design expertise and technology** – This model focuses on assuring that healthcare providers have rapid access to the most current information on communicable disease in an easy access and consistent manner. Tacoma-Pierce County Health Department (TPCHD) provides standardized and up-to-date communicable disease data and information and develops and maintains websites where healthcare providers can access this information. TPCHD works with individual LHJs to tailor these websites to their local context while also efficiently providing routine updates to the information and website maintenance through a standardized approach.

**Assessment (disease surveillance and epidemiology) expertise** – This model makes the expertise of a team of epidemiologist in a data center available to more communities for conducting community health assessment and planning and communicable disease control and prevention. The Spokane Regional Health District (SRHD) data center provides staff, “boots-on-the-ground,” to assist LHJs in engaging with their communities to conduct community health assessments and planning which generally involves communities using data to identify local health problems, set priorities and decide how they will address their local health concerns. SRHD is providing expertise in data analysis and presentation, community engagement and tracking community progress toward health goals.

SRHD is also providing communicable disease control and prevention expertise to surrounding communities by providing data analysis for local decision making, staff to conduct case investigation and contact tracing, staff for surge capacity to assist LHJs in outbreak management and assisting LHJs with onboarding and training of their own new staff.

The evaluation of these initial models (for more detail see [2019 FPHS Evaluation of Shared Services Demonstration Projects](#)) identified the following characteristics of services that are good candidates for sharing:

- Infrequent or sporadic need for services that cost a significant amount of money. For example, surge disease investigations as demonstrated in the TB service delivery demonstration project, and periodic community health assessments.
- Expensive or rare skill set or expertise that is easily transferred or deployed in a time of need and/or does not need to live locally (can be provided from a distance). This is illustrated in the TB service delivery demonstration project and regarding data, epidemiological, and assessment services.
- Services with significant up-front capital and resource investment. For example, services such as higher-quality labs for TB and online resource development require relatively costly up-front investment in technology.
- Services with little marginal cost to increased participation and/or expanding a service to additional agencies. For example, training by video conferencing used in TB can serve more people at very low marginal costs.
- Services that are or can be delivered “virtually.” All the cases demonstrated ways online and virtual platforms can be leveraged for information sharing, data collection and case review with experts and among colleagues.

In the 2019-2021 biennium, the original models were expanded and additional communities and LHJs are receiving these services. Additionally, two more new models are being tested. One is a different model for **sharing staff and expertise** to provide assessment (disease surveillance and epidemiology) and communicable disease services. This model shares one epidemiologist among three LHJs to provide communities in central Washington the expertise and staff for conducting community health assessment and planning and assisting with disease investigation, contact tracing and outbreak management when needed. The epidemiologist is hired by one LHJ, is physically based in another, and serves all three LHJs that are testing this model.

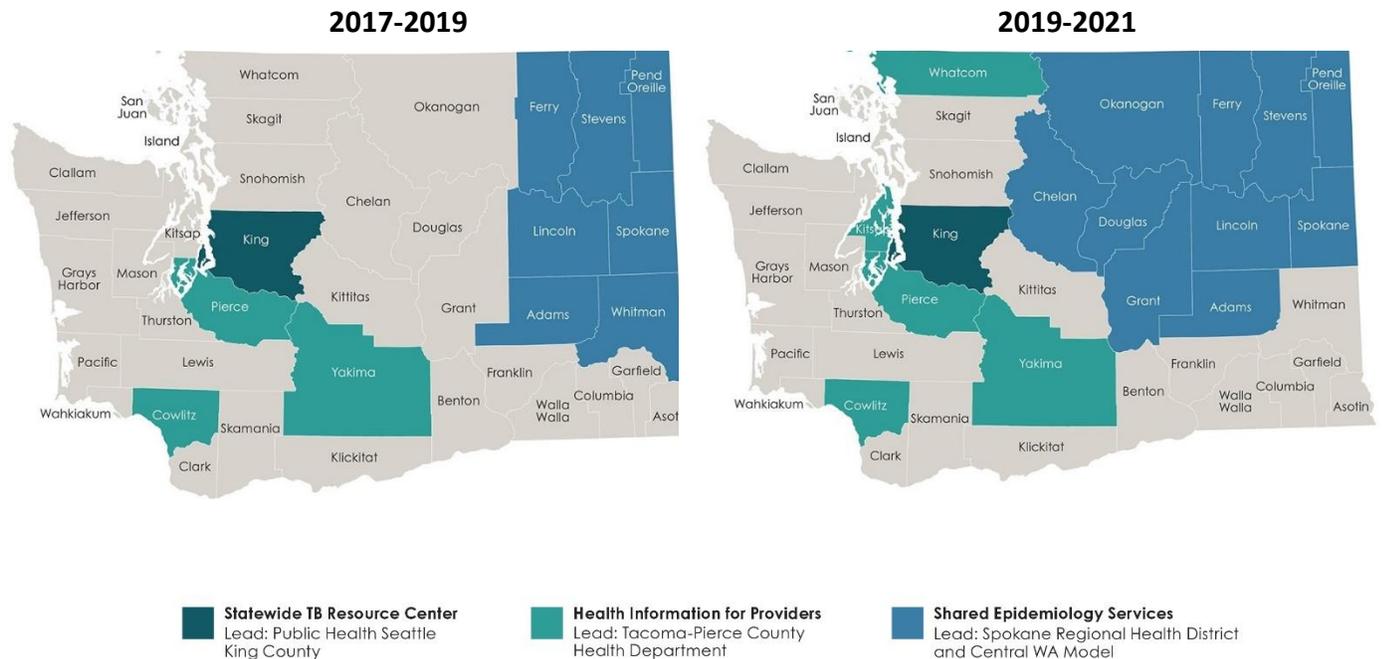
The second new model focuses on **investing in specific health outcomes** such as making progress statewide toward eliminating Hepatitis C. This model directs resources proportional to the problem. This “burden of disease” model uses data to target investments where specific health problems are occurring, standardized workload estimates (number of cases to be addressed, per staff person, per year), priorities and metrics to achieve the most significant impacts for improving health outcomes.

The **tribally driven FPHS process** is also transforming the system. This includes collaborative working relationships on the state and local level; sharing of data, information, policies, and resources; and development of tribal approaches for communicable disease prevention, control and surveillance. Once again, Washington is leading the nation – this time through the work of tribes. Recently the Centers for Disease Control and Prevention (CDC) praised AIHC for their work regarding tribal legal preparedness and response to the COVID-19 pandemic. The CDC found the model plans, policies, codes and resolution developed by AIHC to be the most relevant and practical resources available and they are sharing them across the country.

Systems transformation and the development and testing of these new models are applicable to other diseases and health problems and other core public health services. All these efforts have been critically valuable during the COVID-19 response and the burden of disease model is being used to allocate COVID-19 funding. Together, the governmental public health system is using new funding, new models, evaluation and performance data and lessons learned to transform how core public health services are delivered and to track progress toward full implementation.

A significant proportion of the 2021-2023 FPHS budget request is for funding to expand the use of these types of new service delivery models to provide core public health services to more communities across the state and to continue improving effectiveness, efficiency and equity. The budget request also includes funds for tribal organizations to build on and further advance their work to provide core public health services for American Indian/Alaska Native (AI/AN) people both on and off reservations. The funds requested will also support continued advancement in how tribal public health, the Department of Health, the State Board of Health, and local health jurisdictions work together in the most effective, efficient and equitable way in the delivery of FPHS, to serve all people in Washington.

**Figure 4: Expansion of successful new service delivery models.** Sharing staff, expertise and technology are ways to ensure the efficient use of FPHS funding.



**Figure 5: The “burden of disease” model is being used to invest in eliminating Hepatitis C in Washington.** The model uses data to invest where specific health problems are occurring and where the most significant impact to health outcomes can be made.

**Investing in Outcomes – Burden of Disease Model for Hepatitis C  
2019-2021**



## Progress toward Full Implementation of FPHS

Change in the capacity of the governmental public health system to provide FPHS is measurable. A small but measurable improvement in the capacity of the system to deliver FPHS was noted after the initial investment. The annual and biennial data collection is part of the overall FPHS accountability process and will continue to track progress toward full implementation of FPHS.

During the 2017-2019 biennium, the one-time investment of \$15 million appropriated was focused on communicable disease and the other capabilities that support that.

During the 2019-2021 biennium, \$28 million is focused on the highest priority, fund first FPHS: communicable disease, environmental public health, assessment (disease surveillance, epidemiology and community health assessment) and the other capabilities that support them. This includes:

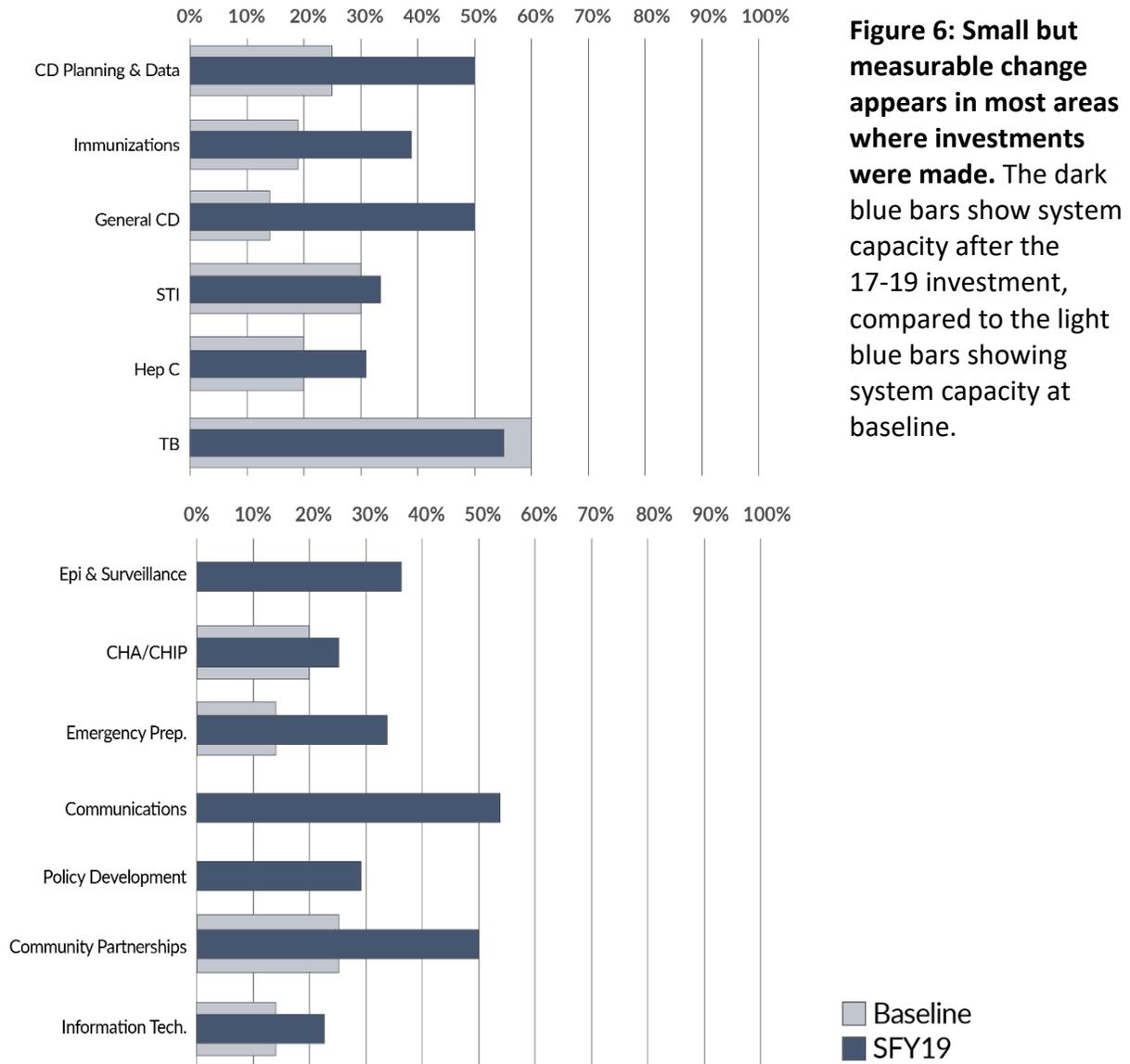
- Data and information for decision-making
- Partnership with communities for planning, prioritizing, and coordinating action
- Disease prevention through promoting immunizations
- Disease control by interrupting transmission and stopping the spread of disease or mitigating environmental risks to reduce injury and disease.

To deliver these services most effectively, efficiently and equitably, the following types of investments were made:

- Infrastructure – funds to provide FPHS statewide
- New Service Delivery Models – funds to provide FPHS to more than one jurisdiction
- Reinforcing capacity – funds to each LHJ to provide FPHS in their jurisdiction
- Tribal – funds to tribal organizations to develop and begin delivering FPHS to AI/AN who live on and off reservations

These investments made some critical improvements that positioned the system to respond better to COVID-19 than would have been the case without them. Planning had begun for modernizing data systems and migrating to a Cloud environment. A new module for outbreak management was built and deployed in the Washington Disease Reporting System (WDRS), the existing statewide communicable disease data system. Experienced scientists at the public health lab that would have been laid-off without these funds, were retained. In some LHJs, staff that conduct disease investigations who were at risk of being laid-off were retained and in other LHJs, additional staff were hired and trained and some disease investigation backlogs were reduced. All of these investments in FPHS were immediately put to use in responding to the new virus. However, a small investment and chronic underfunding meant that the system was still starting in a deficit in responding to the pandemic. Much of FPHS remains unfunded.

At the end of the 2017-2019 biennium, data was collected on the system capacity in the areas where investments were focused – communicable disease and the supporting capabilities. This data was compared to baseline and the results are measurable changes in almost every area where investments were made. The exhibits below display the comparisons.



**Figure 6: Small but measurable change appears in most areas where investments were made.** The dark blue bars show system capacity after the 17-19 investment, compared to the light blue bars showing system capacity at baseline.

Additional information is available in the [FPHS 2017-2019 Investment Report \(SFY19\)](#).

## Progress toward Better Health

Like public safety (fire, police), public utilities (power, water), and other public infrastructure (roads, sewers), there is a foundational level of public health services that must exist everywhere for services to work anywhere. Counting negative events that didn't happen because for example electricity is provided safely, or outbreaks were avoided because populations are vaccinated, is an ongoing challenge for infrastructure and prevention. Measuring the human toll and economic impact of the absence or failure of these, as in the case of wildfires or the opioid epidemic, is sadly much easier. COVID-19 has done what decades of research studies, journal articles and media stories document but were unable to drive home – public health and especially the foundational public health services, not only contributes to better health, it is essential for health.

In addition to tracking progress toward full funding, how the funds were spent and changes in system capacity, select metrics measure changes in output of the system that are core to better health. Is the governmental public health system providing more service – services that are known to prevent or slow the spread of disease and improve health of the population? The metrics in use and results so far are presented below.

**Promoting immunizations** – one of the most cost-effective strategies to prevent the spread of vaccine preventable disease.

- Percent of toddlers (19-35 months) who have completed the standard series of recommended vaccinations.
- Percent of children (4-6-year-olds) who have completed the standard series of recommended vaccinations.

After the initial investment in 2017-2019, both metrics were moving in the right direction. Changes in how rates are calculated were made during 2019, and the new data is not comparable with older data. So, 2019 becomes the new baseline to which future time periods will be compared.

**Stopping the spread of disease** – by tracking it (disease surveillance) and interrupting transmission.

The sooner disease data is available and disease investigation is completed, the sooner the spread of disease is interrupted and stopped. This leads to better health because fewer people get sick and it reduces long-term and costly consequences for individuals, families, businesses, communities and the state. Metrics measure:

- Availability and completeness of data for Hepatitis C cases
- Case investigations completed for cases of gonorrhea, including assuring that people are prescribed the correct, curative treatment
- Contact tracing for cases of syphilis

These three conditions were selected as indicators because:

- These conditions occur frequently so changes in the amount of resources available for disease investigations should be observable in these data; it would take more time and be more difficult to see changes for conditions that occur less frequently or sporadically
- In most of the state, the same staff who investigate these conditions investigate all communicable diseases, so changes in the amount of staff time available should be observable in these data.
- Modern data systems are essential to tracking disease and stopping its spread; changes in data availability and the speed of access should be observable in these data.

After the initial investment in 2017-2019, these metrics are also moving in the right direction. Electronic data became available for Hepatitis C as a result of this funding. This allows public health to track the disease and target efforts most effectively to improve health and work toward elimination of Hepatitis C. More case investigations were completed, and more people received curative treatment for gonorrhea and more people were alerted that they were exposed to syphilis and encouraged to seek care.

More data will be available with each year to track progress of FPHS investments toward better health. Additional metrics are also in development.

The legislature's 2017-2019 investment in FPHS is making measurable progress toward better health by preventing people from getting sick and assuring correct care for those who are.

## Conclusion

Legislative funding provided for FPHS is making a positive impact. The capacity of the governmental public health system to provide FPHS is increasing. New service delivery models are expanding access to core services that weren't previously available in some communities. More people are prevented from getting sick and are receiving correct care when they are sick. Yet so much remains unfunded and undone.

Going forward, it is critical for the state to provide adequate, dedicated, stable funding for full implementation of FPHS statewide that keeps pace with inflation and demand for services. As Washington is currently experiencing, the results of chronic underfunding of public health results in increased and avoidable health care costs, reduced productivity in our economy, and needless suffering from preventable disease and death. The COVID-19 pandemic is the most recent and visible example - but far from the only one. Other recent and painful examples with tragic consequences include Hepatitis A outbreaks, long-term consequences of untreated Hepatitis C, the opioid epidemic and growing rates of youth suicide.

An adequately funded public health system that delivers the foundational public health services statewide provides:

- Data and information for decision-making
- Partnership with communities for planning, prioritizing, and coordinating action
- Disease prevention through promoting immunizations, minimizing risk factors and using other proven and promising cost-effective population-based interventions to avoid or delay onset of injury and disease
- Disease control by interrupting transmission and stopping the spread of disease or mitigating environmental risks to reduce injury and disease

All of which lead to better health.



# Appendices

## Appendix A – Revised Code of Washington

### **RCW [43.70.512](#)**

#### **Public health system—Foundational public health services—Intent.**

(1) Protecting the public's health across the state is a fundamental responsibility of the state and is accomplished through the governmental public health system. This system is comprised of the state department of health, state board of health, local health jurisdictions, sovereign tribal nations, and Indian health programs.

(2)(a) The legislature intends to define a limited statewide set of core public health services, called foundational public health services, which the governmental public health system is responsible for providing in a consistent and uniform way in every community in Washington. These services are comprised of foundational programs and cross-cutting capabilities.

(b) These governmental public health services should be delivered in ways that maximize the efficiency and effectiveness of the overall system, make best use of the public health workforce and evolving technology, and address health equity.

(c) Funding for the governmental public health system must be restructured to support foundational public health services. In restructuring, there must be efforts to both reinforce current governmental public health system capacity and implement service delivery models allowing for system stabilization and transformation.

### **RCW [43.70.515](#)**

#### **Foundational public health services—Funding.**

(1) With any state funding of foundational public health services, the state expects that measurable benefits will be realized to the health of communities in Washington as a result of the improved capacity of the governmental public health system. Close coordination and sharing of services are integral to increasing system capacity.

(2)(a) Funding for foundational public health services shall be appropriated to the office of financial management. The office of financial management may only allocate funding to the department if the department, after consultation with federally recognized Indian tribes pursuant to chapter [43.376](#) RCW, jointly certifies with a state association representing local health jurisdictions and the state board of health, to the office of financial management that

they are in agreement on the distribution and uses of state foundational public health services funding across the public health system.

(b) If joint certification is provided, the department shall distribute foundational public health services funding according to the agreed-upon distribution and uses. If joint certification is not provided, appropriations for this purpose shall lapse.

(3) By October 1, 2020, the department, in partnership with sovereign tribal nations, local health jurisdictions, and the state board of health, shall report on:

(a) Service delivery models, and a plan for further implementation of successful models;

(b) Changes in capacity of the governmental public health system; and

(c) Progress made to improve health outcomes.

(4) For purposes of this section:

(a) "Foundational public health services" means a limited statewide set of defined public health services within the following areas:

(i) Control of communicable diseases and other notifiable conditions;

(ii) Chronic disease and injury prevention;

(iii) Environmental public health;

(iv) Maternal, child, and family health;

(v) Access to and connection with medical, oral, and behavioral health services;

(vi) Vital records; and

(vii) Cross-cutting capabilities, including:

(A) Assessing the health of populations;

(B) Public health emergency planning;

(C) Communications;

(D) Policy development and support;

(E) Community partnership development; and

(F) Business competencies.

(b) "Governmental public health system" means the state department of health, state board of health, local health jurisdictions, sovereign tribal nations, and Indian health programs located within Washington.

(c) "Indian health programs" means tribally operated health programs, urban Indian health programs, tribal epidemiology centers, the American Indian health commission for Washington state, and the Northwest Portland area Indian health board.

(d) "Local health jurisdictions" means a public health agency organized under chapter [70.05](#), 70.08, or [70.46](#) RCW.

(e) "Service delivery models" means a systematic sharing of resources and function among state and local governmental public health entities, sovereign tribal nations, and Indian health programs to increase capacity and improve efficiency and effectiveness.

## Appendix B – Progress toward System Transformation

### New Service Delivery Models

#### Sharing Staff, Expertise & Technology

##### Assessment

- Regional Epidemiology Services for Eastern WA – Data Center Model (provided by Spokane Regional Health District). Serving: 3 LHJs – Adams, Lincoln, NE Tri. Services include: compiling, presenting, and maintaining public health data for each LHJ on a common webpage at [County Health Insights](#); Assist LHJs in conducting Community Health Assessments and Community Health Improvement Processes every 4-5 years and working with the community to use these tools and products to guide community efforts and investments and track progress toward health goals.
- **NEW in 2019-2021:** Regional Epidemiology Services for Central WA – Shared Epidemiologist Model (1 FTE hired by Chelan-Douglas, based in Okanogan). Serving: 3 LHJs – Chelan-Douglas, Grant, Okanogan.

##### Communicable Disease (CD)

- Regional CD Epidemiology for Eastern WA (provided by Spokane Regional Health District). Serving: 3 LHJs – Adams, Lincoln, NE Tri-County. Services include onboarding of new CD staff through training and providing technical assistance including expertise and capacity for disease investigation, 24/7/365, as needed.
- Healthcare Provider Resources web page (provided by Tacoma-Pierce County Health Department). Serving: 4 LHJs – Cowlitz, Yakima. **NEW in 2019-21:** Whatcom, Kitsap (in development). Services include tailoring for each LHJs, a common approach to CD data on the web that can be easily updated and maintained, centrally, by one LHJ (TPCHD). Current examples:

<https://www.yakimacounty.us/2140/NEW-Provider-Resource-Page>

<http://providers.whatcomcounty.org/>

<https://cchhsproviderresources.org/>

*“The Cowlitz Provider Resources site with its dedicated COVID-19 webpage as well as the ability to post our Region IV Health Updates, Advisories and Alerts, allows us to offer our providers an easily-accessible one-stop-shop to get current and historical information relevant to our community. Our site seems to have regular activity, but its value is most noticeable when there is something of public health significance happening, most recently with the measles outbreak and now the COVID-19 pandemic, our providers*

*know where they can turn for information as well as subscribe for emailed updates.” – Cowlitz County*

*“The Provider Resources website has been absolutely critical in our mass communications to our providers. In being able to utilize COVID-19 we have been able to send out timely information and know that it was reaching our providers. With the many changes that were made throughout COVID-19, having a quick, flexible communications system that was able to house so much information was absolutely essential. We simply would not have been as successful in communicating with our providers if it were not for the provider resources website. Not only were we able to provide county specific information, but it was enormously helpful to receive relevant information that came pre-packaged and ready to send out by TPCHD. Having the support from TPCHD, specifically Sarah Franz, on days, nights and weekends was invaluable.” – Yakima County*

- Statewide TB Services (provided by Public Health – Seattle-King County). Serving: all LHJs and all active cases of TB. Services include consultation with expert TB clinical staff, technology for and monitoring of patients treatment, staff to assist with contact investigation and testing, and training.

### **Investing in Outcomes – Burden of Disease Model NEW in 2019-2021**

- Hepatitis C was prioritized as the first condition to be addressed using this new model. Of all Hepatitis C cases, 90 percent of them are in just 17 LHJs (Benton-Franklin, Chelan-Douglas, Clallam, Clark, Cowlitz, Grays Harbor, Lewis, Mason, King, Kitsap, Skagit, Snohomish, Spokane, Tacoma-Pierce, Thurston, Whatcom, and Yakima). Funds (\$3 million/biennium) are disbursed to these LHJs based on the burden of disease. Allocations recalculated biennially based on the data.

Each LHJ is using the funds to address Hepatitis C cases in their jurisdiction using common priorities, standardized surveillance, and minimum standards of practice, metrics and staffing models established by the statewide Communicable Disease workgroup. The priorities for SFY21 (July 2020–June 2021) are: a) Surveillance – entering labs into the Washington Disease Reporting System (WDRS), enter acute cases into WDRS and b) Investigation – focus on acute cases: people aged 35 or younger, newly diagnosed, pregnant women, people seen in the ED/inpatient, Black, Indigenous and People of Color or other historically marginalized population and incorporate Hepatitis B work.

## **Tribal FPHS and System Transformation**

Tribes are also participating in system transformation. As a part of the governmental public health system, Tribes and Indian health programs are engaged their own tribally driven process to define FPHS delivery framework, including their costs and gaps. The American Indian Health Commission (AIHC) serves on the FPHS Steering Committee on behalf of tribes and coordinates the tribally driven process.

FPHS funds appropriated by the legislature during the 2019-2021 biennium and invested in the tribally driven process are yielding results in many areas. In addition to developing a common set of definitions for Tribal FPHS (TFPHS) programs and core capabilities; a crosswalk of the TFPHS definitions with the non-tribal FPHS definitions and implementing an assessment of TFPHS core programs and capabilities; examples, include:

- For the 29 federally-recognized tribes in Washington and the American Indian/Alaska Native (AI/AN) people served by tribal clinics in Washington, tribes are being convened to share their experiences, polices, inventory control, etc. and the reporting of tribal public health data needs from tribal health clinics is being coordinated.
- For American AI/AN people living on and off reservations in Washington:
  - Assessments are being conducted to determine the available assets and needs for the prevention, control and management of communicable disease in urban tribal communities and in Indian Health Service and tribal health clinics on reservations.
  - Data is being compiled and linked to produce a corrected baseline report card of communicable disease for Washington.
  - During disease investigations, tribes and tribal organizations are working closely with the governmental public health system to ensure proper protocols are followed for the collection and analysis of data, dissemination of information and to assure that the process is respectful and confidential according to indigenous protocols. Protocols for disease investigation and control for AI/AN in Washington are being developed based on the guidance, consultation, and advice of AI/AN TFPHS community partners.

Participating in emergency preparedness events and exercises conducted by TFPHS governmental partners and making recommendations to the Tribal FPHS workgroup based on the needs/asset assessment for the prevention, control, and management of communicable diseases in Washington's urban tribal communities.

## Appendix C – Progress toward Full Implementation

During the 2017-2019 biennium, the one-time investment of \$15 million appropriated to FPHS was focused on communicable disease. The investment allowed the public health system to do things like:

- Conduct disease surveillance and investigations. In some areas, the FPHS funds provided more disease investigations than were conducted without these funds. In other areas the FPHS funds maintained the amount of disease investigations when other fund sources were reduced and created risk of reduced disease investigations. Some jurisdictions were able to clear back-logs of cases, others were able to dramatically reduce response times which reduces the spread of disease and others are now able to proactively investigate all case reports rather than having to prioritize which cases to pursue which has risks. Overall, the funds supported some additional staff time, statewide, for disease investigation. Hiring, training, and building experience in these additional staff statewide, before an emergency occurred, is an investment that has been critical to the state's COVID-19 response.
- Maintain and expand public health laboratory services, which are essential for our communities in the tracking, reporting and monitoring of communicable disease. Again, having staff and equipment in place, in use, and ready for an emergency before it occurs means starting a little less behind in responding.
- Begin planning data consolidation.
- Shared service demonstration projects were piloted:
- Statewide coordination of tuberculosis prevention and control
- Epidemiology and community health assessment expertise to multiple LHJs in Eastern Washington.
- Expertise and technical assistance to LHJs in making timely information available to health care providers in their communities.

For more examples, see the [FPHS 2017-2019 Investment Report \(SFY19\)](#), Appendix F.

During the 2019–21 biennium, \$28 million was appropriated to FPHS with a focus on the highest priority “fund first” FPHS in communicable disease, environmental public health, assessment (epidemiology, disease surveillance and community health assessment) and the other capabilities that support them. Examples of how these funds are being invested include:

- Infrastructure – investment to provide FPHS for the whole state
  - FPHS funds invested to modernize data systems provided the required state match to draw an additional \$3.4 million in federal funds. Ongoing work includes: planning and design of a modernized, modular, flexible data system integrated across diseases and health issues and establishing the environment in Cloud to house data and data systems, including elements such as firewalls, switches, circuits, etc.

- Developed and implemented new modules in the Washington Disease Reporting System (WDRS) for outbreaks and Hepatitis C. The outbreak module was instrumental in allowing Washington to immediately begin collecting needed data for the COVID-19 response. Now data on Hepatitis C cases, investigations and linkage to care are available electronically allowing public health leaders to focus resources and prioritize efforts.
- Purchased laboratory equipment and supplies for Hepatitis C serology testing. This same equipment and staff that are funded with FPHS funds have been critical in increasing capacity for COVID-19 testing.
- New Service Delivery Models – investments to provide FPHS to more than one jurisdiction or investments that are focused in a new way.
  - The previous pilots are being expanded to include additional jurisdictions and services.
  - New models are being implemented
- Reinforcing Capacity – investment in each LHJ to deliver FPHS in their jurisdiction
  - Increase in disease investigation staff and training not only means that more cases of STDs, syphilis, measles, pertussis, etc. are investigated in a timely fashion, it also meant more staff were available to be redirected to the COVID-19 response and COVID-19 case investigation and contact tracing.
  - Updated outbreak response plans critical to local disease outbreaks and local COVID-19 response.
  - Increased partnerships with schools and other community groups and use of health data in community planning and action.
- Tribal – investments in tribal organizations to develop delivery of some FPHS for AI/AN people who live on and off reservations.

The investment from the previous and current biennia are making some critical improvements that positioned the system to respond to COVID-19 better than would have been the case without these funds. However, a small investment and chronic underfunding meant that the system was still “coming from behind” to try to respond to the pandemic. So much necessary work remains unfunded.

## Appendix D – Progress toward Better Health

### Metrics

#### Promoting Immunizations

Year 1 of the initial investment (SFY18) – data shows a slight improvement in immunization rates over baseline.

Year 2 of the initial investment (SFY19) – changes were made in how population level data are compiled in the Immunization Information System (IIS) so this data is not comparable to previous years and will serve as the new baseline for this measure.

Promoting Immunization					
	SFY17 Baseline	SFY18	Change from Baseline	SFY19 New Baseline	Change from Baseline
Immunization coverage among 19-35-month-olds	60%	65%*	+4%*	59%**	Data not comparable
Immunization coverage among 4-6-year-olds	45%	47%*	+2%*	43%**	Data not comparable

\* Data points included in the 2018 Report to the Legislature

\*\* Changes were made in how population level data are compiled in the Immunization Information System (IIS).

#### Hepatitis C Disease Investigation

Year 1 of the initial investment (SFY18) – data on disease investigation of Hepatitis C was not available due to outdated legacy data systems.

Year 2 of the initial investment (SFY19) – data that will serve as baseline for this measure is now available. A portion of the initial FPHS investment was used to modernize a critical data system. The FPHS funds combined with a 90% federal match enabled the launch of the Hepatitis C module in the Washington Electronic Disease Reporting System (WDRS). The results are the availability of data to assess the situation, prioritize and focus efforts in the most effective and efficient way, and track progress in linking infected people to curative treatment and stopping the spread of disease.

Hepatitis C Disease Investigation					
	SFY17 Baseline	SFY18	Change from Baseline	SFY19 Baseline	Change from Baseline
Acute Hepatitis C					
Cases were reviewed by public health staff*	N/A	N/A	N/A	98%	N/A
Cases with completed investigations				65%	
Chronic Hepatitis C					
Cases were reviewed by public health staff*	N/A	N/A	N/A	47%	N/A
Cases with completed investigations				2%	
Chronic Hepatitis C in people born in 1992 or after					
Cases were reviewed by public health staff*	N/A	N/A	N/A	60%	N/A
Cases with completed investigations				5%	

### Gonorrhea and Syphilis Disease Investigation

Year 1 of the initial investment (SFY18) – data shows that for people diagnosed with gonorrhea or syphilis, more of them received disease investigation and appropriate treatment over baseline.

Year 2 of the initial investment (SFY19) – data shows that for people diagnosed with gonorrhea or syphilis, more of them received disease investigation and appropriate treatment over baseline.

Gonorrhea and Syphilis Disease Investigation					
	SFY17 Baseline	SFY18	Change from Baseline	SFY19	Change from Baseline
Gonorrhea cases interviewed					
Number of cases	3987	5418	1413	4822	835
Percent of cases	46%	49%	3%	43%	-2%
Gonorrhea cases interviewed that are getting appropriate treatment					
Number of cases	3362	4663	1301	4186	824
Percent of cases	84%	86%	2%	87%	2%
Syphilis cases interviewed					
Number of cases	1131	1359	228	1392	261
Percent of cases	71%	73%	1%	67%	-5%

## Appendix E – Links to Reference Documents

### FPHS Reference Materials

[FPHS Definitions 1.4, March 2019](#)

[2020 FPHS Committees, Charter, Rosters](#)

### FPHS Reports

[2020 FPHS 17-19 Investment Report \(SFY19\)](#)

[2019 FPHS Evaluation of Shared Services Demonstration Projects](#)

[2018 FPHS Report to the Legislature](#)

[2018 FPHS Baseline Assessment Report](#)

[2017 FPHS Report to the Legislature](#)

[2016 FPHS Report to the Legislature](#)

[2015 FPHS Policy Workgroup Report](#)

[2015 FPHS Final Technical Report](#)

[2013 FPHS Preliminary Cost Estimation Model Report](#)

### Related Efforts in Other States

[Ohio Public Health Partnership - FPHS](#)

[Oregon Health Authority – Public Health Modernization](#)

### Related Efforts Nationally

[For the Public's Health: Investing in a Healthier Future, IOM \(2012\)](#)

[Public Health Executive Leadership Forum/RESOLV](#)

[Public Health National Center for Innovation – FPHS](#)