



Agency Recommendation Summary

The Department of Health requests funding to maintain core Public Health systems. Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, funding ended after September of 2021. The Department received Coronavirus funding from ARPA, for SFY22-23, but ongoing funds are needed to maintain these core Public Health systems. Without continued funding, these core systems, which demonstrated their importance to the state's ability to respond and correspond to communicable disease outbreaks, would cease to exist. These systems delivered a vast array of collecting, tracking and reporting tools, and provided significant improvements in data infrastructure.

Fiscal Summary

Fiscal Summary <i>Dollars in Thousands</i>	Fiscal Years		Biennial	Fiscal Years		Biennial
	2024	2025	2023-25	2026	2027	2025-27
Staffing						
FTEs	65.3	65.3	65.3	65.3	65.3	65.3
Operating Expenditures						
Fund 001 - 1	\$11,533	\$11,533	\$23,066	\$11,533	\$11,533	\$23,066
Total Expenditures	\$11,533	\$11,533	\$23,066	\$11,533	\$11,533	\$23,066

Decision Package Description

Problem:

DOH has developed four mission critical public health systems which have already proven their worth during this current COVID-19 pandemic and many other areas of essential Public Health work. These systems have been supported by federal funding in the past provided through the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. Access to HITECH funding ended after September 2021. Additional funding is needed to support the maintenance and operation (M&O) activity to sustain these systems.

Background

What is HITECH?

The HITECH Act is one of the last remaining components of the economic stimulus bill called the American Recovery and Reinvestment Act (ARRA) of 2009. The five goals of HITECH were to:

- Improve quality, safety and efficiency of the U.S. healthcare system;
- Allow healthcare providers to better engage patients in their care;
- Increase coordination of care for patients requiring treatment from various providers;
- Improve the entire health status of the U.S. population; and
- Ensure the privacy and security of patient clinical and payment information.

One of the main strategies to achieve these goals was to transition healthcare providers away from paper-based health records to electronic health records (EHR). Thus, earlier stages of HITECH implementation involved distributing incentive payments to healthcare providers to adopt and maintain new EHR systems. This funding was distributed through the federal Medicare and state Medicaid programs.

However, adding EHRs in provider offices and hospitals are not good enough to achieve HITECH aspirations. It was also critical to improve the overall data infrastructure supporting U.S. healthcare and public health systems to ensure the accuracy of health-related data collection and the security of such data as it is shared across systems to inform patient treatment and public health activities. Therefore, the HITECH Act provided significant funding for states to improve data infrastructure.

How did HITECH Support Public Health?

During this currently COVID19 pandemic, four core public health systems – funded through the HITECH Act – have demonstrated their importance to the state's ability to respond to communicable disease outbreaks:

RAINIER Suite

The RAINIER (Reporting Array for Incident, Noninfectious and Infectious Event Response) Suite includes five interconnected applications which centralize the collection and processing of statewide mandatory reporting of disease and environmental public health conditions. The cornerstone application of the RAINIER Suite is the Washington Disease Reporting System or WDRS which is the main surveillance tool used by DOH and the local health jurisdictions (LHJ) for case management and outbreak response. This suite also includes the Sexually Transmitted Disease (STD) Hub for Electronic Laboratory Data Input (or SHELdIn) system which focuses primarily on the delivery of laboratory reports related to STDs. The other three suite applications collect laboratory reports from commercial, public health and hospital sources, verify their accuracy, and standardize the information so it can be stored in the WDRS and SHELdIn systems. This allows case managers around the state to access and use the data to inform public health activities.

The Role of RAINIER Suite in COVID-19 Response

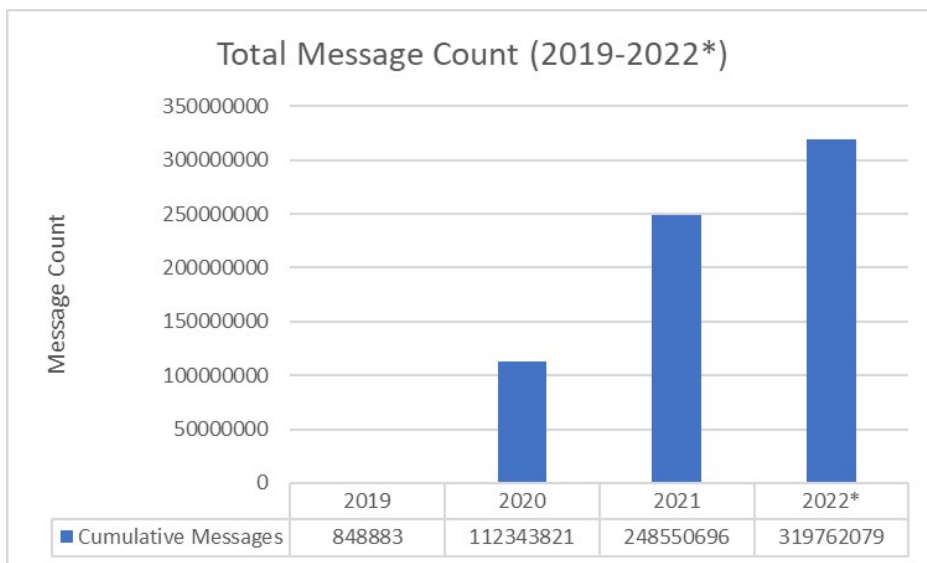
The RAINIER suite has proven to be a critical tool in DOH’s COVID19 response as it is the source of data for conducting contact tracing – cases from WDRS are retrieved and imported into the Contact Risk Exposure Surveillance Tool (CREST) for case and contact investigation. COVID19 cases are created through either an electronic laboratory report (ELR) processing into WDRS, or LHJ entry into WDRS, these cases are then investigated, and the required data is submitted to the federal Centers for Disease Control and Prevention (CDC) on a weekly basis. Prior to COVID 19 and beyond COVID 19 the RAINIER Suite of applications is critical for all notifiable conditions reporting to the state in Washington. It is critical to the state’s ability to meet our statutory requirements as outlined in WAC 246.101 to support both healthcare and local health in meeting state and federal reporting requirements associated with over 100+ notifiable conditions monitored by the state of Washington. It is also the system of record for the state of Washington’s notifiable conditions data.

RHINO Program

The Rapid Health Information NetwOrk (RHINO) program is responsible for the real-time collection, maintenance, interpretation, and dissemination of healthcare encounter data. Statute RCW 43.70.057 requires healthcare facilities to report Emergency Departments visits, 90% of which are submitted within 24 hours. As of November 2021, 100% of non-federal emergency departments and over 800 outpatient clinics (including urgent, primary, and specialty care) across the state submit data to RHINO. In return, RHINO is required to make those data available to participating healthcare facilities, as well as state, local, and tribal public health agencies. Healthcare and public health agencies use the data to detect emerging health concerns like outbreaks, as well as measure and monitor other public health concerns.

The RHINO Program has been operational for over a decade and funding to maintain the systems has been challenging, which leads to underutilization of both healthcare encounter data and the RHINO informatics platform [Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE)] due to limited staff and system capacity supporting grant-specific topics. Over time the volume of data collected has risen exponentially due to increased ED onboarding efforts and improved coverage across Washington, introducing new challenges for data storage and processing that need to be addressed (Figure 1).??The RHINO program is regularly requested to provide support in response to new and existing public health emergencies but is unable to do so sustainably with the current staffing and system struggles to meet statutory obligations and have capacity to remain responsive to public health agency needs.

Figure 1. Total Message Count over time (2019-2022*)?



Data through 7/20/2022 14:00

The Role of RHINO Program in COVID19 Response

RHINO was the first data source used for evaluation of visit trends in Washington following the identification of the first COVID19 in the nation. At that time, there was no specific surveillance system or specific data being collected for COVID19 as it was an emerging threat. RHINO was – within days of the first case – able to tailor a data query to provide insight into whether emergency department and clinic visits, and inpatient hospitalizations in Washington were demonstrating changes in trends not explained by influenza and other respiratory viruses. This analysis indicated the presence of COVID19 in larger numbers. Furthermore, when community spread of COVID19 was first identified in Washington in February 2020, the detail available in the RHINO data allowed public health practitioners to identify emergency department visits potentially associated with residents or employees of long-term care facilities for early identification of facilities that may have had undiagnosed COVID19 cases.

Washington Immunization Information System (WAIIS)

WAIIS is a secure, web-based application available to authorized, licensed healthcare providers all day, every day. The tool is designed to

store patient immunization information, help forecast needed immunizations, and assist with ordering vaccines. WAIS receives up to 97 percent of its data through electronic data exchange through provider EHRs. Used by more than 56,000 organizations, such as medical offices, pharmacies, and hospitals, the system contains over 80 million vaccination records for over eight million unique individuals. Epidemiology staff and LHJs rely on WAIS for data when responding to an outbreak event or conducting necessary surveillance. Schools use the system to ensure students have the required vaccinations for school entry. DOH uses the system to produce the required reporting for the CDC, the federal Centers for Medicare and Medicaid Services (CMS), and HCA, along with other needed reporting.

The Role of WAIS in COVID19

Response WAIS plays a core role in the COVID19 response, once a vaccine was available to the public, this system was front and center in the state's COVID19 vaccine distribution and administration tracking. Data entering into the IIS was analyzed and interpreted to make crucial strategic decisions in vaccination allocation and public/provider outreach. Furthermore, the increased volume of data required significant and costly upgrades to the application infrastructure. The IIS also supported secondary applications such as consumer access tools and mass vaccination software. The consumer access tools allow users to view their vaccination records and the software offered a free scheduling, registration, and transmission tool for healthcare providers. Large IIS data requests requiring both system and staff resources increased significantly during the pandemic and have now expanded to include data for all vaccines, not just COVID vaccines. DOH prioritized interface onboarding for COVID-approved providers and started participating in exchanging data with other jurisdictions and states to improve data completeness. Although many of the enhanced IIS features were a result of COVID, DOH has been applying these tools to non-COVID vaccinations with great effect. The sustainment of IIS functions and remaining current with national standards will improve state immunization coverage rates and better prepare the state for future pandemics.

Data Exchange Services

Data Exchange Services consolidate the means through which DOH submits and receives healthcare data. It promotes efficiency, reduces provider burden related to data exchange with public health, and improves interoperability with DOH's clinical partners. This critical system supports clinical partners in exchanging data with electronic laboratory reporting, immunizations, syndromic surveillance (RHINO), electronic case reporting (eCR), cancer registry, prescription monitoring (PMP), newborn screening, child developmental health (birth defects registry, etc.) and emergency medical services. It is a scalable system, thus allowing future programs to leverage the benefits of this system. Its use has already resulted in cost efficiencies by reducing the initial costs to establish new data feeds from clinical partners and avoiding overhead costs of maintaining multiple connections. Providers use this system to send legally mandated data to DOH for public health purposes (such as laboratory and case reports for all notifiable conditions) and can receive data to make informed patient care decisions (immunization history or controlled substance history). Many other DOH programs are on a roadmap to begin using this shared service such as vital statistics and situational response reporting.

The Role of Data Exchange in COVID19

Response Data critical to the COVID19 response comes through these data exchange services including laboratory results and emergency department visits. By using automated connections to provider laboratory and medical record systems DOH can receive these important data in near real time to more quickly investigate new cases and prevent the spread of the disease. These services ensure public health and clinical partners are able to efficiently transport data in a secure and automated fashion for better public health surveillance and case investigation and for better clinical care. In 2019, DOH exchanged over 50 million transactions through the state HIE. In 2021, DOH exchanged over 105 million transactions. Handling this data increase would have been even harder without a shared data exchange service for our core systems.

Proposal:

Requesting General Fund State dollars to support continued maintenance and operations of these existing systems, which would also allow us the ability to ensure these systems stay operational and are available to support statewide Public Health and Healthcare support. Having the GFS also allows DOH to seek Medicaid funding to supplement the funding needed to support the maintenance and operation.

DOH is working closely with HCA to seek Medicaid funding to support these systems. Medicaid will only cover the Medicaid benefit level of the system. Assumptions are based on general Medicaid Enterprise System (MES) funding rules for IT Maintenance & Operations (M&O) expenditures. Unlike HITECH funding, which covered 90 percent of all design, development, and implementation costs to build the system, MES federal dollars will only cover 75 percent of the Medicaid Benefit Level of M&O costs. Since public health systems generally benefit a broad spectrum of the state's entire population, only the costs that are associated with the state's Medicaid population are considered eligible. Based on July 2021 data, HCA reports a total about 2.05 million Washington residents are enrolled in Medicaid. The U.S. Census estimates Washington State population at 7.7 million individuals. This means only about 24.4 percent of any broad public health system can be argued to support Medicaid clients. For the purposes of this funding request, it is assumed MES federal funding will only effectively cover 18 percent (75 percent of 24.4 percent, rounded up) of M&O system costs; the state will need to cover the remaining 82 percent. DOH will continue to work with HCA to seek Medicaid funding. It will take time to get funding through Medicaid because each system must be fully certified through the Medicaid Streamlined Modular Certification. This process will take DOH and HCA a few years to get all four-system certified.

Alternative:

Current funding will end June 30, 2023, and DOH does not have funding for these systems beyond that. If funding is not identified for these systems DOH will have to redirect other funding for other core public health programs, reduce funding, or risk the system's ability to function for

their core public health mission. If this request is not properly funded, a variety of adverse impacts will result.

Critical data collection needed for all diseases, including COVID19, cannot be sustained and data will not be extracted and submitted to CDC;

Changes and creative solutions to capture relevant data for all diseases will not be maintained and local partners will need to use their own resources to implement less effective, workaround processes to capture this data.

State level visibility to disease prevalence across LHJs will be hindered and communications with the state will suffer;

Any data needed to inform decisions about mitigation and prevention measures will not be available and/or need to be clumsily pulled together from disparate, incomplete data sources;

Data quality will degrade over time and become progressively less reliable for surveillance and decision making. This will render DOH and other governmental public health system partners less able to detect and understand emerging public health threats;

Less capability to support data users in LHJs which will limit their ability to investigate health concerns and perform timely response in their jurisdictions;

Providers will not be able to electronically update their EHR systems with the immunization history needed to inform the best clinical care decisions. Providers would have to use inefficient and time-consuming manual login processes to retrieve current information needed to make important healthcare decisions and report updated immunization information.

Schools would not have access to the information needed to verify compliance with state school entry requirements. DOH's ability to properly respond to an outbreak event like COVID19 evaluate coverage rates, and identify communities with unimmunized or under immunized individuals would be severely hampered as the data would not be current or complete;

Critical information needed for COVID19 response and other critical DOH work like immunizations, prescription drug monitoring and cancer surveillance will no longer be automated or efficient to receive. DOH's public health surveillance systems will need to consider reverting to manual methods of data collection and sharing (i.e. paper, fax and manual data entry) ;

DOH's ability to properly conduct case investigation, contact tracing and surveillance will be critically hampered;

Providers will need to log into portals or fax requests, which aren't always timely enough to make important healthcare decisions. Providers may not be able to see data of patients that received services outside their system.

?Not funding this proposal will result in less support for near real-time surveillance efforts on new and existing conditions. The RHINO team, for example, will be unable to respond to all data requests and surveillance efforts (including active case finding and outbreak investigation) in a timely manner, reducing access to healthcare encounter data that may be used in response activities and public health research.

The ability to meet CMS standards and conditions for continued funding would be compromised as CMS expects states to reuse technology, they have invested in like the Health Information Exchange; and

The department's ability to comply with new federal laws surrounding information blocking will be hampered (<https://www.healthit.gov/curesrule/>). These laws require data to be transmitted using national standards in an interoperable fashion. The current data exchange services provide the infrastructure for these requirements to be met.

Assumptions and Calculations

Expansion, Reduction, Elimination or Alteration of a current program or service:

FTEs that are in this request are existing positions that provide the maintenance and operations support for the core public health data systems. These systems were developed and/or enhanced using the HITECH funding that was made available through the Medicaid program. Since that funding is no longer available the positions that support this work have been maintained and contract costs to keep the systems live have been maintained.

Detailed Assumptions and Calculations:

RAINIER Suite

Key staff in DOH's Informatics and Epidemiology program areas maintain the RAINIER Suite enterprise application. This request asks for staff to configure, test, and communicate system changes; troubleshoot issues; create relevant reports; work with surveillance staff and investigation staff to utilize data correctly and consistently; work with information technology (IT) staff to outline, implement, and test changes ; and work with external partners (i.e., LHJs, Tribes, CDC) to report and/or enable the reporting of required information (in some cases, this reporting is a requirement to maintain receipt of federal funding). A breakdown of the FTE for the RAINIER Suite is below.

FTE	Position	FFY 24 Salary
0.50	IT ARCHITECTURE - SENIOR/SPECIALIST	\$ 60,810
3.25	IT APPLICATION DEVELOPMENT - JOURNEY	325,104
2.00	IT QUALITY ASSURANCE - JOURNEY	200,064
0.50	IT BUSINESS ANALYST - IT MANAGER	60,810
4.00	IT BUSINESS ANALYST - JOURNEY	400,128
4.00	EPIDEMIOLOGIST 1	340,080
4.00	EPIDEMIOLOGIST 3 (NON-MEDICAL)	471,216
1.00	MANAGEMENT ANALYST 5	91,524
1.00	HEALTH SERVICES CONSULTANT 3	75,120
1.00	WMS03	129,336

RHINO Program

This request for funding includes 2.0 FTE Epidemiologist 2 positions and 1.0 FTE IT Business Analyst (Journey) and 0.25 FTE IT Data management (journey) positions to support the maintenance of the RHINO/syndromic surveillance data and program. This funding will be used to support two key domains of activity: 1) ongoing data quality monitoring and investigation staff to utilize data correctly and consistently; work with information technology (IT) staff to outline, make, and test changes ; and work with external partners (i.e., LHJs, Tribes, CDC) to report and/or enable the reporting of the required information (in some cases, this reporting is a requirement to maintain receipt of federal funding). A breakdown of the FTE for the RHINO is below.

FTE	Position	FFY 24 Salary
1.00	IT BUSINESS ANALYST - JOURNEY	\$ 100,032
0.25	RESEARCH INVESTIGATOR 3	26,265
2.00	EPIDEMIOLOGIST 2 (NON-MEDICAL)	197,184

WAIS

Key staff in the Office of Immunization and Health Technology Services help to perform, monitor, and troubleshoot interface connections and data quality issues so that system users have access to the most timely, accurate, and complete information possible. Staff also support public inquiries for consumer tools. IT staff ensure that the infrastructure runs smoothly 24 hours a day so that messages can be received and responded to in real-time.

Reporting back to the CDC is a requirement for all the federal funding we receive, including supplemental funding received for the influenza and COVID19 response. A breakdown of the FTE for the WAIS is below.

FTE	Position	FFY 24 Salary
0.75	EPIDEMIOLOGIST 3 (NON-MEDICAL)	\$ 81,603
0.50	HEALTH SERVICES CONSULTANT 4	41,448
2.00	HEALTH SERVICES CONSULTANT 3	150,240
0.75	EPIDEMIOLOGIST 2 (NON-MEDICAL)	73,944
1.00	HEALTH SERVICES CONSULTANT 2	66,420
1.00	IT SYSTEM ADMINISTRATION - JOURNEY	105,060
0.50	IT PROJECT MANAGEMENT - JOURNEY	52,530

Data Exchange Services

Key staff in informatics help ensure that DOH’s laboratory and clinical partners are able to have their data feeds validated against national standards. This ensures the data can be ingested into DOH systems and used and that queries from our clinical partners are responded to (like immunization history). IT staff ensure that the infrastructure runs smoothly each day to send and receive these messages. They also build out new routes when required to bring in new data streams or to report data to federal partners like the CDC. Reporting the data to the CDC is often a requirement for the federal funding we receive for COVID19 and other public health surveillance. A breakdown of the FTE for the Data Exchange Services is below.

FTE	Position	FFY 24 Salary
0.20	IT ARCHITECTURE - SENIOR/SPECIALIST	\$ 24,324
1.00	IT APPLICATION DEVELOPMENT - JOURNEY	100,032
0.50	IT APPLICATION DEVELOPMENT - SENIOR/SPECIALIST	57,912
1.00	EPIDEMIOLOGIST 1	85,020
3.00	EPIDEMIOLOGIST 3 (NON-MEDICAL)	326,412
2.00	HEALTH SERVICES CONSULTANT 3	150,240
5.00	EPIDEMIOLOGIST 2 (NON-MEDICAL)	492,960
1.00	SENIOR EPIDEMIOLOGIST (NON-MEDICAL)	123,120
1.00	WMS03	129,336

Workforce Assumptions:

Workforce Assumptions FY24 Projections Only

FTE	Job Classification	Salary	Benefits	Startup Costs	FTE Related Costs
0.7	IT ARCHITECTURE - SENIOR/SPECIALIST	\$85,000.00	\$28,000.00	\$3,000.00	\$5,000.00
4.3	IT APPLICATION DEVELOPMENT - JOURNEY	\$425,000.00	\$152,000.00	\$18,000.00	\$32,000.00
0.5	IT APPLICATION DEVELOPMENT - SENIOR/SPECIALIST	\$58,000.00	\$20,000.00	\$2,000.00	\$4,000.00
2.0	IT QUALITY ASSURANCE - JOURNEY	\$200,000.00	\$72,000.00	\$8,000.00	\$15,000.00
0.5	IT BUSINESS ANALYST - IT MANAGER	\$61,000.00	\$20,000.00	\$2,000.00	\$4,000.00
5.0	EPIDEMIOLOGIST 1	\$425,000.00	\$163,000.00	\$21,000.00	\$38,000.00
7.8	EPIDEMIOLOGIST 3 (NON-MEDICAL)	\$843,000.00	\$292,000.00	\$32,000.00	\$59,000.00
1.0	MANAGEMENT ANALYST 5	\$92,000.00	\$34,000.00	\$4,000.00	\$8,000.00
0.5	HEALTH SERVICES CONSULTANT 4	\$41,000.00	\$16,000.00	\$2,000.00	\$4,000.00
5.0	HEALTH SERVICES CONSULTANT 3	\$376,000.00	\$152,000.00	\$21,000.00	\$38,000.00
7.8	EPIDEMIOLOGIST 2 (NON-MEDICAL)	\$764,000.00	\$275,000.00	\$32,000.00	\$59,000.00
1.0	HEALTH SERVICES CONSULTANT 2	\$66,000.00	\$28,000.00	\$4,000.00	\$8,000.00
5.0	IT BUSINESS ANALYST - JOURNEY	\$500,000.00	\$179,000.00	\$21,000.00	\$38,000.00
1.0	IT SYSTEM ADMINISTRATION - JOURNEY	\$105,000.00	\$37,000.00	\$4,000.00	\$8,000.00
1.0	SENIOR EPIDEMIOLOGIST (NON-MEDICAL)	\$123,000.00	\$41,000.00	\$4,000.00	\$8,000.00
0.5	IT PROJECT MANAGEMENT - JOURNEY	\$53,000.00	\$19,000.00	\$2,000.00	\$4,000.00
-	ADDITIONAL START UP COSTS AND EQUIP	\$0.00	\$0.00	\$228,000.00	\$0.00
0.3	IT DATA MANAGEMENT - JOURNEY	\$26,000.00	\$9,000.00	\$1,000.00	\$2,000.00
2.0	WMS03	\$259,000.00	\$84,000.00	\$8,000.00	\$15,000.00
12.0	FISCAL ANALYST 2	\$637,000.00	\$308,000.00	\$0.00	\$0.00
7.6	HEALTH SERVICES CONSULTANT 1	\$401,000.00	\$193,000.00	\$0.00	\$0.00
65.3		\$5,540,000.00	\$2,122,000.00	\$417,000.00	\$349,000.00

Estimated expenditures include salary, benefit, and related costs to assist with administrative workload activities. These activities include policy and legislative relations; information technology; budget and accounting services; human resources; contracts; procurement; risk management, and facilities management.

Strategic and Performance Outcomes

Strategic Framework:

This request supports the Governor's Results Washington Goal 4: Healthy and Safe Communities. In particular, it links to the following outcomes:

- Preventing Substance Abuse and Improving Recovery;
- Ensuring Access to Quality Healthcare;
- Taking Action to End the Opioid Crisis; and
- Improving Behavioral Health.

This proposal supports the Dept. of Health's **Transformational Plan Priority II. Health Systems and Workforce Transformation**, in that All Washingtonians are well served by a health ecosystem that is robust and responsive, while promoting transparency, equity, and trust. It is well publicized in the media that aged individuals and those with living with existing health complications are more vulnerable to the negative effects of COVID19. However, DOH data show the suffering was also disproportionate among racial lines:

Hispanic, Native Hawaiian, or Other Pacific Islander residents are nine times more likely to contact COVID19 than those of Whites;

Hospitalization rates are seven times higher for Hispanics and 10 times higher for Native Hawaiians or Other Pacific Islanders than those of Whites;

Case and hospitalization rates for Blacks and American Indians or Alaska Natives are three times higher than those of Whites; and

Death rates are over three times higher among Hispanics and Native Hawaiians or Other Pacific Islanders, twice as high among American Indians or Alaska Natives, and over 50 percent higher among Blacks and Asians compared to Whites.

While this proposal will benefit all Washington residents, detecting and preventing the spread of notifiable conditions (including COVID19) will most benefit those individuals and communities who were disproportionately harmed by this pandemic.

This decision package robustly supports Governor Jay Inslee's priorities for Washington as shared in the Results Washington goals by working to promote healthy and safe communities.

Performance Outcomes:

The four systems contained within this request have demonstrated their importance to the state's ability to respond to many public health threats including the COVID19 pandemic and the opioid crisis. Some of the performance outcomes that will be achieved through this request are:

Critical data collection needed for all diseases, including COVID19, will be sustained and data would be able to be extracted and submitted to CDC;

Changes and creative solutions to capture relevant data for all diseases will be maintained and local partners will not need to use their own resources to implement less effective, workaround processes to capture this data.

State level visibility to disease prevalence across LHJs and their communications with the state will be supported;

Data inform decisions about mitigation and prevention measures will be available and will not need to be pulled together from disparate, incomplete data sources;

Data quality will be sustained and will remain reliable for surveillance and decision making. This will allow DOH and the other governmental public health system partners to detect and understand emerging public health threats;

Sustained capability to support data users in LHJs and their ability to investigate health concerns and perform timely response in their jurisdictions;

Providers will be able to electronically update their EHR systems with the immunization history needed to inform the best clinical care decisions;

Schools will have access to the information needed to verify compliance with state school entry requirements.

Critical information needed for critical DOH work like disease outbreak, immunizations and cancer surveillance will be automated or efficient to receive;

DOH will be able to properly conduct case investigation, contract tracing and surveillance;

Improved capacity to comply with statutory requirements; and

Improve agency ability to link datasets efficiently for more robust insight

Equity Impacts

Community outreach and engagement:

This proposal will positively impact health equity by ensuring DOH will be able to generate more robust health equity data and enable intentional efforts to produce products that highlight health disparities. Improved data on social determinants of health applied to the expansive number of health issues captured in healthcare encounter data will be an invaluable asset. Public health partners can use the data and products to identify and engage with impacted communities, implement effective strategies, and evaluate program performance. Additionally, WA-ESSENCE has the capability to set up alerts for specific health concerns and populations so that jurisdictions can be notified of statistically significant increases in visits. This would allow jurisdictions to independently identify and respond more rapidly to burgeoning concerns in their community as well as create both broadened and targeted interventions.

Disproportional Impact Considerations:

This proposal also supports new work the State Board of Health has undertaken to address health equity. New rules that go into effect January 2023 require that labs, providers, and facilities subject to reporting notifiable conditions must include race, ethnicity, and language. Data Exchange will be bringing in these new values for use in the RAINIER suite. This will benefit our case investigations as well as surveillance work for better informed decision making.

Beyond addressing health equity work, this proposal supports equitable access to data by shifting data back to the local health jurisdictions and tribal partners working with their communities and facilities collecting the data. The WA-ESSENCE platform has built-in analysis tools so that jurisdictions can directly access their data and tailor basic analyses without third-party software. Furthermore, the platform will reduce the number of resources required by our partners to collect, analyze, and interpret the data.

Target Populations or Communities:

It is already well publicized in the media that aged individuals and those with living with existing health complications are more vulnerable to the negative effects of COVID19. However, DOH data show the suffering was also disproportionate among racial lines:

Hispanic, Native Hawaiian, or Other Pacific Islander residents are nine times more likely to contract COVID19 than those of Whites; Hospitalization rates are seven times higher for Hispanics and 10 times higher for Native Hawaiians or Other Pacific Islanders than those of Whites; Case and hospitalization rates for Blacks and American Indians or Alaska Natives are three times higher than those of Whites; and Death rates are over three times higher among Hispanics and Native Hawaiians or Other Pacific Islanders, twice as high among American Indians or Alaska Natives, and over 50 percent higher among Blacks and Asians compared to Whites. American Indian and Alaska Natives have lower life expectancy and a disproportionate level of diseases compared to other population groups

While this proposal will benefit all Washington residents by detecting, preventing, and remediating the spread of all public health threats, it will most benefit those individuals and communities who were disproportionately harmed by this pandemic.

Other Collateral Connections

Puget Sound Recovery:

N/A

State Workforce Impacts:

N/A

Intergovernmental:

The systems supported by this request are sourced by and are accessed by various entities, including other government agencies. Laboratory data provided through the RAINIER Suite and surveillance data provided through RHINO informs public health activities in the LHJs.

All communities statewide who benefit from public health and seek healthcare are impacted by this proposal. This includes tribal, urban, and rural communities. DOH's ability to collect, analyze, and disseminate data allows all communities to better prepare for, address, and monitor emerging and existing public health issues. State agencies that are also impacted by public health will benefit such as: Office of Financial Management, Washington Traffic and Safety Commission, Department of Social and Health Services, Labor and Industries, Department of Health, and Department of Ecology.??

Stakeholder Response:

While most stakeholders of this proposal are governmental entities, the information provided by WAIS helps healthcare providers and Health plans to provide better clinical care to their patients. Several providers heavily rely on the WAIS for their immunization programs. Data Exchange services also supports healthcare providers via immunization and PMP queries and newborn screening results are coming online. Data exchange services also support hospitals and providers in meeting public health reporting objectives for CMS Medicare regulations. DOH anticipates that Tribes and LHJs will support this proposal, as it will increase the visibility and usability of their data while ensuring confidentiality. DOH expects neutrality or support of this request from stakeholders.

State Facilities Impacts:

N/A

Changes from Current Law:

N/A

Legal or Administrative Mandates:

N/A

Reference Documents

[IT 2023-25PrioritizationWorksheetIT - HTS DataExchange.xlsx](#)
[IT 2023-25PrioritizationWorksheetIT - HTS RAINIER.xlsx](#)
[IT 2023-25PrioritizationWorksheetIT - HTS RHINO.xlsx](#)
[IT 2023-25PrioritizationWorksheetIT - HTS WAIS.xlsx](#)
[ITaddendum_2023-MCPHS-DataExchange.docx](#)
[ITaddendum_2023-MCPHS-RAINIER.docx](#)
[ITaddendum_2023-MCPHS-RHINO.docx](#)
[ITaddendum_2023-MCPHS-WAIS.docx](#)
[MaintainCorePHSystFNCaI_2023-25 07282022 FinalDraft.xlsm](#)

IT Addendum

Does this Decision Package include funding for any IT-related costs, including hardware, software, (including cloud-based services), contracts or IT staff?

Yes

Objects of Expenditure

Objects of Expenditure <i>Dollars in Thousands</i>	Fiscal Years		Biennial	Fiscal Years		Biennial
	2024	2025	2023-25	2026	2027	2025-27
Obj. A	\$5,539	\$5,539	\$11,078	\$5,539	\$5,539	\$11,078
Obj. B	\$2,126	\$2,126	\$4,252	\$2,126	\$2,126	\$4,252
Obj. C	\$3,059	\$3,059	\$6,118	\$3,059	\$3,059	\$6,118
Obj. E	\$417	\$417	\$834	\$417	\$417	\$834
Obj. J	\$47	\$47	\$94	\$47	\$47	\$94
Obj. T	\$345	\$345	\$690	\$345	\$345	\$690

Agency Contact Information

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