Call to Order: Welcome to this Regular Session of the Island County Board of Health.

Additions or Changes to the Agenda:

Approval of the Minutes:
September 20, 2016 Regular Session
Attachment: Minutes

Public Input /Comments:
The Board values the public’s input. This time is set aside to hear from the public on subjects of a health related nature, not on the scheduled agenda. All information given is taken under advisement. Unless emergent in nature no action is taken. To ensure proper recording of comments, state your name and address clearly into the microphone. Limit your comment to two minutes. The Board may entertain public comment on specific agenda items when discussed.

Presentations:
1. Laura Luginbill, Assessment & Healthy Communities Director will provide the progress update of the Community Health Improvement Plan.
2. Keith Higman, Health Services Director will lead a presentation regarding Foundational Public Health Services. Attachment: A New Vision for Washington State

Contracts: Keith Higman, Health Services Director will present one contract as follows:

Legislative Update: None.

Report from Public Health: Keith Higman, Health Services Director

Adjourn: The next Regular Session of the Island County Board of Health will be held Tuesday, November 15, 2016 at 1:00pm in the Commissioners’ Hearing Room (B-102) in the Coupeville Annex Building.
Members Present: Commissioner Jill Johnson, Chair; Commissioner Helen Price Johnson; Commissioner Richard M. Hannold; Dr. Grethe Cammermeyer; Mayor Bob Severns, Capt. Frederick J. McDonald (Ex-officio member) and Dr. Brad Thomas, Executive Secretary to the Board

Audio Recording: https://www.islandcountywa.gov/Commissioners/boh/2016/092016BOHAudio.MP3

Call to Order: Commissioner Jill Johnson, Chair, called to order this Regular Session of the Island County Board of Health at 1:02pm.

Additions or Changes to the Agenda: None. Commissioner Richard M. Hannold moved to approve agenda as presented. Mayor Bob Severns seconded the motion. Agenda as presented approved unanimously.

Approval of Minutes: Mayor Bob Severns made a motion to approve the minutes of August 16, 2016. Commissioner Richard M. Hannold seconded the motion. Minutes of August 16, 2016 approved unanimously.

Public Input or Comment: Public Comment was heard from Mr. Rick Abraham regarding jet noise and the resolution approved at the August 16, 2016 Regular Session of the Island County Board of Health.

Presentations:

1. Keith Higman, Health Services Director made a brief presentation regarding the Regional On-site Sewage Loan Program at which time a handout was provided to the Board: Clean Water Loan - Craft3. A question and answer period followed. Craft3 is a non-profit, non-bank Community Development Financial Institution providing Clean Water Loans with support from public and private partners including the US Environmental Protection Agency and the State of Washington.

Contracts: Keith Higman Health Services Director presented one Memorandum of Understanding (MOU), one contract and one contract amendment as follows:

1. MOU: Regional On-site Sewage Loan Program; WA State Department of Health/WA State Department of Ecology HD-12-2016. This MOU is the mechanism whereby Island County can join other participating counties in the Regional Loan On-Site Sewage Loan Program. Following discussion, the Commissioner Helen Price Johnson made a motion to approve and Dr. Grethe Cammermeyer seconded the motion. Memorandum of Understanding No. HD-12-2016 approved unanimously.


Legislative Update: None.

Public Health Report:
1. Keith Higman, Health Services Director provided an update to the Community Health Assessment process and the progress made by the four active work groups. The Interpersonal Abuse work group met August 29th. The Access to Care work group met on September 14th and is scheduled to meet again on September 29th. The Depression and Suicide work group met on September 14th. The Housing work group met on September 1st and is scheduled to meet again October 1st. The active community members of the work groups are on track to process their work through an eight session meeting schedule convening at least monthly. Laura Luginbill, Assessment & Healthy Communities Director provided each work group a strong framework to create work plans consistent with the steps toward Public Health Accreditation and the creation of the Community Health Improvement Plan (CHIP).

Board Comments/Announcements: Commissioner Helen Price Johnson asked if a conversation around statewide Foundational Public Health Services could be brought forward at the next Board of Health Regular Session.

Adjourn: There being no further business before the Island County Board of Health, Commissioner Jill Johnson, Chair, adjourned the meeting at 1:52pm.

The next Regular Session of the Island County Board of Health is scheduled for Tuesday, October 18, 2016 in the Commissioners’ Hearing Room B-102 – Coupeville, Annex.

Submitted: Brad Thomas, MD

Minutes approved this _____ day of _____ 2016

Brad Thomas, MD

ISLAND COUNTY BOARD OF HEALTH

Commissioner Jill Johnson, Chair
## FPHS POLICY WORKGROUP MEMBERS

### Co-Chairs of Policy Workgroup
- **John Wiesman**
  Secretary, Washington State Department of Health
- **Todd Mielke**
  Commissioner, Spokane County, District 1
- **Marilyn Scott**
  Whe-Che-Litsa Vice Chairman, Upper Skagit Indian Tribe

### Elected Officials
- **Jim Hembery**
  Mayor, City of Quincy
- **Obie O’Brien**
  Commissioner, Kittitas County, District 3
- **Jim Jeffords**
  Commissioner, Asotin County, District 3
- **Patty Lent**
  Mayor, City of Bremerton
- **Joe McDermott**
  Councilmember, King County, Council District 8

### State Government
- **Jay Balasbas**
  Senior Budget Assistant, Office of Financial Management
- **Richard Pannkuk**
  Senior Budget Assistant, Office of Financial Management
- **Robert Crittenden, MD**
  Senior Health Policy Advisor, Washington State Governor’s Office

### State Associations
- **Anne Tan Piazza**
  President, Washington State Public Health Association
- **Brad Banks**
  Managing Director, Washington State Association of Local Public Health Officials
- **Eric Johnson**
  Executive Director, Washington State Association of Counties
- **Ian Corbridge**
  Clinical Policy Director, Washington State Hospital Association

### Public Health Representatives
- **Danette York**
  Administrator, Lewis County Public Health and Social Services
- **David Windom**
  Administrator, Northeast Tri County Health District
- **Martha Lanman**
  Administrator, Columbia County Public Health
- **Scott Lindquist**
  State Communicable Disease Epidemiologist, Washington State Department of Health
- **Vicki Kirkpatrick**
  Administrator, Mason County Public Health

### Tribal Public Health
- **Andrew Shogren**
  Health Director, Quileute Tribe
- **Barbara Juarez**
  Director, Northwest Washington Indian Health Board
- **Victoria Warren-Mears**
  EpiCenter Director, Northwest Portland Area Indian Health Board
- **Jan Olmstead**
  Public Health Project Manager, American Indian Health Commission

### Co-Chairs of Technical Workgroup
- **Barry Kling**
  Administrator, Chelan-Douglas Health District
- **Jennifer Tebaldi**
  Assistant Secretary, Disease Control and Health Statistics Division, Washington State Department of Health

### Washington State Department of Health Staff
- **Karen Jensen**
  Director, Office of Partnership, Planning & Performance, DOH
- **Marie Flake**
  Local Health Liaison, Office of Partnership, Planning & Performance, DOH
A NEW VISION FOR PUBLIC HEALTH IN WASHINGTON STATE

The Problem: The People of Washington are at Risk

1. If we don’t change course, kids will have shorter lifespans than their parents.

2. Many Washingtonians suffer from preventable illness and premature death that public health can help prevent. We know what needs to be done, but we often do not have the capacity to do it.

3. In Washington, public health funding and service levels vary significantly depending on where you live.

4. Public health funding has eroded, threatening basic services and our public health.

Public Health is a Basic Responsibility of Government

Most decision makers agree that public health is a basic responsibility of government. The Revised Code of Washington (RCW) declares that “the social and economic vitality of the state depends on a healthy and productive population” and charges government with the “life and health of the people,” granting authority and responsibility for organizing public health services. The public expects Washington’s public health network to work with health care providers, tribes, communities, and others to do what it can to improve health and reduce costs.

A new Vision is needed to ensure consistent response to 21st century health challenges facing all people in Washington.

The New Vision

While Washington State’s public health network has long been recognized as a national leader, to meet today’s challenges in a rapidly changing world we must rethink which public health services are most important, how they should be provided, and how they should be funded. To do that John Wiesman, Secretary of Health, assembled a diverse Policy Workgroup to define a new Vision for Foundational Public Health Services in Washington State to meet 21st century needs. Members represent a diversity of perspectives coming from statewide health associations, cities, counties, state government, and tribes.

The purpose of this document is to lay out the new Vision for the governmental public health network in Washington State and a new funding model for state and local governments.

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PUBLIC HEALTH AFFECTS EVERYBODY

Among the important health problems public health address are:

- Unclean drinking water
- Unsafe food in restaurants
- Ebola
- Premature birth
- Adolescent marijuana use
- Obesity
- Smoking
- Heart disease

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1 Revised Code of Washington 43.70 and 70.05.
FOUNDATIONAL PUBLIC HEALTH SERVICES: SERVICES FOR ALL PEOPLE IN WASHINGTON

Like public safety (fire, police), public utilities (power, water), and other public infrastructure (roads, sewers), there is a foundational level of public health services that must exist everywhere for services to work anywhere. This foundation – the Foundational Public Health Services (FPHS) – is a subset of all public health services.

FPHS includes foundational programs and supporting capabilities that (1) must be available to all people in Washington and (2) meet one or more of the following criteria:

- Services for which governmental public health is the only or primary provider of the service, statewide.
- Population-based services (versus individual services) that are focused on prevention.
- Services that are mandated by federal or state laws.

Definition

Foundational Public Health Services (FPHS) are a defined, basic set of capabilities and programs that must be present in every community in order to efficiently and effectively protect all people in Washington.

These services provide a strong foundation from which the state and local communities can deliver Additional Important Services that respond to and are local community priorities. Full description and definitions of capabilities and programs are available here online.
FPHS Framework and Tribal Public Health

Tribes are critical partners in Washington State’s governmental public health network and the new Vision. They help ensure that services are provided to all residents of Washington, and their inclusion promotes the integrity of FPHS statewide.

While tribal elected leaders and tribal public health representatives participated in the policy workgroup, tribal perspectives have not been incorporated in some key decision areas. More work is anticipated in the near future to fully integrate tribes into the FPHS framework. For more information on tribal public health, see page 13 in the Background.

Additional Important Services - Services Based on Local Needs

Additional Important Services (AIS) are those services which are critical locally and do not necessarily need to be provided by governmental public health for all people throughout Washington. AIS are a shared responsibility of federal, state, and local governmental public health and other partners.

Although the focus of this report is on FPHS, Additional Important Services will continue to be important to the health of people in Washington and deserve continued funding support. While Foundational Public Health Services are needed equitably statewide for the system to work, Additional Important Services meet local public health threats and priorities that can vary significantly from community to community.

<table>
<thead>
<tr>
<th>Examples of FPHS &amp; AIS</th>
<th>Additional Important Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governmental public health promotes immunizations in all communities to prevent the spread of disease in all communities. This is a Foundational Public Health Service.</td>
<td>Actually giving immunization shots is not a Foundational Public Health Service. In a community with many readily accessible immunization providers, governmental public health may not need to provide this service. In a community without providers, it may be important and valuable for public health to provide this Additional Important Service.</td>
</tr>
<tr>
<td>Governmental public health oversees and enforces state on-site septic system regulations in every jurisdiction because safe waste disposal prevents disease in every community. This is a Foundational Public Health Service.</td>
<td>Counties with significant shellfish production are concerned about the contribution of failing septic systems to poor water quality, which can cause development of toxins in shellfish. In one of these counties, efforts to monitor septic system performance more closely than statewide regulations require could be very important, just as important as any foundational service. But it is not a Foundational Public Health Service because many counties don’t have marine shoreline.</td>
</tr>
<tr>
<td>WIC services are not Foundational Public Health Services.</td>
<td>In some communities there are several providers of WIC services other than public health, and there is no need for public health to be a WIC provider. But in other communities, there is no other agency providing this cost-effective, evidence-based prevention service, and it is important for public health to do so.</td>
</tr>
<tr>
<td>Governmental public health provides treatments to individuals with active contagious tuberculosis (TB), protecting the community from the spread of TB.</td>
<td>Providing treatment to individuals with active contagious TB is not an Additional Important Service.</td>
</tr>
</tbody>
</table>
DELIVERING ON THE VISION

Shared Delivery

Services will continue to be provided by a shared—state, regional, local, and in the future, tribal—delivery system. The state, counties, and some cities collaborate on the delivery of public health services; they complement one another’s efforts with a system-wide view and attention to local needs. In recent years, they have worked together to make great strides in efficient and effective service delivery. The implementation of a new framework will necessitate a fresh look at the service delivery structure currently in place.

An important next step is for state and local representatives to identify ways that the system can build on its current successes to integrate and align service delivery with the FPHS framework. The outcome will be a more cost-effective public health system that can achieve prioritized health outcomes, using regional approaches or other models when appropriate and agreed upon. Without FPHS, the public health network lacks the capacity to consistently respond to public health threats, and the people of Washington will suffer.

RECOMMENDATIONS

1. State funding for public health should ensure that the costs of Foundational Public Health Services are covered in every community.

2. Foundational Public Health Services should be funded with statutorily-directed revenues placed in a dedicated Foundational Public Health Services account.

3. Allocation determinations should be a collaborative process between state and local stakeholders.

4. A robust accountability structure that aligns with the Foundational Public Health Services framework should be collaboratively developed by state and local stakeholders to ensure accountability and return on investment.

5. Tribal public health, with support from the Department of Health, should convene a process to define how the Foundational Public Health Services funding and delivery framework will apply to tribal public health, and how tribal public health, the Department of Health, and local health jurisdictions can work together to serve all people in Washington.

6. Local spending on Additional Important Services should be incentivized.
**Recommendation 1**

State funding for public health should ensure that the costs of Foundational Public Health Services are covered in every community.

Because Foundational Public Health Services are needed in every community to protect the health of Washingtonians, the state should have the primary responsibility for funding FPHS. The state should fund all FPHS provided by the state and local jurisdictions that are neither (1) funded by dedicated federal grants nor (2) paid for by locally-collected fees.

State responsibility for funding FPHS would increase from $175 million to $305 million annually. Some of this increase (about $100 million annually) represents new investments in FPHS. The rest involves a shift of funding responsibility from local to state government, allowing local governments to increase investments in public health services to Additional Important Services for their local communities overall. This cost analysis was developed through the expertise of a “technical” workgroup that performed an in-depth analysis of the cost of providing FPHS statewide. See technical reports for information on how these numbers were calculated.

**Recommendation 2**

Foundational Public Health Services should be funded with statutorily-directed revenues placed in a dedicated Foundational Public Health Services account.

Revenues should be adequate to provide Foundational Public Health Services statewide and be flexible within FPHS to allow for the most effective use by public health. Where possible, the state should leverage federal grant funding for specific programs and state- and locally-collected fees for FPHS. Revenues selected to fund FPHS beyond federal grants and fees should track with the increasing costs of delivering service and increasing population over time, to ensure that FPHS can be adequately provided long-term.

**Recommendation 3**

Allocation determinations should be a collaborative process between state and local stakeholders.

Using the extensive technical work underlying this report, the Washington State Department of Health (DOH) and the Washington State Association of Local Public Health Officials (WSALPHO) should collaborate to develop a model for how to allocate funding to DOH and to each local health jurisdiction (LHJ). This model should be codified, and funding should be distributed from the Foundational Public Health Services account based on agreed upon formulas.
**Recommendation 4**

A robust accountability structure that aligns with the Foundational Public Health Services framework should be collaboratively developed by state and local stakeholders to ensure accountability and return on investment.

When the FPHS framework is implemented, a formalized process will be needed to ensure that FPHS are fully funded, available across the state, used effectively and efficiently, and result in improved health outcomes. The FPHS Policy Workgroup proposes the following key principles for development of an accountability structure:

1. DOH and WASALPHO should collaboratively develop an accountability structure that aligns with the FPHS framework.

2. The accountability structure, and any reporting requirements, should use and build on existing reporting and measurement activity to minimize the administrative burden on the governmental public health network.

3. The accountability system should demonstrate how FPHS funds are used by LHJs and DOH and ensure that Foundational Public Health Services are available across the state, used effectively and efficiently, and result in improved health outcomes.

4. All entities in the governmental public health network should agree to meet a minimum standard of FPHS. Individual agreements with tribal governments should include an accountability component.

5. Local boards of health have the authority to determine priorities and approaches within the framework of FPHS.

6. Variation in the way services are organized and delivered in different communities across the state is expected and appropriate.

The accountability structure will need to demonstrate an impact on health outcomes and public health service delivery across the state, while taking into account the context of individual local jurisdictions. Return on Investment (ROI) can be measured in dollars saved, deaths or hospitalizations prevented, or quality of life improvements. Performance measures will need to be developed by state and local stakeholders.
Recommendation 5

Tribal public health, with support from DOH, should convene a process to define how the Foundational Public Health Services funding and delivery framework will apply to tribal public health, and how tribal public health, DOH, and LHJs can work together to serve all people in Washington.

Washington State is committed to working with tribal governments through negotiated government-to-government partnerships. Tribal public health, with support from DOH, should review definitions for FPHS, and gather and analyze current spending and estimate future costs for delivering Foundational Public Health Services for their defined service area and service populations. It should also be acknowledged that while some relationships among tribes, the state, and LHJs are strong, others need to be developed as part of this process. Governmental public health and public health partners will need to work together across nations and better define roles and responsibilities among the overlapping authorities and jurisdictions of tribes, states, counties and cities.

Recommendation 6

Local spending on Additional Important Services should be incentivized.

Additional Important Services funding shall be shared by LHJs, fees, state, and federal sources as determined by local entities. This shared responsibility could be demonstrated by a proportional match for state funding. For this, the FPHS Policy Workgroup recommends establishing a matching fund to encourage local spending on Additional Important Services. The fund should be developed collaboratively through a process involving both state and local stakeholders, including DOH and WSALPHO and should consider inclusion of fee-based services. Options to generate revenue should be available for local governments to help them fund AIS at current or increased levels.
CALL TO ACTION

The definition of Foundational Public Health Services presents a major paradigm shift for funding public health in Washington State. It provides an opportunity to establish consistent basic public health functions statewide, with strong accountability. Some public health services are so fundamental that they should be available to every person in Washington State. We have few opportunities to transform public health, and this is one of those times.

Legislative Action

Recommended Legislative Actions in 2015 and 2016

1. Adopt the FPHS framework and definitions.
2. Incorporate FPHS into state public health statutes.
3. Establish a dedicated account for FPHS funds.
4. Begin to statutorily dedicate funding to the FPHS account.

Recommended Legislative Actions after 2016

5. Fully fund FPHS with statutorily-directed funds.

LHJ and DOH Action

1. DOH and WSALPHO will collaboratively develop an allocation model and accountability structure that aligns with the FPHS framework.
2. DOH and WSALPHO need to continue to identify public health services that should be using a shared delivery system.

Tribal, DOH, and LHJ Action

1. Tribal public health, in collaboration with the state and with support from DOH, should review FPHS definitions, gather and analyze current spending, and develop an estimate for future costs for delivery of these services.
2. Tribal public health and DOH shall work together to define how the FPHS funding and delivery framework can serve the sovereign nations of Washington.

Policy Workgroup Action

1. Members should educate their constituents and communities about FPHS.
2. Members and their organizations should educate local and state policymakers about FPHS.
Foundational Public Health Services

BACKGROUND

January 15, 2015
What is Public Health?

Public health is the air we breathe, food we eat, our physical activity, our education level, our genetics, and the many circumstances that influence the choices we make about our behaviors.

Since 1900, average life expectancy in the US has increased from 49 years to 80 years; this increase is primarily attributed to public health.

The field of public health started out with controlling and preventing infectious diseases, but has since grown to include food safety, environmental health, child and maternal health, behavioral health (mental health and substance abuse), screening for specific diseases, access to health care, tobacco control, chronic disease control and prevention, emergency preparedness, policymaking, and strategic leadership for communities.

In Washington State’s decentralized public health model, the breadth of public health services provided in any given community varies based on community specific needs and the services provided by other departments and organizations.

Governmental Public Health is Critical

In Washington State, public health ensures we all have:

- Clean water for drinking and for recreation.
- A network in place to control communicable disease outbreaks.
- Safe food to eat in restaurants.
- Access to information about active living and healthy eating.
- Resources to make making healthy choices easy.

Research demonstrates that infants and children with healthy starts achieve brighter futures. The role of public health is to work with community partners to create environments so that children are born healthy and have resilient families who can help them achieve their maximum potential.

All Washingtonians should have the opportunity to make choices that will allow them to live long, healthy lives, regardless of their income, education, racial or ethnic background, or where they live.

Without Governmental Public Health...

- An individual disease could quickly become an epidemic. Public health is our first responder for everyday communicable diseases, like the flu and food borne diseases, and emerging crises that often arise from our global community, like Ebola.
- We would see an even larger discrepancy in health outcomes for mothers and babies according to socioeconomic status. Public health helps ensure a standard of care and equal access to important sources of information at this critical life stage.

Scientists generally recognize five determinants of health of a population:

- Genes and biology: for example, sex and age.
- Health behaviors: for example, alcohol use, injection drug use (needles), unprotected sex, and smoking.
- Social environment or social characteristics: for example, discrimination, income, and gender.
- Physical environment or total ecology: for example, where a person lives and crowding conditions.
- Health services or medical care: for example, access to quality health care and having or not having insurance.

• Our community would be more vulnerable to diseases like measles, mumps, and rubella, which are easily preventable through vaccinations. Public health sets immunization standards for schools and communities.

• Food safety and water quality would go unmonitored. Without regular monitoring, the public would not receive early warnings about hazards in our food and water, making foodborne disease much more common.

**Governmental Public Health Entities**

Like fire and police services, governmental public health is a public safety service; protecting residents is its core function.

The governmental public health network in Washington State is comprised of the following entities:

**Tribal Public Health.** 27 of the 29 federally recognized tribes in Washington State either contract or compact with Indian Health Services (IHS) to provide their own health services. IHS provides health services directly to the remaining two tribes.

**State Public Health.** Washington State charges the Department of Health (DOH) with the preservation of public health, monitoring health care costs, the maintenance of minimal standards for quality in health care delivery, and the general oversight and planning for all of the state’s activities as they relate to the health of its residents.

**Local Public Health.** Washington State charges each county with protecting the life and health of the people within its jurisdiction, and giving them the responsibility and authority to organize public health services. There are 35 local health jurisdictions (LHJs) in Washington that range in size, both in terms of population served and square miles covered, and vary in governance structure. Each LHJ provides services based on its population’s needs.

**Tribal Public Health in Washington State**

Tribes are sovereign nations that define their own service populations and are not obligated by state statute to provide public health services. However, tribes are committed to promoting and protecting the health and well-being of tribal members and all people residing within their self-defined service populations. Historically, tribes have not been funded for public health. Most existing treaties with the federal government include the provision of health care services; however, public health is not specifically named.

Tribal health systems traditionally focus on patient-centered services. Clinical services and public health services are often carried out by the same staff, with clinical services, which involve treating more emergent needs, often prioritized over public health services. The Tribal health system overall is underfunded, significantly impacting its ability to address the public health needs contributing to the health disparities of the American Indian/Alaska Native population of Washington.

**PUBLIC HEALTH PARTNERS**

Keeping our communities healthy is not the job of one agency alone; many organizations include the health and wellness of the people they serve. Governmental public health entities throughout the state are continually working with partners, for example:

**OTHER GOVERNMENT AGENCIES**
- Department of Ecology
- Health Care Authority
- Department of Social and Health Services
- Regional Tribal Public Health Agencies
- County Human Services

**NON-PROFITS**
- Universities
- United Way

**HEALTH CARE DELIVERY ORGANIZATIONS**
- Hospitals
- Clinics
- Tribal clinics

**NATIONAL AND GLOBAL PUBLIC HEALTH ORGANIZATIONS**
- U.S. Centers for Disease Control and Prevention
- Indian Health Services
- Gates Foundation
- Program for Appropriate Technology in Health (PATH)
- World Health Organization
About This Project

The Foundational Public Health Services Technical and Policy Workgroups were formed to create a vision and recommendations for how to ensure that a foundational set of public health services are available statewide. Their work included:

• Defining the set of Foundational Public Health Services.
• Estimating the cost of providing these services statewide.
• Identifying responsibility for funding and implementing the Vision.

The Technical Workgroup accomplished the first two tasks in 2013. Their reports can be found online. In 2014, the Policy Workgroup has worked to strengthen the framework, determine funding responsibility, and create a path for implementation.

FPHS is the product of four years of thoughtful leadership and active stakeholder participation. It is also aligned with new approaches to public health at the national level, taking into account the Institute of Medicine’s report on public health investment and work being conducted by the Public Health Leadership Forum, a collaboration between the Robert Wood Johnson Foundation, the U.S. Centers for Disease Control and Prevention, and the National Coordinating Center for Public Health Services and Systems Research.

Agenda for Change

Washington State is reshaping governmental public health and in 2010 published An Agenda for Change. The Public Health Improvement Partnership’s 2012 Agenda for Change Action Plan charted the next steps including ensuring that a foundational set of public health services are available statewide.

Resources

For more information on the Partnership for Public Health Improvement and Foundational Public Health Services, including links to all materials, visit: www.doh.wa.gov/PHIP
Island County Public Health, herein referred to as “ICPH”, and Christopher Spitters, MD, herein referred to as the “CONTRACTOR”, agree as follows:

I. SERVICE PERIOD

CONTRACTOR shall provide the below described services from January 1, 2017 through December 31, 2017.

II. SCOPE OF WORK

A. Review clinical information and chest radiographs of patients undergoing screening, diagnosis, or follow-up through or under the jurisdiction of ICPH, providing diagnostic classification and submitting physician orders or prescriptions for treatment, monitoring, follow-up, referral or dismissal, as appropriate.

B. Provide ad hoc consultation to public health nurses carrying out management plans for ICPH TB patients.

C. Correspond with and respond to requests for consultation from community-based health care providers on patient management and other medical issues related to tuberculosis screening, diagnosis, and treatment.

D. Correspond as necessary with primary care providers of patients under treatment for TB in ICPH’s jurisdiction, including preparation of written completion of treatment summaries for all cases of active disease.

E. Upon request, provide technical consultation to the ICPH TB Control Program in planning, design, implementation and evaluation of program activities.

F. Review and revise ICPH TB screening, diagnosis, and treatment protocols and recommendations as indicated to maintain consistency with applicable guidelines or standards of practice.

III. ACCESS AND AVAILABILITY

A. CONTRACTOR will generally remain continuously available to ICPH by land and cellular telephone, pager, voice mail, email, and facsimile. Initial response times will be as follows: telephone, pager, voice mail within two hours; email and facsimile within 48 hours. At that time CONTRACTOR will review, triage, and prioritize the work in consultation with ICPH staff and develop a timeline for definitive response or completion of the work request.

B. With at least 48 hours’ notice, CONTRACTOR will notify the Administrator and key program staff when he will not be available as set forth in section III.A above.

C. CONTRACTOR may subcontract or otherwise arrange for contingency coverage for public health medical services with an entity acceptable to ICPH for situations when he will be unavailable for extended periods.
D. ICPH will ensure that radiographs and medical records are promptly forwarded (e.g., within one week of performance of radiograph) to CONTRACTOR at his business address. When more urgent consultation is needed, telephone communication from ICPH will initiate the request for work.

E. CONTRACTOR will generally review the clinical information, make an assessment, set forth recommendations, and ensure delivery back to ICPH within one week of receipt of materials. When more urgent communication of recommendations is merited, CONTRACTOR will make such recommendations via telephone.

IV. COMPENSATION

A. ICPH shall provide CONTRACTOR with compensation of $170 per hour spent providing consultation.

B. CONTRACTOR may bill in quarter-hour (i.e., 15-minute minimum) time increments.

C. ICPH will provide CONTRACTOR with a minimum quarterly compensation of $500.

D. The maximum amount payable to CONTRACTOR under this agreement is $12,500.

V. GENERAL PROVISIONS

A. This contract calls for performance of services of CONTRACTOR as an independent CONTRACTOR and CONTRACTOR will not be considered an employee of Island County government for any purposes.

B. CONTRACTOR shall assume all reasonably anticipated costs associated with the fulfillment of his obligation under this agreement, including but not necessarily limited to professional liability coverage, transportation, medical licensure, continuing education, professional dues, office supplies and equipment, and maintenance and operation of telecommunication devices and services necessary to meet the requirements of Section III.A.

C. As an independent CONTRACTOR, it is understood that neither Island County nor the Island County Health Department is responsible for payroll deductions such as income tax, social security, etc., and the CONTRACTOR must make arrangements according to Internal Revenue Service directives, for the payment of such tax as may apply.

D. The CONTRACTOR shall not discriminate against any person presenting themselves for service because of race, religion, color, sex, sexual orientation, age, national origin, creed, marital status, honorably discharged veteran or military status, the presence of any sensory, mental or physical disability, or the use of a trained dog guide or service animal by a person with a disability in the administration or delivery of services or benefits, under this contract.

VI. REPORTING

A. By the 15th day following the end of each quarter, CONTRACTOR shall provide ICPH a report on the previous calendar quarter’s activity, according to the form attached herein (Exhibit A). An invoice shall be submitted along with this report.
B. ICPH shall provide CONTRACTOR with payment of invoiced services within 10 days of receipt of report/invoice.

VII. INSURANCE/LIABILITY

A. The CONTRACTOR shall maintain, during the life of this contract, General Liability in the amount of $500,000 - $2,000,000 per occurrence and Aggregate to protect the CONTRACTOR from claims for damage for bodily injury, including wrongful death, as well as claims of property damages which may arise from any operations under this Contract, whether such operations be by the CONTRACTOR or by anyone directly employed by or contracting with the CONTRACTOR.

B. The CONTRACTOR shall provide the County with proof of medical malpractice insurance to cover damages resulting from his performance of activities in this contract. The professional liability shall be $1,000,000 per incident and $5,000,000 aggregate, and shall be primary, and not contributory, with any other insurance maintained by the County.

C. Each party shall be responsible for its own liability arising from its respective acts or omissions occurring in the course of performing this agreement. Neither party agrees to assume any liability for the other or defend the other party against any claims against the other party or the liability of third parties arising from the other party’s performance of this agreement. Instead, all rights to indemnity and contribution between the parties to this agreement shall be provided by the laws of the State of Washington.

VIII. HIPAA

Standard HIPAA Business Associate Agreement attached as Exhibit B.

IX. TERMINATION

Either party may terminate this agreement with three (3) months prior written notice.

X. MODIFICATION

This agreement may be amended by mutual agreement expressed in writing and signed by both parties.

This agreement shall be construed and interpreted in accordance with the laws of the State of Washington.

FOR THE CONTRACTOR: FOR ISLAND COUNTY, WASHINGTON

Christopher Spitters, MD Date  Richard M. Hannold, Chair Date
Board of Island County Commissioners

FOR ISLAND COUNTY BOARD OF HEALTH

Jill Johnson, Chair Date
Island County Board of Health
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Christopher Spitters, M.D.
EXHIBIT B

ISLAND COUNTY PUBLIC HEALTH DEPARTMENT
STANDARD HIPAA BUSINESS ASSOCIATE AGREEMENT

Definitions

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. “Business Associate” shall generally have the same meaning as the term “business associate” at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Christopher Spitters, M.D.

(b) Covered Entity. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Island County Public Health Department.


Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI created, received, maintained or transmitted in any Electronic Media form in conformity with the Security Rule. Business Associate agrees to ensure that its agents and subcontractors to whom it provides such electronic PHI meet the same standard.
(d) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(e) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(f) Make available protected health information in a designated record set to the covered entity as necessary to satisfy covered entity’s obligations under 45 CFR 164.524;

(g) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity’s obligations under 45 CFR 164.526;

(h) Maintain and make available the information required to provide an accounting of disclosures to the covered entity as necessary to satisfy covered entity’s obligations under 45 CFR 164.528;

(i) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(j) Make its internal practices, books, and records relating to the use, disclosure and security measures of protected health information available to the Covered Entity or to the Secretary for purposes of determining compliance with the HIPAA Rules.

(k) Provide to Covered Entity or an Individual within 60 days of the receipt of a request, information collected in accordance with subsection (i) above, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR Part 164.

Permitted Uses and Disclosures by Business Associate

(a) Business associate may only use or disclose protected health information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Limited Medical Service Consultant Agreement No. HD-11-2016, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(b) Business associate may use or disclose protected health information as required by law.
(c) Business associate agrees to make uses and disclosures and requests for protected health information consistent with covered entity’s minimum necessary policies and procedures.

(d) Business associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity, except for the specific uses and disclosures set forth below.

(e) Business associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosures are required by law, or business associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies business associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(f) Business associate may provide data aggregation services relating to the health care operations of the covered entity as permitted by 42 CFR Part 164.504(e)(2)(i)(B).

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

(a) Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate’s use or disclosure of protected health information.

(b) Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate’s use or disclosure of protected health information.

(c) Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect business associate’s use or disclosure of protected health information.

Permissible Requests by Covered Entity

Covered entity shall not request business associate to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by covered entity, except if the business associate will use or disclose protected health information for data aggregation or management and administration and legal responsibilities of the business associate.
Term and Termination

(a) **Term.** The Term of this Agreement shall be effective as of the date of the contract and terminate at the end of the contract period or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) **Termination for Cause.** Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the underlying Agreement for services between the Covered Entity and Business Associate if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

2. Immediately terminate this Agreement and the underlying Agreement for services between the Covered Entity and Business Associate if Business Associate has breached a material term of this Agreement and cure is not possible; or

3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) **Obligations of Business Associate Upon Termination.** Upon termination of this Agreement for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

1. Retain only that protected health information which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;

2. Return to covered entity the remaining protected health information that the business associate still maintains in any form;

3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the protected health information;

4. Not use or disclose the protected health information retained by business associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at paragraphs (e) above under “Permitted Uses and Disclosures By Business Associate” which applied prior to termination; and

5. Return to covered entity the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

(d) **Survival.** The obligations of business associate under this Section shall survive the termination of this Agreement.
Miscellaneous

(a) **Regulatory References.** A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(b) **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(c) **Interpretation.** Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.