Washington State Department of HEALTH

WA PUBLIC HEALTH SYSTEM MONTHLY UPDATE

July 2026

The Washington State Department of Health (DOH) works diligently with Local and Tribal Health Jurisdictions to improve the health and well-being of Washington residents. The WA State Public Health System Monthly Update provides an overview of the key health issues impacting Washington state, and the progress we are making in addressing them.

Questions about the WA State Public Health System Monthly Update?

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- **Federal Investments in WA PH Data Systems**
- **Hib Clusters in PNW**
- **WA Hospitals & World Cup Readiness**
- **Preliminary Suicide Death Data**

Building the Public Health Infrastructure of Tomorrow: Federal Investments Modernizing Washington's Public Health Data Systems

For decades, public health data systems across the country, including in Washington, were built program by program. One system for immunizations, another for communicable disease, another for overdose, each with its own standards and login. The result is information that cannot easily move between systems and slower answers when a threat emerges. CDC's Data Modernization Initiative (DMI), launched in 2019, exists to change that. It works to make public health data more accessible, flexible, equitable, and usable for action, integrating people, processes, and technology so that data can move securely across local, state, Tribal, and national partners.

The Challenge: Disconnected Systems

Washington's roughly 50 surveillance systems were developed over many years, largely in response to specific federal grant requirements. Because they were designed in isolation, they use inconsistent data standards, require providers to report the same case to multiple systems, and slow the state's ability to see a complete, current picture during an outbreak. Modernizing this infrastructure is less about buying new software than about connecting what already exists, so that information collected once can be used many times.

Federal Investments Driving the Work

2 federal sources anchor Washington's modernization. The Public Health Infrastructure Grant (PHIG) is the first federal grant dedicated to the core infrastructure of the public health system rather than to a single disease. CDC awarded more than $5 billion through PHIG over 5 years to 107 health departments nationwide, including Washington. Unlike categorical disease grants, PHIG provides flexible support across 3 areas: workforce, foundational capabilities, and data modernization, letting DOH invest in shared infrastructure rather than another single-purpose system. Alongside it, DMI provided Washington roughly $12 million over the past 5 years to improve how its data systems connect. Together, these investments fund the connective tissue that individual programs rely on but rarely pay for: common standards, secure data exchange, and cloud infrastructure.

Faster, More Complete Disease Reporting

The clearest gains are in how quickly disease information reaches public health. Through electronic case reporting (eCR), a hospital's electronic health record automatically sends a report to DOH the moment a reportable condition is diagnosed, replacing manual faxes and phone calls.

As of July 2026, DOH had connected with 76 health care organizations, representing more than 3,170 facilities across the state, with additional organizations being added. eCR also allows eligible hospitals and critical access hospitals, which serve many of Washington's rural communities, to meet federal reporting requirements while cutting the time staff spent on paperwork.

Washington has paired this with near real-time syndromic surveillance. Under state law (RCW 43.70.057), all Washington emergency departments report visit data to DOH's Rapid Health Information Network (RHINO), which tracks respiratory illness, opioid overdoses, and new threats. RHINO also feeds the national picture through CDC's National Syndromic Surveillance Program. The state is further expanding surveillance through wastewater monitoring, which can detect the spread of a pathogen before people seek care.

Better Information for Communities

Modernized data also reaches the public faster and in clearer form. In 2023, DOH launched 2 redesigned public dashboards built on this infrastructure: a Respiratory Illness Data Dashboard that tracks COVID-19, influenza, and RSV activity by region with year-over-year comparisons, and an Opioid and Drug Overdose Dashboard that presents

county-level hospitalizations and deaths in an accessible format the public can act on. Modern visualization and geographic analysis let local health officials and residents see how conditions are changing in their own communities, supporting decisions that once had to wait for a static annual report.

Looking Ahead

Washington continues to modernize across several fronts: disease surveillance and case management, data governance, secure data sharing, chronic disease analytics, cloud informatics, and enterprise data architecture. Some of this work is already visible. A chronic disease surveillance effort delivers timely information on comorbidities to health care partners, and in January 2025 DOH and the Tulalip Tribes signed a data-sharing agreement that advances Tribal data sovereignty and offers a model for secure, respectful exchange. Together these efforts position the state to respond more effectively to both infectious disease threats and emerging public health challenges.

Requests to Congress

- **Sustain flexible infrastructure funding through PHIG.** The grant's value is that it pays for the shared systems, standards, and staff that categorical disease grants cannot. Reducing or ending it would stall modernization already underway and push the state back toward disconnected, single-purpose systems.
- **Protect dedicated Data Modernization Initiative funding.** Interoperability is built over years, not quarters. Steady DMI appropriations are what allow Washington to connect its roughly 50 legacy systems rather than maintain them in parallel.
- **Maintain federal support and requirements for electronic case reporting.** Continued federal backing for eCR keeps disease reports flowing automatically from hospitals, including rural critical access hospitals, and reduces the burden on providers who would otherwise report by hand.

Emerging Hib Clusters in the Pacific Northwest Highlight the Need for Modern Adult Vaccine Strategies

Haemophilus influenzae serotype b (Hib) is a vaccine-preventable cause of invasive bacterial disease, including bacteremia (bloodstream infection), pneumonia, and meningitis. After widespread childhood vaccination, invasive Hib became rare in the United States. However, an outbreak among adults was first identified in King County, Washington, in 2024, when a lab scientist noticed an increase in invasive *H. influenzae* isolates among adults and requested serotyping, a test that identifies the bacterial strain. All 4 initial cases were confirmed as Hib.

From March 2024 through 2025, 30 adult cases of invasive Hib were identified in King County, as shown in Figure 1. Before 2026, invasive *H. influenzae* disease was required to be reported to public health agencies only among children younger than 5 years. As a result, adult cases were not routinely captured through existing surveillance systems. In response to the outbreak, Washington expanded reporting to all ages beginning January 1, 2026, and required isolates (bacterial samples) from normally sterile sites, such as blood, to be sent to the Washington Public Health Laboratories for serotyping. Statewide data from 2026 are preliminary and subject to change. An additional 25 cases were identified across eight counties through July 2026, bringing the total to 55 cases; 40 occurred in King County, as shown in Figure 2.

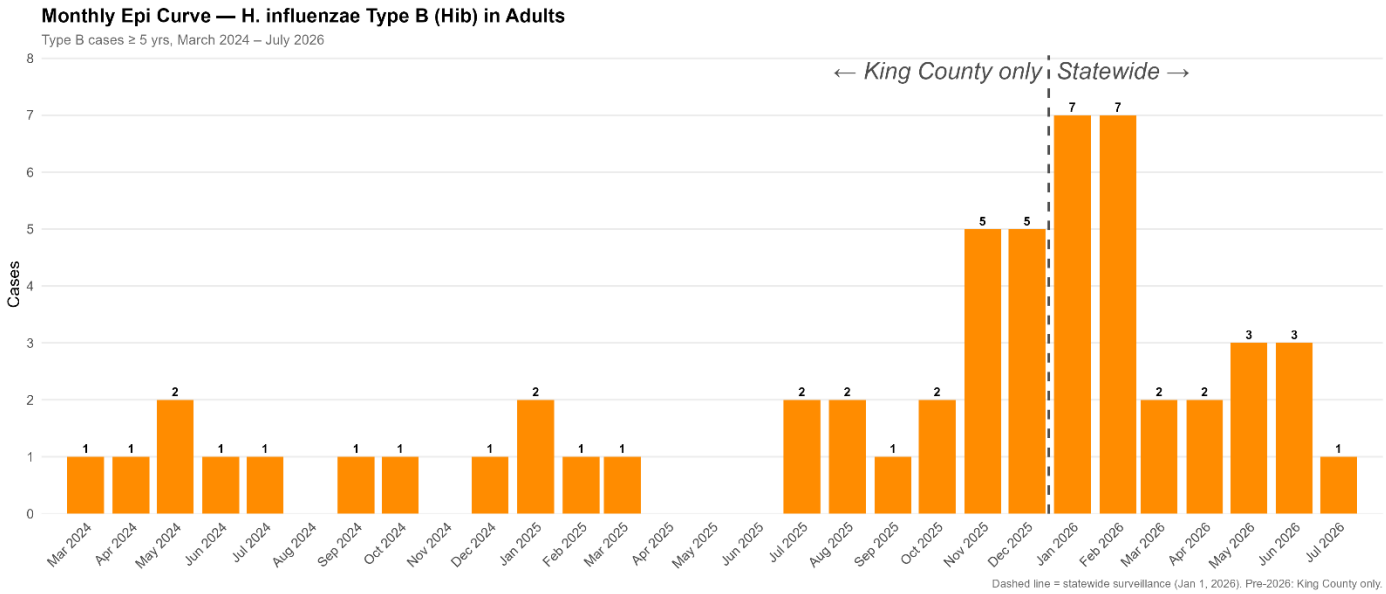

Figure 1: Adult Hub Cases by Month (March 2024-July 2026; n=55) *2026 data is preliminary and subject to change.*

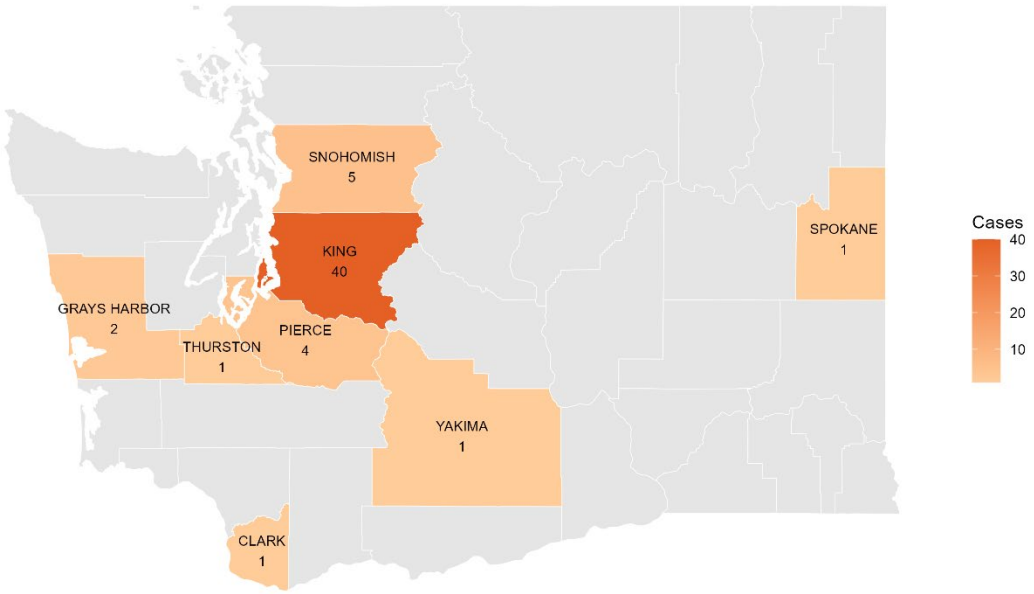

*Figure 2: Adult Hib Case Count by County (March 2024-July 2026; n=55)**
** 2026 data is preliminary and subject to change.*

The burden of disease is substantially higher than expected. Based on CDC national surveillance rates adjusted for Washington's population; fewer than 2 adult cases should be expected annually. The 25 cases identified during the first half of 2026 alone represent an approximately 24 times higher case count than what we would expect. No similar increase in pediatric cases has occurred.

Most case patients (86%) were hospitalized, with an average stay of 6 days, and at least 5 deaths (9%) were attributed to Hib.

Unlike historic Hib disease, which almost always affected young children, nearly all recent Washington patients were adults with complex social and health vulnerabilities. Most are male (75%) with a median age of 56 years. More than 80% were experiencing homelessness or living in a shelter at the time of illness. Substance use, including methamphetamine and fentanyl, was common. Most patients (82%) were born before 1986 and were too old to have received Hib vaccine during childhood, and only 2 (4%) had a documented dose of a Hib-containing vaccine.

Laboratories also compared the genetic makeup of the bacteria across cases, a technique called whole genome sequencing. This has been completed for 48 of 55 isolates (87%), and all sequenced isolates are very closely

related. This suggests ongoing spread of a single, previously undocumented strain over time. The sequencing also linked cases in Washington to cases in Oregon.

Although Hib vaccine is not routinely recommended for this population, CDC is drafting guidance recommending consideration of vaccines during clusters of invasive Hib disease among at-risk adults. Similar outbreaks have prompted adult vaccination campaigns in Alaska and British Columbia. Limited adult studies suggest that a single dose can produce protective antibody levels and is generally well tolerated.

This outbreak highlights the need for enhanced surveillance and evidence-informed vaccination strategies to protect underserved populations at highest risk of severe disease.

The Network Behind the Games: Hospital Preparedness and Washington's World Cup Readiness

Between June 15 and July 6, 2026, Seattle hosted 6 FIFA World Cup matches at Lumen Field, drawing hundreds of thousands of visitors from around the world to the region. Behind the crowd is a community developed medical response plan funded through a federal grant - the Hospital Preparedness Program (HPP), administered by the federal Administration for Strategic Preparedness and Response (ASPR).

In Washington, HPP funds two emergency preparedness Healthcare Coalitions, the Northwest Healthcare Response Network (NWHRN), a 501c3 serving communities across the state and the Healtcare Alliance, a program coordinated through Clark County Public Health.

Created by Congress in 2003, HPP is the only source of federal funding dedicated to health care system readiness. It does not purchase supplies or equipment, nor does it fund or direct hospital resources: it funds the connections. The NWHRN leads collective planning, training, and exercises so that when a single facility is overwhelmed, bed availability, staff, and supplies can be coordinated across many facilities and organizations.

A Patient-Tracking Backbone Already Tested in Washington

When a mass casualty event scatters patients across a dozen emergency departments, the hardest question to answer is where everyone went. HPP funds the answer. WATrac, Washington's web-based patient tracking and bed-capacity system, lets coalitions see in real time which hospitals have room and where each patient was taken. It is the common database that tracks patients across facilities and anchors family reunification. The system is not theoretical. In December 2017, when an Amtrak Cascades train derailed onto Interstate 5 near DuPont, the Northwest Healthcare Response Network activated its coordination center and WATrac within an hour, and helped distribute 69 patients across 9 hospitals. By the end of the day, staff had reconciled the passenger manifest against tracking data to reunite families.

Surge Plans for the Scenarios a Stadium Raises

Ahead of the tournament, NWHRN led work across Washington state to develop and exercise an updated statewide mass casualty response plan, including deeper strategies for emergency medical services coordination, and refreshed 2 specialty surge plans that a large-venue incident makes concrete. NWHRN's burn surge plan is anchored by Harborview Medical Center, the region's Level 1 trauma center and its regional burn center, which since 1974 has treated nearly 20,000 patients from Washington, Alaska, Montana, and Idaho. A separate pediatric mass casualty plan addresses a gap NWHRN and partners have flagged: children need different equipment, dosing, and transport, and most hospitals are not pediatric centers.

A Global Crowd is a Public Health Event

World Cup events concentrate international travel, and with it the movement of disease. In June 2026, the public health agency for Seattle and King County advised health care facilities to collect travel histories, watch for illnesses not endemic to Washington, and report unusual cases quickly, naming measles, hepatitis A, mpox, and tuberculosis among the pathogens of concern given international arrivals. Through NWHRN, the same coalition network that moves trauma patients also moves information, connecting hospitals to public health for surveillance and, when needed, to the region's special pathogen program. The calendar compounds the load. Late June and early July are Washington's season for extreme heat and wildfire smoke, hazards the same network is built to absorb.

Requests to Congress

- **Sustain HPP funding at no less than the $240 million formula level.** HPP is the only federal funding dedicated to health care system readiness, and any reduction will compromise the state's readiness.
- **Protect a funding formula that accounts for risk and patient volume.** As ASPR revisits the formula, Washington's coalitions serve dense urban centers and sparsely populated rural areas. Historically the bridge past competitive relationships provided by HCC have been highly effective in urban environments. However, as our healthcare system encounters a changing risk profile, including major shifts in patient payer mix, it is rural healthcare that is increasingly reliant on the expertise and resources of urban centers to maintain access to care during emergencies. Accordingly, any revised formula must balance risk where patient surge is most likely (urban areas) while recognizing the higher cost of providing care in rural environments and creating connections across less populated areas.
- **Preserve specialty surge and patient-tracking capacity.** Burn and pediatric mass casualty capability and the WATrac tracking system depend on sustained HPP support and losing them would leave Washington slower to place its most vulnerable patients when minutes matter the most.

Preliminary Data Shows Concerning Increase in Suicide Deaths in Washington

Preliminary Washington State Department of Health mortality data indicate that deaths by suicide increased in 2025 after several years of encouraging declines. While 2025 mortality data are preliminary and will continue to be updated through fall 2026, early trends underscore the importance of sustained investments in behavioral health, crisis response, and suicide prevention programs.

Analysis to date suggests the increase disproportionately affects youth ages 10–17, adults age 65 and older, American Indian and Alaska Native communities, Hispanic populations, and White non-Hispanic residents. There is evidence of a rise in youth suicide observed in 2025 preliminary data - from 4.7 to 7.6 per 100,000 (an increase of 2.9 per 100,000). Rural communities are also seeing an increase, where limited access to behavioral health services, workforce shortages, and geographic barriers continue to challenge prevention efforts.

Washington's suicide rate remains above the national average, although it continues to be lower than rates observed in neighboring Oregon, Idaho, and Alaska. Although most suicide deaths occur in Washington's largest population centers (including King and Pierce counties) many rural counties continue to experience the highest per-capita suicide rates. Even modest increases in deaths can translate into significant increases in rates for smaller communities. Rural communities have highlighted persistent disparities in access to behavioral health care and crisis services.

These preliminary findings reinforce the need for continued federal-state partnership to strengthen the behavioral health continuum. Federal investments have helped Washington

- ✓ Expand access to the 988 Suicide & Crisis Lifeline
- ✓ Strengthen community-based crisis response
- ✓ Improve behavioral health infrastructure
- ✓ Support prevention activities that strengthen connectedness and build supportive environments.

A recent study published in the *Journal of the American Medical Association* found that implementation of the 988 Lifeline was associated with significant reductions in suicide mortality among adolescents and young adults nationwide, with the greatest improvements occurring in states with the highest utilization of 988 services. Washington has similarly experienced a decline in suicide deaths among people ages 15–34 since 2021, demonstrating the value of sustained investments in evidence-based crisis intervention even as emerging trends highlight growing needs among other populations.

These data will be finalized in the fall and will be shared broadly with the public and partners at that time. For more information about suicide prevention review the 2025 Washington State Suicide Prevention Plan - a statewide roadmap developed collaboratively with Tribal Nations, state agencies, local health jurisdictions, health care providers, community organizations, and people with lived experience to ensure effective multi-sector suicide prevention efforts continue to make an impact to this growing public heath challenge.

As Congress considers future appropriations, continued support for behavioral health infrastructure, the 988 Suicide & Crisis Lifeline, community-based suicide prevention programs, Tribal behavioral health initiatives, and the public health data systems needed to identify emerging trends will be critical to helping states respond quickly to changing patterns and reduce suicide deaths across all communities.

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