HOUSE BILL REPORT
E2SHB 1152

As Amended by the Senate

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

Brief Description: Establishing comprehensive health services districts.

Sponsors: House Committee on Appropriations (originally sponsored by 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];
Appropriations: 2/19/21, 2/22/21 [DP2S(w/o sub HCW)].

Floor Activity:

Passed House: 3/8/21, 56-41.
Senate Amended.
Passed Senate: 4/11/21, 26-22.

Brief Summary of Engrossed Second Substitute Bill

- Establishes four regional comprehensive public health district centers (regional centers) and the Foundational Public Health Services (FPHS) Steering Committee.
- Creates a Public Health Advisory Board and four regional health officers.
- Modifies the composition of local boards of health in counties with a population under 800,000.
- Adds a null and void clause related to the establishment of the regional centers unless at least $60 million in funding for FPHS is funded in the budget by June 30, 2021.

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.

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).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 20 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Chopp, Cody, Dolan, Fitzgibbon, Frame, Hansen, Harris, Johnson, J., Lekanoff, Pollet, Ryu, Senn, Springer, Stonier, Sullivan and Tharinger.

Minority Report: Do not pass. Signed by 9 members: Representatives Stokesbary, Ranking Minority Member; Corry, Assistant Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Caldier, Dye, Hoff, Jacobsen, Rude and Steele.

Minority Report: Without recommendation. Signed by 3 members: Representatives Chambers, Assistant Ranking Minority Member; Boehnke and Schmick.

Staff: Linda Merelle (786-7092).

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 Engrossed Second Substitute Bill:

Regional Comprehensive Public Health District Centers.

"Regional comprehensive public health district centers" or "regional shared service centers" (regional centers) are defined as a center established to provide coordination of shared public health services across the state in order to support local health jurisdictions. Four regional centers, split evenly between the east side and west side of the Cascades, are established. In addition to the duties and roles determined by the Foundational Public Health Services (FPHS) Steering Committee (Steering Committee), the regional centers may:

- coordinate shared services across the governmental public health system;
- provide public health services;
- conduct an inventory of all current shared service agreements in the region;
- identify potential shared services for the region; and
- analyze options and alternatives for the implementation of shared service delivery across the region.

Each regional center must have an FPHS regional coordinator who is an employee of the Department of Health (DOH).

By January 1, 2023, counties must establish a formal relationship with one primary regional center that is on the same side of the Cascades as the county. A county may also enter into formal or informal relationships with other regional centers, and federally recognized Indian tribes and 501(c)(3) organizations registered in Washington that serve American Indian and Alaska Native people within Washington may enter into formal or informal relationships with the regional centers.

The "governmental public health system" is defined to include the regional centers in addition to the DOH, the State Board, local health jurisdictions, sovereign tribal nations, and Indian health programs located in Washington.

Foundational Public Health Services Steering Committee.
The DOH must convene a Steering Committee that includes members representing the DOH, the State Board of Health (State Board), federally recognized Indian tribes, and a state association representing local health jurisdictions. These four groups may each select members to represent their agency or organization and a co-chair. The maximum number of voting members is 24. Staff support for the Steering Committee is provided by the DOH. Members of the Steering Committee that represent local health jurisdictions and federally recognized Indian tribes that travel more than 100 miles to attend a meeting are eligible for reimbursement of travel expenses.

The Steering Committee shall:

- define the purpose and functions of the regional centers, including, the duties and roles, potential services the regional centers may provide, the process for establishing the regional centers, and how the regional centers should coordinate shared services;
- recommend to the Secretary of Health (Secretary) the roles and duties of the FPHS regional coordinator;

- identify other personnel needed for regional centers;
- identify the range of potential shared services coordinated or delivered through regional centers;
- the location of the four regional centers;
- develop FPHS funding recommendations that promote new service delivery models; and
- develop standards and performance measures for the governmental public health system.

Public Health Advisory Board.
The Public Health Advisory Board (Advisory Board) is established within the DOH. The Advisory Board consists the following members appointed by the Governor, in addition to four nonvoting, ex officio legislative members:

- the Governor's Office;
- the Director of the State Board or the Director's designee;
- the Secretary of the DOH or the Secretary's designee;
- the chair of the Governor's Interagency Council on Health Disparities;
- two representatives from the tribal government public health sector selected by the American Indian Health Commission;
- one Eastern Washington county commissioner selected by a statewide association representing counties;
- one Western Washington county commissioner selected by a statewide association representing counties;
- on organization representing businesses in a region of the state;
- a statewide association representing community and migrant health centers;
- a statewide association representing Washington cities;
- a local health official selected by a statewide association representing Washington local public health officials;
- a statewide association representing Washington hospitals, physicians, or nurses;
- a statewide association representing Washington public health or public health professionals; and
- a consumer nonprofit organization representing marginalized populations.

The Advisory Board may:

- advise and provide feedback to the governmental public health system and provide formal public recommendations on public health;
- monitor the performance of the governmental public health system;
- develop goals and a direction for public health and provide recommendations to improve public health performance and to achieve the identified goals and direction;
- advise the Secretary;
- coordinate with the Governor's Office, DOH, State Board, and the Secretary;
- monitor the Steering Committee's performance, provide recommendations to the Steering Committee, and approve funding prioritization recommendations from the Steering Committee;

- evaluate public health emergency response and provide recommendations for future response, including coordinating with relevant committees, task forces, and stakeholders to analyze the COVID-19 public health response;
- evaluate the use of FPHS funding by the governmental public health system; and
- apply the standards and performance measures developed by the Steering Committee to the governmental public health system.

The DOH must provide staff support for the Advisory Board.

Funding for Foundational Public Health Services.
For fiscal years 2021-2023, of amounts appropriated for FPHS funding that exceed $30 million per biennium, the DOH must allocate 65 percent to shared services, including establishing and operating the regional centers, the regional health officers, and the FPHS regional coordinators, unless the appropriations act specifies otherwise. Beginning fiscal year 2024, of amounts appropriated for FPHS funding, the DOH must allocate funding for shared services as recommended by the Steering Committee and approved by the Advisory Board.

Reporting.
Annually beginning October 1, 2022, the DOH, in consultation with federally recognized Indian Tribes, local health jurisdictions, and the State Board, must submit to the appropriate committees of the Legislature, the Governor, and Advisory Board a report on the distribution of the FPHS funding. The report must contain a statements of the funds provided to the governmental public health system for FPHS, a description of how the funds were distributed and used, the level of work funded for each FHPS, and the progress of the governmental public health system in meeting the standards and performance measures identified by the Steering Committee. The Advisory Board must each October 1st make recommendations to the DOH, FPHS steering committee, the Legislature, and Governor on the priorities for the governmental public health system and FPHS funding.

Regional Health Officer.
Within the DOH the position of regional health officer is created. The Secretary must appoint four regional health officers. One regional health officer on each side of the Cascades must be appointed by January 1, 2022. Regional health officers may: work in partnership with local health jurisdictions, the DOH, State Board, and federally recognized tribes to provide coordination across counties; provide support to local health officers and serve as an alternative for local health officers during vacations, emergencies, and vacancies; and provide mentorship and training to new local health officers. A regional health officer must meet the same qualifications as a local health officer.

Local Boards of Health.
For counties under 800,000, in addition to existing members of the local board of health (board), each board must include members from the following three categories (who may not be elected) that must be approved by a majority vote of the board of county

commissioners:

- 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; and any of the following providers holding an active or retired license in good standing under Title 18 RCW 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 there are one or two members over the nearest multiple of three, those members may be selected from any of the three categories. However, if the board demonstrates that it attempted to recruit members from all three categories and was unable to do so, the board may select members only from the other two categories. There may be no more than one member selected from one type of background or position.

If a federally recognized Indian tribe holds reservation, trust lands, or has usual and accustomed areas within the county, or if a 501(c)(3) organization registered in Washington that serves American Indian and Alaska Native people and provides services within the county, the board must include a tribal representative selected by the American Indian health commission. The number of members selected from the three categories and the tribal representative (if required) must equal the number city and county elected officials on the board.

Any decision by the board 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 board.

The State Board must adopt rules establishing the appointment process for members of the board that are not elected officials.

Counties must pay for expenses incurred by the health district or county for enforcing proclamations of the Governor during a public health emergency.

Notice Requirements for Termination of a Local Health Department or District.

Before terminating an agreement to operate a city and county health department or a health district, the terminating party must: provide 12 months' notice and a meaningful opportunity for the public to comment on the material change; and participate in a good faith mediation process with any affected county, city, or town that objects to the termination.

Rulemaking.
The DOH may adopt rules necessary to implement the act.

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

EFFECT OF SENATE AMENDMENT(S):

The Senate amendment:

- removes all provisions related to:
  - the regional comprehensive public health district centers (also referred to as regional shared service centers);
  - foundational public health services (FPHS) regional coordinators;
  - the FPHS Steering Committee (Steering Committee);
  - regional health officers;
  - funding requirements for shared services;
  - reporting requirements for the Department of Health (DOH), State Board of Health (State Board), local health jurisdictions, and federally recognized tribes; and
  - notice and public input requirements for cities or counties that terminate multi-county health districts or combined city-county health departments;
- modifies the duties and membership of the Public Health Advisory Board (Advisory Board) by:
  - requiring the Advisory Board to perform the listed duties rather than authorizing the Advisory Board to perform the duties;
  - removing duties related to the Steering Committee;
  - requiring the Advisory Board to coordinate with local health jurisdictions, in addition to the Governor, the DOH, State Board, and Secretary of Health; and
  - modifying the membership of the Advisory Board;
- modifies the requirements for local board of health membership composition by:
  - adding active, reserve, or retired armed services members to the other community stakeholder category local boards of health must choose from for the non-elected members of the local board of health;
  - replacing the under 800,000 population threshold for requiring local health jurisdictions to change the composition of their local boards of health and instead applies the board composition requirements to all local health jurisdictions, unless:

- a local health jurisdiction with all elected board members had a public health advisory committee or board in place on January 1, 2021, in which case the jurisdiction may maintain its current board composition, but the jurisdiction's advisory board must meet the new requirements by January 1, 2022; or
- a local board of health comprised solely of elected officials and made up of three counties east of the Cascades mountains establishes a community health advisory board that meets the new requirements by July 1, 2022;

- requiring the members of a local board of health to select a chair to serve for a period of one year at the first meeting of the board of health; and
- establishing community health advisory board requirements, including duties, membership, and governing structure.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on April 12, 2021.

Effective Date: The bill takes effect 90 days after the adjournment of the session in which the bill is passed, except for sections 8 and 11, relating to the membership of local boards of health. However, sections 2, 4 through 7, and 16, relating to regional comprehensive public health district centers are null and void unless at least $60 million for foundational public health services is funded in the budget by June 30, 2021.

Staff Summary of Public Testimony (Health Care & Wellness):

(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.

Staff Summary of Public Testimony (Appropriations):

(In support) The COVID-19 pandemic has exposed the vulnerabilities and limitations of the public health system. The comprehensive health services districts would build on foundational public health models that would increase efficiencies and consistencies in the health system. Necessary resources must be provided. There is a lack of expertise and lived experience in the composition of local boards of health, and it has led to negative impacts during the pandemic. Communities need people who understand and speak to social and economic differences. Decisions will be decided by science.

(Opposed) None.

(Other) Local jurisdictions understand the importance of collaboration. The regionalization of the comprehensive health services districts creates another layer of government that can inhibit communications. None of the current foundational public health reports call for the creation of comprehensive districts. Adequate funding for public health is needed.

Persons Testifying (Health Care & Wellness): (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 Testifying (Appropriations): (In support) Cecilia Anguiano; Molly Voris, Office of the Governor; and Sheila Masteller, Public Health Action Coalition Team of Spokane.

(Other) Alan Melnick and Andre Fresco, Washington State Association of Local Public Health Officials.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): 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.

Persons Signed In To Testify But Not Testifying (Appropriations): None.