HOUSE BILL REPORT
HB 1152

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to supporting measures to create comprehensive public health districts.

Brief Description: Supporting measures to create comprehensive public health districts.

Sponsors: Representatives Riccelli, Leavitt, Stonier, Ormsby, Lekanoff, Pollet, Bronoske and Bateman; by request of Office of the Governor.

Brief History:
Committee Activity:
Health Care & Wellness: 1/21/21, 2/11/21 [DPS].

Brief Summary of Substitute Bill

- Establishes nine comprehensive health services districts and creates six regional health officers.
- Modifies the composition of local boards of health.
- Prohibits a county from making a material change to the county's public health governance structure unless the county notifies the State Board of Health and receives approval of the change, until January 1, 2024.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 10 members: Representatives Cody, Chair; Bateman, Vice Chair; Bronoske, Davis, Harris, Macri, Riccelli, Simmons, Stonier and Tharinger.

Minority Report: Do not pass. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Rude and Ybarra.

Staff: Kim Weidenaar (786-7120).

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Background:

Department of Health.
The Department of Health (DOH) administers various programs and services that promote public health through disease and injury prevention, immunization, newborn screening, professional licensing, and public education. Public health services are provided primarily by a decentralized system of 35 local health jurisdictions, the DOH, and the Washington State Board of Health (State Board).

Local Health Department or District.
Counties' legislative authorities are charged with establishing either a county health department or a health district to assure the public's health. Local health departments and health districts can take various forms and include a single county health department or district, a combined city and county health department, or several counties can join a health district.

Each local public health jurisdiction is governed by a local board of health (board), the membership of which depends on whether the county is a home rule county or part of a local health district. For example, in home rule counties, the membership of the board is governed by the county charter. Elected officials from cities and towns in the county may be appointed to the board. The board may also include individuals who are not elected officials, but such individuals may not constitute a majority of the board. In nonhome rule counties that are not part of a local health district, the county's board of commissioners constitutes the board. The county may expand the membership of the board to include elected officials from cities or towns. The board may also include individuals who are not elected officials, but such individuals may not constitute a majority of the board.

Each local health jurisdiction must appoint a local health officer, who must be an experienced physician or osteopathic physician who has a Master of Public Health degree or equivalent.

Foundational Public Health Services.
"Foundational public health services" is defined as a limited statewide set of defined public health services within the following areas: control of communicable diseases and other notifiable conditions; chronic disease and injury prevention; environmental public health; maternal, child, and family health; access to and linkage with medical, oral, and behavioral health services; vital records; and cross-cutting capabilities including assessing the health of populations, public health emergency planning, communications, policy development and support, community partnership development, and business competencies. "Governmental public health system" means the DOH, the State Board, local health jurisdictions, sovereign tribal nations, and Indian health programs located in Washington. "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.

Foundational Public Health Services Funding.
Funding for foundational public health services must be appropriated to the Office of Financial Management (OFM). The OFM may only allocate funding to the DOH if the DOH, after consultation with federally recognized Indian tribes pursuant to the statutory consultation process, jointly certifies, with a state association representing local health jurisdictions and the State Board, to the OFM that there has been an agreement on the distribution and uses of state foundational public health services funding. If joint certification is provided, the DOH must distribute the funding according to the agreed-upon distribution and uses. If joint certification is not provided, the appropriation for foundational public health services lapses.

Summary of Substitute Bill:

Work Group.
A work group is established to develop and recommend to the State Board of Health (State Board) a public health system to provide foundational public health services through local health jurisdictions, comprehensive health services districts, and the Department of Health (DOH). The work group consists of the following members appointed by the Governor to represent diverse geographic locations:

- two representatives from the Senate;
- two representatives from the House of Representatives;
- three representatives of local public health;
- two representatives of state public health;
- three representatives of counties;
- two representatives of cities;
- one tribal representative;
- one representative with expertise in government finance;
- one state association representative from the Foundational Public Health Services Steering Committee (Steering Committee);
- one public health representative from the Steering Committee;
- one tribal public health representative from the Steering Committee; and
- one technical work group member from the Steering Committee.

The work group must develop a transparent process that includes opportunity for public comment. The work group must provide recommendations to the State Board on the system for counties to form comprehensive health services districts by July 1, 2022. The work group must recommend performance measures and a measure set to the State Board by January 1, 2023. The work group must also submit recommendations to the Legislature on adequate funding of local health jurisdictions and comprehensive health services districts by July 1, 2023.

State Board of Health Rulemaking.

The State Board must adopt rules to provide foundational public health services through local health jurisdictions, comprehensive health services districts, and the DOH. The rules must include:

- a system and process for counties to create comprehensive health services districts;
- performance measures and proposed benchmarks to track the efficiency and effectiveness of local health jurisdictions, comprehensive health services districts, and the DOH;
- a manageable measure set based on readily available data that focuses on overall performance of the system;
- a process for the DOH to certify comprehensive health services districts;
- a process to evaluate local health jurisdictions, comprehensive health services districts, and DOH performance; and
- a process for information and data to be reported by the districts to the DOH.

By November 1, 2024, the State Board must submit to the appropriate committees of the Legislature a report on local health jurisdiction and comprehensive health services district performance based on the identified performance measures.

Funding for Foundational Public Health Services.
Beginning January 1, 2024, comprehensive health services districts are included in the foundational public health services process so that the OFM may only allocate funding to the DOH if the DOH, after consultation with federally recognized Indian tribes pursuant to the statutory consultation process, jointly certifies, with a state association representing local health jurisdictions, the comprehensive health services districts, and the State Board, to the OFM that there has been an agreement on the distribution and uses of state foundational public health services funding. Beginning January 1, 2027, and biennially thereafter, prior to allocating foundational public health funds to comprehensive health services districts, the DOH must evaluate the comprehensive health services districts' performances to satisfy the measure set established in rule.

Comprehensive Health Services Districts.
By January 1, 2024, counties must form comprehensive health services districts. The DOH must certify the comprehensive health services districts. Nine comprehensive health services districts are established and consist of the following counties:

- Skamania, Clark, Cowlitz, and Wahkiakum;
- Lewis, Thurston, Mason, Pacific, and Grays Harbor;
- Jefferson, Clallam, and Kitsap;
- Pierce and King;
- Island, Snohomish, Skagit, Whatcom, and San Juan;
- Chelan, Okanogan, Douglas, and Grant;
- Ferry, Stevens, Pend Oreille, Spokane, Lincoln, Adams, and Whitman;
- Benton, Franklin, Walla Walla, Columbia, Garfield, and Asotin; and
- Kittitas, Yakima, and Klickitat.

Counties with a population over 800,000 may be considered a comprehensive health services district without joining with other counties when the county legislative authority of the county passes a resolution or ordinance to organize such a comprehensive health services district.

Comprehensive health services districts are formed to help diversify and stabilize funding services for public health. Comprehensive health services districts are established to encourage the systemic sharing of resources and functions among state and local governmental public health entities, sovereign tribal nations, and Indian health programs to increase capacity and improve efficiency and effectiveness. Comprehensive health services districts must:

- provide a mechanism for local health jurisdictions in each comprehensive health services district to convene, collaborate, plan, and work together;
- develop a district plan for identification and implementation of shared service delivery options, models, and strategies;
- coordinate with other comprehensive health services districts;
- identify what programs and services can be delivered through a shared or regional system within the district;
- administer and allocate foundational public health services funding to each local health jurisdiction comprising the district;
- provide funding to local health jurisdictions to deliver or purchase shared services from other local health jurisdictions, districts, counties, nonprofits or other jurisdictions, businesses, or entities;
- undertake accountability measures for implementation of foundational public health services within the district;
- report the adequacy of foundational public health services resources for the district to the DOH; and
- as authorized by the district board, provide direct or shared services to local health jurisdictions within the district or to other districts through contracts or other agreements, including, but not limited to: public health services; business, fiscal, and administrative services; acquisition of capital and equipment; communications; and data collection.

Members of the comprehensive health services district board of health are:

- one elected official from each county in the district who serves on a local board of health chosen by that local board of health;
- one elected city official from a city in the district;
- one tribal representative from within the district selected by the Indian Health Board and appointed by the Governor;
- the regional health officer; and
- at least one representative from the following categories appointed by the Governor: (1) public health practitioners, employees of health care facilities, and health care providers; (2) consumers of public health, which includes residents who have self-identified as having faced significant health inequities or as having lived experiences

with public health-related programs; and (3) other community stakeholders, which consists of persons representing the following types of organizations: community-based organizations or nonprofits that work with populations experiencing health inequities in the county, the business community; or the environmental public health regulated community.

City and county elected officials may not constitute a majority of the board. The Governor-appointed members may serve three-year terms and may serve two terms. The board may establish its own bylaws.

Comprehensive health services districts must establish a district health fund in the custody of the county treasurer where the headquarters office of the district is located. Comprehensive health services district expenditures must be authorized by the district board of health.

Each comprehensive health services district must have an administrative officer who is an employee of the comprehensive health services district and is responsible for administering the operations of the district. The administrative officer's salary must be paid by the DOH. Comprehensive health services districts may own, construct, purchase, lease, and maintain real and personal property necessary to conduct the affairs of the district and may sell, lease, convey, or dispose of district real or personal property.

Beginning January 1, 2024, comprehensive health services districts must pay for expenses incurred by the health district or county for carrying out provisions of public health laws, rules, and enforcing proclamations of the Governor during a public health emergency.

District Health Officer.
Within the DOH the position of regional health officer is created. The Secretary of Health must appoint six regional health officers, who are each assigned to a comprehensive health services district.

Local Boards of Health.
Each local board of health must include a tribal appointee selected by the Indian Health Board and members from the following categories (who may not be elected) in addition to existing members of the local board of health:

- public health practitioners, employees of health care facilities, and health care providers, which includes: medical ethicists; epidemiologists; individuals experienced in environmental public health, such as a registered sanitarian; community health workers; holders of master's degrees or higher in public health or its equivalent; employees of a hospital located in the county; physicians or osteopathic physicians; advanced registered nurse practitioners; physician assistants; nurses; dentists; naturopaths; or pharmacists;
- consumers of public health, which includes residents who have self-identified as having faced significant health inequities or as having lived experiences with public

health-related programs; and
- other community stakeholders, which consists of persons representing the following types of organizations: community-based organizations or nonprofits that work with populations experiencing health inequities in the county, the business community; or the environmental public health regulated community.

If the number of board members selected from these three categories is evenly divisible by three, there must be an equal number of members selected from each of the three categories. If the number of board members selected from these categories are not evenly divisible by three, there must be an equal number of members selected from each of the three categories up to the nearest multiple of three. The number of city and county elected officials on the board of health may not constitute a majority of the board. Any decision by the board of health related to the setting or modification of permit, licensing, and application fees may only be determined by the city and county elected officials on the local board of health.

Changes to Public Health Governance.
A county may not make a material change to its public health structure unless:
- the county notifies the State Board of its intention to make a material change and includes a description of the current structure, rationale for the planned change, the impact on current programs, staffing, and funding, and the populations most likely to be affected by the change; and
- the State Board finds that the planned material change would not have an adverse effect on health disparities, social determinants of health, or the provision of health services and approves the change.

Before making a material change to the county's public health governance structure, the county legislative authority must: provide notice and a meaningful opportunity for the public to comment on the material change; participate in a good faith mediation process with any affected county, city, or town that objects to the material change; and approve the material change by a majority vote of the county legislative authority taken in an open meeting. The material change may not go into effect less than 12 months after the vote of the county legislative authority.

A material change to a county's public health governance structure includes joining or withdrawing from a local health district; entering or terminating an agreement for a combined city-county health department; or amending the county charter or enacting an ordinance altering the composition of the local board of health.

If a county does not comply with these requirements, the State Board must issue a preliminary notice of violation to the county, which the county must cure within 30 calendar days. If the county fails to cure the violation within 30 days, the State Board must issue a final notice of violation to the county and send a copy of the final notice to the State Treasurer. Upon notification to the State Treasurer, the State Treasurer must cease all

future distributions from the Dedicated Marijuana Account or the Liquor Excise Tax Fund. The provisions relating to the material change to a county's public health governance expire on January 1, 2024.

Repealed Statutes.
Statutes related to establishing a DOH study on uniform quality assurance and improvement are repealed.

Substitute Bill Compared to Original Bill:

The substitute bill:

- eliminates provisions in the underlying bill related to: establishing and operating comprehensive public health districts; and repealing provisions providing for the establishment and operation of local boards of health, local health districts, local district boards of health, and city-county health departments;
- establishes nine comprehensive health services districts and requires counties to form the districts by January 1, 2024;
- establishes the duties and responsibilities for comprehensive health services districts, including developing a district plan to identify shared service delivery models, coordination with other districts, administering and allocating funding to each local health jurisdiction comprising the district, and reporting the adequacy of resources to the Department of Health (DOH);
- modifies the composition of the work group to include members of the Foundational Public Health Services Steering Committee;
- establishes the membership of each comprehensive health services district board of health;
- requires the State Board of Health (State Board) to adopt rules to regarding comprehensive health services districts and performance measures to track the effectiveness of local health jurisdictions, comprehensive health services districts, and the DOH;
- requires each comprehensive health services district board to establish a district health fund and permits each district to own, purchase, and maintain real and personal property;
- creates the six regional health officers within the DOH who are assigned to a comprehensive health services district;
- modifies the membership of local boards of health to include a tribal representative and representatives with public health or medical backgrounds, consumers of public health, and other community stakeholders beginning July 1, 2022; and
- prohibits a county from making a material change to the county's public health governance structure unless the county notifies the State Board and receives approval of the change, until January 1, 2024.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 4 and 17, relating to the foundational public health services funding and the comprehensive health services districts covering the expenses for carrying out public health laws, rules, and enforcing proclamations of the Governor during a public health emergency, which take effect on January 1, 2024.

Staff Summary of Public Testimony:

(In support) The Legislature has continually underfunded public health and we must determine adequate funding. Everyone deserves to have access to equitable health services and that is not happening in Washington right now, which has become even more apparent during the pandemic. The pandemic has given us an opportunity to strengthen our public health system. Washington has done some great work to ensure the system is responding to the pandemic and the intent of this bill is to continue this work.

This year, we have throughout the state seen what happens when politics are involved in public health. Communities must base public health decisions on science and what is best for the community, not politics. Seventeen local health officers have left, retired, were forced out, or resigned in protest due to the politicization of public health. This bill protects the implementation of evidence-based public health practice. The Department of Health (DOH) has provided support to 23 counties for contract tracing and has provided other management roles because local health jurisdictions could not. Consistency and efficiency across the public health system are important, as is bringing in more voices to the public health decision-making process. This year the Legislature is proposing to fund public health at a substantial level, which paired with regionalization would have a substantial impact.

There has been lots of work done already, but there is still much to do. This bill is a reimagination of how we address public health which is long overdue.

Financing foundational public health is the most important aspect of the bill. The public health system is chronically underfunded. We need to find efficiencies and protect the public health system. Regionalization of public health is a good idea and something that is done in other areas of health care.

The absolute independence of the health officer is critical. Currently many local boards of health have no experience in health or public health. Changing the composition of the boards to provide a better balance is necessary, though the categories found in House Bill 1110 are an improvement with the inclusion of the tribal representative and health officer.

The voices of those who are impacted by health inequities need to be included in the public health system. This bill allows for a refocusing and bringing others aboard to shine a light

on the invisible barriers of health inequities. When leaders make decisions without considering impacts on health and equity the community suffers. We cannot continue to allow politicians to censor public health.

(Opposed) This bill takes away local control. Local health jurisdictions are an integral part of home building and have responsibilities to approve sewer, septic, and water systems. These decisions should be kept at the local level.

The funding for this bill and the public health system comes out of the pockets of taxpayers. This bill creates a government authority that is not responsible to taxpayers, it is taxation without representation.

This bill will kneecap local decision makers. It is confusing as to how making these districts larger will help. Instead it will undermine the trust people have in their local health boards.

(Other) There are many concerns about this major revision to the public health system. The designation of the district health officer as a state employee creates a presumption that the appointment and oversight is linked to the state. This bill shifts the focus from local to regional concerns and raises the question of whether district health officers will have the autonomy to make local decisions or if the direction would come from the state.

Moving from local districts to larger regional jurisdictions will have a negative effect on communities. Currently there are natural interconnected relationships, which may be lost along with local decision making. There is also concern about losing the community support if the local health jurisdiction becomes just a part of a larger district. Local public health has never been more important, and this bill may diminish the positive impacts local public health has on local communities at the time they need public health support most.

People are dying because of bad decisions made by politicians that have no background in health. We need health care and public health professionals making these decisions, not politicians.

The Foundational Public Health Services Steering Committee has been working for many years. The state has invested in this committee and process and it already includes the entire public health system. The foundational public health system has already put together a system of shared services, which are critical.

The pandemic has taught us a lot about our public health system, both where we excel and where we need improvement. It has stretched the public health system. We should be using lessons learned to inform future conversations. Planning to restructure the entire system during a pandemic is not reasonable, is unfair, and takes time away from critical work to fight the pandemic.

Many decisions in health care are made by people who only have the administrative and financial outlook in mind. Doctors do not have the equipment they need, and staff do not have the training they need. Family members are dying because local hospitals do not have the necessary equipment and other families should not have to go through this loss.

Persons Testifying: (In support) Representative Riccelli, prime sponsor; James Sledge, Public Health Action Coalition Team of Spokane; Hallie Burchinal, Compassionate Addiction Treatment; Amber Lenhart; Molly Voris, Office of the Governor; Umair Shah, Washington State Department of Health; Tony Gonzalez; Breean Beggs, Spokane City Council; and Joe McDermott, King County Council.

(Opposed) Steve Edwards; and Josie Cummings, Building Industry Association of Washington.

(Other) Tom Locke, Jefferson County Health Department; Amy Person, Benton-Franklin Health District; Schelli Slaughter, Thurston County Health and Human Services; Theresa Adkinson, Grant County Health District; Keith Grellner, Kitsap Public Health District; Cristina Ortega; and Esther Moses Hypieer.

Persons Signed In To Testify But Not Testifying: Maria Courogen, Washington State Department of Health; Aimee Lybbert; Michael Largent, Whitman County; Sean Graham, Washington State Medical Association; Temple Lentz, Clark County; Derek Young, Pierce County; Mark Larson, Kittitas County Health Department; Jaime Bodden, Washington State Association of Local Public Health Officials; Jennifer Muhm, Washington State Nurses Association; Wendy Speere, Yakima Health First; Bridget Russel, I Heart Yakima; and Ida Moses Hypieer.