H-1117.1

SECOND SUBSTITUTE HOUSE BILL 1152

State of Washington 67th Legislature 2021 Regular Session

By House Appropriations (originally sponsored by Representatives Riccelli, Leavitt, Stonier, Ormsby, Lekanoff, Pollet, Bronoske, and Bateman; by request of Office of the Governor)

READ FIRST TIME 02/22/21.

AN ACT Relating to supporting measures to create comprehensive public health districts; amending RCW 43.70.515, 70.05.030, 70.05.035, 70.46.020, 70.46.031, 70.05.130, 70.08.100, 70.46.090, and 82.08.170; reenacting and amending RCW 69.50.540; adding new sections to chapter 43.20 RCW; adding new sections to chapter 70.05 RCW; adding a new section to chapter 43.70 RCW; creating new sections; repealing RCW 43.70.060, 43.70.064, 43.70.066, 43.70.068, and 43.70.070; providing an effective date; providing contingent effective dates; and providing expiration dates.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature finds the COVID-19 pandemic has been the most difficult challenge in Washington's public health history since the 1918 flu pandemic. More Americans have died from COVID-19 than the number of United States troops killed in combat during World War II. The COVID-19 pandemic response has stressed and strained every part of our society and far surpassed the capabilities of local, state, tribal, and even federal public health agencies. Before the COVID-19 pandemic, the legislature had initiated action to address the critical challenges Washington's public health system faces, including limited organizational capacity, financial resources, and understaffing through beginning to specifically fund

foundational public health services. The COVID-19 pandemic laid bare the shortcomings of Washington's current public health system which have been studied and identified for over a decade. Washington's current public health system was not able to consistently monitor and track the pandemic, staff the many required missions, adequately address the health inequities, and implement standard approaches to disease containment.

The legislature further finds that, in Washington, local health services are currently provided through a decentralized means by 35 local health jurisdictions. In many cases, rural communities are served by smaller local health jurisdictions that have less capacity to provide the full spectrum of foundational public health services than their urban peers. Local health jurisdictions serving smaller populations face challenges providing the full spectrum of foundational public health services and activities to promote and protect the health of all people. In addition, local health jurisdictions are overseen by boards in which most the members do not have direct experience in public health or health care. Since April 2020, a Kaiser health news investigation reports at least 181 local and state health leaders have resigned, retired, or been fired, including 11 local health leaders in Washington. Diseases do not respect borders or boundaries, yet the current decentralized system in Washington creates a patchwork approach with limited accountability and consistency. National peer-review studies report larger jurisdictions perform better on most foundational comprehensive public health services.

The COVID-19 pandemic has amplified the health and social inequities in Washington that existed before its emergence. There are vast inequities in per capita spending for local public health services by population size and geographic location. National peer-review studies report communities with limited public health systems experience low levels of activity participation, low perceived effectiveness, and sparse organizational networks compared to comprehensive public health systems. The inequitable distribution of morbidity and mortality between Black, indigenous, and people of color and other populations demonstrates the large health inequities that must be addressed. Therefore, the legislature finds the state must determine adequate funding of comprehensive health services districts from cities, counties, and the state, with the goal of providing all people with equitable access to foundational public

health services, and once this funding is determined, the legislature finds this investment in the public's health will continue to be prioritized.

The legislature recognizes that public health and health care staff have been overwhelmed, overworked, and their mental and physical health are at risk due to the pandemic. The legislature is thankful for the countless contributions that public health and health care staff have made to combat this deadly public health crisis and pandemic. These contributions and efforts have increased public awareness about the importance of strong infrastructure for our public health system. Therefore, the legislature finds that meaningful discourse about the current public health system is necessary to ensure public trust.

The legislature expects emergencies that threaten the health and well-being of all Washingtonians, emergent and routine, to increase. Restructuring state funding of foundational public health services is not enough to face these threats. The legislature intends for Washington to have a public health system that can respond to 21st century public health emergencies and public health issues, have the capacity to improve health outcomes of BIPOC communities, persons with disabilities, LGBTQ+, rural communities, limited English-speaking persons, and address health equity across the life span.

NEW SECTION. **Sec. 2.** A new section is added to chapter 43.20 RCW to read as follows:

(1) A work group is created to develop and recommend to the state board a public health system to provide foundational public health services to all people in Washington through local health jurisdictions, comprehensive health services districts, and the department.

(2) Members of the work group must include:

(a) Two representatives from the senate;

(b) Two representatives from the house of representatives;

(c) Three representatives of local public health;

(d) Two representatives of state public health;

(e) Three representatives of counties;

(f) Two representatives of cities;

(g) One tribal representative;

(h) One representative with expertise in government finance;

(i) One state association representative from the foundational public health services steering committee;

(j) One public health representative from the foundational public health services steering committee;

(k) One tribal public health representative from the foundational public health services steering committee; and

(l) One technical work group member from the foundational public health services steering committee.

(3) The governor shall appoint the members of the work group and ensure that members represent diverse geographic locations in both rural and urban communities.

(4) The work group shall develop a transparent process, including opportunities for public comment.

(5) By July 1, 2022, the work group must recommend to the state board the system for counties to form comprehensive health services districts as provided in section 6 of this act.

(6) By January 1, 2023, the work group must recommend performance measures and a measure set to the state board to track the efficiency and effectiveness of local health jurisdictions, comprehensive health services districts, and the department.

(7) By July 1, 2023, the work group must submit recommendations to the legislature on adequate funding of local health jurisdictions and comprehensive health services districts, including the following:

(a) Reasonable per capita estimates to deliver foundational public health services;

(b) How new sources of revenue should be allocated; and

(c) Adequate allocation levels to sustain the state public health system.

(8) This section expires December 31, 2024.

NEW SECTION. **Sec. 3.** A new section is added to chapter 43.20 RCW to read as follows:

(1) The state board must adopt rules to provide foundational public health services to all people in Washington through local health jurisdictions, comprehensive health services districts, and the department. These rules must include:

(a) A system and process for counties to create comprehensive health services districts as required by section 6 of this act;

(b) Standard statewide performance measures and proposed benchmarks to track efficiency and effectiveness of local health

jurisdictions, comprehensive health services districts, and the department. The performance measures must include dimensions of:

(i) Improving morbidity and mortality of marginalized communities;

(ii) Improving health equity for all people;

(iii) Data modernization and interoperability across the state public health system;

(iv) Community engagement; and

(v) Emergency preparedness and response;

(c) A measure set that:

(i) Is of manageable size;

(ii) Is based on readily available data;

(iii) Gives preference to nationally reported measures; and

(iv) Focuses on the overall performance of the system, including outcomes and total costs;

(d) A process for the department to certify comprehensive health services districts;

(e) A process to evaluate local health jurisdictions, comprehensive health services districts, and department performance of the measure set developed under (c) of this subsection; and

(f) A process for information and data elements to be reported by comprehensive health services districts to the department.

(2) By November 1, 2024, the state board shall submit a report to the appropriate committees of the legislature on local health jurisdictions and comprehensive health services districts performance based on the performance measures established under subsection (1)(b) of this section.

Sec. 4. RCW 43.70.515 and 2019 c 14 s 2 are each amended to read as follows:

(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, comprehensive health services districts, 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. The department must evaluate comprehensive health services districts' performances to satisfy the measure set identified in section 3 of this act before allocation on January 1, 2027, and biennially thereafter.

(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 and sections 2 and 3 of this act:

(a) "Comprehensive health services districts" means the districts established under section 6 of this act to provide coordination and shared services to local health jurisdictions.

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

((~~(c)~~)) (d) "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)~~)) (e) "Local health jurisdictions" means a public health agency organized under chapter 70.05, 70.08, or 70.46 RCW.

((~~(e)~~)) (f) "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.

NEW SECTION. **Sec. 5.** A new section is added to chapter 70.05 RCW to read as follows:

(1) Members of the comprehensive health services district board of health include:

(a) The following city and county elected officials:

(i) Each county in the district must have one elected official who serves on a local board of health chosen by that local board of health; and

(ii) One elected official from a city in the district that is selected by a statewide association representing cities;

(b) The regional health officer assigned for the district by the department;

(c) A tribal representative from within the district selected by the Indian health board and appointed by the governor;

(d) At least one representative from the following categories to be appointed by the governor:

(i) Public health, health care facilities, and providers. This category consists of persons practicing or employed in the county who are:

(A) Medical ethicists;

(B) Epidemiologists;

(C) Experienced in environmental public health, such as a registered sanitarian;

(D) Community health workers;

(E) Holders of master's degrees or higher in public health or the equivalent;

(F) Employees of a hospital located in the county;

(G) Physicians or osteopathic physicians;

(H) Advanced registered nurse practitioners;

(I) Physician assistants or osteopathic physician assistants;

(J) Registered nurses;

(K) Dentists;

(L) Naturopaths; or

(M) Pharmacists;

(ii) Consumers of public health. This category consists of county residents who have self-identified as having faced significant health inequities or as having lived experiences with public health-related programs such as: The special supplemental nutrition program for women, infants, and children; the supplemental nutrition program; home visiting; or treatment services. It is strongly encouraged that individuals from historically marginalized and underrepresented communities are given preference. These individuals may not be elected officials and may not have any fiduciary obligation to a health facility or other health agency and may not have a material financial interest in the rendering of health services; and

(iii) Other community stakeholders. This category consists of persons representing the following types of organizations located in the county:

(A) Community-based organizations or nonprofits that work with populations experiencing health inequities in the county;

(B) The business community; or

(C) The environmental public health regulated community.

(2) In the event of a vacancy of a comprehensive health services district board position that was occupied by a member who was selected under subsection (1)(d) of this section, the board must promptly notify:

(a) Statewide organizations representing physicians, nurses, public health officials, counties, and cities;

(b) Accountable communities of health; and

(c) Any other organizations deemed appropriate by the board.

(3) City and county elected officials who are members of the comprehensive health services district board may not constitute a majority of the board.

(4) Governor appointed members may serve three-year terms and may serve two terms.

(5) The comprehensive health services district board may establish bylaws to govern the board.

NEW SECTION. **Sec. 6.** A new section is added to chapter 70.05 RCW to read as follows:

(1) By January 1, 2024, counties must form comprehensive health services districts as established by this section. The department must certify each comprehensive health services district.

(2) The following nine comprehensive health services districts are established and consist of the following counties:

(a) Skamania, Clark, Cowlitz, and Wahkiakum;

(b) Lewis, Thurston, Mason, Pacific, and Grays Harbor;

(c) Jefferson, Clallam, and Kitsap;

(d) Pierce and King;

(e) Island, Snohomish, Skagit, Whatcom, and San Juan;

(f) Chelan, Okanogan, Douglas, and Grant;

(g) Ferry, Stevens, Pend Oreille, Spokane, Lincoln, Adams, and Whitman;

(h) Benton, Franklin, Walla Walla, Columbia, Garfield, and Asotin; and

(i) Kittitas, Yakima, and Klickitat.

(3) 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 a comprehensive health services district under this section.

NEW SECTION. **Sec. 7.** A new section is added to chapter 70.05 RCW to read as follows:

(1) Comprehensive health services districts are established to help diversify and stabilize funding services for public health and 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.

(2) Comprehensive health services districts shall:

(a) Provide a mechanism for local health jurisdictions in each comprehensive health services district to convene, collaborate, plan, and work together with the goal of delivering foundational public health services equitably across the region;

(b) Develop a district plan for identification and implementation of shared service delivery options, models, and strategies;

(c) Coordinate with other comprehensive health services districts, to identify strategies to coordinate public health services and programs within the region;

(d) Identify what programs and services can be delivered through a shared or regional system within the district such as data collection, regional assessment-focused epidemiologists, regional health assessments, foodborne illness, health care associated infection programs, vaccine preventable disease investigation, emergency strike teams, and toxicology;

(e) Administer and allocate foundational public health services funding to each local health jurisdiction comprising the district;

(f) 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;

(g) Undertake accountability measures for implementation of foundational public health services within the district;

(h) Report the adequacy of foundational public health services resources for the district to the department; and

(i) As authorized by the district board of health, 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:

(i) Public health services;

(ii) Business, fiscal, and administrative services;

(iii) Acquisition of capital and equipment;

(iv) Communications; and

(v) Data collection.

NEW SECTION. **Sec. 8.** A new section is added to chapter 70.05 RCW to read as follows:

(1) Each comprehensive health services district shall establish a district health fund in the custody of the county treasurer of the

county in which the headquarters office of the comprehensive health services district is located. All receipts received by the district must be deposited into the fund. Expenditures by the district must be authorized by the district board of health and must be disbursed through the fund. The county auditor of the county shall keep the record of the receipts and disbursements.

(2) The treasurer shall keep all funds and moneys of the district separate and apart from all other funds and moneys in the treasurer's custody.

NEW SECTION. **Sec. 9.** A new section is added to chapter 70.05 RCW to read as follows:

A comprehensive health services district may own, construct, purchase, lease, add to, and maintain any real and personal property or property rights necessary to conduct the affairs of the district. A comprehensive health services district may sell, lease, convey, or otherwise dispose of any district real or personal property no longer necessary to conduct district affairs. A comprehensive health services district may enter into contracts to carry out this section.

NEW SECTION. **Sec. 10.** A new section is added to chapter 70.05 RCW to read as follows:

Notwithstanding any provisions to the contrary contained in any city or county charter, and to the extent provided by the city and the county under appropriate legislative enactment, employees of the comprehensive health services district may be included in the personnel system or civil service and retirement plans of the city or the county or a personnel system for the comprehensive health services district that is separate from the personnel system or civil service of either county or city if residential requirements for these positions are coextensive with the county boundaries. The city or county may pay parts of the expense of operating and maintaining the personnel system or civil service and retirement system and contribute to the retirement fund on behalf of employees sums as may be agreed upon between the legislative authorities of the city and county.

NEW SECTION. **Sec. 11.** A new section is added to chapter 70.05 RCW to read as follows:

The administrative officer, an employee of the comprehensive health services district, shall act as executive secretary and administrative officer for the comprehensive health services district and shall be responsible for administering the operations of the district. The administrative officer's salary must be paid by the department.

NEW SECTION. **Sec. 12.** A new section is added to chapter 43.70 RCW to read as follows:

The position of regional health officer is created within the department. The secretary shall appoint six regional health officers, who are each assigned to a comprehensive health services district.

Sec. 13. RCW 70.05.030 and 1995 c 43 s 6 are each amended to read as follows:

(1) In counties without a home rule charter, the board of county commissioners, a tribal appointee selected by the Indian health board, and members selected under subsection (2) of this section, shall constitute the local board of health, unless the county is part of a health district pursuant to chapter 70.46 RCW. The jurisdiction of the local board of health shall be coextensive with the boundaries of said county.

(2)(a) The remaining board members must be persons who are not elected officials and must be selected from the following categories:

(i) Public health, health care facilities, and providers. This category consists of persons practicing or employed in the county who are:

(A) Medical ethicists;

(B) Epidemiologists;

(C) Experienced in environmental public health, such as a registered sanitarian;

(D) Community health workers;

(E) Holders of master's degrees or higher in public health or the equivalent;

(F) Employees of a hospital located in the county;

(G) Physicians or osteopathic physicians;

(H) Advanced registered nurse practitioners;

(I) Physician assistants or osteopathic physician assistants;

(J) Registered nurses;

(K) Dentists;

(L) Naturopaths; or

(M) Pharmacists;

(ii) Consumers of public health. This category consists of county residents who have self-identified as having faced significant health inequities or as having lived experiences with public health-related programs such as: The special supplemental nutrition program for women, infants, and children; the supplemental nutrition program; home visiting; or treatment services. It is strongly encouraged that individuals from historically marginalized and underrepresented communities are given preference. These individuals may not be elected officials and may not have any fiduciary obligation to a health facility or other health agency, and may not have a material financial interest in the rendering of health services; and

(iii) Other community stakeholders. This category consists of persons representing the following types of organizations located in the county:

(A) Community-based organizations or nonprofits that work with populations experiencing health inequities in the county;

(B) The business community; or

(C) The environmental public health regulated community.

(b) The board members selected under this subsection must be approved by a majority vote of the board of county commissioners.

(c) In the event of a vacancy of a board position that was occupied by a member who was selected under this subsection, the board must promptly notify:

(i) Statewide organizations representing physicians, nurses, public health officials, counties, and cities;

(ii) Accountable communities of health; and

(iii) Any other organizations deemed appropriate by the board.

(d) If the number of board members selected under this subsection is evenly divisible by three, there must be an equal number of members selected from each of the three categories.

(e) If the number of board members selected under this subsection is 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. If there is one member over the nearest multiple of three, that member may be selected from any of the three categories. If there are two members over the nearest multiple of three, each member over the nearest multiple of three must be selected from a different category.

(3) The board of county commissioners may, at its discretion, adopt an ordinance expanding the size and composition of the board of health to include elected officials from cities and towns and persons other than elected officials as members so long as ((~~persons other than~~)) the city and county elected officials do not constitute a majority of the total membership of the board.

((~~An~~)) (4) Except as provided in subsection (2) of this section, an ordinance adopted under this section shall include provisions for the appointment, term, and compensation, or reimbursement of expenses.

(5) The number of city and county elected officials on the board of health may not constitute a majority of the board.

(6) 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 board.

Sec. 14. RCW 70.05.035 and 1995 c 43 s 7 are each amended to read as follows:

(1) In counties with a home rule charter, the county legislative authority shall establish a local board of health and may prescribe the membership and selection process for the board, a tribal appointee selected by the Indian health board, and members selected under subsection (2) of this section.

(2)(a) The remaining board members must be persons who are not elected officials and must be selected from the following categories:

(i) Public health, health care facilities, and providers. This category consists of persons practicing or employed in the county who are:

(A) Medical ethicists;

(B) Epidemiologists;

(C) Experienced in environmental public health, such as a registered sanitarian;

(D) Community health workers;

(E) Holders of master's degrees or higher in public health or the equivalent;

(F) Employees of a hospital located in the county;

(G) Physicians or osteopathic physicians;

(H) Advanced registered nurse practitioners;

(I) Physician assistants or osteopathic physician assistants;

(J) Registered nurses;

(K) Dentists;

(L) Naturopaths; or

(M) Pharmacists;

(ii) Consumers of public health. This category consists of county residents who have self-identified as having faced significant health inequities or as having lived experiences with public health-related programs such as: The special supplemental nutrition program for women, infants, and children; the supplemental nutrition program; home visiting; or treatment services. It is strongly encouraged that individuals from historically marginalized and underrepresented communities are given preference. These individuals may not be elected officials and may not have any fiduciary obligation to a health facility or other health agency, and may not have a material financial interest in the rendering of health services; and

(iii) Other community stakeholders. This category consists of persons representing the following types of organizations located in the county:

(A) Community-based organizations or nonprofits that work with populations experiencing health inequities in the county;

(B) The business community; or

(C) The environmental public health regulated community.

(b) The board members selected under this subsection must be approved by a majority vote of the board of county commissioners.

(c) In the event of a vacancy of a board position that was occupied by a member who was selected under this subsection, the board must promptly notify:

(i) Statewide organizations representing physicians, nurses, public health officials, counties, and cities;

(ii) Accountable communities of health; and

(iii) Any other organizations deemed appropriate by the board.

(d) If the number of board members selected under this subsection is evenly divisible by three, there must be an equal number of members selected from each of the three categories.

(e) If the number of board members selected under this subsection is 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. If there is one member over the nearest multiple of three, that member may be selected from any of the three categories. If there are two members over the nearest multiple of

three, each member over the nearest multiple of three must be selected from a different category.

(3) The county legislative authority may appoint to the board of health elected officials from cities and towns and persons other than elected officials as members so long as ((~~persons other than~~)) the city and county elected officials do not constitute a majority of the total membership of the board.

((~~The~~)) (4) Except as provided in subsection (2) of this section, the county legislative authority shall specify the appointment, term, and compensation or reimbursement of expenses.

(5) The jurisdiction of the local board of health shall be coextensive with the boundaries of the county.

(6) The local health officer, as described in RCW 70.05.050, shall be appointed by the official designated under the provisions of the county charter. The same official designated under the provisions of the county charter may appoint an administrative officer, as described in RCW 70.05.045.

(7) The number of city and county elected officials on the board of health may not constitute a majority of the board.

(8) 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 board.

Sec. 15. RCW 70.46.020 and 1995 c 43 s 10 are each amended to read as follows:

(1) Health districts consisting of two or more counties may be created whenever two or more boards of county commissioners shall by resolution establish a district for such purpose. Such a district shall consist of all the area of the combined counties.

(2) The district board of health of such a district shall consist of not less than five members for districts of two counties and seven members for districts of more than two counties, including two representatives from each county who are members of the board of county commissioners and who are appointed by the board of county commissioners of each county within the district, a tribal appointee selected by the Indian health board, and members selected under subsection (3) of this section, and shall have a jurisdiction coextensive with the combined boundaries.

(3)(a) The remaining board members must be persons who are not elected officials and must be selected from the following categories:

(i) Public health, health care facilities, and providers. This category consists of persons practicing or employed in the county who are:

(A) Medical ethicists;

(B) Epidemiologists;

(C) Experienced in environmental public health, such as a registered sanitarian;

(D) Community health workers;

(E) Holders of master's degrees or higher in public health or the equivalent;

(F) Employees of a hospital located in the county;

(G) Physicians or osteopathic physicians;

(H) Advanced registered nurse practitioners;

(I) Physician assistants or osteopathic physician assistants;

(J) Registered nurses;

(K) Dentists;

(L) Naturopaths; or

(M) Pharmacists;

(ii) Consumers of public health. This category consists of county residents who have self-identified as having faced significant health inequities or as having lived experiences with public health-related programs such as: The special supplemental nutrition program for women, infants, and children; the supplemental nutrition program; home visiting; or treatment services. It is strongly encouraged that individuals from historically marginalized and underrepresented communities are given preference. These individuals may not be elected officials, and may not have any fiduciary obligation to a health facility or other health agency, and may not have a material financial interest in the rendering of health services; and

(iii) Other community stakeholders. This category consists of persons representing the following types of organizations located in the county:

(A) Community-based organizations or nonprofits that work with populations experiencing health inequities in the county;

(B) The business community; or

(C) The environmental public health regulated community.

(b) The board members selected under this subsection must be approved by a majority vote of the board of county commissioners.

(c) In the event of a vacancy of a board position that was occupied by a member who was selected under this subsection, the board must promptly notify:

(i) Statewide organizations representing physicians, nurses, public health officials, counties, and cities;

(ii) Accountable communities of health; and

(iii) Any other organizations deemed appropriate by the board.

(d) If the number of board members selected under this subsection is evenly divisible by three, there must be an equal number of members selected from each of the three categories.

(e) If the number of board members selected under this subsection is 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. If there is one member over the nearest multiple of three, that member may be selected from any of the three categories. If there are two members over the nearest multiple of three, each member over the nearest multiple of three must be selected from a different category.

(4) The boards of county commissioners may by resolution or ordinance provide for elected officials from cities and towns and persons other than elected officials as members of the district board of health so long as ((~~persons other than~~)) the city and county elected officials do not constitute a majority of the total membership of the board.

((~~A~~)) (5) Except as provided in subsection (3) of this section, a resolution or ordinance adopted under this section must specify the provisions for the appointment, term, and compensation, or reimbursement of expenses. ((~~Any multicounty health district existing on the effective date of this act shall continue in existence unless and until changed by affirmative action of all boards of county commissioners or one or more counties withdraws [withdraw] pursuant to RCW 70.46.090.~~))

(6) At the first meeting of a district board of health the members shall elect a chair to serve for a period of one year.

(7) The number of city and county elected officials on the board of health may not constitute a majority of the board.

(8) 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 board.

Sec. 16. RCW 70.46.031 and 1995 c 43 s 11 are each amended to read as follows:

(1) A health district to consist of one county may be created whenever the county legislative authority of the county shall pass a resolution or ordinance to organize such a health district under chapter 70.05 RCW and this chapter.

((~~The~~)) Except as provided in subsection (3) of this section, the resolution or ordinance may specify the membership, representation on the district health board, or other matters relative to the formation or operation of the health district.

(2)(a) In addition to the membership of the district health board determined through resolution or ordinance under subsection (1) of this section, the board must also include a tribal appointee selected by the Indian health board, and members selected under (b) of this subsection.

(b) The remaining board members must be persons who are not elected officials and must be selected from the following categories:

(i) Public health, health care facilities, and providers. This category consists of persons practicing or employed in the county who are:

(A) Medical ethicists;

(B) Epidemiologists;

(C) Experienced in environmental public health, such as a registered sanitarian;

(D) Community health workers;

(E) Holders of master's degrees or higher in public health or the equivalent;

(F) Employees of a hospital located in the county;

(G) Physicians or osteopathic physicians;

(H) Advanced registered nurse practitioners;

(I) Physician assistants or osteopathic physician assistants;

(J) Registered nurses;

(K) Dentists;

(L) Naturopaths; or

(M) Pharmacists;

(ii) Consumers of public health. This category consists of county residents who have self-identified as having faced significant health inequities or as having lived experiences with public health-related programs such as: The special supplemental nutrition program for women, infants, and children; the supplemental nutrition program;

home visiting; or treatment services. It is strongly encouraged that individuals from historically marginalized and underrepresented communities are given preference. These individuals may not be elected officials and may not have any fiduciary obligation to a health facility or other health agency, and may not have a material financial interest in the rendering of health services; and

(iii) Other community stakeholders. This category consists of persons representing the following types of organizations located in the county:

(A) Community-based organizations or nonprofits that work with populations experiencing health inequities in the county;

(B) The business community; or

(C) The environmental public health regulated community.

(c) The board members selected under this subsection must be approved by a majority vote of the board of county commissioners.

(d) In the event of a vacancy of a board position that was occupied by a member who was selected under this subsection, the board must promptly notify:

(i) Statewide organizations representing physicians, nurses, public health officials, counties, and cities;

(ii) Accountable communities of health; and

(iii) Any other organizations deemed appropriate by the board.

(e) If the number of board members selected under this subsection is evenly divisible by three, there must be an equal number of members selected from each of the three categories.

(f) If the number of board members selected under this subsection is 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. If there is one member over the nearest multiple of three, that member may be selected from any of the three categories. If there are two members over the nearest multiple of three, each member over the nearest multiple of three must be selected from a different category.

(3) The county legislative authority may appoint elected officials from cities and towns and persons other than elected officials as members of the health district board so long as ((~~persons other than~~)) the city and county elected officials do not constitute a majority of the total membership of the board.

(4) The number of city and county elected officials on the board of health may not constitute a majority of the board.

(5) 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 board.

((~~Any single county health district existing on the effective date of this act shall continue in existence unless and until changed by affirmative action of the county legislative authority.~~))

Sec. 17. RCW 70.05.130 and 1993 c 492 s 242 are each amended to read as follows:

All expenses incurred by the state, health district, or county in carrying out the provisions of ((~~chapters 70.05 and~~)) this chapter and chapter 70.46 RCW or any other public health law, ((~~or~~)) the rules of the department of health enacted under such laws, or enforcing proclamations of the governor during a public health emergency, shall be paid by the ((~~county~~)) comprehensive health services district the county is located in and such expenses shall constitute a claim against the general fund as provided in this section.

NEW SECTION. **Sec. 18.** A new section is added to chapter 43.20 RCW to read as follows:

(1) A county may not make a material change to its public health governance structure unless:

(a) The county notifies the state board of its intention to make the material change. The notification must, at a minimum, include:

(i) A description of the current governance structure, including the relationships between its component parts;

(ii) Whether the current governance structure is meeting the county's governance, legal requirements, and objectives;

(iii) The county's rationale for the planned material change, including:

(A) Opportunities for new collaborations or funding; and

(B) Effects on health and equity;

(iv) The impact the planned material change will have on current public health programs, staffing, or funding; and

(v) The populations most likely to be affected by the planned material change, including:

(A) How the change would change staffing and capacity;

(B) How the change in staffing capacity will affect services to the community; and

(C) The communities that will be most directly affected;

(b) The state board has found that the planned material change would not have an adverse effect on health disparities, social determinants of health, or the provision of public health services in the county. For a combined city-county health department established under chapter 70.08 RCW, the state board has also found that the planned material change would not have an adverse effect on health disparities, social determinants of health, or the provision of public health services in the partner city; and

(c) Based on the findings in (b) of this subsection, the state board has approved the material change.

(2) Prior to making a material change to a county's public health governance structure, the county legislative authority shall:

(a) Provide notice and a meaningful opportunity for the public to comment on the material change including, but not limited to, at least two public meetings held at different locations within the county. For a combined city-county health department established under chapter 70.08 RCW, the county and city must jointly conduct a third public meeting within the boundaries of the partner city;

(b) Participate in good faith in a mediation process with any affected county, city, or town that objects to the material change. The mediator must be appointed by the state board and be paid for by the county seeking the material change; and

(c) Approve the material change by a majority vote of the county legislative authority taken in an open public meeting. Upon approval of the material change under subsection (1)(c) of this section, the county legislative authority shall immediately transmit notice of the approval to the state board.

(3) The material change may not go into effect less than 12 months after the vote of the county legislative authority under subsection (1) of this section. The county may not reduce the amount of funding it appropriates for public health purposes for at least 36 months after the vote of the county legislative authority under subsection (1) of this section.

(4) For purposes of this section, a material change to a county's public health governance structure includes, but is not limited to:

(a) Joining or withdrawing from a local health district under chapter 70.46 RCW;

(b) Entering or terminating an agreement for a combined city-county health department under chapter 70.08 RCW; or

(c) Amending the county charter or enacting an ordinance altering the composition of the local board of health.

(5) This section expires January 1, 2024.

NEW SECTION. **Sec. 19.** A new section is added to chapter 43.20 RCW to read as follows:

(1) The state board shall monitor the implementation of any material change to a county's public health governance structure to ensure the county's compliance with section 18 of this act.

(2) If the state board determines that the county has not complied with section 18 of this act, it shall issue a preliminary notice of violation to the county.

(3) Upon receipt of a preliminary notice of violation, the county must immediately cease all activities related to the material change and cure the violation within 30 calendar days.

(4) If the county fails to cure the violation within 30 calendar days, the state board shall issue a final notice of violation to the county and send a copy of the final notice to the state treasurer.

(5) This section expires January 1, 2024.

Sec. 20. RCW 70.08.100 and 1949 c 46 s 10 are each amended to read as follows:

Agreement to operate a combined city and county health department made under this chapter may after two years from the date of such agreement, be terminated by either party at the end of any calendar year upon notice in writing given at least ((~~six~~)) 12 months prior thereto. The termination of such agreement shall not relieve either party of any obligations to which it has been previously committed. Termination of the agreement is subject to the requirements of section 18 of this act.

Sec. 21. RCW 70.46.090 and 1993 c 492 s 251 are each amended to read as follows:

Any county may withdraw from membership in said health district any time after it has been within the district for a period of two years, but no withdrawal shall be effective except at the end of the calendar year in which the county gives at least ((~~six~~)) 12 months' notice of its intention to withdraw at the end of the calendar year. No withdrawal shall entitle any member to a refund of any moneys paid to the district nor relieve it of any obligations to pay to the

district all sums for which it obligated itself due and owing by it to the district for the year at the end of which the withdrawal is to be effective. Any county which withdraws from membership in said health district shall immediately establish a health department or provide health services which shall meet the standards for health services promulgated by the state board of health. No local health department may be deemed to provide adequate public health services unless there is at least one full time professionally trained and qualified physician as set forth in RCW 70.05.050. Withdrawal from a health district is subject to the requirements of section 18 of this act.

Sec. 22. RCW 69.50.540 and 2020 c 357 s 916 and 2020 c 236 s 4 are each reenacted and amended to read as follows:

The legislature must annually appropriate moneys in the dedicated marijuana account created in RCW 69.50.530 as follows:

(1) For the purposes listed in this subsection (1), the legislature must appropriate to the respective agencies amounts sufficient to make the following expenditures on a quarterly basis or as provided in this subsection:

(a) ((~~One hundred twenty-five thousand dollars~~)) $125,000 to the health care authority to design and administer the Washington state healthy youth survey, analyze the collected data, and produce reports, in collaboration with the office of the superintendent of public instruction, department of health, department of commerce, family policy council, and board. The survey must be conducted at least every two years and include questions regarding, but not necessarily limited to, academic achievement, age at time of substance use initiation, antisocial behavior of friends, attitudes toward antisocial behavior, attitudes toward substance use, laws and community norms regarding antisocial behavior, family conflict, family management, parental attitudes toward substance use, peer rewarding of antisocial behavior, perceived risk of substance use, and rebelliousness. Funds disbursed under this subsection may be used to expand administration of the healthy youth survey to student populations attending institutions of higher education in Washington;

(b) ((~~Fifty thousand dollars~~)) $50,000 to the health care authority for the purpose of contracting with the Washington state institute for public policy to conduct the cost-benefit evaluation and produce the reports described in RCW 69.50.550. This

appropriation ends after production of the final report required by RCW 69.50.550;

(c) ((~~Five thousand dollars~~)) $5,000 to the University of Washington alcohol and drug abuse institute for the creation, maintenance, and timely updating of web-based public education materials providing medically and scientifically accurate information about the health and safety risks posed by marijuana use;

(d)(i) An amount not less than ((~~one million two hundred fifty thousand dollars~~)) $1,250,000 to the board for administration of this chapter as appropriated in the omnibus appropriations act;

(ii) ((~~One million three hundred twenty-three thousand dollars~~)) $1,323,000 for fiscal year 2020 to the health professions account established under RCW 43.70.320 for the development and administration of the marijuana authorization database by the department of health;

(iii) ((~~Two million four hundred fifty-three thousand dollars~~)) $2,453,000 for fiscal year 2020 and ((~~two million seven hundred ninety-three thousand dollars~~)) $2,793,000 for fiscal year 2021 to the Washington state patrol for a drug enforcement task force. It is the intent of the legislature that this policy will be continued in the 2021-2023 fiscal biennium; and

(iv) ((~~Ninety-eight thousand dollars~~)) $98,000 for fiscal year 2019 to the department of ecology for research on accreditation of marijuana product testing laboratories;

(e) ((~~Four hundred sixty-five thousand dollars~~)) $465,000 for fiscal year 2020 and ((~~four hundred sixty-four thousand dollars~~)) $464,000 for fiscal year 2021 to the department of ecology for implementation of accreditation of marijuana product testing laboratories;

(f) ((~~One hundred eighty-nine thousand dollars~~)) $189,000 for fiscal year 2020 to the department of health for rule making regarding compassionate care renewals;

(g) ((~~Eight hundred eight thousand dollars~~)) $808,000 for fiscal year 2020 and ((~~eight hundred eight thousand dollars~~)) $808,000 for fiscal year 2021 to the department of health for the administration of the marijuana authorization database;

(h) ((~~Six hundred thirty-five thousand dollars~~)) $635,000 for fiscal year 2020 and ((~~six hundred thirty-five thousand dollars~~)) $635,000 for fiscal year 2021 to the department of agriculture for compliance-based laboratory analysis of pesticides in marijuana;

(i) ((~~One million one hundred thousand dollars~~)) $1,100,000 annually to the department of commerce to fund the marijuana social equity technical assistance competitive grant program under RCW 43.330.540; and

(j) ((~~One million one hundred thousand dollars~~)) $1,100,000 for fiscal year 2021 to the department of commerce to fund the marijuana social equity technical assistance competitive grant program under Engrossed Second Substitute House Bill No. 2870 (marijuana retail licenses); and

(2) From the amounts in the dedicated marijuana account after appropriation of the amounts identified in subsection (1) of this section, the legislature must appropriate for the purposes listed in this subsection (2) as follows:

(a)(i) Up to ((~~fifteen~~)) 15 percent to the health care authority for the development, implementation, maintenance, and evaluation of programs and practices aimed at the prevention or reduction of maladaptive substance use, substance use disorder, substance abuse or substance dependence, as these terms are defined in the Diagnostic and Statistical Manual of Mental Disorders, among middle school and high school-age students, whether as an explicit goal of a given program or practice or as a consistently corresponding effect of its implementation, mental health services for children and youth, and services for pregnant and parenting women; PROVIDED, That:

(A) Of the funds appropriated under (a)(i) of this subsection for new programs and new services, at least ((~~eighty-five~~)) 85 percent must be directed to evidence-based or research-based programs and practices that produce objectively measurable results and, by September 1, 2020, are cost-beneficial; and

(B) Up to ((~~fifteen~~)) 15 percent of the funds appropriated under (a)(i) of this subsection for new programs and new services may be directed to proven and tested practices, emerging best practices, or promising practices.

(ii) In deciding which programs and practices to fund, the director of the health care authority must consult, at least annually, with the University of Washington's social development research group and the University of Washington's alcohol and drug abuse institute.

(iii) For each fiscal year, the legislature must appropriate a minimum of ((~~twenty-five million five hundred thirty-six thousand dollars~~)) $25,536,000 under this subsection (2)(a);

(b)(i) Up to ((~~ten~~)) 10 percent to the department of health for the following, subject to (b)(ii) of this subsection (2):

(A) Creation, implementation, operation, and management of a marijuana education and public health program that contains the following:

(I) A marijuana use public health hotline that provides referrals to substance abuse treatment providers, utilizes evidence-based or research-based public health approaches to minimizing the harms associated with marijuana use, and does not solely advocate an abstinence-only approach;

(II) A grants program for local health departments or other local community agencies that supports development and implementation of coordinated intervention strategies for the prevention and reduction of marijuana use by youth; and

(III) Media-based education campaigns across television, internet, radio, print, and out-of-home advertising, separately targeting youth and adults, that provide medically and scientifically accurate information about the health and safety risks posed by marijuana use; and

(B) The Washington poison control center.

(ii) For each fiscal year, the legislature must appropriate a minimum of ((~~nine million seven hundred fifty thousand dollars~~)) $9,750,000 under this subsection (2)(b);

(c)(i) Up to six-tenths of one percent to the University of Washington and four-tenths of one percent to Washington State University for research on the short and long-term effects of marijuana use, to include but not be limited to formal and informal methods for estimating and measuring intoxication and impairment, and for the dissemination of such research.

(ii) For each fiscal year, except for the 2017-2019 and 2019-2021 fiscal biennia, the legislature must appropriate a minimum of ((~~one million twenty-one thousand dollars~~)) $1,021,000 to the University of Washington. For each fiscal year, except for the 2017-2019 and 2019-2021 fiscal biennia, the legislature must appropriate a minimum of ((~~six hundred eighty-one thousand dollars~~)) $681,000 to Washington State University under this subsection (2)(c). It is the intent of the legislature that this policy will be continued in the 2019-2021 fiscal biennium;

(d) Fifty percent to the state basic health plan trust account to be administered by the Washington basic health plan administrator and used as provided under chapter 70.47 RCW;

(e) Five percent to the Washington state health care authority to be expended exclusively through contracts with community health centers to provide primary health and dental care services, migrant health services, and maternity health care services as provided under RCW 41.05.220;

(f)(i) Up to three-tenths of one percent to the office of the superintendent of public instruction to fund grants to building bridges programs under chapter 28A.175 RCW.

(ii) For each fiscal year, the legislature must appropriate a minimum of ((~~five hundred eleven thousand dollars~~)) $511,000 to the office of the superintendent of public instruction under this subsection (2)(f); and

(g) At the end of each fiscal year, the treasurer must transfer any amounts in the dedicated marijuana account that are not appropriated pursuant to subsection (1) of this section and this subsection (2) into the general fund, except as provided in (g)(i) of this subsection (2).

(i) ((~~Beginning~~)) Except as provided in (g)(iv) of this subsection (2), beginning in fiscal year 2018, if marijuana excise tax collections deposited into the general fund in the prior fiscal year exceed ((~~twenty-five million dollars~~)) $25,000,000, then each fiscal year the legislature must appropriate an amount equal to ((~~thirty~~)) 30 percent of all marijuana excise taxes deposited into the general fund the prior fiscal year to the treasurer for distribution to counties, cities, and towns as follows:

(A) Thirty percent must be distributed to counties, cities, and towns where licensed marijuana retailers are physically located. Each jurisdiction must receive a share of the revenue distribution under this subsection (2)(g)(i)(A) based on the proportional share of the total revenues generated in the individual jurisdiction from the taxes collected under RCW 69.50.535, from licensed marijuana retailers physically located in each jurisdiction. For purposes of this subsection (2)(g)(i)(A), ((~~one hundred~~)) 100 percent of the proportional amount attributed to a retailer physically located in a city or town must be distributed to the city or town.

(B) Seventy percent must be distributed to counties, cities, and towns ratably on a per capita basis. Counties must receive ((~~sixty~~))

60 percent of the distribution, which must be disbursed based on each county's total proportional population. Funds may only be distributed to jurisdictions that do not prohibit the siting of any state licensed marijuana producer, processor, or retailer.

(ii) Distribution amounts allocated to each county, city, and town must be distributed in four installments by the last day of each fiscal quarter.

(iii) By September 15th of each year, the board must provide the state treasurer the annual distribution amount, if any, for each county and city as determined in (g)(i) of this subsection (2).

(iv) The total share of marijuana excise tax revenues distributed to counties and cities in (g)(i) of this subsection (2) may not exceed ((~~fifteen million dollars~~)) $15,000,000 in fiscal years 2018, 2019, 2020, and 2021, and ((~~twenty million dollars~~)) $20,000,000 per fiscal year thereafter. It is the intent of the legislature that the policy for the maximum distributions in the subsequent fiscal biennia will be no more than ((~~fifteen million dollars~~)) $15,000,000 per fiscal year.

(v) Upon receipt of a final notice from the state board of health under section 19(4) of this act that a county has failed to comply with section 18 of this act, the treasurer shall cease all future distributions to the county under this subsection (2).

Sec. 23. RCW 82.08.170 and 2020 c 357 s 919 are each amended to read as follows:

(1) Except as provided in subsections (4) ((~~and (5)~~)) through (6) of this section, during the months of January, April, July, and October of each year, the state treasurer must make the transfers required under subsections (2) and (3) of this section from the liquor excise tax fund and then the apportionment and distribution of all remaining moneys in the liquor excise tax fund to the counties, cities, and towns in the following proportions: (a) ((~~Twenty~~)) 20 percent of the moneys in the liquor excise tax fund must be divided among and distributed to the counties of the state in accordance with the provisions of RCW 66.08.200; and (b) ((~~eighty~~)) 80 percent of the moneys in the liquor excise tax fund must be divided among and distributed to the cities and towns of the state in accordance with the provisions of RCW 66.08.210.

(2) Each fiscal quarter and prior to making the ((~~twenty~~)) 20 percent distribution to counties under subsection (1)(a) of this

section, the treasurer shall transfer to the liquor revolving fund created in RCW 66.08.170 sufficient moneys to fund the allotments from any legislative appropriations for county research and services as provided under chapter 43.110 RCW.

(3) During the months of January, April, July, and October of each year, the state treasurer must transfer ((~~two million five hundred thousand dollars~~)) $2,500,000 from the liquor excise tax fund to the state general fund.

(4) During calendar year 2012, the October distribution under subsection (1) of this section and the July and October transfers under subsections (2) and (3) of this section must not be made. During calendar year 2013, the January, April, and July distributions under subsection (1) of this section and transfers under subsections (2) and (3) of this section must not be made.

(5) During the 2015-2017 and 2019-2021 fiscal biennia, the liquor excise tax fund may be appropriated for the local government fiscal note program in the department of commerce. It is the intent of the legislature to continue this policy in the subsequent fiscal biennium.

(6) Upon receipt of a final notice from the state board of health under section 19(4) of this act that a county has failed to comply with section 18 of this act, the treasurer shall cease all future distributions to the county under this section.

NEW SECTION. **Sec. 24.** The following acts or parts of acts are each repealed:

(1) RCW 43.70.060 (Duties of department—Promotion of health care cost-effectiveness) and 1989 1st ex.s. c 9 s 108;

(2) RCW 43.70.064 (Health care quality—Findings and intent—Requirements for conducting study under RCW 43.70.066) and 1995 c 267 s 3;

(3) RCW 43.70.066 (Study—Uniform quality assurance and improvement program—Reports to legislature—Limitation on rule making) and 1998 c 245 s 72, 1997 c 274 s 3, & 1995 c 267 s 4;

(4) RCW 43.70.068 (Quality assurance—Interagency cooperation) and 1997 c 274 s 4 & 1995 c 267 s 5; and

(5) RCW 43.70.070 (Duties of department—Analysis of health services) and 1995 c 269 s 2202 & 1989 1st ex.s. c 9 s 109.

NEW SECTION. **Sec. 25.** (1) Sections 4 and 17 of this act take effect January 1, 2024, if the funding contingency in section 28 of this act is satisfied.

(2) Sections 13 through 16 of this act take effect July 1, 2022.

NEW SECTION. **Sec. 26.** Sections 1, 3, and 5 through 12 of this act take effect July 1, 2022, if the funding contingency in section 28 of this act is satisfied.

NEW SECTION. **Sec. 27.** Sections 20 through 23 of this act expire January 1, 2024.

NEW SECTION. **Sec. 28.** If sufficient funding for the purposes of sections 1, 3 through 12, and 17 of this act, referencing this act by bill or chapter number, and sections 1, 3 through 12, and 17 of this act by section number, is not provided by June 30, 2022, in either the 2021-2023 omnibus appropriations act or the 2022 supplemental appropriations act, sections 1, 3 through 12, and 17 of this act are null and void. The requirement of sufficient funding is satisfied if, by June 30, 2022, the department of health, after consultation with the state board of health, local health jurisdictions, and tribes, provides written notice of the sufficiency of funding to the office of financial management, which must provide notice of satisfaction of this contingency to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the office of financial management.

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