

DOH-810-017
JANUARY 2024

SFY23



FOUNDATIONAL PUBLIC HEALTH
SERVICES IN WASHINGTON STATE

State Fiscal Year 2023 INVESTMENT REPORT



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State Fiscal Year 2023 Investment Report

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Acknowledgments

This report was produced in January 2024 by the Rede Group for the Foundational Public Health Services Steering Committee and the governmental public health system in Washington state.

Rede Group project team:

- Beck Wright
- Erin Charpentier



Special thanks to DOH and WSALPHO partners:

- Amanda Gefroh
- Brianna Steere
- Carolyn Cartwright
- Chris Goodwin
- Jaime Bodden
- Jeff Ketchel
- Samantha Fuller

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Acronyms

AIHC	American Indian Health Commission
CBO	Community-Based Organization
CD	Communicable Disease
CDIVP	Chronic Disease, Injury, and Violence Prevention
CHA/CHIP	Community Health Assessment and Improvement Plan
COVID-19	Coronavirus Disease 2019/Severe Acute Respiratory Syndrome Coronavirus 2
DIS	Disease Intervention Specialist
DOH	Washington State Department of Health
ELR	Electronic Laboratory Reporting
EPH	Environmental Public Health
FPHS	Foundational Public Health Services
FTE	Full-time Equivalent
GIS	Geographic Information System
HCV	Hepatitis C Virus

HIR	Health Impact Review
LHJ	Local Health Jurisdiction
MCH	Maternal, Child, and Family Health
NSDM	New Service Delivery Model
PHIMS-STD	Public Health Issue Management System - Sexually Transmitted Disease
SBOH	State Board of Health
SFY	State Fiscal Year
TB	Tuberculosis
WAPC	Washington Poison Center
WDRS	Washington Disease Reporting System
WSALPHO	Washington State Association of Local Public Health Officials

Executive Summary

Land Acknowledgment

Washington state resides on the traditional homes of many Indigenous Peoples, including the current home of 29 Sovereign tribal nations who are our partners in public health. We honor the original peoples as the first, unbroken caretakers of the land and waters in their rooted territories. Public health's origins trace back to these ancestral stewards who lived the values of physical, emotional, and social wellbeing in both the person and community.

The governmental public health system supports tribal sovereignty, self-determination, and upholding government-to-government relationships. We commit to working with Tribes to shape a future that supports the health of all people and all communities in Washington.

This report shares information about the progress local public health, the State Board of Health, and the Washington State Department of Health have made in Foundational Public Health Services delivery. Beginning in Fiscal Year 2024, tribal FPHS will be included in this report to reflect the complete governmental public health system in Washington state.

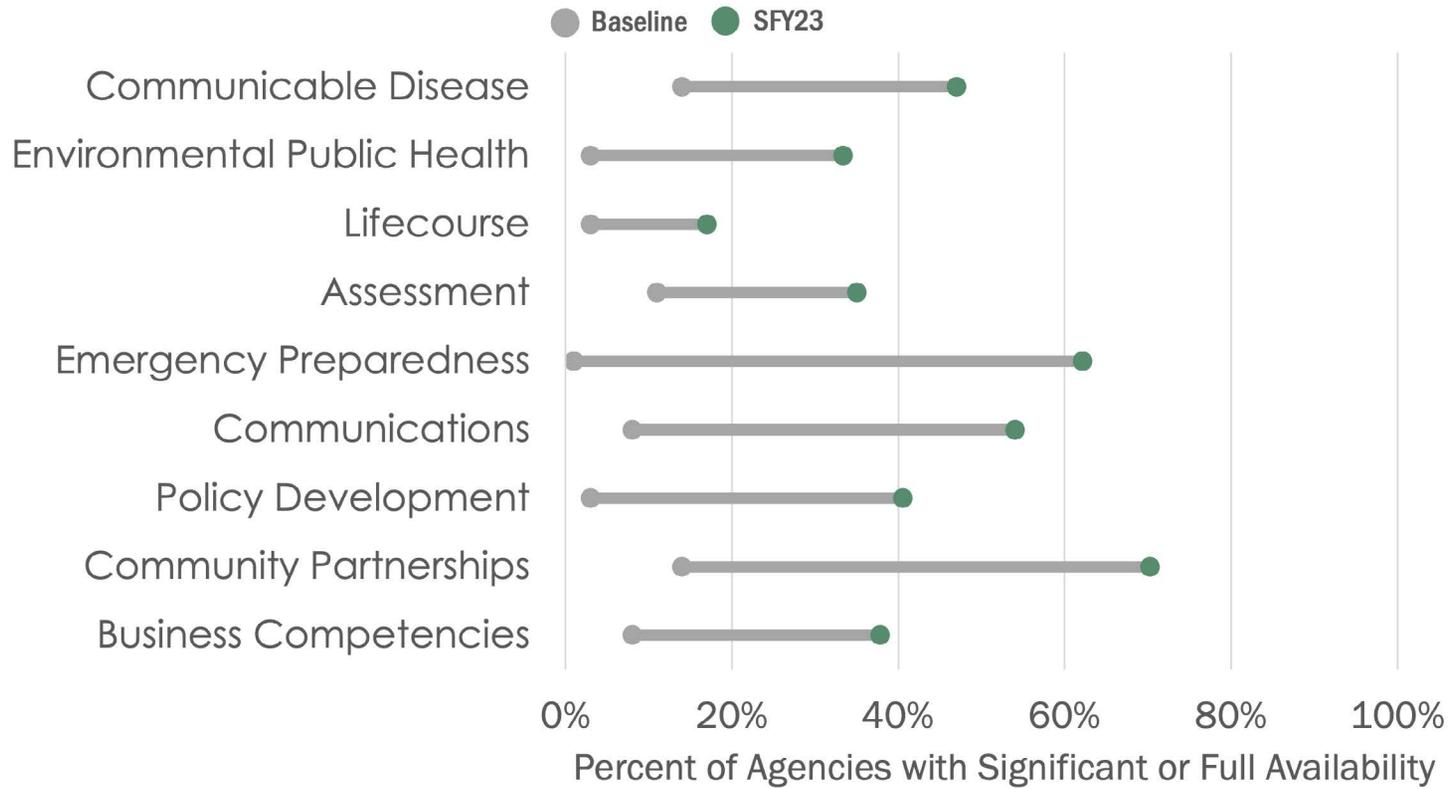
Background

Washington state has made funding public health a priority through public health modernization and the foundational public health services (FPHS). There has been consistent and increasing funding appropriated to improve the governmental public health system since the 2018-2020 biennium, after the 2018 baseline report identified a gap of \$225 million annually that is needed to implement FPHS completely. In State Fiscal Year 2023 (SFY23), 50% of the gap, or \$112 million, was appropriated to provide FPHS across the state to support the health of all people in Washington, regardless of where they live. The FPHS Steering Committee, made up of State Board of Health (SBOH), Washington State Department of Health (DOH), local health jurisdictions (LHJ), and tribal representation, is the decision-making body for the allocation of FPHS funding appropriations.

System Capacity

As investments have been made in FPHS, the availability of these foundational services has increased. Investments have been made in the FPHS areas of communicable disease and foundational capabilities (assessment, emergency preparedness, communications, policy development, community partnerships, and business competencies) since SFY19, adding investments in environmental public health in SFY20. As of SFY23, investments have been made in all FPHS program and capability areas, although at 50% of the total funding need identified in 2018. Figure 1 displays the change in the percent of agencies with significant and full availability of FPHS from baseline to SFY23 at the Foundational Program and Capability level. There has been progress made in all areas, with more progress made the longer an area has been invested in.

Figure 1: FPHS availability at area/capability level, baseline to SFY23



Key Takeaways

Sustained, regular investment in FPHS has led to an overall increase in the availability of FPHS across the Washington State governmental public health system over the six years it has received funds.

- As investments have been made in FPHS, there has been an increase in capacity across the governmental system. Some investment has now been made in all of the FPHS programs and capabilities resulting in incremental availability increases as shown.
- This state-wide investment provides the infrastructure needed to continue existing services for many public health agencies, especially those that have faced staffing and/or funding shortages.
- FPHS funding has provided the flexibility for agencies to innovate and be nimble in order to provide the types of services most needed in their communities as well as be adaptable to new and emerging threats.
- There has been an increase over time in the number of shared FPHS services, and there is willingness across the system for more sharing of services where appropriate.
- Many efforts are being made within the public health system to improve equity, including assessing where inequities are in collaboration with community; authentic partnership building; and developing culturally and linguistically appropriate communication materials.

- The impact of the COVID-19 pandemic on the ability for public health agencies to engage in foundational work greatly reduced the ability for agency staff to work on anything else as they faced the pandemic response for nearly three years. It is a testament to the dedication of public health staff and the importance of foundational funding that any progress was made in increasing the availability of FPHS across the system during one of the biggest public health emergencies that has faced the governmental public health system.



Background

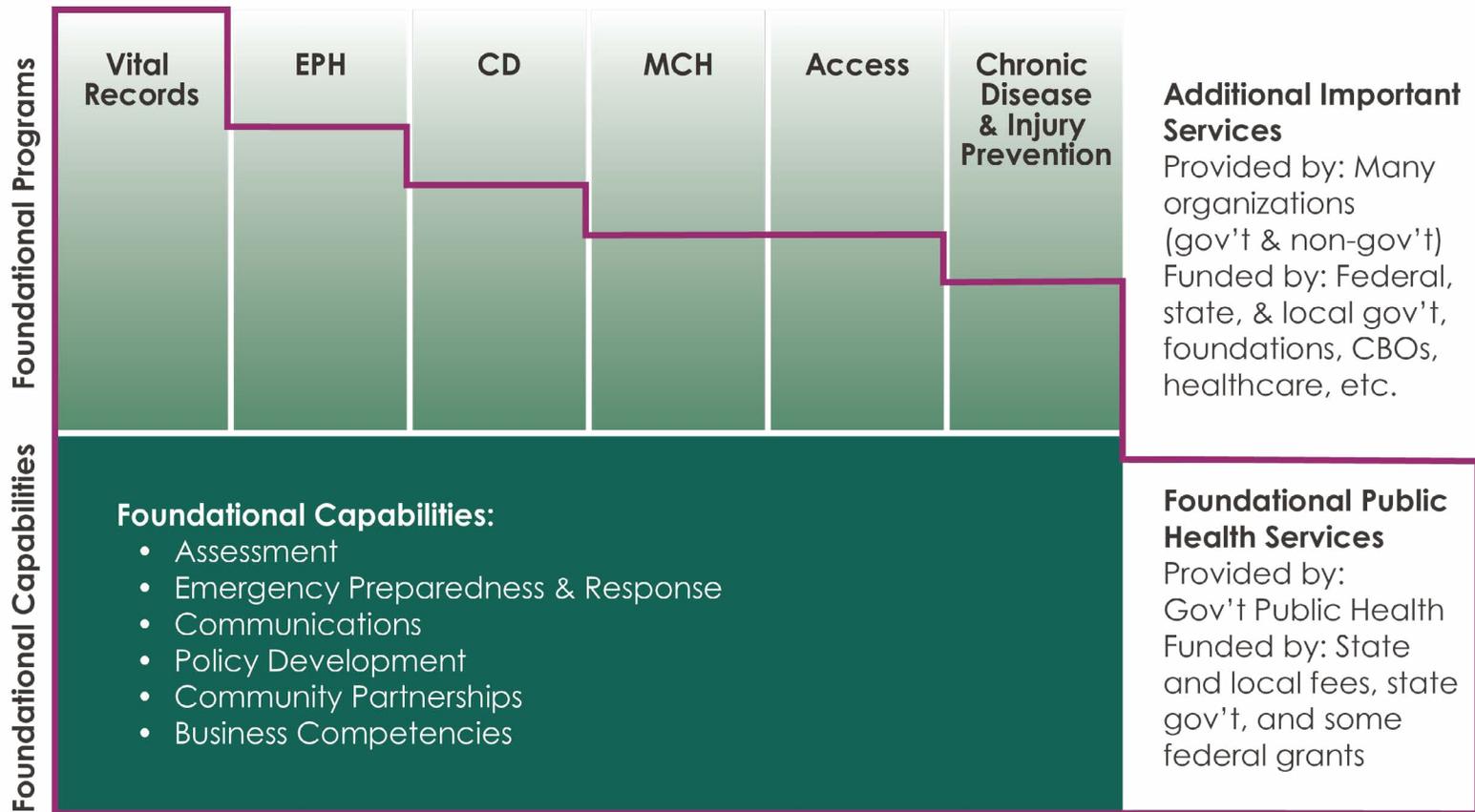
“Protecting the public’s health across the state is a fundamental responsibility of the state and is accomplished through the governmental public health system.”¹

Washington state has been providing some level of public health services since the mid-1900s, and has been engaged in a concerted effort over the past 10-plus years to modernize the governmental public health system.

The framework for Foundational Public Health Services (FPHS)² in Washington state includes Foundational Programs and Foundational Capabilities, as listed in Figure 2. The intent of public health modernization is that FPHS are available to all people in Washington state, regardless of where they live. Stable, consistent funding for FPHS is critical for the governmental public health system to be able to pivot to address new public health emergencies such as the COVID-19 pandemic, measles outbreaks, and the opioid epidemic.

1. [RCW 43.70.512](#)
2. [Foundational Public Health Services](#) are population-based, prevention-oriented services that primarily the government provides everywhere, in order for the system to function anywhere.

Figure 2: The FPHS framework: A limited, defined set of core services provided by the governmental public health system



Baseline Assessment

The 2018 Washington State Public Health Transformation Assessment Report for State and Local Public Agencies (Baseline Report) provided a baseline assessment (using 2016 calendar year data) of current spending on FPHS, the gap in resources for full availability of FPHS, level of sharing of FPHS between agencies, and the level of availability in FPHS across the system. The baseline assessment only included three of the four parts of the governmental public health system - DOH, SBOH, and LHJs. At the time of the baseline assessment Washington Tribes were providing public health services as they could but were not connected to the statewide FPHS efforts. The main takeaways of the baseline assessment were as follows:

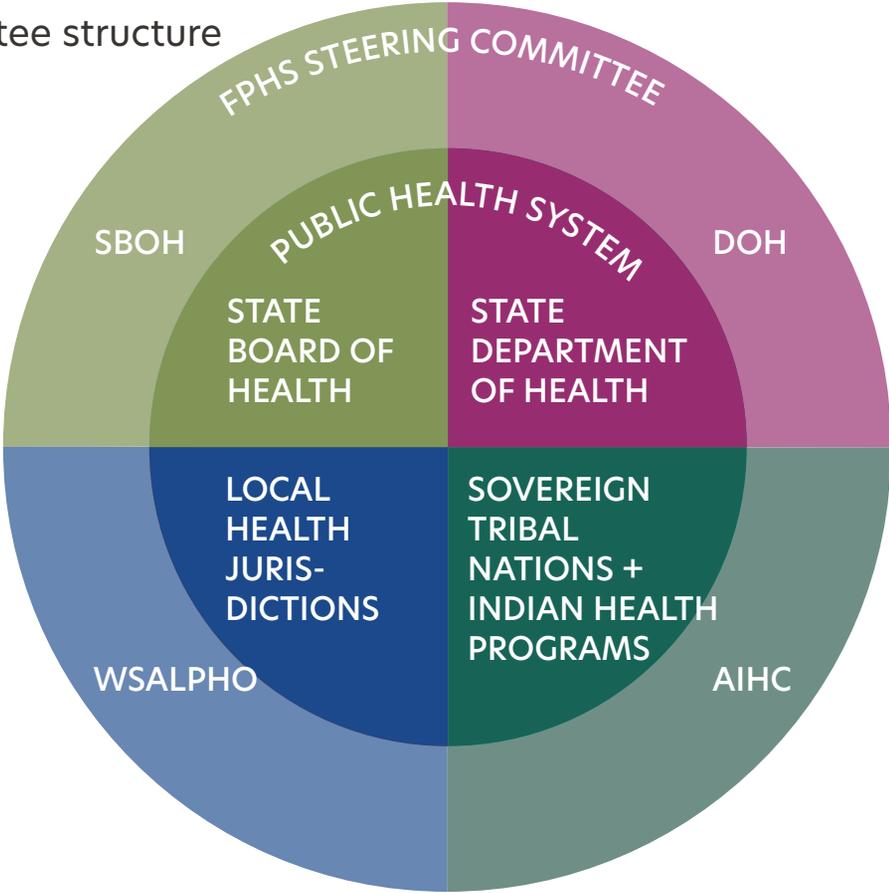
- Although the governmental public health system was providing much of FPHS, no foundational program or capability was fully or significantly available across the statewide system
- LHJs reported significant cross-jurisdictional sharing
- There was wide variability in where the gaps in FPHS availability were across agencies and across the statewide system
- Baseline expenditures for FPHS were estimated at \$368 million in a year, which was approximately two-thirds of the cost of full FPHS implementation
- The estimated additional funds needed from the state government to ensure FPHS availability to all communities in Washington was \$225 million annually (in 2018 dollars)

FPHS Service Delivery Models

According to RCW 43.70.515, “service delivery model” is the systematic sharing of resources and function across the governmental public health system to increase capacity and improve efficiency and effectiveness. Substitute House Bill 1496 (Chapter 14, Laws of 2019) required that any FPHS funding allocations must be jointly certified by specific public health system partners in consultation with federally recognized Tribes, which led to the creation of the FPHS Steering Committee (Figure 3). A portion of the funds appropriated by the legislature each biennium are invested in testing and evaluating new service delivery models. Example projects include building tuberculosis (TB) expertise and surge capacity within Public Health - Seattle & King County to provide support to all LHJs to address TB in their communities, and Tacoma-Pierce County Health Department developing and maintaining communicable disease websites for health care providers in multiple LHJs.

Figure 3: FPHS committee structure

**FPHS
SUPPORT
STAFF**



**FPHS PROJECT
MANAGEMENT
TEAM (PMT) +
CO-CHAIRS**

LHJs are represented by WSALPHO and American Indian Health Commission (AIHC) participates on behalf of sovereign tribal nations and Indian health programs.

FPHS SUBJECT MATTER EXPERT (SME) WORKGROUPS

CD
Communicable disease

EPH
Environmental public health

ASSESSMENT
Epidemiology + surveillance

EPR
Emergency preparedness + response

LIFECOURSE
Communicable disease and injury prevention, maternal + child health, access + linkage to care

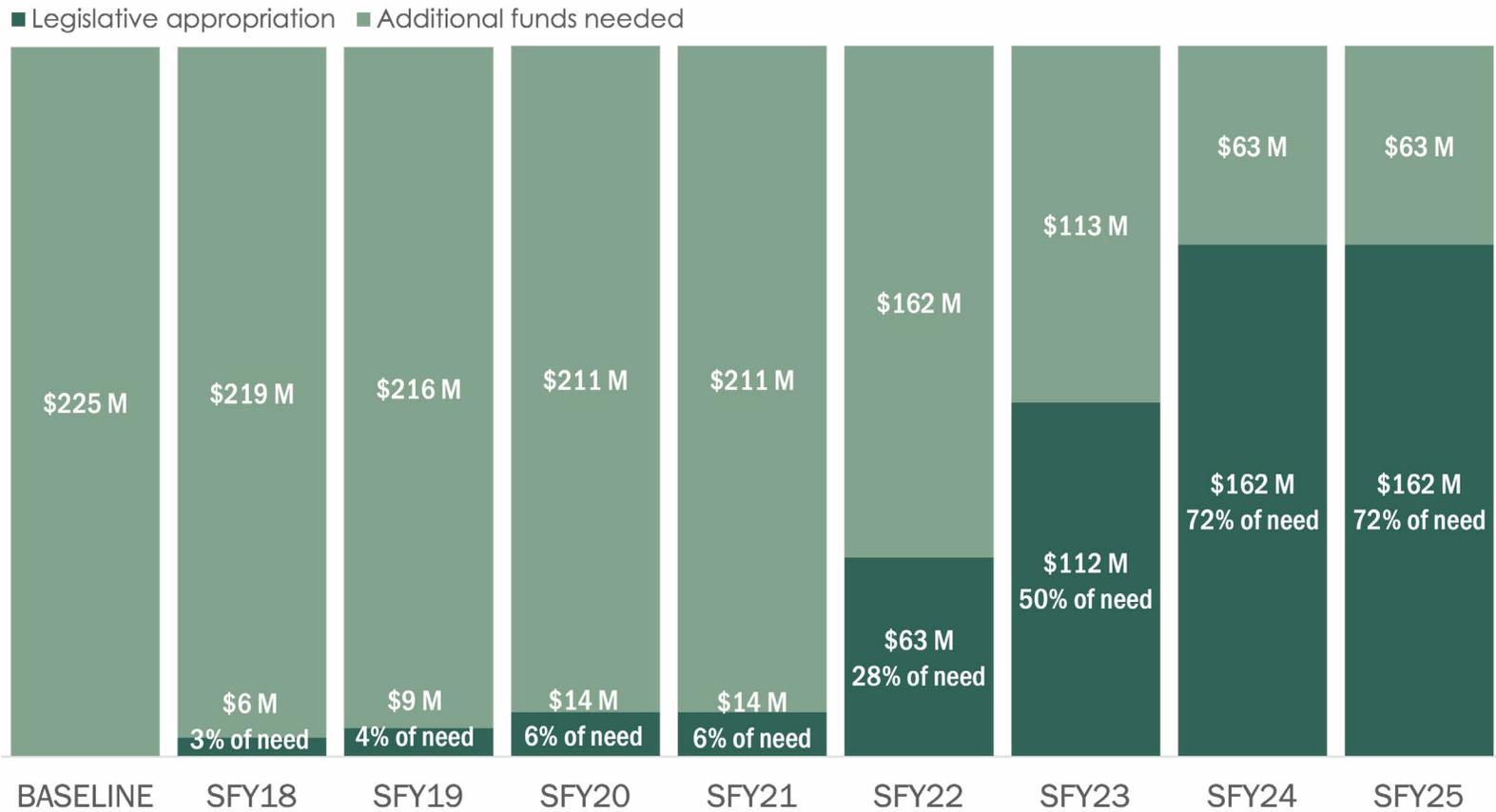
FOUNDATIONAL CAPABILITIES
Communications, policy development, community partnerships, and business competencies

Funding

FPHS Appropriations

The 2018 Baseline Report estimated a FPHS funding gap of \$225 million annually to fully implement public health services across the state. Figure 4 displays legislative appropriations for FPHS through the 2023–2025 biennium.

Figure 4: FPHS investment and gap, in millions

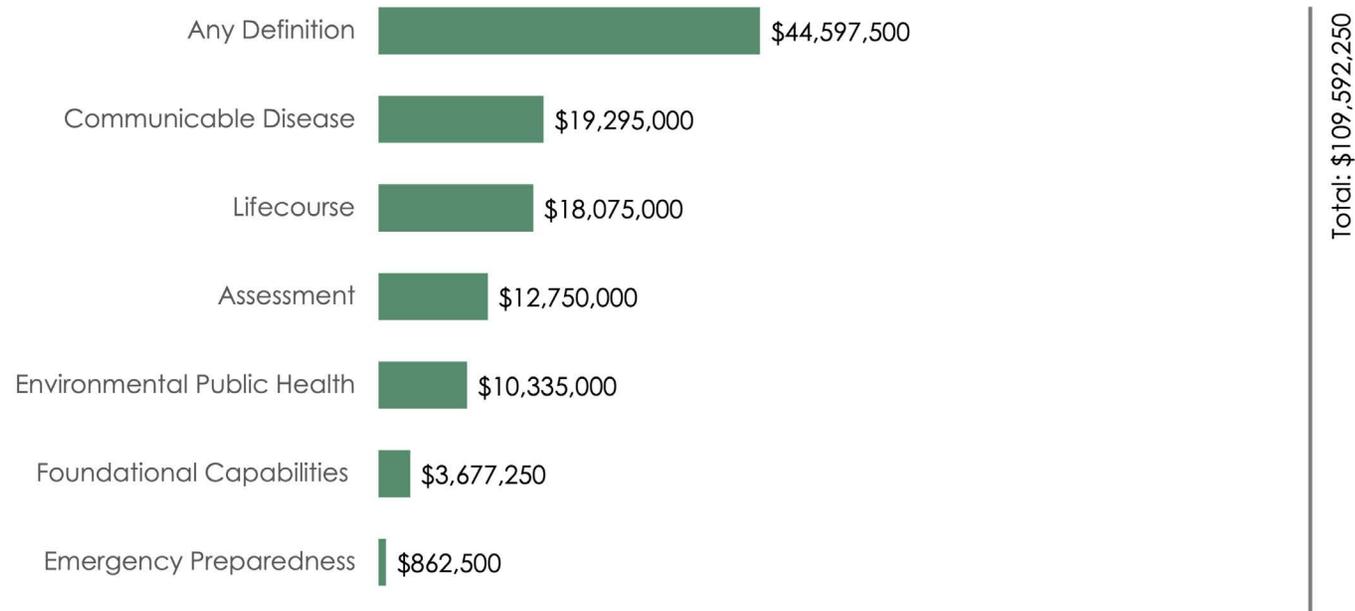


SFY23 Allocations

The FPHS Steering Committee determined how SFY23 appropriations would be allocated across the governmental public health system. Per law, tribal consultation and joint certification among all parts of the system that they were in agreement on the distribution and use of state FPHS funds across the public health system was required before funds were released to DOH for distribution. The legislature appropriated \$112 million for FPHS for SFY23; Figure 5 displays how those funds were allocated by the FPHS Steering Committee.

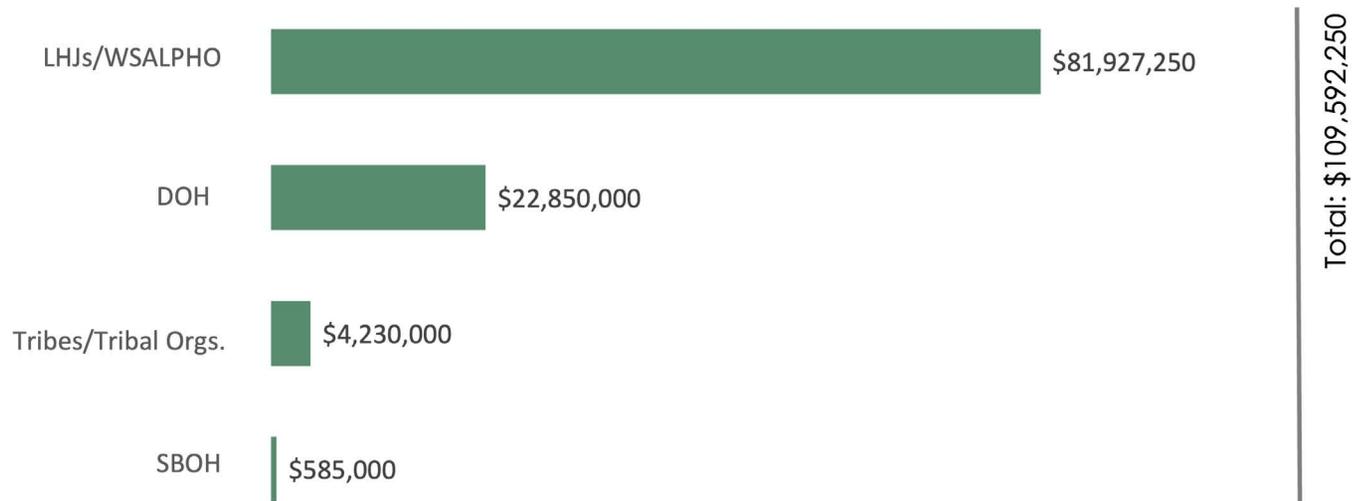
Among the categories, the most funds were allocated to “any definition,” which means the allocated amount could be spent by agencies in any FPHS area. Communicable disease had the highest allocation of any specific FPHS Program or Capability.

Figure 5: SFY23 allocations by FPHS area



When reviewing allocations by type of system partners, the vast majority of FPHS funds were allocated to LHJs, whereas the lowest amount was allocated to SBOH.

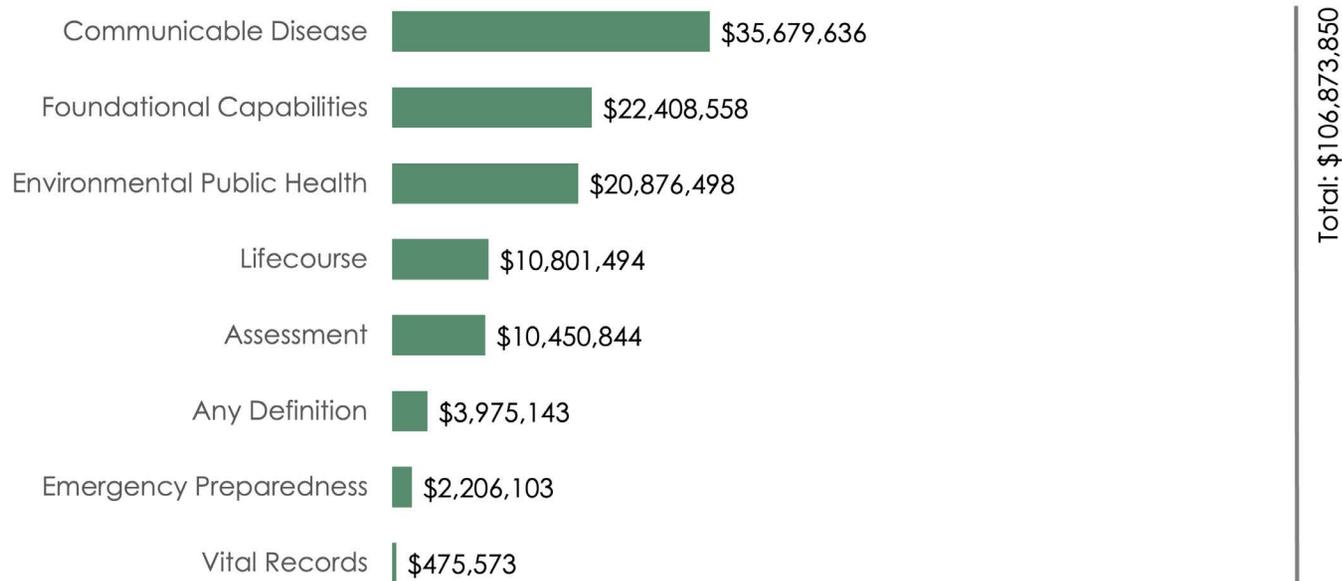
Figure 6: SFY23 allocations by system partner



SFY23 Spending

LHJs, SBOH, and DOH reported how they spent the FPHS funds allocated to their agency by FPHS activities. Of the funds allocated to FPHS, \$106,873,850 was spent by the governmental public health system across all FPHS Capabilities and Programs. Over one-third (\$36 million) was spent in the communicable disease program area, with the majority (\$27 million) spent on disease investigation. The lowest amount of FPHS funding was spent on vital records (\$0.5 million). Spending data includes LHJs, DOH, SBOH, Tribes/tribal organizations, and WSALPHO. For further details on spending by LHJs, DOH, and SBOH, see Appendix A.*

Figure 7: SFY23 spending



*Spending data reflect information reported in June 2023, with some corrected spending in January 2024. See Appendix A for full details.

SFY23 spending

FPHS Area	Capability	Amount Spent	% of total
Environmental Public Health	Environmental Public Health Data & Planning, Radiation, Land Use	\$7,361,012	7%
	Environmental Public Health Inspections	\$13,515,486	13%
Foundational Capabilities	Emergency Preparedness	\$2,206,103	2%
	Communications, Policy Development, and Community Partnership Development	\$7,205,809	7%
	Assessment (Epi & Surveillance, CHA, CHIP)	\$10,450,844	10%
	Business Competencies and Information Technology	\$15,202,749	14%
Communicable Disease	Promote Immunization	\$924,457	1%
	Public Health Lab	\$3,181,195	3%
	Communicable Disease Data & Planning	\$4,374,316	4%
	Communicable Disease Investigation	\$27,199,667	25%
Lifecourse	Maternal Child Health	\$3,935,691	4%
	Access/Linkages to Care	\$3,442,964	3%
	Chronic Disease, Injury, Violence Prevention	\$3,422,839	3%
Vital Records	Vital Records System and Birth and Death Certificates	\$475,573	0.4%
Any Definition	Any Definition	\$3,975,143	3.7%
	Total	\$106,873,850	100%

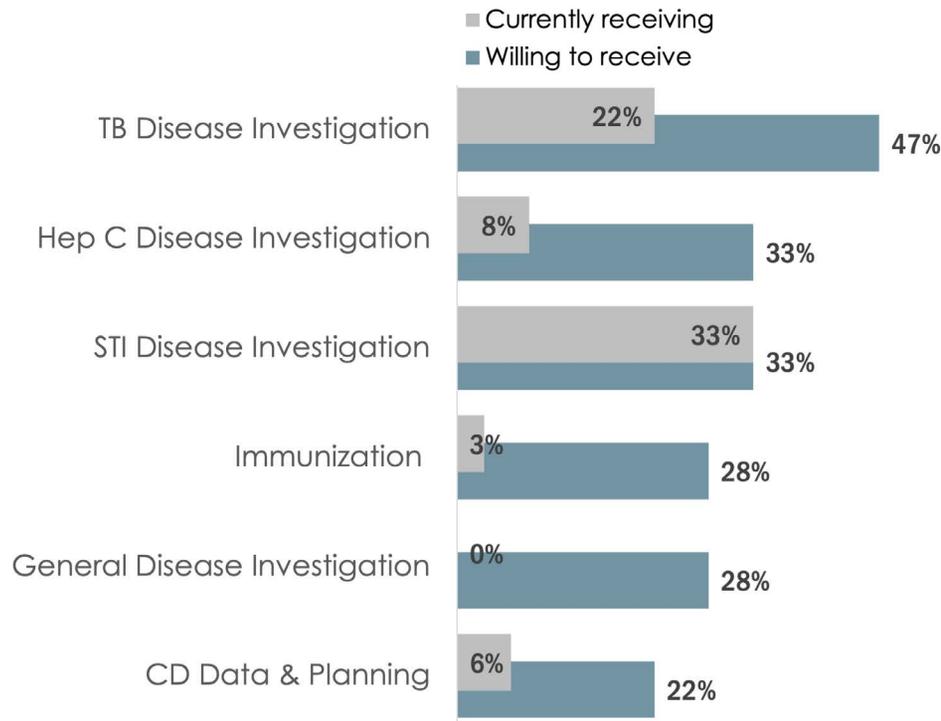
Cross-Jurisdictional Sharing

LHJs, SBOH, and DOH reported on SFY23 sharing (defined as the reporting agency receiving services from another agency), as well as on their willingness to receive and willingness to provide services in the future. One important question when reviewing the data is where the gaps are between agencies that are currently receiving shared services and agencies that are willing to receive shared services. Figures 8-13 display the percent of agencies that were significantly or completely receiving shared services in SFY23 and those who reported that they were willing to significantly or completely receive shared services in the future. See Appendix E for methodology.

Communicable Disease

Figure 8 displays the percent of LHJs who reported receiving communicable disease (CD) foundational public health shared services in SFY23 in comparison to the percent of LHJs who reported a willingness to receive CD shared services in the future, showing areas of currently shared services and opportunities for increased sharing of services. Tuberculosis (TB) disease investigation had the highest percent of agencies receiving shared services from another agency in SFY23 (22%), and also the most willingness in significantly or completely receiving shared services in the future (47%). No agencies reported significantly or completely receiving general disease investigation services from another agency, although almost a third of agencies reported willingness to receive shared services in the future (28%). The lowest percent of agencies reported willingness to receive CD data and planning shared services in the future (22%).

Figure 8: Communicable disease sharing gap



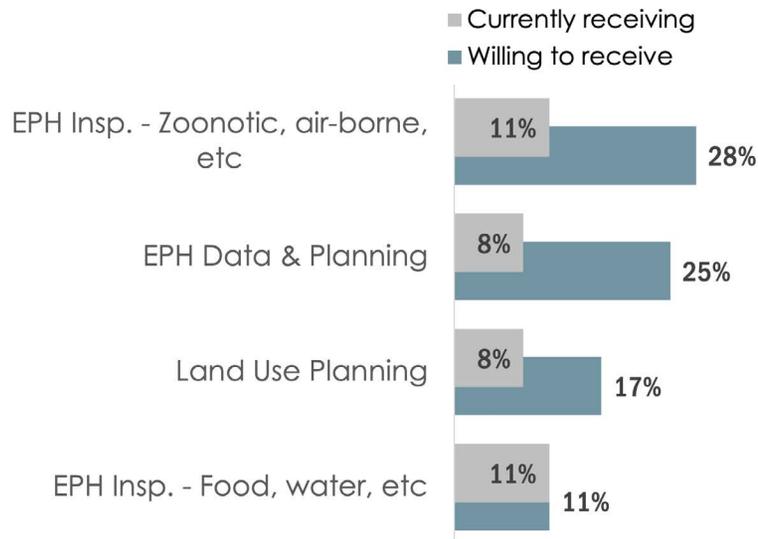
“FPHS funds have allowed us to act as a resource for any interested LHJ across the state for active TB case management and consultations, longitudinal complex case management and consultations, contact investigation consultation and support, congregate setting investigations consultation and support, Class B immigrant and refugee support, and civil surgeon reporting support.”

Public Health-Seattle &
King County

Environmental Public Health

There was a lower percent of agencies currently receiving and willing to receive shared services for environmental public health (EPH) than for communicable disease. About one-tenth of agencies reported currently receiving shared services for zoonotic, airborne, and other related EPH investigation shared services (11%) compared to almost one-third willing to receive shared services in the future (28%).

Figure 9: Environmental public health sharing gap



Lifecourse

The percent of agencies that reported currently receiving and future willingness to receive lifecourse shared services are similar to EPH services. There were very few agencies who received lifecourse shared services in SFY23, and about a quarter of agencies reported willingness to receive lifecourse shared services in the future.

Vital Records

Providing birth and death certificates was the only area where a higher percent of agencies (28%) reported significantly or completely receiving shared services than reported a willingness to receive shared services in the future (19%).

Figure 10: Lifecourse sharing gap

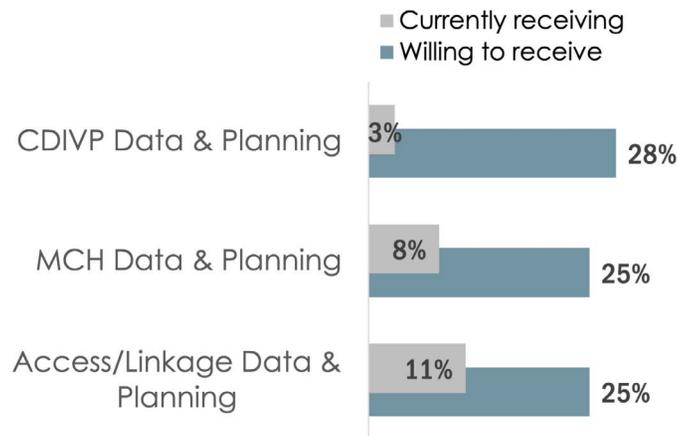
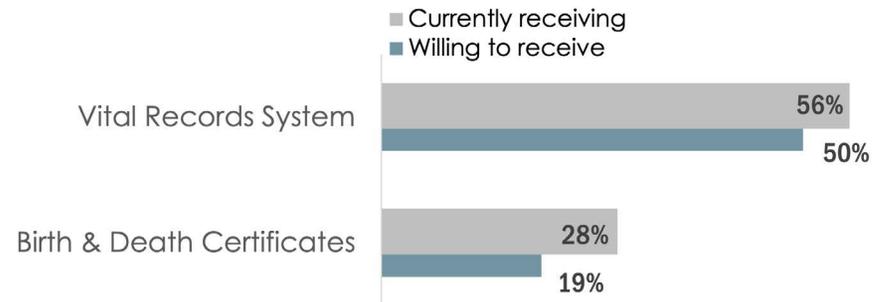


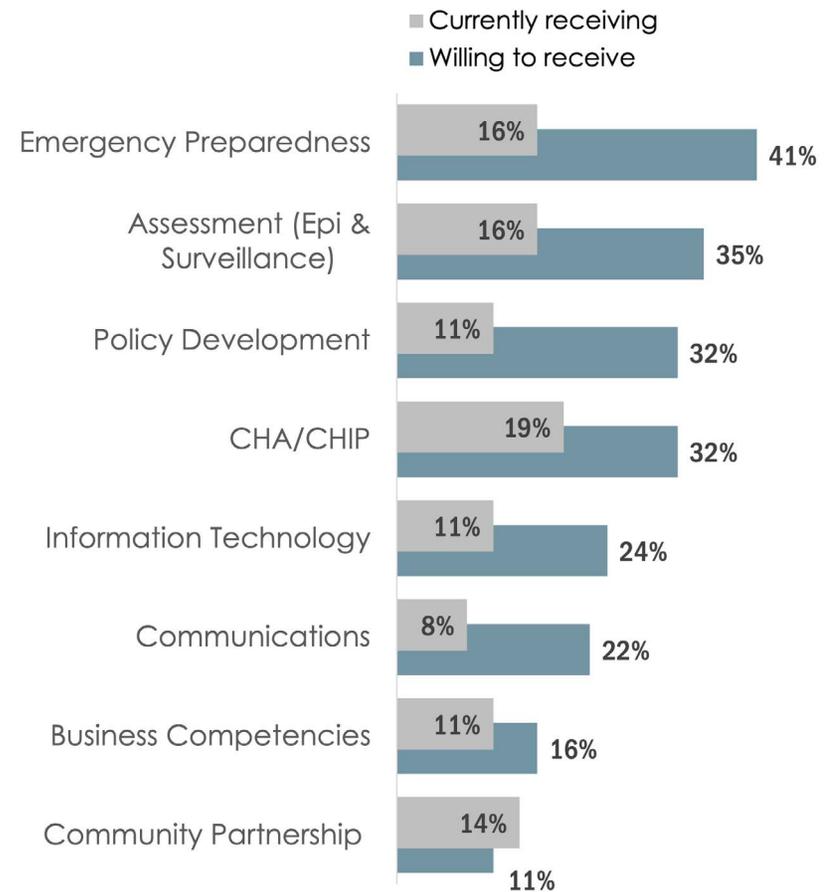
Figure 11: Vital records sharing gap



Foundational Capabilities

There were more agencies that reported significantly or completely receiving foundational capabilities from other agencies than most FPHS areas (described above). Agencies reported the most current sharing in the foundational capability areas of community health assessments/improvement plans (19%), emergency preparedness (16%), and assessment (16%). About a third of agencies reported willingness to significantly or completely receive these three shared services, as well as policy development, in the future.

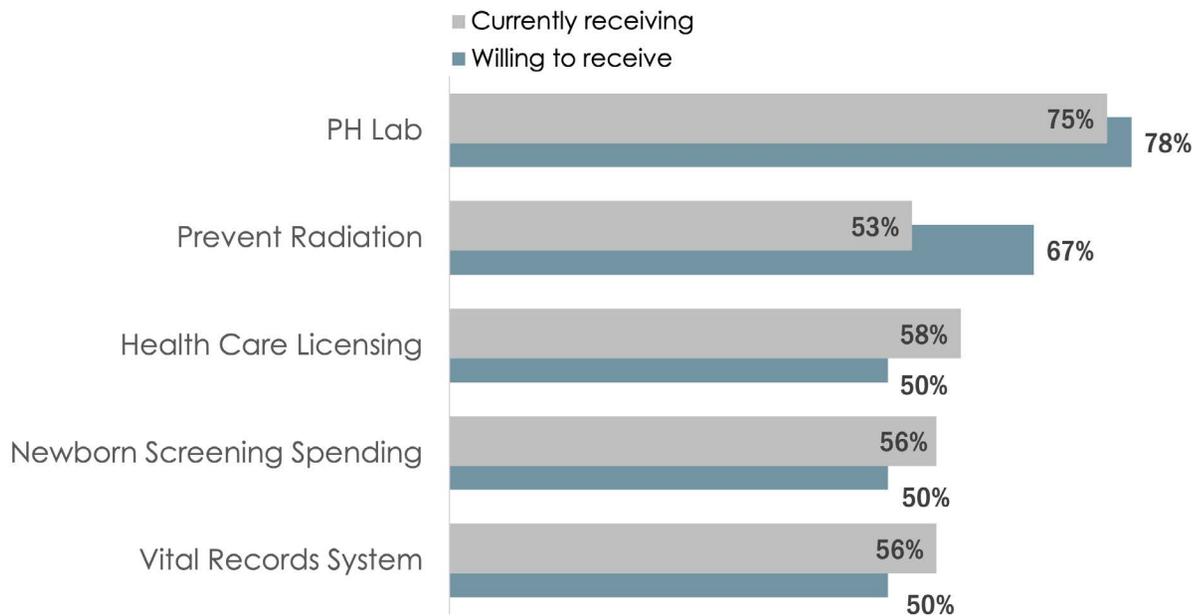
Figure 12: Foundational capabilities sharing gap



Centralized Services

There are a set of services that are centralized, or provided by one main agency (primarily DOH). For centralized services, there are much smaller gaps in the percent of LHJs who are currently receiving these services and who are willing to receive these services in the future. Ideally all LHJs would report receiving centralized services, and the fact that they aren't all reporting completely receiving shared services from another agency may be more a reflection of issues with the reporting question than a lack of shared services being provided at the local level; for example, if an LHJ did not need public health lab service in SFY23, they may have reported no sharing or minimal sharing, but the service is available from DOH when needed.

Figure 13: Centralized services sharing gap



Service Delivery Innovation

Agencies were asked to share examples of how FPHS funds have supported innovation and transformation within the agency, as well as with external partners.

Some agencies reported developing tools as examples of innovation. Types of tools/resources mentioned included a model lead prevention program, a resource guide, protocols and data systems to focus on chronic untreated hepatitis C infections, a checklist and resources for pool operators to support compliance, technical resources and response guidance for climate-related events, GIS capabilities, and a “model program” for climate and health activities across the public health system.

A few agencies mentioned innovative practices related to assessment/analysis. Examples included a county-level assessment of unhoused people, completing a gaps analysis, and conducting community listening sessions. A few agencies also mentioned training in response to this question, noting that FPHS funds allowed for better training for staff and partners.

And finally, many agencies reported the use of technology as innovative practices. Examples included building out or creating new web pages, electronic medical record system improvements, online environmental

“One great example of innovation was sending staff, community members, and local board of health members through some training that will help us reach the most vulnerable populations in our county. At the same time, it helps bolster our relationships with some of our colleagues and others who may not have had positive public health interactions in the recent past. It also informs our board of health of some of our communities’ issues and problems.”

Asotin County Health District

health application and information systems, the development of data dashboards, and transitioning to technology to increase internal team communications.

Externally, many agencies reported innovative practices in working with partners. Types of partners mentioned included daycares, K-12 schools, universities, health systems, community-specific navigators, community based organizations (CBOs), community members and fire departments. Other partnerships built on government-to-government relationships such as working with Tribes, other local health jurisdictions, or government agencies. Some ways that community partners were engaged included providing training, convening meetings, developing plans together, conducting assessments together, building relationships, increased access to care, increased communication mechanisms, and developing community-based messaging.

Some agencies also reported expanded programming as service delivery innovation. Examples included expansion of services to more community members, broader implementation of low-barrier treatment with buprenorphine, providing disaster preparedness workshops, providing services to houseless communities,

“Mobile public health van received in March 2023—allowing us to take public health services to the community where they live, work, and play.”

San Juan County Public Health

expanding rapid syphilis testing, providing chronic disease self-management classes, providing mental health first aid classes, and building out an air quality program.

A few agencies also specifically mentioned communications efforts, on topics such as vaccines, food safety, suicide prevention, and opioid abuse prevention.

Health Equity

Agencies shared several examples of how FPHS funds helped them address health disparities or inequities in their community. Over half of agencies named programs they built, expanded, or continued that addressed specific communities experiencing inequities. For example, agencies mentioned an outreach program for African immigrants, an outreach program for Pacific Islanders related to tuberculosis, data analysis on the disparate impacts of Mpox for men who have sex with men, and provision of naloxone to high-risk populations. About one-fourth of agencies explicitly mentioned partnering with other organizations to better reach communities who experienced inequities.

Another way that agencies addressed health disparities and inequities in their communities was by working to

“Funding allowed for an expanded approach to communications, allowing for effective information sharing and coordination among community partners. This enhanced collaboration facilitated the exchange of ideas, best practices, and lessons learned, leading to more impactful interventions.”

Island County Public Health

improve communications; creating outreach materials that would resonate with the community, improving outreach to hard-to-reach populations, and trying new communication channels. About half of agencies also discussed improved ability to provide materials or services in other languages.

Many agencies began their work to address inequities by collecting data on what inequities exist in their communities and their progress in addressing them. Community Health Assessments were specifically identified as a method agencies used to help identify the inequities they needed to address. They also increased surveillance activities, allowing agencies to identify communities experiencing disparate rates of disease and target outreach.

Apart from carrying out full-on programs, some agencies also worked to improve access to resources for communities experiencing inequities, like COVID-19 tests, air cleaner kits, and immunizations. Mobile resource or service delivery was mentioned to be important for serving communities experiencing inequities.

Finally, some agencies mentioned helping staff develop their knowledge and skills related to addressing inequities through conversation and training opportunities.

“Through assessment of health disparities in the community and ongoing outreach to populations with chronic disease and injury risks, we hope to continue to see improvements in health outcomes for marginalized and vulnerable populations in our county.”

Skamania County Public Health

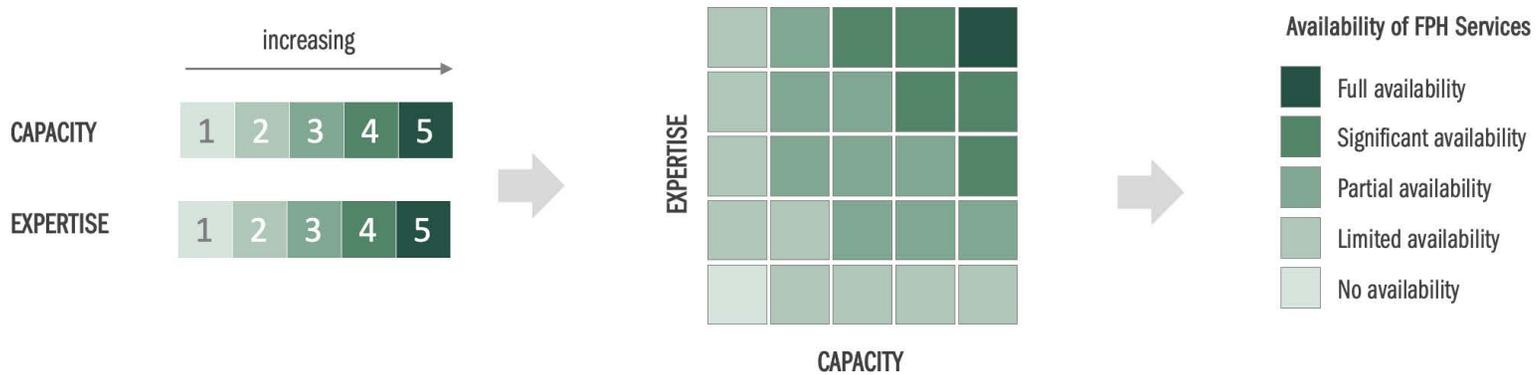
Changes in Capacity

In the baseline assessment and each annual report, agencies were asked to self-assess their capacity and expertise for Foundational Programs and Capabilities. SFY23 is the first reporting year that assessed all FPHS Capabilities and Programs since the baseline assessment. Using a five-point scale, LHJs, SBOH, and DOH rated 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, five areas related to lifecourse (which includes maternal child health, chronic disease and injury prevention, and access and linkages to clinical care), two areas related to vital records, and eight foundational capabilities.

Capacity and expertise scores were combined to create an estimate of the availability of FPHS in each jurisdiction. Availability was then categorized and color coded. For some figures in this report, significant and full availability were combined to visualize differences from baseline. Comparison of levels of availability includes data from LHJs, DOH, and SBOH.

Figure 14: How availability of FPHS is interpreted

See Appendix E for methodology.



Agencies rate the availability of FPHS in their jurisdiction on a five-point scale in terms of capacity and expertise (separately).

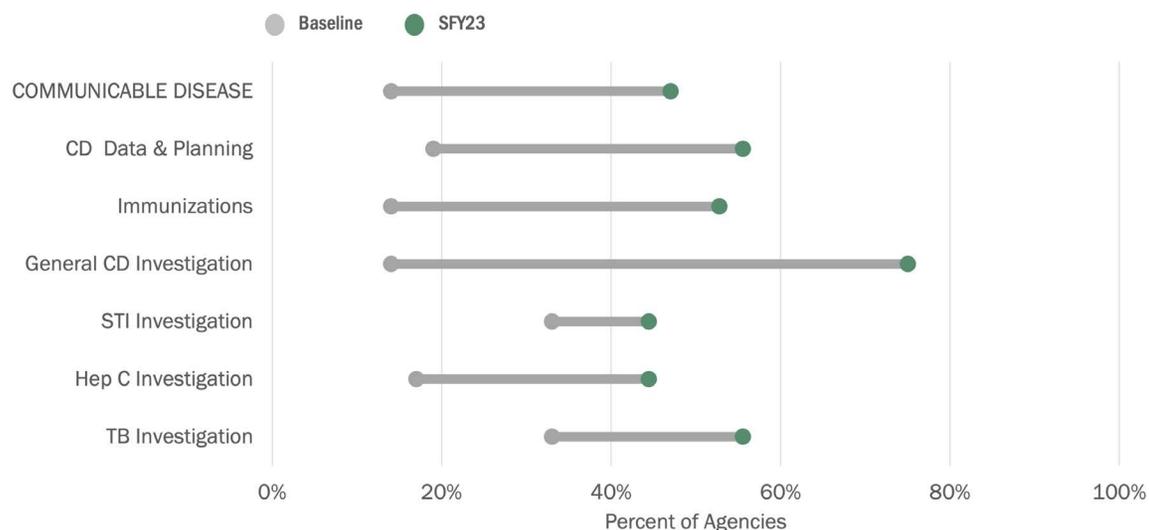
These measures are combined during analysis.

The combined measure interprets availability of FPHS on a five-point scale ranging from 'No availability' to 'Full Availability'.

Communicable Disease

All areas of communicable disease have seen an increase in service availability between baseline and SFY23. The top row in Figure 15 is a roll-up of the areas under communicable disease; overall, there has been a 240% increase in the percent of agencies with full and significant availability of communicable disease services. General communicable disease investigation saw the largest increase (440% increase), and sexually transmitted infection investigations saw the smallest increase (33% increase).

Figure 15: Changes in communicable disease availability



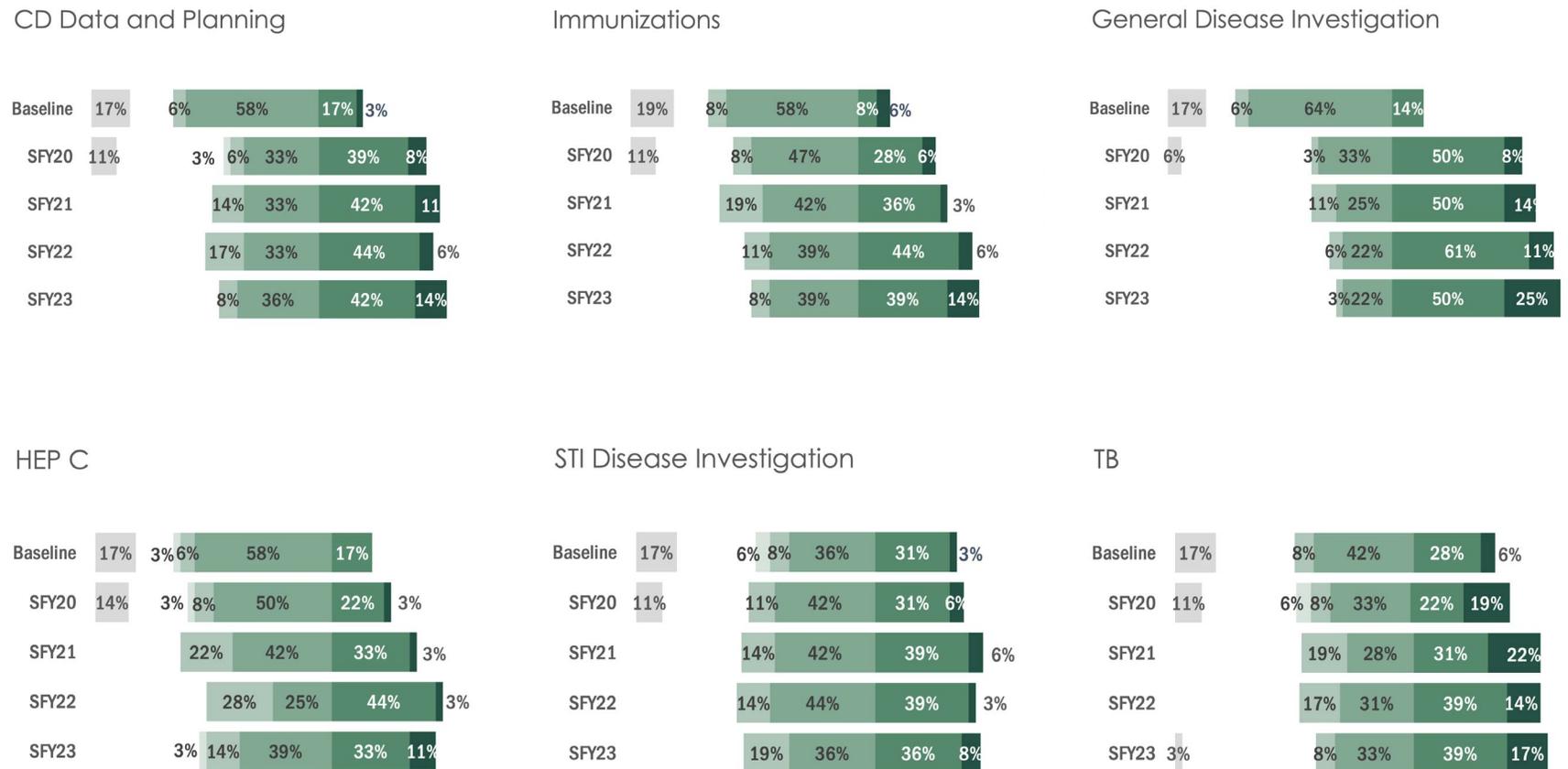
“FPHS Case Investigation funding allowed us to respond proactively to the Mpox outbreak by deploying medication to our hospitals and clinics that treat HIV patients prior to our first case. The funding allowed us to pull staff from more restrictive funding sources to be able to address this emerging infectious disease threat ahead of having an outbreak in our community. That flexibility is crucial with communicable disease work.”

Spokane Regional Health District

Figure 16 displays the changes in availability for all communicable disease FPHS areas from baseline to SFY23. Although there has been some fluctuation between years, there is an upward trend in availability across all areas.

- Missing
- Not Available
- Limited Availability
- Partial Availability
- Significant Availability
- Full Availability

Figure 16: Changes in communicable disease availability detail



Annual Report Highlight:



Hepatitis C

FPHS funding has deepened efforts locally and statewide to investigate cases of hepatitis C virus (HCV) and connect clients to care. Prior to 2019, HCV surveillance investigations were conducted on a very limited basis due to lack of resources. As a result, surveillance data is largely incomplete and impedes the ability to accurately characterize the overall burden of HCV in Washington.

FPHS funding was allocated for the 2023-2025 biennium, with \$1.3 million allocated to the Office of Infectious Disease (OID), DOH for SFY23 to continue to address HCV using shared priorities, standardized surveillance methods, minimum standards of practice, common metrics, and staffing models developed by the FPHS Communicable Disease Subject Matter Expert workgroup. Funds allocated to OID were used to develop a comprehensive HCV Disease Intervention Specialist (DIS) program to strengthen HCV surveillance data quality and to prevent disease transmission through linkage to care and supportive services activities. The funding supports four FTE DIS that are stationed regionally throughout the state to conduct HCV surveillance investigations

through a shared services model with 16 local health jurisdictions (LHJs). They also provide ongoing technical assistance for all counties requesting assistance.

With FPHS funds, the HCV DIS program has been able to achieve the following:

- Strengthen overall data quality through surveillance investigation, which informed focused interventions
- Allow clients the opportunity to access curative treatment, especially for disproportionately impacted populations
- Interrupt disease transmission through prioritized intervention
- Develop key partnerships to better understand barriers to treatment and share process improvements

Seventeen LHJs also received \$1.5 million in total funding to address hepatitis C in SFY23, and other LHJs reported using FPHS case investigation funds for HCV work, as well. A portion of these funds has been used to cultivate thoughtful partnerships at the local level with healthcare providers across the state, enabling broader system collaboration around HCV tracking and engagement in care. Many LHJs reported specific examples of partnerships such as with Family Medicine Residency programs, perinatal providers, and county/regional healthcare coalition workgroups to provide outreach and education to increase testing and treatment of HCV. Public Health-Seattle & King County also provided HCV testing and treatment at the Downtown Needle Exchange and developed protocols and provider training to offer low-barrier HCV treatment at their Sexual Health Clinic.

Environmental Public Health

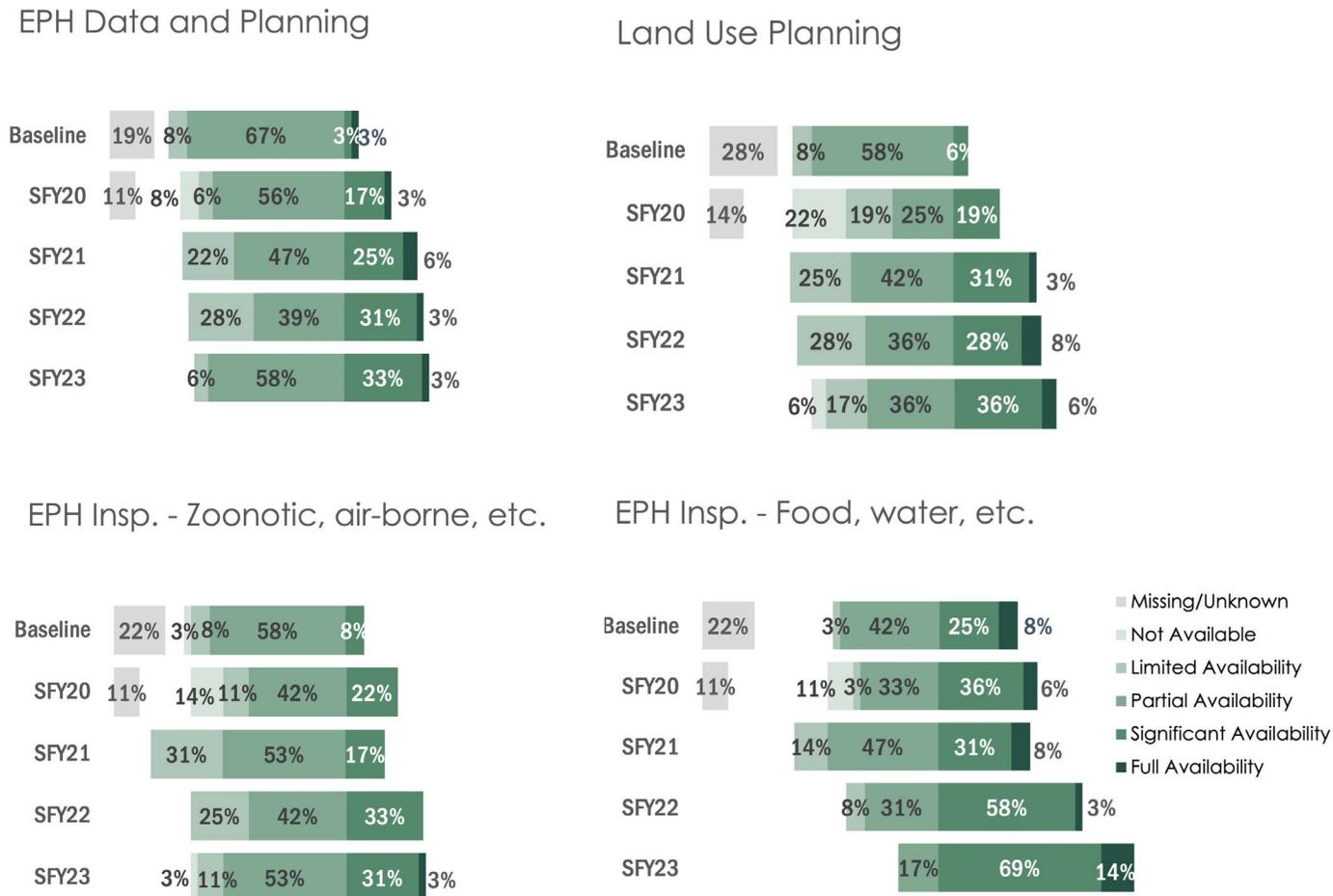
All areas of environmental public health have seen an increase in service availability between baseline and SFY23. The top row in Figure 17 is a roll-up of the areas under environmental public health; overall, there has been a 1100% increase in the percent of agencies with full and significant availability of environmental public health services. The area that had the largest increase in availability was land use planning (650% increase), and the area with the smallest increase was food, water, waste inspections (150% increase).

Figure 17: Changes in environmental public health availability



Figure 18 displays the changes in availability for all environmental public health areas from baseline to SFY23. Although there has been some fluctuation between years, there is an upward trend in availability across all areas since baseline.

Figure 18: Changes in environmental public health availability detail



Annual Report Highlight:



Environmental Public Health

Environmental Public Health (EPH) is a very broad category. This highlight reflects on some of the benefits affecting children in school across the state, with a case study of one mid-sized LHJ.

Recent FPHS investments in EPH have allowed at least five rural LHJs to hire or train environmental health specialists to establish or enhance their monitoring and mitigation of environmental health threats in schools - air quality in particular was mentioned by LHJ recipients as a priority. Additionally, FPHS funding to the State Board of Health has supported their research and policy development efforts regarding school environmental health and indoor air quality.

In 2022, the Benton-Franklin Health District (BFHD) utilized FPHS funding to develop its first School Environmental Health & Safety (EH&S) Program. The BFHD School EH&S program provides health and safety oversight for 103 public and private schools in Benton and Franklin counties. BFHD developed a routine inspection program for K-12 schools, beginning with a focus on laboratory safety and chemical hygiene in

secondary school programs. Many area schools had never participated in a laboratory rehabilitation program and benefited greatly from the renewed focus on safety in this area.

BFHD's School EH&S Program addresses an existing gap in regulation and oversight of school environments. This intervention helps promote and ensure that school environments are conducive to learning and protects the health of building occupants. In addition, the program helps local school districts make healthy, safe, and cost-effective choices that address environmental health priorities. Each of the 42 schools BFHD inspected in their first year had opportunities for improvement in the areas of chemical segregation (96% of schools out of compliance), hazardous waste disposal (92% out of compliance), and housing "ban candidate" chemicals, or chemicals that were not deemed appropriate for the grade-level (86% out of compliance). A great success following the 2022-2023 routine inspections is the mass cleanout of school laboratories that is currently underway by many of the schools inspected. Several hazardous chemicals, such as elemental mercury, formaldehyde, chloroform, and many shock-sensitive chemicals, are in the process of being removed from local schools. In addition, BFHD has partnered with DOH Office of Radiation Protection to remove several radioactive items found in school laboratories.

Lifecourse

SFY23 was the first year agencies were assessed on their expertise and capacity for the lifecourse areas of FPHS since the baseline assessment. The top row in Figure 19 is a roll-up of the areas under lifecourse; overall, there has been a 500% increase in the percent of agencies with full and significant availability of lifecourse services. The lifecourse area with the most change was maternal, child, and family health data and planning (1100% increase) and the area with the least change was access and linkages to clinical care (233% increase).

Figure 19: Changes in lifecourse availability

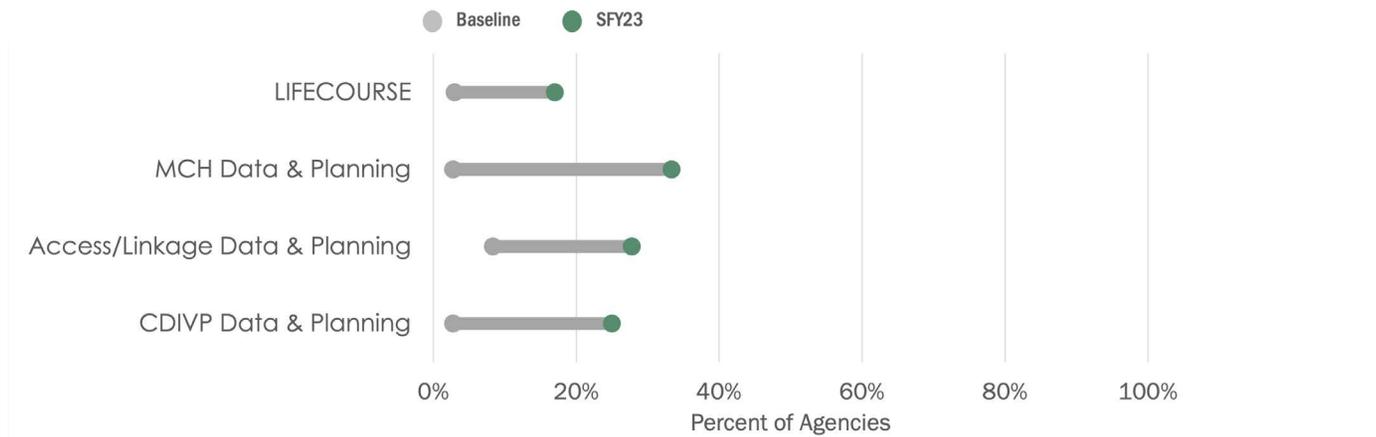
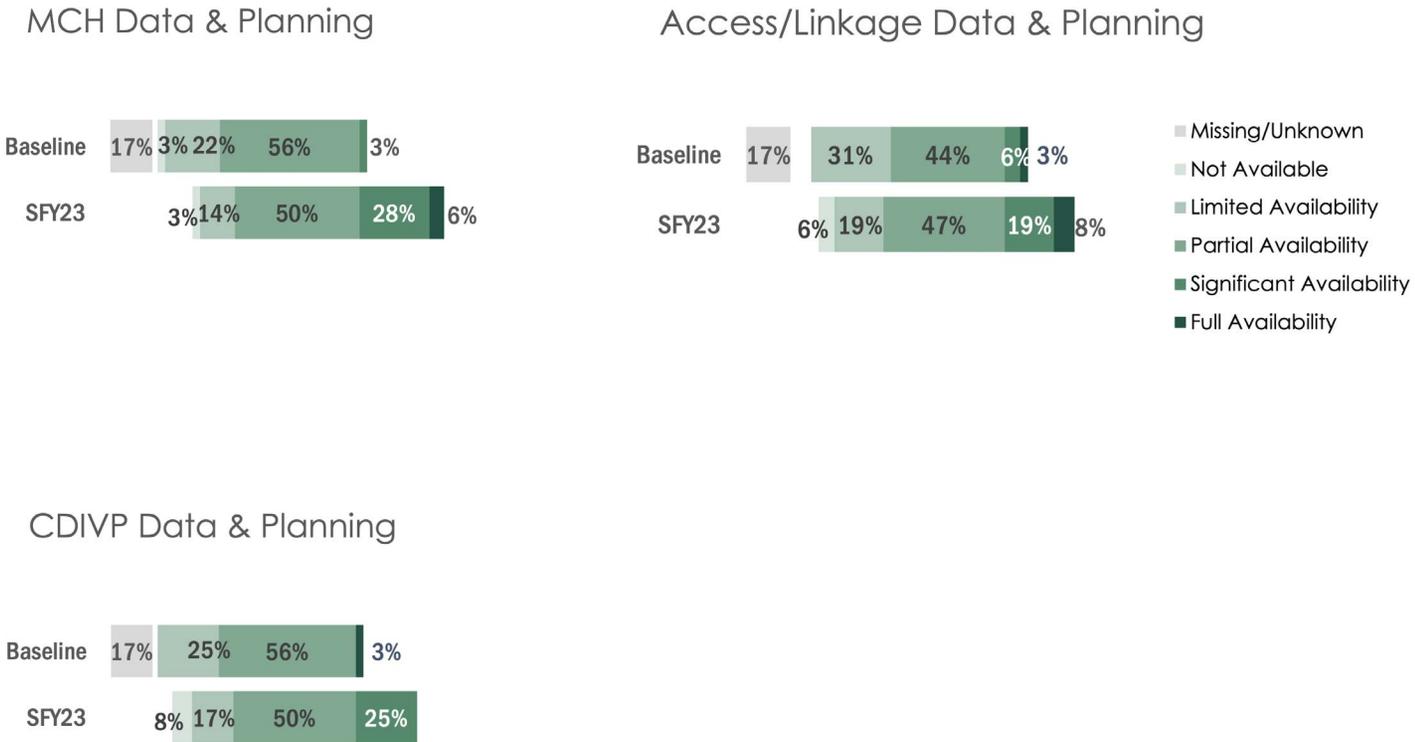


Figure 20 displays the changes in availability for all lifecycle areas from baseline to SFY23. With only two data points, a trend cannot be established, but there was an increase in availability since baseline.

Figure 20: Changes in lifecycle availability detail



Annual Report Highlight:



Child Death Review

Child Death Review (CDR) is a programmatic approach to reducing deaths and injuries of children from nonnatural causes. The work is mainly done at a local level, convening local agencies and organizations to holistically examine cases to identify and implement prevention opportunities. CDR is unique to local health agencies because it requires collecting and discussing confidential information with local partners. LHJs are well-situated to provide expertise in assessment and have established relationships with essential partners.

Prior to this FPHS investment, there were only a handful of active CDR programs across the state, and they were almost all underfunded and understaffed. There are now seventeen CDR programs in the state, most of which participate in a statewide community-of-practice convened by the Washington State Department of Health (DOH), with training support from the National Center for Fatality Review and Prevention. Nine of these CDR programs are funded via FPHS specifically for CDR

programs, and the others have prioritized some of their more flexible FPHS funding to support programs on their own.

Because they now have sustainable funds, LHJ CDR programs can effectively work to prevent future childhood deaths and injuries by examining potential causes and providing evidence for policy or public health interventions. Frequently, childhood deaths disproportionately affect marginalized communities, and these programs illuminate those disparities while working to reduce them. CDR program approaches also carry substantial overlap and opportunities for improving prevention of drug-related deaths and suicide deaths; an LHJ with a strong CDR program is well set up to also engage in those areas.

Vital Records

SFY23 was the first year agencies were assessed on their expertise and capacity for vital records since the baseline assessment. Only one of the two areas in the vital records services program area was assessed for LHJs at baseline, providing birth and death certificates, since the vital records system is a centralized service provided by the state. There was a 38% increase in the availability of birth and death certificates services between baseline and SFY23.

Figure 21 displays the changes in availability for the administration of birth and death certificates from baseline to SFY23. With only two data points, a trend cannot be established, but there was an increase in availability between the two years this area was assessed.

Figure 21: Changes in vital records availability

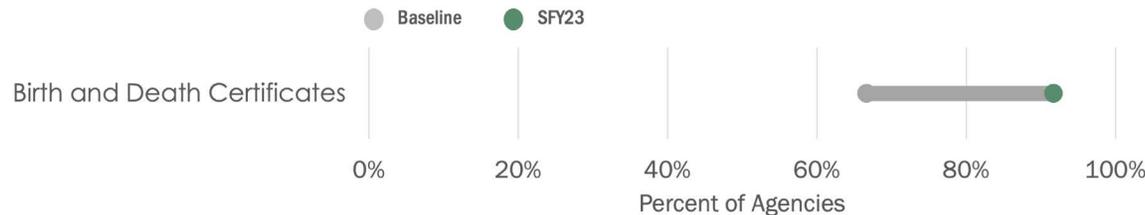
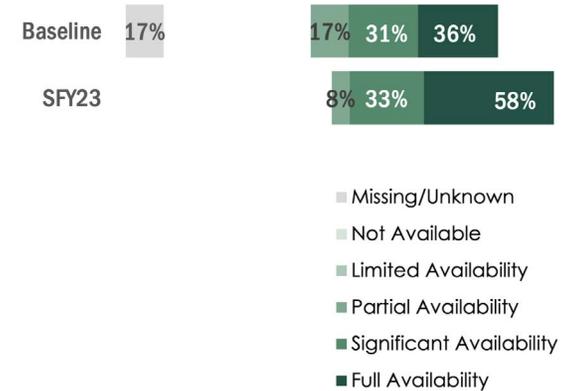


Figure 22: Changes in vital records availability detail

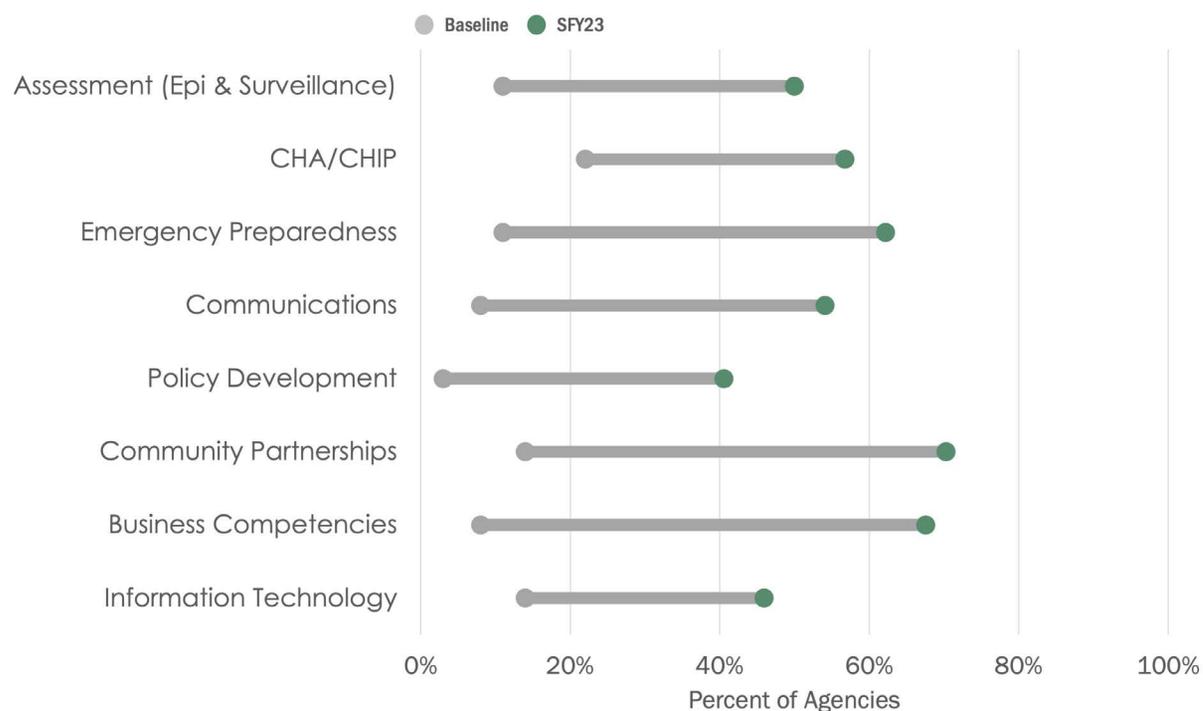
Birth and Death Certificates



Foundational Capabilities

All foundational capabilities have increased in availability between baseline and SFY23. The capability with the largest change was policy development (1400% increase) and the capability with the smallest change was conducting community health assessments/improvement planning (163% increase).

Figure 23: Changes in foundational capabilities availability



“We have been able to use our Community Health Needs Assessment to engage directly with our communities and tackle the issues that they have identified. During the pandemic our rural communities’ trust in public health was eroded and we are now actively working at building that trust by meeting them where they are and addressing their needs with accurate data and guidance.”

Whitman County Public Health

Figure 24 displays the changes in availability for the foundational capabilities. There has been an increase across all foundational capabilities compared to baseline, with the degree of change dependent on the capability.

Figure 24: Changes in foundational capabilities availability detail

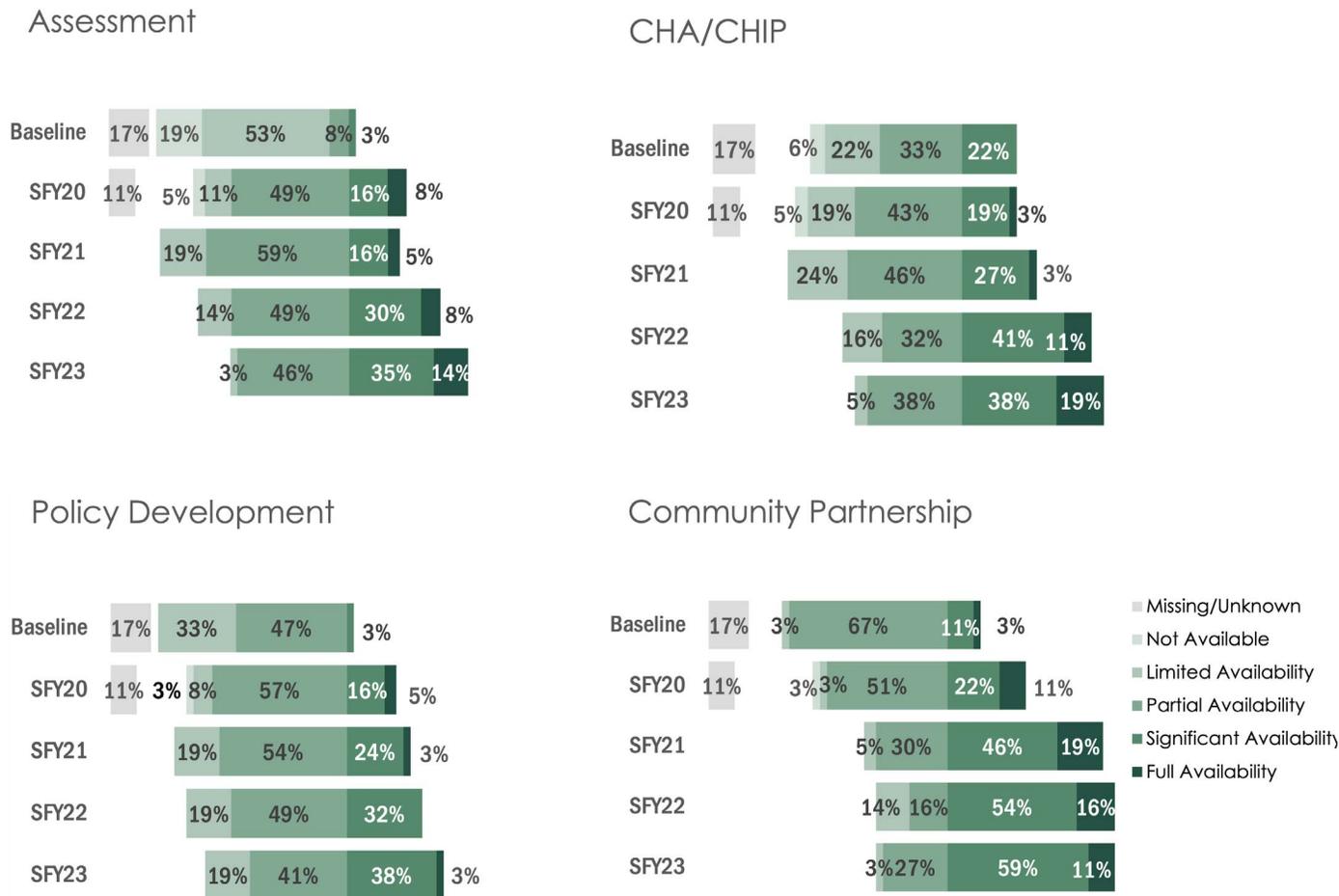
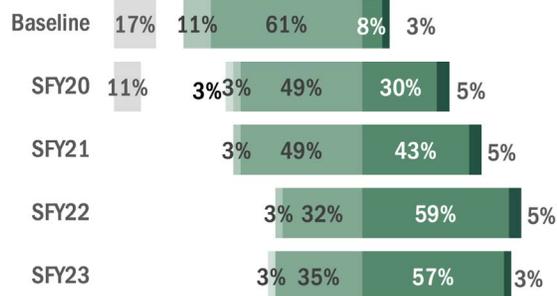
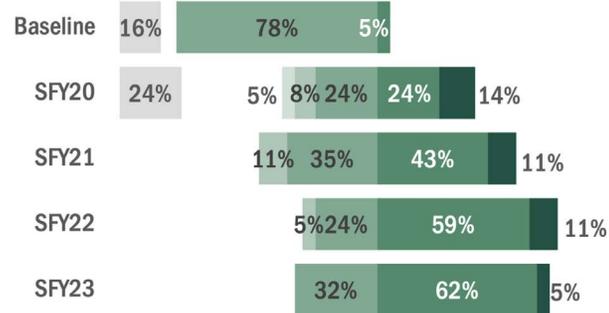


Figure 24 continued.

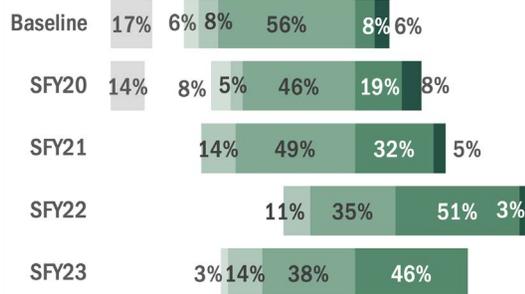
Emergency Preparedness



Business Competencies



Information Technology



Communications



- Missing/Unknown
- Not Available
- Limited Availability
- Partial Availability
- Significant Availability
- Full Availability

Annual Report Highlight:



Foundational Capabilities

Many system partners used FPHS funding to improve communications, business competencies and operations, and community partnerships. Many LHJs reported using FPHS funds to hire Communications staff (some for the first time) or retain Communications staff brought on during COVID. These investments in Communications improved internal processes to increase the quality and frequency of information shared to the public via social media, blog posts, etc. Communications staff also improved relationships with local media to provide them with public health information in a format and schedule that better meets their needs. Dedicated Communications staff have allowed LHJs to focus on engaging communities who may be disproportionately impacted to ensure that they can give input into messaging to improve efficacy. This has increased the ability to reach specific communities and has improved community partnerships. This enhanced collaboration facilitated the exchange of ideas, best practices, and lessons learned, leading to more impactful interventions between healthcare providers, government

agencies/departments, nonprofit organizations, and other stakeholders. The SBOH also used FPHS funds to support a Communications Consultant position to provide critical support for managing and responding to public comment and media inquiries, handling public records requests, maintaining websites, and shifting from virtual meetings to hybrid meeting formats.

Many LHJs also reported using FPHS funds to improve business operations including hiring fiscal managers/staff, contracts and procurement staff, providing staff training, purchasing and upgrading office equipment, and digitizing documentation. Some LHJs also reported enhancing their IT systems to build databases for internal use and better serve the public by providing Web-based access to public health information and services. One rural LHJ had been relying on a small, burdened county IT department and was able to bring IT expertise in-house with FPHS funds. These investments have improved efficiency in operations and increased the public's ability to access PH services and information on the Internet. DOH also reported improvements in IT capabilities and business competencies. DOH has continued to enhance cloud-based environments and systems, including the cloud-based disease reporting systems to increase scalability and processing speed. DOH has invested in improving visualizations and dashboards to assist LHJs and community in making informed health decisions. DOH has also used FPHS investments to provide more support to the tribal liaison team to improve engagement with Tribes and enhance the fiscal/contract team to improve tracking of FPHS investments. FPHS funds allowed the SBOH to expand Health Impact Review (HIR) capacity and hire and train another HIR Policy Analyst, allowing the SBOH to continue to evaluate a variety of new, complex policy topics and increase outreach to legislators and the

Governor's Office. The SBOH also used FPHS funding to expand its efforts to be more accessible to the people who live in Washington. As a result, the SBOH is now able to provide American Sign Language interpretation and Spanish Language interpretation at all Board and Health Disparities Council meetings.

Annual Report Highlight:



Assessment

Beginning with the initial FPHS demonstration projects, funding to support necessary local epidemiology capacity has been a key investment area. Local epidemiology capacity has been supported and improved in different ways based specifically on the local needs - through shared services projects, regional epidemiologists, and direct increases in local epidemiologists within local health jurisdictions.

By adding to the FPHS investment each biennium, as of SFY23, each LHJ that stated they were interested in receiving funding for epidemiology capacity had received it. In SFY23, the FPHS Steering Committee also chose to invest additional funding for each LHJ to support Assessment (surveillance and epidemiology) work. These combined investments have resulted in robust improvements in LHJs capacity and capabilities for Assessment work as demonstrated by the examples below.

Four LHJs (Chelan-Douglas, Grant, Kittitas, and Okanogan) have developed the North-Central Washington Epi Consortium which has allowed the participating

jurisdictions to benefit from shared services and resources to deliver stronger assessment and epidemiology. This consortium has allowed the LHJs to recruit, hire, and train their assessment and epidemiology staff, embark on regional projects, and access support and expertise from technical partners to improve local programs.

Additionally, four small, rural LHJs reported hiring (or contracting with) an epidemiologist for the first time in SFY23 as a result of FPHS investments. The Administrator from Jefferson County shared that having their first in-house epidemiologist “completely changes our ability to handle data collection strategies internally and affords the ability to begin building pathways for assessment information, from distillation to visualization, with transparency so that the public, our community partners, and grantors access [data] more equitably.” Some of these epidemiologists are coordinating with other epidemiology and assessment staff in neighboring counties to prepare regional reports and coordinate data. To further support these investments, a coordinated investment for Statewide Assessment/ Epidemiology Workforce Development helps support staff by providing pathways to learn from colleagues, participate in relevant trainings, and upskill technical skills to best meet the needs of their communities.

Larger counties reported many benefits of the FPHS funding related to Assessment capacity including additional support for epidemiologists around assessment and evaluation, help for LHJs to prioritize their resources more appropriately, and greater ability to assess and analyze data sets (quantitative and qualitative) to ensure they continue to their mission of prioritizing communities who are experiencing negative health outcomes, geographic disparities related to access to care, and more.

Annual Report Highlight:



Emergency Preparedness and Response

In 2021, conversations with public health emergency preparedness and response professionals surfaced a need for supporting on-call staff receiving high levels of emergency calls outside of business hours. The after-hours project workgroup composed of local health jurisdiction (LHJ) and DOH staff formed with the intent to:

1. Reduce the burden of public health calls received outside of LHJ business hours.
2. Reduce administrative burden by lowering the overall cost per agency for a dedicated after-hours call service available across the public health system.
3. Provide more consistent responses to the public and healthcare providers who call public health outside of business hours.

Following an investment of \$250,000, the workgroup supported the creation of an after-hours call procedure, and the DOH entered into a contract with Washington Poison Center (WAPC) to provide after-hours on-call screening to 12 LHJs. A

consistent call service supports the communities served by the governmental public health system to ensure a rapid and appropriate service, while protecting our public health workforce from unnecessary disruptions outside of work hours.

From August 2022 to June 2023, WAPC screened 1346 calls (112 calls monthly). Sixty percent of those calls were addressed by WAPC, and 40% were routed to the appropriate LHJ on-call staff number. Calls received supported communicable disease, environmental public health, maternal and child health, vital records, and other essential public health functions. Feedback from LHJs on this service include:

- Reduction in the after-hours call burden on local staff
- Increased response time to public health questions and concerns
- Continuity among responses that the public are receiving across Washington

All LHJs currently using this service are continuing their participation with ongoing contract support from DOH. At least three LHJ partners requested to be added to the service, but program service was limited due to FPHS funding. A future opportunity for this program includes expanded funding to give more LHJ partners across the system access to this service.

Annual Report Highlight:



Health Impact Reviews (Policy Development)

The Washington State Board of Health (SBOH) received FPHS funding to expand capacity for Health Impact Reviews (HIRs), which are conducted in collaboration with the Governor's Interagency Council on Health Disparities (Council). HIRs are completed at the request of a legislator or the Governor and are a Health in All Policies and Equity in All Policies tool that analyze how proposed legislation may impact health and equity in Washington state. HIRs are objective, non-partisan, and evidence-based.

Washington state legislation impacts every community in the state, particularly underserved and marginalized communities. HIRs present information on a variety of policy topics that impact individual and community health, including education, behavioral and environmental health, economics, the criminal and civil legal systems, and additional topics. Legislators have shared that HIRs provide clarity and highlight equity considerations on particularly challenging bill topics. Legislators have used HIR findings to understand equity implications,

inform their decision-making process or policy direction, and talk with colleagues about a bill. Community-Based Organizations (CBOs) have used HIR findings to conduct further research on specific topics, educate and communicate with partners, and engage in state-level work to address health inequities.

Expanded FPHS funding for HIRs enabled the Board to achieve the following:

- Complete eight HIRs during the 2023 Legislative Session
- Hire and train another full-time HIR Policy Analyst, bringing the Team's capacity to 2.6 FTE (FPHS funding supports 1.6 FTE HIR Policy Analysts)
- Increase outreach to legislators and the Governor's Office
- Complete additional HIRs during the interim
- Further improve HIR processes and products
- Provide additional staff support to the Board and to the Council, including research related to perinatal health, reproductive justice, extreme heat, and health justice
- Explore methods for further integrating equity-focused frameworks; tribal involvement; and compensation for key informant interviewee participants
- Attend an event on co-governance with community organizations and state agencies working to align statewide efforts on economic, environmental, and health justice
- Work with the Environmental Justice Interagency Work Group and state agencies to support development of Environmental Justice Assessments as part of implementing the Healthy Environment for All (HEAL) Act

Overall, FPHS funding allows Board staff to evaluate a variety of policy topics, highlighting Health and Equity in All Policies and providing critical and insightful information to advance state-level equity work.

Centralized Services

There are a few FPHS that are considered centralized services, meaning one entity is responsible for that service being available across the state. LHJs, DOH, and SBOH have been asked to assess their capacity and expertise in public health lab services and prevention of radiation exposure for several years, reflecting on the capacity and expertise of other entities providing these services for their jurisdiction. SFY23 was the first year that agencies were asked to also assess newborn screening and health care licensing services, however, most agencies did not provide this assessment at baseline so there are no data to compare to. Public health lab services have increased in availability by 300%, and prevention of radiation services have increased by 400% since baseline.

Figure 25: Changes in centralized services availability

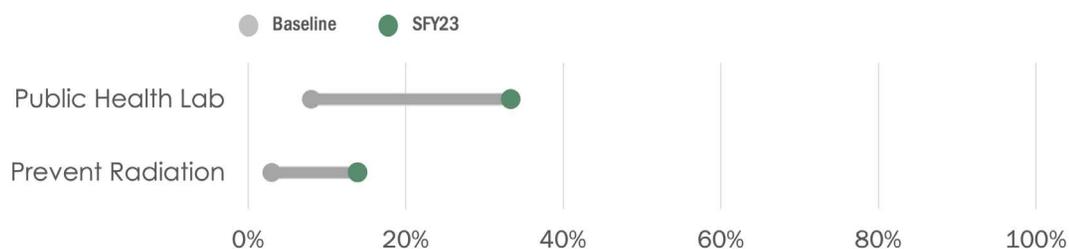
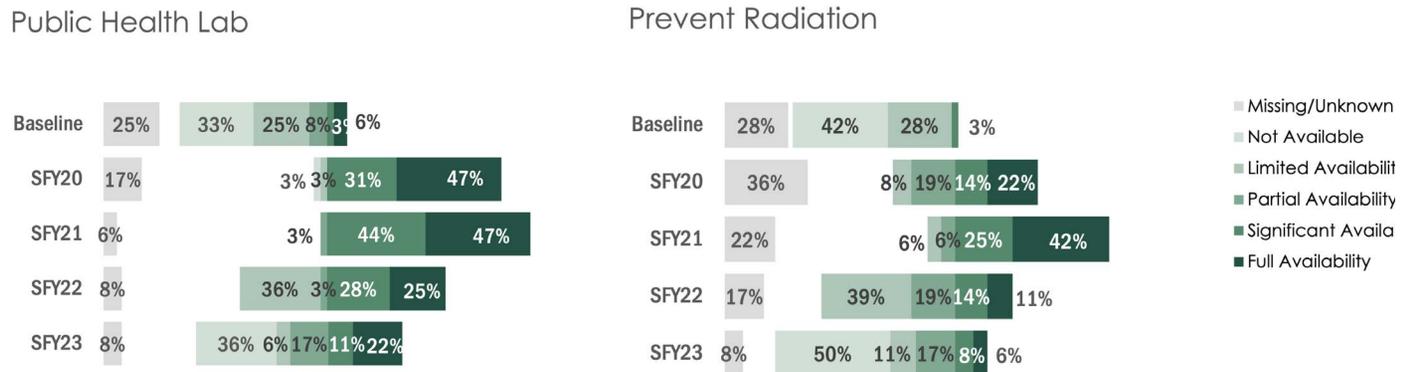


Figure 26 displays the availability of the public health lab and prevent radiation services over time. The reduction in availability between SFY20 and SFY23 was likely due to a change in reporting rather than a change in the availability of services.

Figure 26: Changes in centralized services availability detail



Outcomes

The FPHS Steering Committee selected data indicators to monitor the impact of investing in the governmental public health system. These indicators fell into two categories, disease investigation and immunization rates.

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, syphilis) were selected for outcome measurement because these conditions are priorities for public health intervention and also occur at a frequency such that impacts of investments in FPHS communicable disease investigation capacity should be observable in the data.

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.

The specific indicators selected to monitor the impact of FPHS funding are as follows:

1. Gonorrhea cases interviewed

2. Gonorrhea cases interviewed with correct treatment on record based on CDC recommended treatment guidelines
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 who have completed the standard series of recommended vaccinations
7. Children 4-6 year-olds who have completed the standard series of recommended vaccinations

Indicator data are dependent on data systems. Modernizing data systems and automating steps in the process, like linking laboratory reports with disease investigation data, continues to be a work in progress. 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 a human to enter the information into the respective statewide disease surveillance systems, called Public Health Issue Management System-Sexually Transmitted Disease (PHIMS-STD) and Washington Disease Reporting System (WDRS).

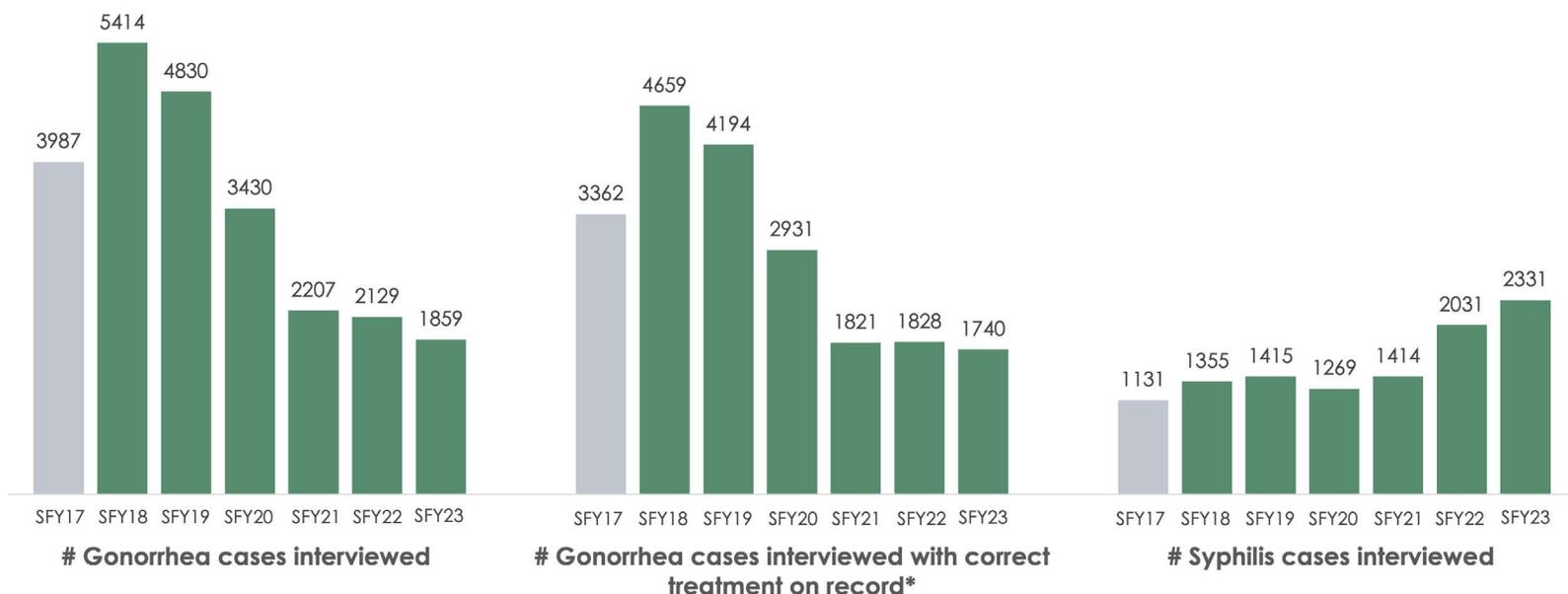
“We more than doubled the number of case interviews completed for gonorrhea and chlamydia in FY2023 leading to identification of additional partners and improved access to expedited partner therapy provided by our division or through a partner clinic.”

Skagit County Public Health

Gonorrhea & Syphilis Case Interviews

The number of gonorrhea case interviews and the number of gonorrhea cases interviewed with appropriate treatment reported continued a downward trend since SFY18. There were more syphilis case interviews conducted in SFY23 than in SFY22, continuing a generally upward trend in syphilis interviews since baseline. These numbers were maintained and achieved in the context of continually increasing STI case burdens and the emergence of new public health challenges such as COVID-19 and Mpox, with resource constraints necessitating focus on priority sub-populations.

Figure 27: Gonorrhea & syphilis case interviews



*Correct treatment is based on CDC recommended treatment guidelines: single 500mg dose of ceftriaxone OR alternative dual therapy if ceftriaxone cannot be used. There is some variation across time with this analysis due to the change in CDC treatment recommendations in 2021, as well as the introduction of new treatment variables in March 2020 to PHIMS-STD.

Hepatitis C Case Investigation

The 2020 supplemental budget provided an initial \$3 million of additional funding for the 2019-2021 biennium to begin addressing hepatitis C. This funding was allocated again for the 2021-2023 biennium, with \$1.5 million allocated for SFY23 to continue to address hepatitis C using shared priorities, standardized surveillance methods, minimum standards of practice, common metrics, and staffing models developed by the FPHS Communicable Disease Subject 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

Figures 28-30 display the total number of hepatitis C case investigations reviewed by public health (PH) staff, compared to the number with complete case investigations, by fiscal year, with SFY19 as the baseline for comparison. Each figure addresses a hepatitis C case type or cohort. The number of completed case investigations for all three types of hepatitis C has fluctuated over the past five fiscal years. The number of completed case investigations for acute hepatitis C in SFY23 was a little more than half the number completed at baseline (37 cases vs. 65 cases). The number of completed case investigations for chronic hepatitis C in SFY23 was about a third more than the number completed at baseline (253 cases vs. 183 cases). And the

number of completed case investigations for hepatitis C among people born in 1992 or later was slightly more in SFY23 compared to baseline (43 cases vs. 36 cases).

Figure 28: Acute hepatitis C case investigations

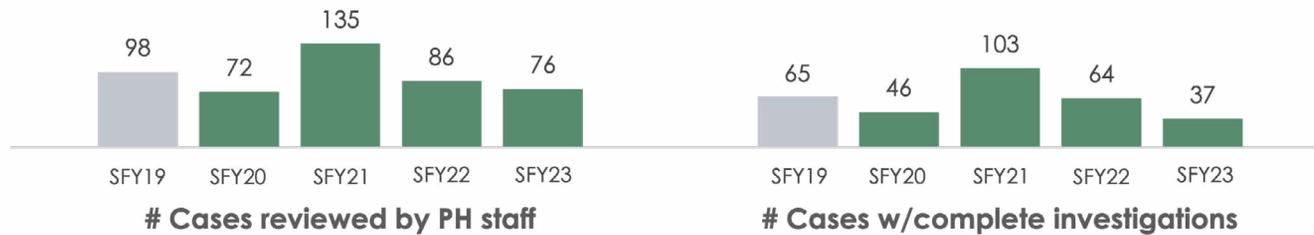


Figure 29: Chronic hepatitis C case investigations

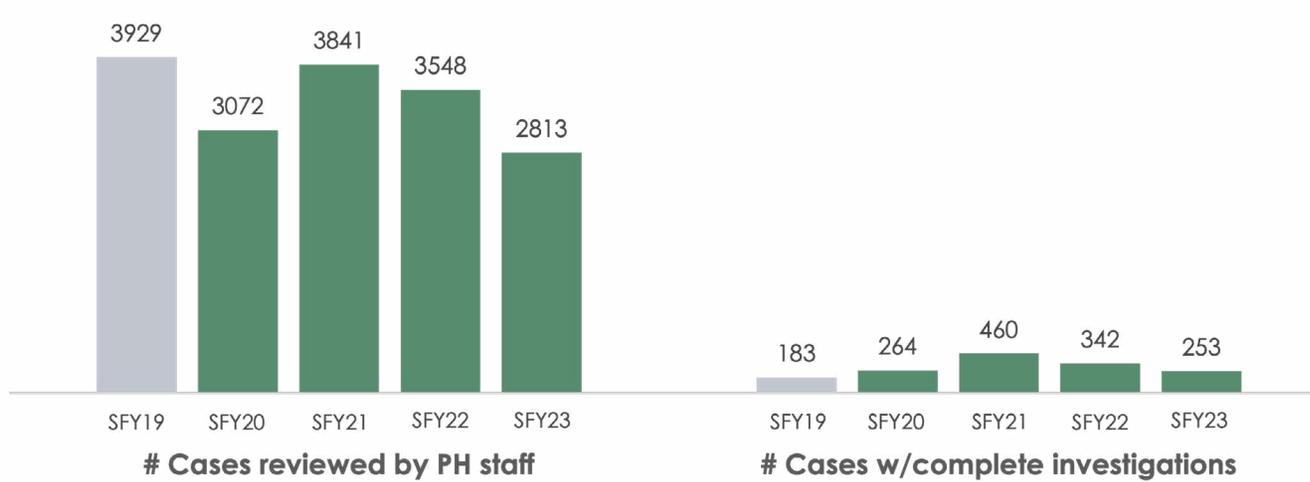
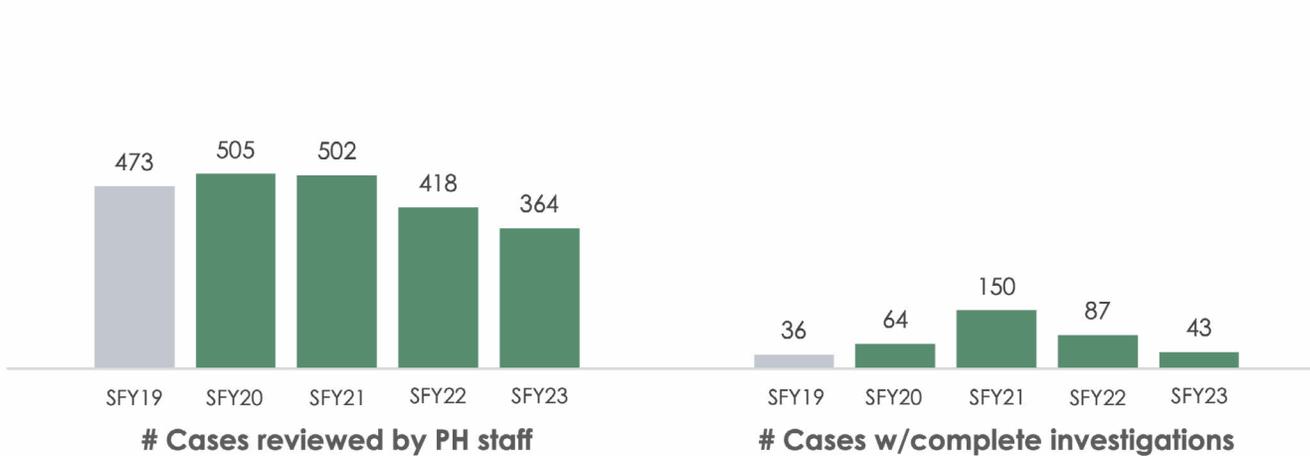


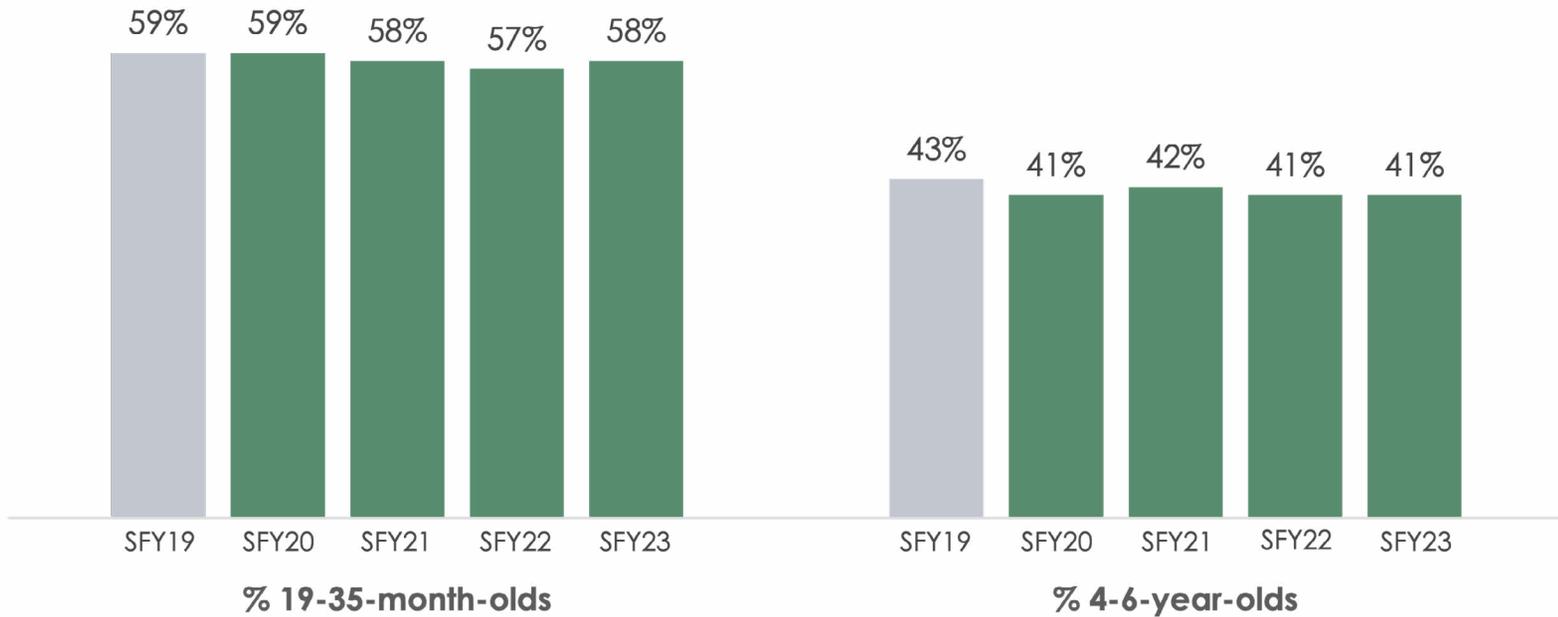
Figure 30: Chronic hepatitis C (born after 1992) case investigations



Completed Immunization Series

Rates of completed immunization series* for 19-35-month-olds and 4-6-year-olds have remained consistent since 2019.

Figure 31: Immunization series completed



*The completed immunization series for 19-35-month olds consists of DtaP (diphtheria, tetanus, and acellular pertussis), polio, MMR (measles, mumps, and rubella), hepatitis B, Haemophilus influenzae type B, varicella (chickenpox), and PCV (pneumococcal conjugate) vaccines. The completed immunization series for 4-6-year-olds consists of DtaP (diphtheria, tetanus, and acellular pertussis), Haemophilus influenzae type B, polio, hepatitis B, MMR (measles, mumps, and rubella), varicella (chickenpox), HepA (hepatitis A) and PCV (pneumococcal conjugate) vaccines.

Appendix

Appendix A: Spending data by LHJ, DOH, SBOH by FPHS

Appendix B: Full sharing data

Appendix C: Summary of qualitative data

Appendix D: Changes in capacity

Appendix E: Methodology

Appendix A: Dollars Spent by FPHS Area/Capability

Dollars spent on communicable disease areas

	CD Data & Planning	Promote Immunization	Disease Investigation - General CD	Disease Investigation - STI	Disease Investigation - Hepatitis C	Disease Investigation - TB	Public Health Lab Spending (centralized)
Adams	\$14,403	\$28,165	\$52,214	\$3,207	\$783	\$83,594	\$0
Asotin	\$124	\$323	\$4,195	\$293	\$169	\$1,266	\$0
Benton-Franklin	\$1,955	\$0	\$696,241	\$73,668	\$34,243	\$51,568	\$0
Chelan-Douglas	\$0	\$0	\$10,592	\$0	\$24,739	\$23,372	\$0
Clallam	\$160,000	\$20,000	\$100,000	\$20,000	\$0	\$50,000	\$0
Clark	\$115,746	\$5,864	\$1,528,639	\$146,019	\$117,000	\$430,215	\$0
Columbia	\$0	\$1,537	\$5,127	\$150	\$0	\$833	\$0
Cowlitz	\$59,769	\$0	\$31,924	\$0	\$965	\$647	\$0
Garfield	\$11,374	\$187	\$2,533	\$58	\$0	\$0	\$0
Grant	\$0	\$6,593	\$73,849	\$50,709	\$0	\$72,202	\$0
Grays Harbor	\$274,002	\$0	\$103,052	\$0	\$0	\$22,412	\$0
Island	\$79,758	\$18,539	\$343,457	\$59,106	\$19,509	\$13,708	\$0
Jefferson	\$0	\$4,200	\$100,800	\$0	\$0	\$7,000	\$0
Kitsap	\$172,097	\$0	\$180,469	\$682,068	\$58,025	\$21,000	\$0
Kittitas	\$0	\$10,000	\$20,000	\$0	\$0	\$0	\$0
Klickitat	\$0	\$57,228	\$58,363	\$0	\$0	\$17,451	\$0
Lewis	\$0	\$0	\$181,336	\$0	\$3,186	\$10,330	\$0
Lincoln	\$0	\$12,562	\$14,181	\$6,448	\$6,608	\$0	\$0
Mason	\$0	\$8,863	\$95,739	\$0	\$2,289	\$88,689	\$0
NE Tri-County	\$0	\$10,329	\$116,539	\$4,040	\$11,662	\$1,705	\$0
Okanogan	\$124,207	\$26,565	\$126,565	\$44,848	\$11,500	\$5,500	\$0
Pacific	\$24,719	\$154	\$69,285	\$0	\$0	\$0	\$0
San Juan	\$0	\$76,539	\$85,347	\$16,798	\$2,141	\$5,084	\$0
Seattle-King	\$772,519	\$115,773	\$5,365,535	\$625,550	\$669,389	\$748,549	\$0
Skagit	\$134,016	\$49,055	\$232,977	\$87,276	\$22,893	\$76,048	\$0
Skamania	\$2,669	\$25	\$27,980	\$133	\$15	\$578	\$0
Snohomish	\$91,311	\$103,706	\$1,496,183	\$216,367	\$0	\$855	\$0
Spokane	\$0	\$237,690	\$679,000	\$179,310	\$173,000	\$28,000	\$0
Tacoma-Pierce	\$248,334	\$18,587	\$2,596,680	\$38,760	\$157,409	\$45,648	\$0
Thurston	\$4,800	\$59,706	\$207,914	\$87,798	\$27,077	\$215,598	\$0
Wahkiakum	\$49,972	\$50,056	\$28,491	\$39,972	\$0	\$0	\$0
Walla Walla	\$55,373	\$2,211	\$97,000	\$3,000	\$3,000	\$11,300	\$0
Whatcom	\$663,401	\$0	\$424,851	\$0	\$88,619	\$30,550	\$0
Whitman	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Yakima	\$0	\$0	\$335,000	\$0	\$47,261	\$21,000	\$0
DOH	\$1,213,768	\$0	\$4,048,978	\$603,084	\$1,001,484	\$316,003	\$3,181,195
SBOH	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Dollars spent on environmental public health areas

	EPH Data & Planning	EPH Inspections – Food, water, waste, lead	EPH Inspections – Zoonotic, air-borne, wildfire, other	Prevent Radiation Exposure (centralized)	Land Use Planning
Adams	\$182	\$25,372	\$106	\$0	\$0
Asotin	\$127	\$24,064	\$2,886	\$0	\$0
Benton-Franklin	\$42,435	\$654,201	\$158,374	\$6,550	\$117,409
Chelan-Douglas	\$122,552	\$0	\$0	\$0	\$0
Clallam	\$120,000	\$48,000	\$0	\$0	\$0
Clark	\$587,194	\$667,257	\$47,313	\$0	\$0
Columbia	\$6,886	\$83,215	\$827	\$0	\$82
Cowlitz	\$0	\$142,516	\$0	\$0	\$0
Garfield	\$1,141	\$13,295	\$292	\$15	\$0
Grant	\$412,042	\$133,394	\$40,118	\$0	\$27,302
Grays Harbor	\$62,046	\$153,887	\$0	\$0	\$100,067
Island	\$79,677	\$292,375	\$17,866	\$0	\$127,654
Jefferson	\$164,824	\$259,219	\$79,924	\$0	\$0
Kitsap	\$30,433	\$536,438	\$12,464	\$8,380	\$0
Kittitas	\$230,000	\$0	\$0	\$0	\$0
Klickitat	\$3,913	\$283,457	\$16,288	\$0	\$0
Lewis	\$0	\$217,189	\$866	\$0	\$130,630
Lincoln	\$92,247	\$66,642	\$558	\$0	\$0
Mason	\$0	\$184,866	\$0	\$0	\$0
NE Tri-County	\$399	\$329,095	\$7,389	\$0	\$1,480
Okanogan	\$50,000	\$9,184	\$17,000	\$0	\$16,138
Pacific	\$111,489	\$32,146	\$0	\$0	\$33,365
San Juan	\$32,315	\$80,737	\$0	\$0	\$0
Seattle-King	\$1,026,914	\$1,269,888	\$475,238	\$0	\$484,852
Skagit	\$31,109	\$271,143	\$21,477	\$0	\$0
Skamania	\$3,582	\$70,272	\$0	\$0	\$0
Snohomish	\$0	\$1,481,059	\$0	\$0	\$0
Spokane	\$20,000	\$99,254	\$700,472	\$118	\$28,156
Tacoma-Pierce	\$448,668	\$486,072	\$586,645	\$0	\$895,575
Thurston	\$0	\$249,380	\$10,183	\$0	\$157,186
Wahkiakum	\$51,057	\$9,943	\$11,165	\$0	\$17,833
Walla Walla	\$221,000	\$195,000	\$86,050	\$0	\$52,500
Whatcom	\$504,525	\$76,275	\$0	\$0	\$0
Whitman	\$129,461	\$0	\$0	\$0	\$0
Yakima	\$287,027	\$0	\$0	\$0	\$0
DOH	\$15,982	\$1,796,173	\$980,978	\$17,392	\$249,101
SBOH	N/A	N/A	N/A	N/A	N/A

Dollars spent on lifecourse areas

	MCH Data & Planning	Newborn Screening (centralized)	Access/Linkage Data & Planning	Health Care Licensing (centralized)	Chronic Disease, Injury & Violence Prevention Data & Planning	Vital Records System (centralized)	Birth and Death Certificates
Adams	\$0	\$0	\$4,072	\$0	\$452	\$0	\$15,415
Asotin	\$0	\$0	\$7,741	\$0	\$72,105	\$0	\$8,130
Benton-Franklin	\$158,621	\$0	\$49,846	\$0	\$60,426	\$0	\$0
Chelan-Douglas	\$23,335	\$0	\$69,627	\$0	\$242,267	\$0	\$0
Clallam	\$0	\$0	\$20,000	\$0	\$0	\$0	\$0
Clark	\$83,000	\$0	\$67,485	\$0	\$758,068	\$0	\$95,900
Columbia	\$0	\$0	\$5,464	\$0	\$2,171	\$0	\$7,506
Cowlitz	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Garfield	\$4,308	\$0	\$1,584	\$0	\$37,305	\$0	\$1,544
Grant	\$0	\$0	\$45	\$0	\$308,366	\$0	\$32,927
Grays Harbor	\$22,882	\$0	\$474,645	\$0	\$247,734	\$0	\$30,570
Island	\$179,357	\$0	\$41,369	\$0	\$60,072	\$0	\$69,083
Jefferson	\$117,667	\$0	\$117,667	\$0	\$116,839	\$0	\$0
Kitsap	\$122,948	\$0	\$104,038	\$0	\$269,622	\$0	\$0
Kittitas	\$0	\$0	\$200,000	\$0	\$153,000	\$0	\$0
Klickitat	\$36,467	\$0	\$0	\$0	\$24,387	\$0	\$0
Lewis	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Lincoln	\$2,545	\$0	\$31,033	\$0	\$50,261	\$0	\$15,068
Mason	\$0	\$0	\$0	\$0	\$0	\$0	\$0
NE Tri-County	\$0	\$0	\$14,582	\$0	\$16,972	\$0	\$169
Okanogan	\$18,069	\$0	\$24,000	\$0	\$0	\$0	\$90,542
Pacific	\$76,351	\$0	\$134,797	\$0	\$141,877	\$0	\$15,467
San Juan	\$0	\$0	\$208,514	\$0	\$0	\$0	\$0
Seattle-King	\$35,742	\$0	\$274,724	\$0	\$0	\$0	\$17,613
Skagit	\$105,757	\$0	\$56,080	\$0	\$59,736	\$0	\$0
Skamania	\$1,028	\$0	\$909	\$0	\$3,434	\$0	\$0
Snohomish	\$657,479	\$0	\$0	\$0	\$0	\$0	\$0
Spokane	\$278,732	\$0	\$0	\$0	\$523,268	\$0	\$0
Tacoma-Pierce	\$258,450	\$0	\$508,251	\$0	\$0	\$0	\$0
Thurston	\$46,896	\$0	\$174,296	\$0	\$33,479	\$0	\$0
Wahkiakum	\$60,070	\$0	\$178,796	\$0	\$83,495	\$0	\$30,639
Walla Walla	\$1,055	\$0	\$10,550	\$0	\$35,600	\$0	\$45,000
Whatcom	\$384,052	\$0	\$100,044	\$0	\$0	\$0	\$0
Whitman	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Yakima	\$170,160	\$0	\$283,813	\$0	\$116,026	\$0	\$0
DOH	\$128,708	\$537,012	\$278,992	\$0	\$5,875	\$0	\$0
SBOH	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Dollars spent on foundational capabilities

	Community Health				Community			
	Assessment (Epi & Surveillance)	Assessment and Improvement Plan	Emergency Preparedness	Communications	Policy Development	Partnership Development	Business Competencies	Information Technology
Adams	\$11,049	\$3,241	\$0	\$2,052	\$710	\$5,382	\$143,518	\$395
Asotin	\$82	\$21,717	\$7,450	\$2,562	\$18,298	\$2,174	\$644,873	\$7,600
Benton-Franklin	\$235,388	\$23,908	\$0	\$297,603	\$3,498	\$23,482	\$0	\$314,584
Chelan-Douglas	\$316,728	\$90,000	\$180,875	\$9,275	\$0	\$0	\$637,600	\$162,040
Clallam	\$0	\$50,000	\$0	\$100,000	\$5,000	\$43,000	\$100,000	\$10,000
Clark	\$167,586	\$151,724	\$173,089	\$49,497	\$49,497	\$29,395	\$169,512	\$0
Columbia	\$0	\$65,657	\$2,458	\$2,781	\$4,885	\$20,560	\$271,799	\$0
Cowlitz	\$0	\$0	\$864	\$0	\$0	\$0	\$26,357	\$67,958
Garfield	\$1,347	\$53,310	\$5,837	\$37,024	\$20,306	\$36,362	\$120,922	\$78
Grant	\$81,030	\$43,490	\$0	\$51,179	\$31,987	\$0	\$0	\$120,767
Grays Harbor	\$0	\$25,662	\$44,337	\$89,616	\$0	\$49,489	\$25,500	\$25,000
Island	\$59,757	\$142,202	\$69,707	\$13,892	\$0	\$6,900	\$0	\$6,012
Jefferson	\$79,167	\$28,853	\$0	\$139,971	\$0	\$0	\$78,000	\$0
Kitsap	\$254,593	\$116,424	\$0	\$150,000	\$0	\$0	\$0	\$0
Kittitas	\$60,000	\$30,000	\$15,000	\$70,000	\$20,000	\$20,000	\$175,000	\$15,000
Klickitat	\$0	\$0	\$0	\$0	\$0	\$0	\$266,353	\$0
Lewis	\$48,011	\$22,758	\$44,278	\$12,887	\$127	\$0	\$129,581	\$21,018
Lincoln	\$12,420	\$71,184	\$1,345	\$6,791	\$2,027	\$58,278	\$293,982	\$158,820
Mason	\$10,932	\$51,258	\$3,500	\$31,298	\$19,667	\$12,931	\$82,689	\$0
NE Tri-County	\$353	\$42,773	\$0	\$1,505	\$2,076	\$60,542	\$311,748	\$458,644
Okanogan	\$56,357	\$141,565	\$12,245	\$39,000	\$46,000	\$10,001	\$187,714	\$88,000
Pacific	\$103,935	\$136,120	\$20,129	\$10,311	\$35,909	\$11,242	\$129,703	\$0
San Juan	\$0	\$130,154	\$32,595	\$30,035	\$0	\$0	\$198,726	\$22,014
Seattle-King	\$158,992	\$1,283,951	\$877,425	\$937,186	\$249,195	\$580,966	\$0	\$0
Skagit	\$19,882	\$49,415	\$106,683	\$105,094	\$25,667	\$98,857	\$223,803	\$3,032
Skamania	\$179	\$66,878	\$52,399	\$458	\$10,895	\$9,363	\$397,154	\$19,461
Snohomish	\$0	\$1,519,040	\$0	\$0	\$0	\$0	\$0	\$0
Spokane	\$115,000	\$671,271	\$0	\$0	\$0	\$106,727	\$396,002	\$0
Tacoma-Pierce	\$121,133	\$50,571	\$283,228	\$58,917	\$128,469	\$40,718	\$318,446	\$135,848
Thurston	\$19,109	\$2,888	\$37,260	\$9,931	\$308,250	\$80,394	\$449,192	\$463,662
Wahkiakum	\$60,000	\$30,000	\$0	\$1,649	\$0	\$8,572	\$151,231	\$20,059
Walla Walla	\$150,000	\$60,000	\$5,899	\$52,247	\$25,000	\$15,000	\$50,000	\$32,215
Whatcom	\$119,208	\$42,125	\$0	\$136,277	\$0	\$0	\$112,698	\$177,608
Whitman	\$292,040	\$168,368	\$0	\$299,508	\$90,192	\$198,615	\$113,816	\$0
Yakima	\$210,000	\$29,734	\$0	\$2,000	\$176,602	\$49,134	\$721,253	\$65,985
DOH	\$2,248,566	\$21,761	\$229,500	\$184,630	\$0	\$0	\$3,239,211	\$2,551,607
SBOH	\$0	\$0		\$60,000	\$400,000	\$36,000	\$78,460	\$10,500

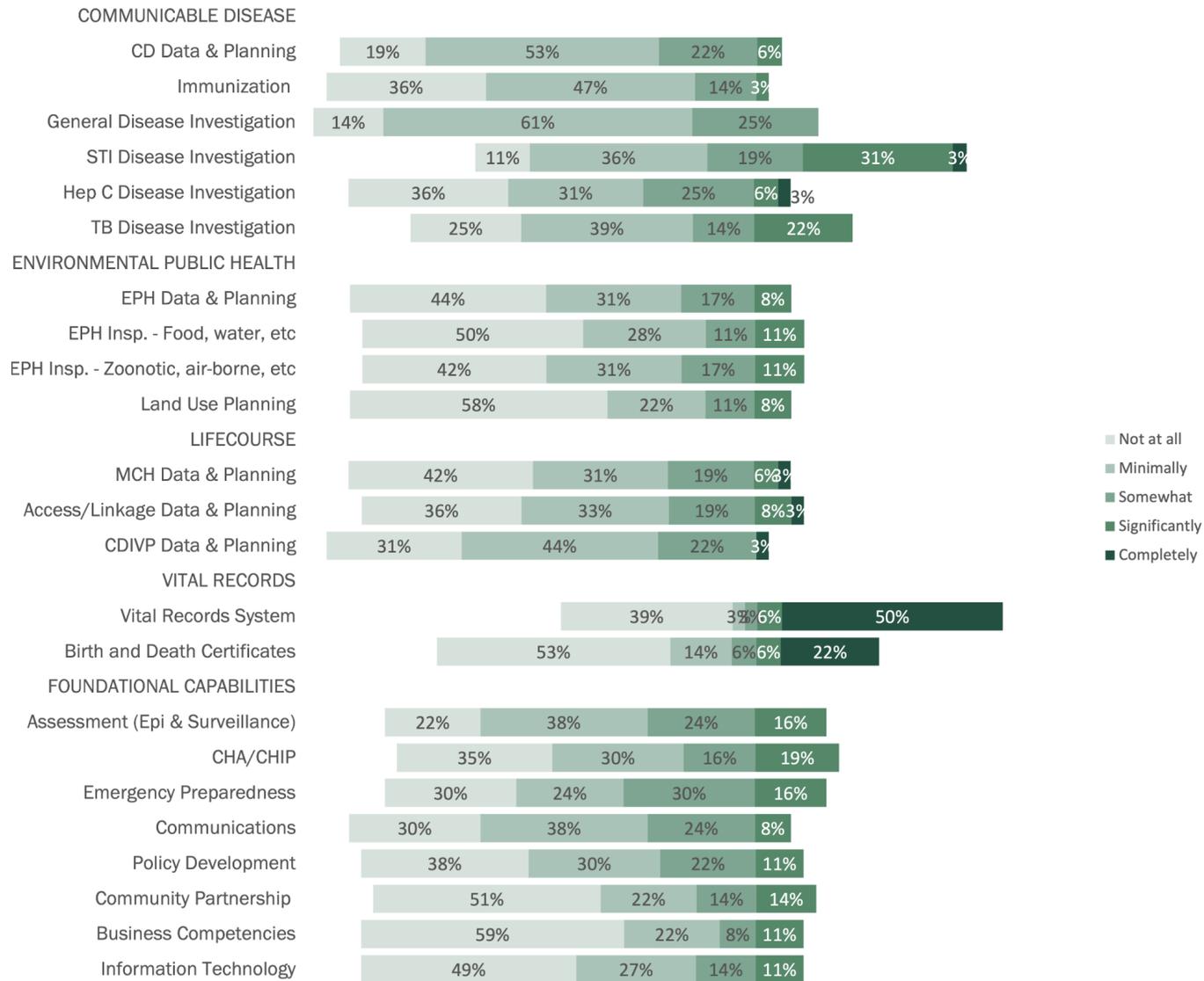
Appendix B: Shared FPHS

Agencies were asked to rate on a 5 point likert scale (not at all, minimally, somewhat, significant, and completely) how much they received FPHS services from another agency in SFY23, their willingness to receive FPHS services from another agency in the future, and their willingness to provide services to another agency in the future.

Current Sharing of FPHS

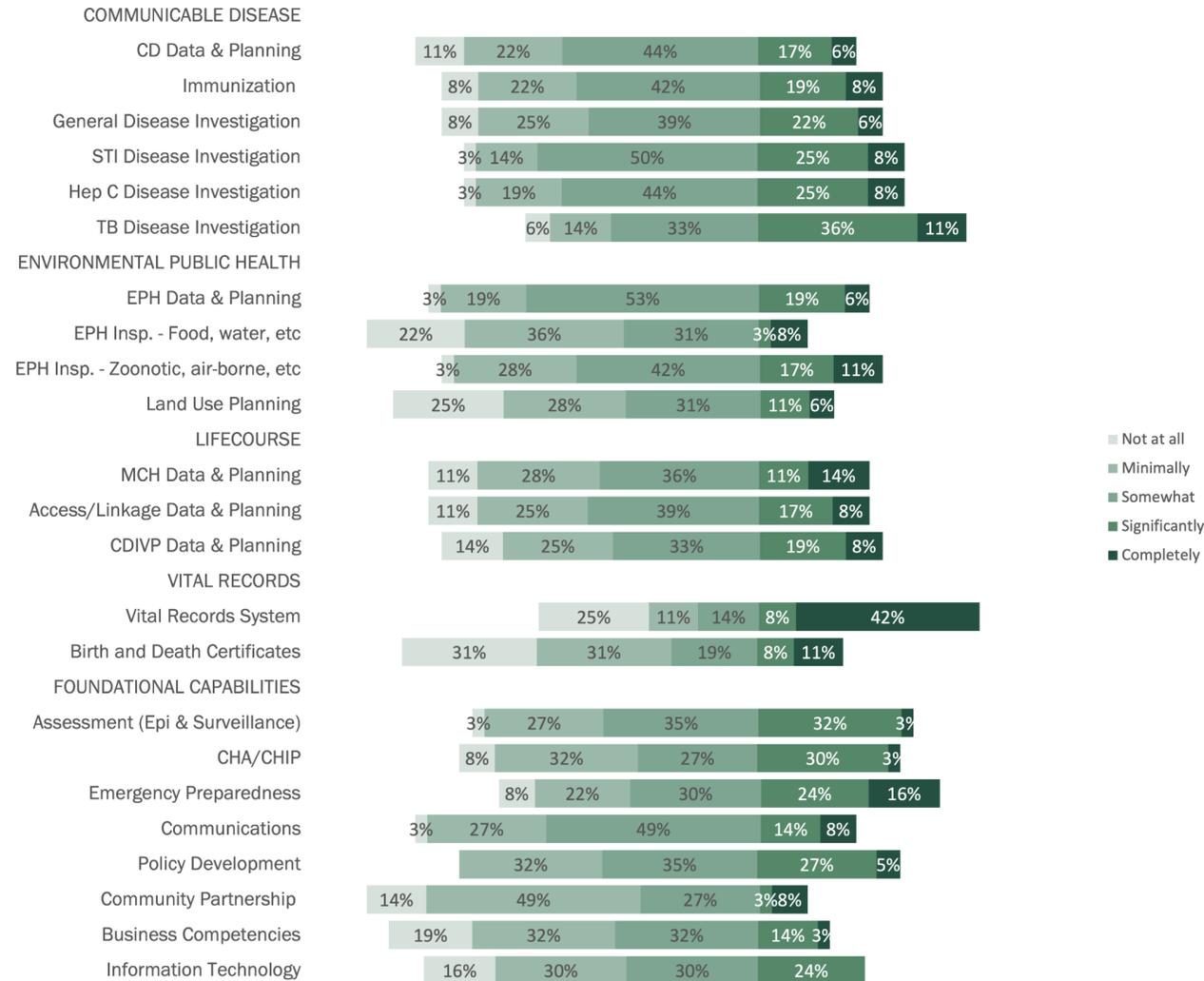
Agencies were asked "To what extent did this jurisdiction receive shared services from another public health agency (e.g. King, Spokane, Tacoma-Pierce, Regional Epi, DOH, SBOH, etc.) for these FPHS activities July 2022 thru June 2023. If the actives were entirely provided by another entity (i.e. PHL, radiation, please rate current sharing as 5)."

SFY23 Sharing of FPHS



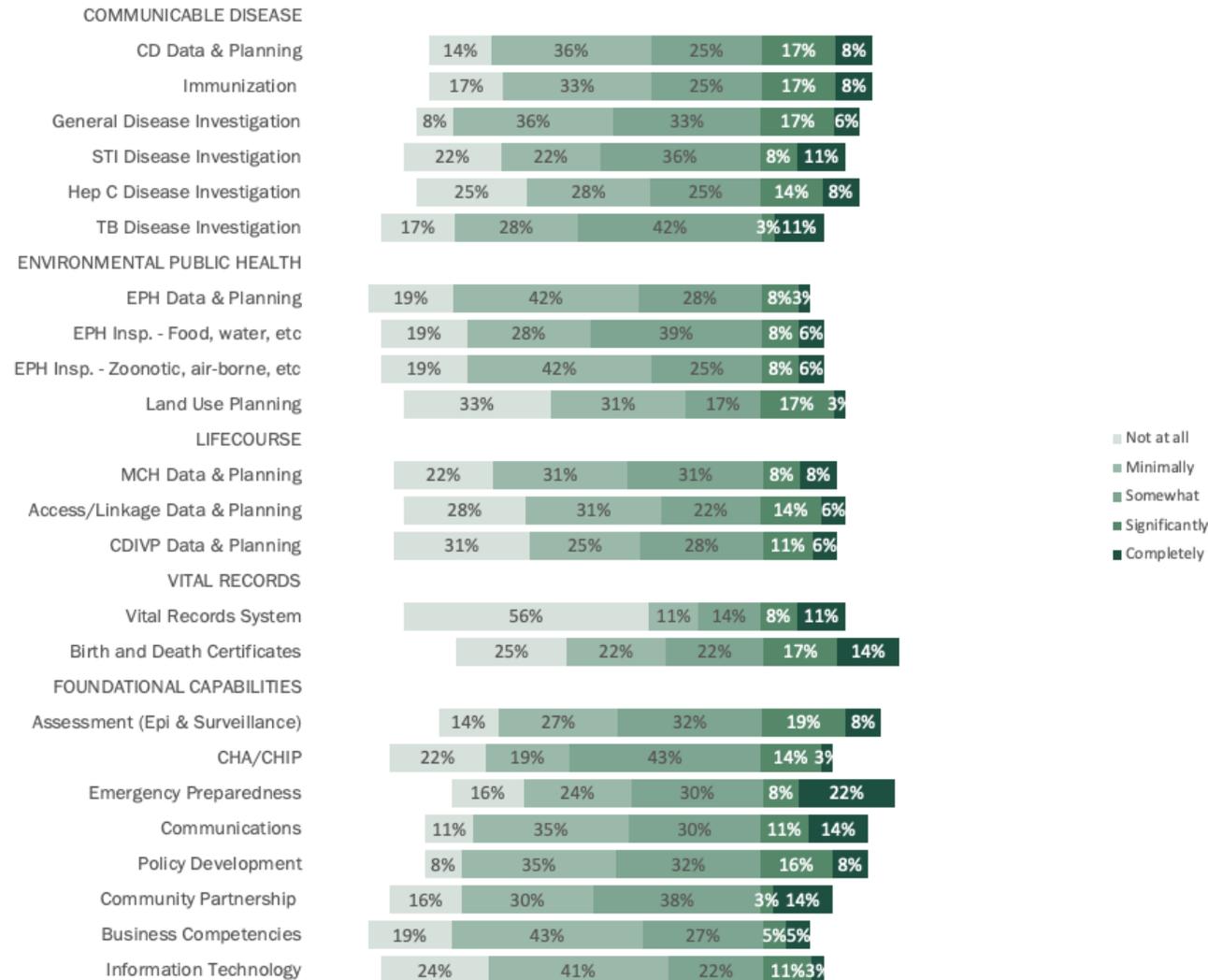
Willingness to Receive FPHS

Agencies were asked, "To what extent would you be willing to work with another public health agency that has capacity/expertise to deliver the service in your jurisdiction?"



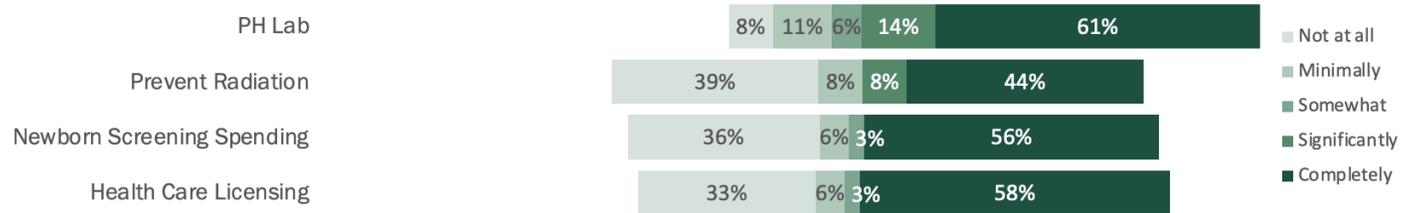
Willingness to Provide FPHS

Agencies were asked, "To what extent would you be willing to work with another public health agency to provide capacity/expertise to deliver the service in that jurisdiction?"

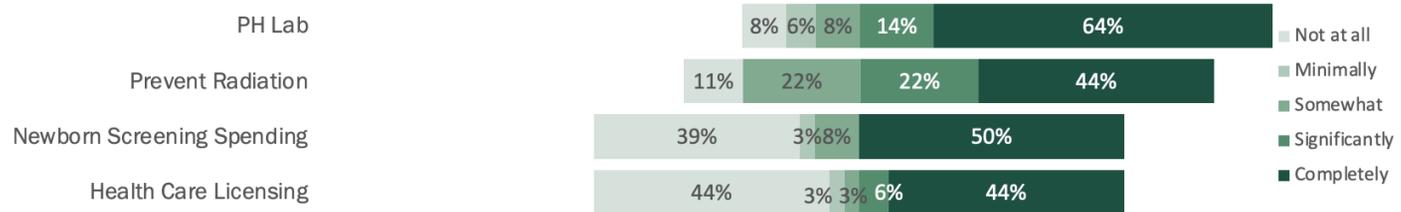


Centralized Services

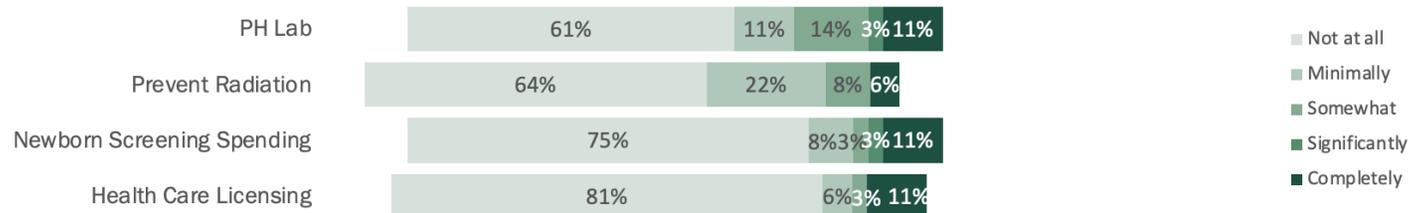
SFY23 Sharing of FPHS: Centralized Services



Willing to Receive FPHS: Centralized Services



Willing to Provide FPHS: Centralized Services



Appendix C: WA FPHS SFY23 Qualitative Data

Introduction

Annual assessment reports were completed by 35 LHJs, SBOH, and DOH. These are annual reports that agencies complete on an annual basis to document progress in the implementation of foundational public health services in Washington state.

Six open-ended questions were asked on the SFY23 reporting tool:

1. From July 2022 to June 2023, what changed in the capacity, expertise or structure of how FPHS are delivered in your jurisdiction?
2. From July 2022 to June 2023, what changed for communities in your jurisdiction regarding FPHS available to them?
3. Please give examples of how FPHS funds have supported innovation and transformation either within your agency or between your agency and the community and/or public health partners.
4. Please describe any challenges or barriers to using FPHS funds this year.
5. How have FPHS funds helped address health disparities or inequities in your community?
6. 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.

Findings

Changes in capacity, expertise, or structure of FPHS delivery; changes for community in FPHS availability

These two questions have been combined due to large overlap in response themes. plement FPHS completely.

Agencies reported many changes in capacity, expertise, and structure of how FPHS funds were delivered in their jurisdictions over the past fiscal year, as well as changes for how FPHS funds were available to the community. The most frequently mentioned change was in staffing; almost all agencies reported making changes related to staffing, including hiring/recruitment activities, expanding staff capacity, training staff, and working on staff retention. New staff were hired across a range of programs and brought new expertise to organizations to help fill gaps and expand programing. Hiring new staff, along with solidifying organizational processes and dedicating time and funds to training staff, increased capacity for over half of agencies.

Over half of agencies also discussed changes in expertise related to data collection or management. Some conducted assessments of needs for the whole community or for specific populations in their communities, some built out data dashboards, and some adopted new technology to assist them with data management. Several mentioned that FPHS funds allowed them to complete more robust Community Health Assessments, or that due to lack of funding in the past, they had not been able to regularly conduct CHAs; FPHS allowed them to do so. They worked with new technologies to make data more available to the community.

Other logistical changes included:

- Improving IT systems
- Implementing or enhancing EMR systems
- Upgrading technology for staff
- Updating, modernizing, and streamlining organizational processes

Some agencies mentioned that making these processes easier and expanding their organizations allowed them to respond more quickly to community needs and to be more proactive, whereas in the past limited capacity only allowed them to be reactive.

Many agencies discussed expanding existing programs or creating new ones to better serve their community's specific needs.

"We are recreating critical programs that we lost due to budget cuts over the last 20 years. FPHS funding has allowed us to bring back many of these programs and deliver community education addressing healthy eating and nutrition." -Agency respondent

Over half of agencies discussed that FPHS funding allowed them to create or deepen relationships with partners like schools, long term care facilities, CBOs, and advisory committees. According to respondents, these partnerships allowed them to better reach the community, do targeted work for those experiencing inequities, and improve the quality of their services. Some examples of new/expanded programs included:

"...Planning was made possible by FPHS funding, allowing staff to work with community partners to develop comprehensive strategies and set achievable goals for sustained health improvement, implementing the social ecological model and logic model approaches to evaluation." -Agency respondent

"These collaborations not only improved health outcomes but also strengthened partnerships between stakeholders, the department, and the community, creating a sustainable framework for ongoing collaboration." -Agency respondent

Other changes for organizations and communities included:

- Improvements to communications/health messaging
- Investments in emergency preparedness
- Increased ability for surveillance and environmental risk monitoring

Examples of innovation and transformation

Agencies were asked to share examples of how FPHS funds have supported innovation and transformation, either within the agency, as well as with external partners. There were four primary themes that arose related to internal agency innovation; tool/resource development, assessment/analysis, training, and technology. Three themes were identified related to external innovation; relationship building, expanded programming/services, and communications.

Some agencies reported developing tools as examples of innovation. Types of tools/resources mentioned included a model lead prevention program, a Resource Guide that contains local community resources and acts as a compliment to 211, protocols and data systems to focus on chronic untreated HCV cases and support

providing HCV follow up and treatment, a checklist and resources for pool operators to support compliance, technical resources and response guidance for climate related events such as wildfire smoke, GIS capabilities for storytelling and data visualization, and a “model program” for climate and health activities across the public health system, including model program elements to assess and reduce exposures to smoke, harmful algal blooms, and heat.

A few agencies mentioned innovative practices related to assessment/analysis. Examples included a county-level assessment of unhoused people, complete a gaps analysis, and conducting community listening sessions. A few agencies also mentioned training in response to this question, noting that FPHS funds allowed for better training for staff and partners.

“This funding also has provided additional systems capacity for better training and management of public health staff to help ensure that staff are being supported in learning, understanding, and following best practices.” -Agency respondent

And finally, many agencies reported the use of technology as innovative practices. Examples included building out or creating new web pages, electronic medical record system improvements, online environmental health application and information systems, the development of data dashboards, and transitioning to technology that increased internal team communications.

Externally, many agencies reported innovative practices in working with partners. Types of partners mentioned included daycare, K-12 schools, universities, health systems, community specific navigators, community based organizations, other government agencies, community members, other LHJs, fire departments, tribes, and

skilled nursing homes. Some ways that community partners were engaged included providing training, convening meetings, developing plans together, conducting assessments together, building relationships, increased access to care (including testing and treatment), increased communication mechanisms (e.g. newsletters and websites), and developing community-based messaging.

Some agencies also reported expanded programming and services as examples of innovation. Examples included expansion of services to more community members, broader implementation of low barrier treatment with buprenorphine, providing disaster preparedness workshops, providing services to houseless communities, expanding rapid syphilis testing, providing chronic disease self-management classes, providing mental health first aid classes, and building out an air quality program.

“Mobile public health van received in March 2023--allowing us to take public health services to the community where they live, work, and play.” -Agency respondent

A few agencies also specifically mentioned communications efforts, including topics such as vaccines, food safety, suicide prevention, and opioid abuse prevention.

“Funding allowed for an expanded approach to communications, allowing for effective information sharing and coordination among community partners. This enhanced collaboration facilitated the exchange of ideas, best practices, and lessons learned, leading to more impactful interventions.” - Agency respondent

Challenges or barriers to using FPHS funds

Agencies were asked what challenges or barriers they experienced when using FPHS funding. Most challenges agencies reported related to staffing or to funding logistics and requirements. Over half of agency respondents discussed staffing challenges that hindered their ability to effectively use FPHS funding. Specifically,

- Counties were not able to carry out all the programs/activities they hoped because they faced challenges when trying to recruit new staff members who would help with these activities. Many mentioned that their counties lacked qualified candidates.
- Although there was a need for additional staff, counties were unable to house these staff due to their physical office space. A few mentioned that they could not use FPHS funding to expand.
- Keeping up with the need for additional staff was challenging; the hiring process took time.
- Counties experienced high staff turnover rates.
- Capacity of current staff members and also of partners posed a challenge to implementing programs/services funded with FPHS dollars.

Many of the challenges that respondents shared about funding logistics related to the timing of funding disbursement or allowed time for spending. Over one-third of respondents commented on this barrier. Many said that the delay in announcement of funds was a challenge, as it delayed the start to their work or caused the funding to not be in alignment with county policies/budget cycles.

"The limited timeframe for spending funds created pressure to allocate resources efficiently and effectively, which was difficult to align with the timelines for funding review and approval." -Agency respondent

Another barrier identified by respondents was the rigidity of spending requirements. Respondents desired more flexibility so they could use funds as they best saw fit for their communities.

Respondents also felt they needed to become more comfortable with funding definitions, or that the county/community needed more information on how FPHS funding could be spent.

Finally, respondents shared that it took time to develop programs, train staff, and stand up new processes, which felt like a challenge at times.

How health disparities or inequities were addressed

Agencies shared several examples of how FPHS funds helped them address health disparities or inequities in their community. Over half of agencies named programs they built, expanded, or continued that addressed specific communities experiencing inequities. For example, agencies mentioned an outreach program for African immigrants, an outreach program for Pacific Islanders related to Tuberculosis, data analysis on the disparate impacts of Monkeypox for men who have sex with men, and provision of Narcan to high-risk populations. About one-fourth of agencies explicitly mentioned partnering with other organizations to better reach communities who experienced inequities.

Another way that agencies addressed health disparities and inequities in their communities was by working to improve communications; creating outreach materials that would resonate with the community, improving outreach to hard-to-reach populations, and trying new communication channels. About half of agencies also discussed improved ability to provide materials or services in other languages.

Many agencies began their work to address inequities by collecting data on what inequities exist in their communities and their progress in addressing them. Community Health Assessments were specifically identified as a method agencies used to help identify the inequities they needed to address. They also increased surveillance activities, allowing agencies to identify communities experiencing disparate rates of disease and target outreach.

Apart from carrying out full-on programs, some agencies also worked to provide resources to communities experiencing inequities, like COVID-19 tests, air cleaner kits, and immunizations. Mobile resource or service delivery was mentioned to be important for serving communities experiencing inequities.

“Through assessment of health disparities in the community and ongoing outreach to populations with chronic disease and injury risks, we hope to continue to see improvements in health outcomes for marginalized and vulnerable populations in our county.” -Agency respondent

Finally, some agencies mentioned helping staff develop their knowledge and skills related to addressing inequities through conversation and training opportunities.

Improvements due to COVID-19 response

When asked to provide examples of any new ways FPHS services were delivered during the COVID-19 response, a few main themes arose, including technology changes, provision of virtual services, changes in service delivery, and staffing. Types of technology changes that were mentioned included public facing data dashboards, online surveillance tools, switching to cloud-based technology, electronic timekeeping systems, and digitizing all records.

“FPHS Case Investigation funding has allowed SRHD to develop its communicable disease epidemiologists with their data management and informatics skills. This involved training in Tableau for data visualization, R Studio for analysis, SQL for database management and REDCap for data collection. This new capability in our team allowed SRHD epidemiologists to develop a dashboard for wastewater surveillance that is being used to provide a real-time snapshot of COVID-19 activity in our community. In future years, we hope that this will also provide that same community picture for influenza and RSV. We have used this new informatics capacity in our team to automate surveillance processes and improve our data collection for both reportable and non-reportable diseases of concern.

Shifting to virtual services was a theme related to how some agencies delivered FPHS services differently due to COVID-19. Some specific examples included virtual meetings, virtual directly observed therapy (DOT) for TB, online forms, web based services (such as permitting, applications, vital records, food borne illness investigations), online training, virtual site visits, and telehealth.

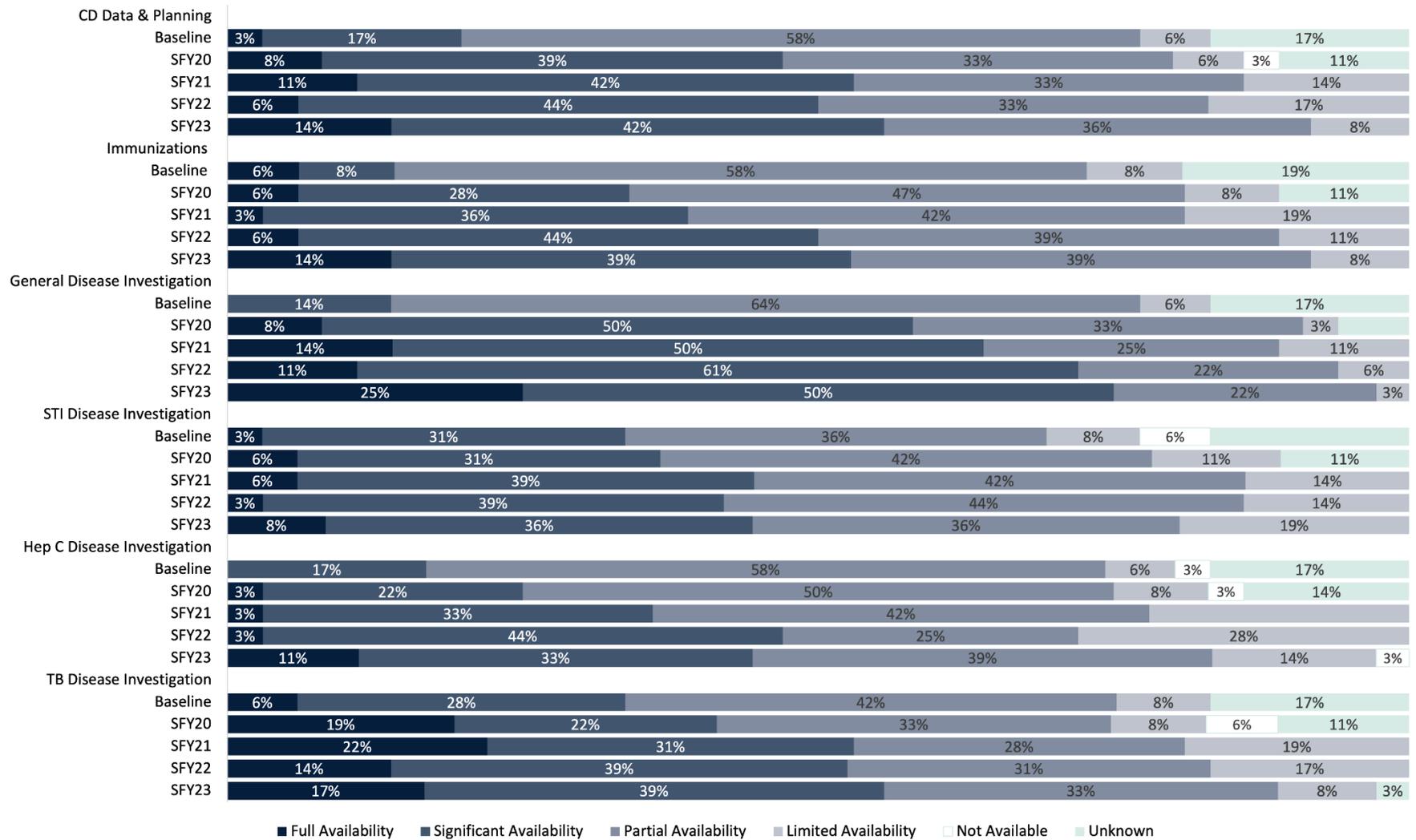
A few agencies reported how FPHS funding either supported hiring additional staff to provide COVID-19 responses, or allowed LHJs to maintain staff who were initially hired with COVID-19 funding. Also, as has been mentioned in response to previous questions, respondents shared how they utilized partnerships or increased partnerships throughout the pandemic, and how they were able to maintain those relationships as they are able to pivot to other public health issues.

Appendix D: Changes in Capacity

In the baseline assessment and each annual report, agencies were asked to self-assess their capacity and expertise for Foundational Programs and Capabilities. Using a five-point scale, LHJs, SBOH, and DOH rated their capacity and expertise for seven foundational program areas and eight foundational capabilities. Capacity and expertise scores were combined to create an estimate of the availability of FPHS in each jurisdiction. Availability was then categorized and color coded. Figures in this appendix provide data over time since baseline. Lifecourse and Vital Records are not included because there is only baseline and SFY23 data, which is already in the body of the report.

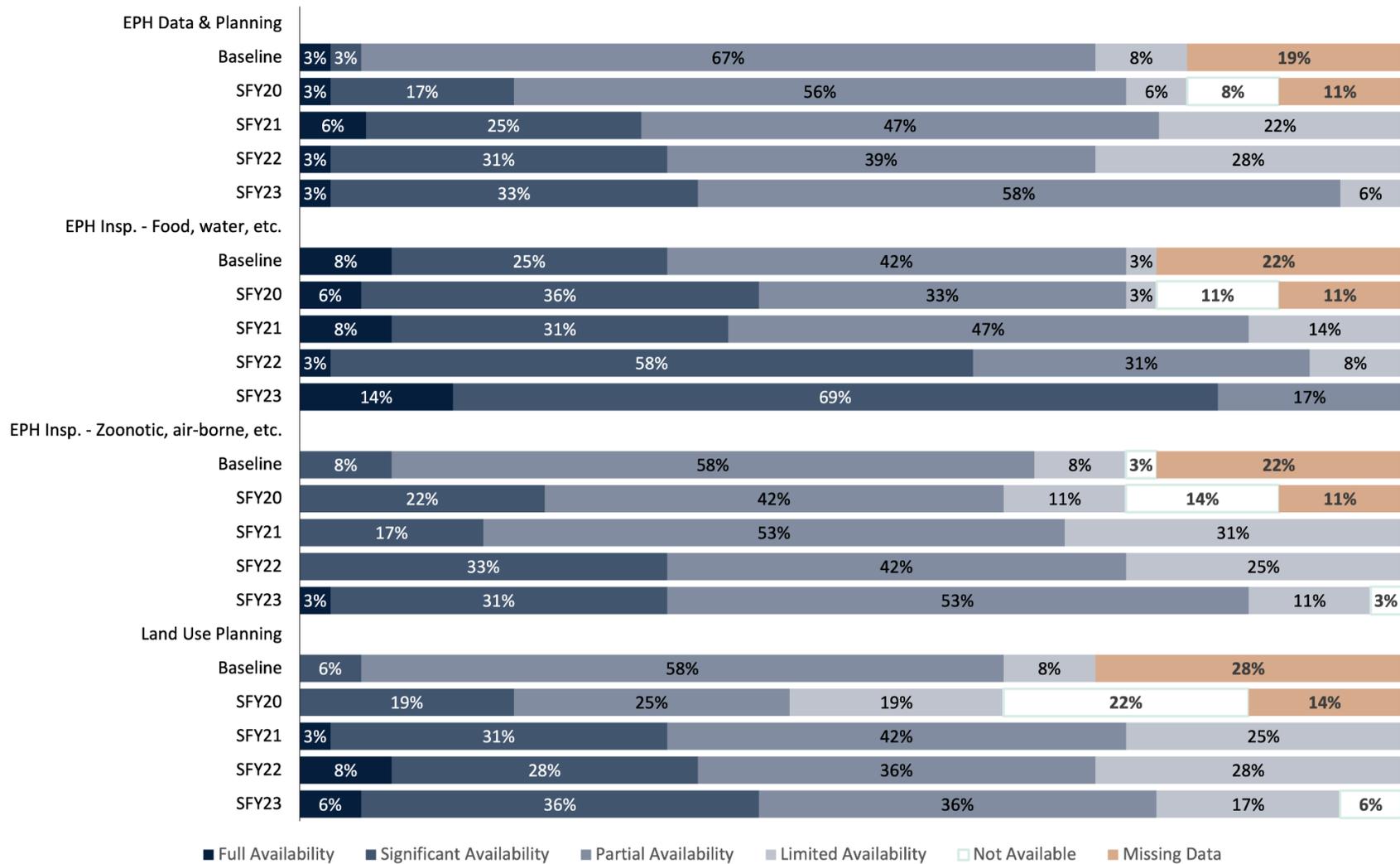
Communicable Disease

Comparison - Availability of Communicable Disease FPHS Services, Baseline, SFY20, SFY21, SFY22, SFY23



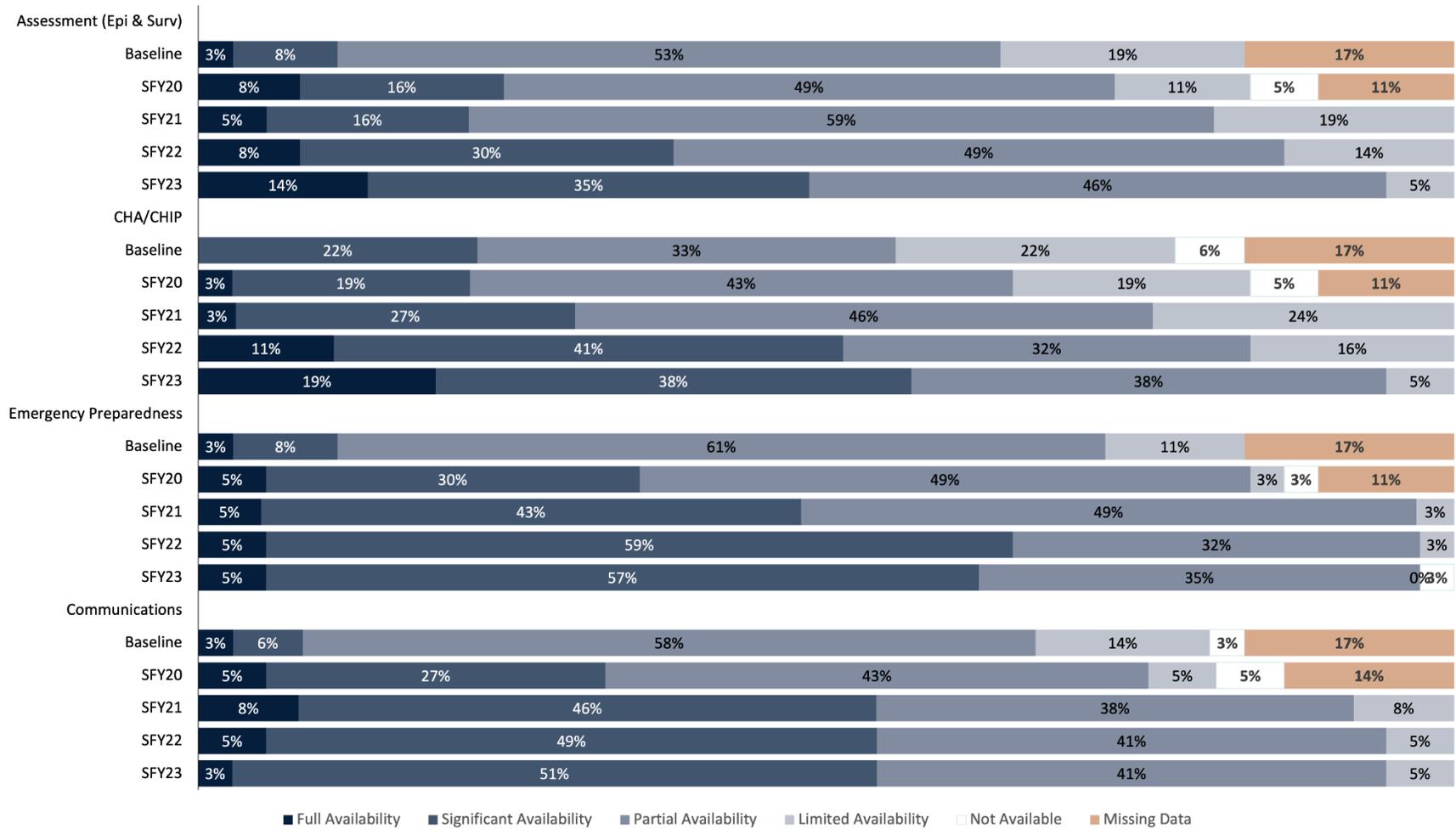
Environmental Public Health

Comparison - Availability of Environmental Public Health Services, Baseline, SFY20, SFY21, SFY22, & SFY23

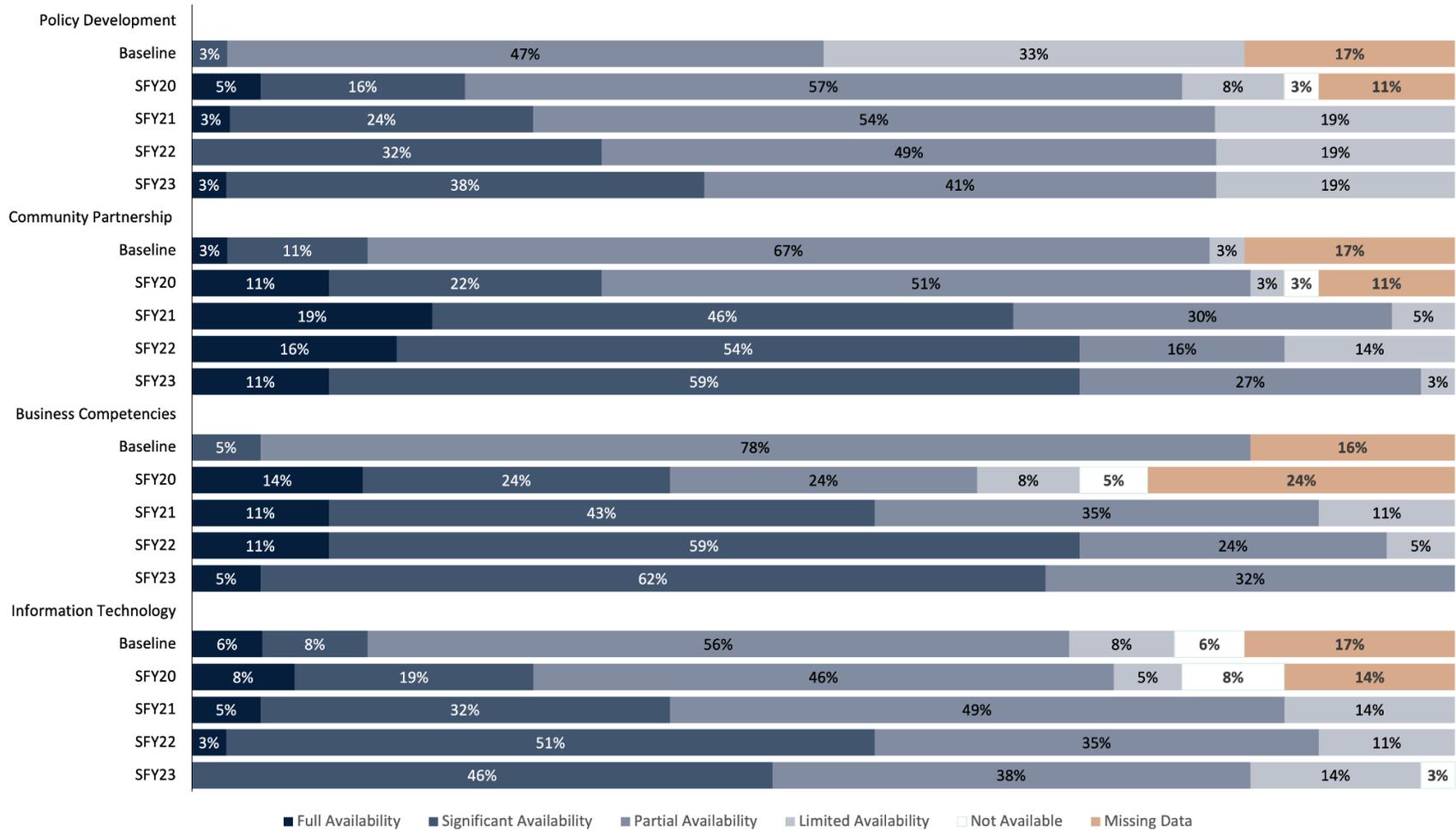


Foundational Capabilities

Comparison - Availability of Foundational Capabilities, Baseline, SFY20, SFY21, SFY22, & SFY23

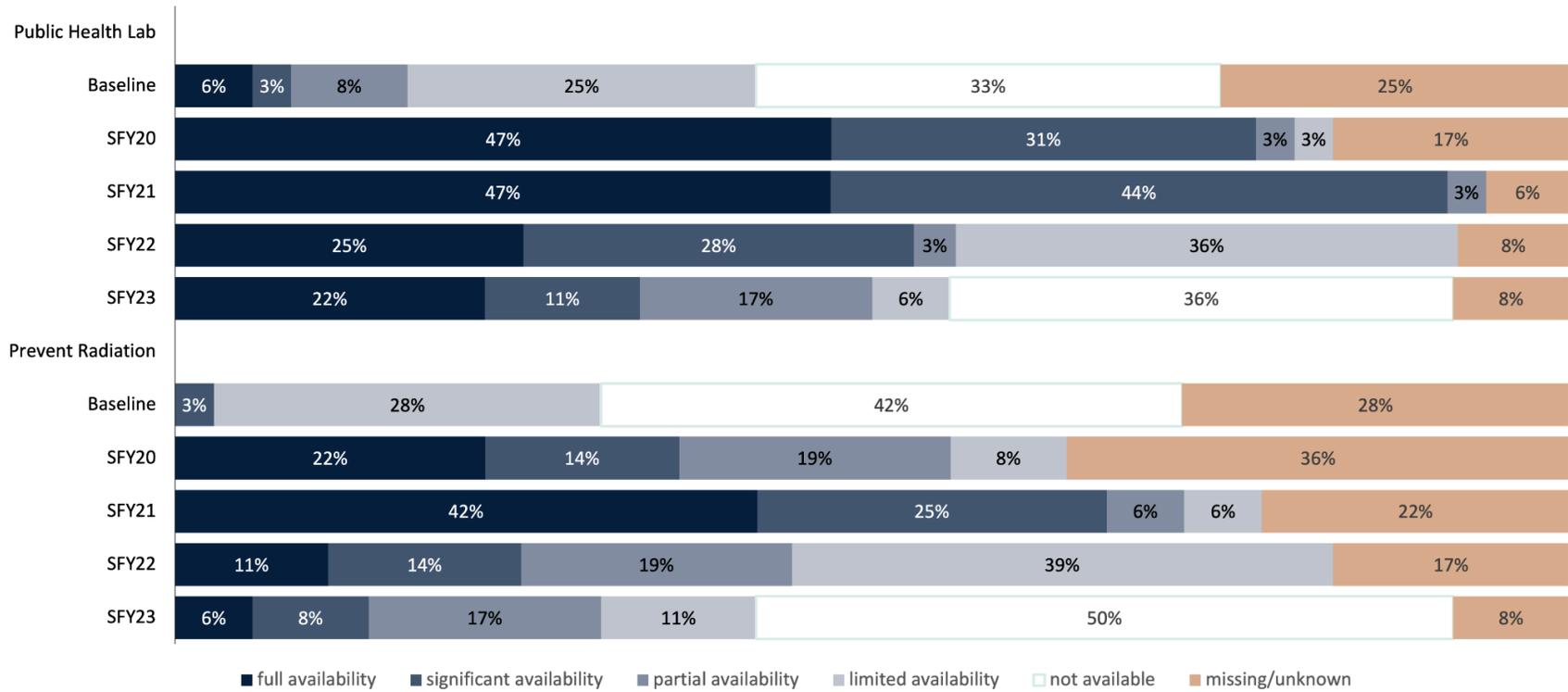


Comparison - Availability of Foundational Capabilities, Baseline, SFY20, SFY21, SFY22, & SFY23



Centralized Services

Comparison - Availability of Centralized Services, Baseline Baseline, SFY20, SFY21, SFY22, & SFY23



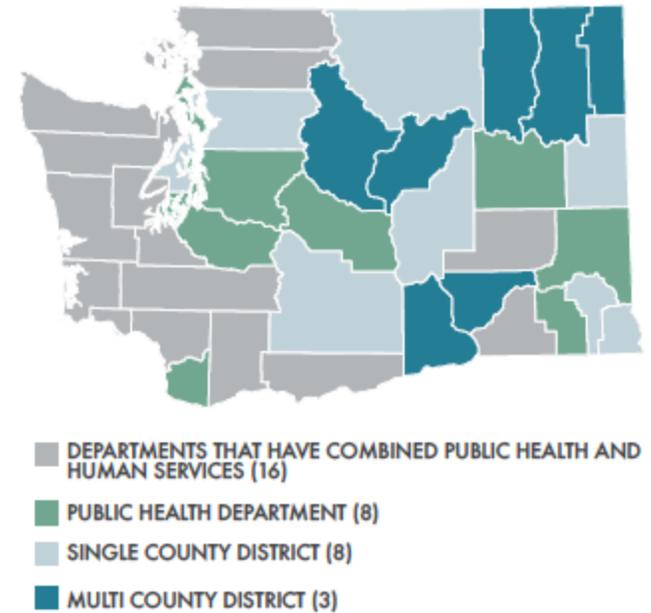
Appendix E: Methodology

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 SFY23 annual report analysis:

1. How available are FPH services across the governmental public health system?
2. How has the availability of FPHS across the governmental public health system changed as the state has invested in FPHS? (comparing SFY23 over time)



Data collection

SFY23 reports were received from all 35 LHJs, DOH, and SBOH in August-Sept 2023. WSALPHO supported LHJs to collect reports and conduct quality reviews on submitted reports. Completing annual reports to DOH was a condition of receiving SFY24 FPHS funding. DOH provided data reports for FPHS indicators (immunizations and disease investigations).

Analytic approach

The primary approach to the SFY23 report data is descriptive, addressing:

- How the system spent FPHS funds by FPHS area and by agency type

- The availability of Prevention and Control of Communicable Disease and Other Notifiable Conditions (CD) services, including the following areas:
 - CD Data & Planning
 - Promote Immunizations
 - Disease Investigation:
 - General Communicable Disease
 - Syphilis, gonorrhea and HIV
 - Hepatitis C
 - Tuberculosis
 - Public Health Lab (centralized service)
- The availability of Environmental Public Health (EPH) services, including the following areas:
 - EPH Data & Planning
 - EPH Inspections
 - Food, water, waste, lead,
 - Zoonotic, air-borne, wildfire, other
 - Prevent Radiation Exposure (centralized service)
 - Land Use Planning & Sustainability
- The availability of Lifecourse services*, including the following areas:
 - Maternal Child Health (MCH) Data & Planning
 - Newborn screening (centralized service)
 - Access/Linkage Data & Planning
 - Health Care Licensing (centralized service)
 - Chronic Disease, Injury, and Violence Prevention (CDIVP)
- The availability of Foundational Capabilities, including the following areas:
 - Epidemiology & Surveillance
 - Community Health Assessment & Improvement Planning
 - Emergency Preparedness

- Communications
- Policy Development
- Community Partnership Development
- Business Competencies
- Information Technology
- Comparative analysis on the availability of services from baseline to SFY23
- Comparative analysis on the availability of services overtime (baseline, SFY20, SFY21, SFY22, SFY23)
- The level of current sharing (defined as receiving services from another agency) in the delivery of FPH services
- The level of interest to provide FPH services to or receive FPH services from other agencies in the future
- Themes and important narratives related to changes in the delivery of and access to FPH services during SFY23
- Themes and important narratives related to the response to COVID-19
- Themes and important narratives related to innovative practices during SFY23
- Themes and important narratives related to addressing equity during SFY23
- Changes over time in indicators for CD disease case investigation and immunization rates

*These areas were assessed for the first time since baseline

Please note: Data on the FPHS elements were not collected or analyzed exactly as they are displayed in the FPHS Functional Definitions Manual¹, so for purposes of this report they will be referred to as "areas." For example, some FPHS elements were combined, such as CD data and CD planning into CD data and planning; and some elements were split up, such as disease investigation being split into 4 areas (general, STI, Hep C, and TB disease investigation).

Data review and interpretation

Rede staff worked with a team of DOH and WSALPHO staff to review analyzed data and discuss interpretation of findings. This team also worked on the outline, structure, and content of the State Fiscal Year 2023 Investment Report.

¹ <https://www.doh.wa.gov/Portals/1/Documents/1200/WA%20FPHS%20Functional%20Definitions%20Manual%2011-17.pdf>

Limitations

As self-reported data, the information collected through the annual reporting tool has inherent limitations. These include respondent biases, an uneven understanding of the functional definitions and terminology, and challenges with assessing oneself accurately.