SENATE BILL REPORT
E2SHB 1152

As of March 27, 2021

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: Passed House: 3/8/21, 56-41.
Committee Activity: Health & Long Term Care: 3/24/21, 3/26/21 [DPA-WM, DNP]. Ways & Means: 3/31/21.

Brief Summary of Amended Bill

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

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Frockt, Vice Chair; Conway, Keiser, Randall, Robinson and Van De Wege.

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.

Minority Report: Do not pass.
Signed by Senators Muzzall, Ranking Member; Holy, Padden, Rivers and Wilson, J.

Staff: Greg Attanasio (786-7410)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Corban Nemeth (786-7736)

Background: 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. 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 non-home 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 Department of Health (DOH), the State Board of Health (BOH), 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). OFM may only allocate funding to DOH if 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 BOH, to OFM that there is an agreement on the distribution and uses of state foundational public health services funding. If joint certification is provided, 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 Amended 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 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 a regional coordinator who is a DOH employee.

By January 1, 2024, counties must establish a formal relationship with one primary regional center on the same side of the Cascades as the county. A county may also enter into formal or informal relationships with other regional centers. 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.

Foundational Public Health Services Steering Committee. DOH must convene a steering committee that includes members representing DOH, BOH, 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 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 make recommendations to the public health advisory board to:

- 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 the roles and duties of the 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 foundational public health services 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 DOH. The advisory board consists of the following members appointed by the Governor, in addition to four nonvoting, ex officio legislative members:

- a representative from the Governor's Office;
- the Director of BOH or the director's designee;
- the Secretary of 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;
- one 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;
- a statewide association representing Washington physicians;
- a statewide association representing Washington nurses;
- a statewide association representing Washington public health or public health professionals; and
- a consumer nonprofit organization representing marginalized populations.

The advisory board shall:

- 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 and report to the Secretary of DOH;
- coordinate with the Governor's Office, DOH, BOH, and the Secretary of Health;
- 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 use of foundational public health services 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.

Funding for Foundational Public Health Services. For the2021-2023 biennium, amounts appropriated for foundational public health services funding that exceed $60 million per biennium, DOH must allocate 65 percent to shared services, including establishing and operating the regional centers, the regional health officers, and the regional coordinators, unless the appropriations act specifies otherwise.

Reporting. Annually, beginning October 1, 2023, DOH, in consultation with federally recognized Indian Tribes, local health jurisdictions, and BOH, must submit to the appropriate committees of the Legislature, the Governor, and advisory board a report on the distribution of the foundational public health services funding. The report must contain a statement of the funds provided to the governmental public health system for foundational public health services, a description of how the funds were distributed and used, the level of work funded for each service, and the progress of the governmental public health system meeting the standards and performance measures identified by the steering committee. The advisory board must, each October 1st, make recommendations to DOH, the steering committee, the Legislature, and Governor on the priorities for the governmental public health system and foundational public health services funding.

Regional Health Officer. The position of regional health officer is created within DOH. The secretary must appoint four regional health officers. One regional health officer on each side of the Cascades must be appointed by January 1, 2023. Regional health officers may:
- work in partnership with local health jurisdictions, DOH, BOH, 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. Beginning July 1, 2023, in addition to existing members of the board, each board must include unelected members from the following three categories 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: 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: active, reserve, or retired armed services members, community-based or nonprofit organizations 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. If the board demonstrates 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 must equal the number of city and county elected officials on the board.

Any decision by the board related to setting or modifying permit, licensing, and application fees may only be determined by the city and county elected officials on the board.

A local board of health comprised solely of elected officials may retain its current composition if the local health jurisdiction had a public health advisory committee or board with its own bylaws established on January 1, 2021. By January 1, 2022, the public health

advisory committee or board must meet the requirements for community health advisory boards established in the bill. Any future changes to local board of health composition must meet the requirements for elected and unelected membership.

The BOH must adopt rules establishing the appointment process for members of the board who 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.

Community Health Advisory Boards. Community health advisory boards must:

- provide input to the local board of health on the selection of administrative officers and local health officers;
- use a health equity framework to assess community health needs and review public health policies and priorities;
- evaluate the impact of proposed policies and programs;
- promote public participation in identification of public health needs;
- provide community forums as assigned by the local board of health;
- establish community task forces as assigned by the local board of health;
- review and make recommendations on the annual budget; and
- review and advise on the jurisdiction's progress in achieving performance measures;

The advisory board must consist of 9 to 21 members appointed by the local board of health. The membership must be diverse and include:

- members with expertise in: health care access; physical environment; housing, education, and employment; business and philanthropy; communities that experience inequities; government, and tribal government;
- consumers of public health services; and
- community stakeholders including nonprofit organizations, the business community, and those regulated by public health.

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. 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.

Null and Void Clause. If at least $60 million is not appropriated for foundational public health services by June 30,2021, provisions relating to the steering committee, regional shared services centers, and regional health officers are null and void.

EFFECT OF HEALTH & LONG TERM CARE COMMITTEE AMENDMENT(S):

- Clarifies that the advisory board shall review and approve recommendations from the steering committee.
- Adds armed services members to the list of other community stakeholders who can serve as unelected members of a local health board.
- Creates separate seats on the advisory board for associations representing physicians, nurses, and hospitals.
- Adds disease burden and population measures to the factors the steering committee should consider when recommending new service delivery models for public health services.
- Changes the threshold of public health funding from $30 million to $60 million, above which 65 percent of funding must be allocated to shared services and removes operating regional centers and funding regional health officers and coordinators from the what may be consider shared services.
- Standardizes language in the statutes regulating the composition of local health boards so they all contain the same language concerning appointment of a local health officer, electing a board chair, and establishing the jurisdiction of the board.
- Removes the population threshold for requiring changes to the composition of local boards of health and applies the composition requirements to all local health jurisdictions, unless a jurisdiction with all elected board members had a public health advisory committee or board in place on January 1, 2021. Those jurisdictions may maintain their current board composition, but the jurisdiction's advisory board must meet requirements established in the bill by January 1, 2022.
- Establishes community health advisory board requirements, including duties, membership, and governing structure.
- Delays implementation dates for forming contractual relationships with regional centers, appointing regional health officers, submitting reports on public health funding, and changes to the composition of local boards of health.

Appropriation: The bill contains a null and void clause requiring specific funding be provided in an omnibus appropriation act.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains several effective dates. Please refer to the bill.

Staff Summary of Public Testimony on Engrossed Second Substitute House Bill

(Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: Anyone anywhere in the state should be able to rely on the same level of public health services. This bill will allow for more consistent and equitable delivery of public health services and build on existing work. Many of the changes to the public health system only go into effect with a significant increase in funding. There would be no hierarchy between regional centers and local health jurisdictions, it would be a cooperative partnership. The bill would bring in needed expertise to local health boards.

CON: This bill would diminish the public's ability to engage in policy decisions at the local level.

OTHER: Insulating public health from politics is needed, but this bill does not achieve that. There has not been enough time for stakeholder engagement. The bill would be another administrative layer without helping to deliver services. The bill does not address lack of funding. There should be a facilitated discussion among all stakeholders on improving the public health system after the pandemic has ended. There should be assurance that a regional approach will not stop local decision making. The provisions of the bill can be implemented without legislation if it is determined that they are needed.

Persons Testifying (Health & Long Term Care): PRO: Representative Marcus Riccelli, Prime Sponsor; Ashlin Mountjoy, Washington Academy of Family Physicians; Dr. Pam Kohlmeier, PHACTS; Priyanka Bushana, Health Sciences Student Advocacy Association; Joe McDermott, Councilmember, King County,; Michael Dunn, NEWESD 101; Justin Gill, Washington State Nurses Association; Kate White Tudor, Washington Association for Community Health; Umair Shah, Secretary, Department of Health; Maria Courogen, Washington State Department of Health; Deb Harper, MD, PHACTS, Washington State Medical Association.

CON: Betsy Howe, Citizens Optimizing OSS Management Washington.

OTHER: Councilmember Derek Young, Washington State Association of Counties and Pierce County; Councilor Temple Lentz, Washington State Association of Counties and Clark County; Commissioner Kate Dean, Washington State Association of Counties and Jefferson County; Dr. Mark Larson, Washington State Association of Local Public Health Officials and Kittitas County; Keith Grellner, Washington State Association of Local Public Health Officials and Kitsap Public Health District.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): PRO: Kelly Cooper, Washington State Department of Health.