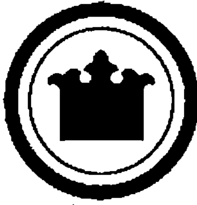


KING COUNTY

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Signature Report

September 18, 2003

Motion 11796

Proposed No. 2003-0384.1 **Sponsors** Gossett and Edmonds

1 A MOTION approving the proposed public health priorities
2 and funding policies in response to a proviso outlined in the
3 2003 Budget Ordinance, Ordinance 14517, Section 82.
4
5
6 WHEREAS, public health completed and the county executive transmitted to the
7 county council on May 1, 2003, as required, the report outlining the proposed public
8 health priorities and funding policies, and
9 WHEREAS, the report represents a data driven decision-making process for
10 determining service priorities and funding policies, and
11 WHEREAS, the decision-making process begins with the identification of the
12 legal mandates and the Washington State Public Health Standards for which the
13 Seattle/King County department of public health is responsible, and
14 WHEREAS, the decision-making process then links these legal mandates and
15 public health standards to an epidemiological needs assessment of the changing health
16 status in various population groups in King County, and

17 WHEREAS, the decision-making process selects science-based interventions and
18 strategies that have the greatest potential to promote health and prevent disease that
19 address the identified epidemiological needs, and
20 WHEREAS, this decision-making process for determining public health priorities
21 and funding policies is intended to provide the basis for any significant changes in public
22 health's budget during the remainder of 2003 that may be necessitated by state legislative
23 action:
24 NOW, THEREFORE, BE IT MOVED by the Council of King County:

25 The King County executive response to the proviso related to the 2003 Budget

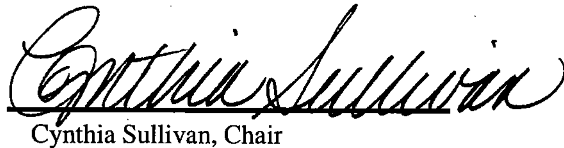
26 Ordinance, Ordinance 14517, Section 82, is hereby approved.

27

Motion 11796 was introduced on 8/25/2003 and passed by the Metropolitan King County Council on 9/18/2003, by the following vote:

Yes: 11 - Ms. Sullivan, Ms. Edmonds, Mr. von Reichbauer, Ms. Lambert, Mr. Phillips, Mr. Pelz, Mr. McKenna, Mr. Constantine, Mr. Hammond, Mr. Gossett and Mr. Irons
No: 0
Excused: 2 - Ms. Hague and Ms. Patterson

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON



Cynthia Sullivan, Chair

ATTEST:

Anne Noris, Clerk of the Council

Attachments A. Proviso Report Public Heath - Seattle & King County Public Health Priorities and Funding Policies

Proviso Report
Public Health – Seattle & King County

Public Health Priorities and Funding Policies

With the adoption of the 2003 King County Budget, Public Health – Seattle & King County was requested to provide a report outlining proposed public health priorities and funding policies. The proviso in the 2003 Budget reads:

> "The executive shall submit, by May 1, 2003, proposed public health priorities and funding policies for council review and approval. The funding policies shall specify how the various types of funding sources available to the department will be used to meet current priority public health needs and shall specifically include priorities for the use of flexible funds such as county current expense and some categories of state funding. The priorities shall be based upon an analysis of current public health needs and shall include definition and priority ranking of services to meet those needs. Once adopted, these service priorities and funding policies are intended to provide the basis for any significant changes in budget during the remainder of 2003 that may be necessitated by state legislative action."

INTRODUCTION

In response to this proviso, Public Health presents a data driven decision-making process to determine service priorities and funding policies. The process is presented in a prioritization framework that first identifies and demonstrates responsiveness to Washington State Public Health Standards and legal requirements. These requirements are then linked to an epidemiological needs assessment to gauge changing health status and population challenges facing the citizens of King County. Next science-based interventions to promote health and to prevent disease are identified and aligned with available resources that maximize revenues, service capacity and healthy outcomes. Two hypothetical examples illustrate how this prioritization framework is implemented at the program level when financial resources are reduced. At the conclusion of this response, a brief summary of overall public health funding and a description of the State Public Health Standards is provided.

A FRAMEWORK FOR PRIORIZATION

Public Health uses a prioritization framework to make evidence-based, scientifically sound and publicly responsive decisions regarding funding for programs. Because prioritization is an ongoing task and not a static, one time exercise, the decision making framework reflects the flexibility Public Health needs to guide its prioritization processes in a dynamic, continuously changing arena of public health issues and revenues.

LEGAL REQUIREMENTS

The foundation of the prioritization framework begins with an examination of existing legislative actions that dictate the department's required functions. Public Health has identified the following three types of legislation that influence its services and programs:

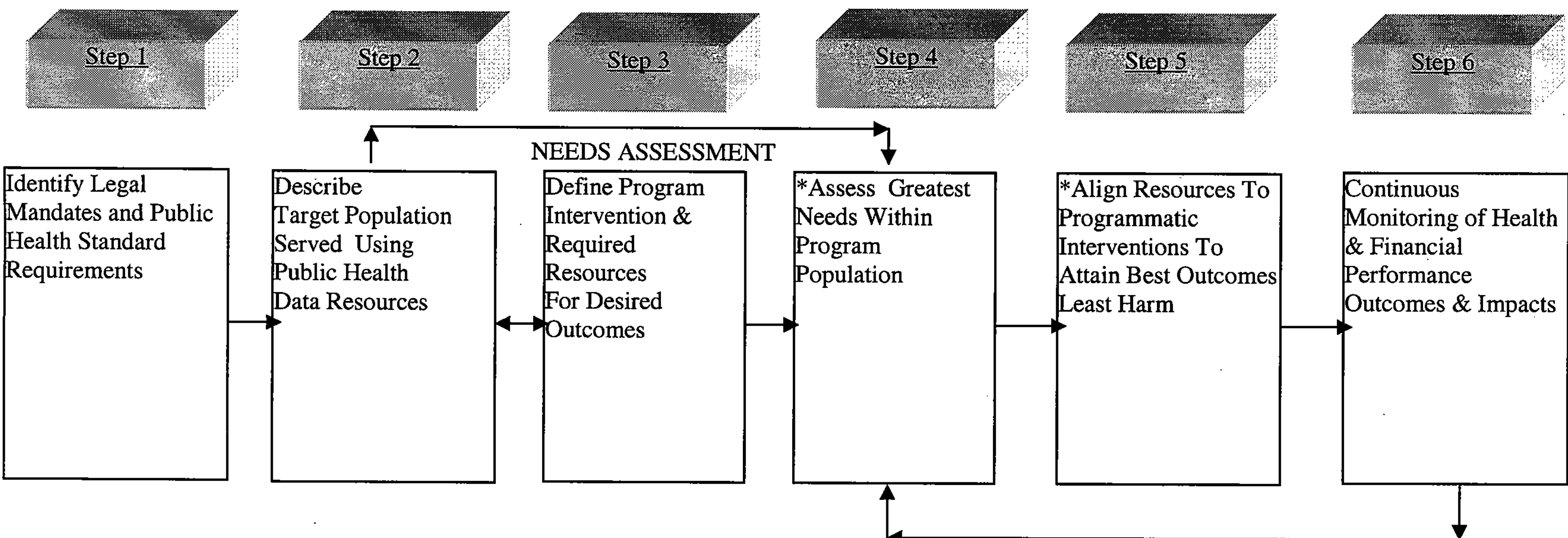
- Adopted service agreements between King County and the City of Seattle. The Interlocal Agreement (amended in 1996) and the subsequent Joint Executive Committee (JEC) Plan finalized in 1998 define critical and enhanced services for Public Health. The JEC Plan defines a "Critical" service, as a service that state and national public health officials agree should be available to every resident. Critical services are based on the former Revised Code of Washington (RCW). An "Enhanced" service is a service that, while not part of the critical elements of public health practice, is a service of proven effectiveness often provided by public health organizations when categorical funds are available for this purpose. "Critical/Enhanced" service supports a higher level or a specialized level of activity above the critical baseline.
- The Washington State Public Health Standards developed by the State Department of Health in the mid nineties define areas of services and program activity that all local health departments must provide. The standards aligned with our Public Health programmatic areas are depicted in Addendum C.
- Legally Mandated Services are requirements legislated by Federal, State and King County governments.

In addition to meeting legal requirements, the next step in this prioritization process is conducting a needs assessment, using local and national data on critical and emerging public health issues. Details of the needs assessment are included in the next section of this report.

The needs assessment and prioritization process proceeds through the following five steps:

1) Identifying the population served using Public Health data resources
2) Identifying current program services
3) Identifying key areas of greatest need within the population
4) Assessing current health needs relative to program services
5) Aligning resources to key areas based on the greatest impact and the least harm

The flow chart on the following page illustrates the prioritization framework. It depicts the six steps and their interactions:



*Assessment & Alignment Based On:
- Public Health Standards
- Evidence of Effectiveness
- Science
- Legal Mandates

04/24/2003

Needs assessment is a critical step in the overall prioritization process. Given the changing needs of the population and given the continuously developing science for the most effective interventions, an ongoing needs assessment is required. For example, an increase in the rates of a disease in a particular population would cause a funding shift in order to more actively intervene with that at risk population segment. An ongoing needs assessment is what detects this change in disease trends.

PUBLIC HEALTH ASSESSMENT – (Approach used in Steps 2-3)
Public Health – Seattle & King County has ready access to a wide array of up-to-date data on the health of residents across the county, both at a neighborhood level and by demographic groups such as race, socioeconomic status, age, and gender. Public Health turns the data into useful information to drive policy, formulate public health interventions and inform managers, front-line staff, and the public on emerging issues and public health priorities through reports, presentations and briefings.

Public Health draws on multiple data sources for its analysis, including:

- Statistical files on births, deaths, hospitalizations, communicable diseases and sexually transmitted diseases
- Random surveys of health status, health care access, behavioral risks and community strengths and challenges
- Socio-economic status and population tables from the U.S. Census

These data are analyzed and interpreted using standard epidemiological methods. Rapid and reliable analysis is made possible by Public Health's widely recognized state-of-the-art computer applications (such as VistaPHw). For instance, to analyze King County's heart disease death rate, the department looks at trends over time, describes racial/ethnic and socio-economic status disparities, and compares risk in different neighborhoods. Public Health does the same kind of analysis with behavioral risk factors (like smoking or physical inactivity) or health care access indicators (like insurance coverage).

Public Health connects the results of data analysis with the knowledge of science-based interventions drawn from published reports or best practices in other parts of the country. This assists Public Health in identifying priorities and specific intervention strategies for public health action. This proactive approach allows us to screen for trends and disparities without waiting for subject-specific reports.

Public Health analyzes a wealth of health data on residents of King County that provide both broad coverage of public health issues and in-depth investigations of specific problems. The department uses state-of-the-art tools for rapid and reliable data analysis, and shares findings in a variety of reports, presentations, and briefings. The data is used to support implementation of effective, science-based interventions. The data assists Public Health to create resources through grant funding. Several activities look at the most recent available data to detect emerging trends in public health problems, and will be used in an ongoing effort to detect both new and persistent public health priorities. The results are used as a basis for the *Health of King County*, the omnibus report on the

health of county residents, which will be published later this year. (See Addendum A for a listing of some recent reports produced by Public Health that have informed department action).

Public Health relies heavily on the data produced in the systems described above. The work of data gathering and assessment allows Public Health to meet its increasingly difficult budget challenges with the knowledge that it is applying its resources to its most serious issues. Public Health must continue to meet the challenges of complying with providing legally mandated services, State Public Health Standards, and the Seattle-King County Interlocal Agreement, with diminishing discretionary resources and increasingly categorical funding limitations. The following describes Public Health's approach to these challenges.

APPLYING THE PRIORITIZATION FRAMEWORK

The Prioritization Framework is applied to all Public Health programs regardless of funding source. If a program is entirely funded by a grant, the framework is used to balance increasing expenditures within the grant funding limits. If programs funded from multiple funding sources are required to reduce one of these funding sources such as Current Expense (or State Public Health Funding), the same framework is implemented.

Once the level of the CX (or State Public Health Funding) reduction is known, the department takes two initial steps: 1) identifies any potential increase in existing revenues or new revenues 2) eliminates flexible, non categorical funds from all enhanced services and reprograms this funding to the critical service program that is experiencing the decline (in CX or State Public Health Funding). If there is still a resource gap, deeper level program/funding prioritization takes place. Working as a team, Public Health Leadership will consider options for final budget reduction decisions.

Two examples of how the prioritization framework is applied to changes in resource availability are depicted below. In the examples Public Health assumes a target reduction of 50% of CX in the Child Care Health Program and a 50% reduction of State Public Health Funding in the Immunization Clinics Program.

Example #1 – Child Care Health: 50% reduction of CX

Step 1: Identify Legal Mandates and Public Health Standard Requirements

The Child Care Health Program assists child care providers to meet these licensing requirements specific to the child care industry.

Health and Nutrition

WAC 388-150-210- Health Care Plan

Licensee shall maintain current written health policies and procedures for staff orientation and use and for the parent. See Pg.24-25.

Centers licensed for 13 or more children, licensee shall use a MD. PA or RN to assist in the development, approval and periodic review of the center's health care plan. The health care provider shall sign and date the health plan.

WAC 388-150-220 Health Supervision and Infectious Disease Prevention
This relates to health care and physical exam for newly enrolled child and all immunization requirements. Includes licensee observe and screen child for signs of illness, exclusion policies, sanitizing equipment, child hand washing, disinfecting, TB tests, exclusion of staff for CD, staff hand washing. See pages 26-27.

WAC 388-150-230 Medication Management
Includes policies on prescription and non-prescription medications, labeling, storage and administration. See pages 28-29.

WAC 388-150-240 Nutrition
Covers food meeting nutritional needs of the child, food allergies and emergency plan, food safety and menu planning-Pages 30-32.

WAC 388-150-250 Kitchen and Food Service
Food storage, meet food standards, food safety issues, catering food safety. Pages 32-33.

WAC 388-150-260
Drinking and Eating Equipment

Care of Young Children

WAC 388-150-270 Care of infants (under 12 months)
Diapering, Feeding, ensuring safety and nurturing infants, sleeping equipment and safe sleep positions, program growth and development stimulation, Nursing Consultation requirement (nurse monthly visits for sites that have license for 4 or more infants). Pgs.33-37.

Safety and Environment

WAC 388-150-280 General safety, maintenance and site
Indoor safety and facility maintenance.

WAC 388-150-290 Water Safety
Includes wading and swimming pools.

WAC 388-150-295 Water Supply, Sewage and Liquid Wastes

WAC 388-150-310 First Aid Supplies

WAC 388-150-320 Outdoor Play Area

WAC 388-150-350 Laundry

WAC 388-150-360 Nap and Sleep Equipment
Includes form of bedding and cleanliness.

WAC 388-150-370 Storage

WAC 388-150-380 Program Atmosphere
Includes light, temperature and noise guidelines.

Records, Reporting and Posting

WAC 388-150-450 Child records and Information
Includes medical and health data.

WAC 388-150-460 Program Records
Includes Nursing Consultation, injury and illness records.

WAC 388-150-480 Reporting of Death, Injury, Illness, Epidemic or Child Abuse

Step 2: Identify Population Served

The Child Care Health Program serves all children, youth in child care settings in King County. This represents approximately 55,000 children age 0 – 5 in child care and approximately 71,800 children age 6 – 12 in out-of-school-time care. The program works with families, communities, and child care staff to provide a physically and emotionally safe and healthy place for children.

Step 3: Identify Program Services

Program Interventions

- Crisis intervention, including communicable disease control and response to outbreaks, children of concern, and referrals from the Division of Childcare and Early Learning (Childcare Licensing- DSHS).
- Multidisciplinary consultation (nursing, nutrition, mental health) to licensed centers and homes in King County.
- Health and safety training for child care providers (both licensed and informal, e.g. family, friends, and neighbors). Mandated classes include First Aid, Bloodborne Pathogens, Child Abuse and Neglect, and other health and safety topics.
- Web-based and hard copy health and safety publications for providers and parents.

- Individual consultation with families and providers for children of concern.

Critical Health Services Provided by Child Care Health

- **Communicable Disease Prevention and Control:**
  Prevention and control of CD, including exclusion policies, foodborne illness, pertussis, E. Coli, Salmonella, SARS, shigella, etc.
- **Immunizations**
  Assisting providers in complying with state requirements.
- **Disaster Preparedness**
  Planning for earthquake, bioterrorism, other natural or man-made disasters.
- **Children of Concern/Chronic Disease**
  Early identification and referral for children with asthma, diabetes, severe allergies, developmental delays, socio-emotional and mental health concerns, obesity, failure to thrive, abuse and neglect. Linking children and families to medical homes.
- **Injury Prevention**
  Indoor and outdoor safety, healthy environment, safe sleep practices.
- **Nutrition/Physical Activity**
  Healthy nutrition and physical activity to assure optimal growth and development.
- **Childhood Growth and Development**
  Brain development, readiness to learn, behavior management, oral health, early identification and referral to 0-6 Programs and health care providers.

Step 4: Identify Key Areas of Greatest Need within the Population

Every year more children spend more of their time in child care settings in King County. Many of the staff in child care need training in the areas outlined in Step 2, above. Many King County child care environments are unsafe and unhealthy. All of the interventions and services identified in Step 2 are critical. In identifying the key areas of greatest need within the population, the Child Care Health program will not eliminate any of the critical health services provided. Rather, the program will identify the populations in child care settings at greatest risk in King County and select the interventions that reach the greatest number of populations at risk.

Step 5: Assess Program Services Relative to Greatest Health Needs

The Child Care Health program is in the process of performing an assessment of every licensed child care center in King County (12 or more children). The assessment includes the critical health services described in Step 2, as well as income eligibility for subsidized programs. The assessment tool determines which child care center has the greatest need for critical health services and, therefore, will receive more training, intervention, consultation, and referrals from Child Care Health program staff. Centers with a high number of risk factors who serve higher need populations receive return visits. Centers with a low number of risk factors do not receive a return visit, but continue to receive information through the Child Care Health web site, newsletter and training. In order to have the greatest impact on the population in child care settings,

child care homes would not receive assessment visits but would have access to the web site, newsletter, and training. The focus is on population-based assessment, training, and consultation and less on consultation on health needs of individual children. Therefore, the program would focus on assessment and training of child care center staff and facilities in the areas of communicable disease prevention and control; immunization compliance; injury prevention; emergency preparedness; childhood growth and development; nutrition and physical activity; and, chronic disease identification, prevention, and treatment. The number of assessments and the level of training will depend on the resources available.

Step 6: Align Resources and Programs to Key Areas—Greatest Impact/ Least Harm

In summary, in order to prioritize Child Care Health program services Public Health will align with the public health standards and select best practices that would have the greatest impact on the population served, while doing the least harm. In the following reduction scenario, it is difficult to do "little harm"; however Public Health has selected strategies that would reach the largest population in need, and provide the most critical health information that will impact the greatest number of people at risk for the lowest cost.

Child Care Health program activities relate to and support all five core Public Health Performance Standards. In doing this analysis, however, the program selected the first three standards as guides for prioritizing services. They are:

- Standard #1 – Understanding key health issues (assessment of child care health centers)
- Standard #2 – Protecting people from disease (assessment, consultation and training)
- Standard #3 – Assuring a safe and healthy environment (facility assessment, injury prevention, chronic disease prevention)

In a scenario in which Child Care Health program Current Expense funding was reduced by 50%, the following services would continue.

1) Only mandated training in areas such as HIV/ bloodborne pathogens, first aid, child abuse and neglect. Additional training provided as resources permit.
2) Public health nurse visits to child care centers limited to referrals from licensing and crisis intervention situations, such as communicable disease outbreaks.
3) Web-based and hard copy health and safety publications for providers and parents.
4) Child care centers in King County (12 or more children) would be assessed every two years-instead of once per year.

In a scenario in which Child Care Health program funding was reduced by 50%, the following services would be discontinued.

1) Eliminate routine annual assessment of child care centers (656 centers in King County).
2) Eliminate on-site visits to licensed family homes (1500 in King County).
3) Eliminate individual consultation with families and providers for children of concern (asthma, diabetes, severe allergies, developmental delays, socio-emotional and mental health concerns, obesity, failure to thrive, abuse and neglect).
4) Reduce early identification services and referrals to medical and dental homes.
5) Reduce health and safety training for child care providers.

The reduction would result in a significant reduction of provider staff, support costs and, consequently, program encounters. 3.5 FTE provider positions would be eliminated. The calculations are as follows:

2003 Total Current Expense	$738,168
50% cut in Current Expense	$369,084
HCFA Match Revenue lost with cut	$95,616
Other Fee Revenue lost with cut	$32,069
Total funds lost due to cut in CX funds	$496,769
Total Child Care Health Visits lost:	1,183
Percent of Child Care Health visits lost	22.9%
Total Child Care Health Training lost:	182
Total participants not trained:	1633
Probable Child Care Health positions lost:	3.5 FTE

Example #2 – Immunization Clinics: 50% reduction of state public health funding

Step 1: Identify Legal Mandates and Public Health Standard Requirements

The Washington State Statute that deals with immunization is RCW 28A.210, the regulations are in WAC Chapter 246-100-166. Government agencies such as Washington Department of Health and Public Health - Seattle & King County assure the law and regulations are carried out. The immunization law and regulations deal with the immunization of children attending child care facilities, preschools and schools.

Step 2: Identify Population Served

Public Health provides direct immunization clinic services at nine clinic sites in King County. The populations served include:

- Children age 0-18, primarily those from low-income uninsured families, who have difficulty accessing regular health care providers (e.g. interpreter services needed), and who may be high risk for vaccine-preventable diseases (e.g. hepatitis B). Most families are very low-income, many need interpretation services, and many do not have regular health care providers.
- Adults including seniors, primarily low-income uninsured, those who have difficulty accessing regular health care providers (e.g. interpreter services needed), and those at high risk for vaccine-preventable diseases (e.g. hepatitis A and B, influenza and pneumoccocal pneumonia). Seniors, homeless adults, and populations endemic with hepatitis A and B are often seen in our clinics.
- Clients seeking travel immunizations. Most clients are low to middle income.

Step 3: Identify Program Services

There are nine Public Health immunization clinic sites throughout King County. Immunizations are also provided at other sites as part of other services, such as teen clinics and family planning services. The services provided are:

- General immunizations, for children and adults, compose the bulk of our services.
- Communicable disease response, such as blood draws, special immunization clinics, and TB testing. Recent communicable disease response activity includes assisting with smallpox vaccination and preparation, and responding to outbreaks of pertussis, measles, hepatitis A and meningitis. Hepatitis A and B require ongoing response activity.
- Travel immunizations, provided at only three Public Health clinic sites. Travel immunization services are self-supported financially by patient fees, with no public fund support.
- The total number of immunization visits in 2002 was 46,379. There were 41,247 general immunization visits and 5,132 visits for travel. Approximately 50% were children and 50% were adults.
- The total budget for our nine immunization clinics in 2003 is $3,546,273. For general immunizations, the cost per visit is $47.44 excluding the cost of vaccine. Immunizations are charged to clients on a sliding scale based on income; the cost of immunizations for adults slides to the cost of the vaccine, immunizations for children slides to zero as Public Health obtains childhood vaccines for free from the state.

Step 4: Identify Key Areas of Greatest Need within the Population

From a public health perspective, immunizations are important to prevent and control the spread of vaccine-preventable diseases to individuals and to communities. Public Health encourages King County residents to obtain their immunizations through their regular

health care providers. To support this effort, we distribute childhood vaccine to all health care providers, and give education and technical assistance to providers, and support community education efforts through a number of venues such as the CHILD Profile Health Promotion program.

While Public Health works closely with the private health sector to assure that immunizations are provided and promoted in the community, Public Health retains a direct service role. The greatest need for direct clinical immunization services is to:

- Focus on populations that are most vulnerable to disease
- Prioritize immunization where epidemiological data shows incidence and potential spreading of disease, rapid transmission of disease, and potential harm of the disease
- Serve populations that do not have access to private health care providers,
- Assure that we retain the capability to quickly respond to disease outbreaks

These priorities match national priorities and state standards.

Currently, there are several areas of concern. These include declining child immunization rates in King County, low rates of influenza and pneumoccocal pneumonia immunization among seniors, high incidence of hepatitis B disease, and concerns about bioterrorist incidents that include smallpox. Recent outbreaks of pertussis and measles highlight the potential for disease spread.

Step 5: Assess Program Services Relative to Greatest Health Needs

Program resources have been aligned over the years to directly respond to the above priorities. We continue general immunization services for all ages, knowing that disease transmit between age groups.

In the general immunization services, Public Health serves populations that do not have access to other services to assure that vulnerable populations are immunized and to retain a minimal level of immunization among communities for "herd immunity" (i.e. if a minimum portion of a population is immunized, the overall community is protected).

Public Health immunizes against diseases that national studies and standards indicate are essential for protection of our communities. Public Health monitors disease incidence and target responses where outbreaks occur and among under-immunized populations.

Public Health emphasizes a minimum level of service at each site in order to minimally serve the targeted populations and retain an outbreak response capacity.

The nine Public Health immunization clinics currently have minimal staffing to retain nearly fulltime clinic hours at each site. Most sites have one fulltime nurse with clerical support. Past experience shows one cannot retain part-time clinic hours due to access

limitations that lead to declining community usage, and due to difficulties in retaining qualified part-time staff.

Travel immunization services are retained at three clinic sites. They are self-supported financially by patient fees, with no public fund support. Retention of this service retains Public Health expertise, and reduces Public Health cost to follow-up on any low-middle income travelers who otherwise might forego immunization and potentially bring diseases back to our communities.

Step 6: Align Resources and Programs to Key Areas—Greatest Impact/ Least Harm

The impact of a 50% cut in state public health funds to the immunization clinics would be substantial. Public Health's priority is to apply our limited resources to obtain the greatest impact and reduce harm done by program cuts. Because the immunization clinic program priorities are already targeted at the highest need areas, the best choice is to scale down the level of service but retain the targeted priorities.

The nine immunization clinics currently have minimal staffing to retain nearly fulltime clinic hours at each site. Most sites have one fulltime nurse with clerical support. As mentioned above, past experience shows one cannot retain part-time clinic hours due to access limitations, which lead to declining community usage, and due to difficulties in retaining qualified part-time staff. Thus the only choice is to reduce the number of clinic sites. A 50% cut in state funds would probably require closure of two clinic sites.

2003 Total State money:	$758,833
50% cut State money:	$379,416
Patient fees lost with cut in State funds	$115,059
Total funds lost due to cut in State funds	$494,475
Total immunization visits lost:	10,423
Percent of general immunization visits lost	25.3%
Probable immunization nurses lost:	2.4 FTE
Probable clinic closures:	Two

Closure of the two sites and resulting reduction in immunization visits would result in the following impacts:

- Reduced capacity to handle communicable disease outbreaks such as measles, influenza, hepatitis A, smallpox, and pertussis
- Reduced capacity to address declining child immunization rates (declined from 86% in 1998 to 72% in 2001, for children 19-35 months of age)
- Reduced capacity to impact already high incidence of hepatitis B, pertussis, influenza and pneumoccocal influenza

PUBLIC HEALTH FUNDING IN KING COUNTY

Four categories of funding comprise the 2003 Public Health budget of $235 million dollars. The categories are:

- Grants and Contracts
- Patient Generated and Client Fees
- Levy and Designated Local Hazardous Waste Collection Fees
- Core funding is comprised of Current Expense (CX), State Public Health funding and City of Seattle General Fund (GF) allocations to SKC-PH. Core funding is dedicated state and local funding predominately designated by legislative bodies to support Public Health services. Prior to the amendment of the Interlocal Agreement and the JEC Plan with the City of Seattle, core funding supported critical Public Health services. With implementation of the JEC Plan, General Fund is allocated to enhanced services.

The following chart depicts the revenue categories and their contributions to the entire budget:

Chart #3 - Categories of Public Health Funding

CATEGORY	TOTAL	%
Core (CX, GF, and State Public Health funding only)	31,301,345	13.3%
Levies and Regulatory Fees (Ed Levy, EMS Levy and LHW)	50,379,504	21.4%
Patient Generated Revenues and Fees	50,518,743	21.5%
Grants and Contracts (Includes Jail Health)	103,060,532	43.8%
TOTAL	235,260,124	100.00%

The first three categories in this chart are categorical and must support services that match the purpose of the funding source. For example, EMS levy funding can only fund designated EMS services. Environmental Health permit fees can only support permit activities designated in the fee legislation. Family Planning grants require revenues be programmed to support family planning activities. Because they are categorical, these funds are not flexible or easily moved to address emerging needs or critical services. These categorical funds augment the service level of critical and legally mandated Public Health services. These categorical funds are integral to the department's ability to increase capacity and to provide needed services. They comprise 87% of the department's budget.

The remaining 13% of the $235 million dollars in the department budget is core public health funding. Originally, core public health funding was the most flexible, and therefore most amenable to prioritization of the four revenue categories. Enabling legislation of these core revenues allowed support of a broad range of services to address continuing and emerging public health needs. However, the flexibility of core Public Health funding has dramatically decreased in recent years.

As stipulated in the amended 1996 Interlocal Agreement with the City of Seattle and the Year 2001 Joint Executive Plan (JEC) between Seattle and King County, General Fund

contributions to Public Health could only be allocated to enhanced services for Seattle residents; by the year 2004, no Seattle General Fund can support critical programs. This requirement has limited the flexibility of this important funding source.

Initially, State Motor Vehicle Excise Tax (MVET), now replaced with other state public health funding, could be budgeted to support public health programs that met the needs of the local health jurisdiction. The state did not transmit/require a specific scope of work to be completed by the local jurisdictions; local jurisdiction performance was not reviewed by the state. Public Health prioritizes this funding to support critical services. However, at the beginning of the next biennium, July 1, 2003, this flexible state public health funding is likely to become somewhat categorical. The State will no longer forward funding to local jurisdictions directly. It will be allocated to the State Department of Health and then awarded to local public health jurisdictions through the consolidated contract. Funding will be directly linked by this contract to compliance with Washington State Public Health Standards. This contract will reduce the ability to quickly move these funds to address priority issues and will increase infrastructure needs to manage the contracts. This requirement is currently included in the House Budget, the Senate Budget and the Governor's budget.

The remaining component of core Public Health funding is County Current Expense (CX). It is the most flexible for prioritization but it also has constraints. The two requirements that restrict flexibility of CX are the requirement to support critical services and the need to support legal mandates for which the County has responsibility for compliance.

With passage of the Public Health Improvement Plan in 1993, Washington counties were required to provide critical Public Health services. As presented earlier in this report, the designation of which services are critical was outlined and jointly agreed upon by the City of Seattle and King County in the 2001 Joint Executive (JEC) Plan. Both governments agreed to categorize critical services according to WAC 246-05-020 which governed public health services at the time the Interlocal Agreement with Seattle was passed. The City of Seattle Council and the King County Council have approved the JEC plan. When implementing the plan, Public Health only budgeted CX in critical Public Health programs as defined by the agreement. Public Health also budgeted State Public Health Funding in critical programs.

In addition to the provision of critical services, CX is further constrained by the need to allocate it to legally mandated projects such as the Medical Examiners Office (refer to chart addendum C for a complete list of mandated services), Interpretation Services, and support for local King County elected. Because of limitations of existing revenue sources and federal regulations, these programs rely heavily on Current Expense funding.

The above services are classified as Legally Mandated in Addendum B in the Core Public Health Funding for 2003 Budget chart. In these programs CX is one of the predominant, if not the most predominant, funding source. The services provided by the Medical Examiner's Office include Autopsy Examinations, Indigent Remains, and Investigations.

These services were mandated by RCW 68.50.010 and Council Motions Number 10293 and Number 11225. Interpretation Services are required through both federal and state mandates so that non-English speaking populations seeking medical attention through the Public Health programs can be served adequately. The King County Elected Officials budget is part of the King County Cost Allocation Plan that cannot be included in the overhead recovery applied to all the department's revenue sources. It is considered unallowable per OMB Circular A-87, Section D, Unallowable Costs, Number 6 – Governor's expenses and Number 8 Legislative expenses.

These services classified as Legally Mandated do not represent fully the programs within the Public Health Department that have legal mandates associated with them. About half the department's budget is attributable to programs with some form of mandate. Examples of programs with mandates associated with them include:

- Immunization Programs
- Sexually Transmitted Disease Services
- Family Planning
- Child Care
- Epidemiology
- Tuberculosis Control
- AIDS/HIV Services

A DESCRIPTION OF STATE PUBLIC HEALTH STANDARDS

In 1993, Washington State responded to the increasing need to measure public health as a system in order to improve overall public health protection and to ensure that exemplary practices can be established systematically. The Washington State Legislature enacted legislation to establish minimum public health standards and the State's Public Health Improvement Plan (PHIP). In 1995 the Washington State legislature accepted the first PHIP and required performance-based contracts. By 1998, the PHIP contained a model of Standards for Public Health, using a framework of single performance standards for all parts of the state's public health system, with unique local and state level measures to address the different responsibilities at state and local levels. After two intensive field tests of the standards and the measures themselves, the Baseline Evaluation of Public Health Performance Standards was implemented in the summer of 2002.

In all, there are five core public health performance standards promulgated by the state:

- Standard #1 (AS) - Understanding key health issues (assessment, monitoring and surveillance)
- Standard #2 (CD) - Protecting people from disease (specific disease control activities)
- Standard #3 (EH) - Assuring a safe and healthy environment (air, water, food and built environment)
- Standard #4 (PP) - Promoting healthy living (population and individual health promotion and education)

- Standard #5 (AC) - Helping people get the services they need (providing and/or facilitating access to care)

These standards are analogous to hospital accreditation standards, as a certain functional level for each standard is necessary to achieve a functioning whole. While each local health jurisdiction is expected to meet the five standards, the standards do not presume that each local jurisdiction will have the same needs, demands or challenges at any given time. A large and complex county will obviously require more activities to meet standards than a small county. Addendum C depicts allocation of CX and State Public Health Funding to the State Public Health Standards.

In summary, Public Health is, in this proviso response, presenting a data driven decision making process, one that takes into account existing legislative requirements -- the amended Interlocal Agreement, the JEC Plan, the State Public Health Standards and legal mandates. Given a particular target reduction in real time, Public Health will conduct a needs assessment and determine Public Health service priorities. This prioritization framework will be aligned with available resources - both categorical and flexible funding. While Public Health has always had elements of this decision-making approach, Public Health has refined it significantly, as described above, for application as the department begins deliberations and decisions for the 2004 budget and beyond.

ADDENDUM A – Examples of Public Health reports that have informed department actions:

- A report on diabetes (http://www.metrokc.gov/health/phnr/eapd/reports/diabetes.pdf) documenting increasing mortality and substantial racial disparities helped provide the basis for the federally-funded REACH community diabetes intervention project.

- A report on the increase in childhood asthma (http://www.metrokc.gov/health/phnr/eapd/reports/asthmaweb.pdf) supported the successful grant funding of the King County Asthma Forum, (http://www.metrokc.gov/health/asthma/forum.htm), an asthma prevention network, and other new and existing asthma-related activities.

- A report describing the disturbing increase in obesity (http://www.metrokc.gov/health/datawatch/obesity.pdf) has been a data resource that generated community interest and supported the beginning of a major cross-department effort to address this issue.

- Public Health produces Communities Count: Social and Health Indicators Across King County (http://www.communitiescount.org), a report on indicators identified by residents as sustaining healthy people and strong neighborhoods, as well as social, economic and health problems of concern. The project collects data on and tracks indicators in areas such as Basic Needs and Social Wellbeing, Safety and Health and Community Strength. The baseline report was released in 2000 and the first follow-up was issued in early 2003. The report has identified the growing gap between rich and poor, the lack of affordable housing, the high number of school dropouts and preparing young children for learning (among other areas) as major reasons for concern. The report is issued every two years.

ADDENDUM B

The following chart denotes the allocation of Current Expense and State Public Health funding in the adopted 2003 budget:

Chart #5 - Core Public Health Funding for 2003 Budget

2003 BUDGET					
CORE PUBLIC HEALTH FUNDING					
PROJECT DESCRIPTION	CURRENT EXPENSE FUNDING	STATE PUBLIC HEALTH FUNDING	SEATTLE GENERAL FUND	OTHER FUNDING	2003 TOTAL ADOPTED BUDGET
PUBLIC HEALTH NURSING & OTHER FAMILY SUPPORT	441,705	1,445,288		17,125,786	19,012,779
CHILD CARE HEALTH	255,869	45,775	127,553	1,740,592	2,169,789
FAMILY PLANNING - CLINICAL, COMMUNITY SERVICE OFFICES, HEALTH EDUCATION	132,477	1,570,112	102,891	7,512,929	9,318,409
IMMUNIZATIONS	605,835	782,038	234,456	4,076,492	5,698,821
SEXUALLY TRANSMITTED DISEASES	418,464	1,374,070		2,745,386	4,537,920
TUBERCULOSIS CONTROL	354,153	604,707		1,162,088	2,120,948
WOMEN INFANTS & CHILDREN	33,968	962,432		4,429,849	5,426,249
EPIDEMIOLOGY & COMMUNITY BASED PRACTICE	800,376	270,080		1,758,193	2,828,649
DRINKING WATER PROTECTION		18,452		284,001	302,453
WASTE WATER DISPOSAL				1,569,252	1,569,252
VECTOR/NUISANCE CONTROL	303,695			309,582	613,277
LIVING ENVIRONMENT		31,184		958,243	989,427
FOOD PROTECTION	68,935	132,394		4,829,089	5,030,418
MEAT INSPECTION				308,471	308,471
HIV/AIDS - PREVENTION & CLINICAL SERVICES	626,513	487,195	291,328	3,037,963	4,442,999
HEALTHY AGING	181,588	130,869		130,494	442,951
INJURY PREVENTION	5,656	99,486		158,039	263,181
BREAST & CERVICAL HEALTH PROGRAM		97,693		2,016,663	2,114,356
COMMUNITY CLINIC PHARMACY PROGRAM				78,512	78,512
HEALTH EDUCATION/PROMOTION		566		1,706,081	1,706,647
SUB-TOTAL CRITICAL SERVICES	4,229,234	8,052,341	756,228	55,937,705	68,975,508
PARENT CHILD SERVICES FOR HIGH RISK FAMILIES		642,787	224,983	5,902,866	6,770,636
TUBERCULOSIS CONTROL			196,250	24,112	220,362
CHEMICAL/PHYSICAL HAZARDS	139,197			35,157	174,354
LABORATORY	869,917	45,712		583,280	1,498,909
HIV OUTREACH/INTERVENTION & CARE CONTRACTS	230,108	284,685	655,091	5,990,387	7,160,271
CORE COMMUNITY ASSESSMENT	181,730	212,670	195,011	820,895	1,410,306
SUB-TOTAL CRITICAL ENHANCED SERVICES	1,420,952	1,185,854	1,271,335	13,356,697	17,234,838
TEEN HEALTH CENTERS & CONTRACTS			869,268	2,297,730	3,166,998

COORDINATED FAMILY SERVICES		21,039	35,921	1,487,135	1,544,095
MATERNAL CARE			35,984	748,286	784,270
FAMILY HEALTH				6,682,998	6,682,998
GERIATRICS			162,718	29,936	192,654
REFUGEE HEALTH ACCESS PROGRAM				326,014	326,014
COMMUNITY BASED ORAL HEALTH SERVICES			156,253	432,751	589,004
CLINICAL DENTAL SERVICES			577,249	4,516,635	5,093,884
HEALTH CARE FOR THE HOMELESS NETWORK			774,767	3,248,847	4,023,614
PHARMACY PROFESSIONAL SERVICES				2,468,437	2,468,437
CHILDREN AND FAMILY COMMISSION	1,433,962				1,433,962
HEALTHY HOMES				333,830	333,830
COMMUNITY HEALTH CARE CONTRACTS & COURIER	736,510		5,083,009	876,459	6,695,978
COMMUNITY FAMILY HEALTH	39,535			45,100	84,635
SEATTLE EDUCATION LEVY				952,981	952,981
SCHOOL NURSING			126,948	870,550	997,498
HIV PLANNING COUNCIL				123,604	123,604
TRENDS IN DRUG RESISTANT TUBERCULOSIS				122,009	122,009
DRUGS / ALCOHOL SEATTLE SERVICES			1,039,516		1,039,516
SEATTLE BUDGET LIAISON			79,624		79,624
BEST BEGINNINGS - SEATTLE			238,870	413,547	652,417
HEALTH CARE ACCESS AND OUTREACH			315,959	950,095	1,266,054
ASTHMA PROGRAMS			172,987		172,987
BREAST AND CERVICAL HEALTH CONTRACTS				741,324	741,324
METHADONE VOUCHERS			327,498		327,498
MASTER HOME ENVIRONMENTALIST			56,375		56,375
SUB-TOTAL ENHANCED SERVICES	2,210,007	21,039	10,052,946	27,668,268	39,952,260
MEDICAL EXAMINER	2,731,108			260,400	2,991,508
INTERPRETATION PROGRAM	507,176	360,952	243,913	1,558,594	2,670,635
KING COUNTY OFFICIALS	1,693,422				1,693,422
SUB-TOTAL LEGALLY MANDATED SERVICES	4,931,706	360,952	243,913	1,818,994	7,355,565
SUB-TOTAL SERVICES NOT CATEGORIZED	1,247,255	(4,682,417)	0	105,177,115	101,741,953
TOTAL	14,039,154	4,937,769	12,324,422	203,958,779	235,260,124

ADDENDUM C

2003 BUDGET						
CX ALLOCATION TO STATE PUBLIC HEALTH STANDARDS						
PROJECT DESCRIPTION	STATE STANDARDS					CURRENT EXPENSE FUNDING
	CD	AS	EH	PP	AC	
PUBLIC HEALTH NURSING & OTHER FAMILY SUPPORT	X	X		X	X	441,705
CHILD CARE HEALTH	X	X	X	X		255,869
FAMILY PLANNING - CLINICAL, COMMUNITY SERVICE OFFICES, HEALTH EDUCATION	X	X		X	X	132,477
IMMUNIZATIONS	X	X		X	X	605,835
SEXUALLY TRANSMITTED DISEASES	X	X		X	X	418,464
TUBERCULOSIS CONTROL	X	X		X	X	354,153
WOMEN INFANTS & CHILDREN		X		X	X	33,968
EPIDEMIOLOGY & COMMUNITY BASED PRACTICE	X	X		X		800,376
VECTOR/NUISANCE CONTROL	X		X			303,695
FOOD PROTECTION	X	X	X	X		68,935
HIV/AIDS - PREVENTION & CLINICAL SERVICES	X	X		X	X	626,513
HEALTHY AGING		X		X		181,588
INJURY PREVENTION		X		X		5,656
SUB-TOTAL CRITICAL SERVICES						4,229,234
CHEMICAL/PHYSICAL HAZARDS			X			139,197
LABORATORY	X	X				869,917
HIV OUTREACH/INTERVENTION & CARE CONTRACTS	X	X		X	X	230,108
CORE COMMUNITY ASSESSMENT				X		181,730
SUB-TOTAL CRITICAL ENHANCED SERVICES						1,420,952
TOTAL						5,650,186

ADDENDUM C

2003 BUDGET						
SPH ALLOCATED TO STATE STANDARDS						
PROJECT DESCRIPTION	STATE STANDARDS					STATE PUBLIC HEALTH FUNDING
	CD	AS	EH	PP	AC	
PUBLIC HEALTH NURSING & OTHER FAMILY SUPPORT	X	X		X	X	1,445,288
CHILD CARE HEALTH	X	X	X	X		45,775
FAMILY PLANNING - CLINICAL, COMMUNITY SERVICE OFFICES, HEALTH EDUCATION	X	X		X	X	1,570,112
IMMUNIZATIONS	X	X		X	X	782,038
SEXUALLY TRANSMITTED DISEASES	X	X		X	X	1,374,070
TUBERCULOSIS CONTROL	X	X		X	X	604,707
WOMEN INFANTS & CHILDREN		X		X	X	724,779
EPIDEMIOLOGY & COMMUNITY BASED PRACTICE	X	X		X		270,080
DRINKING WATER PROTECTION	X		X	X		18,452
LIVING ENVIRONMENT	X		X	X		31,184
FOOD PROTECTION	X	X	X	X		132,394
HIV/AIDS - PREVENTION & CLINICAL SERVICES	X	X		X	X	487,195
HEALTHY AGING		X		X		130,869
INJURY PREVENTION		X		X		99,486
BREAST & CERVICAL HEALTH PROGRAM		X		X	X	97,693
HEALTH EDUCATION/PROMOTION	X	X	X	X		566
SUB-TOTAL CRITICAL SERVICES						7,814,688
PARENT CHILD SERVICES FOR HIGH RISK FAMILIES	X	X		X	X	642,787
LABORATORY	X	X				45,712
HIV OUTREACH/INTERVENTION & CARE CONTRACTS	X	X		X	X	284,685
CORE COMMUNITY ASSESSMENT		X				

						212,670
SERVICES PROVIDED BY OTHER					X	237,653
SUB-TOTAL CRITICAL ENHANCED SERVICES						1,423,507
TOTAL						9,238,195