

# WASHINGTON STATE DEPARTMENT OF HEALTH FOUNDATIONAL PUBLIC HEALTH SERVICES MEETING

*Meeting six of the Foundation Public Health Services Work Group took place on September 17<sup>th</sup>, 2014 at the Port Gamble S'Klallam Tribal Reservation Long House from 9:30am to 3:30pm.*

## WELCOME AT TRIBE LONGHOUSE

Kelly Sullivan, the Executive Director of the Port Gamble S'Klallam Tribal Services welcomed all foundational public health services (FPHS) workgroup members to the Port Gamble Tribal Reservation. She explained that the work group is meeting at the Long House, which is called the House of Knowledge and is used by tribal member for important ceremonies and events.

John Wiesman, the Washington State Secretary of Health, thanked the tribe for welcoming the FPHS policy workgroup. He explained that the work group has focused on attending meetings in different locations - Local Health Jurisdictions (LHJs), Department of Health (DOH), important legislative buildings, and now at the Port Gamble S'Klallam tribal reservation. Marilyn Scott also thanked the S'Klallam tribe for inviting the work group to the tribal reservation.

## MEETING INTRODUCTION

John thanked all work group members for coming to the meeting at the tribal reservation. The saying, if you have seen one LHJ, you have seen one LHJ, is also true with tribes. He stated that while it is important for LHJs and tribes to address the issues in their communities, there are also areas for coming together. He also thanked Marilyn for her leadership in these discussions.

Marilyn welcomed everyone to the meeting. She explained that the state of Washington has 29 different tribes, and they all have different relationships with their LHJs. It is important to this project that the tribal perspective is represented at these meetings.

Fauna Larkin from BERK welcomed all participants to the meeting. She stated that this meeting would be focused on finalizing the FPHS definitions and drafting elements of the funding alternative put forward at the previous meeting (FPHS policy workgroup meeting 5).

## FPHS DEFINITIONS

John explained that he had a few additions to the FPHS definitions (see attached definitions document).

A Work Group member asked about the difference between delivery of FPHS and what is defined as FPHS. John responded that certain programs and services have to exist, and in places where no other organization can offer them, public health is responsible for everything up to the delivery of those services. The delivery of these services is not FPHS.

John reminded the work group members that it was impossible for the FPHS to stay the same forever, and they are most likely to change. There is no way the work group can create definitions that everyone agrees with 100%. The majority of the workgroup members were ready to move forward and discuss the financial aspects of Alternative 1.

## FINANCIAL ASPECTS OF ALTERNATIVE 1

Emmy McConnell from BERK reviewed the financial aspects of Alternative 1. There was discussion about local funding for FPHS, which is aggregated in the chart but cannot be moved from one jurisdiction to another jurisdiction. There was concern that if increased funding for FPHS came from the state, local funds that currently support FPHS would be used for for other county priorities and not go to the LHJ's Additional Important Services (AIS).

There were some questions asked about how the administrative overhead was taken into account, especially for different types of LHJs. Emmy explained that the technical group gathered data from a representative sample of seven LHJs of different sizes and geographies. Additionally, Emmy explained that overhead was folded into the other FPHS program areas as well not just business competencies.

John reminded the policy work group members that certain AIS services were important to the jurisdictions, more important than FPHS. But, they are different for each jurisdiction.

## FURTHER EDITS TO FPHS

John discussed some final editions to the FPHS definitions after discussions with work group members – including changing language in the definitions in Chronic Disease and Injury Prevention to reduce rates of alcohol and other drug use as well as rates of tobacco use.

Work group members commented that adding alcohol and other drug use would raise the cost significantly, and there was discussion as to whether alcohol and other drugs should be included in the FPHS definitions.

## GALLERY WALK

During the Gallery Walk, Work group members rotated around six different stations and contributed feedback in small groups. After lunch, Fauna summarized the comments from each station (for more detail see attached posters with workgroup member comments):

- The **financial summary station** included work group members asking for the numbers to presented in a more simple way;
- The **FPHS fees station** included comments about advantages and disadvantages about the different ways to appropriate local fees;
- The **role of current spending station** included concerns that AIS would be heavily affected;
- The **FPHS gap station** included comments about a potential surcharge and some potential funding mechanism included surcharges on marijuana, tobacco and e-cigarettes;
- The **Service Delivery station** included several advantages and disadvantages of the following strategies – foundational reporting system for LHJs, combining jurisdictions, incentivizing sharing and partnerships, per capita, centralized reporting on assessment, standardizing service delivery and technology, centers of expertise, and ROI;
- The **tribal public health station** included issues about tribal sovereignty, concerns with fees, federal government verses state government responsibilities, technology assistance, membership names for a work group were suggested, and it was suggested the work group includes LHJs that work with tribes and LHJs that do not work with tribes. The State Tribal Leaders Health summit was suggested as a place to begin discussion and engage tribal leadership.

## Group Discussion Following the Gallery Walk

During the discussion following the gallery walk, the policy work group members discussed the following concerns - a county commissioner is responsible for funding more than public health, and how best to approach legislators for finances but explain the need to keep local money as AIS.

There was some discussion as to whether AIS spending data should be collected and analyzed but it was suggested that it would take a long time. It was also pointed out that AIS will be different across the state, and it should not be mandated by the state. Another work group member pointed out that the alternatives to FPHS have worked well, and the LHJs are at risk of losing the foundation they have built as well as well as the financial resources.

With regards to how to approach the legislator for finances, work group members pointed out that this was something that really needed to be addressed.

## OTHER ALTERNATIVES

Fauna asked the work group members to each think of a new alternative and answer the following questions: What should be the local responsibility for FPHS? A) Given your response to this, what does this mean for state responsibility for funding FPHS? How much of the state’s current spending on AIS should be moved to FPHS to begin to fill that gap? B) Given what you think the local role is for FPHS, if any of it is local fee supported, what is the “least worst” option for ensuring those fee supported services are maintained in every community across the state? C) Given that you are probably asking for some new revenue at the state level, what service delivery reforms are the “least worst” reforms?

After the work group members thought of their alternatives, Fauna asked Obie O’Brien, Joe McDermott, and Vicki Kirkpatrick to share their suggested alternatives.

<b>Obie O’Brien</b>	<b>Jim McDermott</b>	<b>Vicki Kirkpatrick</b>
<ul style="list-style-type: none"> <li>A. Locals should maintain current fee spending/ revenue. State responsibility should be to maintain cost containment. No unfunded mandate.</li> <li>B. Fee and local funding contribution mixed and matched and cover 100% of the cost of providing FPHS.</li> <li>C. Find flexibility by not ending funding to non-mandated non-FPHS (AIS).</li> </ul>	<ul style="list-style-type: none"> <li>A. Maintain current local contribution assuming it is consistent across the state. If it isn’t the local come up with it, or a statewide agreement on what that cost recovery percentage is. Do the swap and draw the line. State funds fully FPHS.</li> <li>B. Locals required on an annual or biennial basis to demonstrate what they do with those funds – local reporting.</li> <li>C. Accountability measures. Agreeing to centralized service delivery.</li> </ul>	<ul style="list-style-type: none"> <li>A. Locals are responsible for 100% of fee based programs</li> <li>B. New revenue: surcharge on health plans across the system to fund FPHS, use current money to support AIS.</li> <li>C. Service Delivery: continue to partner and share locally</li> </ul>

The discussion that followed included: potential revenue sources, and the importance of having local jurisdictions to contribute some funding for FPHS, even if a small amount.

John responded that if there was a large infusion of state dollars, there would be something the locals would have to give up for those dollars. For example, if there is a core intervention for a service, which core intervention would be required by all LHJs.

## NEXT STEPS AND CLOSING STATEMENTS

Fauna thanked work group members for attending in person, and reminded everyone of the next meeting in Wenatchee on October 15<sup>th</sup>.

Marilyn thanked everyone for attending the meeting in person, and stated that she really appreciated everyone that visited the S’Klallam Tribal Reservation for this meeting. She explained that it was critical for the work group to get a picture of the tribal perspective, and she reminded the group that they had just seen one perspective and every one of the 29 federally recognized tribes in Washington are different.

John stated that he was incredibly pleased with where the policy work group is heading. He explained that he saw now why it was so important to include non-public health people especially in the politics of how to get things framed. He thanked everyone for the time they have spent on this project, and stated that he feels lucky to have such a committed group of people at the table. John thanked the tribal partners for being a part of this policy work group noting that they could have easily refused to be a part of this group, but chose to join and be a part of the discussion. He closed the meeting by stating the following.

“To be in a place like this, it reminds us that we are part of a system and that we all live in Washington. The state has incredible health disparities in ways that are not acceptable. This work and this funding will help the state give every one of its citizens a healthy start.”

# FINANCIAL SUMMARY OF FPHS FUNDING ALTERNATIVE 1

Under Alternative 1, the State is responsible for funding FPHS, except for federally-funded and local fee supported costs.

## What are the current funding sources for FPHS spending?

Existing <b>federal categorical funding</b>	\$56 M	19%
Existing <b>state fee support</b> for FPHS	\$87 M	29%
Existing <b>local fee support</b> for FPHS	\$62 M	21%
Existing <b>state general and dedicated funding</b>	\$64 M	21%
<b>Local government funding</b> for FPHS	\$30 M	10%
<b>Current Total Spending on FPHS</b>	<b>\$299 M</b>	<b>100%</b>

## How would funding responsibility for FPHS be distributed under this alternative? <sup>1</sup>

Most existing <b>federal categorical funding</b> would continue <sup>2</sup>	\$51 M	13%
<b>State fee support</b> for FPHS would be maintained	\$87 M	23%
<b>Local fee support</b> would be maintained	\$62 M	16%
State would fund all remaining FPHS costs (through existing <b>state general and dedicated funding</b> and to-be-identified sources)	\$180 M	47%
<b>Local government funding</b> would no longer have responsibility for FPHS	-	0%
<b>Total FPHS Cost Estimate</b>	<b>\$380 M</b>	<b>100%</b>

## Given current funding sources, what would the additional responsibility for funding FPHS be under this alternative?

<b>Current Total Spending on FPHS</b>	<b>\$299 M</b>	
(1) <i>Local government funding would no longer be used to support FPHS</i>	<i>(\$30 M)</i>	
(2) <i>Existing federal categorical funding not expected to continue</i>	<i>(\$5 M)</i>	
(3) <i>Current spending on FPHS by LHJs above the cost estimates<sup>3</sup></i>	<i>(\$14 M)</i>	
<b>Current Funding Aligned FPHS Funding Alternative 1</b>	<b>\$250 M</b>	
<b>Total FPHS Cost Estimate</b>	<b>\$380 M</b>	
<i>Current Funding Aligned with FPHS Funding Alternative 1</i>	<i>\$250 M</i>	
<b>Remaining FPHS Responsibility for State Funding to Address</b>	<b>\$130 M<sup>4</sup></b>	

<sup>1</sup> All numbers presented in this document do not include tribal information.

<sup>2</sup> The Technical Workgroup estimates that about \$4.8 million in current federal funding is not reliable enough to assume it continues going forward.

<sup>3</sup> See previous explanation of this number

<sup>4</sup> This number reflects the \$100 million gap plus the removal of \$30 million in local flexible funding that currently pays for FPHS.

**POLICY WORKGROUP MEMBER NOTES:**

- 130M/299M =  $\uparrow$ 42% sounds like a reasonable deficit from my experience
- Simplify the numbers for discussion
- Leaving in licensing fees at 50-60M is a political liability. You could perhaps leave it in the definition but remove it from all the current and proposed funding levels
- Taking locals out of the funding scheme is a mistake(matching).

# FPHS FEES: AN EXPLANATION

Fees support 50% of current FPHS spending and 39% of the estimated cost of FPHS.

## At the state level

- State fees support \$87 million of current FPHS spending
- Fees pay for the following services at the state level:
  - Drinking water: Operating permits for public water systems, water plan review, system inspections
  - Radiation protection: use of radioactive materials, inspections of industry uses
  - Commercial shellfish licensing and certification
  - Newborn screening
  - Healthcare professional licenses/certification
  - Birth and death certificates
- Some fee-based services fully recover their costs through fees. Other services may not fully recover their costs, often for policy reasons or fees that are set in statute by the Legislature

## At the local level

- Local fees support \$62 million of current FPHS spending
- Fees pay for the following services at the local level:
  - Community food safety: Restaurant inspections, food worker cards
  - Wastewater management: Wastewater and reclaimed water use, sewer plan review, on-site system permits
  - Water recreation facilities
  - Birth and death certificates
- Some fee-based services fully recover their costs through fees, while other services may not fully recover their costs
- There are variations in the level of fee recovery among LHJs. There are multiple reasons for this variation, such as political decisions to support fee-based services with general taxes, economic development goals, and the influence of fixed costs at smaller jurisdictions or for smaller programs. However, birth and death certificate fees are set by the legislature.

## Changes Under FPHS Funding Alternative 1:

State is responsible for funding FPHS, except for federally-funded and local fee supported costs.

- Under this alternative, locals would be required to make commitments regarding the level of support for fee-based FPHS:
  - Since the state is funding all non-fee supported services, the legislature would need to ensure that appropriate support for fee based programs are being collected at the local level to avoid inequitable state funding support
  - If locals are not committed to a certain level of fee support, FPHS may not be fully funded statewide

## FPHS FEES: YOU WEIGH IN

### (POLICY WORKGROUP MEMBER COMMENTS IN BLUE)

<p style="margin: 0;">What should the local commitment to charge fees be?</p> <p style="margin: 0;"><i>Identify the advantages and disadvantages of the following ways to achieve consistency.</i></p>		
Methods	Advantages	Disadvantages
Locals could be required to maintain current cost recovery levels in their fee-based FPHS	Some political coverage for locals	<ul style="list-style-type: none"> <li>Loss of local control</li> <li>Continued inequity in recovery cost</li> </ul>
Locals could be required to recover a minimum percentage of costs for the same service across the state.	Cover some political coverage for locals	<ul style="list-style-type: none"> <li>Loss of local control</li> <li>Unclear whether difference would be state or local responsibility</li> <li>Uniform % without clarity is not enough</li> </ul>
Locals could be required to fund 100% of identified costs of identified fee-based FPHS, and may use a combination of fees and local funding to do so.	<ul style="list-style-type: none"> <li>Flexibility</li> <li>Local control in what gets passed on to “user”</li> <li>Status quo</li> <li>Not hearing a lot of concerns statewide</li> </ul>	
The state could set the fee rate in order to ensure a certain amount of funding from locals for FPHS.	(But does provide certainty)	<ul style="list-style-type: none"> <li>Functionally &amp; fundamentally doesn’t work</li> <li>Not enough information to force out county differences</li> <li>Costs to provide services varies widely across the state</li> </ul>
Other ideas?	Consider if there are a few programs administered locally then setting a fee at state level makes sense	<p><b>Concerns:</b> Legal Limitations on the amount of the fee that can be collected (e.g. “only the costs to administer the service” but no identified revenue source for additional/ancillary services). <b>Example:</b> Fees can recover costs of food inspection program but not cover cost of outbreak investigation.</p>

# ROLE OF CURRENT PUBLIC HEALTH SPENDING ON NON-FPHS SERVICES UNDER ALT.1 (POLICY WORKGROUP MEMBER COMMENTS IN BLUE)

Under Alternative 1, the State is responsible for funding FPHS, except for federally-funded and local fee supported costs.

*The Legislature may want current spending on non-FPHS services to be used to address the identified state responsibility.*

DOH and LHJs currently spend about \$560 million per year on public health services not defined as FPHS. ★ [Need to better understand what's in here](#)

- The majority of this funding (\$383 M) is from federal categorical funding and fees charged for services, and is therefore tied to supporting only specific services.
- The state general fund (\$49 million) and state dedicated funds (\$62 million) total \$111 million, which is being spent on non-FPHS and could be available for FPHS.
- **Local government funding**

	OPTIONS		
	MAXIMUM SHIFT <small>The state would shift all moveable state funding currently spent on non-FPHS services to address its FPHS responsibility</small>	MINIMUM SHIFT <small>The state would shift some state funding currently spent on non-FPHS services to address its FPHS responsibility</small>	NO SHIFT <small>The state would not use any state funding currently spent on non-FPHS services to address its FPHS responsibility</small>
What would the state be responsible for?	<ul style="list-style-type: none"> <li>• State would be responsible for finding new revenue to fund \$19 M</li> </ul>	<ul style="list-style-type: none"> <li>• State would be responsible for finding new revenue to fund the Gap (\$100 M)</li> </ul>	<ul style="list-style-type: none"> <li>• State would be responsible for finding new revenue to fund the Gap (\$100 M) plus current local government funding spent on FPHS (\$30 M)</li> </ul>
What is the impact on other public health services?	<ul style="list-style-type: none"> <li>• \$111 M in state funding spent on non-FPHS services would be shifted to FPHS</li> <li>• \$30 M in local government funding would become available for other local priorities, including non-FPHS services currently funded by the state</li> </ul>	<ul style="list-style-type: none"> <li>• \$30 M in state general funds spent on non-FPHS services would be shifted to FPHS</li> <li>• \$30 M in local government funding would become available for other local priorities, including non-FPHS services currently funded by the state</li> </ul>	<ul style="list-style-type: none"> <li>• \$30 M in local government funding would become available for other local priorities</li> </ul>
Remaining FPHS Responsibility	\$130 M	\$130 M	\$130 M
Funding from state general fund dollars currently spent on non-FPHS	(\$49 M)	(\$30 M)	-
Funding from state dedicated dollars currently spent on non-FPHS	(\$62 M)	-	-
<b>Implied need for new state funding</b>	<b>\$19 M</b>	<b>\$100 M</b>	<b>\$130 M</b>

## NON-FPHS SERVICES: YOU WEIGH IN (POLICY WORKGROUP COMMENTS IN BLUE)

### Non-FPHS Services and Your Solution Space

*Given our solution space conversation about political, institutional, and financial realities, and the changes to funding for other public health services, please identify your concerns, advantages, and level of support for each potential shift under Alternative 1.*

**Would there be a mandate that  
\$50M be spent on public health?**

	<b>MAXIMUM SHIFT</b> The state would shift all moveable state funding currently spent on non-FPHS services to address its FPHS responsibility	<b>MINIMUM SHIFT</b> The state would shift some state funding currently spent on non-FPHS services to address its FPHS responsibility	<b>NO SHIFT</b> The state would not use any state funding currently spent on non-FPHS services to address its FPHS responsibility
<b>Concerns</b>	<ul style="list-style-type: none"> <li>• State funded AIS would be heavily impacted. Examples:               <ul style="list-style-type: none"> <li>○ HIV Treatment?</li> <li>○ Does this help us accomplish our goal?</li> <li>○ What is this spent on today? (necessary to know)</li> </ul> </li> <li>• Money is much more earmarked than it appears</li> <li>• What of this money is leveraging grants?</li> </ul>	<ul style="list-style-type: none"> <li>• Call it “local priority funding of \$30M from locals”</li> <li>• The same from the state perspective</li> <li>• Need specific examples</li> <li>• No guarantee locals will shift to AIS – risking this money               <ul style="list-style-type: none"> <li>○ Match w/ state for AIS?</li> <li>○ Other incentives?</li> </ul> </li> <li>• State will want some way for locals to contribute to system; locals should have ongoing responsibility</li> </ul>	Politically, you’ll have to do some shifting
<b>Other Comments</b>	State codified support if AIS goes away	Would it be more palatable to legislature if we said each county would support X% of AIS?	Matching and other ideas may be more palatable
<b>Your Level of Support</b>	Need to communicate what’s in AIS today	<b>NOTE: Standards – national accreditation standards – is there value there in helping us find what funding should be?</b>	

# FPHS GAP: A BREAKDOWN BY PROGRAM

Under Alternative 1, additional state funding responsibility for FPHS would be \$130M.  
What does this actually buy us?

Foundational Element	Estimated FPHS Gap	Current Spending Supported by Local Government Funding	Estimated State Responsibility Under Alternative 1	Notes about this gap
Foundational Capabilities	\$16 M	\$8 M	\$24 M	While foundational capabilities defined in FPHS are generally provided today, additional funding is needed to provide a uniform level statewide.
Communicable Disease	\$7 M	\$8 M	\$15 M	While communicable disease services defined as FPHS are generally provided today, additional funding is needed to provide a uniform level statewide.
Chronic Disease and Injury Prevention	\$53 M	\$2 M	\$55 M	About \$43 million of additional funding would go to new and increased activities for tobacco and healthy eating, active living (HEAL) programs. Additionally, \$10 million is needed to raise the level of current activities to a uniform level statewide as described in the FPHS definitions.
Environmental Public Health	\$14 M	\$7 M	\$21 M	Additional funding will mostly go towards increased service in the areas of land use planning, built environment, and toxic exposures.
Maternal/Child/Family Health	\$6 M	\$5 M	\$11 M	While maternal/child/family health services defined as FPHS are generally provided today, additional funding is needed to provide a uniform level statewide.
Access/Linkage to Oral & Clinical Health Care	\$3 M	--	\$3 M	This is an emerging area due to ACA implementation, and many government public health entities are not adequately providing these services today. Additional funding is needed to provide the defined services uniformly statewide.
Vital Records	\$0.3 M	\$0.3 M	\$0.6 M	Additional funding will go to DOH and LHJs to provide Vital Records program services at a uniform level statewide.
<b>TOTAL</b>	<b>\$100 M</b>	<b>\$30 M</b>	<b>\$130 M</b>	

**THE GAP: YOU WEIGH IN**  
**(POLICY WORKGROUP MEMBER COMMENTS IN BLUE)**

What questions, comments, or concerns do you have about the breakdown?

- Charge on revenue received for the delivery of healthcare -Barry
- Surcharge (or ↑ premium) on health insurance to fund all FPHS (how to manage insurance industries concerns about reciprocity) – Suzie/Scott
- Chronic
- F. Capabilities – Assessment – ↓ cost by regionalizing
- VR – could the cost be ↓ by consolidating where the service is offered
- VR – ↑ fee to 100% of cost (explore this, what would the cost per certificate be?)

Are there any particular funding mechanisms that seem like a good fit for one or more of these elements?

- Chronic Disease \$55M – Some of this could be funded by marijuana, tobacco, e-cigarette tax?
- Injury prevention – ie. Sr. Fall – Get some HUD \$?
- Tribal Gaming Compacts require “community contributions” – could this be a fundable source? – Barbara
- Access & Chronic – use \$ from innovation grant as a starting point. Then include funding of PH’s role and FPHS (all) via funding healthcare payment reform.

# FPHS SERVICE DELIVERY: IMPLICATIONS AND TRADE-OFFS (POLICY WORKGROUP MEMBER COMMENTS IN BLUE)

## Service Delivery Today

Public Health services are delivered in Washington State through a decentralized public health system characterized by local control and partnerships between LHJs, DOH, and others.

### Implications of FPHS Funding Alternative 1:

State is responsible for funding FPHS, except for federally-funded and local fee supported costs

*The more the state is responsible for funding FPHS, the more it will have an interest in ensuring that its funds are used **efficiently** and **effectively**.*

<p><b>Efficient Use of State Funds</b> “We’re not spending more than we need to”</p>	<p>The state legislature could decide that they have an interest in managing per capita costs for LHJ delivered FPHS once the state is responsible for funding them. Examples of cost management strategies could include:</p> <ul style="list-style-type: none"> <li>Requiring that smaller jurisdictions provide certain services through shared arrangements with other LHJs</li> <li>Having DOH deliver some services currently provided by locals, particularly smaller jurisdictions</li> <li>Distribute or allocate state support of FPHS on a per capita basis – <b>Doesn’t take into account variation of needs</b></li> <li>Requiring smaller local jurisdictions to combine to form larger jurisdictions – <b>Base + per capita might work</b></li> </ul> <p><b>Notes: Incentivize cross-jurisdictional sharing or partnering; need to be willing to show efficiency; keep options on the table</b></p>
<p><b>Effective Use of State Funds</b> “We’re getting what we expect from our investment”</p>	<p>The Legislature would want to ensure that the funds for FPHS are being spent effectively; ensuring that state funding is spent in a way that achieves the objectives of FPHS.</p> <p>Examples of effectiveness strategies could include:</p> <ul style="list-style-type: none"> <li>Creating performance measures and reporting requirements to ensure accountability for spending state funds ★</li> <li>Standardizing service delivery processes and technology used in service delivery ★</li> <li>Implementing best practices across all jurisdictions             <ul style="list-style-type: none"> <li>Creating centers of expertise to act as a resource for local service provision ★</li> </ul> </li> </ul> <p><b>Notes: Look at being a resource, not giving a mandate</b></p>

## FPHS SERVICE DELIVERY: YOU WEIGH IN (POLICY WORKGROUP MEMBER COMMENTS IN BLUE)

Strategies for Efficient and Effective Use of State Funds			
<i>Identify the advantages and disadvantages of the service delivery strategies identified on the previous page as well as other potential strategies you'd like to discuss.</i>			
Strategies	Advantages	Disadvantages	
Efficient Use	Foundational Reporting System for LHJs (Effective)	<ul style="list-style-type: none"> <li>Ready for field testing</li> </ul>	<ul style="list-style-type: none"> <li>• One more administrative burden for LHJs</li> <li>• How would this work for Tribes? Eg. EPH. How would Tribes report this – PH doesn't do this.</li> </ul>
	Combining jurisdictions		<ul style="list-style-type: none"> <li>• Local communities want independence and won't support it</li> <li>• Similar for Tribes, Tribes respond to community needs</li> <li>• Decide priorities</li> </ul>
	Incentivize sharing & partnerships	<ul style="list-style-type: none"> <li>• Already being done</li> <li>• Provides flexibility to reach goal and local control</li> </ul>	
	Per capita		<ul style="list-style-type: none"> <li>• Doesn't take into account variation of needs</li> <li>• No support unless there is a base</li> </ul>
	Centralized reporting on assessments	<ul style="list-style-type: none"> <li>• Cost savings</li> <li>• Consistency</li> </ul>	
Effective Use	Standardizing service delivery & technology	<ul style="list-style-type: none"> <li>• Makes sense and is fair, economies of scale with technology (licenses)</li> <li>• DOH could help with technology and support consistency</li> <li>• All on the same page with consistent understanding of FPHS</li> </ul>	
	Centers of expertise		<ul style="list-style-type: none"> <li>• Adding another layer and costs</li> <li>• Resources of expertise are already there</li> </ul>
	ROI	Demonstrates effective use of \$	

# INTEGRATING TRIBAL PUBLIC HEALTH IN THE FPHS FRAMEWORK

## Tribal Public Health in Washington State

Federally recognized Indian tribes are sovereign nations:

- Each tribe has a sovereign to sovereign relationship with the United States Government.
- Tribes are not subject to state laws.
- Tribes create their own health care laws and regulations.

There are 29 federally recognized Native American tribes in Washington

Treaties between the federal government and tribes in Washington state guarantee a right to public health; each tribe has a separate arrangement with federal Indian Health Service (IHS) to ensure those treaty provisions are met.

Tribal public health varies significantly by tribe, differences can include:

- What public health services are delivered.
- How the service population is determined and to whom the service is delivered, for example services may be delivered to tribal members only, to all American Indians and Alaska Natives served by a tribe's clinic, and/or to non-native community members.
- The tribal health delivery model, for example tribes may operate their own clinics, may partner with local community clinics, and/or have clinics operated by HIS.
- The cost of providing services and the funding for services, including the mix of tribal government funding, IHS funding, grant funding, and state contracts.

### Implications of FPHS Funding Alternative 1:

State is responsible for funding FPHS, except for federally-funded and local fee supported costs

Data about FPHS funding and spending by tribal public health in Washington has not yet been gathered, analyzed, and modeled. Therefore, the implications of FPHS Alternative 1 on tribal public health funding are not clear.

**Questions that need to be answered for tribal public health FPHS under Alternative 1**

- *Would Tribes receive funding from the State for FPHS to cover their current spending on FPHS except for federally funded and fee supported costs?*
  - *If yes, how much more funding would the State be responsible for?*
- *Would Tribes that do not collect fees begin collecting fees?*
  - *If yes, would those fees need to be consistent across tribes?*
- *What is the tribal public health FPHS gap?*
- *How would the state influence service delivery of FPHS by tribal public health?*

## INTEGRATING TRIBAL PUBLIC HEALTH IN THE FPHS FRAMEWORK (POLICY WORKGROUP MEMBER COMMENTS IN BLUE)

DOH is considering collaborating with tribal representatives and others on a tribal public health workgroup to better include and integrate tribal public health into the FPHS framework, regardless of the funding alternative ultimately recommended by the policy workgroup.

What additional questions and issues should a FPHS tribal public health technical workgroup consider?	What suggestions do you have for workgroup membership, formation or processes?	What other strategies do you suggest for integrating and including tribal public health in the FPHS Framework?
<p><b>Sovereignty:</b> With regards to the issue of sovereignty, how would the tribes respond to the state's influence of FPHS?</p> <p><b>Fees:</b></p> <ul style="list-style-type: none"> <li>• That will be difficult. Tribes pay into certain LHJs for certain services, but do those funds come back to the tribe?</li> <li>• There will be tribes that don't want to work with the state because it infringes on sovereignty.</li> <li>• Would we make it an obligation for LHJs to provide services to tribes?</li> <li>• Tribes are in different places (not only geographically)</li> </ul> <p><b>Federal &amp; State Governments:</b></p> <ul style="list-style-type: none"> <li>• Treaty says the Federal government will provide public health services to the tribes.</li> <li>• Why is the state providing public health services to the tribes?</li> </ul> <p><b>Technology Assistance:</b></p> <ul style="list-style-type: none"> <li>• State can provide technical assistance on tribal public health codes</li> </ul> <p><b>Data:</b></p> <ul style="list-style-type: none"> <li>• May not take into account tribal data systems</li> </ul>	<p><b>Membership:</b></p> <ul style="list-style-type: none"> <li>• Marilyn Scott</li> <li>• Joe Finkbonner – Executive Director of NW Portland area Indian tribe Health Board</li> <li>• People that were in the original technical group</li> <li>• The Healing Lodge</li> <li>• AIHC</li> <li>• NWWIHB</li> <li>• SPIPA</li> <li>• Urban Indian Health Board</li> <li>• Northwest Indian College</li> <li>• Andrew S.</li> </ul> <p><b>Formation or Processes:</b></p> <ul style="list-style-type: none"> <li>• Ask the tribes for feedback about formation on processes:</li> <li>• Include LHJs that do not currently work with tribes. To have understanding of sovereignty both ways.</li> </ul>	<p><b>State Tribal Leaders Health Summit – November 14<sup>th</sup>:</b></p> <p>Begin discussion/engage tribal leadership and report back</p> <p><b>Regionalizing public health regions for the tribes:</b></p> <ul style="list-style-type: none"> <li>• Example: Accountable Communities of Health</li> <li>• Cluster according to the need</li> <li>• Experts go back to the tribes</li> </ul>