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Washington State Department of Health

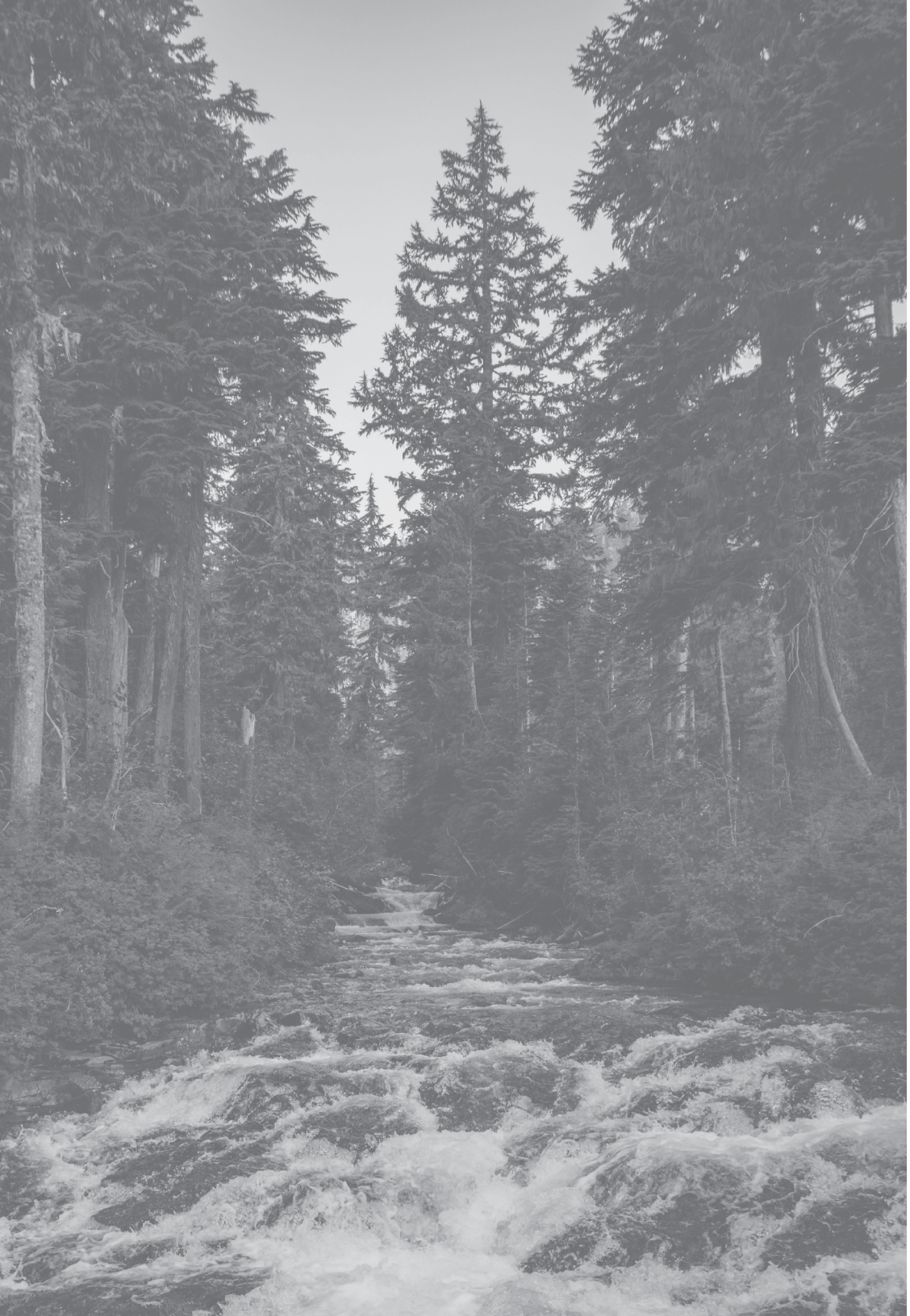
Foundational Public Health Services in Washington State

2019-2021 INVESTMENT REPORT

STATE FISCAL YEAR 2020 (SFY20)

DOH 820-119

AMENDED AUGUST 2023



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DOH Publication number: 820-119

ACKNOWLEDGMENTS

This report was produced in January 2021 by the Rede Group for the Foundational Public Health Services Steering Committee and the governmental public health system in Washington state.

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CONTENTS

CONTENTS

FIGURES

ACRONYMS

AIHC	American Indian Health Commission
CCC	Cross-Cutting Capabilities
CD	Communicable Disease
CHA/CHIP	Community Health Assessment and Improvement Planning
COVID-19	Coronavirus Disease 2019 or Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)
DOH	Department of Health
EPH	Environmental Public Health
FPHS	Foundational Public Health Services
LHJ	Local Health Jurisdiction
NSDM	New Service Delivery Model
SBOH	State Board of Health
SFY	State Fiscal Year
TB	Tuberculosis
WDRS	Washington Electronic Disease Reporting System
WSALPHO	Washington State Association of Local Public Health Officials

EXECUTIVE SUMMARY

The Foundational Public Health Services (FPHS) 2019-2021 Investment Report for State Fiscal Year 2020 (SFY20) is an annual report looking at progress made towards full funding and implementation of foundational services across the public health system in Washington state.

KEY FINDINGS:

FPHS investments are making incremental improvements in Washington's ability to provide FPHS and improve the statewide system, however, more funding is needed to fully implement FPHS services

The SFY20 investments provided much-needed capacity for the governmental public health system to pivot and rapidly respond to COVID-19 in 2020

There is significant willingness to receive and provide shared FPHS services above the current levels of sharing

The COVID-19 response effort that ramped up during the second half of SFY20 makes it difficult to draw conclusions from data collected during this period about the implementation of FPHS services across the governmental public health system

PURPOSE + BACKGROUND

PURPOSE

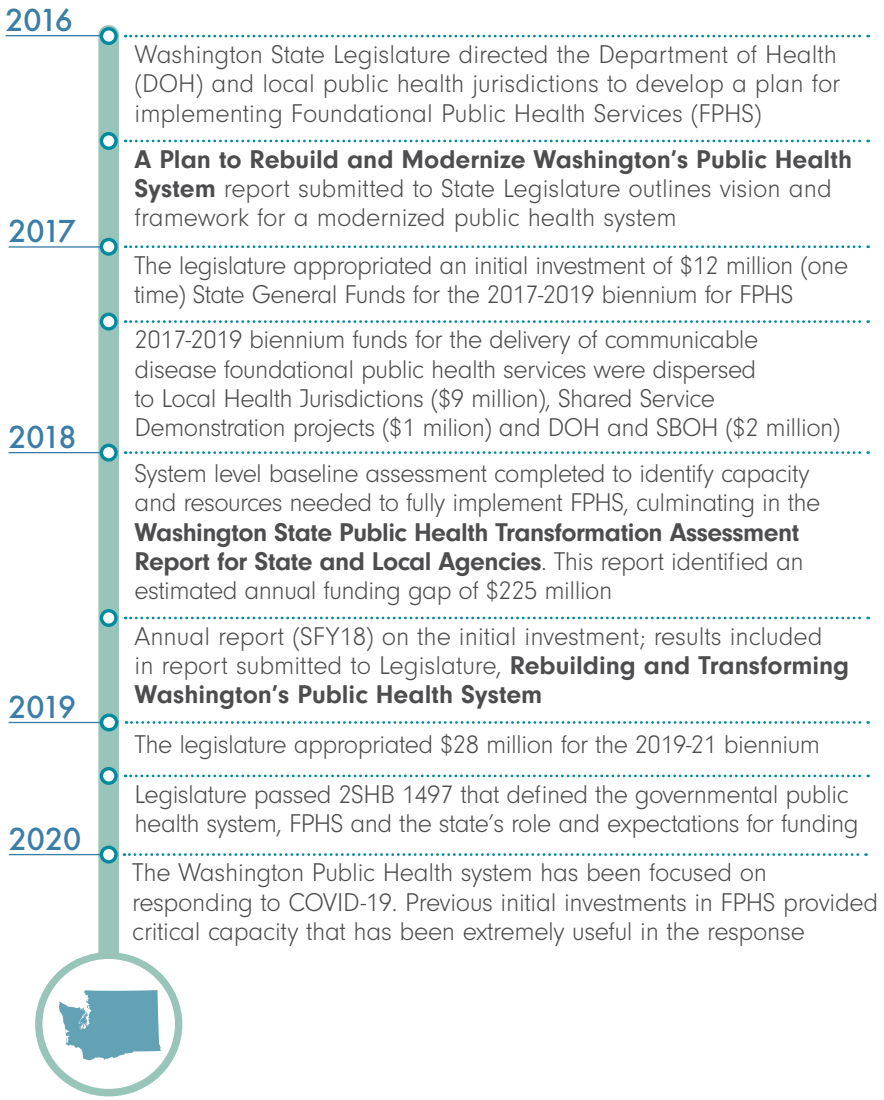
This report is part of the Washington state Foundational Public Health Services accountability system. The aim of the accountability system is to inform, using performance data, the continual improvement of the governmental public health system in delivering foundational public health services statewide in the most effective, efficient and equitable manner possible with the funds available. The accountability system looks at FPHS inputs—funding and new service delivery models—and their impact on the system's performance (e.g., capacity, expertise, increases or decreases in foundational public health services provided, and, eventually, outcome data). Covering State Fiscal Year 2020 (SFY20), this report is designed to help public health leaders in Washington state monitor how FPHS funds were spent and examine the effect of funding systemwide.

This is the second report comparing annual reporting by state and local agencies that receive state FPHS funds to a baseline assessment to evaluate changes in the implementation of FPHS through new ways of visualizing these data. As the FPHS accountability system matures, routine reports will be provided.

A BRIEF TIMELINE

In 2015, a workgroup of elected officials from cities, counties, tribes, and state government representatives reviewed the FPHS framework and concluded that because FPHS are needed in every community, the state should have the primary responsibility for funding. Their six recommendations continue to guide this work. Figure 1 outlines subsequent important events in this work.

Figure 1: FPHS Select Highlights in Washington



PURPOSE + FOCUS

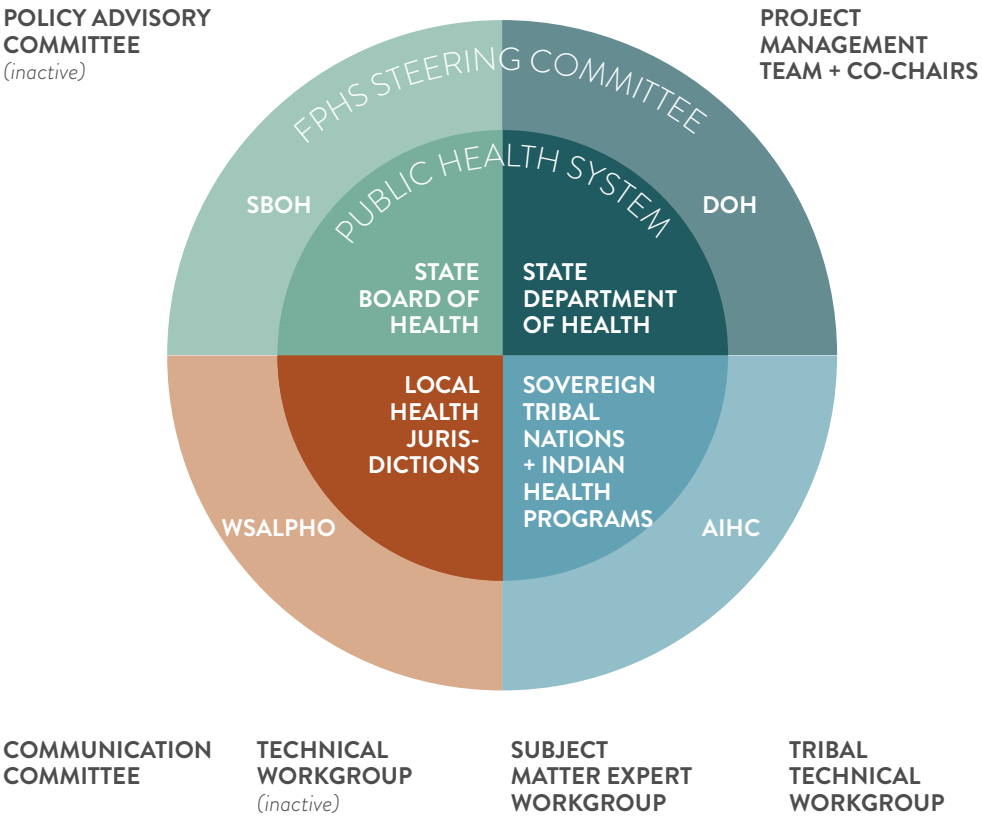
FOCUS

In response to pressing public health needs, Washington is embarking on an urgent and innovative effort to modernize its public health system. The legislature appropriated $28 million for Foundational Public Health Services (FPHS) for the 2019- 2021 biennium (July 2019-June 2021). The FPHS Steering Committee, comprised of representation from the four parts of the governmental public health system (see Figure 2), focused this investment on providing foundational communicable disease services; environmental health services; and cross-cutting capabilities of assessment, emergency preparedness and response, communications, policy, partnering, business functions and information technology that support all FPHS work. More details on the allocation of funds can be seen in Figure 4 in the Summary section of the report.

The funds were allocated as follows:

$15 million to LHJs for reinforcing capacity
$1.2 million to Tribal organizations
$4.3 million for new service delivery models
$7.5 million for infrastructure projects
= $28 million

Figure 2: FPHS committee structure



LHJs are represented by the Washington State Association of Local Public Health Officials (WSALPHO) and the American Indian Health Commission (AIHC) participates on behalf of sovereign tribal nations and Indian health programs

PURPOSE + FOCUS

FPHS BASELINE ASSESSMENT

An extensive FPHS Baseline Assessment was conducted for the first time with three of the four parts of the governmental public health system—DOH, LHJs, and SBOH—and the results were published in 2018. Based on calendar year 2016 data, the report provided significant baseline information on the level of FPHS implementation (capacity and expertise), sharing of service delivery (current and future sharing) and estimated costs (total cost to implement, current spending, and funding gap), using existing structures and models at the time. Tribes were not included in the baseline assessment because they were engaged in their own tribally driven process to define FPHS delivery framework, including costs and gaps analysis.

Summary findings from the baseline report include:

- Although the governmental public health system is implementing much of FPHS, no foundational program or capability is being implemented fully or significantly across the statewide system
- LHJs reported significant cross jurisdictional sharing
- There is wide variability in where the gaps are across agencies and across the statewide system
- Baseline expenditures for FPHS were estimated at $368 million annually, approximately two-thirds of the cost of full FPHS implementation
- The estimated additional funds needed from state government for full FPHS implementation is $225 million annually (based on 2018 monetary value)

COVID-19 CONTEXT

The World Health Organization declared a COVID-19 pandemic in March 2020. Since then, the entire Washington Public Health system has been focused on responding to COVID-19. Responding to a pandemic is foundational work of the governmental public health system; previous initial investments in FPHS provided critical capacity that has been extremely useful in the response. Due to the magnitude of the pandemic and the impact of the accompanying response on the public health system, it is difficult to identify and describe the specific impact of FPHS funding during this period.

For more information about Washington state's Foundational Public Health Services, visit: www.doh.wa.gov/fphs

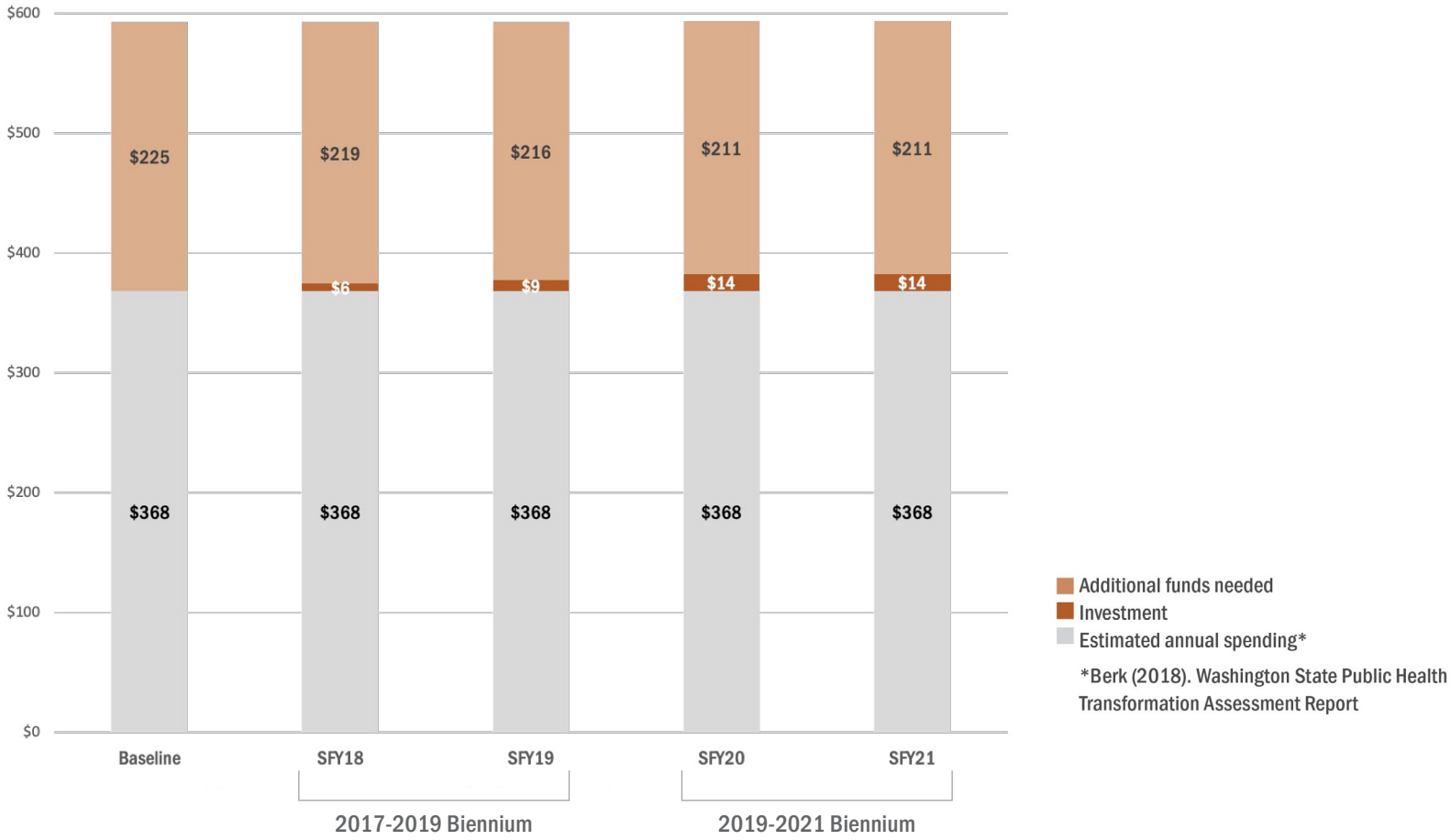
SECTION 1: SUMMARY DATA

SUMMARY DATA - FUNDING

FPHS FUNDS NEEDED & APPROPRIATED

The 2018 Washington State Public Health Transformation Assessment Report for State and Local Public Agencies (baseline), included estimated costs (total cost to implement, current spending, and funding gap) and thus how much more would be needed from the Washington State Government in order to fully implement public health services across the state. Figure 3 compares the original funding gap ($225 million) to the funding appropriated to FPHS by the Legislature for the 2017-2019 and 2019-2021 Bienniums.

Figure 3: FPHS Estimated Annual Spending, Investment and Additional Funds Needed, in Millions

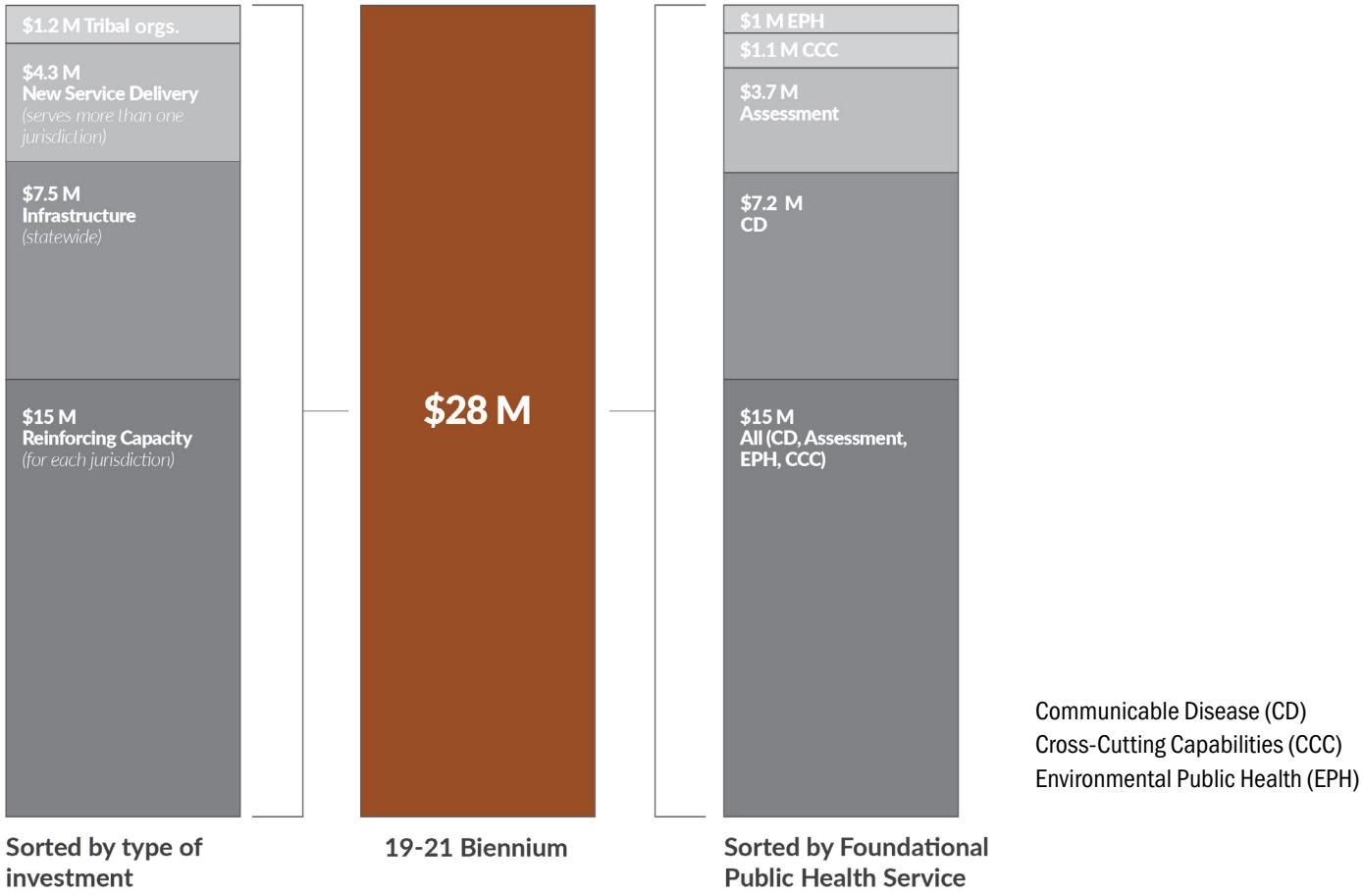


SUMMARY DATA - FUNDING

HOW FUNDS WERE ALLOCATED

Figure 4 displays two different ways of viewing how the FPHS steering committee allocated FPHS funds for the 2019- 2021 biennium. The legislature appropriated $28 million to FPHS; the left column displays how that $28 million was allocated by type of investment, and the right column displays which FPHS service areas the funding was allocated to. This report does not include details on the FPHS funds allocated to Tribal organizations.

Figure 4: Investment - How FPHS Funds Were Allocated, 19-21 Biennium



Communicable Disease (CD)
Cross-Cutting Capabilities (CCC)
Environmental Public Health (EPH)

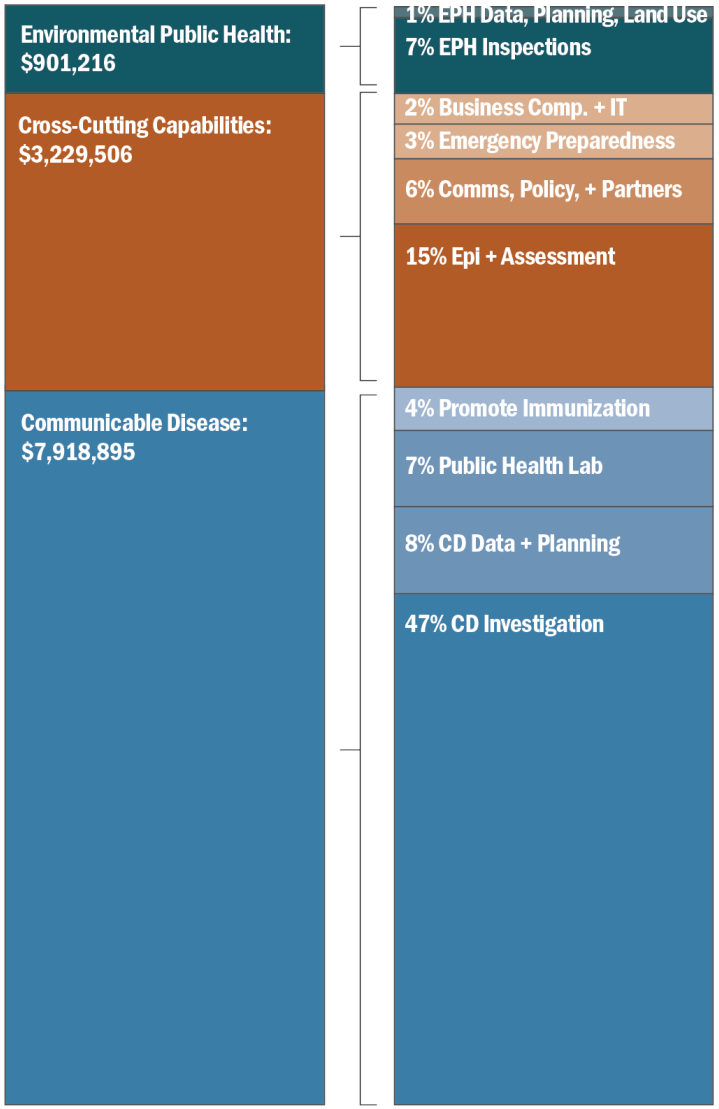
SUMMARY DATA - FUNDING

HOW FUNDS WERE SPENT SFY20

Of the funds allocated for SFY20, a total of $12,049,617 was spent on communicable disease, environmental health, and cross-cutting capabilities by LHJs, DOH, and SBOH. Possibly due to COVID-19, not all jurisdictions spent their full allocation of FPHS funds, and data from two LHJs were not received in time to be included in this report. As a result, the total amount spent does not match the total amount allocated. Nearly half of funding, (47%) was spent on communicable disease investigation ($5,674,177), which could have included case and contact tracing, isolation, and quarantine efforts related to COVID-19, as well as other communicable disease investigations. Additionally, other areas where spending for COVID-19 response might have been included are communications, community partnership development, and emergency preparedness. Analysis of how FPHS funds were invested includes data from all reports received: LHJs, DOH and SBOH, plus spending data from four new service delivery models. For further details about how FPHS funds were spent in SFY20, see pages 28-31 of this report.

Environmental Public Health $901,216 (7%)	Environmental Public Health Data, Planning, + Land Use	$67,898	1%
	Environmental Public Health Inspections	$832,617	7%
Cross-Cutting Capabilities $3,229,506 (27%)	Business Competencies + Information Technology	$299,330	2%
	Emergency Preparedness	$406,369	3%
	Communications, Policy Development, + Community Partnership Development	$754,717	6%
	Epidemiology + Surveillance, CHA/CHIP	$1,769,091	15%
Communicable Disease $7,918,895 (65%)	Promote Immunization	$448,567	4%
	Public Health Lab	$838,363	7%
	CD Data + Planning	$957,788	8%
	CD Investigation	$5,674,177	47%
	Total	$12,049,617	100%

Figure 5: How FPHS Funds Were Spent, SFY20



SUMMARY DATA - WHAT CHANGED

QUALITATIVE DATA ANALYSIS

Agencies reported on four open-ended questions:

1. In the LAST year, what has changed in the capacity, expertise or structure of how FPHS are delivered in your jurisdiction?;
2. In the LAST year, what has changed for the people of your jurisdiction about the FPHS available to them?;
3. Please give examples of how past FPHS investments impacted your jurisdiction's ability to respond to COVID-19 including how that investment was used or was of benefit in the COVID-19 response; and
4. Please give examples of any new ways FPHS services were delivered during the COVID-19 response that were an improvement over the old way and describe why it was an improvement.

Using Dedoose[1] software, Rede staff identified codes and looked for common themes in the responses. The following respondents are included in this analysis:

- 33 Local Health Jurisdictions
- 2 State Agencies (DOH, SBOH)

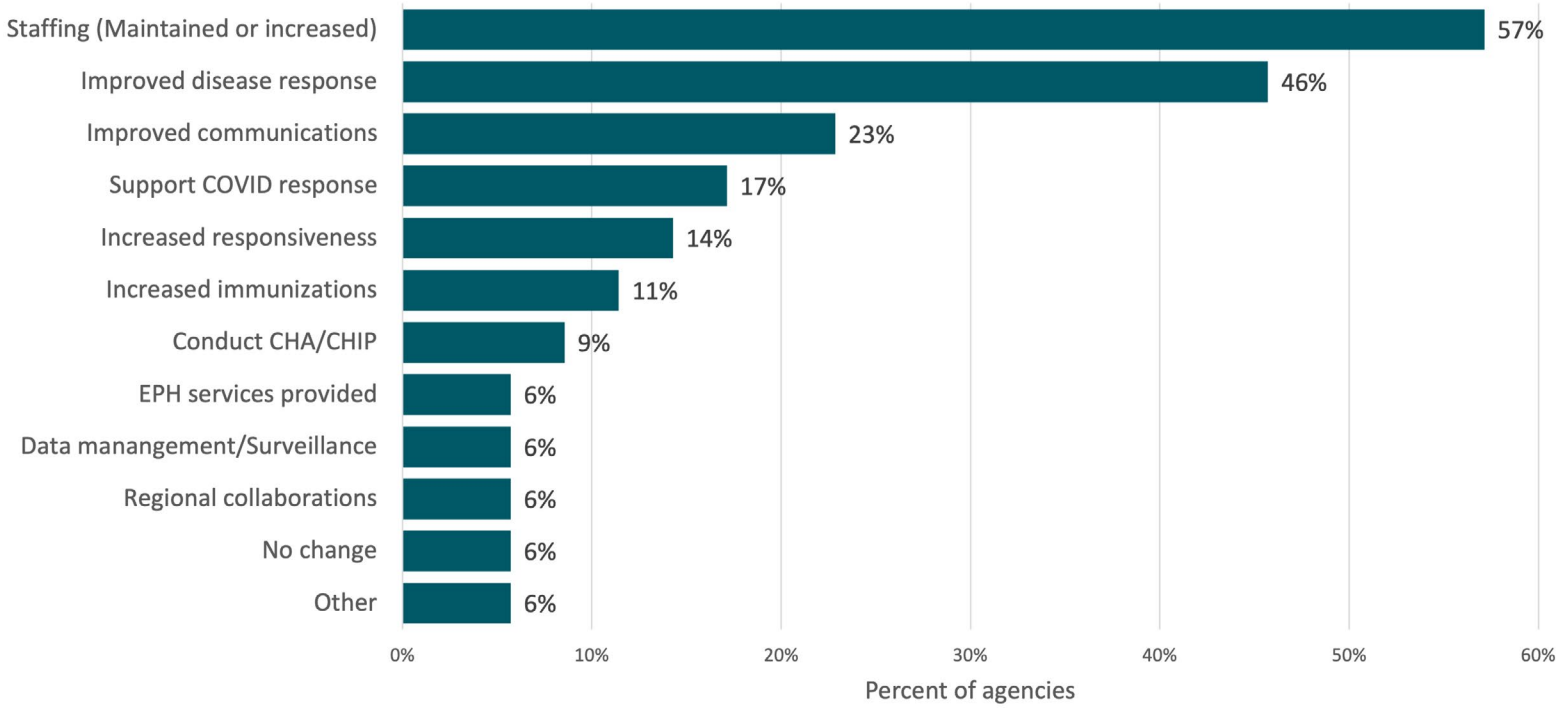
Figures 6, 7 and 8 display the percent of agencies that reported each identified theme from the open-ended responses. Themes drawn from the first two questions are displayed together in Figure 6 because the two questions resulted in similar and duplicative responses. See Appendix A for all of the responses to the open-ended questions.

1. Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com.

SUMMARY DATA - WHAT CHANGED

QUALITATIVE DATA ANALYSIS

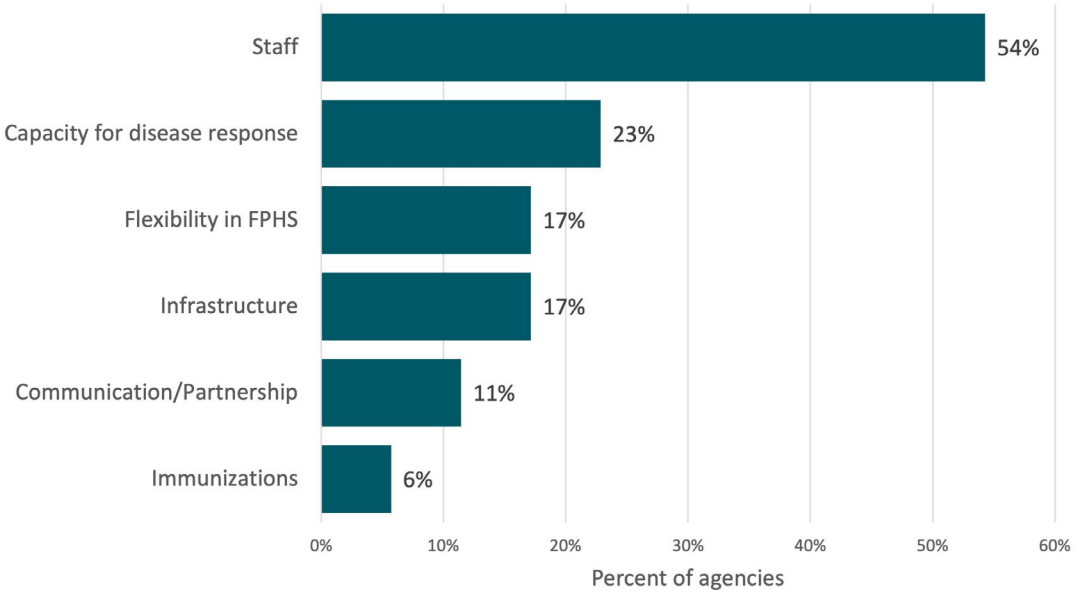
Figure 6: What has changed in the capacity, expertise, or structure of how FPHS are delivered in your jurisdiction? And, what has changed for the people of your jurisdiction about the FPHS available to them? Combined responses, SFY 20



SUMMARY DATA - WHAT CHANGED

QUALITATIVE DATA ANALYSIS

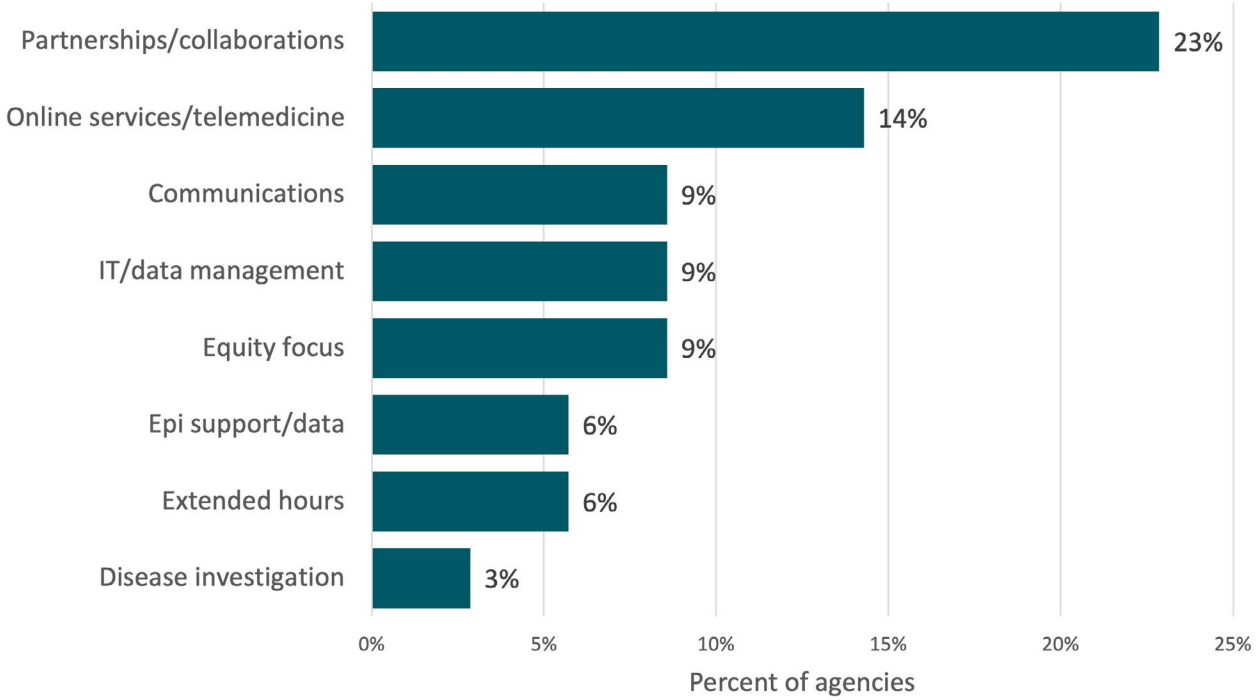
Figure 7: Examples of how past FPHS investments impacted your jurisdictions ability to respond to COVID-19, SFY20



SUMMARY DATA - WHAT CHANGED

QUALITATIVE DATA ANALYSIS

Figure 8: Examples of any new ways FPHS services were delivered during the COVID-19 response that were an improvement over the old way, SFY20



SUMMARY DATA - WHAT CHANGED

LEVEL OF IMPLEMENTATION COMPARISON - SFY20 TO BASELINE

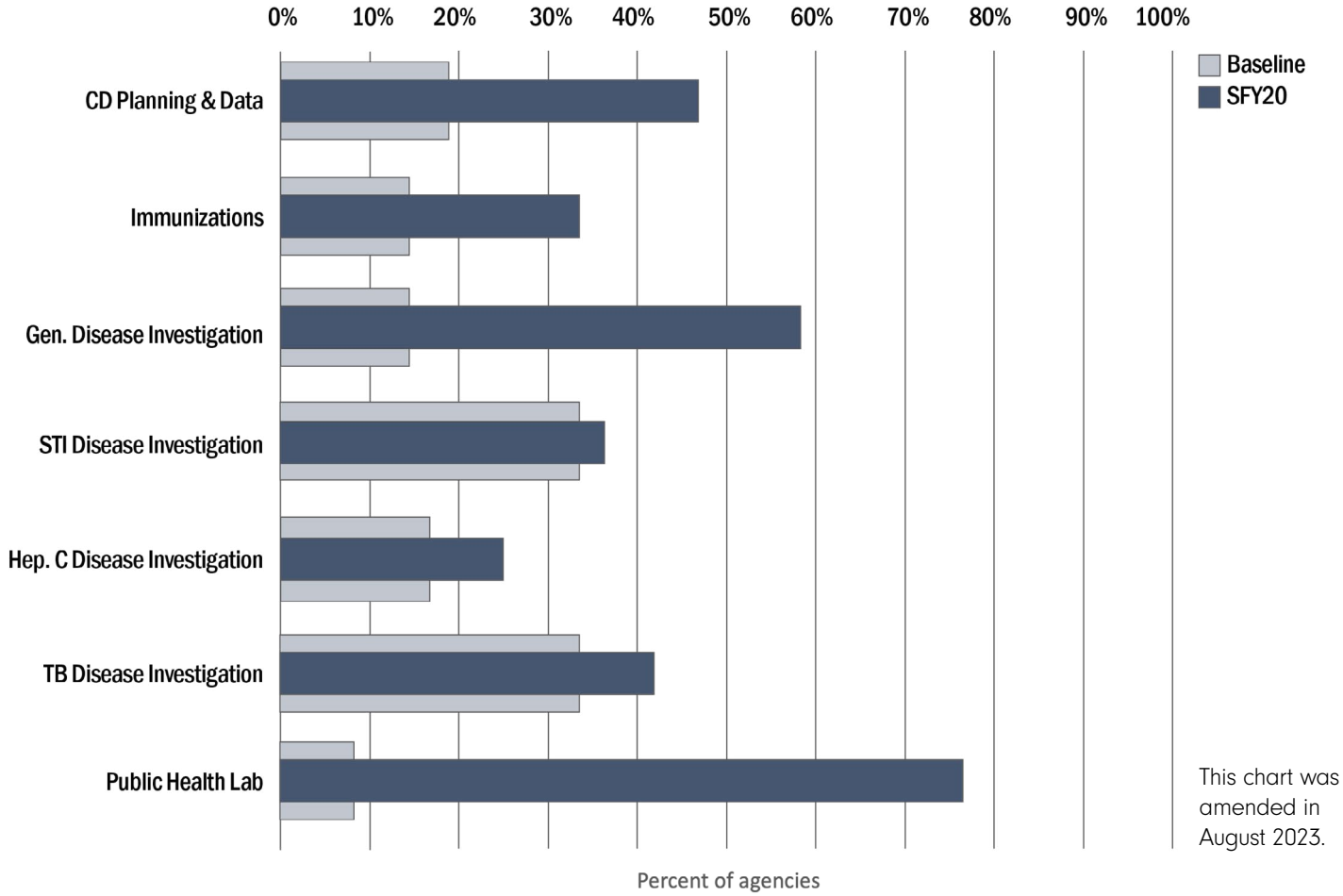
Agencies self-assessed their capacity and expertise for seven areas related to the prevention and control of communicable disease and other notifiable conditions, five areas related to environmental public health, as well as eight cross-cutting capabilities. Level of implementation is a calculated measure based on self-assessed capacity and expertise.

To better visualize changes between baseline and SFY20, the percent of agencies who reported that they are significantly or fully implementing the FPHS areas were grouped for comparison. Figures 9, 10, and 11 display this comparison for communicable disease services, environmental public health services, and cross-cutting capabilities.

SUMMARY DATA - WHAT CHANGED

There has been an increase in the implementation of all communicable disease foundational public health services between baseline and SFY20, especially in communicable disease planning and data, general communicable disease investigations, and public health lab services.

Figure 9: Comparison - percent of agencies reporting significantly & fully implemented communicable disease services, baseline to SFY20

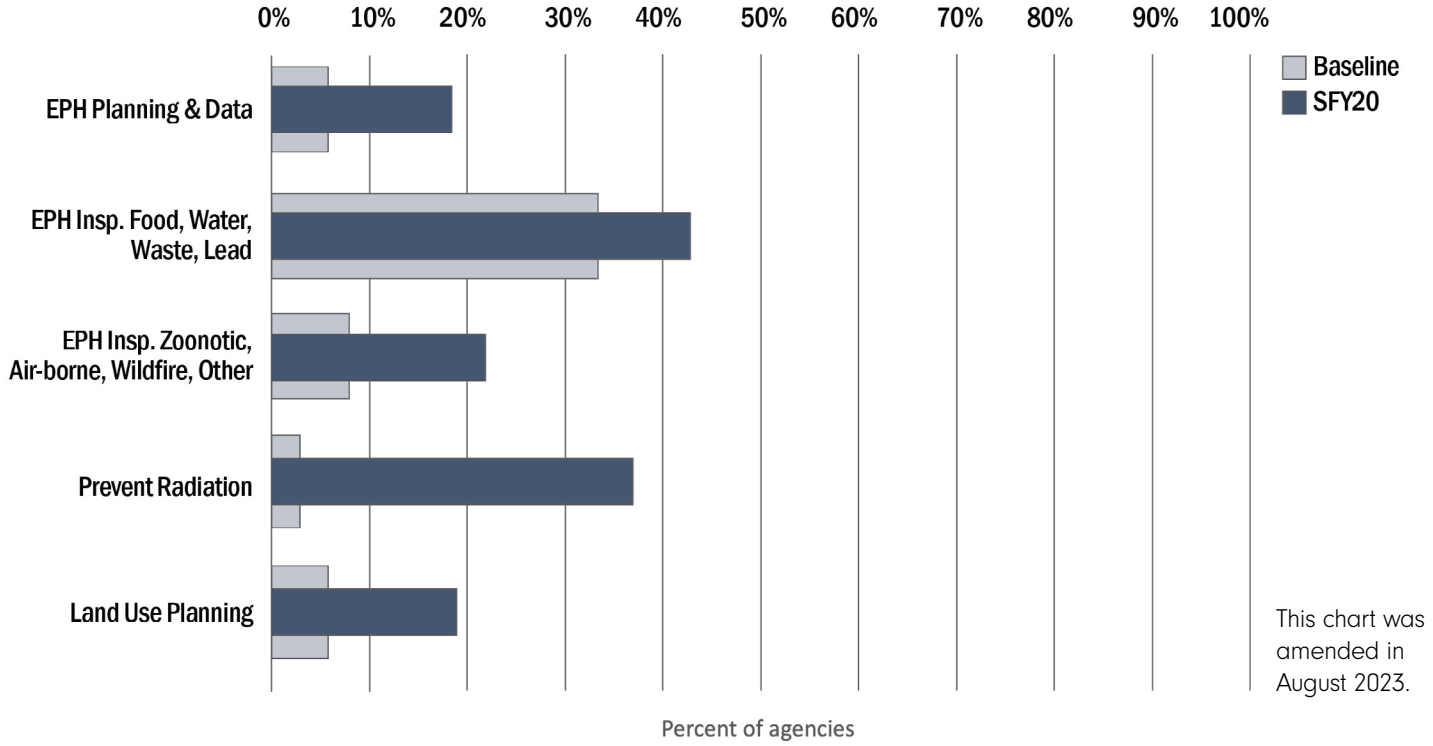


This chart was amended in August 2023.

SUMMARY DATA - WHAT CHANGED

There has been an increase in the implementation of all foundational environmental public health services between baseline and SFY20, most significantly for preventing radiation exposure.

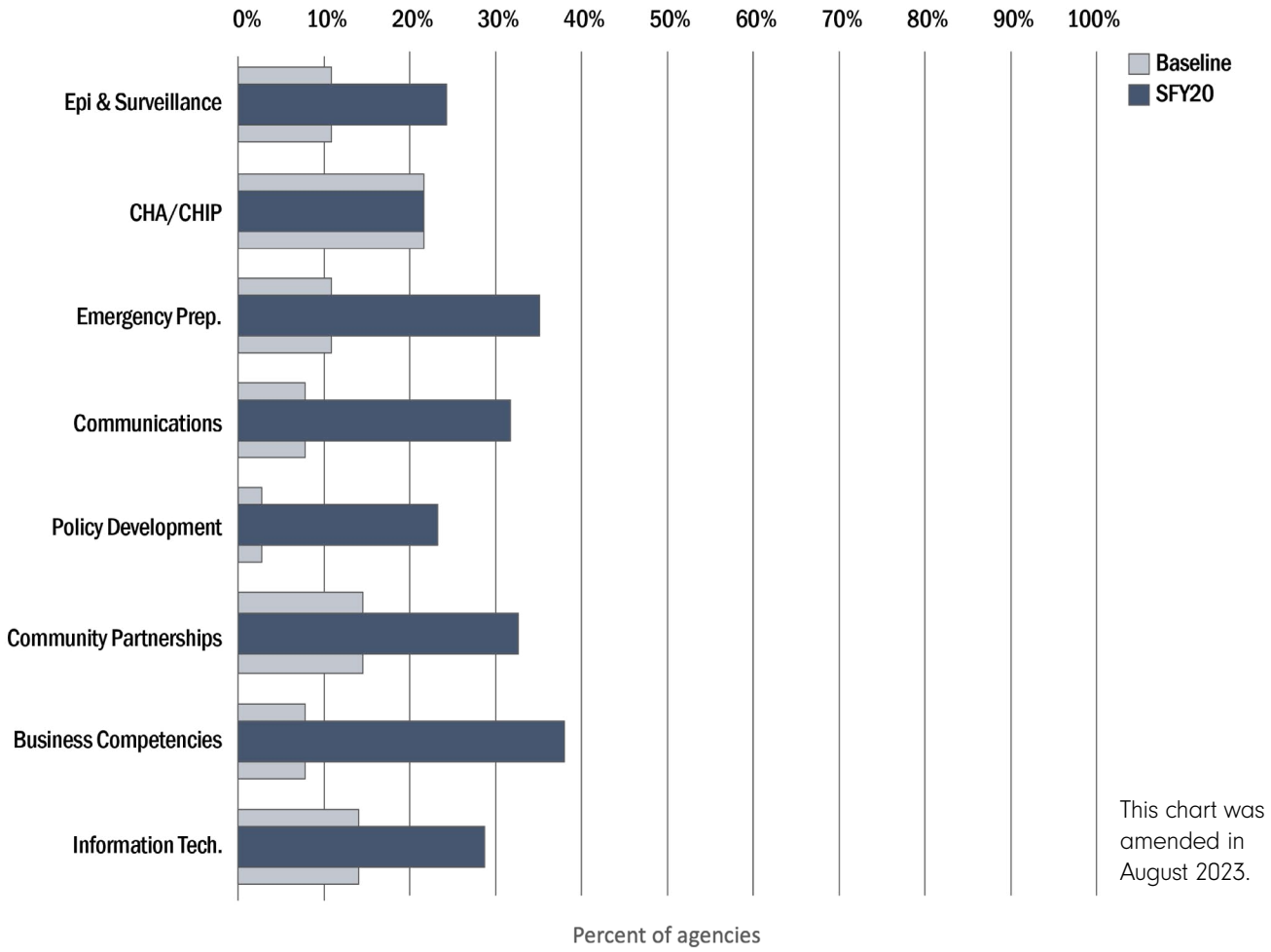
Figure 10: Comparison - percent of agencies reporting significantly & fully implemented environmental public health services, baseline to SFY20



SUMMARY DATA - WHAT CHANGED

There has been an increase in the implementation of most cross-cutting capabilities between baseline and SFY20, with the exception of community health assessment and improvement planning (CHA/CHIP) capabilities being reported at the same level in SFY20 as baseline.

Figure 11: Comparison - percent of agencies reporting significantly & fully implemented cross-cutting capabilities, baseline to SFY20



This chart was amended in August 2023.

SUMMARY DATA - IMPACT

MEASURING OUR WORK

Measuring the impact of investment in FPHS includes monitoring indicators of the public health services provided. The FPHS Steering Committee selected indicators in the following areas:

DISEASE INVESTIGATIONS

The sooner disease investigation is conducted and completed, the sooner disease transmission is interrupted, and the spread of disease is slowed or stopped. This results in fewer people getting sick and fewer long-term and costly consequences of disease for individuals, families, businesses, communities and the state.

Tracking the number of cases investigated each year for specific conditions is an indicator of public health system capacity – from data systems to staffing to do the work. Three conditions (Hepatitis C, gonorrhea and syphilis) were selected because these conditions occur frequently and thus the impact of investments in FPHS communicable disease should be observable in the data.

In much of the state, the same staff that investigate these three conditions also investigate most or all other communicable diseases that occur sporadically or less frequently. For this reason, these conditions are considered indicators of the overall statewide capacity for disease investigation.

These metrics reflect FPHS funded efforts by LHJs, SBOH, DOH, and four new service delivery models. These metrics also reflect efforts by DOH regional staff that use other funding (including ten disease investigation specialists that investigate high priority LHJs cases of syphilis and gonorrhea and one staff person investigating high priority LHJ cases of Hepatitis C).

Indicator data are dependent on data systems. Modernizing and automating data systems, including linking laboratory reports with disease investigation data, continues to be a work in progress. FPHS funds are essential to these efforts. Lab results that are not submitted through the Electronic Laboratory Reporting (ELR) system for these conditions are reported to LHJs via fax on paper and require staff to enter the information into the Washington Disease Reporting System (WDRS).

Given that all resources were directed toward pandemic response during the second half of this reporting period, it is likely that a number of paper reports were not yet entered into the data system by the close of this reporting period.

IMMUNIZATION SERIES COMPLETION RATES

Complete vaccination is the most effective and efficient way to prevent disease. Tracking the percent of children who have completed the recommended immunization series for their age is an important indicator for this.

Promoting vaccination through developing and maintaining statewide data systems; analyzing, sharing and using data; setting immunization policy; and communicating with and engaging the healthcare system and communities for planning and coordination are foundational roles of the governmental public health system. These metrics reflect the FPHS funded efforts of LHJs, SBOH and DOH, and others.

SUMMARY DATA - IMPACT

DISEASE INVESTIGATION AND IMMUNIZATION INDICATORS

1. Gonorrhea cases investigated
2. Gonorrhea cases investigated that are receiving dual treatment (for both gonorrhea and chlamydia at the same time)
3. Newly diagnosed syphilis cases that receive partner services interview
4. New positive Hepatitis C lab reports that are received electronically which have a completed case report
5. New positive Hepatitis C case reports with completed investigations
6. Children 19-35 months old who have completed the standard series of recommended vaccinations*
7. Children 4-6 years old who have completed the standard series of recommended vaccinations*

TRACKING DISEASE INVESTIGATIONS

Prioritizing which health issues to address with limited resources is typical for the statewide public health system. Directing all available resources to COVID-19 response has exacerbated this exponentially.

Investigations of communicable and infectious diseases other than COVID-19 were prioritized and addressed to the extent possible during this reporting period. The fact that any conditions other than COVID-19 were investigated during this reporting period may be an indicator of the importance and value of ongoing sustainable investments in foundational public health services – services that individuals, families, communities, the healthcare system and businesses depend on everywhere, every day, even during a crisis such as a pandemic. This situation is reflected in the disease investigation indicators being used to track the impact of FPHS investments.

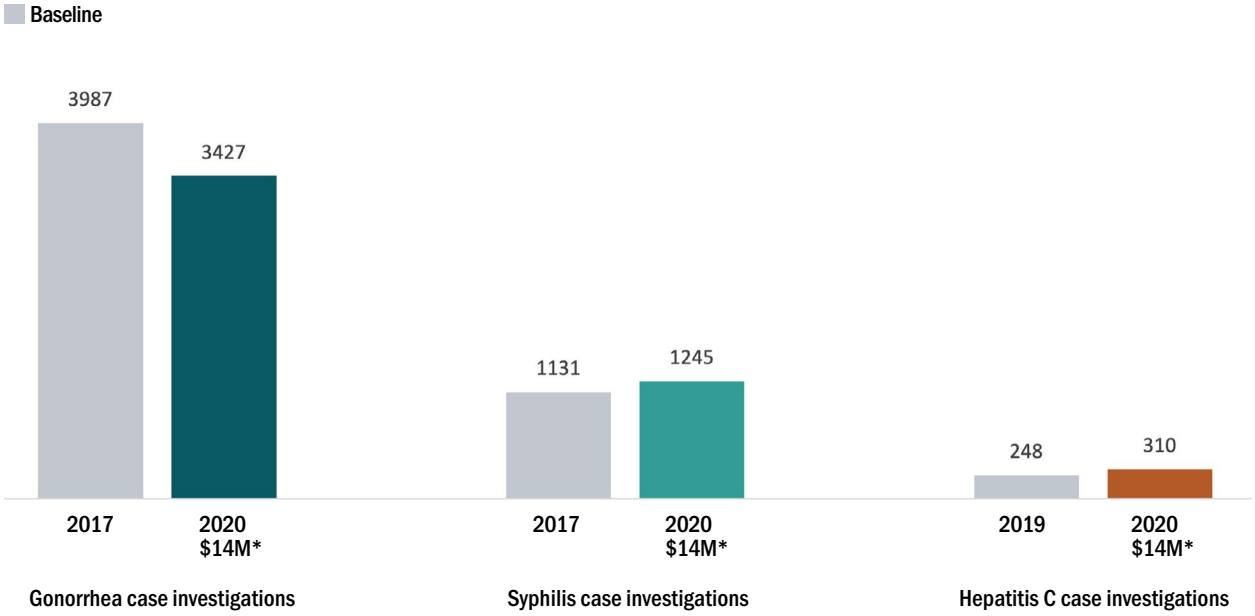
Resources were focused on disease investigation and contact tracing for syphilis cases due to the paramount importance of preventing congenital syphilis, which causes blindness, neuro-developmental disabilities or still-birth; preventing outcomes of untreated infection such as ocular syphilis or neurosyphilis; and prevention of HIV for which syphilis increases risk. Washington averages five or more cases of congenital syphilis each year. Prenatal syphilis is preventable and should not happen—any case of congenital syphilis indicates a failure of the healthcare and public health systems. Investigation of syphilis cases is generally more labor intensive than gonorrhea cases; therefore fewer cases can be investigated with the same amount of resources. Syphilis cases have been trending in a population that is harder to reach (heterosexual people who use drugs and are unstably housed), and requires more time and effort to reach for case investigations.

Comparing the number of cases investigated at baseline to SFY20 for each of the three conditions shows a reduction in the number of gonorrhea cases investigated, but a small increase in the number of syphilis and Hepatitis C cases investigated (see Figure 12, next page).

**Immunization data for SFY20 is not available at the time of this report.*

SUMMARY DATA - IMPACT

Figure 12: Number of case investigations, comparing baseline to SFY20

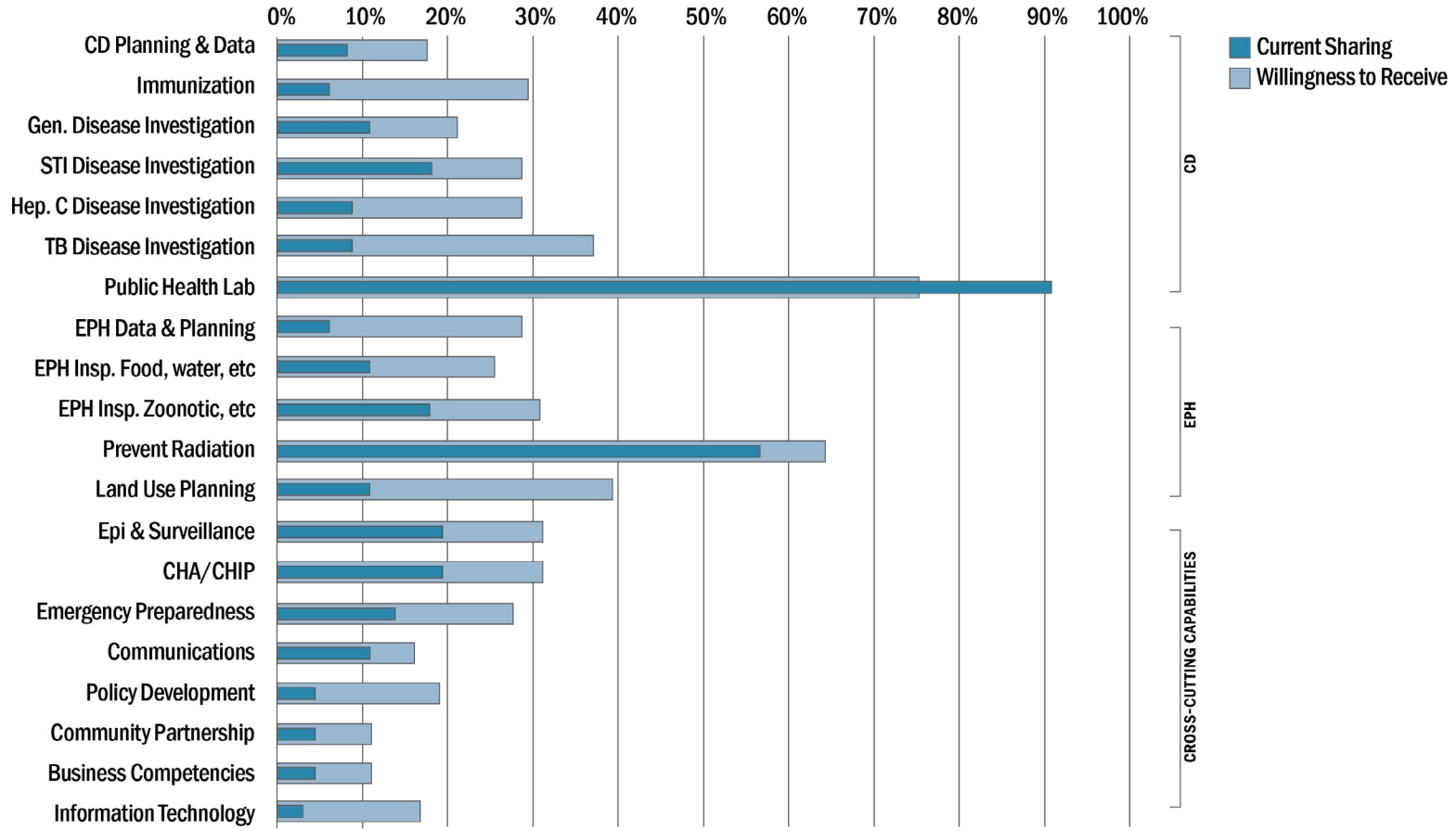


*Total FPHS Appropriation

SUMMARY DATA - FUTURE SHARING

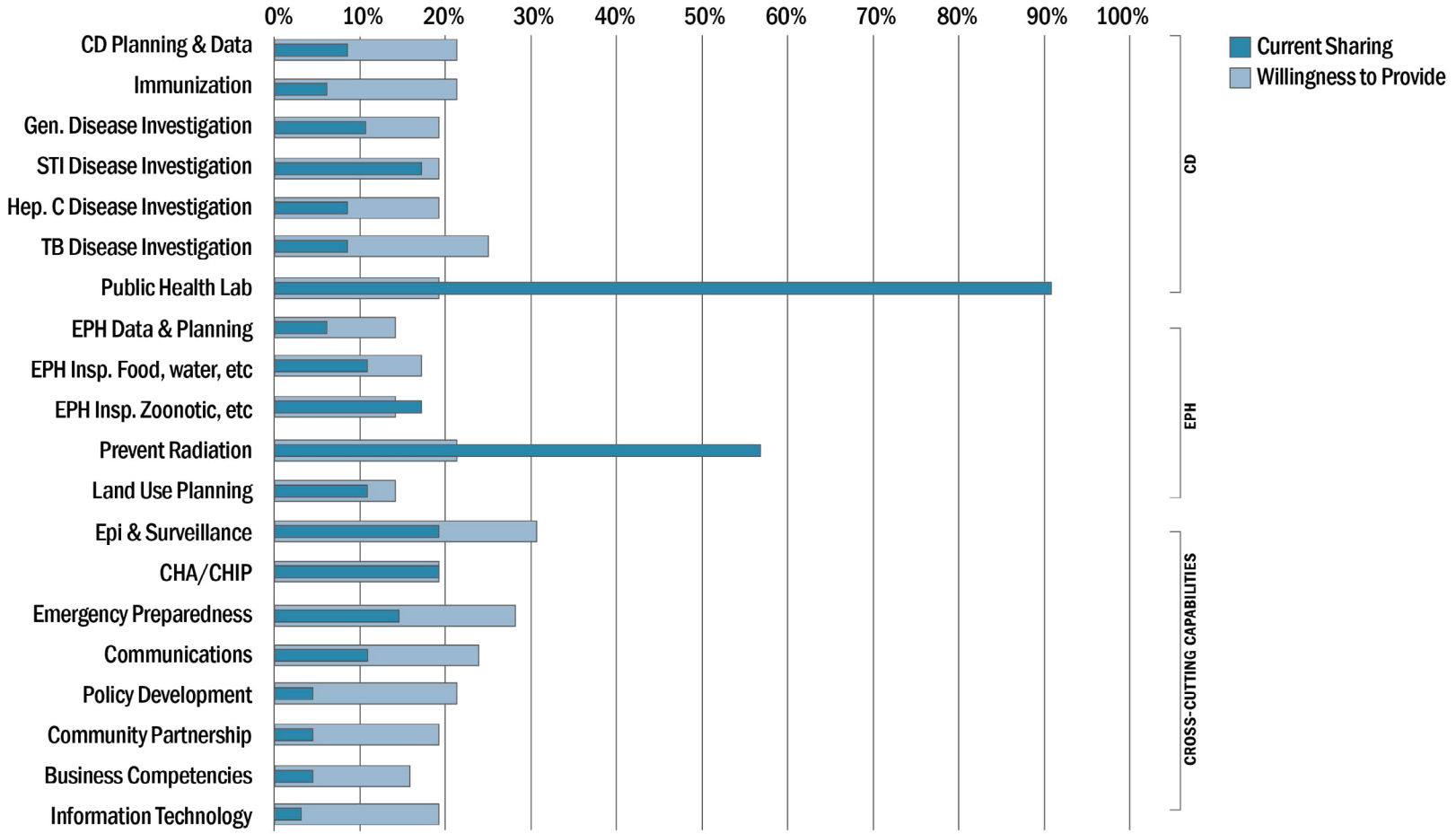
During this reporting period, agencies were asked if they would be willing to provide services to other jurisdictions, as well as if they would be willing to receive services from other jurisdictions. Figures 13 and 14 compare the percentage of agencies that currently were completely or significantly sharing in the delivery of these services to those that were willing to receive services from other agencies, and the percentage of agencies that currently were completely or significantly sharing in the delivery of these services to those that were willing to provide services to other agencies. These data are helpful for identifying opportunities for future new service delivery models in the delivery of FPHS across the state. Future sharing figures include data from LHJs, DOH and SBOH.

Figure 13: Percent of agencies completely or significantly sharing compared to agencies completely or significantly willing to **receive** services in the future, SFY20



SUMMARY DATA - FUTURE SHARING

Figure 14: Percent of agencies completely or significantly sharing compared to agencies completely or significantly willing to **provide** services in the future, SFY20



SECTION 2: DETAILED DATA

DETAILED DATA - FUNDING

The following tables display details on how SFY20 FPHS funds were spent. Table 1 shows the FPHS program areas in which dollars were spent by type of investment: LHJs, new service delivery models (NSDM), and state agencies (DOH & SBOH).

Tables 2-4 show how much each LHJ spent in each FPHS service area. This report does not include how Tribal organizations invested SFY20 FPHS funds.

TABLE 1: FPHS DOLLARS SPENT BY TYPE OF AGENCY, SFY20

	FPHS Program area	*Total*	*LHJs*	*NSDM**	*DOH/SBOH*
Communicable Disease	CD Data and Planning	$957,788	$630,351	$241,000	$86,437
	Promote Immunization	$431,440	$336,170	$0	$95,270
	Disease Investigation - General CD	$4,247,136	$4,247,136	$0	$0
	Disease Investigation - Syphilis, Gonorrhea and HIV	$716,528	$716,528	$0	$0
	Disease Investigation - Hepatitis C	$186,833	$186,833	$0	$0
	Disease Investigation - TB	$411,495	$157,593	$253,902	$0
	Public Health Lab	$838,363	$0	$0	$838,363
	Communicable Disease Total	$7,789,582	$6,274,610	$494,902	$1,020,070
Environmental Public Health	EPH CD and Planning	$44,272	$44,272	$0	$0
	EPH Inspections - Food, etc.	$750,194	$242,159	$0	$508,035
	EPH Inspections - Zoonotics, etc.	$82,424	$18,291	$0	$64,133
	Radiation Prevention	$700	$700	$0	$0
	Land Use Planning	$23,626	$23,626	$0	$0
	Environmental Public Health Total	$901,216	$329,048	$0	$572,168
Cross-Cutting Capabilities	Epidemiology & Surveillance	$1,492,601	$166,344	$0	$1,326,257
	Community Health Assessment and Improvement Plan	$276,490	$68,490	$208,000	$0
	Emergency Preparedness	$406,369	$406,369	$0	$0
	Communications	$134,902	$134,902	$0	$0
	Policy Development	$442,520	$69,801	$0	$372,719
	Community Partnership Development	$177,295	$177,295	$0	$0
	Business Competencies	$167,683	$167,683	$0	$0
	Information Technology	$131,647	$131,647	$0	$0
	Cross-Cutting Capabilities Total	$3,229,506	$1,322,530	$208,000	$1,698,976
Total (CD, EPH and Cross-Cutting)		$11,920,304	$7,926,188	$702,902	$3,291,214

*New service delivery models

TABLE 2: DOLLARS SPENT ON COMMUNICABLE DISEASE AREAS BY LHJ

	CD Data and Planning	Promote Immunization	Disease Investigation: General CD	Disease Investigation: STI	Disease Investigation: Hepatitis C	Disease Investigation: TB	Total
Adams	$19,732	$13,416	$1,497	$5,572	$0	$21,561	$61,778
Asotin	$337	$58	$504	$356	$0	$80	$1,335
Benton-Franklin	$0	$0	$142,649	$0	$0	$0	$142,649
Chelan-Douglas	$0	$0	$124,198	$0	$0	$0	$124,198
Clallam	$0	$17,127	$112,186	$0	$0	$0	$129,313
Clark	$0	$0	$258,263	$0	$0	$2,509	$260,772
Columbia	$195	$5,784	$8,576	$1,004	$331	$452	$16,342
Cowlitz	$0	$0	$7,820	$0	$0	$0	$7,820
Garfield	$3,945	$2,799	$4,752	$500	$500	$500	$12,996
Grays Harbor	$0	$0	$117,545	$0	$0	$18,851	$136,396
Jefferson	$0	$18,806	$12,573	$0	$0	$0	$31,378
Kitsap	$11,962	$0	$74,388	$76,923	$17,002	$0	$180,275
Kittitas	$0	$0	$68,338	$0	$0	$0	$68,338
Klickitat	$0	$500	$40,000	$0	$0	$13,000	$53,500
Lewis	$0	$0	$5,060	$4,855	$0	$0	$9,915
Lincoln	$0	$5,450	$32,450	$0	$0	$0	$37,900
Mason	$0	$0	$9,508	$0	$0	$0	$9,508
NE Tri-county	$249	$76	$2,061	$297	$811	$332	$3,826
Okanogan	$20,000		$20,000	$0	$0	$0	$40,000
Pacific	$0	$0	$55,505	$0	$0	$0	$55,505
San Juan	$0	$33,599	$33,112	$0	$178	$0	$66,889
Seattle-King	$436,172	$0	$2,234,032	$220,426	$0	$14,728	$2,905,358
Skagit	$3,069	$9,143	$72,059	$14,782	$6,140	$1,742	$106,935
Skamania	$317	$2,586	$158	$0	$0	$0	$3,061
Snohomish	$0	$0	$314,301	$199,037	$24,567	$0	$537,905
Spokane	$0	$148,290	$198,790	$84,333	$19,072	$0	$450,485
Tacoma-Pierce	$97,052	$71,467	$110,531	$57,435	$63,734	$8,019	$408,238
Thurston	$21,920	$11,157	$76,720	$41,968	$3,849	$34,894	$190,508
Wahkiakum	$2,000	$2,500	$15,000	$0	$0	$0	$19,500
Walla Walla	$2,400	$1,540	$6,520	$7,540	$1,540	$7,540	$27,080
Whatcom	$0	$0	$189,226	$0	$0	$0	$189,226
Whitman	$11,000	$9,000	$11,000	$1,500	$1,500	$250	$34,250
Yakima	$0	$0	$0	$0	$47,609	$33,134	$80,743

TABLE 3: DOLLARS SPENT ON CROSS-CUTTING CAPABILITIES BY LHJ

	Epidemiology & Surveillance	CHA/CHIP	Emergency Preparedness	Communications	Policy Development	Community Partnership Development	Business Competencies	Information Technology	Total
Adams	$656	$0	$0	$0	$460	$5,812	$0	$0	$6,928
Asotin	$0	$0	$0	$7,471	$0	$10,061	$5,254	$0	$22,786
Benton-Franklin	$59,270	$0	$63,668	$0	$0	$0	$0	$0	$122,938
Chelan-Douglas	$0	$0	$0	$0	$0	$0	$0	$0	$0
Clallam	$0	$0	$0	$0	$0	$0	$0	$0	$0
Clark	$0	$0	$114,870	$0	$0	$0	$0	$0	$114,870
Columbia	$8,041	$7,582	$13,459	$2,202	$7,668	$23,060	$7,335	$3,319	$72,666
Cowlitz	$0	$0	$0	$0	$0	$0	$0	$0	$0
Garfield	$3,280	$12,331	$11,438	$6,092	$13,537	$20,136	$6,530	$5,850	$79,194
Grays Harbor	$0	$0	$0	$0	$0	$0	$0	$0	$0
Jefferson	$0	$8,000	$0	$30,000	$0	$0	$30,622	$0	$68,622
Kitsap	$31,859	$0	$0	$0	$0	$0	$0	$0	$31,859
Kittitas	$0	$0	$0	$0	$0	$0	$0	$0	$0
Klickitat	$0	$0	$5,500	$1,000	$1,500	$0	$0	$10,000	$18,000
Lewis	$1,197	$0	$0	$4,706	$1,482	$0	$0	$0	$7,385
Lincoln	$9,850	$22,153	$0	$0	$1,897	$0	$0	$3,650	$37,550
Mason	$0	$0	$0	$0	$0	$0	$0	$0	$0
NE Tri-county	$249	$13	$0	$199	$649	$2,728	$59,151	$17,765	$80,754
Okanogan	$0	$0	$0	$20,000	$0	$0	$0	$30,000	$50,000
Pacific	$0	$0	$3,948	$0	$0	$4,066	$0	$0	$8,014
San Juan	$0	$0	$33,111	$0	$0	$0	$0	$0	$33,111
Seattle-King	$0	$0	$75,000	$38,450	$0	$0	$0	$0	$113,450
Skagit	$2,948	$5,422	$0	$0	$0	$16,762	$0	$0	$25,132
Skamania	$0	$0	$0	$2,582	$25,818	$5,484	$40,767	$10,212	$84,863
Snohomish	$0	$0	$0	$0	$0	$0	$0	$0	$0
Spokane	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tacoma-Pierce	$0	$0	$0	$0	$0	$0	$0	$0	$0
Thurston	$3,293	$3,293	$11,569	$0	$0	$240	$9,850	$16,472	$44,717
Wahkiakum	$5,000	$0	$35,706	$5,500	$9,440	$4,500	$2,354	$2,500	$65,000
Walla Walla	$8,400	$8,696	$14,600	$13,800	$4,800	$8,240	$3,120	$0	$61,656
Whatcom	$0	$0	$0	$0	$0	$0	$0	$0	$0
Whitman	$4,300	$1,000	$23,500	$2,900	$2,550	$3,500	$2,700	$3,200	$43,650
Yakima	$28,000	$0	$0	$0	$0	$72,706	$0	$28,679	$129,385

TABLE 4: DOLLARS SPENT ON ENVIRONMENTAL PUBLIC HEALTH BY LHJ

	EPH Planning & Data	EPH Inspections: Food, Water, Waste, Lead	EPH Inspections: Zoonotic, Air-borne, Wildfire, Other	Prevent Radiation	Land Use Planning	Total
Adams	$0	$26,561	$1,103	$0	$3,629	$31,293
Asotin	$504	$75,374	$0	$0	$0	$75,878
Benton-Franklin	$0	$0	$0	$0	$0	$0
Chelan-Douglas	$0	$0	$0	$0	$0	$0
Clallam	$0	$0	$0	$0	$0	$0
Clark	$0	$0	$0	$0	$0	$0
Columbia	$0	$10,492	$500	$0	$0	$10,992
Cowlitz	$0	$2,302	$0	$0	$0	$2,302
Garfield	$3,639	$2,794	$1,377	$0	$0	$7,810
Grays Harbor	$0	$0	$0	$0	$0	$0
Jefferson	$0	$0	$0	$0	$0	$0
Kitsap	$0	$0	$0	$0	$0	$0
Kittitas	$0	$0	$0	$0	$0	$0
Klickitat	$0	$15,000	$3,500	$0	$10,000	$28,500
Lewis	$0	$0	$0	$0	$0	$0
Lincoln	$10,000	$14,550	$0	$0	$0	$24,550
Mason	$0	$32,499	$0	$0	$0	$32,499
NE Tri-county	$367	$14,550	$213	$0	$290	$15,420
Okanogan	$10,000	$0	$0	$0	$0	$10,000
Pacific	$7,710	$23,130	$0	$0	$5,613	$36,453
San Juan	$0	$0	$0	$0	$0	$0
Seattle-King	$0	$0	$0	$0	$0	$0
Skagit	$0	$0	$0	$0	$0	$0
Skamania	$52	$30	$0	$0	$0	$82
Snohomish	$0	$0	$0	$0	$0	$0
Spokane	$0	$0	$0	$0	$0	$0
Tacoma-Pierce	$0	$0	$0	$0	$0	$0
Thurston	$0	$0	$0	$0	$0	$0
Wahkiakum	$1,000	$10,000	$2,000	$0	$2,500	$15,500
Walla Walla	$0	$7,876	$2,694	$0	$694	$11,264
Whatcom	$0	$0	$0	$0	$0	$0
Whitman	$11,000	$7,000	$2,500	$700	$900	$22,100
Yakima	$0	$0	$4,404	$0	$0	$4,404

DETAILED DATA - WHAT CHANGED

QUALITATIVE DATA ANALYSIS:

Below are select responses to open ended questions assessing what changed in the past year regarding delivery of FPHS services, how FPHS supported COVID-19 response, and how FPHS delivery changed due to COVID-19. See Appendix A for all responses.

WHAT HAS CHANGED FOR THE PEOPLE OF YOUR JURISDICTION ABOUT THE FPHS AVAILABLE TO THEM?

- Pacific County was able to complete a CHA and develop a CHIP, working with many of the necessary partners in the county. They also created a Health Advisory Subcommittee under the Health & Human Services Advisory Board, giving them the opportunity to discuss the CHIP and use the community to create improvements in the county's health.
- Mason County's outreach to the public around disease intervention multiplied in both volume and sophistication in three languages in both electronic and in-person communication.
- NE Tri-County made improvements to their website and social media information sharing, and enhanced coordination with local partners for better delivery of services to the public.
- Okanogan County made improvements to their online systems to allow the public to be able to find inspection reports/information.
- San Juan County dedicated staff to function as "liaisons" to a variety of businesses and organizations. They schedule and hold "COVID-19 partner" calls to disseminate information and answer questions. These efforts reinforce their role as a trusted source for public health information in the community
- Seattle-King County cross-trained staff on isolation and quarantine to ensure people living homeless who were infected with Hepatitis A could safely isolate.

EXAMPLES OF HOW PAST FPHS INVESTMENTS IMPACTED YOUR JURISDICTION'S ABILITY TO RESPOND TO COVID-19.

- Chelan-Douglas County utilized the flexibility of FPHS to commit funds to the COVID-19 response when they did not have any other funding source. Now that other funding sources are available, being able to move FPHS funding to support other programs as needed has been crucial to sustain "normal" service operations/staffing.
- Jefferson County found that having funding in capabilities as well as communicable disease and immunizations provided flexibility to respond more effectively to COVID-19 and to ensure effective communication with residents and partners.
- Skagit County maintained a stable, trained staff. They made use of their entire public health staff in their COVID-19 response. They pulled in most EH and CD and CHW immediately, which was critical to their response.
- Snohomish County reported that FPHS investments allowed them to have enough staff to meet the needs of their community pre-COVID-19. When COVID-19 arrived, they were more nimble with their staffing to accommodate the increase in workload until they were able to hire more people.
- Spokane County reassigned three FPHS funded staff (STD investigator, immunization outreach coordinator, and hepatitis C coordinator) to COVID-19 response starting in March 2020. They have been conducting case investigations, contact notifications, business consultations, and coordinating community testing.
- FPHS funding allowed Whitman County to expand staffing for greater capacity to respond to any contingency.

DETAILED DATA - WHAT CHANGED

QUALITATIVE DATA HIGHLIGHTS:

EXAMPLES OF NEW WAYS FPHS SERVICES WERE DELIVERED DURING THE COVID-19 RESPONSE THAT WERE AN IMPROVEMENT OVER THE OLD WAY AND DESCRIBE WHY IT WAS AN IMPROVEMENT.

- Clark County migrated to a new web based platform that will be used for all their infectious disease work.
- Cowlitz County enhanced their outreach and engagement with vulnerable or underserved populations, including the micronesian community.
- Lincoln County participated in developing cross-jurisdictional models that allowed higher trained staff from other jurisdictions to support their staff in activities and community response.
- NE Tri-County utilized technology to attend meetings with community partners and provide direct services (such as in WIC), and worked to improve processes for electronic submission of applications and environmental health design work that reduces in-person interactions (which results in improvements in efficiency and reduced costs incurred by clients).
- Pacific County signed a contract with Clark County in January for a regional health officer which supported their COVID-19 response in the way they had hoped for - the ability to share COVID-19 response documents, mass media, and health officer support all helped to ensure the public received the information they needed to assist them in supporting the State's response and decreasing the numbers of positive cases/deaths to COVID-19.
- During the initial stage of the response, we were able to rapidly mobilize surge staff from the infectious disease emergency response team to assist with disease investigation, contact tracing, data entry, and isolation and quarantine of people under investigation. The FPHS investment into building and training an Infectious Disease Response Team provided critical capacity to respond to a dynamic situation. FPHS investments in permanent staff members within our Communicable Disease and Sexual Health Clinic programs gave us a larger pool of staff to deploy to the COVID-19 response work while maintaining other communicable disease investigation work in the beginning of the pandemic.
- Spokane County's work with wrap around support for individuals/families in quarantine/isolation also highlighted the coordinated need for community partnerships and the internal cross divisional approach to assisting those with health concerns. Staff have completed a large volume of COVID-19 interviews that has given them more tools to gain information from patients, especially when they are reluctant to talk. Working with treatment centers around COVID-19 issues has allowed them to make some connections in the community that will be useful in HCV work. Staff have learned more about how treatment centers work and what HCV clients go through when they go to treatment for substance abuse.

DETAILED DATA - WHAT CHANGED

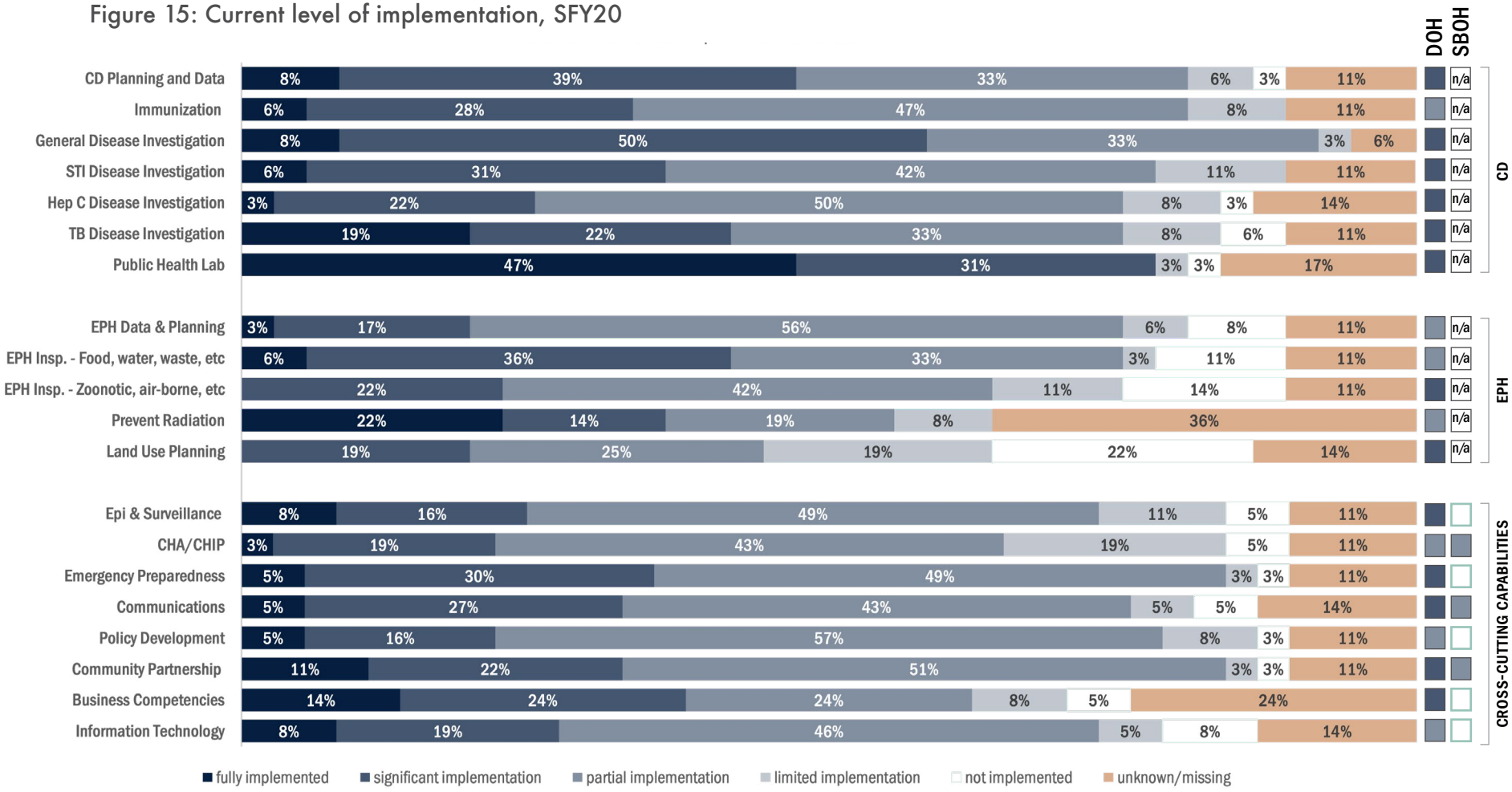
LEVEL OF IMPLEMENTATION

Agencies self-assessed their capacity and expertise for seven areas related to prevention and control of communicable disease and other notifiable conditions, five areas related to environmental public health, as well as eight cross-cutting capabilities. Level of implementation is a calculated measure based on self-assessed capacity and expertise. For centralized shared services, such as public health lab and preventing radiation exposure, agencies assessed themselves on the level of implementation in their jurisdiction based on that centralized service. A fully implemented FPHS program area would be indicated by 100% of respondents in the darkest blue color in Figure 15. Analysis of implementation includes data from: LHJs, DOH and SBOH.

When comparing current implementation to baseline, progress is measured by more agencies reporting higher levels of implementation. This can be seen by more of the rows being darker for SFY20 (see Figures 16, 17 and 18). In the majority of FPHS areas, there has been an increase in implementation.

DETAILED DATA - WHAT CHANGED

Figure 15: Current level of implementation, SFY20

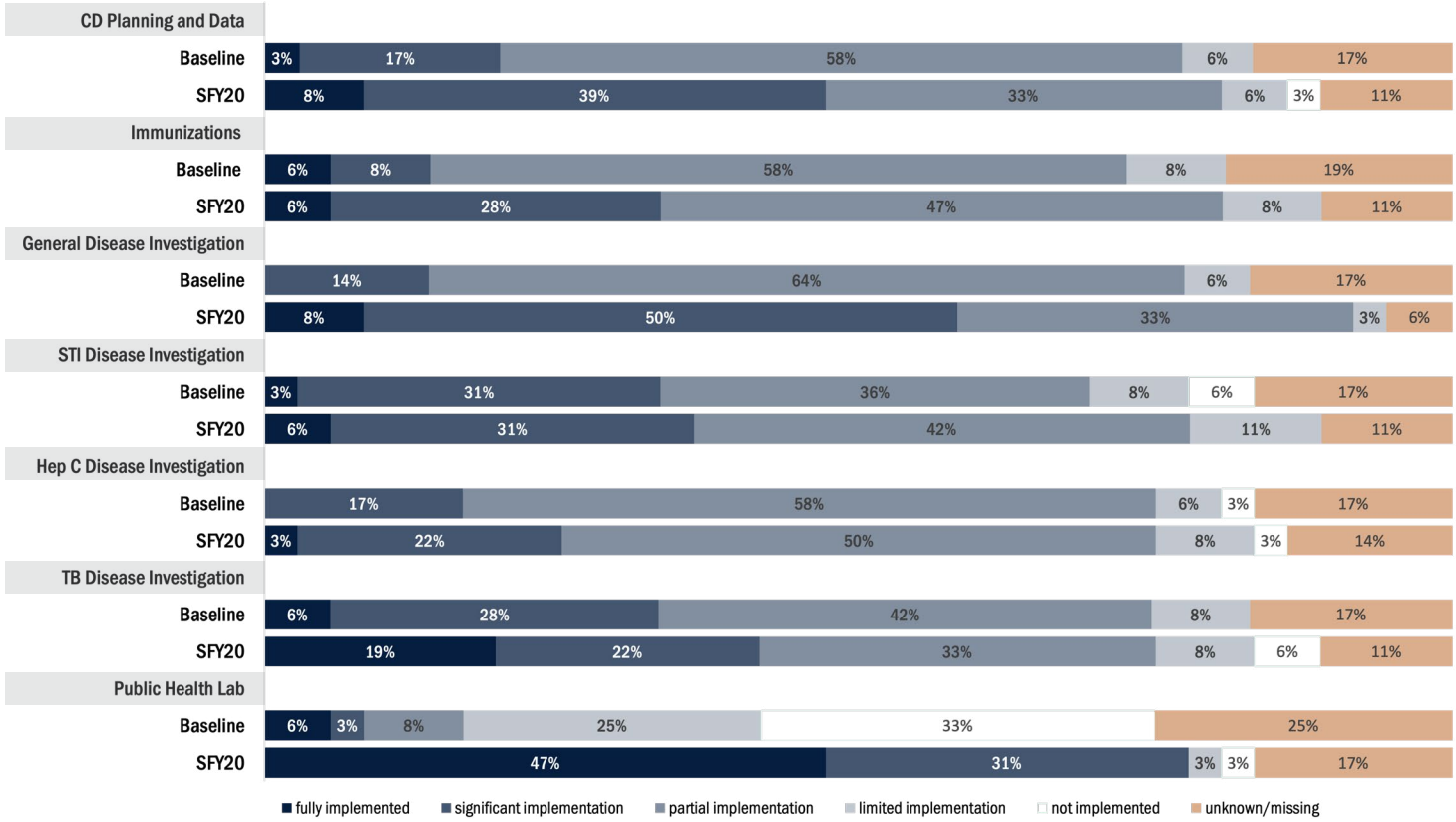


DETAILED DATA - WHAT CHANGED

COMPARISON OF SFY20 IMPLEMENTATION LEVELS TO BASELINE: COMMUNICABLE DISEASE SERVICES

The communicable disease service that has seen the biggest increase in implementation is public health lab services, with 78% of agencies reporting fully or significantly implementing this service compared to 9% at baseline—a 767% increase. General communicable disease investigation also saw an increase with 58% of agencies fully or significantly implementing this service, compared to 14% at baseline; a 314% increase. The area that had the least change in implementation is sexually transmitted disease investigation, with 37% of agencies reporting fully or significantly implementing this service, compared to 34% at baseline; a 9% increase.

Figure 16: Comparison - percent of agencies reporting significantly & fully implemented communicable disease services, baseline to SFY20



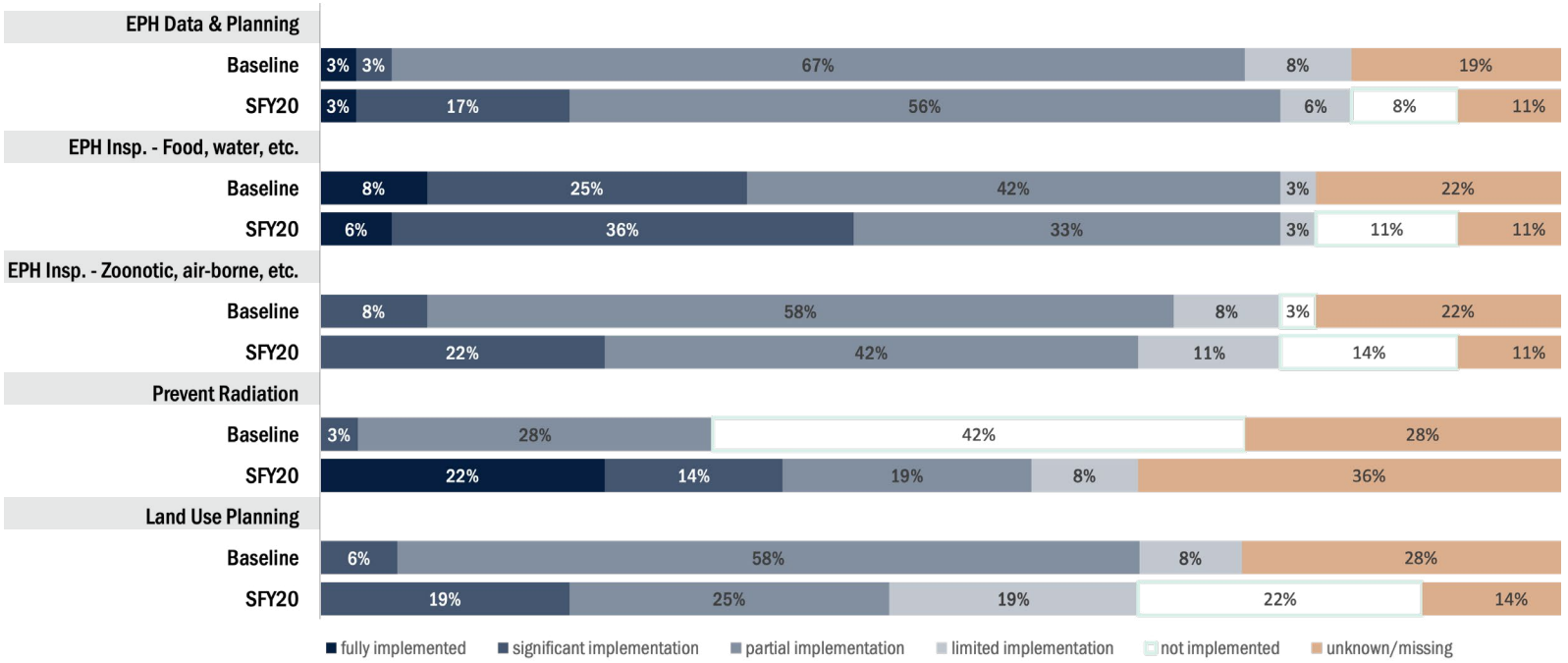
This chart was amended in August 2023.

DETAILED DATA - WHAT CHANGED

COMPARISON OF SFY20 IMPLEMENTATION LEVELS TO BASELINE: ENVIRONMENTAL PUBLIC HEALTH

The environmental public health service that has seen the biggest increase in implementation is preventing radiation exposure with 36% of agencies reporting fully or significantly implementing this service compared to 3% at baseline, an 1100% increase. Environmental public health data and planning increased to 20% of agencies fully or significantly implementing this service, compared to 3% at baseline, a 567% increase. The area that saw the smallest increase in implementation is food, water, waste and lead inspections, with 45% of agencies reporting fully or significantly implementing this service, compared to 35% at baseline, a 29% increase.

Figure 17: Comparison - percent of agencies reporting significantly & fully implemented environmental public health services, baseline to SFY20



This chart was amended in August 2023.

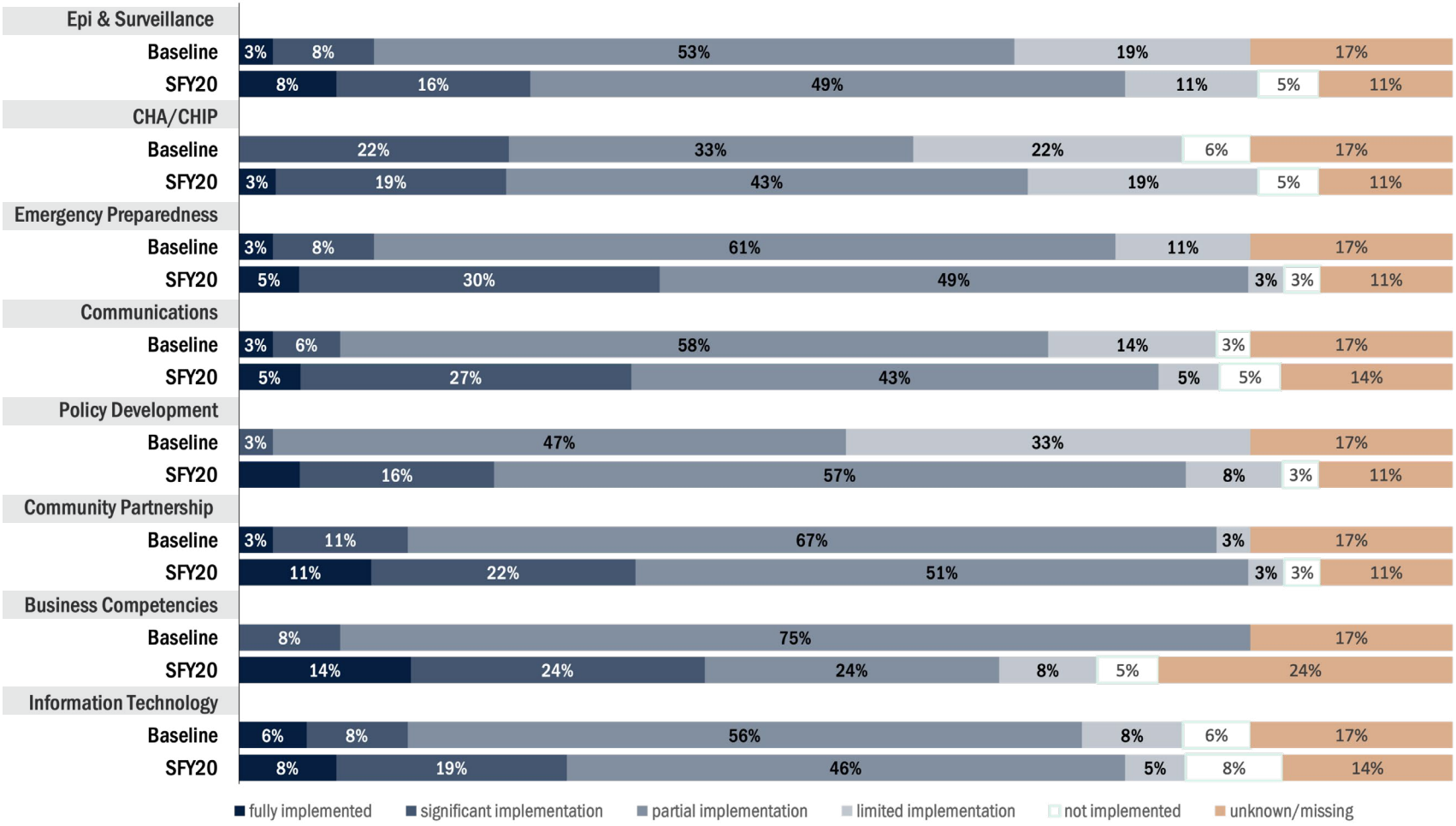
DETAILED DATA - WHAT CHANGED

COMPARISON OF SFY20 IMPLEMENTATION LEVELS TO BASELINE: CROSS-CUTTING CAPABILITIES

The cross-cutting capability that has seen the biggest increase in implementation is business competencies with 38% of agencies reporting fully or significantly implementing this service compared to 5% at baseline; a 660% increase. Communications experienced a similar increase with 32% of agencies fully or significantly implementing this service, compared to 6% at baseline; a 433% increase. The area that saw no increase in implementation is community health assessment and planning, with 22% of agencies reporting fully or significantly implementing this service, compared to 22% at baseline.

DETAILED DATA - WHAT CHANGED

Figure 18: Comparison - percent of agencies reporting significantly & fully implemented cross-cutting capabilities, baseline to SFY20



This chart was amended in August 2023.

DETAILED DATA - IMPACT

INDICATOR DATA

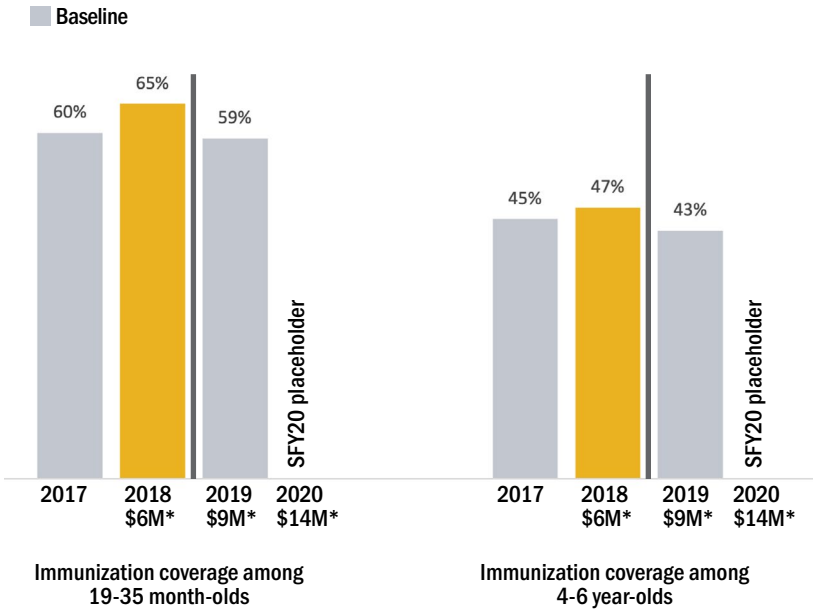
As mentioned previously in the summary section of this report, the FPHS Steering Committee agreed to a set of indicators to monitor the impact of FPHS funding on the governmental public health system's ability to reduce the spread of disease in Washington. The following tables display the full data sets for these indicators. Data on immunization rates were not available for SFY20 as of the time of this report.

TABLE 5: IMMUNIZATION COVERAGE

	SFY 17	SFY 18	Change from baseline	SFY 19 new baseline	Change from baseline	SFY 20
Immunization coverage among 19-35-month-olds	60%	65%*	4%	59%**	not comparable	N/A
Immunization coverage among 4-6-year-olds	45%	47%*	2%	43%**	not comparable	N/A

*Data points included in the 2018 Report to the Legislature.
** Changes were made in how population level data are compiled in the Immunization Information System (IIS). For more detail see the Technical Notes at this link: https://www.doh.wa.gov/Portals/1/Documents/Pubs/348-565-ImmunizationDataTechnicalNotes.pdf

Figure 19: Immunization indicators



*Total FPHS Appropriation

Note: SFY19 and subsequent immunization data not comparable to previous years due to change in reporting.

DETAILED DATA - IMPACT

GONORRHEA AND SYPHILIS CASE INVESTIGATIONS

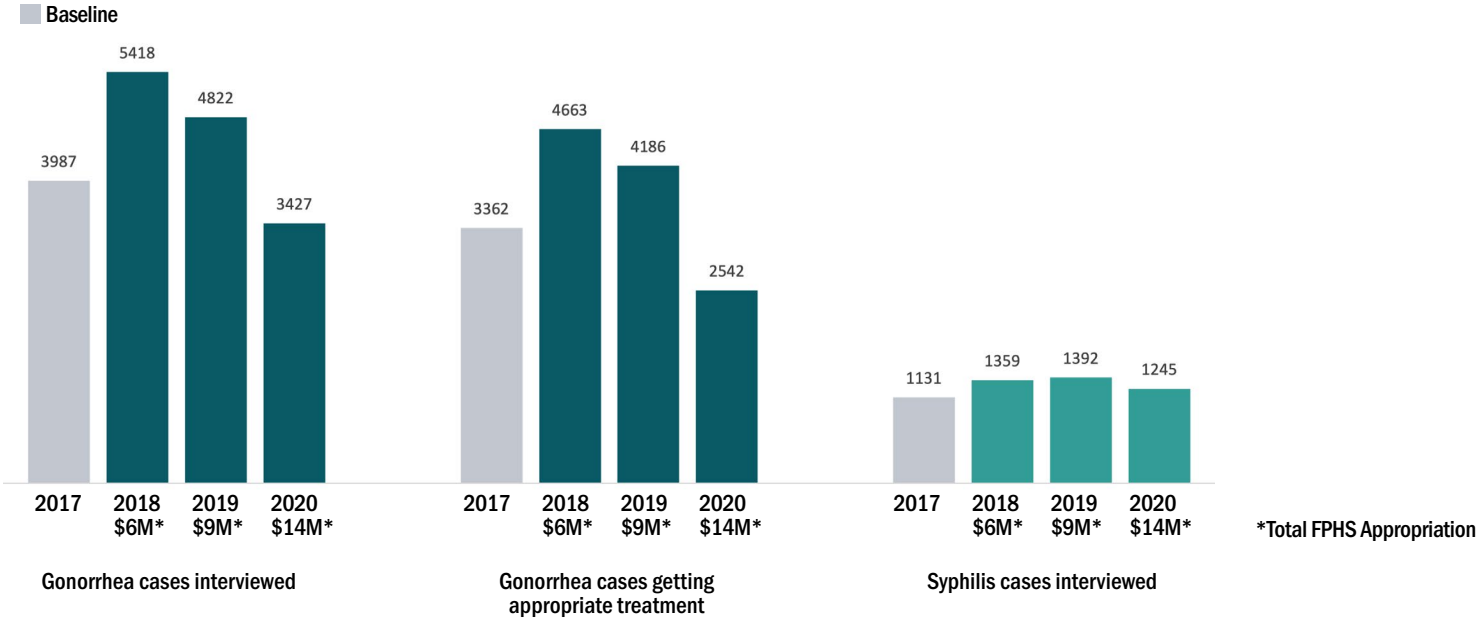
Comparing baseline to subsequent years:

- More gonorrhea cases were interviewed in the two years after baseline (SFY18 & 19) and fewer during the pandemic (SFY20). Corresponding changes are seen in the number of cases that were confirmed to be on dual treatment for gonorrhea using the appropriate two drug regimen.
- More syphilis cases were interviewed each year than during the baseline year.

TABLE 6: GONORRHEA & SYPHILIS CASE INVESTIGATION

		Initial one-time investment of $12M					2019-2021 Investment of $28M		
	SFY 17 baseline	SFY 18	Change from baseline	SFY 19	Change from previous year	Change from baseline	SFY 20	Change from previous year	Change from baseline
Gonorrhea cases interviewed									
Number	3987	5418	1431	4822	-586	835	3427	-1395	-560
Percent	46%	49%	3%	43%	-12%	-2%	30%	-30%	-16%
Gonorrhea cases interviewed that are getting appropriate treatment									
Number	3362	4663	1301	4186	-477	824	2542	-1644	-820
Percent	84%	86%	2%	87%	1%	2%	74%	-15%	-10%
Syphilis cases interviewed									
Number	1131	1359	228	1392	33	261	1245	-147	114
Percent	71%	73%	1%	67%	-8%	-5%	62%	-7%	-10%

Figure 20: Gonorrhea & syphilis case investigation



DETAILED DATA - IMPACT

HEPATITIS C CASE INVESTIGATION

Previously, data on disease investigation of Hepatitis C was not available due to outdated legacy data systems. State FPHS funds were used to develop and launch the Hepatitis C module in the statewide Washington Electronic Disease Reporting System (WDRS). This investment is making data available that will serve as a baseline for this measure beginning in SFY19.

The 2020 supplemental budget provided an additional $3 million for the biennium to begin addressing Hepatitis C using shared priorities, standardized surveillance methods, minimum standards of practice, common metrics and staffing models as developed by the FPHS Communicable Disease Subjective Matter Expert workgroup. These funds were allocated using a burden of disease model to the 17 LHJs that represent 90% of all Hepatitis C cases in the state for the following priorities:

- Surveillance – entering labs and acute cases into WDRS.
- Investigation – focus on acute cases: people aged 35 or younger, newly diagnosed, pregnant women, people seen in the Emergency Department or inpatient settings, Black, Indigenous and People of Color or other historically marginalized populations.

The funding allocation method used SFY19 Hepatitis C data and will be revised biennially, based on the most currently available data. Initial funding was distributed at the close of SFY20 so it is unlikely to have an impact on the SFY20 data and more likely to show up in SFY21.

Comparing the number of cases investigated at baseline to SFY20 for each of the three sub-categories of Hepatitis C shows fewer acute cases investigated and slightly more chronic cases investigated during the pandemic.

TABLE 7: HEPATITIS C CASE INVESTIGATION

		Initial one-time investment of $12M		*2019-2021 Investment of $22M*	
	SFY 17	*SFY 18*	*SFY 19 baseline*	*SFY 20*	*Change from baseline*
Acute Hepatitis C					
*Cases were reviewed by public health staff **	*N/A*	*N/A*	*98%*	*91%*	*-6.4%*
Cases with completed investigations	*N/A*	*N/A*	*65%*	*58%*	*-6.8%*
Chronic Hepatitis C					
*Cases were reviewed by public health staff **	*N/A*	*N/A*	*47%*	*56%*	*9.2%*
Cases with completed investigations	*N/A*	*N/A*	*2%*	*5%*	*2.7%*
Chronic Hepatitis C in people born in 1992 or after					
*Cases were reviewed by public health staff **	*N/A*	*N/A*	*60%*	*79%*	*19.3%*
Cases with completed investigations	*N/A*	*N/A*	*5%*	*10%*	*5.5%*

*Admin field complete

DETAILED DATA - IMPACT

Figure 21: Acute hepatitis C case investigations

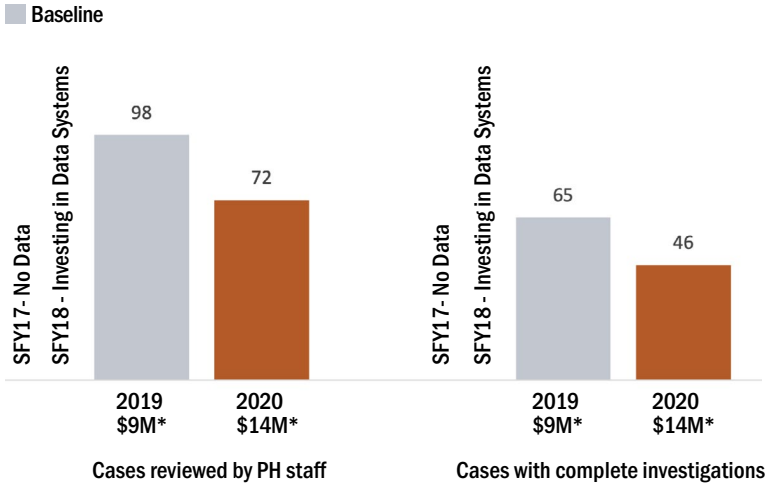


Figure 22: Chronic hepatitis C (born after 1992) case investigations

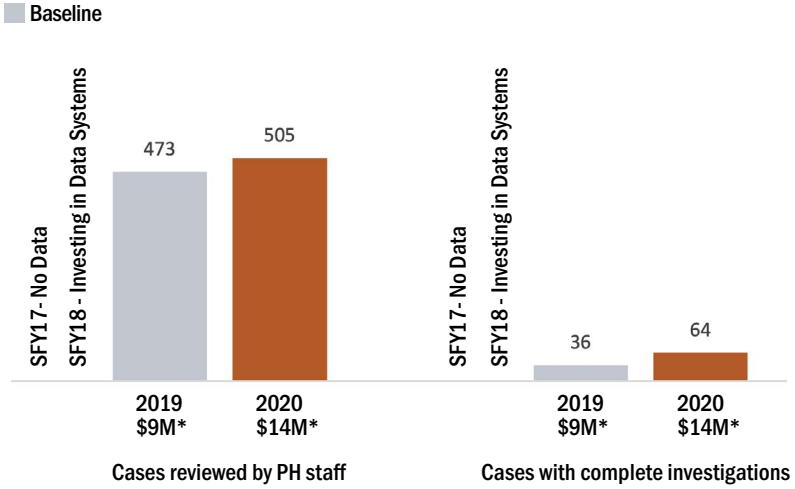
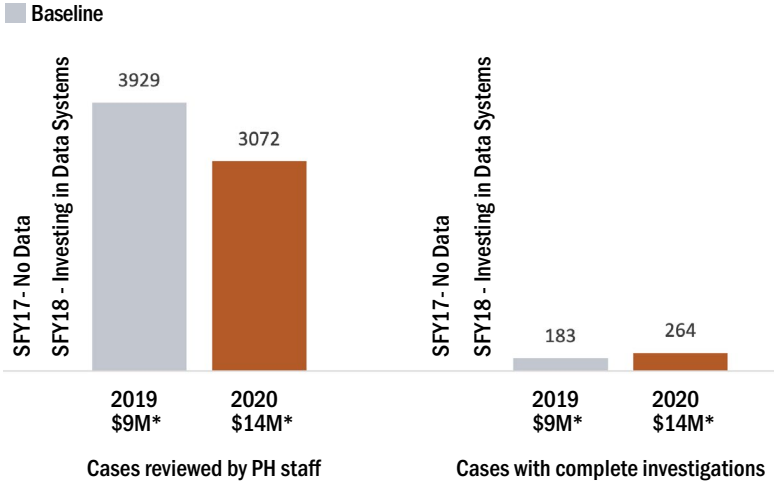


Figure 23: Chronic hepatitis C case investigations



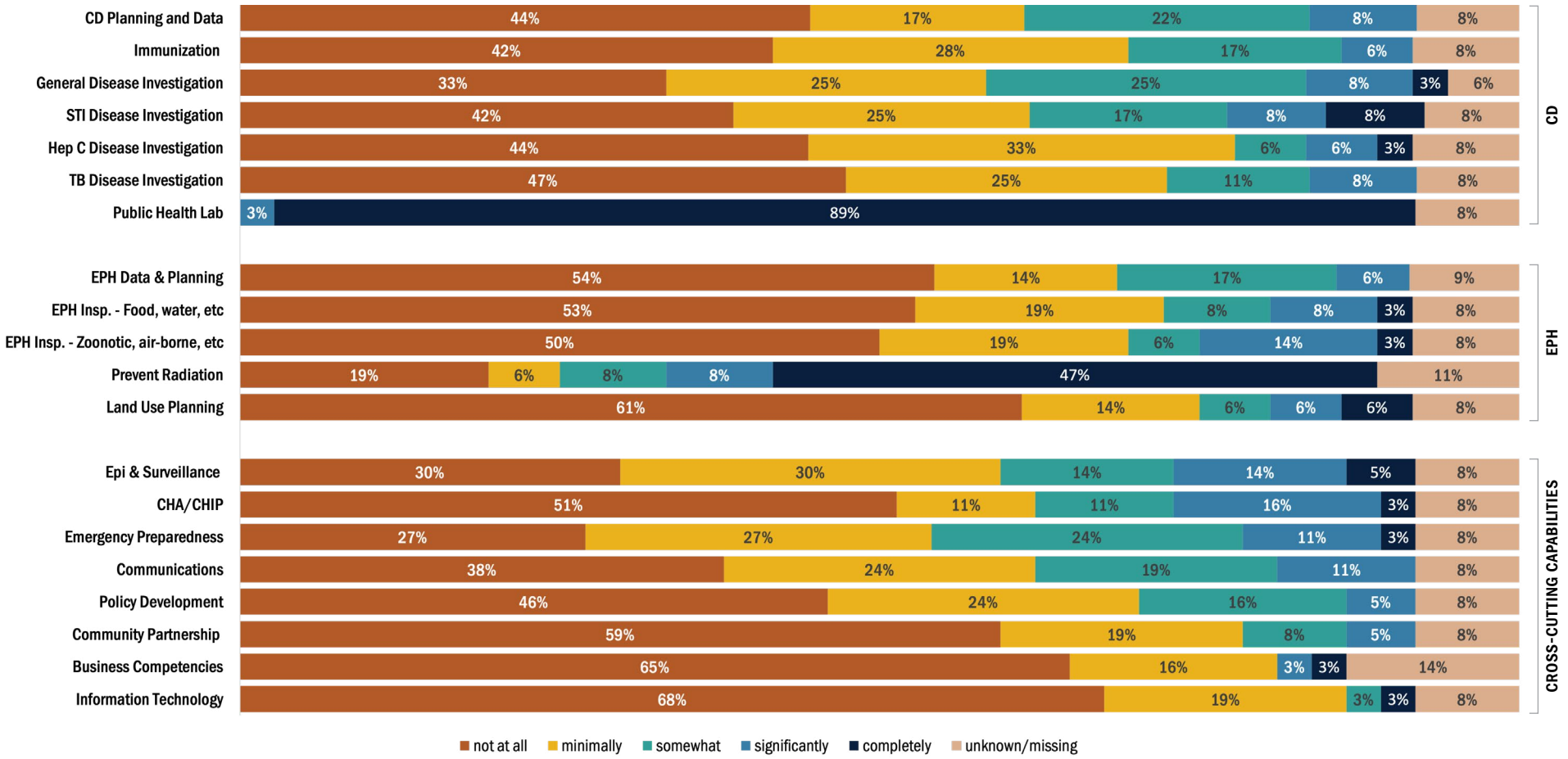
*Total FPHS Appropriation

DETAILED DATA - FUTURE SHARING

Agencies reported how much they currently share in the delivery of services with other agencies, their willingness to receive services from other agencies, and their willingness to provide services to other agencies. Analysis of sharing services includes data from LHJs, DOH, and SBOH. Across FPHS areas (minus centralized services), a third or more of agencies were not currently sharing services with other jurisdiction(s) at all (Figure 25). The FPHS definitions clearly indicate that public health lab and preventing radiation exposure are centralized services provided by the state. Among agencies who submitted reports, all reported significantly or completely sharing public health lab services. Over a third of respondents indicated they were somewhat, minimally, or not sharing services related to preventing radiation exposure services.

DETAILED DATA - FUTURE SHARING

Figure 24: Current level of sharing, SFY20

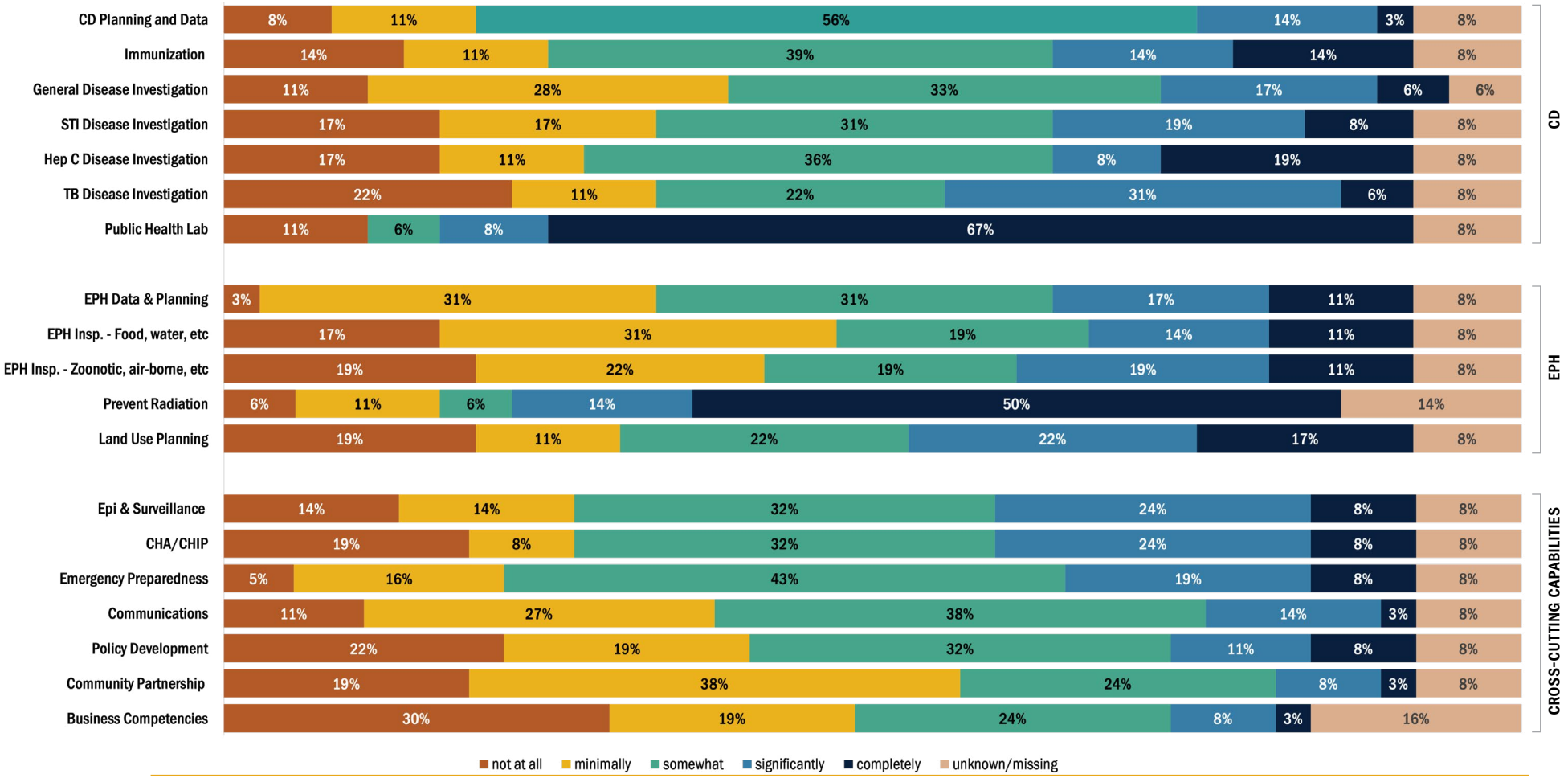


DETAILED DATA - FUTURE SHARING

Figures 25 and 26 display levels of interest in future sharing of FPHS services by agencies. Between 11%-39% of agencies were completely or significantly willing to receive services from other jurisdictions, and between 3%-30% were not at all willing to receive services from another jurisdiction.

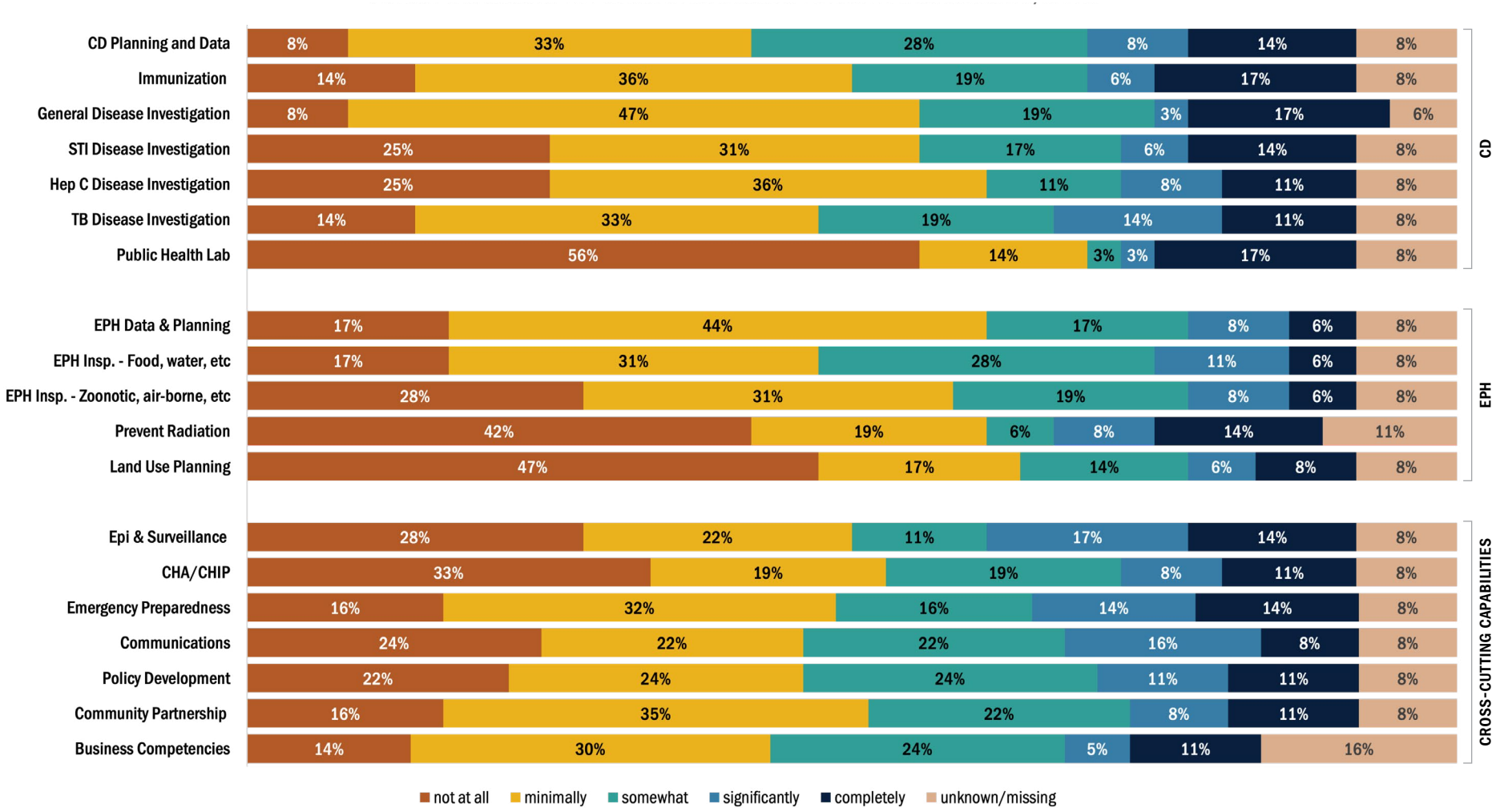
Depending on the FPHS area (excluding public health lab and preventing radiation), between 14%- 31% of agencies were completely or significantly willing to provide services to other jurisdictions, and between 8%-47% were not at all willing to provide services to other jurisdictions.

Figure 25: Future willingness to **receive** FPHS services from another jurisdiction, SFY20



DETAILED DATA - FUTURE SHARING

Figure 26: Future willingness to **provide** FPHS services to another jurisdiction, SFY 20



METHODOLOGY

Agencies receiving FPHS funding are required to submit annual reports describing how they invested the dollars they received, their level of capacity and expertise for delivery of FPHS, and their level of current sharing in the delivery of services and interest in sharing in the delivery of services in the future.

GUIDING QUESTIONS

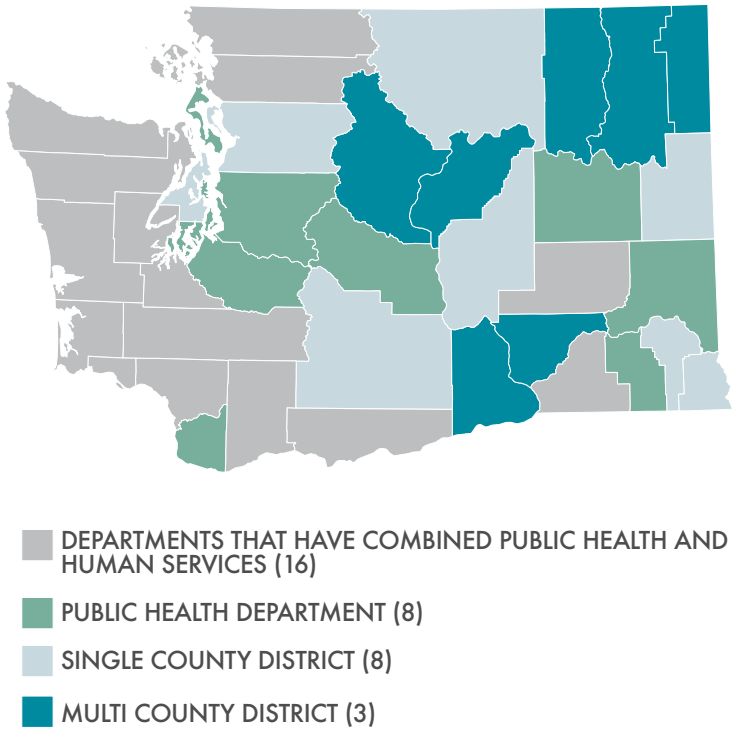
There are two essential questions guiding the FPHS SFY20 annual report analysis:

- To what degree are communicable disease services, environmental public health services and cross-cutting capabilities currently implemented across the state?
- How has dedicated funding impacted implementation of FPHS? (comparing SFY20 to baseline)

DATA COLLECTION

Reports were received from 33 out of 35 LHJs, DOH and SBOH. Submitting annual reports to DOH was a condition of receiving SFY21 FPHS funding. Not all LHJs submitted reports, and not all LHJs submitted reports with complete data by the deadline for inclusion in data analysis. Due to the extenuating circumstances of COVID-19 and all resources being directed to the pandemic response, incomplete reports were accepted and analyzed. Additionally, for the first time this year, jurisdictions were able to select "Unknown" as a response option. This data has been combined with missing or incomplete data to make up the “Missing/Unknown” category.

Figure 27: Washington State Local Health Jurisdictions



METHODOLOGY

ANALYTICAL APPROACH

The primary approach to the SFY20 report data is descriptive, addressing:

- How funds were invested
- To what degree the FPHS areas of prevention and control of communicable disease and other notifiable conditions were implemented (calculated measure based on self-assessed capacity & expertise)
  - CD data & planning
  - Promote immunizations
  - Disease investigation:
    - General communicable disease
    - Syphilis, gonorrhea and HIV (shortened to STI in some figures)
    - Hepatitis C (shortened to Hep C in some figures)
    - Tuberculosis (TB)
  - Public health lab
- To what degree the FPHS areas of environmental public health were implemented (calculated measure based on self-assessed capacity and expertise)
  - EPH data & planning
  - EPH inspections
    - Food, water, waste, lead
    - Zoonotic, air-borne, wildfire, other
  - Prevent radiation exposure
  - Land use planning & sustainability
- To what degree the FPHS cross-cutting capabilities were implemented (calculated measure based on self-assessed capacity and expertise)
  - Epidemiology & surveillance
  - Community health assessment & improvement plan
  - Emergency preparedness
  - Communications
  - Policy development
  - Community partnership development
  - Business competencies
  - Information technology
- The level of current sharing in the delivery of services
- The level of interest to provide services to or receive services from other jurisdictions
- Themes and important narratives related to changes in the delivery of and access to FPHS services
- Themes and important narratives related to the response to COVID-19
- Comparative analysis on the level of implementation from baseline to SFY20

2. Washington State Department of Health. FPHS Functional Definitions Manual. Retrieved from: https://www.doh.wa.gov/Portals/1/Documents/1200/WA%20FPHS%20Functional%20Definitions%20Manual%2011-17.pdf

APPENDIX

APPENDIX A

QUALITATIVE DATA ANALYSIS

Agencies reported on four open-ended questions: "In the LAST year, what has changed in the capacity, expertise or structure of how FPHS are delivered in your jurisdiction?," "In the LAST year, what has changed for the people of your jurisdiction about the FPHS available to them?," "Please give examples of how past FPHS investments impacted your jurisdiction's ability to respond to COVID-19 including how that investment was used or was of benefit in the COVID-19 response.," and "Please give examples of any new ways FPHS services were delivered during the COVID-19 response that were an improvement over the old way and describe why it was an improvement." Using Dedoose software, Rede staff identified codes and looked for common themes in the responses.

The tables below include the responses to these four questions. Questions 1 and 2 have been combined for analysis due to the overlap and similarities in response.

TABLE 8: RESPONSES TO "IN THE LAST YEAR, WHAT HAS CHANGED IN THE CAPACITY, EXPERTISE OR STRUCTURE OF HOW FPHS ARE DELIVERED IN YOUR JURISDICTION?" AND "IN THE LAST YEAR, WHAT HAS CHANGED FOR THE PEOPLE OF YOUR JURISDICTION ABOUT THE FPHS AVAILABLE TO THEM?" COMBINED AND GROUPED BY THEME.

Theme	*Agency*	*Response to question:*
Staffing	*Asotin*	*After a year of trying, unable to recruit Env Health Specialist, resolved to hiring Environmental & Public Health Assistant who is being trained in EH duties.*
	Clallam	*Due to Covid-19, staff restructuring, hiring additional case managers/contact tracing support.*
	Clark	*This funding has allowed us to maintain our increased Infectious Disease epidemiology capacity established through the first round of funds.*
	Columbia	*Change in staffing and training in FPHS coding and time allocation*
	Garfield	*More training to staff about FPHS and coding training.*
	Grays Harbor	*Our capacity to investigate and control communicable disease has increased from 0.7 FTE to 7 FTE. This has included both new hires and the reassignment of duties for existing employees*
	Kitsap	*During July 2019-June 2020, KPHD maintained a staffed Communicable Disease program and refilled 2 Epi positions due to turnover.*

APPENDIX A

	Klickitat	*There have been a lot of leadership changes and flux during this time period. In this time we have had a director leave, an interim director and have hired a new director*
	Lewis	*With our one long term Communicable Disease Nurse retiring at the end of 2020, we have added another CD nurse to our team and been able to assure 5 months of overlap training time. Similarly we have begun training another team member in communications.*
	Lincoln	*It has also allowed us to share expertise in communicable disease investigations and response through trainings provided by SRHD as well as cross jurisdictional sharing of SRHD staff in support of our work*
	Mason	*We have increased staffing in response to COVID 19*
	Pacific	*We were able to pay the additional cost for a regional Health officer through this funding.*
	SBOH	*The Board received continued funding for a .6 FTE to complete health impact reviews, and new funding for 1 FTE policy advisor and modest increase for Assistant Attorney General expenses.*
	Seattle-King	*FPHS funding in 2019 allowed us to hire permanent staff: 8.5 FTEs for our Communicable Disease team; 1.5 FTEs for our Sexual Health Clinic team. These staff have increased the stability of our disease investigation teams. Prior to receiving this funding, we often relied on a patchwork of short-term temporary employees to fill gaps in our capacity to provide FPHS. One of the added positions expanded our in-house expertise in addressing zoonotic diseases. The funding also bolstered our cross-cutting capabilities by adding a program manager within our Emergency Preparedness program and a communications specialist dedicated to communicable disease. These positions played a key role in addressing a hepatitis A outbreak among people living homeless, which required activating an incident command structure to organize and coordinate response activities and communicate key messages to impacted communities.*
	Skamania	*We had a change in structure, removing a nurse manager position and shifting the administrative work to our contracted ARNP & and administrative assistant. Clinic work previously done by the nurse manager is now being done by the contracted ARNP & Full time RN*
	Snohomish	*We have a full time public health nurse in our childcare health outreach program that is helping to support childcare facilities that experience disease outbreaks*

APPENDIX A

	Spokane	*The additional hepatitis C funds allowed us to hire 1.0 FTE and begin working closer with those who need treatment. We have been minimally working on hepatitis C cases in the past.*
	Tacoma-Pierce	*We have maintained capacity previously added through FPHS funding. This includes a dedicated communicable disease epidemiologist and hepatitis coordinator.*
	Walla Walla	*We now have a full time Preparedness Coordinator, Communications Coordinator and Epidemiologist, who all started in April 2020 and were billed to CARES, however, in the future this will go to FPHS funding. Also, we have added a Disease Investigator who works with our Community Health Nurse and will come out of FPHS.*
	Whitman	*Increased 1 FTE, have had the capacity to deliver services to where the residents are*
Improved disease response	*Benton-Franklin*	*BFHD has improved our ability to assemble, activate and operate under an ICS structure for outbreak investigation. This has included the assembly of teams from Emergency Preparedness, Communicable Disease, Environmental Health, Performance Management and Public Information. This team in various forms have successfully investigated and implemented interventions for Norovirus, Hepatitis A, and most currently COVID-19. The utilization of ICS even with small outbreaks has improved the depth of our team, fostered working relationships and taken advantage of the wide range of skill sets within the agency.* *BFHD has also improved the ability to respond, track and work through Hep C cases to ensure that STI data is managed quickly.*
	Clark	*We have seen improvements in ability to support local surveillance efforts, improve data management for infectious disease at the local level and improve outbreak response protocols. Continued support from FPHS funding allows CCPH to provide essential FPHS services within the Infectious Disease program.*
	Cowlitz	*FPHS investments have also helped us expand and improve our case work with index STD cases and their partners.*
	DOH	*More cases were investigated and contacts traced, provided care coordination*
	Jefferson	*We continue to respond to infectious disease reports amid our COVID-19 response.*
	Kitsap	*We received an increase in funding which we were able to allocate to Assessment/Epidemiology to expand our CD/STI surveillance, evaluation and data reporting.*

APPENDIX A

	Mason	*Response to COVID has exercised and sharpened the skills of staff in case investigation, tracing, disease response and management.*
	Okanogan	*We have utilized a covid contact tracing program for hospital and clinic labs to enter data*
	San Juan	*The biggest change has been in our staff capacity beyond responding to COVID-19. The majority of our staff are assisting in our ongoing response, leaving less staff capacity for other foundational programs. Thus, the majority of funding is going to both Disease Investigation - General CD and Emergency Response. The increased emphasis on the Emergency Response and Disease Investigation will build our staff capacity and expertise in both of these foundational areas.*
	Seattle-King	*cross-trained staff on isolation and quarantine to ensure people living homeless who were infectious with hepatitis A could safely isolate*
	Snohomish	*Prior to COVID we had started offering STD testing at a community court in Edmonds and we had been exploring offering court ordered HIV testing at the Lynnwood jail.* *We continue to be able to provide Hep C testing at the syringe exchange and are exploring other areas where we can outreach to vulnerable populations who may not have access to testing.*
	Spokane	*67 syphilis cases completed with treatment; 12 hepatitis C cases investigated and offered treatment*
	Tacoma-Pierce	*Maintained enhanced capacity to support investigations into vaccine preventable disease outbreaks such as measles.*
	Thurston	*Cross training Departments staff in case investigation follow-up and outbreak response has resulted in an ability to respond more expediently to outbreaks and put prevention and intervention steps in place earlier to reduce potential morbidity and mortality.*
	Whitman	*We have been more proficient at keeping up with CD reporting, primarily gonorrhea and chlamydia.*
	Yakima	*The Needle exchange program was able to gain additional resources to provide better services at the exchange site.*
Communications	*Clark*	*Increased Epi support has also allowed an increase in data product availability shared with community partners.*
	Jefferson	*A strong program of messaging for COVID-19, immunizations on both our website and on social media has been possible because of FPHS*

APPENDIX A

	Lewis	*Our past investments in communications played a significant role in our ability to respond to COVID-19. We were able to quickly stand up a social media profile, maintain professional daily case updates, and develop materials for a demanding public. While the messages that we were delivering were not always popular, our professional appearance and delivery helped to provide validity to our message.*
	Mason	*The outreach to the public around disease intervention has multiplied in both volume and sophistication in three languages in both electronic and in-person communication.*
	NE Tri-County	*Improvements to website and social media information sharing, enhanced coordination with local partners that results in better delivery of services to the public*
	Okanogan	*Will be able to find inspection reports, septic information [online]*
	San Juan	*We have dedicated staff to function as "liaisons" to a variety of business and organizations. We schedule and hold "COVID-19 partner" calls with these organizations to disseminate information and answer questions. All of these efforts are reinforcing our role as a trusted source for public health information in the community.*
	Thurston	*Technology improvements have provided us with mechanisms to more inclusively engage public health partners, stakeholders and county residents and provide them with information that is critical to the public's health.*
Support COVID response	*Jefferson*	*COVID-19 funding together with the increased FPHS (an additional $58,000) enabled us to move some FPHS funding to other capabilities. Communication has almost no funding yet is a critical component of our COVID-19 response. We put funding there.*
	Pacific	*We were able to support a FTE to support Contact tracing for COVID and hope to continue this FTE in the future for all CD work in our county.*
	Seattle-King	*The FPHS Emergency Preparedness program manager supported the section in creating incident action plans, identifying resource gaps and needs, and used lessons learned and corrective action items identified in the After-Action Report to improve coordination and response. FPHS also supported ongoing capacity building within the department's infectious disease emergency response team, which proved critical for surge staff during COVID-19 response.*

APPENDIX A

	Thurston	*In March 2020 as we hired a long vacant Community Health Nurse position in our Disease Control and Prevention Division Covid-19 hit derailing regular Foundational Public Health Services activities and moving us into an Incident Command Structure involving many Department staff. We shifted staff resources pre receipt of state and federal funding resources designated for COVID response, from Environmental Health, Emergency Preparedness, Maternal Child Health/Nurse Family Partnership, and Administration to COVID activities arguably Foundational Public Health Activities. Staff were temporarily assigned to positions in the Department Incident Management Team to provide oversight and management for the incident including communication and the Disease Control and Prevention Division where staff were trained to investigate and follow-up reported COVID cases contacts.*
	Walla Walla	*Walla Walla has been successful in adding capacity in the areas of Communicable Disease and Epidemiology in 2020, this is largely in response to COVID-19, but has benefited our overall capacity for the future.*
	Whatcom	*WCHD built additional cross-cutting capabilities related to emergency response, communications, data systems and data management, business competencies needed to respond to COVID.*
Community Outreach	*Garfield*	*Increased community outreach and school outreach.*
	Pacific	*We have continued to expand the community partners we interact with in a variety of ways*
	San Juan	*We continue to strengthen our Community partnerships even thru the COVID-19 response. We have dedicated staff to function as "liaisons" to a variety of business and organizations.*
	Seattle-King	*We continued to build relationships with community partners to promote access to resources and support for disease outbreak*
	Skamania	*We transitioned an LPN that was working primarily in the Behavioural Health program to spending more time in FPHS and Maternal Child Health. Increasing the community outreach and partnership development work being done within the community*
LHJ responsiveness	*Benton-Franklin*	*In addition to improving the speed of our response though the use of ICS a new reporting portal has been established on the District website easing the barriers to reporting illness and other issues for the members of the public. Involving multi-disciplinary skills in response and the delivery of FPHS services improves the speed and responsiveness of the agency.*
	Gray Harbor	*The increased number of public health professionals trained and experienced in communicable disease investigation and control and in functioning*

APPENDIX A

		as part of a multi-agency incident management team provides the people of Grays Harbor County with the assurance of more capacity to respond to a communicable disease emergency.
	Lincoln	*Lincoln County residents have been provided with health department staff that are more competent in assessment practices, data evaluations and communicable disease expertise.*
	Snohomish	*FPHS funding allowed us to respond to COVID a bit quicker since we had staff that we could surge around.*
	Thurston	*An enhanced duty officer system has allowed us to respond more quickly to emergencies and immediately notifiable conditions.*
Increased Immunizations	*Jefferson*	*We continue to promote immunizations to improve vaccination rates. COVID-19 has presented a special challenge since kids were not in school and only some are in school now so we are working with Jefferson Healthcare to increase access to children's vaccines. We also will have a flu vaccine campaign and we are talking and planning for all vaccines, including COVID-19 when it becomes available.*
	Seattle-King	*collaborated with a community health clinic to co-lead a childhood immunizations clinic in January 2020*
	Spokane	*Hep A vaccines given: over 2,600, childhood vaccines: 700 vaccines to 430 children, preschool immunization work included: shared the Childcare Imms Record Management Toolkit to childcare sites in support of their requirement to maintain and update immunization record*
	Whitman	*We have been able to provide vaccinations in rural communities that do not have those services in them.*
CHA/CHIP	*Garfield*	*Increased work on community assessment and community health improvement plan*
	Lincoln	*This has allowed us to conduct a community health assessment and community health improvement plan.*
	Pacific	*We were able to complete a CHA and develop a CHIP for the county, working with many of the necessary partners in the county. Along with this effort we created a Health Advisory Subcommittee under the Health & Human Services Advisory Board. This gives us the opportunity to discuss the CHIP and use the community to create improvements in the county's health.*
Regional collaboration	*Lincoln*	*The biggest change was the ability to work with Spokane Regional Health District, Northeast Tricounty Health District, Adams, Whitman and Asotin on a cross jurisdictional sharing model to utilize assessment and communicable disease expertise of SRHD.*

APPENDIX A

	Thurston	*Public Health partners from DOH, counties across Western Washington (Mason, Clark and King), and a former Health Officer stepped in to fill the Health Officer void and contribute to shared services.*
Data management/ Surveillance	*Clark*	*We have seen improvements in ability to support local surveillance efforts, improve data management for infectious disease at the local level and improve outbreak response protocols.*
	Okanogan	*Used FPHS funds to work with software developer for EH and Covid-19 disease surveillance and contact tracing program*
EPH Services	*Cowlitz*	*During this period, our Environmental Health Staff began reviewing and prioritizing inspection items listed in the DOH/OSPI K-12 Health and Safety Guide. We began development of a list of priority items which will be the foundation of an inspection checklist. The checklist will be used to guide staff through routine inspections and will encompass different types of schools/programs. We have also spent time planning how we would roll out the program to school staff which will include forming an ad-hoc committee with the school districts, where we will preview the checklist, ask for feedback and discuss frequency of inspections. Most of the work was planned to begin in the spring but was put on hold due to COVID-19 and the reallocation of staff resources. The project has remained on hold while schools restructure and utilize distance learning. We anticipate with all these changes it will be several months before we will be able to form the Ad-Hoc Committee. Staff have also attended laboratory safety training to prepare for school chemistry lab inspections.*
	NE Tri-County	*better ability to respond to environmental health related complaints*
Other	*DOH*	*DOH provided more centralized services and capacity for the system in data systems, policy development, case investigation and contact tracing, care coordination, laboratory capacity.*
	NE Tri-County	*FPHS were used to ensure NETCHD had capacity and expertise in key areas of business competencies, technology, and environmental health services that would not have been possible without these essential allocations.*

APPENDIX A

	SBOH	*During FY2020, the Board completed 15 HIRs, two more than what was completed in FY2018 (the last short Legislative Session). This is more than double the number of HIRs completed in 2016 (7 HIRs). Health Impact Review capacity helps ensure that health and equity are considered during policy and budget decision-making. This FTE has also assisted in increasing much needed research and policy development capacity for the Board and the Governor's Interagency Council on Health Disparities. For example, prior to the start of the 2020 Legislative Session, staff completed a HIR on HB 1932, Concerning vapor products. The research, analysis, and findings of this HIR were presented to the Board of Health to inform them of emergency rule-making related to E-cigarette or Vaping Product Use-Associated Lung Injury. The 0.6 FTE worked on this analysis, and presented the findings to the Board.* *In follow up surveys and meetings with requesters, one hundred percent have stated that Health Impact Reviews are an important tool to inform legislative decision-making. Requesters stated that HIRs provide important information to talk with other legislators, provide unbiased data and information, and give weight and credibility to bills and their work. Health Impact Reviews are frequently referenced in bill reports, mentioned in bill briefings by committee staff, cited by legislators during public hearings, and asked about during hearings.* *In the 2019 biennial budget, the Board received funding to hire 1 FTE to increase our policy development capacity, and a modest increase of funds to cover Assistant Attorney General costs. The additional policy capacity provided much needed support for the Board's work to adopt rules for the Handling of Human Remains as a result of ESSB 5001 Concerning human remains (Chapter 432, Laws of 2019), and initiate rulemaking to update the state Communicable Disease rules as required by ESHB 1551 Communicable Disease Control (Chapter 76, Laws of 2020) and update the state's Notifiable Conditions rules. During 2019, the Board utilized the increased AAG services to support the Board's flavored vapor products ban, and advise on issues such as disease control and surveillance, PFAS, and virtual open public meetings.*
No change	*Adams*	*Minimal changes; no staff or policy changes during this time*
	Chelan-Davis	*No change*

APPENDIX A

TABLE 9: RESPONSES TO "PLEASE GIVE EXAMPLES OF HOW PAST FPHS INVESTMENTS IMPACTED YOUR JURISDICTIONS ABILITY TO RESPOND TO COVID-19 INCLUDING HOW THAT INVESTMENT WAS USED OR WAS OF BENEFIT IN THE COVID-19 RESPONSE." GROUPED BY THEME.

Theme	*Agency*	*Response to question:*
Staff	*Benton-Franklin*	*One of the first actions BFHD took with FPHS dollars was the creation of an Epidemiologist position within the department. This skill set has been invaluable from the analysis of data to the setup of an early RedCap database to manage cases during this outbreak. This effort has continued as the response changes in an effort to track multiple efforts from investigation, notification and care coordination processes.*
	Clallam	*Hired RN that was able to proceed in meeting COVID needs as well the hiring of case managers and contact tracers to assist with the monitoring of COVID cases.*
	Clark	*Having increased Epi capacity allowed us to quickly develop and implement new investigation protocols and a COVID specific data management system. FPHS funds were also used to support costs for staff responding to this pandemic.*
	DOH	*Laboratory staff funded for routine conditions were able to pivot to COVID testing.*
	Grays Harbor	*Previous FPHS allocations have been used to support communicable disease investigation activities. This provided experienced staff to lead newer investigators as we scaled up our capacity to respond to COVID*
	Kitsap	*We had seasoned disease investigators trained and experienced in standard methods and systems.*
	Kittitas	*Our only public health nurse is retiring and clinic services have declined (including the revenue generated by clinic fees), but FPHS funding allows us to bring on a new PH Nurse (at lower FTE) so that we can continue to have medical expertise associated with CD investigation.*
	Mason	*Disease investigation and shellfish protection have been our major past investments. Disease investigation certainly helped in providing experience to three staff over the previous single staff member.*
	San Juan	*Staffing, enhancing our communications and building community partnerships. The past FPHS investments have enabled our Department to restructure and enhance our outreach/community partnership efforts. As a result, we had staffing in place to quickly respond to COVID-19.*

APPENDIX A

	SBOH	*The State Board of Health has a small office (10 staff). During COVID-19, one of our team members was activated full time for approximately 3.5 months, another staff person has provided additional support periodically on an as needed basis. Both supported the community outreach and engagement efforts of Joint Incident Command.*
	Seattle-King	*During the initial stage of the response, we were able to rapidly mobilize surge staff from the infectious disease emergency response team to assist with disease investigation, contact tracing, data entry, and isolation and quarantine of people under investigation (PUIs). The FPHS investment into building and training an Infectious Disease Response Team provided critical capacity to respond to a dynamic situation. FPHS investments in permanent staff members within our Communicable Disease and Sexual Health Clinic programs gave us a larger pool of staff to deploy to the COVID-19 response work while maintaining other communicable disease investigation work in the beginning of the pandemic.*
	Skagit	*Stable FPHS funding allows us to maintain a stable, trained staff. We made use of our entire public health staff in our response. We pulled in most EH and CD and CHW immediately and it was critical to our response.*
	Snohomish	*FPHS investments had allowed us to have enough staff to meet the needs of our community pre-covid. When COVID arrived we were able to be a bit more nimble with our staffing to accommodate the increase in workload until we were able to hire more people.*
	Spokane	*We reassigned 3 FPHS funded staff (STD investigator, immunization outreach coordinator, and hepatitis C coordinator) to COVID response starting in March 2020. They have been conducting case investigations, contact notifications, business consultations, and coordinating community testing.*
	Tacoma-Pierce	*Investment in an FPHS funded dedicated communicable disease epidemiologist greatly enhanced our ability to quickly respond to the COVID19 pandemic and helped bridge the gap before additional federal funding became available. The epidemiologist was helpful in supporting planning by providing accurate and timely data describing the populations disproportionately impacted by the pandemic.*
	Wahkiakum	*By providing some stability in funding we had more staffing then we might have had otherwise.*
	Walla Walla	*have ongoing funding support of FPHS, it was easier to get permanent positions approved for COVID-19 response. Without this funding we could not have full time Preparedness, Communications, or Epi support.*
	Whatcom	*Past FPHS investments have increased availability of trained communicable disease staff who were able to immediately contribute to the COVID-19 response.*
	Whitman	*Past FPHS funding allowed us to expand our staffing allowing us greater capacity to respond to any contingency*

APPENDIX A

Increased capacity for disease response	*Cowlitz*	*Past FPHS investments improved our jurisdications capacity and expertise related to communicable disease case and contact investigations which was of benefit in our COVID-19 response.*
	Grays Harbor	*Previous FPHS allocations have been used to support communicable disease investigation activities. This provided experienced staff to lead newer investigators as we scaled up our capacity to respond to COVID*
	Kitsap	*We had seasoned disease investigators trained and experienced in standard methods and systems.*
	Mason	*Disease investigation and shellfish protection have been our major past investments. Disease investigation certainly helped in providing experience to three staff over the previous single staff member.*
	Okanogan	*Hospitals and clinics enter contact information for positive covid clients which allows us to respond quickly to meet the DOH timelines*
	San Juan	*We have responded to several communicable disease outbreaks over the past 6-years. As a result, we have had a framework (investigation, contact tracing, isolation/quarantine, communications and partnership development) in place to successfully respond.*
	Seattle-King	*During the initial stage of the response, we were able to rapidly mobilize surge staff from the infectious disease emergency response team to assist with disease investigation, contact tracing, data entry, and isolation and quarantine of people under investigation (PUIs). The FPHS investment into building and training an Infectious Disease Response Team provided critical capacity to respond to a dynamic situation. FPHS investments in permanent staff members within our Communicable Disease and Sexual Health Clinic programs gave us a larger pool of staff to deploy to the COVID-19 response work while maintaining other communicable disease investigation work in the beginning of the pandemic.*
	Thurston	*Thurston County Public Health Emergency Preparedness and Response Program, CDC Public Health Law Program and Thurston County Prosecuting Attorney's Office partnered to sponsor a 7-hour Public Health Emergency Law Training for Thurston County Departments, neighboring LHJs, and other community partner organizations. The training introduced attendees to key statutes, regulations, and legal principles critical to emergency planning and response. Understanding the legal elements of a pandemic have proven critical in the department's ability to effectively respond to COVID -19 particularly around isolation and quarantine.* *Cross division staff training offered by Disease Control and Prevention staff and held in 2018-2019 to train staff to investigate and follow up notifiable condition reports and respond to outbreaks proved an invaluable headstart to COVID-19 response as staff had been introduced to the basic concepts and principles of response.*

APPENDIX A

Infrastructure (IT, phone, data management, etc.)	*Clark*	*Having increased Epi capacity allowed us to quickly develop and implement new investigation protocols and a COVID specific data management system.*
	Columbia	*FPHS services were critical to allow for business competencies and communication and community outreach.*
	DOH	*FPHS funds were invested in the development of new data system modules that enabled Washington to being COVID data collection immediately at the beginning of the pandemic; investments in laboratory equipment intended for Hepatitis C could be used for COVID testing;*
	Grays Harbor	*We also invested in new accounting software, which supports our ability to analyze the costs of response in real-time.*
	Lincoln	*We have also seen advancements and improvements in public health infrastructure such as phone and computer systems to support public health that would not have been achieved without FPHS funding*
	Wahkiakum	*We also used some of those funds for infrastructure which allowed us to be able to move into effective distance work where possible.*
Flexibility	*Asotin*	*Allowed flexibility to shift attention to pandemic duties and responsibilities immediately and as needed.*
	Chelan-Douglas	*Since FPHS has flexibility, we were able to commit those funds to COVID-19 response when we did not have any other funding source. Now that other funding sources are available, being able to move FPHS funding to support other programs as needed has been crucial to sustain "normal" service operations/staffing.*
	Clark	*Having increased Epi capacity allowed us to quickly develop and implement new investigation protocols and a COVID specific data management system. FPHS funds were also used to support costs for staff responding to this pandemic.*
	Jefferson	*Having funding in capabilities as well as CD & Immz. provided flexibility to respond more effectively to COVID-19 & to ensure effective communication with our residents & partners..*
	Seattle-King	*During the initial stage of the response, we were able to rapidly mobilize surge staff from the infectious disease emergency response team to assist with disease investigation, contact tracing, data entry, and isolation and quarantine of people under investigation (PUIs). The FPHS investment into building and training an Infectious Disease Response Team provided critical capacity to respond to a dynamic situation. FPHS investments in permanent staff members within our Communicable Disease and Sexual Health Clinic programs gave us a larger pool of staff to deploy to the COVID-19 response work while maintaining other communicable disease investigation work in the beginning of the pandemic.*

APPENDIX A

	Yakima	*We are currently making an effort to use FPHS funds where they were intended at the beginning of the year. We are currently trying to fund COVID 19 responses through other DOH grants. However, it is comforting to have flexibility within the FPHS program to pivot and use those funds to fight COVID, if needed.*
Communication & Partnership	*Columbia*	*FPHS services were critical to allow for business competencies and communications and community outreach*
	Garfield	*Community partnerships and communications that FPHS funding allowed to build community collaboration needed immediately with COVID-19 response*
	NE Tri-County	*Improved presence in social media and information sharing with dedicated staff time to keep information current*
	Thurston	*Epidemiology Assessment, and TCPHEPR staff convened a Department committee to work on a Limited English Proficiency (LEP) Project and plan to assist the Department in effectively serving those who speak a language other than English, by ensuring systems are in place to provide timely and meaningful access to interpretation and translation services at no cost to those we serve. The plan and project include:* ● *A pilot to encourage staff who speak a language other than English to be certified as an interpreter and/or translator to provide interpretation or translation services to customers.* ● *The plan supports staff training on linguistic and cultural competence, meaningful access to language services, best practices for providing information to audiences with limited English proficiency and emerging language access issues all critical to reaching all populations during an emergency.*
Immunizations	*Pacific*	*Mass vaccination plans, along with working on an MOU with one of our community health partners to provide mass vaccinations within their health care system. We also signed the pharmacy MOU with the State.*
	Spokane	*The immunization coordinator has begun preparing for potential COVID-19 vaccine distribution*
None	*Adams*	*Our agency didn't use FPHS dollars for COVID-19 response*
	Skamania	*FPHS didn't affect our ability to respond to COVID-19. COVID-19 response took away from the ability of our agency to do some of the work we have planned with FPHS funds.*

APPENDIX A

TABLE 10: RESPONSES TO "PLEASE GIVE EXAMPLES OF ANY NEW WAYS FPHS SERVICES WERE DELIVERED DURING THE COVID-19 RESPONSE THAT WERE AN IMPROVEMENT OVER THE OLD WAY AND DESCRIBE WHY IT WAS AN IMPROVEMENT." GROUPED BY THEME.

Theme	*Agency*	*Response to question:*
Disease Investigation	*Tacoma-Pierce*	*We have also designated a separate group under our investigation unit to work with facilities such as long term care facilities. This has allowed for enhanced expertise and fewer points of contact.*
Partnerships/ collaboration (internal & external)	*Benton-Franklin*	*In the entire response to COVID-19 BFHD has activated emergency operations early, realigned the functions of staff to focus skill and staffing where needed during particular phases of the pandemic. Staff from all areas of the department have taken on new tasks, implemented new functions and yet continued to operate required services at least a basic level. The experience gained from operating in an ICS structure made adaptations to this large and lengthy operation significantly easier on staff as they had beyond training but experience in stepping out of their normal job duties. In the past many services, departments and functions within the agency were not linked by a common function by practicing, responding and working together with the expansion of FPHS services silos have been removed and the agency is better equipped to respond to a variety of ever shifting challenges.*
	Cowlitz	*During COVID-19 response, FPHS services were delivered by redeploying staff between programs to create surge capacity*
	Garfield	*Involving multiple agencies ie Healthcare, Mental health, emergency mgmt, Emergency services, Public health, hospital, clinic, library, transportation, and govt in bi-weekly meetings defining COVID19 needs and gaps within the community.*
	Lincoln	*FPHS supported the development of cross jurisdictional models allowing higher trained staff from other jurisdictions to support our staff in our activities and community response.*
	Pacific	*Having signed a contract with Clark County in January for a regional health officer supported our COVID response in the way we had hoped for, the ability to share COVID response documents, mass media, and health officer support all helped to assure the public received the information they needed to assist them in supporting the State's response and decreasing the numbers of positive cases/deaths to COVID.*
	Seattle-King	*We increased reliance on DOH to provide expertise and clinical guidance; support with PPE procurement and distribution; contact tracing and overall collaboration on communication strategies.*
	Spokane	*The wrap around support for individuals/families in quarantine/isolation has also highlighted the coordinated need for community partnerships and the internal cross divisional approach to assisting those with health concerns. Staff have completed a large volume of COVID interviews that has given them more tools to gain information from patients, especially when they are reluctant to talk. Working with treatment centers*

		around COVID issues has allowed us to make some connections in the community that will be useful in HCV work. Staff have learned more about how treatment centers work and what HCV clients go through when they go to treatment for substance abuse.
	Walla Walla	*We really leaned on our community partnerships during this time. Although we added additional capacity for staffing, it takes a while to train these staff and we needed support immediately. Thus, our healthcare partners and infection control nurses have been critical and these relationships will be long lasting.*
Online/ Telemedicine	*Klickitat*	*In addition to some significant and abrupt changes of leadership - our biggest transition in change of services from in person to remote services.*
	Lewis	*In response to COVID we needed to maximize what services could be provided online. One of these services we provided an all online option for was requesting and paying for birth certificates. This has allowed customers to complete a request and payment process nights and weekends.*
	NE Tri-County	*Use of technology to attend meetings with community partners and provide direct services (such as in WIC), and work to improve processes for electronic submission of applications and environmental health design work that reduces in-person interactions (which results in improvements in efficiency and reduced costs incurred by clients.*
	Seattle-King	*While the pandemic required us to implement immediate changes to some FPHS services, such as closing in-person services and shifting them online, it is too soon to know if these are an improvement over the old way of doing business. Our Sexual Health Clinic held some telemedicine visits; however, in general, fewer patients were seen and as a result, fewer partners contacted...Our Tuberculosis program has created some efficiencies by utilizing telemedicine for some of our patient visits via a Zoom platform. We use this as an option for patients who don't feel comfortable coming into the clinic and imagine we will offer this service after COVID-19.*
	Thurston	*The Department embarked, pre-pandemic, on updating, improving and structuring Department meeting room technology to accommodate virtual meetings to allow us to include partners and stakeholders who may otherwise be unable to attend. The technological improvements have been critical to staff and partners in the days of COVID for staff and partners alike to meet and stay connected and updated.*
Communications	*Mason*	*We used live radio, television and social media as a means to reach out. We accessed the resources of the Joint Information Command to multiply our resources and reach.*
	San Juan	*We convene regular "partner" calls to provide COVID updates and answer questions from our community partners (medical, schools, camps, resource centers and businesses).*
	Yakima	*We have improved in our communications to the public, social media presence, and our staff has gained efficiencies with technology.*
Equity	*Cowlitz*	*Enhanced outreach and engagement with vulnerable or underserved populations including the micronesian community.*

APPENDIX A

	Skagit	*We have staffed additional public health nurses and community health workers and expanded our services to assure all can be provided in Spanish as well as English.*
	Yakima	*We created an equity platform for non english speaking people by developing website communication w/ english and spanish versions.*
IT/Data Management	*Clark*	*The biggest improvement is the work we've done around data management and the migration to a new web based platform that will be used for all our infectious disease work.*
	DOH	*Case investigation and contact tracing implemented modern software so staff could work from anywhere (e.g. home) and contact people statewide. This opened the door for more shared staffing and the ability to shift resources, without having to physically move people, to where the staff are needed. It provides an effective and efficient mechanism for providing "surge" capacity when and where resources are needed.*
	Okanogan	*Trying to get away from Access as our primary database system and move entirely to HealthSpace. We are able to trace each covid cases and map outbreaks*
Expanded hours	*Snohomish*	*We recently moved to a more remote based workforce with half of our staff working from home. This has allowed some work to be done outside of the typical hours and allowed us to reach people who we may have missed in the past.*
	Thurston	*Thurston County Public Health Emergency Preparedness and Response Program, Disease Control and Prevention staff, and Department Administration partnered in the months preceding the pandemic to develop, train staff, and implement a new afterhours Duty Officer plan utilizing a 24/7 call center that improved reporting and response time for after hours urgent/emergency notification from residents and community service providers. The plan became an integral part of Covid-19 response as an efficient way for urgent/emergency and immediately notifiable condition reporting during non-business hours and improved Department after hours response.*
Epi/Data	*Grays Harbor*	*We have an epidemiologist on staff who provides analysis of the metrics related to COVID-19. This allows us to make data-driven policy decisions to address COVID-19 and other communicable diseases.*
	Tacoma-Pierce	*We have significantly strengthened and improved our CD data and planning as a result of the COVID pandemic, with more in-depth analysis produced on a daily and weekly basis. For example, we now have automated data dashboards that pull data from databases, rather than requiring creation of new reports each time.*
Other	*Asotin*	*FPHS services took a significant hit due to COVID-19 as the district shut down or significantly delayed basic services for an extended period of time as all HR were used to handle COVID-19 activities.*
	Spokane	*Looking ahead to the work of immunizations, we have learned a great deal about providing medical services using a curbside process. Our plan is to be able to offer vaccinations (both childhood, influenza and potentially COVID-19) using this model.*