



Agency Recommendation Summary

The Department of Health requests funds to address sustainment of a core-level of case investigation capacity developed during the COVID-19 pandemic that will be critical in supporting local health jurisdictions response to emerging infectious disease threats in the upcoming biennium. For future biennia, we propose additional funding that captures core functions of surveillance and informatics. During the COVID-19 pandemic, state level communicable disease surveillance and response capacity was developed to support the critical needs and gaps among local health jurisdictions (LHJs) and Tribes. This capacity will continue to be a critical infrastructure component for ongoing and emergent communicable disease surveillance and response needs. We are already flexing a portion of staff capacity, where available, to support the current responses to the monkeypox virus, highly pathogenic avian influenza, and tuberculosis. The pandemic has demonstrated the value and utility of this capacity for LHJs and Tribes not only as a critical gap filler but also as surge capacity.

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	0.0	44.2	22.1	135.4	146.0	140.7
Operating Expenditures						
Fund 001 - 1	\$0	\$7,201	\$7,201	\$15,309	\$16,670	\$31,979
Total Expenditures	\$0	\$7,201	\$7,201	\$15,309	\$16,670	\$31,979

Decision Package Description

Outbreaks of existing and newly emerging communicable disease are increasing globally in an ever increasingly connected world. International outbreaks are a plane ride away. Prior to the pandemic, Washington experienced an average of 2-3 outbreaks per year - Mumps, multiple Measles outbreaks, Acute Flaccid Myelitis, Vaping associated Lung Illness, to highlight a few. These public health responses required both local and state level public health agencies to cobble together staffing, systems and approaches to attempt to meet the need. Capacity was scrappy but never adequate.

The response capacity developed at the state level to support local COVID-19 response has direct applicability to future communicable disease response needs to support ongoing gaps and surge capacity needs. This capacity is among staff specializing in disease investigations, surveillance, informatics and response support and coordination.

We propose maintaining a base capacity of surge response staff to support ongoing needs in the upcoming biennium in the area of case investigations and in the future to support areas of surge surveillance and response coordination needs. In addition this includes staffing resources and technology to allow for successful rapid application of investigation tools and support of broader surveillance and response needs.

While there is some capacity at the local level to respond to ongoing communicable disease investigation needs, there is no surge capacity to meet the emergent outbreak needs. This is clearly evident with the public health response to the current outbreak of monkeypox virus. Local health jurisdictions are now requesting DOH surge disease investigation support to assist and supplement their local staffing. DOH is prioritizing providing this support along with maintaining current COVID response capacity but the capacity is coming from other critical state-level activities. In the future, DOH investigation surge capacity would complement and enhance local capacity during surge events.

This proposal seeks to solve the problem of how to systematically and equitably staff response to communicable disease surge events. It is inefficient and likely impossible to have all local health jurisdictions and tribes maintain surge capacity due to the infrequency and unpredictability of surge events at the local level. However, the entire public health system across the state collectively has a frequent and predictable need for surge capacity. Therefore a pool of case investigators and centralized surveillance and informatics backbone at the state level with capability to deploy to hotspots and areas of greatest need will collectively provide benefit to the entire public health system in the following ways:

- Supporting and enhancing local case investigation response in a quick and robust way to help prevent outbreaks from spreading locally and across the state.
- Preserving local staffing capacity bandwidth to maintain local core capacity to respond to day-to-day communicable disease issues in spite of a surge event
- Preventing local staff burnout and attrition that often accompanies intense response events
- Supporting the tools and applications that allow for state-wide and cross-jurisdictional situational awareness while preserving local response staff to focus on response within their communities

We have a proven track record with this approach. Below we provide a snapshot of the level of COVID-19 investigation capacity

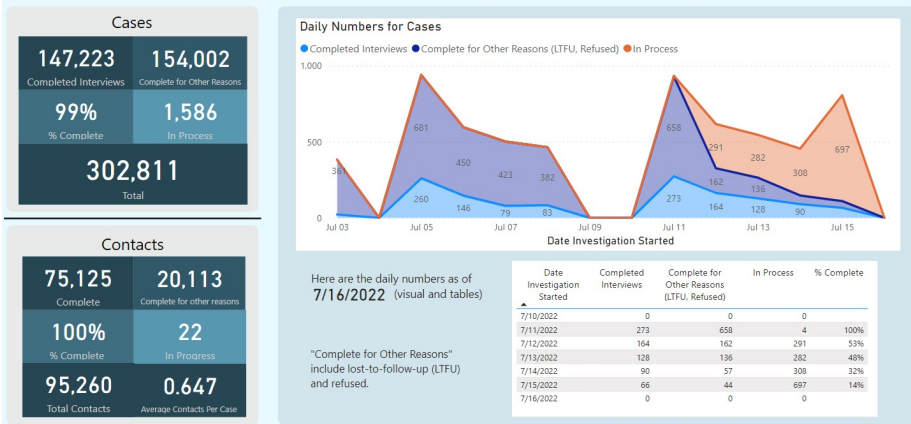
and performance that we currently provide as a centralized resource for our local health jurisdiction partners.

Daily Numbers

The Daily Numbers displays the number of interviews conducted by our Outbreak Support Specialist (OSS) team. Cases are people who tested positive for COVID-19 and contacts are those who had close contact with and were identified by cases.

Numbers on the left detail the totals for all assessments starting 7/14/2020. Visuals on the right present recent daily data.

Week's End: 7/2/2022, 7/9/2022, 7/16/2022, 7/23/2022
 Month: Jul 2022
 Quarter: QTR 3



In addition to COVID-19, we are working to have staff trained to provide surge capacity to other areas of current and emergent need. We currently have investigation staff trained to support several other specialized investigations noted in this table.

Total Investigators	COVID	Monkeypox	Foodborne	STI	Childcare Settings	Wa Notify/OTC
49	49	17	6	9	12	23

At this time the surveillance, informatics and response coordination support is funded through other short-term federal dollars. These staffing resource needs are imperative to the success of a centralized case investigation team as well as to the success of local level response capacity. In future biennial surveillance and response support capacity will expand to cover the state infrastructure needs

In addition to the proposal, we explored 2 specific alternatives as well as the option of doing nothing.

Of note the options below do not take into consideration the ongoing need for state-based surveillance and informatics efforts. These functions require a state-wide approach to service all 35 local health jurisdictions and supplement 29 tribal partners and their centralized epidemiology centers. Without state infrastructure to support state-wide, regional and cross-jurisdictional disease surveillance policy-makers at a state and community level would lose visibility on the impacts diseases of public health significance have within their community. This would lead to further gaps in preventative service, policies and community level supports for expanding health issues and declining wellness.

Alternative #1 – local-based surge capacity

In this scenario, each local jurisdiction would be responsible to hire, train and maintain its own surge investigation staff.

Pros

- Local staffing are accustomed to local needs, issues and special considerations for their community
- Preserve local jurisdiction capacity to address day-to-day communicable disease obligations.

Cons

- The staffing footprint total and cost to have FTE in every jurisdiction will be significantly higher as compared to a centralized DOH resource.
- Training and maintaining this additional workforce creates additional burden on each individual local jurisdiction.
- When there are no surge events, the surge investigation staff will likely not have enough work to keep them busy.

Alternative #2 – Externally contracted state-level surge investigation team

In this scenario, DOH would contract with an external vendor who then hires and maintains a surge investigation workforce. During the COVID-19 pandemic, DOH used this approach to supplement the substantial need of LHJs after the state National Guard staffing support in this area was sunsetting.

Pros

- Staffing capacity is not an administrative burden to DOH
- Capacity could, in theory, be scaled according to the need although there are challenges with the speed of ramping up capacity using contracted resources.
- Preserve local jurisdiction capacity to address day-to-day communicable disease obligations.

Cons

- The cost would be substantial. From our experience during the COVID-19 pandemic, an external vendor does come at a cost much higher than hiring and maintaining internal staffing,
- While scalability is attractive, our experience is that it takes a minimum of 4-6 weeks for a contractor to provide additional staff to meet an increased demand. This timeframe would likely provide minimal benefit to local jurisdictions when timeliness is critical for response and containment.

Assumptions and Calculations

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

Assumptions: 1) profile below is only partial and represents non-COVID capacity for emerging surge needs such as monkeypox and tuberculosis. 2) This footprint ensures capacity to handle 2-3 large, multijurisdictional outbreaks per year. 3) the remaining profile for investigations dedicated to COVID-19 is in the COVID-19 decision package. 4) the combination of this proposal and the COVID-19 proposal represents a 40% reduction.

Detailed Assumptions and Calculations:

For the previous biennium the case investigation surge capacity was stood up and dedicated to supporting COVID-19 case investigations. We summarized below the past, current, proposed and future staffing profiles.

PAST AND CURRENT – Staffing profile (2019-21 to present)

Assumptions: 1) profile supports up to 20 LHJs in COVID case investigation and contact tracing of priority populations only.

Staffing profile

Administrative leadership: 3 FTE
Disease investigator supervisors: 7 FTE
Disease investigators: 50 FTE
Investigation System Epidemiologists: 15 FTE
Data Support: 49 FTE
Surveillance: 9.5 FTE Informatics: 14 FTE

PROPOSED – Staffing profile (2023-25) –

Assumptions: 1) profile below is only partial and represents non-COVID capacity for emerging surge needs such as monkeypox and tuberculosis. 2) This footprint ensures capacity to handle 2-3 large, multijurisdictional outbreaks per year. 3) the remaining profile for investigations dedicated to COVID-19 is in the COVID-19 decision package. 4) the combination of this proposal and the COVID-19 proposal represents a 40% reduction.

Staffing profile

Administrative leadership: 1 FTE
Disease investigator supervisors: 1 FTE
Disease investigators: 10 FTE
Investigation System Epidemiologists: 3 FTE
Starting FY25: Informatics 14 FTE, Surveillance: 9.5 FTE,
and Data Support 12 FTE

FUTURE – Staffing profile 25-27 and beyond)

Assumptions: 1) As demand for COVID support capacity decreases, capacity for surge surveillance, investigations, and coordination shift to this proposal. This is where we would see the additional FTE profile summarized as follows:

Staffing profile summary

Surge Case Investigation: 10 FTE
Surge Surveillance: 9.5 FTE
Surge Response Support and Coordination: 15 FTE
Informatics: 14 FTE
Data Support: 12 FTE

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.

FY2025 \$7,201,000 FTE 44.2
FY2026 \$15,309,000 FTE 101.00
FY2027 \$16,670,000 FTE 108.5

Workforce Assumptions:

Workforce Assumptions FY25 Projections Only

FTE	Job Classification	Salary	Benefits	Startup Costs	FTE Related Costs
5.0	EPIDEMIOLOGIST 1	\$425,000.00	\$163,000.00	\$21,000.00	\$38,000.00
10.0	EPIDEMIOLOGIST 2 (NON-MEDICAL)	\$986,000.00	\$355,000.00	\$42,000.00	\$76,000.00
7.0	EPIDEMIOLOGIST 3 (NON-MEDICAL)	\$762,000.00	\$264,000.00	\$29,000.00	\$53,000.00
2.0	SENIOR EPIDEMIOLOGIST (NON-MEDICAL)	\$246,000.00	\$82,000.00	\$8,000.00	\$15,000.00
2.0	HEALTH SERVICES CONSULTANT 1	\$112,000.00	\$52,000.00	\$8,000.00	\$15,000.00
9.0	HEALTH SERVICES CONSULTANT 2	\$598,000.00	\$257,000.00	\$37,000.00	\$68,000.00
6.0	HEALTH SERVICES CONSULTANT 3	\$451,000.00	\$182,000.00	\$25,000.00	\$45,000.00
2.0	HEALTH SERVICES CONSULTANT 4	\$166,000.00	\$64,000.00	\$8,000.00	\$15,000.00
1.2	WMS02	\$137,000.00	\$47,000.00	\$5,000.00	\$9,000.00
44.2	TOTAL FTE	\$3,882,000.00	\$1,466,000.00	\$183,000.00	\$334,000.00

Strategic and Performance Outcomes

Strategic Framework:

This package directly relates to the Governor’s Results Washington goal of “Healthy and Safe Communities.” By ensuring we have communicable disease surge investigation capacity that is deployable to local health jurisdictions during surge events, we are able to assist with containing an outbreak and minimizing health impacts to a community. Additionally, this capacity ensures that local health jurisdiction staffing can continue to meet its day-to-day communicable disease obligations rather than be solely focused on a surge event.

This package also supports the agency transformation plan HEALTH SYSTEMS AND WORKFORCE TRANSFORMATION All Washingtonians are well served by a health ecosystem that is robust and responsive, while promoting transparency, equity, and trust. We employed these approaches for investigation capacity during the COVID-19 pandemic to great effect. We would seek to build upon this work and seek to integrate as appropriate with agency initiatives.

Performance Outcomes:

Performance outcomes for biennium 23-25:

- # of LHJs and tribes supported
- # of staff trained for specific condition areas, by condition area.
- % of completed investigations by outbreak, disease, and condition area
- % of investigations completed without errors by outbreak, disease, and condition area

Performance outcomes expected for biennium 25-27 and beyond:

- # of LHJs and tribes supported
- # of staff trained for specific condition areas, by condition area.
- % of completed investigations by outbreak, disease, and condition area
- % of investigations completed without errors by outbreak, disease, and condition area
- Investigation performance outcomes from biennium 23-25
- Annual Internal and External needs and gaps assessment
- Annual Communicable Disease and Epidemiological focused External Partner Engagement Plan
- 95% Project Management support rate
- Integration of COVID-19 Lessons into Communicable Disease Response Plans
- Surge pool of 200 trained personnel for Epidemiological Response Teams
- 100% of investigators completed refresher trainings
- Enhancement of surveillance systems to accommodate 100% new and emerging conditions causing outbreaks
- Automation of data management and reporting tasks for 100% of outbreaks
- Development and regular release of surveillance data products for internal and external use for 100% of outbreaks

Equity Impacts

Community outreach and engagement:

Our approach will be to take our tools and lessons learned during the COVID-19 pandemic to ensure we continue to take an equity-based approach. Case investigations teams use the following strategies as a proactive means to ensure we were infusing considerations of health inequities into their day-to-day work.

Those key areas were:

- Weekly engagement with our LHI and tribal partners to discuss emergent and jurisdiction-specific needs specific to health equity
- Development of investigator training curriculum using a proactive health equity approach that tailors how interviews are conducted regarding

- culturally and linguistically diverse populations
- socially diverse and marginalized communities
- immigrant and refugee communities
- engagement with persons living homeless
- approaching investigations through cultural humility and sensitivity

Use of case data information to prioritize cases of potential greatest need. While case data are limited when initially reported to public health, we developed a prioritization for targeting investigations to areas of higher risk and vulnerability to COVID-19. We would use similar approaches as necessary during surge events upon request.

One-on-one technical assistance and specialized investigations for jurisdictions in need of more assistance.

Disproportional Impact Considerations:

Additionally, we will engage community partners through existing DOH avenues to ensure our workforce remains engaged and relevant to the evolving needs as we did during the COVID-19 pandemic.

As we aim to expand our surveillance and informatics work in 2026, we will continue to foster approaches centered around data equity, assuring data products and tools developed are intentional, well vetted by the community and meet the needs of public health practitioners to identify and target health inequities across their communities. This has and will continue to be a metric of success for our informatics and surveillance work out of the department.

Target Populations or Communities:

We know from the COVID-19 pandemic and in previous outbreaks in Washington that outbreak surge events disproportionately impact communities experiencing health inequities. The more support we can provide to reduce the size and scope of an outbreak, the less impact it will have on these communities.

Other Collateral Connections

Puget Sound Recovery:

N/A

State Workforce Impacts:

N/A

Intergovernmental:

This proposal seeks to provide enhanced surge support for local health jurisdictions and tribes upon request during outbreak surge events. As this is a capacity that is upon request, we do not anticipate opposition. We used this same model for COVID-19 to great effect and would intend to use the same engagement and support approach for surge support.

Stakeholder Response:

No stakeholder impacts anticipated.

State Facilities Impacts:

N/A

Changes from Current Law:

N/A

Legal or Administrative Mandates:

This proposal is not in response to any legal issues, audit findings, executive order or task force recommendations.

Reference Documents

[FinancialCalculator_2023-25_ver24.0 DISEASES INVESTIGATION SURGE SUPPORT.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?

No

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	\$0	\$4,739	\$4,739	\$9,907	\$10,821	\$20,728
Obj. B	\$0	\$1,881	\$1,881	\$4,061	\$4,408	\$8,469
Obj. E	\$0	\$247	\$247	\$578	\$621	\$1,199
Obj. T	\$0	\$334	\$334	\$763	\$820	\$1,583

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