CITY OF MARYSVILLE AGENDA BILL

EXECUTIVE SUMMARY FOR ACTION

CITY COUNCIL MEETING DATE: 11/7/16

AGENDA ITEM:	
Snohomish Health District Presentation	
PREPARED BY:	**DIRECTOR APPROVAL:**
Gloria Hirashima, Chief Administrative Officer	
DEPARTMENT:	
Executive	
ATTACHMENTS:	
1. Frequently Asked Questions 2. Snohomish Health District Assessment 3. Snohomish Health District Strategic Plan 4. Draft Funding Formula and Resolution provided by Snoh. Health District	
BUDGET CODE:	**AMOUNT:**
SUMMARY:	

Peter Mayer, Deputy Director of the Snohomish Health District (SHD) will provide an overview and presentation regarding the funding request and current services provided by SHD. Attached are background materials relating to SHD's current situation, mission and situational assessment.

RECOMMENDED ACTION:

Where have you seen the biggest decreases in funding?
As you can see in the attached spreadsheet, the Health District has been experiencing flat or declining funding from most federal, state and local funding sources over the last decade or so. This is coupled by Snohomish County's fast-growing population and our rising expenses needed to respond to increasingly complex diseases, food threats and social issues like suicide prevention and the opioid epidemic.

Who is ultimately responsible for public health?
Under the Constitution, states are responsible for public health. Here in Washington, county governments are primarily responsible for the provision and funding of public health. State law does not stipulate funding levels nor establish a funding formula, which is why there is a wide range across the state. Counties are primarily responsible for public health with authority to create city-county health departments or health districts. Counties are required to establish a board of health and they have certain authority to determine local governance structure. Our District has the largest Board of Health in the state, composed of 10 city mayors or councilmembers and the five county councilmembers.

How are other local health jurisdictions structured, and what is their funding mix?
Please see the attached map and spreadsheet. Within Washington's 39 counties, there are 35 local health jurisdictions. They are currently arranged in the following five ways:

- Single county standalone district (like Snohomish Health District)
- Multi-county district (like Chelan-Douglas Health District)
- Public health department (like Whatcom County)
- Public health and human services department (like Cowlitz County Health and Human Services or Grays Harbor Public Health and Social Services)
- City-County public health agencies (like Public Health Seattle-King County and Tacoma-Pierce County Health Department)

With the various structures, there are even more differences when looking at funding. The funding mix varies greatly, based on population, income/property tax levels, access to federal and state grants, etc. It is also important to note that a few agencies (like Public Health-Seattle & King County and Spokane Regional Health District) are designated federally qualified health centers (FQHC) who qualify for reimbursement from Medicare and Medicaid for services they provide. FQHC's are typically community-based organizations that provide comprehensive primary care and preventive care, including health, oral and mental health/substance abuse services to persons of all ages regardless of their ability to pay or health insurance status. Long standing FQHC's in Snohomish County serving our local needs include Sea Mar Community Services and the Community Health Center of Snohomish County.

Do you receive funding from local hospital districts, like Stevens Public Hospital District No. 2 (Verdant Health Commission)?
The four hospital districts in Snohomish County generate revenue from a variety of sources, including collecting property taxes for their operations, which is something public health districts

like ours are not able to do. While we do collaborate with Verdant and the others in the county, we have not received direct funding from them (aside from approximately $2,000 Verdant contributed toward a special immunization forum). While hospital districts are primarily charged with owning and operating public hospitals, state law enables them to provide other health related services similar to some of the work of the Health District. This includes promoting vaccines and implementing programs to improve the health of the communities they serve. Hospital districts have defined boundaries for their work- most often a portion of a county, while the Health District is responsible for the entire county. Unlike hospital districts, public health is responsible for essential services like responding to communicable disease outbreaks, permitting and inspection food establishments, and developing policies to protect the public and promote healthier years of life.

Where did the idea of a per capita contribution come from?
This is not a new concept for Snohomish County, as we became the first local health jurisdiction in the state to form a city-county partnership back in 1966. Eleven of the 18 cities in the county voluntarily contributed $0.50 per capita to public health, and in the years that followed, the number of cities and rate of contribution increased. At one point, some cities were contributing as much as $2.70 per resident.

Since adoption of the agency's update to its Strategic Plan in 2014, the Board and agency staff have engaged in a deliberative process for the past 2+ years exploring new or expanded revenue and governance structures to better support the District's delivery of foundational services and capabilities. The top two local revenue options identified by the Board at a September 2015 retreat were a countywide public safety sales tax and/or per capita contributions from the cities and towns, in addition to increased per capita contributions from Snohomish County.

What if not all of the cities, towns and the county contribute?
It is true that we cannot require every jurisdiction to make a per capita contribution, even though several cities have expressed a desire to make sure this is equitable. While there are still services that would be continued regardless of contribution, our ability to partner with those communities on unique programs or activities would be significantly diminished.

If you're asking the County <u>and</u> the cities/towns to contribute, isn't that double-dipping?
Our per capita request for the County is for all residents, whether living inside or outside of a city. We believe there are programs and services that the Health District provides that benefit all residents—whether within an incorporated or unincorporated area- and fundamentally different than services at the city level—therefore should be supported by County-wide funding. For instance, we envision the County funding to support work like making opioid/heroin overdoses a notifiable condition, facilitating work to create a county-wide needle cleanup program, more work on trauma-informed approaches, resources for education and outreach to prevent addiction, and data and program evaluation.

Then there are also more targeted programs and services that we are either currently providing, or have plans to provide, that are specific to the cities/communities. That is where we believe the cities' funding is best utilized. We've shared some of the examples in our presentations to the cities, but we intend to work with each city to determine what their biggest priorities are and where we can provide support. This could include helping cities with nuisance properties &

homeless camps, school district-specific assistance on adverse childhood experiences trainings, participation with community forums and coalitions, and community-level data and program evaluation.

This sounds like you're adding programs and services, so how will per capita contributions really make an impact in your short- and long-term financial situation?
We are in the midst of our 2017 budget planning, as are each of you. While there are still decisions to be made in regards to expenses, we do have a select number of existing, budgeted vacancies that could be repurposed into roles that would implement the vision laid out above. Staff will continue to have discussions with our Board's Budget Ad Hoc Committee, as well as the cities and county on program needs and interest, to help determine where to refocus the limited resources. The final numbers may shift slightly up or down based on those decisions.

Are we asking for more money from the state?
There is a large effort that has been years in the planning to bring a legislative ask forward in the upcoming session. This will be the first phase in a multi-year plan, focused on ensuring sustainable funding at the state level is refocused so that all residents of Washington, regardless of where they live, have the same essential public health services. In addition to funding, this requires rebuilding the governmental public health system in a way that promotes flexibility and sharing of services so that we can be nimble and proactive. This will take time, and we do not expect to see any significant influx of funding here locally until late-2017 at the earliest. The larger legislative ask is currently slated for the 2019-2021 biennium.

What are the next steps?
The Board has asked staff to start developing an interlocal agreement that can be used in continued discussions with each agency. The preference expressed was to have a two-year agreement, but we intend to develop an agreement and set of deliverables that meet the needs of each jurisdiction. We will share this draft agreement once approved by our legal counsel.

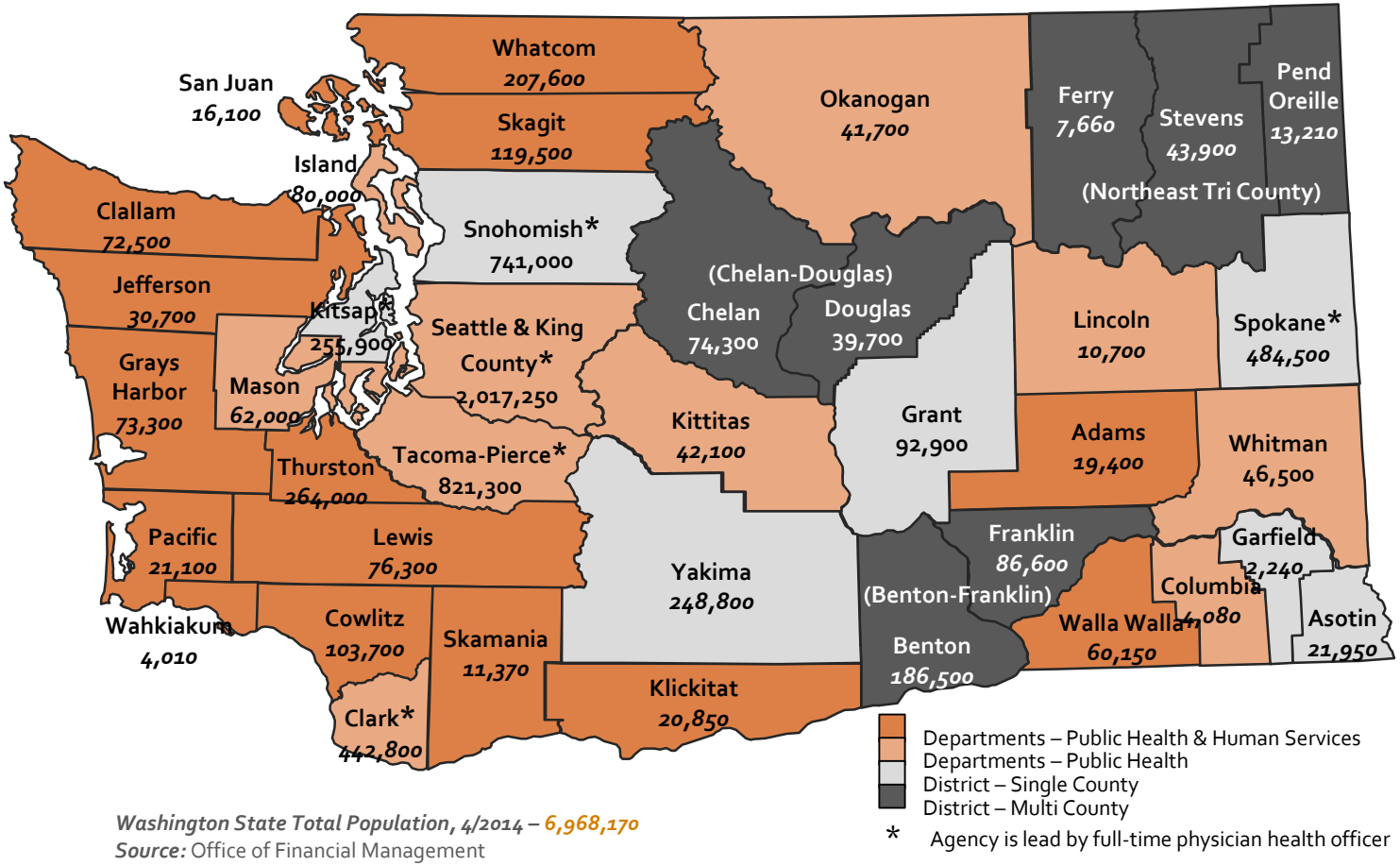
In the meantime, please contact Heather Thomas, Public & Government Affairs Manager at (425) 339-8688 or hthomas@snohd.org if you need any additional information or would like District staff to meet with you further.

SNOHOMISH HEALTH DISTRICT

GENERAL FUND REVENUE HISTORY 2004-2014

	Actual 2004	Actual 2005	Actual 2006	Actual 2007	Actual 2008	Actual 2009	Actual 2010	Actual 2011	Actual 2012	Actual 2013	Actual 2014	Actual 2015	Budget 2016
Federal Grants *	3,830,806	5,278,267	6,899,887	9,905,623	4,419,898	4,119,797	4,089,394	3,531,791	3,969,251	4,216,570	3,682,948	-	-
State Grants *				5,361,537	3,931,149	3,497,300	3,584,810	2,594,858	2,228,520	1,669,060	838,866	-	-
State Discretionary *	5,360,465	5,895,359	5,676,648	2,258,207	2,258,207	2,258,207	2,258,207	2,098,533	2,258,207	2,845,749	3,433,291	-	-
TTL State	5,360,465	5,895,359	5,676,648	7,619,744	6,189,356	5,755,507	5,843,017	4,693,391	4,486,727	4,514,809	4,272,157	-	-
County MHCD Sales Tx	-				-	-	900,000	900,000	900,000	900,000	900,000	681,793	400,000
County NFP							598,034	494,413					
County Per Capita	2,173,071	2,173,071	2,004,995	1,528,530	1,528,530	1,726,738	1,255,310	1,238,265	1,215,108	653,200	653,200	653,200	653,200
County TB	881,924	881,924	1,050,000	1,526,465	1,526,465	1,526,465	1,097,890	1,114,935	1,038,092	1,600,000	1,600,000	1,600,000	1,600,000
County Grants	78,538	59,451	35,000	35,000	64,192	-	-	-	-	-	-	-	-
TTL County	3,133,533	3,114,446	3,089,995	3,089,995	3,119,187	3,253,203	3,851,234	3,747,613	3,153,200	3,153,200	3,153,200	2,934,993	2,653,200
Local-Other										18,488			
Licenses and Permits	1,991,929	2,336,547	2,178,679	2,348,290	2,072,247	2,442,652	2,762,666	2,658,259	2,863,806	3,146,117	3,077,096	-	-
Charges for Services	3,247,354	3,276,748	3,385,162	3,444,458	3,257,101	3,113,641	2,828,277	2,642,600	2,803,701	2,857,537	2,623,468	-	-
Misc	470,138	594,141	718,773	649,724	407,023	282,935	303,625	245,800	293,803	251,274	270,434	-	-
TTL Local	5,709,421	6,207,436	6,282,614	6,442,472	5,736,371	5,839,228	5,894,568	5,546,659	5,961,310	6,273,416	5,970,998	-	-
Total Revenue	**18,034,225**	**20,495,508**	**21,949,144**	**27,057,834**	**19,464,812**	**18,967,735**	**19,678,213**	**17,519,454**	**17,570,488**	**18,157,995**	**17,079,303**		

Local Health Jurisdictions (LHJs)



Washington State Total Population, 4/2014 – 6,968,170
Source: Office of Financial Management

Source: Department of Health

Local Health Jurisdictions and Revenue Sources
2014
SUMMARY

							Revenue from State			Revenue from Federal		Revenue from Local		
	Basis of Accounting	OFM April 2014 Population Estimate	FTEs	Total Expenditures	Expenditures Per Capita	Total Revenues	State from DOH	County Public Health Assistance	State from Other	Federal through DOH	Federal from Other	Local Government Contributions	Licenses, Permits & Fees	Misc/Fund Balance/ Other
San Juan	Accrual	16,100	25.0	3,878,308	241	3,927,822	60,127	189,853	724,658	327,240	238,416	1,323,159	1,058,571	5,798
Jefferson	Cash	30,700	35.0	4,175,736	136	3,905,462	109,310	184,080	453,543	549,155	250,658	741,852	1,604,806	12,059
Seattle-King	Accrual	1,981,900	1223.0	229,287,826	116	222,477,279	7,355,861	2,999,023	12,226,790	15,173,044	21,374,336	53,862,944	76,971,956	32,513,325
Garfield	Accrual	2,240	3.7	236,694	106	219,633	1,238	93,154	565	78,845	2,890	32,503	10,199	239
Columbia	Cash	4,080	4.2	418,838	103	418,837		120,255		131,607	28,739	77,711	53,067	7,458
Wahkiakum	Cash	4,010	5.0	402,255	100	449,348			117,096	141,766	12,997	82,579	26,013	68,897
Whatcom	Accrual	207,600	74.4	17,396,615	84	16,378,883	34,501	1,214,301	5,492,930	1,007,206	602,031	4,835,533	3,130,702	61,679
Clallam	Cash	72,500	23.7	5,849,431	81	5,849,430	53,801	291,400	1,146,752	650,679	341,940	1,145,584	1,178,860	1,040,414
Klickitat	Accrual	20,850	14.4	1,548,015	74	1,397,091	51,455		287,878	291,687	84,458	56,271	618,327	7,015
Lewis	Accrual	76,300	27.6	5,103,731	67	5,373,353	18,754	263,134	1,047,894	936,251	353,275	876,315	1,845,506	32,224
Lincoln	Accrual	10,700	6.3	649,257	61	649,256		81,213	42,308	186,052	51,092	95,126	103,360	90,105
Pacific	Cash	21,100	12.8	980,828	46	910,771	30,190	169,075	84,860	436,548	95,998	80,525	8,007	5,568
Spokane	Accrual	484,500	188.3	20,464,692	42	20,784,272	379,990	2,877,318	3,251,862	5,383,139	1,290,889	1,542,192	5,784,230	274,652
Island	Accrual	80,000	39.0	3,274,613	41	3,308,767	22,019	163,332	258,164	686,400	145,869	459,148	1,573,302	533
Kitsap	Cash	255,900	92.9	10,072,809	39	10,072,809	385,534		1,840,780	1,345,896	191,353	557,711	6,115,626	(364,091)
Skagit	Accrual	119,500	33.1	4,662,220	39	4,680,621	52,188	449,745	292,216	872,671	453,360	1,353,827	1,203,299	3,317
Skamania	Cash	11,370	4.5	439,884	39	436,218	24,578	111,257	5,080	122,459		62,128	110,716	
Adams	Cash	19,400	8.8	737,454	38	701,169		86,550	110,016	209,633	21,079	120,128	152,695	1,068
Mason	Accrual	62,000	21.6	2,292,326	37	2,292,481	45,246	227,448	177,471	730,515	131,934	460,519	517,038	2,310
Tacoma-Pierce	Accrual	821,300	240.5	29,548,244	36	29,878,023	351,345	4,143,167	564,753	5,680,721	768,830	5,485,281	12,304,068	579,858
Kittitas	Accrual	41,900	17.8	1,474,703	35	1,474,702		134,320	110,946	217,791		267,038	538,555	206,052
Northeast Tri	Accrual	64,770	23.5	2,270,760	35	2,270,760	66,204	248,929	51,289	556,294	63,549		1,167,999	116,496
Grays Harbor	Accrual	73,300	40.3	2,349,816	32	2,349,817	103,926	228,321	40,091	914,720	164,617	563,908	330,268	3,966
Benton-Franklin	Cash	273,100	82.2	8,702,021	32	8,702,320	19,977		1,688,913	1	766,356	722,711	2,512,460	32,446
Asotin	Cash	21,950	7.0	683,938	31	539,767	159,890		9,219	185,461	54,381	12,500	114,376	3,940
Cowlitz	Accrual	103,700	26.5	3,131,701	30	3,131,702		477,981	57,355	160,561	383,740	266,184	1,046,986	738,895
Thurston	Accrual	264,000	63.7	7,956,753	30	8,444,009	53,804	726,714	796,491	712,831	458,682	1,890,910	3,725,835	78,742
Okanogan	Accrual	41,700	13.2	1,230,707	30	1,258,282			353,825	225,748	25,624	112,787	526,983	13,315
Walla Walla	Accrual	60,150	19.2	1,716,426	29	1,891,785		302,173	27,238	377,695	221,616	388,582	412,802	161,679
Chelan-Douglas	Cash	114,000	33.0	3,012,538	26	2,889,966		399,633	148,185	446,724	248,671	457,820	1,182,685	6,248
Grant	Accrual	92,900	24.1	2,398,011	26	2,253,170	5,879	297,763	83,609	765,154	129,627	267,734	666,149	37,255
Whitman	Cash	46,500	17.8	1,134,404	24	1,134,404		189,355	9,859	269,467	12,910	389,699	245,342	17,772
Clark	Accrual	442,800	78.5	10,257,668	23	9,562,450	245,667		2,023,137	1,938,305	132,795	1,491,449	3,736,051	(4,954)
Snohomish	**Accrual**	**741,000**	**139.7**	**16,445,591**	**22**	**17,726,147**	**76,518**	**3,433,291**	**762,348**	**3,366,373**	**289,159**	**3,153,200**	**5,593,002**	**1,052,256**
Yakima	Accrual	248,800	25.9	3,119,937	13	2,727,346	16,250	401,472	698,569	224,672	84,685		1,266,850	34,848
Total		**6,932,620**	**2696.1**	**407,304,750**		**400,468,152**	**9,724,252**	**20,504,257**	**34,986,689**	**45,303,310**	**29,476,556**	**83,235,557**	**137,436,692**	**36,841,384**

SOURCE: BARS A Reports
Compiled by DOH

Sources of State Flexible Funding for Local Public Health

Historically, "Flexible" state General Funds have been conveyed to local health jurisdictions (LHJ) via three primary mechanisms to address a variety of public health services:

- **Local Capacity Development Funds** (LCDF) were used by each LHJ to participate in and improve performance on public health standards and in the area of greatest public health need;

- **Blue Ribbon Commission/5930 Funds** did not represent a program unto itself, but rather funding to enhance LHJ's performance to address statewide priorities, which include stopping communicable diseases before they spread and reduce the impact of chronic disease. Specific performance measures included increasing the number of childhood immunizations given, more timely and complete communicable disease investigations, and increasing efforts to stop the obesity epidemic;

- **Motor Vehicle Excise Tax (MVET) Replacement Funds**- Following voter approval of the tax-limiting Initiative 695, the legislature in 2000 voted to repeal the MVET. During the same session, the legislature appropriated an amount from the state general fund that restored 90% of the lost public health funds. During the 2001 session, the legislature again made up 90% of the difference and has made an equal appropriation, without adjustments for inflation or population growth, in each biennium since.

In the 2013-2014 fiscal budget (3ESSB 5034), the State **combined** Motor Vehicle Excise Tax Funds (MVET), Local Capacity Development Funds (LCDF), and Blue Ribbon Commission/5930 funds into a newly created "**County Public Health Assistance Account**", administered by the Washington State Treasurer (rather than Washington State Department of Health) without specific guidance as to their use. The Snohomish Health District has allocated this funding consistent with past practice.

History of State Flexible Funding for Local Public Health

When tuberculosis (TB) was more common, in the mid-1900s, a portion of local property taxes was set aside for tuberculosis control and general public health. As TB declined, more of the funds were available for general public health. In 1976, the Washington Legislature repealed the requirement that those funds be spent on public health, leaving the cities and counties to determine spending levels for public health. Local government continued to collect the tax but could use it for another purpose.

While counties held the major responsibility for public health, the law made reference to cities as well, without stipulating the amount of cities' financial participation. In practice, not all cities provided funding for public health. Over time, local governments made very different choices, and per capita public health spending came to vary widely from one jurisdiction to another.

Most local funding is derived from county contributions from taxes, fees, or other local sources. With no criteria set for local government contribution, the variation is pronounced. Data for 2007 reveal that local government funding to most public health agencies ranged from just over $1 to nearly $36 per capita, per year. (www.doh.wa.gov/msd/OFS/2007rs/Revsum07.htm)

Motor Vehicle Excise Tax (MVET), I-695 and MVET Replacement Funds – In 1993 the legislature passed the Health Services Act, which shifted 2.95% of motor vehicle excise tax (MVET) revenues from cities to counties for use by local public health departments and districts. This change effectively removed the statutory responsibility for cities to fund public health. It also clarified that counties were responsible and made clear that no city could establish its own health department. This portion of the law was to take effect in 1996. (Some cities continue to contribute to public health, but funding is generally tied to specific services and residence requirements.)

The amount of MVET revenue to be raised by the 2.95% fell roughly $7 million short of what cities had collectively contributed. The legislature provided a special appropriation to make up most of the difference in the years that followed. The idea was that MVET revenues were growing, so the gap would be filled in time and public health would once again have a dedicated source of revenue that kept pace with population growth and inflation.

The distribution of the MVET funds was somewhat problematic. Since MVET funding had been tied to city contributions, the money for each county was linked to the level of past city contributions. This perpetuated the historical variation among jurisdictions.

Following voter approval of the tax-limiting Initiative 695, the legislature in 2000 voted to repeal the MVET. The stability of a dedicated funding source was gone. During the same session, the legislature appropriated an amount from state general fund that restored 90% of the lost public health funds. During the 2001 session, the legislature again made up 90% of the difference and has made an equal appropriation—without adjustments for inflation or population growth—in each biennium since.

Local Capacity Development Funds (LCDF) & Partnership Funds – In 1993 and 1995 sessions bills were passed that created RCW 43.70.520 and 580. In summary this RCW requires that DOH, in partnership with local public health and other partners, develop a public health services improvement plan that includes: standards, determines the cost of meeting the standards, budget and staffing plan, recommended level of funding, and key health outcomes; and requires that this plan be updated and presented to the legislature at the beginning of each biennium. This on-going collaborative partnership is called the Public Health Improvement Partnership (PHIP) and a report on this work is delivered to the legislature at the end of every even-numbered year, prior to the start of the session that proceeds the next biennium.

The budget provisos that accompanied these bills appropriated funds and created the "Urgent Needs Fund" which later was renamed "Local Capacity Development Fund" (LCDF). The bulk of the funds are distributed among all Local Health Jurisdictions (LHJs) according to the distribution formula (base + population) specified in the original budget proviso. The funds are used by each LHJ in the area of greatest need. "Flexible funds" like these are considered to be most important to the public health system because they allow local jurisdictions to address specific local needs, not addressed by other programs or "siloed funding" stream.

As a result of an agreement made between DOH and the LHJs many years ago, a small portion of these funds that would have otherwise been distributed among the LHJs, are pooled together and kept at DOH, are called **"Partnership Funds"** and used to fund collaborative (state / local) system-wide improvements - the work described in the law and carried out under the PHIP.

Blue Ribbon Commission/5930 Funds- (Engrossed Second Substitute House Bill 5930)
The 2006 Washington State Legislature passed Engrossed House Concurrent Resolution (EHCR) 4410 and created the Joint Select Committee (JSC) on Public Health Funding. The JSC was a bipartisan study committee of the House and Senate, tasked with studying the persistent shortfall in public health funding. In response to the committee's request for information, local and state public health officials developed and presented a report titled *Creating a Stronger Public Health System: Setting Priorities for Action* (labeled "Statewide Priorities" on the committee's web site http://www.leg.wa.gov/jointcommittees/PHF/Pages/default.aspx). The report ordered a list of priorities "for the next investment in public health" as follows:

- Stopping communicable diseases before they spread
- Reducing the impact of chronic disease
- Investing in healthy families
- Protecting the safety of drinking water and air
- Using health information to guide decisions
- Helping people get the health care services they need

The committee unanimously concluded that "the lack of a stable source of funding provided specifically for public health services has eroded the ability of local health jurisdictions to maintain a reliable statewide system that protects the public's health." It recommended that the state "provide additional funding in the amount

of approximately $50 million annually during the 2007-2009 biennium, as an initial investment" and that a "dedicated account for public health revenues" be established. Finally, it recommended that these actions be considered "the first step in what must be continuing state and local efforts to fund the public health system at a level that provides the capacity to effectively deliver the five core functions."

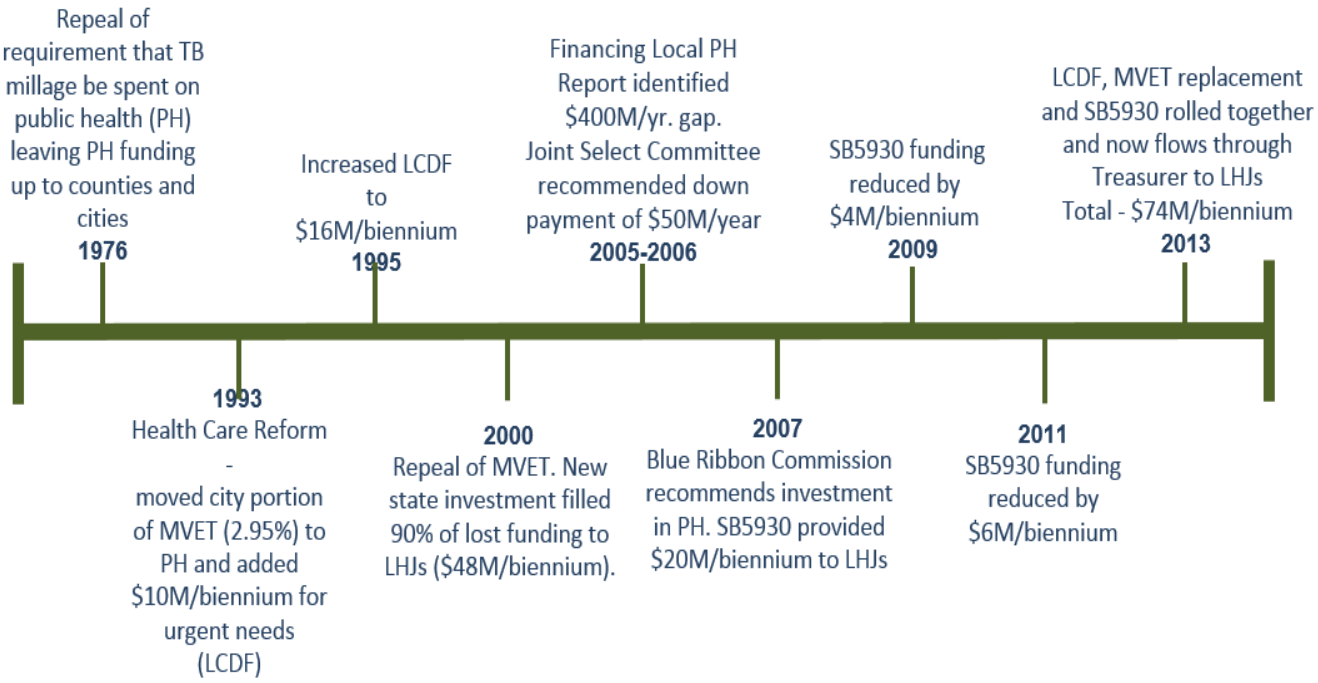
The 2006 Washington State Legislature also established the Blue Ribbon Commission on Health Care Costs and Access and charged it with delivering a five-year plan for substantially improving access to affordable health care for all Washingtonians. In 2007 both the recommendations of the Blue Ribbon Commission and the JSC on Public Health Funding were largely incorporated into Engrossed Second Substitute House Bill (E2SHB) 5930 and passed by the legislature. Sections 60-65 of the bill addressed the public health system and are now codified in RCW 43.70.512–522. The 2007-2009 biennial budget process (SHB 1128, Section 222 (29)) appropriated $20 million per biennium of General Fund State dollars for local public health to implement the public health portion of the new law.

This new public health funding stream and effort, known as "5930" after the bill number, is not a program unto itself, but rather additional funding to enhance public health work in the priorities identified in the *Building a Stronger Public Health System* report. As required by the new law, public health officials made recommendations to the Secretary of Health regarding: a) performance measures for the new funds and b) activities and services that qualify as core public health functions of statewide significance. See http://www.doh.wa.gov/phip/products/5930/overview.htm

County Public Health Assistance Account

In the 2013-2014 fiscal budget (3ESSB 5034), the State combined Motor Vehicle Excise Tax Funds (MVET), Local Capacity Development Funds (LCDF), and Blue Ribbon Commission/5930 funds into a newly created "County Public Health Assistance Account", administered by the Washington State Treasurer (rather than Washington State Department of Health) without specific guidance as to their use. The Snohomish Health District has allocated this funding consistent with past practice.

History of State Support of Local Public Health
"Flexible Funds*"



*Doesn't include state categorical funding

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Snohomish Health District Situation Assessment

Conducted by the William D. Ruckelshaus Center

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The Assessment Team is deeply grateful to the many individuals who gave their time and energy to be interviewed, and to otherwise inform this report.

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DISCLAIMER

The following report was prepared by the William D. Ruckelshaus Center, a joint effort of the University of Washington and Washington State University whose mission is to act as a neutral resource for collaborative problem solving in the State of Washington and Pacific Northwest. University leadership and the Center's Advisory Board support the preparation of this and other reports produced under the Center's auspices. However, the key themes contained in this report are intended to reflect the opinions of the interviewed parties, and the findings are those of the Center's assessment team. Those themes and findings do not represent the views of the universities or Advisory Board members.

EXECUTIVE SUMMARY

The Snohomish Health District (Health District) is an independent special purpose district responsible for providing a range of programs and services that protect and promote public health in Snohomish County. The public health landscape in Snohomish County is in a state of change and transition due, in part, to healthcare reform efforts, ongoing budgetary shortfalls, continued shifts in public health at the federal and state levels, and a growing and changing county population. The Health District believes that it is at a critical juncture related to important delivery of care, funding and governance issues. In the spring of 2016, Health District staff and Board of Health members contacted the William D. Ruckelshaus Center (Center) to help them determine whether and how to best engage interested parties in addressing these issues.

Based on conversations with Board of Health members and Health District leadership, the Center was tasked with conducting a situation assessment to capture a range of perspectives on how the Health District should provide public health services, fund those services, provide effective and efficient governance, and identify opportunities for collaboration.

The Assessment Team conducted semi-structured interviews with 73 individuals involved with public health in Snohomish County. The overall goal of the assessment and this report was to provide a summary of key themes, issues, and perspectives identified from the interviews, and to describe potential process options to better achieve desired outcomes regarding public health service provision, funding, and effective governance.

This report begins with an explanation of the assessment process and methods. The report then provides a summary of information gained through the interviews, focusing on key themes. The last sections of the report present the Assessment Team's conclusions and process recommendations. Supplemental information is provided in appendices.

Key Themes

The Assessment Team conducted interviews with 73 individuals who have or represent an interest in the Health District provided a rich diversity of perspectives, opinions, and ideas. To identify key themes, the Assessment Team paid close attention to themes that arose frequently across interviews, as well as those that were notable for their diversity, uniqueness, or originality. It is important to note that the key themes summarized in this report can be associated with a fairly wide range of responses in interviews, due to the qualitative nature of the review and the analysis process. It is also important to note the number of interviewees that mentioned an issue or shared a perspective does not define its legitimacy, importance, or merit. This section of the report must be read in its entirety to get a full picture of the assessment themes and how they influence the conclusions and recommendations that follow. The following is a distilled list of a few central points from this section.

Vision for public health: While responses varied in scope and content, in general interviewees envisioned a future in which public health would be recognized, relevant, and of value to the people of Snohomish County. Nearly all described success as seeing the health needs of the people of Snohomish County being met – that people would be healthy and living in a healthy,

safe community. Many envisioned a future where services and the entities providing them were less siloed, less reactive, and less focused on temporary fixes. Nearly all expressed a desire for financial viability and the ability to be adaptive and resilient within a changing public health system.

Service delivery and the role of the Health District: Visions of success for service delivery and the Health District's role in providing services varied. Many interviewees connected the success of public health services to the service delivery model of the Health District and responsibility for providing needed services of public health. For some, a future where service delivery was successful meant the Health District was a direct service provider. Others envisioned the Health District as community-based and focused more on policy, outreach, and education. Many interviewees commented on how there is both confusion and disagreement about the Health District's transition to a population-based service delivery model.

Public and partner engagement: Many talked about the importance of the Health District's work and how it is often unnoticed or taken for granted by the public. More proactive public education, maintaining direct services to form personal relationships with the public, and engaging the Board of Health in public outreach were mentioned as possible approaches to increasing public awareness of the Health District's work.

Most interviewees also talked about partner engagement and offered suggestions for expanding the Health District's relationships with existing and potential partners. Interviewees emphasized that these partnerships are not only important for serving the public, but also for educating partners on the role of the Health District in the community.

Funding: Most interviewees identified funding shortfalls as the main obstacle to achieving their vision of public health success in Snohomish County. Many expressed a desire for increased sustainability and stability of funding.

Interviewees frequently mentioned that the cities do not contribute financially to the Health District. Dedicated revenue from cities was frequently mentioned as a source of Board of Health tension and conflict.

Many talked about how funding issues and potential solutions cannot be effectively addressed until the Health District more clearly defines and reaches agreement on purpose, roles, responsibilities and future direction. Some stated that if these issues were not resolved, funding trends will continue to decline, necessitating further service and staffing reductions.

Board of Health: Most interviewees, including a number of Board of Health members, identified Board of Health governance as a key issue. Interviewees identified a variety of issues associated with the Board of Health's structure, including its size, composition, high membership turnover, and the challenge of competing with other demands for members' time as elected officials. Many expressed a lack of clarity about roles and responsibilities of the Board of Health. Several suggested increasing interaction between the Board of Health and the Public Health Advisory Council (PHAC) to engage with community partners represented on the PHAC and provide subject expertise to the Board of Health.

Internal operations: Several interviewees suggested that improved communication between Health District leadership and staff, as well as increased opportunities for staff to interact with and provide input to the Board of Health, would help to build trust, social capacity and alignment within the Health District. Others felt that as the Health District shifts away from direct services, communication between program staff and leadership is essential to ensure a smooth transition. Some suggested that more direct interaction between staff and board members may create positive trends, including knowledge of Health District work functions, and enabling staff with field experience to inform decisions.

Organizational structure: The vast majority of interviewees were either in support of the stand-alone model for the Health District, indifferent, or ambivalent. Organizational structure was frequently considered to be subservient to the importance of effective governance. Many talked about how the issues facing the Health District were connected to a lack of understanding, clarity, and agreement on vision; role of the Health District in service delivery and priorities; strategic planning and future direction. Many thought these governance issues could be addressed under the current model.

Interest in a collaborative process: When asked about the potential for using a collaborative process to address issues outlined in this assessment, nearly all responded positively and many said it was the only way to make progress. Many interviewees suggested collaboration to build clarity and agreement around the roles of the Health District and the Board of Health. Some also suggested collaboration to address funding issues and build commitment for funding public health. They expressed optimism about an approach that would include both political and administrative leadership from the Health District, as well as community partners.

Conclusions

Provided below are the Assessment Team's conclusions based on the perspectives gathered through the interview process:

- **There is support for collaboration** as well as a willingness and desire for a collective vision for public health in Snohomish County.
- Public health is expansive and difficult to define, especially in the current changing public health and healthcare environment. **While visions of success varied in both scope and content, interviewees generally envisioned a future where public health in Snohomish County was valued, services were adequately funded, available, accessible, and coordinated among the entities providing them, and that people would be healthy and living in a healthy, safe community.**
- **There is confusion around one-on-one, population-based, and foundational service models and disagreement about the Health District's role in service delivery.**
- Many shared stories of positive experiences receiving direct services from the Health District and linked the Health District's current successes to the provision of direct services. **There is a sense of identity and purpose attached to directly serving individuals, which makes it difficult for many to accept a transition towards population-based services.**

- **There is little support or desire for changing the Health District's current organizational model at this time. There was instead a great deal of support for improving governance** and gaining clarity and agreement on the vision, mission, future direction, priorities, and service delivery role of the Health District to ensure the future success of public health in Snohomish County.
- **The Board of Health's decision-making process and membership structure conflict with one another,** as majority voting does not work without a balanced representative group. The lack of shared agreement on structure and governance functions, in particular the lack of Board agreement around the County and cities' responsibilities for funding public health, drives the perception that the Board of Health consists of two opposing coalitions: County versus cities.
- **There is no lone entity or single option that can provide the funding necessary** to support public health needs in Snohomish County. **Funding solutions will require the combined leadership and commitment of all parties**, including the Health District, Board of Health, Snohomish County, the cities, federal and state governments, and other partners. In addition, there is a link between understanding the value of public health and willingness of the public and partners to support funding.

Recommendations

The recommendations in this section are based on analysis of what was heard and learned from interviews, exploration of and experience with similar governance and organizational structures, and the Assessment Team's expertise in effective collaborative and multi-party processes.

At this time, a key prerequisite to addressing any of these issues is a decision regarding the organizational model of the Health District. Given interviewees' responses and the uncertainty of the potential social, political, and economic impacts, the Assessment Team believes that now would be a challenging time for the Health District to transition to the authority of Snohomish County. If the decision is to stay with the current organizational model at this time, the Assessment Team has identified elements of the current organizational and governance structure that, if addressed, would help the Health District reach its full potential. The following recommendations provide an approach to addressing these elements.

According to the Health District's 2014 Strategic Plan update, the Health District will need to update its plan for 2017/18. The Assessment Team has identified potential opportunity for collaborative action regarding the future strategic plan and recommends building collaborative capacity for this planning effort. A collaborative planning process would engage involved parties internally and externally to promote mutual understanding, foster inclusive ideas and solutions, build sustainable agreement, and cultivate shared responsibility and commitment to public health in Snohomish County. This will require the collective commitment and support of the Board of Health, PHAC, Health District leadership and staff. Each has a key role in ensuring the success of the Health District and public health in Snohomish County.

However, the Board of Health and Health District will need to take the following initial actions to build the capacity to undertake such a process:

A. Formalize Governance and Enhance Collaborative Leadership Capacity

The Assessment Team recommends the Board of Health and Health District leadership consider a facilitated process to clarify and agree on purpose, roles, responsibilities, authorities, commitments, and accountability. The following will demonstrate both internally and externally a willingness and commitment to more collaborative and actionable governance of public health.

i. Clarify, develop, and agree on governance structure, functions, and operations of the Board of Health and the Health District.

ii. Agree on resource stewardship and a funding strategy for the Health District.

iii. Include collaborative skill-building and the use of less formal processes to build the spirit of collaboration with the PHAC, Health District staff, and the larger public health community.

B. Build Agreement between Health District Leadership and Staff

The Assessment Team perceives a lack of internal clarity and agreement on the Health District's strategic direction and decision-making processes. Although internal Health District operations were outside the scope of this project's assessment, concerns arose around internal organizational functions that could impede strategic progress. The Assessment Team recommends that Health District leadership and staff agree on a process to promote mutual understanding, foster inclusive ideas, build agreement and commitment, and cultivate shared responsibility. The process could include facilitation, internal development, and team building exercises to enable progress towards the 2017/18 Strategic Plan.

I. INTRODUCTION

The Snohomish Health District (Health District) is an independent special purpose district responsible for providing a range of programs and services that protect and promote public health in Snohomish County. A 15-member Board of Health, composed of county and city officials, oversees the policy and budget development of the Health District, while staff oversee programming and delivery of services.

The public health landscape in Snohomish County is in a state of change and transition due, in part, to healthcare reform efforts, ongoing budgetary shortfalls, continued shifts in public health at the federal and state levels, and a growing and changing county population. The Health District believes that it is at a critical juncture related to important delivery of care, funding and governance issues. In the spring of 2016, the Health District staff and Board of Health contacted the William D. Ruckelshaus Center (Center) to help them determine whether and how to best engage interested parties in addressing these issues. The Center is a neutral resource for collaborative problem solving in the State of Washington and the Pacific Northwest, dedicated to assisting public, private, tribal, non-profit, and other community leaders in their efforts to build consensus and resolve conflicts around difficult public policy issues. It is a joint effort of Washington State University hosted and administered by WSU Extension and the University of Washington hosted by the Daniel J. Evans School of Public Policy and Governance (for more information visit www.ruckelshauscenter.wsu.edu).

Based on conversations with Board of Health members and Health District leadership, the Center was tasked with conducting a situation assessment. A situation assessment is an interview-based process undertaken to better understand and explore relevant issues and interests of involved parties and situation dynamics (see Appendix A). An Assessment Team composed of Center-affiliated faculty and staff carried out the assessment using an interview-based process. The Assessment Team conducted interviews with 73 individuals involved with public health in Snohomish County. The goal was to capture a range of perspectives on how the Health District should provide public health services, fund those services, provide effective and efficient governance, and identify opportunities for collaboration.

This report begins with an explanation of the assessment process, followed by a summary of key themes, issues and perspectives identified from the interviews, and concludes with recommendations and process options based on the information gathered from interviewees.

II. THE ASSESSMENT PROCESS

A. Interview Process and Protocol

The Assessment Team conducted interviews and conversations with 73 individuals involved with public health in Snohomish County and familiar with the service delivery, funding, organization model, and governance of the Health District (see Appendix B). Interviews took place from mid-May through August 2016. Interviewees included current and past Board of Health members; Health District administration and staff; Public Health Advisory Council (PHAC) members; healthcare providers; healthcare payers; union representatives; NGOs;

representatives from regulated entities, and leaders in city, county, state and tribal governments.

The process for identifying individuals to interview was iterative. To develop a broad list of potential interviewees, the Assessment Team used membership lists from various councils and committees; online sources; input from Health District personnel, Board of Health members and informed observers; and Assessment Team discussions. The Assessment Team then applied the following criteria to guide the selection of specific individuals to be interviewed:

- Broadly representative of the interests affecting and affected by the issues (how the Health District should provide public health services to the citizens of Snohomish County, fund those services, and provide effective and efficient governance)
- Geographically dispersed
- Representative of the diverse perspectives and views on past and future efforts
- Representative of varied tenure
- Organizational and/or subject matter expertise and leadership
- Interview fits within project time and resource constraints

The Assessment Team used a chain referral method to identify additional potential interviewees. In accordance with this method, each interviewee was asked to identify individuals, interests, or groups they thought would be important to interview. A portion of interview slots was reserved for interviewees identified via this method. As part of this method and in addition to individual interviews, the Assessment Team conducted a series of informal group interviews with staff members from each of the Health District's three divisions as well as administration. The interview list is not meant to be exhaustive, but rather representative. The goal is for all interested parties to have confidence that, whether they were interviewed or not, their perspective is represented on the interview list and in the assessment.

The Assessment Team developed a set of protocols to govern the interview process, based on university research principles and best practices in the field of collaborative decision-making. A consistent sets of interview questions was used for all individual interviews and for informal group interviews (see Appendix C) Interviewees were invited by email and/or phone to participate in an interview and received the interview questions; background information explaining the process, purpose, and how the interview would be used (see Appendix A); and a case statement prepared by the Health District (see Appendix D). The preliminary information emphasized that the interview was voluntary, that the results would be aggregated in a summary report and that specific statements would not be attributed to individual interviewees. Per research protocol, interview notes were not retained beyond the drafting of this report.

B. Data Analysis and Synthesis

The assessment process was qualitative and the analysis involved the identification, organization, and interpretation of key themes from the interviews. After each interview, the Assessment Team entered summaries into an anonymous spreadsheet to enable the assessment of the results of all the interviews in combination. Individual members of the Assessment Team analyzed the interview results separately and then convened as a team for

discussions of observations, key themes and recommendations.

III. KEY THEMES FROM THE INTERVIEWS

The interview questions covered six general areas:

- Interviewees' vision of success for public health and delivery of services in Snohomish County, how to achieve that success, and issues to be addressed along the way
- Challenges and opportunities to addressing those issues
- Approaches to securing dedicated and sustainable funding for public health
- An effective organizational structure for the Health District
- Updates to the Health District's governance model to support that structure
- Strategies for public engagement
- Potential for using collaborative processes to address identified issues

Key themes summarized in this section of the report cover the above general areas as well as other important findings that arose from the interview process. Conducting interviews with 73 individuals who have or represent an interest in the Health District provided a rich diversity of perspectives, opinions, and ideas. To identify key themes, the Assessment Team paid close attention to themes that arose frequently across interviews, as well as those that were notable for their diversity, uniqueness, or originality. It is important to note that the key themes summarized in this report can be associated with a fairly wide range of responses in interviews, due to the qualitative nature of the review and the analysis process. It is also important to note the number of interviewees that mentioned an issue or shared a perspective does not define its legitimacy, importance, or merit. The goal of this section is to provide a summary of key themes and not an exhaustive list or detailed explanation of all perspectives and ideas shared during the interview process.

A. Vision for Public Health

Before responding to a series of vision-related questions, interviewees were asked to share their definition of public health. Many gave an expansive definition that can be broadly summarized as the health and safety of people and communities, using terms such as *assure, ensure, promote, prevent, protect,* and *respond* to describe the role of public health.

Interviewees were then asked to share their vision of success for public health and delivery of services in Snohomish County and milestones by which success could be identified. While responses varied in scope and content, in general interviewees envisioned a future in which public health would be recognized, relevant, and of value to the people of Snohomish County. Nearly all described success as seeing the health needs of the people of Snohomish County being met – that people would be healthy and living in a healthy, safe community.

Many talked about a future where services would be accessible and available to all people in the county. This included medical care, behavioral health services, dental services, healthy food and lifestyle choices, clean and safe food and water, information and educational resources, youth and family services, housing, and transportation, to name a few. Many envisioned a future where services and the entities providing them were less siloed, less reactive, and less

focused on temporary fixes. Nearly all expressed a desire for financial viability and the ability to be adaptive and resilient within a changing public health system.

Interviewees provided a number of things they would see happening 5, 10, or 20 years into the future if they were to determine that public health and the delivery of services was successful. While not an exhaustive list of all the measures of success, some of the more frequently mentioned include:

- Acknowledgment of public health as a key public service function, similar to law enforcement and emergency management;
- Lower mortality and morbidity rates of chronic health conditions such as obesity and heart disease;
- Reduced incidence of opioid and heroin use, addiction, overdose, and death;
- Fewer emergency room visits;
- Increased vaccination rates;
- Fewer maternal and child health emergencies;
- Reduction in adverse childhood experiences;
- Reduced incidence of teen and adult suicide;
- Buy-in and accountability on Board of Health and Health District decisions;
- Reduced incidence of communicable disease;
- Reduced incidence of homelessness;
- Increased safe and affordable housing;
- Reduced exposure to environmental health hazards, pollution and unsafe food and water;
- Greater access to healthy food options and people making healthier food choices;
- Increased prevention and intervention services;
- Reduced gun violence; and
- Greater focus and effort being made to reach out and engaging community partners and the public.

i. Current Successes

Many interviewees talked about both current and past successes of the Health District. A high level of customer service and dedicated staff were frequently mentioned. There was a widespread appreciation of the level of commitment and care district staff have for their clients and the people of Snohomish County. Many stated they can call the Health District for assistance and know they will receive an immediate response. Others mentioned effective working relationships and a high level of trust between Health District staff and the individuals and communities they serve.

When asked about what the Health District does well, many interviewees brought up recent mobilizations around disease outbreaks. The Health District's response to the H1N1 outbreak in 2009 was mentioned as an example of successfully working with community partners to provide immunizations. More recent efforts to educate the public about Zika virus and opioid and heroin abuse were also cited as examples of effective work.

Several interviewees also acknowledged an increased level of commitment from the Board of Health, stating that since January 2016, meeting attendance has greatly improved.

During the interview process, the Health District began reaching out to city councils to request a funding commitment from cities in Snohomish County for public health. This process is still underway, but interviews cited this approach as a promising form of outreach and coalition building.

Interviewees emphasized Snohomish County's culture of convening and collaboration, expressing optimism that a collaborative process around the issues facing the Health District could yield effective engagement and constructive solutions.

B. Service Delivery and the Role of the Health District

Visions of success for service delivery and the Health District's role in providing services varied. Many interviewees connected the success of public health services to the service delivery model of the Health District and responsibility for providing needed services of public health. For some, a future where service delivery was successful meant the Health District was a direct service provider. Others envisioned the Health District as community-based and focused more on policy, outreach, and education.

Some interviewees expressed frustration with the perceived notion that one-on-one services and population-based services are mutually exclusive and instead saw success as providing both, based on the public health needs of Snohomish County. Some interviewees envisioned the Health District only providing critical services, some spoke to only providing core services, and others spoke to only providing foundational services. Several stated the Health District would provide the services that no other entities are authorized, capable, or willing to deliver. And some stated they found the models and terms to be confusing and were unclear about how a population-based service delivery model will be implemented and how it will achieve the Health District's mission and vision.

There were services and responsibilities interviewees frequently mentioned the Health District should provide. Many talked about the Health District's regulatory functions in environmental health, including food safety, water quality, and septic inspections, as a key area of service. Others emphasized the Health District's role in educating politicians, service providers, and the public about public health. Some saw the Health District primarily as a supervising entity that ensures access and availability of services for everyone, even if it does not provide these services. The Health District's ability and legal mandate to monitor patients with infectious diseases, including tuberculosis and STDs, was another function that interviewees emphasized as unique and important.

i. One-On-One, Population-Based, and Foundational Service Models

There were notable inconsistencies in the way interviewees described one-on-on and population-based service delivery models. There were also notable inconsistencies in interviewees' use of terms to describe the services within each of these models. Foundational, individual, direct, critical, core, clinical, and essential were all used to describe the type of services the Health District should provide; however, the distinction among these terms and

their pairing to the delivery models varied across interviews. There were also notable variations in the use of these terms and description of service delivery models in Health District materials. Many interviewees commented on how there is both confusion and disagreement about the Health District's transition to a population-based service delivery model and how this model connects with the responsibility for providing foundational services, as specified by the State Department of Health and Washington State Association of Local Public Health Officials (WSALPHO).

While some interviewees commented that the transition of some services to other community providers was aligned with the Health District's mission and vision for public health, others did not. Some commented there was a lack of clarity around why some services are being transitioned to other providers and others are not, whether the decision was in the best interest of clients receiving services, and what the impact will be on them as well as the Health District. Several said the decision-making process around determining which services to keep and which to transition was slow and not always transparent, which causes stress among staff.

Some interviewees expressed concern and confusion over the quality of services that have been transferred to other providers, mentioning a lack of data on the quality, accessibility, and availability of these services. Many stressed the importance of the Health District's responsibility to monitor and evaluate services provided by community partners to ensure high quality. Some stated that since the Health District's clinics have closed, clients have experienced difficulty scheduling appointments with other providers promptly due to a lack of their clinic's capacity, as well as geographic challenges to access. Some mentioned that services such as home visits are key for some populations to receive appropriate care, expressing skepticism that other agencies have this capability.

Many interviewees linked the Health District's shift away from individual service provision to a lack of funding. Many thought that other community agencies and healthcare providers can provide direct services more inexpensively than the Health District. Others stated that long-term funding for sustaining the Health District's direct service provision is difficult because grants often focus on creating new programs, rather than supporting existing programs.

C. Public Engagement

Interviewees were asked about the effectiveness of the Health District and Board of Health's public engagement efforts and invited to provide suggestions for improving public engagement. Many talked about the importance of the Health District's work and how it is often unnoticed or taken for granted. While some reflected that this lack of visibility is endemic to local government, others felt Health District messaging has primarily focused on educating people about specific public health issues, such as disease outbreaks, and therefore too narrowly topical to communicate the value of the Health District in a comprehensive way.

Direct services like restaurant inspections, vaccinations, and well child visits were frequently identified as an effective form of public engagement. Several interviewees emphasized the high quality of the nurses and other direct service providers at the Health District, stating that their service delivery work serves a public outreach function as well. There was a widespread perception that clients of direct services would be more likely to value the work of the Health

District and understand the role of public health in their daily lives. Reductions to individual services were seen as a potential visibility issue, because fewer people would have personal interactions with the Health District.

For many interviewees, it was unclear how the Board of Health interacts with the public and what the role of the Board is in public engagement efforts. Several did not think the Board of Health was involved in the Health District's public engagement efforts. Others expressed that, while members often interact with the public, they do so primarily as representatives of their city or the County, rather than as members of the Board of Health.

There were many suggestions for increasing opportunities for the Board of Health to engage with the public, including:

- Board members relaying messaging from the health district back to their cities, raising awareness of the Health District's work among city governments and enlisting them as allies in publicizing this work;
- Board members attending public events such as health fairs and restaurant openings as Health District representatives to raise awareness of the Health District's role;
- Health District leadership informing board members when media and news articles are to be released to ensure distribution to their constituents; and
- Increasing opportunities for the public to interact with the Board of Health at their meetings, such as moving the time for public comment earlier in the agenda.

D. Partner Engagement

Most interviewees talked about partner engagement and offered suggestions for expanding the Health District's relationships with existing and potential partners. The Snohomish County Health Leadership Coalition, healthcare providers, payers, community service organizations, school districts, transportation, food service providers, and the media were all mentioned as underutilized partners in education, outreach and service provision. Interviewees emphasized that these partnerships are not only important for serving the public, but also for educating partners on the role of the Health District in the community.

Interviewees cited past partnerships that were successful. These partnerships often revolved around disease outbreaks and emergency preparedness, including H1N1 and MRSA outbreaks and the SR 530 landslide. Interviewees also frequently commented that the Health District is considered a trusted source for public health information and known for its responsiveness to partners.

Some suggested that a focus on the Health District's analytical and monitoring functions could increase partnership possibilities. They thought that greater communication of the Health District's work in epidemiology, surveillance, and analytics could demonstrate the Health District's value as a partner in informing the work of community providers that place greater emphasis on direct services.

Some also suggested that partnership and potential funding opportunities may exist between the Health District and businesses in Snohomish County, with the Health District acting as a broker of health information and bringing partners within the healthcare continuum together

with employers to identify top priorities around community health, wellness challenges, social determinants, quality and access, emphasizing the value of a healthy workforce.

Some interviewees mentioned communication barriers between the Health District, the cities, and the County as an obstacle to partnerships. Some identified confusion about which jurisdiction to approach for a particular problem or question, reporting that the Health District and the County are not always in agreement about which is responsible for handling certain issues. Interviewees felt that this communication gap leads to inefficiencies that may deter potential partners from establishing connections with the Health District.

E. Funding

While interviewees were asked a number of specific questions about funding as part of this assessment, funding was also a consistent theme in responses to questions about vision, governance, organizational structure, and public engagement. Most interviewees identified funding shortfalls as the main obstacle to achieving their vision of public health success in Snohomish County. However, few interviewees specified the amount of funding the Health District receives, how much more is required, and what this additional revenue would fund.

i. Sustainability and Stability

When discussing sustainability and stability, interviewees often talked about the history of funding for public health and how it has impacted the Health District's the ability to maintain direct services. When telling this history, interviewees described initial city per capita contributions, a portion of the Motor Vehicle Excise Tax, County contributions, the backfill provided by the Washington State Legislature, and the 2008 recession's impact on public health funding. Most identified adequate and stable government funding as being critical to sustainability. However, many discussed the decline of governmental revenue streams and were not optimistic about a reversal of this trend in the foreseeable future.

Some expressed frustration with an increasing reliance on grants as a funding source, mentioning the inflexible and restrictive nature of many grants and how they may limit the Health District's ability to react quickly to emergency situations, as well as plan proactively. There were also concerns about the impact of unstable funding sources on clients and organizations who rely on particular Health District programs, as well as the stability of Health District staff positions.

Many mentioned that the Environmental Health Division is financially sustainable, based on its fee-for-service funding. However, a number of interviewees noted that while these fees are able to cover the cost of permit reviews and inspections, they do not cover the cost of other necessary services, such as responding to complaints and water or septic systems failures.

Some interviewees were skeptical of the Health District's representation of funding issues and questioned whether the situation was in fact serious. They stated that while messaging about funding is portrayed as a crisis situation each year, the Health District continues to provide most services. Other felt there is a lack of transparency around financial data and raised questions about its accuracy.

ii. City and County Funding

Interviewees frequently mentioned that the cities do not contribute financially to the Health District. Dedicated revenue from cities was frequently mentioned as a source of Board of Health tension and conflict. Most thought that cities should contribute because city residents receive and benefit from Health District services. Others acknowledged that while cities' contributions would not solve the Health District's overall funding issues, it would help fill some revenue gaps and demonstrate cities' commitment to public health. Most of these interviewees advocated a commitment to per capita funding for the Health District from all of the cities in Snohomish County. Others viewed a per capita contribution from cities as a measure that would unfairly impact smaller cities, given issues related to access and availability of services.

Many interviewees referenced Snohomish County's Proposition 1, which was on the 2016 primary ballot, as a potential catalyst for increased local funding. Proposition 1 highlighted public safety, specifically increasing law enforcement and prosecutorial resources. While there was skepticism about whether the measure would pass, interviewees suggested that if it did, cities may be willing to dedicate a portion of their new sales tax revenue to public health; however, Proposition 1 failed to pass during the interview period of this assessment.

Perspectives varied on the County's capacity to fund the Health District. Several interviewees thought that Snohomish County lacks the funding capacity to absorb the Health District. Others felt that the County has adequate resources, but is not currently willing to prioritize them towards public health needs without receiving a compelling message and evidence of strong strategic direction from the Health District.

iii. Strategic Direction and Communications

Several interviewees underscored the need for clearer vision and strategic direction in order to resolve the Health District's funding issues. Many talked about how funding issues and potential solutions cannot be effectively addressed until the Health District more clearly defines and reaches agreement on purpose, roles, responsibilities and future direction. Some stated that if these issues were not resolved, funding trends will continue to decline, necessitating further service and staffing reductions.

Interviewees linked a public health culture of quiet work to a lack of political capital and leverage, especially when election cycles create competition between agencies for public funding votes. Some suggested the Health District work to develop and communicate a compelling story with a clear and concise message about why funding support is needed and the impact of the Health District's services. Some suggested the Health District try to convey benefits, efficiencies, and cost savings, perhaps linked to population health outcomes or other strategic directives, such as the Health District's unique epidemiological role, or the benefits of population data analytics.

iv. Revenue Source Suggestions

While most interviewees focused on current revenue sources and their inherent limitations, the following is a brief summary of additional suggestions and ideas for increasing revenue:

- Develop an improved public or partner message that clearly describes the Health District's unique attributes and ability to add value to larger team reform efforts, such as the Accountable Communities of Health. These types of transformation efforts depend on integrating and coordinating care between providers. The Health District's provision of population health analytics to integrated provider teams could help direct and coordinate resources more efficiently to specific areas in the county providing the Health District with potential shared funding or fee-for-service revenue.
- Continue conversations with cities around funding public health and explore a city funding contribution model. Interviewees suggested the Health District leadership continue its efforts to reach out to cities through presentations to city governments and include messaging about the Health District's value and funding needs in existing educational efforts.
- Identify grant opportunities that can be consistently relied on annually.
- Build capacity to allow full implementation of grants that already sustain important programs.
- Pursue establishment of a junior taxing authority.
- Create more funded partnerships with the private sector, including Snohomish County employers who may see value in expanding employee health and wellness programs.
- Explore Medicaid provider status to begin billing the Health Care Authority for eligible services. However, there was also an indication that the Health District currently bills all Medicaid-eligible services.
- Consider the various taxing options that many interviewees mentioned to fund public health, including:
    - A countywide or city retail sales tax;
    - A countywide or city property tax;
    - A tax on cannabis products; and
    - Taxes to fund mental health or public safety, with a portion designated for public health.

F. Board of Health

Most interviewees, including a number of Board of Health members, identified Board of Health governance as a key issue to be addressed. Some expressed a lack of confidence in the board members' collective depth and breadth of knowledge of public health and group ability to make informed decisions. Many saw the Board of Health as unengaged and too political. Some attributed this lack of engagement to the competing demands for member's time as public officials. Some questioned their understanding of the services provided by the Health District and how their decisions impact Health District clients and staff.

i. Structure and Membership

Interviewees identified a variety of issues associated with the structure of the Board of Health. Many stated the Board of Health is too large and that its size makes it difficult for members to reach a quorum and have meaningful discussions during meetings. Given the busy schedules of elected officials, interviewees acknowledged that it can be challenging for staff to schedule meetings and engage with Board of Health members between meetings. Some suggested reducing the size of the Board of Health by including only one or two county council members, or by reducing the number of city members and having city members represent multiple cities or geographic areas.

Many mentioned the frequent and high turnover of board members and difficulties it presents for cultivating a common vision, maintaining focus on long-term planning, and building trust, working relationships, and institutional knowledge. Many expressed frustration with one or two year terms, especially given the large time and energy investment required for new members to become familiar with public health and Board of Health work. Some talked about how it can be difficult to engage in meeting discussions and decision-making, given this steep learning curve.

Some interviewees recommended diversifying the membership of the Board of Health beyond elected officials, to improve board education around public health issues, needs, and concerns in Snohomish County. Many suggested adding representatives of public health interests in the county, such as physicians and environmental health interests. Some expressed the belief that that adding non-elected members with longer terms would improve both the Board of Health's public health subject matter expertise and its members' collective institutional knowledge.

ii. Roles, Responsibilities and Accountability

A lack of clarity about roles and responsibilities was an issue that arose repeatedly throughout the interview process. Many were unclear about whether the Board of Health served as the governing body of the Health District or functioned in an advisory role. Some admitted they did not know that the Board of Health existed. Many expressed a lack of clarity around the priorities of the Board of Health and how its decisions aligned with the vision of the Health District.

A majority of interviewees mentioned the role and responsibilities of cities represented on the Board of Health. Many thought it unfair that city representatives constituted a majority vote in funding decisions, yet did not directly contribute financially. Many strongly recommended that the cities financially contribute to the Health District. Nonetheless, many placed a high degree of value on representation by both the County and cities, and emphasized the importance of their ability to inform both county and city governments about Health District efforts.

Some thought the Board of Health lacked functional accountability. For example, interviewees communicated that there is no process to hold members accountable for missed meetings or not informing their peers and constituents about Health District topics and issues. Others mentioned a lack of an entity or structure to hold the Board of Health accountable for making decisions.

iii. Engagement

Many perceived that the Board of Health was unengaged and disconnected. A lack of past meeting attendance was frequently mentioned, although many stated that there were improvements in attendance this year. Many wanted to see both County and city members take greater initiative in educating themselves and their communities about the role of public health and the value of the services provided by the Health District. In addition, many recommended ongoing education and opportunities both on- and off-site for Board of Health members to interact with program staff and learn more about the work of the Health District.

There was a lack of understanding about whether and how Board of Health members representing cities engaged with their respective councils on public health issues. Many suggested that focused direction and guidance be given to Board of Health members about what input they should be seeking from their councils and how that information should be communicated back to the Board of Health and Health District staff. Some suggested that staff provide a brief summary of issues and a list of questions with meeting materials, so members know what to ask their councils. There were also suggestions to have a set time on each agenda for members to update each other on the input they have gathered.

iv. Meetings and Operations

Some interviewees expressed dissatisfaction with Board of Health meeting procedures and preparation. For example, many mentioned the limited time to review Health District materials, sometimes receiving 50 or more pages one to two days prior to a board meeting. Interviewees noted that this short notice limits members' ability to gather input, in particular for city representatives who must communicate with multiple city councils prior to monthly meetings. Some felt the Board of Health did not meet often enough and that a two-hour meeting, once a month, at the end of the workday did not offer the time required for adequate discussion and deliberation prior to making important decisions.

Interviewees recommended a more standardized and structured approach for recruiting city representatives and for orientation and onboarding of new members. Interviewees recommended the Board of Health spend time each year, preferably during orientation, to review and agree upon an annual work plan and operation procedures, including:

- Creating a work plan that articulates the Board of Health's vision, goals, objectives, and how the work of the Board of Health supports the Health District's strategic plan;
- Identifying decisions to be made and how agendas will be structured;
- Clarifying roles, responsibilities, and expectations for individual members, the full Board of Health, the chair and vice chair, the Health Officer, Health District staff, and Board of Health committees; and
- Determining how the Board should engage with District staff, city councils, partners and the public.

v. Engagement with the Public Health Advisory Council

Interviewees spoke favorably of the PHAC and many thought it was an underutilized asset to the Health District. They talked about how members are fairly active and engaged, meet

bimonthly with Health District leadership, and represent a diversity of public health perspectives. Many interviewees were unsure of how the Board and the PHAC interacted and what lines of communication existed between them. There was also a lack of clarity on what was actually done with the PHAC's suggestions and guidance.

Many interviewees suggested the Board of Health interact more with the PHAC. Interviewees noted that the PHAC represents sectors with a stake in public health delivery, and as such holds potential as a means of engaging with community partners, providing subject expertise to the Health District, and spreading awareness of the Health District's work.

Several interviewees suggested ways to improve the integration of the PHAC into the Health District's decision-making processes. Some suggested including procedures for interactions between the PHAC and the Board of Health and clarifying the roles of each in their respective governing documents. Others suggested organizing a yearly orientation or retreat, or periodic joint meetings. Some mentioned the possibility of including some PHAC members on the Board of Health.

G. Internal Operations

An overwhelming number of interviewees spoke to the pride and commitment of the people who work at the Health District. Interviewees both internal and external to the Health District observed negative impacts from recent staff layoffs, clinic closures and funding challenges, including additional workload, less face time with clients, and a heavier administrative burden. Some felt that decreasing the number of staff designated to certain programs and functions limits their ability to build relationships with Health District clients and threatens to compromise quality of service, despite the strong personal commitment of individual staff members. Some interviewees also raised concerns related to succession planning as many staff members are near retirement, leaving institutional experience gaps.

Several interviewees suggested that improved communication between Health District leadership and staff, as well as increased opportunities for staff to interact with and provide input to the Board of Health, would help to build trust, social capacity and alignment within the Health District.

Some expressed concerns about staff morale as a result of a perceived lack of transparency in decision-making. Some mentioned that discussions around cutting programs can last for months, creating staff uncertainty about job stability. Others felt that as the Health District shifts away from direct services, communication between program staff and leadership is essential to ensure a smooth internal transition, as well as maintaining service quality and accessibility provided by others. Some suggested that more direct interaction between staff and board members may create positive trends, including knowledge of Health District work functions, and enabling staff with field experience to inform decisions.

H. Organizational Structure

Interviewees were asked to share perspectives about the effectiveness of the Health District's current stand-alone district model and perceptions around comparisons to the other three

possible public health jurisdiction models, including county department, multi-county and city/county options.

Most responses focused on comparisons between the current stand-alone model and the proposed county department model. A few interviewees offered reasoning against a city/county or multi-county model, citing the lack of a major urban center like Seattle or Tacoma and the differences between Snohomish and neighboring counties' demographic mix and needs.

The vast majority of interviewees were either in support of the stand-alone model for the Health District, indifferent, or ambivalent. Organizational structure was frequently considered to be subservient to the importance of effective governance. Many talked about how the issues facing the Health District were connected to a lack of understanding, clarity, and agreement on vision; role of the Health District in service delivery and priorities; strategic planning and future direction. Many thought these governance issues could be addressed under the current model.

Regardless of model type, most interviewees indicated they seek a structure that:

- Maintains a strategic mission and vision of public health delivery in Snohomish County;
- Encourages effective functional leadership and governance;
- Provides efficient and effective, high quality services to the citizens of the county;
- Supports stable and predictable funding to provide those services;
- Provides accountability and transparency;
- Promotes service flexibility and responsiveness;
- Limits bureaucracy and political interference; and
- Enables effective and collaborative partnerships.

Few interviewees supported a county department model for public health in Snohomish County. Reasons given in support of a county department model included the following:

- Efficiency: Some interviewees anticipated gains in efficiency by combining administrative functions, including information technology and accounting. Others suggested there may be redundant or compatible services, such as septic and well inspections, that might be co-located and streamlined to reduce both redundancy and confusing multiple public entry points between the Health District and the County.
- Stable Funding: Some suggested that functioning as a county department would address the Health District's base budget issue, and provide more sustainable funding by prompting the County to contribute a greater share of the funding for public health efforts. Others commented that the current stand-alone model can no longer function effectively due to inadequate funding.
- Accountability: Some stated there would be greater political accountability under a county-based model. Some suggested that a transition would provide greater clarity about roles, responsibilities, and authority for public health.
- Career Advancement: Some anticipated that Health District staff may have greater job security as well as lateral flexibility and promotion potential within a county department

model. Others stated that staff would benefit from greater compensation under County collective bargaining agreements.

- Integration: Several interviewees believed that transitioning to the County would promote alignment of public health services with the County's human services, resulting in more integrated planning and delivery of a services.

Reasons given in support of a stand-alone district model included the following:

- Flexibility and Responsiveness: Many interviewees mentioned that the Health District's independence allows it the flexibility to provide more personalized and responsive services to clients. This speed and flexibility are important for functions like permitting and inspecting, which rely on quick access to legal assistance from outside council. They worried that a shift to the County might impede this flexibility and responsiveness by requiring public health to function within a larger bureaucracy. Many interviewees expressed general uncertainty around a move to another model and the belief that a smaller organization provides more personal service.
- Autonomy and Integrity: Many were concerned about the risk of public health becoming subservient to other political priorities if transitioned to a county department model. Some worried about dividing public health into multiple county departments. Several mentioned that the Health District currently maintains a degree of political insulation that promotes integrity around program delivery. Some suggested that a county-based model might require the Health District leadership to shift their time and focus away from public health priorities.
- Greater Funding Options: Some interviewees thought that the stand-alone model remains a better option to re-attract city funding participation. Interviewees also thought that the current independent status makes the Health District eligible for a wider array of grants. In addition, some expressed skepticism that a shift to a county-based model would result in additional public health funding, given the county's current overall financial position. Others questioned whether the County has the internal resources necessary to absorb and maintain public health functions.
- Assumed Cost Savings: Many were skeptical about assumed economies of scale and cost savings under a county-based model. Several expressed the belief that any programmatic and administrative cost savings would be negated by increases in staff salaries. Others stated that any savings would be far less than the gaps in funding for essential programs. A few interviewees expressed concern about potential liabilities the County would incur in the event of a transition to a county department. As an alternative to becoming a county department, several supported the notion of the Health District working with others through inter-local agreements to outsource relevant functions and administrative services.

I. Interest in a Collaborative Process

When asked about the potential for using a collaborative process to address issues outlined in this assessment, nearly all responded positively and many said it was the only way to make

progress on these issues. Many interviewees stated that there is a strong culture of convening and collaboration in Snohomish County.

Many interviewees suggested collaboration to build clarity and agreement around the role of the Health District and the Board of Health. Some also suggested collaboration to address funding issues and build commitment for funding public health. They expressed optimism about an approach that would include both political and administrative leadership from the Health District, as well as community partners. Many stated that education about the functions of the Health District and the importance of public health would be a good place to start. Others suggested trust and relationship building as a first step.

IV. CONCLUSIONS

The Assessment Team conducted interviews with 73 individuals involved with public health in Snohomish County. The purpose of this assessment was to gather perspectives on how the Health District should provide public health services, fund those services, provide effective and efficient governance, and identify opportunities for collaboration. Provided below are the Assessment Team's conclusions.

- **There is support for collaboration** as well as a willingness and desire for a collective vision for public health in Snohomish County.
- Public health is expansive and difficult to define, especially in the current changing public health and healthcare environment. There was broad diversity of opinions, perspectives, interests, and values regarding both the current and future direction of public health and the role of the Health District. **While visions of success varied in both scope and content, interviewees generally envisioned a future where public health in Snohomish County was valued, services were adequately funded, available, accessible, and coordinated among the entities providing them, and that people would be healthy and living in a healthy, safe community.**
- **There is confusion around one-on-one, population-based, and foundational service models and disagreement about the Health District's role in service delivery.**
- Many shared stories of positive experiences receiving direct services from the Health District and linked the Health District's current successes to the provision of direct services. **There is a sense of identity and purpose attached to directly serving individuals, which makes it difficult for many to accept a transition towards population-based services.**
- **There is little support or desire for changing the Health District's current organizational model at this time. There was instead a great deal of support for improving governance** and gaining clarity and agreement on the vision, mission, future direction, priorities, and service delivery role of the Health District to ensure the future success of public health in Snohomish County.
- **The Board of Health's decision-making process and membership structure conflict with one another,** as majority voting does not work without a balanced representative

group. The lack of shared agreement on structure and governance functions, in particular the lack of Board agreement around the County and cities' responsibilities for funding public health, drives the perception that the Board of Health consists of two opposing coalitions: County versus cities.

- **There is no lone entity or single option that can provide the funding necessary** to support public health needs in Snohomish County. **Funding solutions will require the combined leadership and commitment of all parties**, including the Health District, Board of Health, Snohomish County, the cities, federal and state governments, and other partners. In addition, there is a link between understanding the value of public health and willingness of the public and partners to support funding.

V. RECOMMENDATIONS

The recommendations in this section are based on analysis of what was heard and learned from interviews, exploration of and experience with similar governance and organizational structures, and the Assessment Team's expertise in effective collaborative and multi-party processes.

At this time, a key prerequisite to addressing any of these issues is a decision regarding the organizational model of the Health District. Given interviewees' responses and the uncertainty of the potential social, political, and economic impacts, the Assessment Team believes that now would be a challenging time for the Health District to transition to the authority of Snohomish County. If the decision is to stay with the current organizational model at this time, the Assessment Team has identified elements of the current organizational and governance structure that, if addressed, would help the Health District reach its full potential. The following recommendations provide an approach to addressing these elements.

According to the Health District's 2014 Strategic Plan update, the Health District will need to update its plan for 2017/18. The Assessment Team has identified potential opportunity for collaborative action regarding the future strategic plan and recommends building collaborative capacity for this planning effort. A collaborative planning process would engage involved parties internally and externally to promote mutual understanding, foster inclusive ideas and solutions, build sustainable agreement, and cultivate shared responsibility and commitment to public health in Snohomish County. This will require the collective commitment and support of the Board of Health, PHAC, Health District leadership and staff. Each has a key role in ensuring the success of the Health District and public health in Snohomish County.

However, the Board of Health and Health District will need to take the following initial actions to build the capacity to undertake such a process:

A. Formalizing the Board of Health governance structure, functions, and operations, and enhancing collaborative leadership capacity of the Board of Health and Health District leadership through facilitated development and engagement activities.

B. Relationship building and enhancement of collaborative capacity between Health District leadership and staff.

These recommendations are discussed in greater detail in the sections below.

A. Formalize Governance and Enhance Collaborative Leadership Capacity

The Assessment Team recommends the Board of Health and Health District leadership consider a facilitated process to clarify and agree on purpose, roles, responsibilities, authorities, commitments, and accountability. The following will demonstrate both internally and externally a willingness and commitment to more collaborative and actionable governance of public health.

iv. Clarify, develop, and agree on governance structure, functions, and operations.

v. Agree on resource stewardship and a funding strategy for the Health District.

vi. Include collaborative skill-building and the use of less formal processes to build the spirit of collaboration with the PHAC, Health District staff, and the larger public health community.

These recommendations are discussed in greater detail below.

i. Formalize Governance Structure, Functions, and Operations

The Board of Health's Charter was last updated in 1997. The Assessment Team recommends that the Board of Health update its Charter and include more robust operating procedures that include at least the following:

- Purpose, duties, and governance functions: Clarify and codify the purpose, responsibilities, and governance functions of the Board of Health. For example, the National Association of Local Boards of Health (NALBOH) offers a model for six functions of public health governance:
    - Policy Development
    - Resource Stewardship
    - Legal Authority
    - Partner Engagement
    - Continuous Improvement
    - Oversight

Whether the Health District uses the NALBOH model or another approach, determining the functions of the Board of Health will be essential to building effective governance and collaborative capacity.

- Roles: Define the roles of Board of Health members and Health District staff, as well as corresponding authorities and responsibilities.
- Membership structure and decision-making processes: If the stand-alone district model is retained, the Board of Health should consider ways to streamline and possibly rebalance its membership in order to address the County/city dichotomy, support more collaborative decision-making, and build continuity that withstands eventual member turnover. In addition, the Assessment Team recommends adding non-elected subject matter experts to the Board of Health to add a diversity of experience in public health.

- Ground Rules: These may include agreements for meeting attendance, interaction with the PHAC, Health District leadership and staff, media, and guidance for Board of Health members when discussing or representing the Health District outside of Board of Health meetings.
- Member Terms: Formally agree to minimum terms of service and explore options to mitigate the impact of member turnover and maximize the continuity of educational investment and decision-making. This will likely require ongoing communication with city governments to align with the various methods used to assign Board of Health membership. Additionally, adding non-elected officials to the Board of Health may help to lessen turnover if those individuals serve longer or more terms.
- Amendment Process: The Charter should be revisited annually and include a process for amending both the Charter and operating procedures.

ii. Resource Stewardship and Funding Strategy

The Assessment Team recommends the Board of Health formalize a financial strategy, teaming with Health District leadership to assure the availability of resources to support the agreed-to direction of public health services in Snohomish County. For example, the NALBOH governance function documentation notes the following resource stewardship suggestions, including availability or development of:

- Legal, financial, human, technological and material resources;
- Agreements to streamline sharing of resources with other government entities;
- A budget aligned with Health District needs;
- Sound long-range planning as part of strategic planning efforts;
- Fiduciary planning and care of Health District funds; and
- Funding advocacy to sustain public health agency activities, when appropriate, from approving/appropriating authorities.

This approach includes considering funding from a variety of available and emerging revenue sources. As part of this strategy, contention over County and city funding needs to be openly and collaboratively addressed.

This stewardship and funding strategy should align with the Health District's strategic planning processes by promoting integration and communication between the Board of Health and Health District leadership and staff. For example, Board of Health members from relevant subcommittees, such as finance or funding, might pair with the Health District's financial and operational leadership.

iii. Collaborative Capacity and Skill Building

In addition to formal and structural adjustments, the Assessment Team recommends developing an environment where Board of Health members, PHAC members, and Health District leadership and staff can learn from one another, share interests and concerns, and create a common base of information in a more informal setting. The process to formalize

governance could include information sharing sessions, informal dialogue and discussion sessions, and dedicated time for team building.

The Assessment Team recommends annual orientation and onboarding that emphasizes team building and provides opportunities to acquire skills in the practice and application of collaborative leadership principles. Joint orientation with the Board of Health and the PHAC, as well as joint meetings throughout the year should also be considered. Team building can increase trust, improve working relationships, and increase capacity to carry out tasks and make informed decisions.

The Assessment Team also recommends that the Board of Health increase its monthly meeting frequency to create more opportunities for engaging with Health District staff, the PHAC, and the public to learn about the work of the Health District and public health needs of the community. A number of processes could be used to support this greater engagement. For example, the Board of Health could convene a "study session" meeting each month that provides a forum for learning, sharing and discussing information, as well as inviting input from interested parties, but where no decisions are made. Meetings or processes convened by the Board of Health which promote collaborative learning experiences and build a habit of collaborative action can serve as the foundation for any approach to strategic planning in 2017/2018.

B. Build Agreement between Health District Leadership and Staff

The Assessment Team perceives a lack of internal clarity and agreement on the Health District's strategic direction and decision-making processes. Although internal Health District operations were outside the scope of this project's assessment, concerns arose around internal organizational functions that could impede strategic progress. The Assessment Team recommends that Health District leadership and staff agree on a process to promote mutual understanding, foster inclusive ideas, build agreement and commitment, and cultivate shared responsibility. The process could include facilitation, internal development, and team building exercises to enable progress towards the 2017/18 Strategic Plan.

VI. APPENDICES

APPENDIX A.

Snohomish Health District Assessment

What is a Situation Assessment?

A situation assessment is the first step to addressing complex public policy issues. The purpose of a situation assessment is to develop a common understanding of the issues, the needs and interests of the parties affected and potentially affected, and the challenges and opportunities associated with different options for addressing the issues. Assessments are typically conducted by a neutral, third-party who interviews a range of people who are knowledgeable about or affected by the issue. Information gathered from the interviews helps to better understand:

- Procedures and substance of the situation.
- Who is affected by or potentially affected by the situation.
- Needs and interest of the parties.
- Issues, challenges, and opportunities associated with different options for addressing issues.
- Whether circumstances are right for collaboration and whether people are ready to collaborate.
- How a collaborative process may be designed and structured.

Based on the information gathered, the third party provides a report summarizing key themes and recommendations on how to proceed. While the assessment report includes a list of who was interviewed, specific statements and key themes are not attributed to individual interviewees.

The report is made available to everyone who participated in the assessment and any other interested parties. The assessment report is meant to inform, rather than dictate a particular course of action and to help parties decide whether to proceed with a collaborative approach.

What is the William D. Ruckelshaus Center?

The William D. Ruckelshaus Center is a neutral resource for collaborative problem solving in the State of Washington and the Pacific Northwest, dedicated to assisting public, private, tribal, non-profit, and other community leaders in their efforts to build consensus and resolve conflicts around difficult public policy issues. It is a joint effort of Washington State University (WSU), hosted and administered by WSU Extension, and the University of Washington (UW) hosted by the Daniel J. Evans School of Public Policy and Governance. More information is available at http://ruckelshauscenter.wsu.edu/about/.

If you have questions about the assessment process, please contact Project Co-Managers Amanda Murphy at Amanda.g.murphy@wsu.edu or 206-219-2490 or Kevin Harris at kevin.harris2@wsu.edu or 206-292-2387.

APPENDIX B.

Snohomish Health District Assessment Interview List

The Ruckelshaus Center contacted, interviewed, or otherwise obtained input from the following people in preparing this report:

Anne Alfred	Snohomish Health District, Environmental Health Division
John Amos	Snohomish County Finance Department
David Bayless	Snohomish Health District, Communicable Disease Division
Jason Biermann	Snohomish City Emergency Management
Mark Bond	City of Mill Creek*
Doug Bowes	United Healthcare
Mary Jane Brell Vujovic	Snohomish County Human Services
Debra Cartmell	Snohomish Health District, Community Health Division
Judy Chapman	Snohomish Health District Administration
Terry Clark	Child Strive
Gary Cohn	Everett School District Superintendent
Christine Cook	City of Mukilteo*
Bryan Cooper, DNP, ARNP	Tulalip Clinic
Cristin Corcoran	Snohomish Health District, Communicable Disease Division
Annie Costello	PTE Local 17
Federico Cruz-Uribe	SeaMar Community Health Centers
Jane Dale	QFC
Bob Drewel	Washington State University
Hans Dunshee	Snohomish County Council*
Chanda Emery	City of Lynnwood Human Services
Albert Fisk, MD	Everett Clinic
Adrienne Fraley-Monillas	City of Edmonds*
Nancy Furness	Snohomish Health District, Communicable Disease Division
Gary Goldbaum, MD	Snohomish Health District
Benjamin Goodwin	City of Lynnwood*
David Gossett	Snohomish County Council, ret.**

Brent Hackney	Brent Hackney Designs***
Kurt Hilt	City of Lake Stevens*
Jeff Hutchison	Snohomish Health District, Environmental Health Division
Hil Kaman	City of Everett Public Health and Safety
Naomi Kern	Snohomish Health District, Communicable Disease Division
Jefferson Ketchel	Snohomish Health District, Environmental Health Division
Ken Klein	Snohomish County Council*
Dan LeFree	Snohomish Health District Administration
Wayne Liao	Snohomish Health District, Environmental Health Division
Mara Marano-Bianco	Snohomish Health District, Community Health Division
Julie Martin	Snohomish Health District, Environmental Health Division
Peter Mayer	Snohomish Health District
Scott Murphy	City of Everett*
Mary O'Leary	Snohomish Health District, Communicable Disease Division
Timo Ochmann	Snohomish Health District Administration
Carrie Parker	Snohomish Health District, Community Health Division
Kent Patton	Snohomish County Executive's Office
Lisa Pederson	Snohomish Health District, Communicable Disease Division
Debbie Pennell	Snohomish Health District Administration
Martha Peppones	Senior Services of Snohomish County***
Kevin Plemel	Snohomish Health District, Environmental Health Division
Dan Rankin	Town of Darrington*
Jeff Rasmussen	City of Monroe*
Elise Reich	Molina Healthcare
Mark Richardson	Snohomish County Sheriff's Office***
Terry Ryan	Snohomish County Council*
Daniel Selove	Snohomish County Medical Examiner
Charlene Shambach	Snohomish Health District, Community Health Division
Barbara Sheets	Snohomish Health District, Community Health Division
Preston Simmons	Providence Regional Medical Center
Mary Sinker	Snohomish Health District Administration

Patric Slack	Snohomish County Sheriff's Office
Dennis Smith	United Way of Snohomish County
David Somers	Snohomish County Executive**
Leonard Sorrin	Premera Blue Cross
Brian Sullivan	Snohomish County Council*
Heather Thomas	Snohomish Health District
Yuan-Po Tu, MD	Everett Clinic
John Weisman	Washington State Secretary of Health
Hanna Welander	Washington State Nurses Association
Jim Welsh	Child Strive***
Brant Wood	Snohomish County PUD #1***
Fred Worthen	Community Transit***
Donna Wright	City of Marysville*
Stephanie Wright	Snohomish County Council*
Patricia Yepassis-Zembrou	Snohomish Health District, Communicable Disease Division
Carl Zapora	Verdant Health Commission

*Denotes current Board of Health member
**Denotes former Board of Health member
***Denotes Public Health Advisory Council member

APPENDIX C.
Interview Questions

Snohomish Health District Assessment
Interview Questions

Assessment Background and Overview:
The Snohomish Health District (Health District) is an independent special purpose district responsible for providing a range of program and services that protect and promote public health in Snohomish County. A 15-member Board, composed of county and city officials, oversees the policy and budget development of the Health District, while staff oversee programming and delivery of services.

The public health landscape, both in Snohomish County and nationally, is in a state of change and transition due, in part, to healthcare reform efforts, ongoing budgetary shortfalls, continued shifts in public health at the federal and state levels, and growing and changing county population. The Health District staff and Board contacted the William D. Ruckelshaus Center[1] to help them determine whether and how to best engage interested parties in addressing these significant issues.

The Health District believes that they are at a critical juncture related to important delivery of care, funding and governance issues.[2] The Ruckelshaus Center met with Board members and staff and, based on those conversations, suggested conducting a situation assessment. A situation assessment is an interview-based process undertaken to better understand and explore relevant issues and interests of involved parties and situation dynamics. It is a typical first step in designing a collaborative process that reveals useful information to inform next steps forward, whether that involves a collaborative process or not. The product of such an assessment is typically a report articulating the major issues and key parties involved, documenting their interests and perspectives, and analyzing/exploring the prospects for a collaborative process to address those issues.

The Center is conducting interviews to gather perspectives regarding how the Health District should provide public health services to the citizens of Snohomish County, fund those services, and provide effective and efficient governance. The Center will also gather input on opportunities for a collaborative process.

As an individual or representative of an organization with a particular role or interest in, or knowledge of public health, you have been identified as an interview candidate. We hope you will agree to participate, or assist by identifying the most appropriate person to speak with us.

Interviews take approximately 60 minutes, and participation is voluntary. Interviewees can choose at any time during the interview to decline to answer a question or end the interview. A copy of the assessment interview questions will be provided ahead of time to interviewees.

[1] The William D. Ruckelshaus Center (Center) is a joint effort of the University of Washington and Washington State University, created to foster collaborative public policy in Washington and the Pacific Northwest. The Center assists public, private, tribal, nonprofit, and other leaders to build consensus, resolve conflicts, and develop innovative, shared solutions.
[2] Note: Attached Snohomish Health District 'Case Statement'

The assessment report will include a list of who was interviewed and key themes that emerged from the interviews. Specific statements will not be attributed to individual interviewees. The final report is expected to be completed by the end of August 2016.

More information about the Ruckelshaus Center is available at: http://ruckelshauscenter.wsu.edu/about/.

Questions

1. What organization(s) or entity(s) do you represent? What are your title, role and responsibilities?
2. Please briefly describe your experience and interest with respect to public health services in Snohomish County.
3. We would like to ask a few visionary questions. Imagine it's sometime in the future (5, 10, 20 years) and the delivery of public health services in Snohomish County has been successful. How will you know? What will you see (or not see) happening? What will be the same? What will be different?
4. What do you see as the major issues that would need to be addressed to achieve this level of success?
5. What are the challenges or barriers to addressing these issues?
6. How might these challenges or barriers be overcome? Do you have suggestions for approaches or processes to address those issues and fulfill your vision?

Funding Options

7. What would successful and sustainable financing of public health in Snohomish County look like over the long term? What will you see happening or not happening? What will be the same as today or different?
8. What are the major challenges to achieving that success? Where are the opportunities for progress?
    a. Would the 'status quo' need to change to make progress? Why or why not?
9. What additional options could be considered for financing public health in Snohomish County? What are the 'benefits' of those options? What are the 'costs' of those options?
10. Which options do you think are most likely to be supported and why? What options do you think are least likely to be supported and why?

Organizational and Governance Structure Options

The Health District is interested in reviewing its current organizational and governance structures, including the process the Board uses to conduct its business, to promote greater engagement, accountability, more effective decision making, and efficiency.

11. What is your impression of the effectiveness of the current 'single stand-alone district' model? Is public health in Snohomish County best served by the current organizational structure? If yes, why? If no, why not and what should the model look like?

12. What is your overall impression of the effectiveness of the current 15-member Board governance structure[3]? What are the most effective features? What, if any, changes or improvements could be made? Is public health in Snohomish County best served by the current governance structure of the District? If yes, why? If no, why not and how should the District be governed?

Public Engagement

13. How does the District and Board interact with the public? What's working well? Why? What's not working well? Why?
14. What suggestions do you have for creating effective public engagement?

Opportunities for Collaborative Process

15. In a typical collaborative process, involved parties are brought together as a group to share perspectives, define issues, identify interests and common ground, generate options for addressing issues, and seek agreement.

    Do you feel there is potential for using a collaborative process to address any of the issues you've identified during this interview? If yes, who would need to be involved and why? If no, how do you think the issues could be resolved?

Wrap-up

16. Is there anyone else you think we should be interviewing? Why is it important to speak to them?
17. What should we have asked that we did not? Do you have any questions for us?

[3] Note: Attached Snohomish Health District 'Case Statement', page 2

Staff Interview Questions

1. Tell us about your roles and services provided? What's your typical day look like?
2. Have roles/responsibilities changed over time? If so, why?
3. Think back over your time at SHD and all the things SHD has accomplished. What went particularly well? What services are you most proud of?
4. If you could make one change that would make SHD better, what would you do and why?
5. Imagine it's sometime in the future (5, 10, 20 years) and the delivery of public health services in Snohomish County has been successful. How will you know? What will you see (or not see) happening?
6. What is the role of SHD in your future vision? What is the role of your division/department in your vision?
7. What are the major challenges to achieving that success? Where are the opportunities for progress?
8. What is your impression of the effectiveness of the current single stand-alone district model? Is public health in Snohomish County best served by the current organizational structure? If yes, why? If no, why not and what should the model look like?

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Case Statement: Public Health Funding and Structure Challenges in Snohomish County

The Snohomish Health District is undergoing significant transitions in its delivery of public health services countywide—a result of a growing and changing county population, declining revenues to support public health, a larger health system transformation occurring nationally and health care innovation initiated at the state level.

The agency has been responding over the last several years by streamlining, forming new partnerships with other health care providers and non-profits, and moving toward a provision of foundational services and capabilities. These moves transition the District out of direct, one-on-one clinical interactions, to a more appropriate role of ensuring that the county population as a whole is benefitting from public health services.

To provide the greatest impact for the greatest number of people and achieve better health outcomes, four central issues must be resolved:

- Finding agreement on public health's fundamental role in Snohomish County;
- Determining the best organizational structure to fulfill that role;
- Updating governance configuration that supports that structure; and
- Securing dedicated and sustainable funding that preserves local public health.

Given that **Snohomish County ranks 34th among the 35 local public health jurisdictions in Washington in terms of per capita health spending**, any delays in addressing these issues further erodes our ability to address major public health conditions and significant health disparities across the county.

The People of Snohomish County are at Risk

Without a concerted focus on carrying out public health's fundamental responsibilities, with the dedicated funding and structures in place to support it, our residents and communities will suffer. We will be forced to decide which is more important: preventing disease or preventing injuries; providing healthy starts for kids or assuring safe places to live and work; stopping the cycle of violence or preventing suicides. What is the right decision for Snohomish County?

There shouldn't be a choice. We all deserve better.

Agreement on Public Health's Role in Snohomish County

The declining financial resources dedicated to public health in our community have been at the forefront of many discussions with the Board over the last 18-24 months. Closely tied to this is a strategic focus on the local, state and national efforts designed to channel staff, funding, and resources into those programs that must be performed by public health.

While direct one-on-one programming will always be an essential need in the community, many of these services are no longer arenas where the Health District is the sole service provider, nor are they aligned with the future vision of public health in Snohomish County. This approach is consistent with aligning our resources where public health is uniquely qualified, and identifying ways that the Health District can affect the greatest good for the greatest number of people in our community.

Moving forward, it is imperative that we are aligned internally, politically and with our many partners on where our role is in the variety of issues facing Snohomish County.

Organizational Options for Local Public Health in Washington

Councilmember Ken Klein provided a proposal in September 2015 to transition the authority of the Health District to Snohomish County government in a process to be completed by January 1, 2017. Several board members expressed interest in moving forward with an assessment, including other options.

Within Washington's 39 counties, there are 35 local health jurisdictions. They are currently arranged in the following five ways:

- Single county standalone district (like Snohomish Health District)
- Multi-county district (like Chelan-Douglas Health District)
- Public health department (like Clark County Public Health)
- Public health and human services department (like Cowlitz County Health and Human Services or Grays Harbor Public Health and Social Services)
- City-County public health agencies (like Public Health—Seattle & King County and Tacoma-Pierce County Health Department)

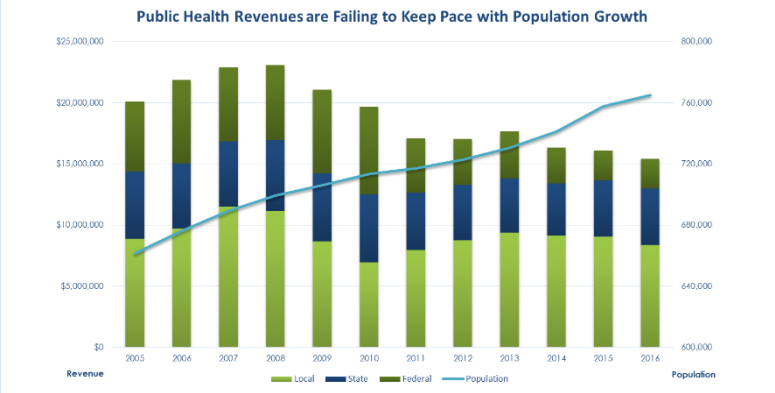
Evaluating a Nearly 20-Year Old Governance Structure

The current governance structure and process the Snohomish Health District Board of Health uses to conduct its business needs to be reviewed. **The initial Health District Charter was first crafted in 1959, with the most recent amendments made in 1997.** The existing charter stipulates a 15-member board comprised of one county councilmember from each of the five districts, one member from the largest city in each district, and the other cities within each district electing one representative. Given the significant changes that have taken place over the last 20 years, a fresh review and consideration of its governance structure and procedures is overdue.

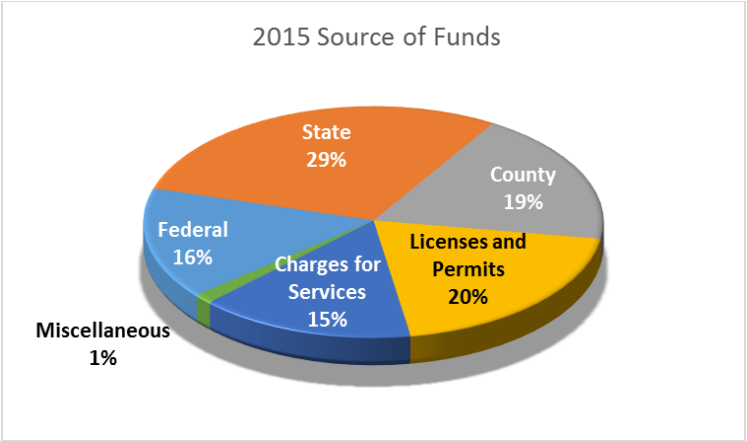
State law (RCW 70.05.030 and RCW 70.46.031) prescribes minimum requirements for the composition of local boards of health. For instance, the Snohomish County Council retains authority to specify the membership and representation of the Health District, as well as appointing elected officials from cities and towns and persons other than elected officials as members of the health district board so long as persons other than elected officials do not constitute a majority. As part of the exploration of new or expanded funding sources, the County Council and fellow board members may determine that a different structure will serve the District's needs more effectively.

Declining Resources to Meet Health Disparities of Growing Population

The Snohomish Health District was funded at $16 million in 2015—**a 22 percent decrease from the funding level of 2005—yet the population has increased by 14 percent in the same 10 year period.** Our job of promoting and preventing healthy behaviors, communities and environments becomes increasingly difficult without the resources to keep pace with the changing and growing population. **Since 2005, the agency has eliminated 74 FTE—a reduction of 34 percent due to static or declining revenues in the face of increased costs**.



The agency relies heavily on 64 percent of its funding coming from intergovernmental revenue (federal, state and county sources) to support public health services. With 65 percent of the District's revenue being "restricted" or "categorical," **the majority of the agency's funds can only be used for specific purposes**. In addition to these sources remaining static or declining, **these funds are limited term, unpredictable and fluctuating grants that limits the District's ability to institute change**. Grant funding, in particular, does not provide the District with the flexibility needed to begin delivering public health services through broader, more community-based mechanisms.



Future funding of public health is anticipated to be a combination of increased state support, dedicated and sustainable local funding from new or expanded sources, and fees for services. There are options to achieve sufficient local funding, but none of them have an easy path forward. Current funding mechanisms include traditional voted and non-voted mechanisms (i.e. sales tax; utility tax, property tax) available to cities and counties, self-generated revenues (i.e. fees, licenses, permits, leases) and intergovernmental revenues (i.e. county, state and federal grants and contracts).

Summary

Snohomish County has been in the news lately for being part of one of the fastest growing regions in the state. This exponential growth certainly has implications to costs and services for all government agencies, but it also means we are responsible for protecting the public health for nearly 760,000 clients (and climbing). While we are adding "clients," we are also experiencing compounded cuts in funding.

Failing to address the fundamental issues mentioned earlier, coupled with continued funding cuts, leads to ripple effects across other programs and service offerings, including diminished partnership opportunities with Snohomish County Human Services, the Regional Drug Task Force, the medical community, and many non-profit organizations. Not only are these partnerships that we value, but they have brought significant benefits to the community.

Ultimately, it is the public's health that is in jeopardy. The Health District's reduced staffing over the years means less capacity to address ongoing and emerging health issues like the opioid epidemic, vapor devices, youth and adult injury prevention, stopping the spread of tuberculosis, and responding to measles and pertussis outbreaks. It restricts our ability to adequately prepare for and respond to emergencies of all kinds, like H1N1, Ebola, and the SR 530 Slide. It limits our ability to know what is happening in the community, develop public policy, communicate important messages to our partners and the public at large, and to mobilize other community resources. Finally, the declining revenues and restricted funding sources significantly limits our ability to nimbly invest staff and programming where it is most needed.

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2014 Strategic Plan Update

JUNE 2014

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Snohomish Health District
2014 Strategic Plan Update

June 24, 2014

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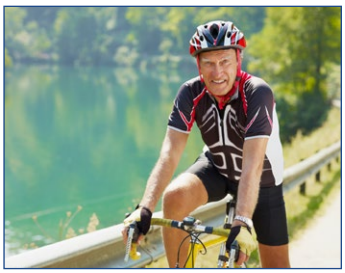


In response to dramatic changes in the public health environment, including the Affordable Care Act, severe budgetary and staffing cuts, and an unrelenting public need, public health agencies in Washington State and throughout the nation are in the midst of redefining priorities, programs and operations. Today's public health funding and delivery system was designed in and for the 20th century. It must be redesigned to meet 21st century demands.

This Strategic Plan Update is a wide-ranging and substantial move toward that redesign. It includes a set of eight initiatives intended to improve service delivery, move expertise out of public health offices and into the community, employ new technologies for enhanced customer service, cut costs, develop a 21st century workforce, improve quality, and acquire sustainable sources of funding. It includes a thorough and comprehensive review of current systems, and strives to correct outmoded and ineffective practices.

The strategies are bold because the Snohomish Health District simply cannot afford to do anything less than what is proposed in this document. The District has been under financial crisis for years. Since 2008 the County's population has grown by 6%, but District revenues have dropped by 24%. Approximately 80 full-time staff positions have been cut. In Washington State, Snohomish County ranks #30 among 35 local public health jurisdictions in terms of per capita public health spending.

This Update seizes on opportunities for the District to proactively steer its future rather than simply continue to react and respond to continued budget shortfalls. It is rooted in the 2009 Strategic Plan, incorporating the mission, vision, and directions that were adopted at that time. It adds a greater level of specificity on key action steps, timelines, and accountability for implementation.

This Update also incorporates a number of values that have historically been embodied by public health professionals and that continue to be at the forefront of the Health District's mission. The initiatives seek to provide service to a larger percentage of Snohomish County's population and in locations that are readily accessible to more people. The initiatives take advantage of new business practices to streamline the District's work, create greater operational efficiencies, and improve customer service.

Most importantly, this Update embodies the principle that no one should be left behind when it comes to the very basic health care needs that face every human being. To that end, significant emphasis is placed on creating new partnerships with other agencies, private providers, and local businesses. SHD is intent on moving carefully and deliberately through this process to ensure that those partners are ready, able, willing, and fully capable of delivering some of the services that have previously been under the purview of the Health District, and we are confident these capable partners exist within our County.

When adopted by the Snohomish Board of Health, this Strategic Plan Update will serve as a roadmap for the District over the next three years. Some of the work outlined here has already begun, and those and those efforts will continue to be supported and expanded. Other initiatives will require new ways of operating and mobilizing. In all, the Update offers an exciting and comprehensive range of opportunities to meet the County's public health needs for decades to come.

The eight strategic initiatives proposed for the next three years include:

1) **Move Patients out of Health District Clinics and into Medical Homes**
   —*Calls for the development of new partners to provide direct clinical services to our current clients.*

2) **Improve Environmental Health Business Practices**
   —*Seeks to use new technologies and streamlined procedures to improve customer service and achieve greater operational efficiency.*

3) **Optimize Delivery of Early Childhood Development Programs**
   —*Places public health personnel in community locations where they can reach more families and children at risk.*

4) **Mobilize Community Health Action Teams**
   —*Takes advantage of new opportunities that make it easier for people to lead healthier lives right where they live.*

5) **Reduce Administrative Overhead Costs**
   —*A thorough examination of the District's administrative overhead and ways to reduce it.*

6) **Institute Workforce Development and Succession Planning**
   —*A set of comprehensive actions to proactively ensure a skilled and motivated workforce now and into the future.*

7) **Improve Health District Funding and Governance**
   —*A reexamination of Snohomish County's current form of public health governance and finance and the pros and cons of a possible change.*

8) **Become Nationally Accredited and Integrate Quality Improvement Principles**
   —*The pursuit of national accreditation and enhanced credibility with funders.*

Introduction

A New Era for Public Health

This Strategic Plan Update from the Snohomish Health District details eight initiatives that are either underway or will be set in motion beginning in mid-2014. These initiatives are designed to propel the District forward into a new era for public health in Snohomish County.

Like public health agencies throughout the nation, the Snohomish Health District has examined its current programs and practices in light of diminishing resources and a vastly changed health care landscape in the United States. With health insurance more widely available to every U.S. citizen, it is becoming more possible for the District's current clients to access comprehensive medical services through providers in the community. We have ways to improve business and technology systems, reduce overhead, streamline processes, and improve customer service. SHD is aware that programs can be enhanced by operating more directly in the community, rather than within the confines of our offices. The District must replace a retiring workforce with new personnel, and perhaps with different skills than have been required in the past. And, our agency embraces the importance of continual quality improvement, especially as we seek to become nationally accredited.

We know there is a much larger percentage of Snohomish County residents who may be at a higher risk, but aren't seeking treatment

This document incorporates a number of important values. Currently a small number of people to whom the District provides clinical services come to us for care. However, we know there is a much larger percentage of Snohomish County residents who may be at a higher risk, but aren't seeking treatment. Hence, the underlying value in the strategic initiatives that move personnel into more visible locations throughout the County, not only to ensure full delivery of the programs we manage but to also convene and facilitate new community initiatives that make it easier for people to lead healthier lives.

The Health District plays a vital role in protecting people from disease, whether through the monitoring of Tuberculosis patients, restaurant inspections, or ongoing data compilation and analysis of emerging health threats. This Strategic Plan Update does not diminish the importance of those programs, but does provide an opportunity to be a better governmental agency by employing new business practices that streamline our work, create greater operational efficiencies, and improve customer service.

This Update is also built upon the value that no one should be left behind when it comes to the very basic health care needs that face every human being. To that end, significant emphasis is placed on creating new, lasting partnerships with other agencies, private providers, and local businesses. SHD is intent on moving carefully and deliberately through this process to ensure that those partners are ready, able, willing, and fully capable of delivering some of the services that have previously been under the purview of the Health District. We are confident these capable partners exist within our County.

The eight Strategic Initiatives outlined in this Update are wide-ranging and substantial. They cannot be achieved without the full commitment and a great deal of hard work from the Board of Health, the District's senior management, and all District staff. These strategies are bold because the District simply cannot afford to do anything less than what we are proposing here. The Snohomish Health District has been under financial

crisis for years; without a full examination of our current practices and a set of sweeping reforms, the District cannot be sustained over the long term.

The purpose of this 2014 Strategic Plan Update is to develop a blueprint for the next three years that provides guidance and direction for the tough financial and operational decisions facing the Snohomish Health District. In addition, this work will be used as a framework for annual budget development, ensuring that funds are allocated and spent in a manner consistent with our goals.

This Strategic Plan Update is meant to be a living, flexible document, and should be viewed as a starting point, not an ending place. Additional opportunities for improvement are likely to present themselves as implementation gets underway, and the District will adjust to explore those opportunities. Likewise, some of the initiatives presented here may not be able to be implemented as initially envisioned, requiring subsequent adjustments. Key to success will be ongoing and frequent communication between District management, staff, and the Board of Health, so that all understand and can proceed together on the best path forward. The District is fully committed to this comprehensive level of communication and engagement.

Each initiative is accompanied by a rationale for its implementation and the anticipated benefits it will deliver. An "issues to be addressed" section highlights the key questions that must be answered prior to further action. Examples where these types of initiatives have worked well in other communities are cited, and each initiative is also supported by a clear set of action steps, key deliverables and milestones.

Key Elements of 2009 Strategic Plan

In 2009 the Snohomish Health District undertook an extensive strategic planning process that engaged local leaders and representatives of more than 80 organizations, and resulted in five broad goals and seven strategic directions. The 2009 Strategic Plan has guided decision-making and financial investment during a time of diminishing resources and a changing public health landscape. All of the Strategic Initiatives introduced in this Plan Update relate back to one or more of the goals highlighted in the 2009 plan, as demonstrated in the charts in the Appendix to this Update.

Moreover, the mission statement and vision statements from the 2009 Plan remain the same:

Snohomish Health District Mission Statement:

To improve the health of individuals, families, and communities through disease prevention, health promotion, and protection from environmental threats.

Since 2009, a number of major national developments have dramatically altered the landscape for local public health.

2009 Strategic Plan Vision Statement:

In 2020, Snohomish County will be the healthiest community in Washington State and its residents will aspire to lead still healthier lives. Snohomish Health District will play a critical role in improving the health of the community by preventing illness and injury through:

- *Protecting the public's health*
- *Demonstrating leadership*
- *Offering partnership*
- *Providing value*
- *Education and promotion*

These elements and themes continue to be core to the agency, and this 2014 Update is grounded in the principles that were developed and agreed to in 2009.

Background and Context

Although the 2009 Strategic Plan has served the agency well, this Update is necessary for a number of reasons, beginning with the fact that many new realities have developed since 2009, including:

- The nation's deepest and most prolonged economic downturn since the Great Depression.
- A more than $10 billion dollar decline in Washington State revenues and more than 11% unemployment in Snohomish County.
- A decrease in financial support to SHD of over $6 million, resulting in loss of 80 full-time positions (more than 30% of the District's workforce).
- Transfer of the Nurse-Family Partnership program to Child Strive, and elimination of the STD Clinic, First Steps Home Visiting, Child Care Health, Injury Prevention, Foster Care Passport, Unintended Pregnancy Prevention and AIDS case management programs, as well as deep reductions to the Immunization Clinic and other programs.

In preparation for 2015 budget preparations, State agencies have been tasked with identifying how they would reduce state general fund dollars by 15%. If implemented, this would equate to a reduction of $120 million to the State Department of Health, which is sure to impact local health jurisdictions. Locally, Snohomish County departments supported by state general fund dollars have been directed to identify and prioritize 6% in reductions. Should the Health District be directed to make such a reduction, approximately $132,000 of annual funding would be in jeopardy. Moving forward the District faces ongoing structural deficits. Annual expenditures are expected to continue to outpace revenues by 3-5%.

Our future challenges include an increasing and aging population for which chronic diseases pose the greatest threat, and the emergence or return of communicable diseases, including pandemic influenza and pertussis.

Since 2009, a number of major national developments have dramatically altered the landscape for local public health. Although health care reform had been underway for a number of years, the 2012 passage of the Affordable Care Act offers new and greatly improved access to comprehensive medical services, changing some of the traditional roles provided by public health. Greater emphasis is also being placed on the need for local public health agencies to become nationally accredited.

The State of Washington has also been at the forefront of policy shifts in public health, and the Strategic Initiatives outlined in this plan fall within the context of those statewide developments. Two of these are the Agenda for Change and the framing of Foundational Public Health Services, which define public health capabilities and programs that no community should be without, regardless of how the services are provided. The table demonstrating how the eight Strategic Initiatives fit within these foundational services is included in the Appendix to this Update. Representatives from the Snohomish Health District have actively participated in these statewide efforts, and continue to monitor and refine the overall work of the District to ensure that local efforts are in concert with these broader statewide goals.

Other Washington State actions of note are the State Health Care Innovation Plan that recognizes the need for community-based efforts to improve health, as well as a general focus on transitioning from individual to population-based health and a greater emphasis on prevention over treatment.

In recognition of these national and state developments and Health District financial challenges, the District has already begun to institute some reforms. These are noted throughout the Strategic Initiatives. For example, consulting resources have been used to evaluate current business systems; the possibility of third-party billing for immunizations and TB clinical services is being pursued; community health assessments have been completed and a community health improvement plan developed. All of these are informative and have been incorporated into the Strategic Initiatives. But the Initiatives take these current actions to another level, and represent a comprehensive, concerted effort to institute the deep and systematic changes that are needed at this time in the Health District's history.

Who Participated?

This Strategic Plan Update was instigated by Health District Director Dr. Gary Goldbaum, MD, MPH, and Deputy Director Peter Mayer. The District's division directors participated in an initial brainstorming of strategic concepts to explore in this process, as did the District Board of Health. Personnel from throughout the District participated in this brainstorming by attending their own listening sessions and were also invited to submit email comments during the brainstorming phase. Three facilitated sessions were offered at the Lynnwood and Everett offices; approximately 85 staff members attended these sessions.

In conducting the listening sessions, the consultant team focused on two primary questions:

1) *What services and programs should the District provide that are not the responsibility of others?*

2) *In light of the expansion of coverage resulting from health care reform, fluctuations in public health funding, and movements at the state and national levels to define Foundational Public Health Services:*
   - *What services and programs should be transitioned from the District's realm of responsibility?*
   - *How can those transitions be carried out as effectively as possible?*
   - *What new or enhanced capacity might be required in order to address new and emerging health issues?*

A number of potential ideas were generated during these sessions. The senior leaders of the District reviewed all of the proposed ideas and refined them into the eight Strategic Initiatives that serve as the core component of this Update.

A Substantial Outline and subsequent Draft Strategic Plan Update were then made available for additional review and comment. The Division Directors weighed in with their opinions and guidance on these two documents, as did the Board of Health at their April 8 and May 13, 2014 meetings.

Health District employees commented on the Draft Plan during a second round of listening sessions on May 28-29, and were also invited to submit email comments on the Draft. Some 65 staff members attended these sessions. The focus of these meetings was on a review of the Draft Plan, with the question to employees: How can we make this Draft Strategic Plan Update a better document? What are your recommendations for edits and changes?

Staff members offered a number of suggestions for changes to the document, and the final plan was modified where possible to address those comments.

Stakeholders were also consulted throughout this planning process. The Public Health Advisory Council weighed in on the Update during three of their monthly meetings on March 26, April 23, and May 28, 2014. An email was sent to 30 Health District partners and other stakeholders soliciting comments on the draft, with three stakeholders responding to that invitation. In addition, nine Health District partners were interviewed regarding their opinions, perspectives, and suggestions on the Draft. The final plan benefited from the input provided by these District stakeholders.

The Board of Health was briefed on the results of the listening sessions and interviews at its June 10, 2014 meeting. Reports on the employee listening sessions and stakeholder feedback are available as a supplement to this Update.

Health District Staff Involvement in Plan Implementation

It is important to note that Health District personnel will continue to be significantly engaged in the implementation of these initiatives. This is a key and crucial component to the success of the eight initiatives outlined here. Through their day-to-day experiences, employees are often in the best position to evaluate issues and offer practical and workable recommendations for change. In addition, it is through ongoing responsibility for implementation that personnel are likely to develop a sense of ownership and pride in making organizational and operational improvements.

Other goals for the implementation of the Update include an increase in communication and collaboration between the various divisions of the District. The current organizational structure can inhibit these interactions, with personnel tending to work only within their defined areas of responsibility. District leadership hopes to encourage new bridge building and professional development opportunities as staff exerts their energies and expertise in new directions.

Health District personnel will continue to be significantly engaged in the implementation of these initiatives

The exact mechanisms for implementation will vary depending on the initiative. In some cases "teams" may be assigned to work on a short-term basis to carry out essential tasks. Other initiatives already have work underway, so staff may be assigned in different ways to carry out new programs or recommendations. As noted throughout the report, the Division Directors will take the lead in determining the structure, mechanism and format for the initiatives under their purview.

Cost to Implement this Strategic Plan Update

It is difficult to determine, at this point, the precise cost of implementing this Update. While a number of the Strategic Initiatives are likely to result in significant cost savings, calculating the full magnitude of those savings is part of this work. This is particularly relevant for Initiatives 1, 2 and 5, with the timeline and anticipated study results explained in the initiative text.

In addition, it is anticipated that outside resources and assistance will be required to support the agency's implementation of this plan, including assessing readiness of community partners, securing written agreements, and developing an implementation framework to assure adequate support of the work teams for each initiative.

Other initiatives may require investments in order to achieve cost savings; spending money to make money. This is particularly true for Strategic Initiatives 2, 6, and 7, where the District is likely to make significant investments in new technologies and software in order to be more efficient and improve customer service over the long-term.

Some of the initiatives may increase costs that must be offset by savings in other areas. District management does not know yet, for example, the costs to co-locate personnel in other agencies (Initiative 3), or how many staff members may be needed to implement Initiative 4, which deploys new community health teams throughout the County. Additionally, many services the District provides are reimbursed by grants and contracts that may offset total costs while other programs are subsidized by fees, charges or the General Fund. As the District moves through the process of implementing these changes we will keep the Board of Health fully informed about what we are learning and where those results might lead.

It is also significant to note that a number of the initiatives are timed to coincide with the 2016 budget process. As SHD works in 2015 to develop transition plans and other mechanisms for change, we will be able to more precisely identify anticipated costs and present those to the Board. Where possible, any needs for the 2015 budget will also be identified, so that District management can bring them forward for discussion by the Board during budgetary deliberations in July of this year.

Ongoing Reports to the Board of Health

In addition to the budgetary discussions highlighted above, the Board of Health will receive regular reports on the implementation of the Strategic Plan Update. Each initiative has at least one or two key milestones that will be reported to the Board, but in addition to those milestones, the Board will receive ongoing information related to the tasks and actions underway, the results of any analysis related to the Initiative, hurdles or roadblocks that have been encountered, progress and new information relevant to each initiative's success.

These reports will follow a consistent format, making it as easy as possible for Board members to keep track of the implementation process. The form that will be used for these reports is included in the Appendix of the Update.

Next Steps

The 2014 Strategic Plan Update is a living document. The eight Strategic Initiatives are works in progress that require the ongoing engagement and attention of the District Board of Health, Senior Management, division directors, and staff. Progress reports and new developments will be communicated to all on an ongoing basis.

In addition, formal check-ins on the progress of the initiatives will occur every six months through June 2016. These will be conducted internally with the District personnel who have been assigned implementation duties. The check-ins, which will be mandatory to success, will include troubleshooting, fine-tuning, and adjusting initiative implementation as needed.

Summary of Initiatives and Key Milestones

STRATEGIC INITIATIVES

		December 2014	January 2015	June 2015	January 2016	December 2016
1	**Move Patients into Medical Homes**	Viable Partners Identified		Transition Planning Completed	Transition of Services Begins	Monitor, Assess, Update and Adjust
2	**Improve Environmental Health Business Practices**	Pilot testing of remote technology and mobile operations completed	EH Staff operating remotely from mobile locations; RFP Issued for New Technology; Services Transition Planning Underway	New Technology Implemented; Plan for Transition of Services Complete	Transition of Services Begins; Technology improvements continue	Monitor, Assess, Update and Adjust
3	**Optimize Delivery of Early Childhood Development Programs**	Viable Partners/ Locations Identified; Grant Funded Pilot Proposal Submitted	Transition Planning Underway	Transition Plan Complete	Transition Begins	Monitor, Assess, Update and Adjust
4	**Mobilize Community Health Action Teams**		Healthy Communities Action Planning Underway	Healthy Communities Action Plan Complete;Budget Presentation to Board	Begin Implementing Healthy Communities Action Plan	Monitor, Assess, Update and Adjust
5	**Reduce Administrative Overhead Costs**	Consultant Reports Presented	Transition Planning Underway	Transition Plans Completed	Transitions Begin	Monitor, Assess, Update and Adjust
6	**Institute Workforce Development and Succession Planning**	Workforce Development Plan Presented	Begin Implementing Workforce Development Plan	Workforce Development Update and Budget Presentation to Board	Implementation Underway; Monitor, Assess, Update and Adjust	Implementation Underway; Monitor, Assess, Update and Adjust
7	**Improve Health District Funding and Governance**	Evaluation Scope and Process Determined	Evaluation Begins	Evaluation Completed and Presented to Board	Actions Underway	Monitor, Assess, Update and Adjust
8	**Become Nationally Accredited and Integrate Quality Improvement Principles**	Accreditation Preparation Plan Complete; QI Council Reconvened	Accreditation Preparations Underway; Revise QI Plan	Accreditation Notice of Intent Submitted; QI Plan Implementation Underway	Accreditation Preparations Underway; QI Plan Implementation Underway	Accreditation Awarded; QI Plan Implementation Underway

SECTION TWO: 2014 Strategic Initiatives

STRATEGIC INITIATIVE 1: Move Patients out of SHD Clinics and into Medical Homes

Assuring access to healthcare and linking people to needed personal health services is a core public health function. Public health agencies should generally provide healthcare only when it is unavailable elsewhere. Over the years the Snohomish Health District assumed the role of clinical patient service for such things as immunization and HIV/STD/Pregnancy testing because providers in the community were not willing or available. Today the delivery of clinical services in Snohomish County has changed. For instance, immunizations are widely available throughout the community. Moreover, Medicaid expansion and the availability of community health centers represent the promise that more adults and children will be seen in community-based "medical homes." In Snohomish County those are the Federally Qualified Health Centers of SeaMar and the Community Health Center of Snohomish County. The mission and responsibility of these organizations is to provide care to everyone, regardless of ability to pay. The medical homes provided by organizations such as these, in combination with the services of private providers, are designed to provide more comprehensive preventive and treatment services within a clinical setting and result in better health outcomes for patients and their families.

This trend presents an opportunity for the District to rethink our role in providing clinical services. Should we continue to offer piecemeal clinical services to small numbers of patients?

This trend presents an opportunity for SHD to rethink its role in providing clinical services. Should we continue to offer piecemeal clinical services to small numbers of patients? Are there sufficient, competent community providers willing to provide these services in a more comprehensive setting? Is this the right time to move clinic patients into medical homes in the community?

Transitioning out of providing certain one-to-one patient services would allow the District to shift attention to other important functions that only public health can provide: informing, educating, and empowering people about health issues; mobilizing community partnerships to identify, prevent, and solve health problems; linking people with needed personal healthcare; and assuring a competent public health and personal healthcare workforce.

Under this initiative, the District will continue to examine its direct service role in clinical services, including but not limited to immunizations, HIV/STD, and TB treatment, with the aim of 1) assuring the competency, availability, and willingness of community-based providers, 2) defining SHD's ongoing role in assuring the quality and availability of services, and 3) connecting patients to needed health care.

Snohomish Health District began looking critically at its clinical services in 2013. Demand for pregnancy testing dropped dramatically due to a change in Medicaid requirements. The District also looked critically at State grant requirements around HIV testing, and now only provides HIV testing to the highest risk groups. By limiting the District's services, and referring low- and moderate-risk people to a community partner that also receives state funding, we are able to recover the cost of staff time and supplies without jeopardizing infection control.

An initial step in assessing clinical services was completed in June 2014. A business management consultant evaluated clinical business processes to determine, among other things, the feasibility of third party billing of insurance, meaning that our current

clients would be asked to pay a portion of the clinical services they receive from the District, and that the District would also bill their insurance providers, if that insurance is in place.

Although the study indicated some possibility of recovering fees through third-party billing, the analysis also demonstrated that the immunization clinic is only operating at 50% of capacity. This seems to indicate that, as predicted, those who need these services are already finding them elsewhere. In order to more adequately recover the costs of the immunization program, in particular, the District would need to actively seek additional patients, a move that runs counter to efforts to connect clients to medical homes.

The consultant team also identified operational changes to the Tuberculosis Program that could increase revenue, reduce expenses, and improve employee satisfaction. These recommendations will inform implementation plans and be incorporated into the 2015 budget process, with the longer-term goal of potential transitions away from a number of clinical services by 2016.

Rationale and Anticipated Benefits

The cost to provide immunization services in the Health District exceeds the per-patient cost in other community settings. It is also likely that patients would be better served in clinics that have adopted the medical home model, where patients' other health issues will be identified and treated. To the extent unrestricted or flexible funds are subsidizing these services, monetary savings resulting from this initiative can be redirected to responsibilities that are unique to public health.

In 2013, Health District staff immunized 4,600 people, or less than .05% of Snohomish County's more than 733,000 residents. Immunizations for the vast majority of County residents were provided in other community settings, including medical offices, community health centers, and pharmacies. SHD estimates that approximately 50% of our immunization patients are covered by insurance. However we don't currently have a systematic way of billing insurance companies directly. Moreover, a business process study suggests limited potential of third party billing to recover additional revenue to support immunizations.

Assuring TB treatment and control is a public health responsibility. However, the District is looking at innovations in the ongoing monitoring of patient treatment that may allow us to more fully engage community providers, take advantage of technology, and also recover some costs when patients have insurance. In 2013, District staff supervised 44 people with active, contagious tuberculosis, and treated another 80 people who were infected but not contagious.

Efficiencies have already been adopted in the following areas:

- The Health District provided 50 pregnancy tests in 2013, however clients are no longer required to have this diagnosis in order to obtain medical coupons. Demand for pregnancy testing has dwindled, and this service has been phased out.

- The Health District provided 443 HIV tests in 2013, 152 of which were "high risk" and reimbursed through our State grant. The State also provides grant funds to our community-based partner, Evergreen Wellness, to provide testing for low- and moderate-risk patients. By limiting District services to the high-risk groups for which SHD receives funding, and referring others to Evergreen Wellness, we are now capturing 100% of the cost for staff and supplies. Staffing levels and assignments continue to be evaluated as staff vacancies occur.

Successful Examples in Other Communities

A number of public health agencies in Washington State have transitioned categorical immunization services out of the health department to other community settings, including Tacoma-Pierce, Seattle-King, Spokane, Thurston, Mason, and Grays Harbor Counties.

Throughout the nation, public health agencies are providing guidance and supervision for Direct Observe Therapy (DOT) to other community settings, including community clinics, community health workers, home care agencies, treatment centers, schools and employers.

Clark County is using devices such as iPads with select TB patients to assure that patients complete their course of treatment. This approach has been effective for patients who travel or prefer to take their medicines at night, allowing public health staff to observe and assure follow through without being onsite with the patient.

Issues to Be Addressed Prior to Implementation

- The Health District and the Board of Health must be satisfied that there are adequate immunization providers, and that services are widely available throughout the County.
- Assuring communicable disease control is a fundamental public health responsibility. However, depending on the severity and complexity of cases, the Health District may be able to transition some patients to private providers or supervise their treatment via video technology.
- SHD and the Board must be satisfied that transitioning direct patient supervision to private providers or the use of technology does not have the unintended consequence of increasing infectious disease rates.
- Because of the District's ongoing responsibility to oversee childhood vaccines through Washington's childhood vaccine program, we have a highly effective quality assurance program for the distribution, proper storage, and proper administration of childhood vaccines. This program includes ongoing contact and professional education with immunization providers throughout Snohomish County. This quality assurance program can be expanded to ensure that private providers, clinics and pharmacies are willing and able to 1) assume our clinic patients, and 2) follow guidelines and protocols.
- Current SHD clinic patients must be connected to services that are both accessible and affordable.
- As the agency's workforce needs change, consideration must be given to implications on District staff, including collaboration with the District's collective bargaining units, honoring labor agreements, and aligning changes with the agency's Workforce Development and Succession planning efforts.

Action Steps and Key Milestones

June 2014-December 2014: Consultant Report on Third Party Billing

Develop plans for implementing the study recommendations regarding billing practices and operational improvements and reflect resources needed as part of the 2015 budget process.

December 2014: Identify and Develop Partnerships

As noted, it is critically important that the Health District have able, willing, and competent partners to carry out these services. Work will begin in July 2014 to recruit new partners to provide clinical services. Dedicated personnel will begin developing these relationships. Tools such as financial incentives or the co-location of SHD staff in these organizations for a period of time will be explored with these potential partners. By December 2014, the District will have a list of those agencies, organizations, and businesses that are capable of, and willing to, assume patients that previously relied on the Health District for these services. The Board of Health will receive a report on these potential partners and the next steps in solidifying agreements with them.

June 2015: Present Transition Plans to the Board of Health

Provided that viable partners can be recruited, District staff will develop transition plans for both the immunization and TB programs. These plans will include quality assurance programs to ensure that providers are willing to assume the care of current SHD patients and are able to provide the quality, access, and timeliness required to be effective players in infectious disease control. The plans will also outline how and when patients will be transitioned to community providers. And, the plans will include a system of agreement between the District and its various partners, for example, "Memorandums of Agreement" that would specify how services would be carried out, the system for quality assurance, and other elements of the new partnerships.

The TB transition plan will also include a set of criteria for determining the profile of patients that must continue to be managed by the Health District, as well as the profile of patients who can safely be monitored electronically or by community providers. An ongoing quality assurance and professional education program will also be developed to assure adequate training and supervision of community providers, as well as a staffing plan that assures community-wide infection control.

SHD will also develop a strategy for professional growth and development plans for SHD staff whose jobs involve direct patient service, and a detailed transition plan for how those jobs will change.

These plans will be submitted to the Board of Health by June 2015 in order to inform the 2016 budget. If the Board approves of these plans, the Health District will move forward with the transition of these services to qualified community providers.

January 2016: Begin Transition of Services

Provided the Board lends its approval, transition of immunization services and TB testing and treatment to community partners will begin in January 2016. It is anticipated that these transitions will take place over a one-year period, with the goal of complete transition by January 2017.

Assignments of Accountability

As Division Director, Nancy Furness has the primary responsibility to implement this Strategic Initiative.

TIMELINE

STRATEGIC INITIATIVE 2: Improve Environmental Health Business Practices

The Health District proposes to conduct a quality improvement process to analyze business practices in the Environmental Health Division. Our goal is to 1) identify technology solutions that make it easier to do business with us online, 2) identify ways to more efficiently deploy staff, and 3) identify and resolve areas of overlapping responsibility with other state and local environmental, planning, and public works agencies.

This year, the Health District initiated a comprehensive review of the information systems that currently support Environmental Health operations. That review is on track. We anticipate that it will result in revisions and, where necessary, elimination of redundant EH-related business processes, policies and procedures. The goal is to improve efficiency and effectiveness, reduce processing times, costs, and variability, and enable exceptional customer/client service whether on-site, over-the-counter or on-line. In the future SHD envisions that the majority of EH-related work will be conducted, accessed, and managed electronically; staff will be sufficiently trained and supported and provided with appropriate data and communication tools.

While laws and regulations dictate what the District must do, it is important to ensure that services are delivered in ways that provide the greatest value to the public.

In addition to this effort, the District will continue to pursue business practices that can ensure improved customer service, workforce efficiencies, and reduce costs. Two actions in this regard include an overhaul of the way in which Environmental Health staff are deployed in the field, and a review of programs and services that may overlap with other regulatory agencies at the state and local levels, including Snohomish County agencies. An exploration of common areas of responsibilities between Snohomish County and the Health District was initiated in 2010. A renewed and expanded commitment is planned. Where overlaps occur with County functions, the District will consider a number of options to create greater efficiencies. For example, District staff might be co-located in other County offices, continuing to provide Health District expertise and rigor on permit review, and also working alongside staff who are also performing permitting duties. Of particular interest is the current use of District staff in processing septic and drainfield plans associated with single-family residential construction, review and permitting of interior remodels of schools, and permitting of food service establishments. Another option may include the transfer of these services away from the Health District to other county agencies.

While these are three major action steps on the road to improvement, the overarching goal of this Initiative is to ensure that Environmental Health service delivery is evaluated on a continual basis to ensure the best possible customer service and the greatest level of staff efficiency.

Rationale and Anticipated Benefits

Most environmental health services are mandated by law and supported by fees. While laws and regulations dictate what the District must do, it is important to ensure that services are delivered in ways that provide the greatest value to the public and as efficiently as possible to control increases in rates and fees.

This continual improvement initiative is likely to result in a myriad of benefits, including but not limited to:

- Online application and payment systems for permits and fees. This will make it easier, and potentially faster, for the business community and the public to work with the Health District.
- Environmental Health inspectors reporting to their inspection sites directly from home, rather than coming first to a Health District office. This will greatly reduce staff drive time, creating substantially greater monetary efficiencies and environmental benefits.
- Some of the services currently provided by the Health District at District offices in Everett could potentially be provided by Health District staff at other locations. Additionally, some SHD services could, instead, be provided by other regulatory or public agencies. The goal of any such efforts is to achieve greater government efficiency and improved customer service. The District will actively identify and implement opportunities to streamline permit application, review, issuance and inspection processes with Snohomish County Planning and Development Services (PDS), and Snohomish County Public Works (PW). This could include co-location of staff, aligning all reviews, inspections and permits around a single product line, coordinating simultaneous site inspections, and expanding over-the-counter and on-line permit types.

Successful Examples in Other Communities

As building and development activities have ebbed and flowed in communities across the State of Washington, the drive for increased economic development has spurred local officials to find efficiencies in the planning and development process. This typically relates to reforms in regulations, codes, permit review and issuance processes, and adjustments to fees and charges, including waivers or "fee holidays." Clark County Community Development as well as Snohomish County's Planning and Community Development Services have implemented a number of process improvements over the past several years, including reducing permit review and issuance time, controlling fee increases, and expanding the permit types made available on-line and over-the-counter.

Issues to Be Addressed Prior to Implementation

SHD and the Board must be assured that:

- The expense of moving business functions online will save time and money, and result in improved customer service. Given the technological magnitude of the proposed information system improvements, it is also important to be as thorough and cautious as possible in selecting the vendor and software designed to result in process improvements.
- As the agency's workforce needs change, consideration must be given to implications on District staff, including collaboration with the District's collective bargaining units, honoring labor agreements, and aligning changes with the agency's Workforce Development and Succession planning efforts.
- Transitions of current Health District Environmental Health programs must occur with capable and willing partners, and must include a quality assurance program to make certain that these services are being implemented with adequate thoroughness and care.

Action Steps and Key Milestones

December 2014: Pilot Testing of Staff Mobility Completed

The District is currently conducting a pilot test of direct mobility between EH Sanitarians and their respective inspection sites. This testing will be complete by December 2014.

January 2015: RFP for New Information Systems Technology/Sanitarians Operating with Greater Mobility

By January 2015, the District will issue an RFP for a new software provider, a first step in instituting the improvements that have been identified through the comprehensive evaluation currently being conducted. The Board will be briefed on this evaluation.

Provided the pilot testing proves effective, Environmental Health staff will begin reporting to their inspection sites directly from their homes, starting in January 2015.

June 2015: Technology Improvements Installed/Review of Service Locations Complete

Testing of the new software will take place during the first six months of 2015. The goal is for the system to be up and running with the public by June 2015, with enhancements continuing through 2015 and into 2016.

The Health District's review of all current Environmental Health services will be substantially completed by June 2015. This review will include recommendations on services that should be relocated or transferred to other agencies, the strategies and benefits for doing so, and implications with such a move. The District will provide a report and series of recommendations to the Board of Health, who can then act on these recommendations in time for the 2016 budget.

Assignments of Accountability

As Division Director, Randy Darst has the primary responsibility to implement this Strategic Initiative. Geoffrey Crofoot is the project manager for the information systems technology components of this initiative.

TIMELINE

DECEMBER 2014

- Pilot Testing of Sanitarian Mobility

JANUARY 2015

- EH Sanitarians Operating with Greater Flexibility
- RFP Issued for New Technology
- Transition Planning Underway

JUNE 2015

- New Technology Implementation Begins
- Plan for Co-location and/or Transfer of Services Substantially Complete and Presented

JANUARY 2016

- Transition Begins
- Technology Improvements Continue

STRATEGIC INITIATIVE 3: Optimize Delivery of Early Childhood Development Programs

The years from birth to five are prime prevention years for children and their families. Behaviors practiced from pre-conception through kindergarten can have lifelong health consequences. The Adverse Childhood Experiences study (see reference in Appendix) concluded that traumas experienced in childhood are major risk factors for the leading causes of illness and death, including substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature death.

The Health District proposes to explore how our programs and services aimed at this life stage can best be coordinated, managed and delivered in order to maximize our contribution toward prevention.

Rationale and Anticipated Benefits

We can't be effective early childhood partners if we remain inside our offices and wait for people to come to us.

Programs aimed at pre-conception to five years of age have been shown to positively impact lifelong health. Some of the benefits of investing in such programs include:

- Improvement in infant survival and health
- Identification of child maltreatment risk facts and intervention with families to prevent child abuse or neglect from becoming chronic and leading to injury or out-of-home placement
- Establishment of medical homes for health care and family support
- Improved nutrition for optimal fetal and child growth and development

The District's Community Health Improvement priorities around youth physical abuse, obesity and suicide also have their roots in early childhood. Acknowledging that we are operating with limited resources, and recognizing that our staff members want to increase interaction with community partners and take services where they are most needed, SHD will examine whether doing our work differently could result in a more effective service delivery network and result in a bigger impact on early childhood development.

Persistent budget reductions have chipped away at the District's capacity to deliver parent and child health programs. While we retain some ability to deliver nutrition, early intervention, and maternity support through WIC, First Steps, and other parent and child health programs, budget reductions have forced SHD to eliminate several programs, including those related to unintended pregnancy prevention, foster care, child care, housing support, and First Steps home visiting. We have also scaled back on oral health services, and transitioned the Nurse/Family Partnership program out of the Health District to a community-based organization.

In keeping with state guidance for the Maternal-Child Health (MCH) Block grant funding, District staff has completed a needs assessment for maternal-child health. SHD proposes to use this data and information to more finely focus efforts to strengthen the systems and networks that deliver services to the County's most vulnerable children. In addition, the District's maternal-child health assessment revealed the need to spend more time out in communities, co-located in organizations that serve vulnerable clients

where they live, work, and attend school. We can't be effective early childhood partners if we remain inside our offices and wait for people to come to us. District personnel need to be out in communities collaborating with others to strengthen the early childhood network of care. Our commitment to community health improvement priorities relies upon our ability to mobilize multiple agencies and sectors, and work as partners with other community organizations.

The Health District is developing a grant proposal to better coordinate and deliver services to families and children under age three in south Snohomish County. This effort involves mobilizing multiple health and social service agencies and a faith-based organization. SHD is utilizing zip code data to highlight south county areas of greatest need.

Another example of rethinking the District's service delivery model is our decision to take First Steps services to parents receiving mental health and chemical dependency services under the county's 1/10th of 1% tax for mental health, chemical dependency, and therapeutic courts.

Examples of Success in Other Communities

Public health agencies throughout Washington State are combining their services with others to meet clients where they live and gather, including public housing communities, community health centers, and Head Start programs. For example, At Spokane Regional Health District, the Neighborhoods Matter project connects neighbors and strengthens communities by addressing the root causes of health issues. It is a targeted community driven, community-based approach to reduce the health disparities impacting maternal, child and family health. Neighborhoods Matter focuses on the strengths of a community, particularly the commitment of its residents and their knowledge of their issues and concerns.

The Tacoma-Pierce County Health Department has established Family Support Centers in almost every area of Pierce County. Each Center helps families with health, education and social resources, including healthy pregnancy, infant and child development, parenting skills and children with special health care needs.

Issues to Be Addressed Prior to Implementation

SHD and the Board of Health must be satisfied that:

- Clear benefits will be achieved by co-locating SHD personnel with partners that share our goals.
- The educational and health care needs of parents and children from birth to five will be better served.

Action Steps and Key Milestones

December 2014: Potential Partners/Locations Identified

By December 2014, the Health District will identify a set of potential partners/locations with which Health District staff could be working more closely. This set will be accompanied by a series of recommendations regarding where SHD personnel can best contribute time and resources to strengthen the system of care for vulnerable children. In developing these recommendations, staff will draw on the data and information collected for the maternal-child health needs assessment and the Community Health Assessment to identify priority needs and potential partner organizations, as well as sites where staff

could conduct their work. Consideration of the impact on service delivery will also be noted, and will include the Health District's Women, Infant Children (WIC), First Steps, and Children with Special Health Care Needs services.

October 2014: Grant Funded Pilot Testing Proposal Submitted

As noted earlier, the District has applied for grant funding to better coordinate and deliver services to families and children under age 3. If successful in procuring the grant, we will begin a pilot project in 2015, with the results of this effort helping to inform this strategic initiative. If we are not successful in procuring the grant, we will review other options for implementation of this initiative.

June 2015: Transition Plan Completed

Provided that the new partners/locations prove viable, the Health District will develop a transition plan identifying how and where staff will be relocated. This plan will include Memorandums of Agreement with our new partners, clear action steps and a timetable for the transition, and a strategy for professional growth and development plans for SHD staff whose jobs will change. This plan will be presented to the Board of Health in June 2015, in time to fully inform and adjust the 2016 budget.

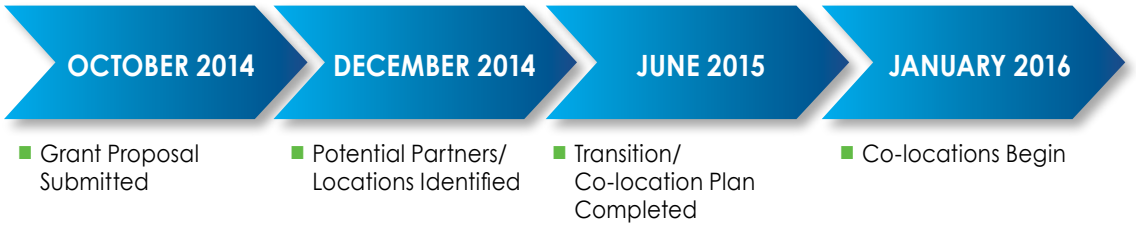
January 2016: Transitions Begin

Provided the Board of Health approves the recommendations, the co-location of SHD staff into partnership organizations will begin in January 2016.

Assignments of Accountability

As Division Director, Charlene Shambach has primary responsibility to implement this Strategic Initiative.

TIMELINE



STRATEGIC INITIATIVE 4: Mobilize Community Health Action Teams

The leading causes of death in Snohomish County – cancer, heart disease, injury – can be traced to conditions in communities that can be changed. Barriers such as a lack of safe places for people to be physically active, poor access to healthy foods, and the proliferation of establishments selling fast food and tobacco are all contributing factors. Public health is uniquely qualified to inform and educate community leaders on policy, systems, and environmental changes that make it easier, more convenient, and more affordable for people to make healthy decisions.

The District's recently completed community health assessment and priority setting process involved multiple players throughout Snohomish County. As a result, the Community Health Improvement Plan (CHIP) includes three priority health issues - youth physical abuse, child and adult obesity, and suicide – that require a community-wide response. SHD's partners rely on us to identify best practice strategies for programs, systems, policies and environmental changes to impact the three priority areas.

Following the Collective Impact model (Stanford Innovation Review, Winter 2011) for bringing about social and health change, the Snohomish Health District is in the position to coordinate the efforts of a broad base of community partners to achieve larger-scale change than could be made through individual efforts. Collective impact requires five elements that strengthen community-based collaborations, leading to enhanced outcomes and impact. These are:

1) An established, common agenda
2) Shared measurement
3) Mutually-reinforcing activities
4) Continuous communication
5) Backbone support

SHD could take any number of actions to comprehensively support community health programs throughout the County. District staff may act as conveners, for example, in bringing together a range of expertise and personnel to address specific community health issues. Staff may be co-located in other agencies in order to lend their expertise to countywide planning or redevelopment efforts. Alternatively, District personnel could participate in shorter-term community health planning task forces as they are introduced in various locations. All of these possibilities, as well as others, will be explored under this initiative.

This work will be further guided by the Surgeon General's national prevention strategies to support active living, healthy eating, and injury and violence-free living:

- Encourage community design and development that supports physical activity.
- Facilitate access to safe, accessible, and affordable places for physical activity.
- Support workplace policies and programs that increase physical activity.
- Increase access to healthy and affordable foods and beverages in communities by implementing nutrition standard policies.
- Implement and strengthen policies and programs to enhance transportation safety.
- Support community and streetscape design that promotes safety and prevents injuries.

- Strengthen policies and programs to prevent violence.
- Provide individuals and families with the knowledge, skills, and tools to make safe choices that prevent violence and injuries.

Rationale and Anticipated Benefits

- Where you live and work determines your health. Research has shown that environmental and social factors play a significant role in the health of communities. People's habits improve when they have access to safe and convenient places to exercise, healthy food, non-smoking environments, and a decreased availability of tobacco.
- The District needs more than our current level of staffing to address the magnitude of chronic disease and injury in Snohomish County, as well as provide the leadership and support necessary to bring collective impact to bear. This initiative will help SHD determine appropriate levels of staffing for the future.
- Every year, Snohomish County, school districts, cities and towns make budget and policy decisions about things like sidewalks, parks, transportation, and the availability of healthy foods and smoke-free environments. These conditions in communities have a direct impact on the health of Snohomish County residents. Adding public health specialists to work with our local governments and schools will, over time, reduce chronic disease and injury rates by assuring that decisions around policies and systems contribute to healthier conditions.

Adding public health specialists to work with our local governments and schools will, over time, reduce our chronic disease and injury rates by assuring that decisions around policies and systems contribute to healthier conditions.

Successful Examples in Other Communities

The following public health agencies have addressed physical activity, nutrition, and obesity with the support of Community Transformation grants from the Washington State Department of Health and the Centers for Disease Control and Prevention: Tacoma-Pierce, Seattle-King, Grant, Spokane, Clark, Cowlitz, and Grays Harbor Counties.

Prior to budget and staff reductions, the Snohomish Health District had similar successes in mobilizing community agencies and partners in Lynnwood and Marysville to address priority health issues.

Issues to be Addressed Prior to Implementation

- In order to insure our efforts will make a measurable difference, SHD will use community health data, zip code data, community mapping, and the Community Health Improvement Priorities to assess the areas where our involvement can have the greatest impact.
- This work requires a long-term investment in order to be effective. Up to now, District efforts to prevent and control chronic disease have been supported by a patchwork of funding sources, including many short-term grants. This initiative requires that we look at all potential revenue sources and think creatively about how local and state funds can be blended to support healthier communities.
- Any plans for expanding the District's capacity to address chronic disease and injury should feature guidance for future decision making about how staff will be deployed, and flexibility so that as community needs and priorities change, District staff can be reassigned to respond to those changes.

Action Steps and Key Milestones

April 2015: Healthy Communities Action Plan

By April 2015, SHD will develop a Healthy Communities Action Plan that considers health inequities and describes 1) health problems to be addressed, 2) the unique contribution of public health (e.g. community health assessment, mobilization, partner development, evidence-based interventions), 3) areas of greatest opportunity (i.e. where our involvement can have the greatest impact), and 4) the sectors, communities, and zip code areas toward which our initial efforts will be directed. The Board of Health will be briefed on this plan.

During plan development, District staff will gather input from the six local health departments in Washington State that conducted Healthy Communities work with support from Community Transformation Grants from the state Department of Health and the Centers for Disease Control and Prevention. Their input will help determine what is required to build and sustain an ongoing healthy community presence.

June 2015: Budget Presentation on Healthy Communities Team

If feasible, the Health District will develop a budget and proposed funding sources for an expanded Healthy Communities team. This will be completed and presented to the Board by June 2015, in time for 2016 budget deliberations.

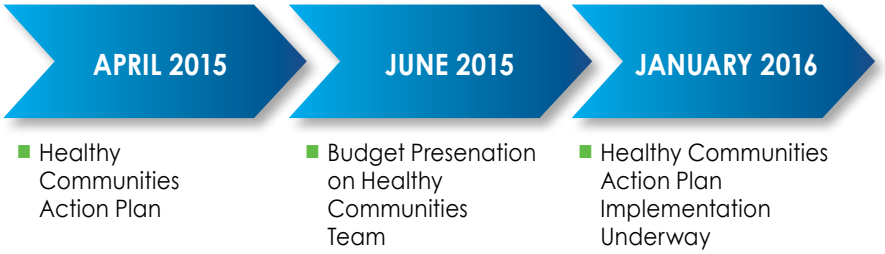
January 2016: Healthy Communities Action Plan Implemented

With Board approval, the Healthy Communities Action Plan will be implemented beginning in January 2016. This effort will benefit from ongoing reporting and evaluation to ensure that staff resources are being used as effectively and appropriately as possible. A reporting mechanism will be created that enables both Health District Leadership and the Board to stay abreast of accomplishments (e.g. health impact of community decisions in such areas as availability of healthy foods, mass transportation, walkability, no-smoking policies, smoking cessation support), and to continue to fine tune the program as it moves forward.

Assignments of Accountability

As Division Director, Charlene Shambach has primary responsibility to implement this Strategic Initiative.

TIMELINE



STRATEGIC INITIATIVE 5: Reduce Administrative Overhead Costs

The initiatives outlined in this Strategic Plan Update could have dramatic impacts on the overall workforce of the Snohomish Health District. As we begin to contemplate a transition away from clinical services, for example, and as we evaluate the potential for staff to be located in other community settings, it is prudent to thoroughly examine the District's current levels of administrative support and staffing throughout the entire agency. Improvements to business practices and processes, and greater use of technology will also redefine the quantity, nature and type of administrative support required. For instance, many tasks that were, in the past, completed by administrative support employees are now systematically processed, verified, and documented as part of new business software systems. Additionally, the physical realignment and combining of District offices and functions can reduce duplication in support staffing.

The District initiated two actions in support of this initiative in our 2014 budget.

In concert with the agency's Workforce Development and Succession planning efforts, the District will carefully assess how the proposed changes will alter the amount and type of administrative support needed. SHD will ensure that administrative skills, work processes and products produced are done at an appropriate quality and at a cost equal to or less than it would cost for outside vendors to complete the same work at equal quality. Such a review will assist us in determining which support functions are best provided in-house, and where competitive contracting may be the best strategy.

The types of administrative support functions that will be reviewed through this initiative include payroll, accounting/business services, purchasing, fleet and facilities management, human resources, information technology, communications, and general administrative/program support. These should be reviewed throughout the organization at both the division and district levels. What does the Health District of the future need in terms of these services and how best to align them? Could they be performed more effectively and efficiently in a consolidated customer service work area, performed by outside vendors or in some combination? What are the implications of such a move, and how might the District implement such changes?

The District initiated two actions in support of this initiative in our 2014 budget. The first was to develop an information technology strategic plan/gap analysis to guide us over the next 2-5 years in planning, procuring, implementing and managing the current and future technology investments and resources for both geographic and information services. This plan will help set the agency's direction over the next several years and objectively identify and assess the internal and external staff resources and various technology strategies to most effectively support the District's effort. This work is currently underway, assisted by external IT planning expertise.

A second action item is a Cost of Service and Allocation Study, also approved by the Board of Health for 2014 expenditures. The initiative includes the development of an indirect cost allocation plan, a method to determine and assign the cost of central services to the internal users of those services in a reasonable and equitable manner. Indirect costs are those costs incurred for common or joint purposes, benefiting more than one division or program and not readily assignable to a specific division or program. Examples include technology services, accounting, human resources, and facility and fleet operations and maintenance. The District has engaged outside expertise to

evaluate agency data, allocation and cost factors and financing strategies, and will develop customized financial models to calculate indirect costs and properly allocate them in compliance with regulatory requirements.

These are two important first steps in moving forward with this strategic initiative. Depending on the results of this work, the District could implement a variety of actions to make certain that administrative costs are truly commensurate with the needs of the District. Staff may be redeployed to other functions, for example, and/or some administrative functions could begin to be competitively contracted.

Rationale and Anticipated Benefits

- It may be possible to achieve significant monetary savings if these services are physically realigned, technology is leveraged to a greater extent, business practices and processes refined and competitive contracting explored.
- Staff may be redirected toward other priority work, and opportunities for greater cross training can occur.
- Efficiencies in business practices and processes will enable improved internal and external customer service and help control costs.
- Such efforts create value, cost savings, or at a minimum focus attention on comparable service costs. Using such methods as peer benchmarking (comparing the costs and quality of our services to those of similar agencies) also helps to ensure that industry-leading best management practices are fully utilized.
- Business competencies are a Foundational Public Health Capability. We can't be successful in preventing disease and promoting health if we are not competent in information technology, human resources, fiscal and contract management, facilities and operations, and communications. The question is how much support is needed, and whether some of this support can be procured more economically outside the District.

Successful Examples in Other Communities

Local governments throughout the State of Washington have carefully scrutinized and assessed opportunities for more flexible and efficient service delivery strategies, particularly associated with administrative and indirect support costs.

The City of Bellevue instituted a "Service First" initiative that dramatically realigned customer service support functions throughout the city. The philosophy is based on the assumption that customers shouldn't have to understand city business or how the city is organized to receive service. Services and information should be easy to access and customer needs should be addressed as simply as possible (one stop, one click, one call). A centralized "Service First Desk" was established to facilitate customer service across all city services.

The City of Vancouver reinvented their administrative support, reception and customer service related functions in preparation for a move into a new city hall facility that co-located the majority of all city services into one building. Support staffing needs were reassessed when more central reception and city service-related functions were located together, and multiple departments shared common workspace in open floor plan environments.

The City of Vancouver also engaged in competitive contracting, and has developed a "Competitive Contracting Handbook" that could be of assistance as the Health District undertakes this evaluation.

Issues to Be Addressed Prior to Implementation

- A transition of this magnitude cannot be implemented quickly. Care must be taken to thoroughly understand the benefits of the ways in which these services are currently provided throughout the District.
- Likewise, the implications of any such changes must be carefully determined. Monetary savings, in and of itself, will not be worth it if contracted or competitively managed services are not of adequate quality or are inefficient.
- Like any major reorganization, this transition will need to be phased in on a gradual basis in order to protect the integrity and function of the District as a whole.
- The District must be reassured that quality vendors are accessible and able to provide all of the services necessary should some administrative functions be procured externally.
- As the agency's workforce needs change, consideration must be given to implications for current staff, including collaboration with the District's collective bargaining units, honoring labor agreements, and aligning changes with the agency's Workforce Development and Succession planning efforts.

Action Steps and Key Milestones

December 2014: Consultant Reports Presented

The two consultant reports referenced earlier, which relate to the information technology gap analysis and indirect cost allocation plan, will be delivered to the District by of the end of the third quarter of 2014. These reports will be discussed with the Board of Health, and the recommendations from these reports will be used to guide the District in any subsequent staffing, financial and operational decisions.

June 2015: Transition Plans Presented

Based on the reports and Board discussions, planning for any staff transitions and independent contracting will take place during the first six months of 2015. The Board will be kept apprised of this effort and the completed plan will be presented to the Board in June 2015 to inform the Board's decision-making related to the 2016 budget.

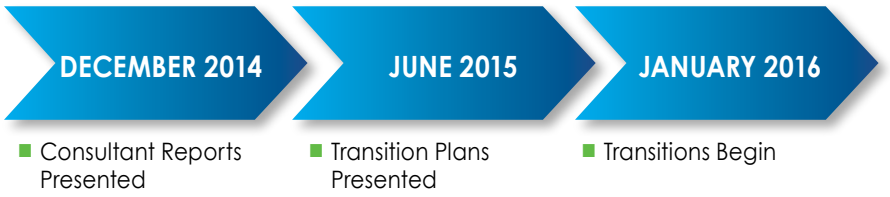
January 2016: Transitions Begin

Should they prove to be feasible, cost-effective and beneficial to the District as a whole, transitions to revised staffing levels and/or competitive contracting will begin in January 2016.

Assignments of Accountability

Deputy Director Pete Mayer will have primary responsibility to implement this Strategic Initiative.

TIMELINE



STRATEGIC INITIATIVE 6: Institute Workforce Development and Succession Planning

A major challenge facing the Health District – and across all sectors nationwide – is the pending retirement of the Baby Boom generation. A significant percentage of SHD's workforce will retire within the next five years, and replacements for many of these employees have not been identified. As the District rethinks how we deliver programs and services, new programs are developed and other services are transitioned out of the District, the skills and staffing levels needed to carry out our work will likely shift as well. We must also ensure that our current workforce remains supported, motivated, healthy and up to date on the latest public health innovations. The District is committed to helping our current staff achieve success.

Toward this end, the District will continue its efforts to enact a workforce development and succession plan to ensure adequate staffing levels, skills and needs well into the future. Workforce development planning was introduced to District management in mid-2013, with seven key goals presented at that time:

- Manage and reduce labor costs without negatively impacting productivity.
- Identify and prepare leaders and managers for future openings (succession planning).
- Fill vacancies in key roles immediately with capable talent.
- Maintain a flexible contingent workforce.
- Proactively move talent internally to maximize the return on talent.
- Target retention activities on current high performers.
- Increase the overall productivity of the workforce.

The District will continue to build on this initial effort, and has recently hired a new Human Resources Director, Teri Smith, who will provide leadership and motivation to complete and implement the Workforce Development plan.

As the District rethinks how we deliver programs and services, new programs are developed and other services are transitioned out of the District, the skills and staffing levels needed to carry out our work will likely shift as well.

Rationale and Anticipated Benefits

- A primary driver of such a plan is to stabilize the SHD workforce by avoiding staff lay-offs or panic hiring, and to ensure we have the right number of people with the right skills in the right places at the right time.
- Succession planning is necessary for any large organization and is certainly needed for the District given the significant number of impending retirements and loss of institutional knowledge.
- The opportunity to retain existing employees by offering well-defined career paths and opportunities for job enrichment and professional development will help minimize loss of institutional knowledge, and leverage experienced public health professionals.
- The identification and active development or recruitment of personnel with the skills needed to carry out the District's priorities will result in a workforce that is fully prepared to meet the challenges of the future.
- Current staff members have expressed a desire for more training and support, especially as the District begins its robust analysis of potential innovations. Revised training plans and exposure to these new developments will equip staff to be better informed and prepared to both suggest, and carry out, these innovations.

- Proactively communicating workforce needs for budgeting and operating performance purposes will minimize disruption and abrupt changes in course.
- Cost savings can be generated by planning for and reducing employee turnover.

Successful Examples in Other Communities

A number of organizations have implemented workforce development plans, including Spokane Regional Health District, Snohomish County Planning and Development Services, Clark County Public Health, and the City of San Francisco.

Issues to Be Addressed Prior to Implementation

- Although the District has a great deal of existing data on retirement eligibility and service credits, this information needs to be carefully evaluated and both short- and longer-term strategies developed to address these shifting personnel needs. Some vacancies may need to be filled immediately, while other positions may need to be redesigned and filled with people who bring differing skill sets necessary to meet new District job requirements.
- Some positions may be impossible to accurately describe until the District has completed some of the other Strategic Initiatives outlined in this document. For example, the results of Strategic Initiative 1, which calls for a transition away from clinic services, will significantly inform the creation of new job descriptions.
- Another important element of this review and ongoing work will be to determine the types of personnel and diverse skills sets needed to extend beyond previously narrowly scoped public health job descriptions and roles. We know that the workforce of the future will need to demonstrate both the ability and flexibility to work outside traditional programs and divisions and across multiple programs and divisions.
- Current staff members have expressed interest in enhanced training and broader exposure to new public health ideas and trends. A training "needs assessment" must be completed in order to ensure that employees are knowledgeable about Core Public Health Functions, Foundational Public Health Capabilities and Programs, national accreditation standards and other cutting edge public health trends. They want to be knowledgeable and prepared to fit into the public health agency of the future.

Action Steps and Key Milestones

December 2014: Workforce Development Plan Presented

By the end of this year, the workforce development planning effort begun in 2013 will be completed. The results of this planning work will be discussed with the Board of Health, including a series of recommendations on the next steps for human resources within the District. These are likely to include both short-term and longer-term action items.

March 2015: Workforce Development Update

Given the myriad of personnel decisions likely to be impacted by this initiative, it will be important to regularly update the Board, for example, as vacancies are filled, redefined or left open.

June 2015: Workforce Development Budget Presentation

As the workforce development work gets underway, the District will provide the Board of Health with a series of recommendations for the longer-term needs and directions for the District's workforce. This information will be provided in time to inform the Board on its 2016 budget deliberations, ensuring that all budgetary requirements can be fulfilled.

Assignments of Accountability

Deputy Director Pete Mayer will have primary responsibility for this Strategic Initiative.

TIMELINE

DECEMBER 2014
- Workforce Development Plan Presented

MARCH 2015
- Workforce Development Update

JUNE 2015
- Workforce Development Budget Presentation

JANUARY 2016
- Implementation Underway
- Monitor, Assess, Update and Adjust

STRATEGIC INITIATIVE 7: Improve Health District Funding and Governance

It is essential to look at potential funding and structure changes to Washington's governmental public health network. The lack of a dedicated, sustainable funding source for public health in Washington continues to be a significant concern. We have a public health funding and delivery system that was designed in and for the 20th century. It must be redesigned to meet 21st century demands.

Annual state general fund revenues, the most flexible funding source that the State Department of Health (DOH) can use to meet state needs, have decreased by approximately $18 billion over the past four years. During that same time period, population and service needs have increased. For DOH specifically, their allocation of state flexible dollars has decreased $95 million, or 38% since 2010. This decrease has impacted almost every state program. Federal funds continue to make up about half of the budget.

Locally and since 2008, the County's population has grown by 6%, while financial support for the District has dropped 24%. A reduction of approximately 80 full-time equivalents (FTES) occurred during this same period. In Washington State, Snohomish County ranks #30 among 35 local public health jurisdictions in terms of per capita health spending.

Our public health funding and delivery system was designed in and for the 20th century. It's time for a 21st century redesign.

The State has responded. The Public Health Improvement Partnership has been tasked by the Legislature to provide overall leadership and coordination of public health issues to improve and protect health across the State.

The Partnership is composed of representatives from tribal nations, local health agencies and boards of health, the State Board of Health and other state and federal agencies. In 2012, the Partnership adopted an Agenda for Change Action Plan to guide the transformation of the public health network in addressing the continuously changing economic and healthcare landscape. This action plan commits to the following three approaches:

- Strategically prioritize public health work to focus on preventing communicable disease and other health threats, fostering healthy communities and environments, and partnering with the healthcare system to improve the health of our communities;
- Develop a performance management and accountability mechanism which uses activities and services, indicators and standards to measure the performance of the public health system in the state;
- Ensure that every resident in Washington can access a foundational set of public health services, no matter where they live.

Foundational Public Health Services Policy and Technical Workgroups have been convening to define this uniform set of foundational public health services, and to provide information about the cost of providing these services. SHD Director and Health Officer Dr. Gary Goldbaum is participating on the Technical Work Group, which has been working to develop a reasonable estimate of what it would cost to provide a uniform level of foundational public health services statewide. Efforts are underway in aligning funding and service delivery models to support the foundational definition and ensure sustainable provision of these services long-term. Draft definitions for the foundational public health services were developed and vetted in 2012; a final report and recommendations is expected in December 2014. A link to this work is provided in the Appendix to this Update.

Locally, the Snohomish Health District receives funding from federal grants, Washington State's public health fund, and from Snohomish County. Currently, approximately $3.1 million, or 17 percent of the District's overall funding, is provided by the County. This appropriation is made on an annual basis and is determined by both public health needs and available public funds. Similar to DOH federal funding ratios, over half of the District's funding relies on state and federal support; this is a troubling scenario with the declines that continue to negatively impact these sources.

City residents benefit from SHD programs and services. In years past, cities within Snohomish County contributed funding to SHD but that funding has been eliminated. City representatives still serve on the Board of Health, with the result that they are providing governance and direction to an agency that they do not monetarily support.

In addition to an evaluation of funding, the District proposes to review the current governance structure and process the Board of Health uses to conduct its business. The initial Health District Charter was first crafted in 1959, with the most recent amendments made in 1997. The District would be doing itself a disservice without a fresh review and consideration of its governance structure, Board procedures, and sustainable District financing options.

The review will incorporate these types of questions: Is this system as effective as it might be? Is it equitable? What is the reasoning behind current governance, and what benefits does that structure provide? In contrast, are there other models that might be more effective in providing consistent, reliable, and equitable funding for public health programs and services. For example, might countywide options include a levy, utility or sales tax initiative? Likewise, might a different governance structure and set of authorities be more effective and equitable (e.g. new legislation enabling health districts to enact levies)? With or without a new governance structure, what is an appropriate and effective set of "Rules of Procedure" for the Board, including committee structures, public participation opportunities, member terms, officer election protocols, and agenda format?

Rationale and Anticipated Benefits

- With a statewide effort underway to define basic public health services and capabilities, more efficient strategies can be employed in pursuing basic funding.
- While the current local system does have some benefits and has performed relatively well, there are likely a number of changes that could result in more equitable and consistent funding. The current local system gives city representatives a voice in Health District governance without an accompanying financial investment. Regardless of the outcome, services provided by the Health District will continue to benefit all residents of Snohomish County. In an era of decreasing revenue, the District must address disparities in funding and governance.
- In addition, Board of Health members are all elected officials who are stretched for time among a number of competing priorities. The Board might be augmented by other stakeholders who have direct linkages and responsibilities related to public health.
- It is prudent for any organization to periodically review operating rules and procedures, and the Board of Health is likely to benefit from a systematic evaluation of its subcommittee structure, meeting frequency, size and composition of the board and meeting ground rules.

Successful Examples in Other Communities

Health departments and districts throughout Washington State are governed by a wide variety of models. In Grant County, for example, every city contributes to the funding of the Public Health Department, with funding amounts determined by city population size and ability to pay.

Issues to Be Addressed Prior to Implementation

- It will be important to determine how a change of this magnitude can best be developed and agreed to. For example, the Board may want to appoint a "Blue Ribbon Commission" that would include representatives from both the Board and key stakeholder groups. Alternatively, the Board could appoint a small group of its own members to structure the process by which options will be examined and potential funding and governance changes will be considered. This decision will be the first step in carrying out this initiative.
- These types of evaluations can be difficult to carry out without the parties feeling defensive and protective of the existing operational mode. A neutral party will be needed to both provide information on other possibilities and to implement the careful evaluation necessary to determine what, if any, changes might be pursued.
- Unlike the other strategic initiatives in this document, this initiative will require a larger audience and "voice" before it can be implemented. New County governance and finance language would need to be crafted, a public vote may be necessary and some actions may require the attention of the Snohomish County Council. All of these possibilities must be carefully delineated prior to the pursuit of any change.

Action Steps and Key Milestones

November 2014: Determine Evaluation Process

The Board of Health will work with District senior management to determine how this evaluation should be carried out. This will also be the time to determine any budgetary additions necessary for this process, for example, support for a facilitation team for a Blue Ribbon Commission, and/or an independent expert on public governance and finance.

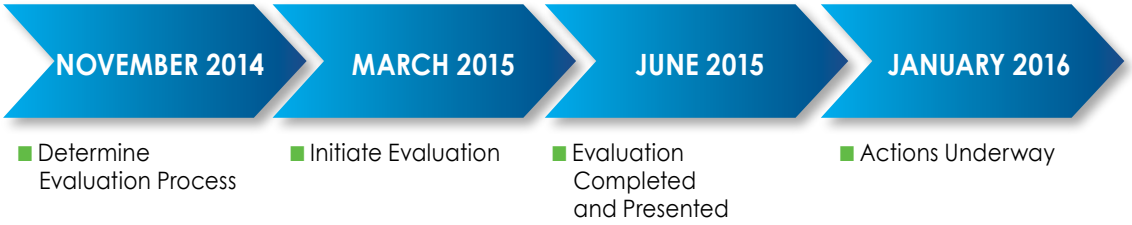
March 2015: Initiate Evaluation

The evaluation would be initiated in January 2015, with the goal of providing a report to the Board by May of 2015. Any potential changes to governance and finance would then be addressed through the 2016 budgetary process.

Assignments of Accountability

Agency Director and Health Officer Gary Goldbaum, MD, MPH, and Deputy Director Pete Mayer will lead this effort with the Board of Health and in close collaboration with agency legal counsel.

TIMELINE



STRATEGIC INITIATIVE 8: Become Nationally Accredited and Integrate Quality Improvement Principles

The Health District proposes to pursue national public health accreditation. Accreditation advances the quality and performance of all health departments in the country, improving and protecting the health of the public. Accreditation ensures that no matter where people live, they can be confident that their local public health department is providing the highest-quality services possible. Accreditation calls for adherence to a set of standards that encourage continuous improvement of services. It is also anticipated that future federal and state funding will be conditioned on meeting the national standards verifiable through the accreditation process.

In concert with the pursuit of accreditation, the Health District will refresh its Quality Improvement (QI) Plan to identify new strategies in assimilating key QI principles and practices into the organization. QI in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes and other measurable indicators of quality that serve to achieve equity and improve the health of the community.

Accreditation ensures that, no matter where people live, they can be confident that their local public health department is providing the highest-quality services possible.

QI is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization. The intent is to embed it in every aspect of organizational practice, with the end goal of constantly striving to provide optimal service to the public at an optimal price. This initiative will reflect the knowledge gained from preliminary QI efforts, recommend new structures and tactics to "institutionalize" a total quality and performance management culture, and identify alternative strategies to incorporate QI-related methods into the District's daily work activities rather than as a "program" or "activity" unto itself.

Rationale and Anticipated Benefits

The concept of uniform standards in the public health community began to emerge in the late 1980's. Since that time, work has continued at both the state and national levels to establish a unified vision for the role of public health, the essential public health services, and a unifying "system management" that ensures a continual improvement system of diagnosis, monitoring, service delivery, and healthier communities.

For the Snohomish Health District, accreditation would mean that the District would be measured against these national standards, which would then allow us to identify areas in need of improvement and directly link those measurement results to a QI process. It will hold SHD to a nationally recognized system of accountability, and will ensure that we are being measured and monitored in line with a larger overarching system of established quality standards.

Moreover, it appears inevitable that future state and national grant funding will more likely be awarded to those public health agencies that have achieved national accreditation status. The organizations distributing those grants want to be reassured that their monies will be spent wisely and well. Accreditation will give the District a competitive edge at the funding table.

Initiating and maintaining a performance management and quality improvement process enables an ongoing, systematic approach to improving results through evidence-based decision making, continuous organizational learning, and a focus on accountability for performance. When performance management is integrated into all aspects of an organization's management and policy-making processes, it can transform that organization's practices in a manner that allow it to be more focused on achieving improved results for the public it serves.

Successful Examples in Other Communities

A number of public health agencies throughout the country have initiated the process to become accredited. In Washington State, the State Department of Health is nationally accredited, as is the Spokane Regional Health District.

Quality improvement planning and processes are an integral part of public health operations, with exemplary practices underway by Kitsap Public Health District, Spokane Regional Health District and Tacoma-Pierce County Health Department.

Issues to Be Addressed Prior to Implementation

The Health District has already begun to prepare for the process of accreditation. This is a formal effort that requires adherence to a specified plan of action. This takes time, but the process is well defined and is uniform for all agencies working toward accreditation. The primary challenge is to lay out a coherent plan for how the Health District will pursue accreditation, including roles and management among key staff and any additional funding needed to support the effort.

Action Steps and Key Milestones

July 2014: Quality Improvement Council Reconvenes

The agency's Quality Improvement Council will reconvene with adjusted membership to help develop and recommend new approaches in supporting quality improvement throughout the agency including refreshing the SHD Quality Improvement Plan.

January 2015: Update/Revise Quality Improvement Plan

The District will undertake a process to update its Quality Improvement Plan.

May 2015: Preparation Plan Presented

The District will identify a plan of action for the pursuit of accreditation, including all of the action steps required, staff roles and responsibilities, and any necessary funding. Funding to support a temporarily dedicated staff member to lead this effort is included in the 2014 adopted budget and work is anticipated to get underway soon. It will require approximately 18-24 months of focused effort by a host of District staff. The Board will be apprised of this plan and the staff activities associated with the accreditation pursuit.

A revised Quality Improvement Plan will be completed and implementation will begin.

September 2015: Notice of Intent

The District must provide the Public Health Accreditation Board a "notice of intent" to pursue accreditation. Once this notice has been issued, the District will have one calendar year to complete the requirements.

September 2016: Accreditation Awarded

Provided accreditation standards, timelines and goals can be met, national accreditation should be achievable by this date.

Assignments of Accountability

This initiative will be the primary responsibility of Deputy Director Pete Mayer.

TIMELINE

JULY 2014
- Reconvene QI Council

JANUARY 2015
- Revise QI Plan

MAY 2015
- Accreditation Preparation Plan Presented
- Implement QI Plan

SEPTEMBER 2015
- Accreditation Notice of Intent Submitted

SEPTEMBER 2016
- Accreditation Awarded

Appendix

Click here for link to the Snohomish Health District 2009 Strategic Plan and Health District Budget documents

Click here for link to the Washington State Work currently underway, for example, the Foundational Public Health Services and other documents

Charts: Relationship of 2014 Strategic Plan Update to the 2009 plan and to the statewide work on page 42

Report format that will be used for quarterly Board of Health reports regarding the implementation of the Strategic Initiatives on page 44

2014 Strategic Plan Update Supplements – Available Upon Request

Reports from the employee listening sessions that informed the development of this Strategic Plan Update

Summary of the key informant interviews that informed the development of this Strategic Plan Update

Initiative 3 refers to the ACE Study

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego. More than 17,000 Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction. To date, more than 50 scientific articles have been published and more than 100 conference and workshop presentations have been made.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. Progress in preventing and recovering from the nation's worst health and social problems is likely to benefit from understanding that many of these problems arise as a consequence of adverse childhood experiences.

2014 Strategic Initiatives are Grounded in 2009 Strategic Directions	Move patients into medical homes	Improve Environmental Health business practices	Optimize delivery of early childhood development programs	Mobilize community health action teams	Reduce administrative overhead costs	Institute workforce development & succession planning	Improve Health District funding & governance	Become nationally accredited
Assure provision of basic public health services to protect the population's health and safety.	✓	✓	✓	✓		✓	✓	✓
Support healthy lifestyles and environments for the prevention of chronic disease and injuries.		✓		✓				
Create support for stable and adequate public health funding.					✓		✓	✓
Expand partnerships to share resources and responsibility for the public's health.	✓	✓	✓	✓			✓	
Improve the quality of and access to information and education about disease and injury prevention across the community.	✓	✓	✓	✓				
Leverage technology to broaden community outreach and to improve the public's health.	✓	✓			✓			
Increase public involvement in public health policy and direction.			✓	✓			✓	

2014 Strategic Initiatives Are Grounded in 2009 Strategic Vision	Protecting the Public's Health	Demonstrating Leadership	Offering Partnership	Providing Value	Education and Promotion
Move patients into medical homes		✓	✓		
Improve Environmental Health business practices	✓	✓	✓	✓	
Optimize delivery of early childhood development programs	✓	✓	✓	✓	✓
Mobilize community health action teams	✓	✓	✓	✓	✓
Reduce administrative overhead costs		✓		✓	
Institute workforce development and succession planning	✓	✓		✓	
Improve Health District funding and governance	✓	✓			
Become nationally accredited	✓	✓		✓	✓

2014 Strategic Initiatives are Grounded in Statewide Foundational Health Programs		Foundational Public Health Programs					
		Communicable Disease Control	Chronic Disease and Injury Prevention	Environmental Health	Maternal/Child/ Family Health	Access/Linkage with Clinical Health Care	Vital Records
STRATEGIC INITIATIVES	Move patients into medical homes	✓			✓	✓	
	Improve Environmental Health business practices			✓			
	Optimize delivery of early childhood development programs		✓		✓	✓	
	Mobilize community health action teams		✓		✓		
	Reduce administrative overhead costs						
	Institute workforce development and succession planning						
	Improve Health District funding and governance						
	Become nationally accredited	✓	✓	✓	✓	✓	✓

2014 Strategic Initiatives are Grounded in Statewide Foundational Public Health Capabilities		Foundational Capabilities That Cut Across All Programs					
		Assessment	Emergency Preparedness and Response	Communications	Policy Development and Support	Community Partnership Development	Business Competencies
STRATEGIC INITIATIVES	Move patients into medical homes	✓			✓	✓	
	Improve Environmental Health business practices						✓
	Optimize delivery of early childhood development programs	✓		✓		✓	
	Mobilize community health action teams	✓			✓	✓	
	Reduce administrative overhead costs						✓
	Institute workforce development and succession planning						✓
	Improve Health District funding and governance				✓	✓	✓
	Become nationally accredited	✓	✓	✓	✓	✓	✓

Snohomish Health District
Implementation of 2014 Strategic Plan Update
Quarterly Report to the District Board of Health

Date_____

Quarterly Highlights: Here's What We Are Most Proud Of

_____

Brief Details: Successes, Hurdles, Next Steps

INITIATIVE 1
Moving Patients out of Health District Clinics and Into Medical Homes

INITIATIVE 2
Improve Environmental Health Business Practices

INITIATIVE 3
Optimize Delivery of Early Childhood Development Programs

INITIATIVE 4
Mobilizing Community Health Action Teams

INITIATIVE 5
Reducing Administrative Overhead Costs

INITIATIVE 6
Institute Workforce Development and Succession Planning

INITIATIVE 7
Improve Health District Funding and Governance

INITIATIVE 8
Become Nationally Accredited and Integrate Quality Improvement Principles

Any major course corrections anticipated? Yes No

What can the Board expect at the next quarterly report?

RESOLUTION NO. ___

A RESOLUTION PERTAINING TO A VOLUNTARY PER CAPITA CONTRIBUTION TO THE SNOHOMISH HEALTH DISTRICT

WHEREAS, to promote the public health in Snohomish County, Washington, the Board of County Commissioners of Snohomish County, Washington, established a Health District on January 1, 1959, embracing all of the territory within Snohomish County, Washington, and all cities and towns therein; and

WHEREAS, in 1966 the Snohomish Health District became the first local health jurisdiction in the state to organize a city-county cooperative health program with cities indicating a willingness to participate financially in support of Health District programs; and

WHEREAS, on January 1, 1967, eleven of 18 cities and towns agreed to voluntarily contribute $0.50 per capita to the Health District in return for public health services; and

WHEREAS, per capita contributions from towns and cities continued and in 1986, with such contributions ranging from $1.60 to $2.70 per capita until the early 1990s; and

WHEREAS, in 1993, counties assumed exclusive financial responsibility for public health relying on Motor Vehicle Excise Tax (MVET) revenues; and

WHEREAS, in 2000, the Washington State Legislature repealed MVET and backfilled only 90% of lost public health funds; and

WHEREAS, state funding for local public health has decreased 65.7% from a peak of $27.29 per capita in 2000 to $9.36 per capita in 2014; and

WHEREAS, the Health District has experienced a 22% decrease from its 2005 funding level while the county population has increased by 14 percent in the same 10-year period; and

WHEREAS, since the "peak" of 2008, the Health District has reduced its staffing by 37 percent (85 FTE) due to static or declining revenues in the face of increased costs; and

WHEREAS, the Health District ranks 34th out of 35 local health jurisdictions in the state for public health expenditures per resident; and

WHEREAS, the Health District's ability to perform its most essential functions have been severely compromised since the great recession; and

WHEREAS, the Health District serves an essential public safety function whether ensuring safe food, schools, and septic systems, responding to disasters, or preventing and responding to disease outbreaks; and

WHEREAS, threats to the public's health in the form of foodborne illness such as E.coli and salmonella, communicable diseases such as pertussis, tuberculosis, measles, Zika, and Ebola and natural disasters such as the Oso/SR530 mud slide respect no municipal boundaries; and

WHEREAS, public health is a shared responsibility and regional public health threats require regional responses and close partnerships with every city and town in Snohomish County; and

WHEREAS, consistent with RCW 70.05, the Snohomish County Council is responsible for establishing the Snohomish Health District Board of Health, with jurisdiction coextensive with the boundaries of the county, to supervise all matters pertaining to the preservation of life and health of the people within its jurisdiction; and

WHEREAS, an effective, regional public health response to the threats to public health in Snohomish County requires the cooperation, participation and support of Snohomish County and all of the cities and towns in Snohomish County; and

WHEREAS, Snohomish County and the cities and towns therein seek to improve and sustain healthy years of life of their residents by engaging in an enhanced partnership with the Health District. This partnership will provide stable funding for public health priorities that would be established to meet the unique needs of each community.

NOW, THEREFORE, BE IT RESOLVED, the City Council of _____ hereby states its intent to contribute $2.00 per capita* to the Snohomish Health District, commencing January 1, 2017, conditioned on the execution of a mutually agreeable written agreement that sets forth the terms and conditions of such contribution.

Approved, this xx day of October 2016.

APPROVED AS TO FORM AND LEGALITY: **APPROVED:**

_____ _____

ATTEST:

_____

**As of the April 1, 2016, Washington State Office of Financial Management (OFM) Population estimate*