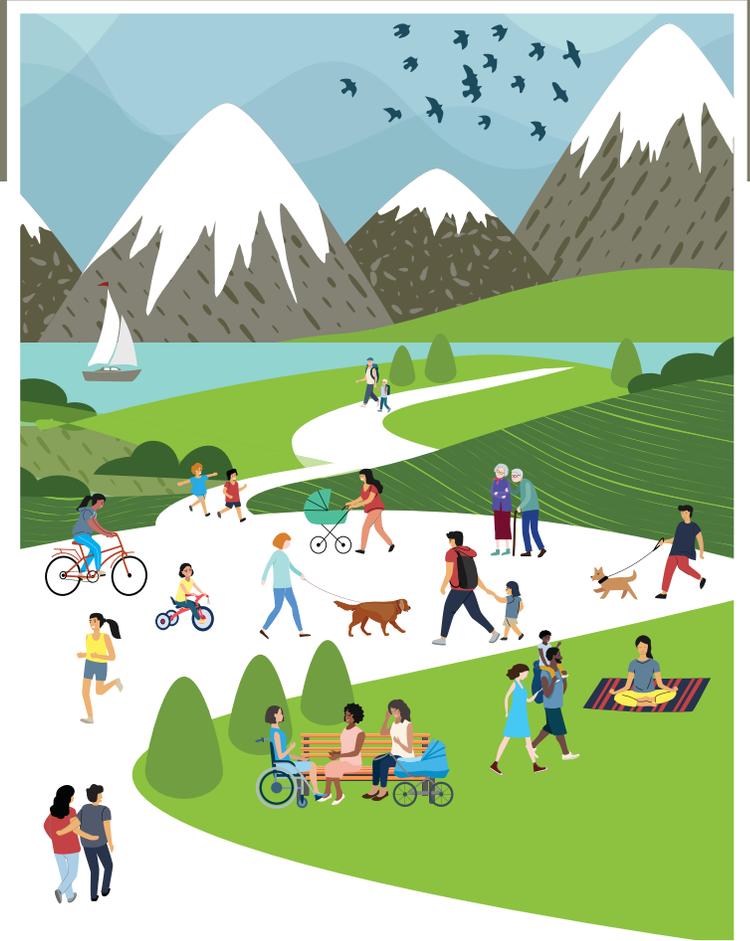




**SNOHOMISH  
COUNTY**   
HEALTH DEPARTMENT



# GOLD

# STANDARD

— EVALUATION REPORT

2025

# Table of Contents



Background .....	3
Executive Summary.....	4
Public Health Accreditation Standards – Assessment.....	5
Foundational Public Health Services and Capabilities – Assessment.....	8
CSTE Framework for Improving Applied Epidemiology – Assessment.....	11
Funding & Staffing Level Comparison Across Local Health Jurisdictions .....	14
Equity Review of Current Practices, Standards and Capacity.....	17
References .....	20

## Tables:

Table 1: PHAB Standards & Measures Self-Assessment Results, 2024.....	6
Table 2: Foundational Public Health Capabilities Self-Assessment Results, 2024 .....	9
Table 3: Epidemiology and Informatics Capabilities Self-Assessment Results, 2023 .....	12
Table 4: Epidemiologists per 100,000 population, 2023 .....	13
Table 5: LHJ Local Revenue Comparison, WA counties with populations of 500,000 – 999,000,2024 .....	15
Table 6: LHJ Local Revenue Comparison, counties with populations of 500,000 – 999,000, 2024 .....	15
Table 7: Median revenue & expenditure comparison with national benchmark, populations of 500,000 – 999,999 ....	16

## Appendices:

Appendix A - Results of PHAB Pathways Standards Review.....	22
Appendix B - FPHS Standards .....	25
Appendix C - CSTE Framework .....	54
Appendix D - Equity Review and Assessment Phase 1 .....	93

# Background



In April 2023, the Snohomish County Executive’s Office released a Strengthening Public Health policy brief. The brief provides six recommendations, created by a Strengthening Public Health Workgroup, aimed at identifying measures intended to move public health in Snohomish County forward following integration into county government. Recommendations address a variety of public health roles from data and informatics, disaster preparedness, and provision of limited clinical services.

One recommendation is to “complete a ‘Gold Standard’ evaluation of the Health Department”. Six components of the Gold Standard evaluation are listed as:

- A review and assessment using the public health accreditation standards and measures for local and state public health departments.
- Assessment and gap analysis of both state and national standards for foundational public health services and capabilities.
- An assessment and comparison analysis of other local public health agencies serving similar populations and size to Snohomish County – both within Washington State and across the nation.
- An equity inclusion review of standards, practices, and capacity to engage in such work.
- An applied epidemiology capacity assessment utilizing the draft Council of State and Territorial Epidemiologists Framework for Improving Applied Epidemiology during Public Health Transformation.
- Suggestions for the improvement of customer service, including strategies of education and behavior change, in a regulatory environment.

After further consideration and discussion, the customer service component was removed from the evaluation. There is a customer service initiative infused throughout all Snohomish County departments, as well as work being done within the Health Department, which provided confidence that improvement would occur without being specifically called out in this evaluation.

The remainder of this report will focus on the first five components.

# Executive Summary



After operating as the Snohomish Health District since 1959, the Snohomish County Health Department was established in 2023, integrating as a new department within Snohomish County government. The goal of the transition was to improve public health services within the county.

Assessing and evaluating department capabilities and competencies against state and national public health standards provides an opportunity to celebrate successes and identify areas for growth and improvement.

The Snohomish County Health Department shares many characteristics and struggles with local health jurisdictions in Washington State and across the United States. Funding for public health is perennially inadequate to serve the growing demands and expectations of the population. Constrained funding creates staff shortages and important, fundamental work of protecting and advancing the public's health remains undone.

Areas of strength include:

- The prevention and control of communicable disease.
- The ability to investigate, diagnose, and address health problems and hazards.
- Providing certified birth and death certificates in compliance with state law and rule.
- Capability to develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of food service establishments, water recreational facilities, solid waste and facilities, hazardous waste facilities, and school that address environmental public health concerns.

Areas of growth include:

- Contributing to an effective system that enable equitable access to services and care needed to be healthy.
- Creating and championing policy, plans, and laws that impact health.
- Improvement and innovation of public health functions through the on-going evaluation, research, and continuous quality improvement.

Findings of this report offer a point-in-time window into the health department showing that, despite chronic under-investment, health department staff are constantly striving to serve the residents of Snohomish County with quality public health services. To best advance public health, similar assessments are required at 3-5 year intervals. Repeated and consistent assessment allows the department to make intentional adjustments and to better understand impacts to local public health as it responds to ever-changing backdrop of funding, political uncertainty, and needs of the community.

# Public Health Accreditation Standards – Assessment



## Background

The Public Health Accreditation Board (PHAB) is a national organization that administers accreditation activities and sets standards for local, tribal and state health departments to achieve accreditation. Version 2022 Standards & Measures for Initial Accreditation is the current guidance for accreditation. Initial accreditation standards and measures are built on ten domains which aligns to the ten essential public health services.

- Domain 1: Assess and monitor population health status, factors that influence health, and community needs and assets.
- Domain 2: Investigate, diagnose, and address health problems and hazards affecting the population.
- Domain 3: Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
- Domain 4: Strengthen, support, and mobilize communities and partnerships to improve health.
- Domain 5: Create, champion, and implement policies, plans, and laws that impact health.
- Domain 6: Utilize legal and regulatory actions designed to improve and protect the public’s health.
- Domain 7: Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy.
- Domain 8: Build and support a diverse and skilled public health workforce.
- Domain 9: Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
- Domain 10: Build and maintain a strong organizational infrastructure for public health.

Within each domain are multiple standards and measures. For initial accreditation this includes twenty standards and eighty-seven measures.

PHAB additionally publishes standards and measures for Pathways Recognition as a step toward accreditation and performance improvement (PHAB, 2022). The Pathways Recognition Program consists of a subset of thirty-four measures and standards as described in initial accreditation requirements. Pathways for Recognition Program standards and measures are the basis for this review.

## Methodology

Between September and December 2023, ten leadership staff at the Snohomish County Health Department were provided the Pathways for Recognition standards and measures related to their scope of responsibility and subsequently interviewed. Each were asked to provide a self-assessment of the current state of readiness to provide the necessary documentation for accreditation.

For each measure, readiness was assessed using the responses of “yes”, “no”, “partial” or “outdated”. Responses are defined as:

Response	Definition
Yes	The Department is able to meet the documentation requirements for the measure at this time.
No	The Department does not currently have any portion of the required documentation for the measure.
Partial	The Department currently could meet some, but not all, of the documentation requirements.
Outdated	Documentation exists, and it would need to be updated to meet accreditation standards.

# Public Health Accreditation Standards – Assessment



## Results

The PHAB Standards & Measures for Pathways Recognition consists of thirty-four measures across the ten domains. They include at least one measure for each of the ten essential public health services. Appendix A to this report contains a complete list of the measures and the status of readiness of the Department for each measure.

Results show that the Department is ready to meet documentation requirements for 38% (13) of the Pathways Recognition Program measures. The remaining 62% (21) of measures are in varying stages of readiness with one-third of those measures having none of the required documentation. Specific levels of readiness are found in Table 1.

**Table 1:** PHAB Standards & Measures Self-Assessment Results, 2024

Status	Percent	Number
Yes	38%	13
Partial	35%	12
Outdated	6%	2
No	21%	7

Domains (each of which represents an essential public health service) where the Department is most ready to meet accreditation standards are:

- Domain 1: Assess and monitor population health status, factors that influence health, and community needs and assets.
- Domain 2: Investigate, diagnose, and address health problems and hazards affecting the population.
- Domain 3: Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
- Domain 10: Build and maintain a strong organizational infrastructure for public health.

Conversely, the domains where the Department is least ready for accreditation are:

- Domain 5: Create, champion, and implement policies, plans, and laws that impact health.
- Domain 7: Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy.
- Domain 8: Build and support a diverse and skilled public health workforce.
- Domain 9: Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.

# Public Health Accreditation Standards – Assessment



## Recommendations

For Snohomish Health Department to seek and obtain national accreditation through PHAB for full accreditation or the Pathways Recognition Program, significant preparation will be needed. Functional areas that need investment include: 1) policy development and analysis; and 2) community relationship development to ensure access to care and services for all the residents of Snohomish County. Additional staff will likely be necessary for the Department to meet accreditation standards in these areas.

The full accreditation process itself is lengthy, time-consuming, costly, and will require additional department staff capacity. The annual accreditation fee charged by PHAB for a health department the size of Snohomish is \$11,200. The body of work required to guide the Department through the initial accreditation, and subsequently maintain accreditation, is more than can reasonably be added to an existing staff member's job duties.

Health Department leadership, along with staff from the County Executive's office, will need to weigh the pros and cons of pursuing national public health accreditation. Accreditation standards are a valuable benchmark to strive for, regardless of the outcome of such a decision process. At a minimum, the Department should embark on a three-year plan to meet Pathways Recognition Program accreditation standards in all domains as this will provide a solid foundation to achieving full accreditation.

# Foundational Public Health Services and Capabilities – Assessment



## Background

Foundational Public Health Services and Capabilities are a, “defined, basic set of capabilities and programs that must be present in every community in order to efficiently and effectively protect all people in Washington”. In 2015, the Foundational Public Health Services (FPHS) Policy Workgroup published a report that laid out a plan for implementing FPHS in Washington State. (WA Department of Health, 2015)

Following this, in 2018, the FPHS Steering Committee, comprised of state, tribal and local public health leaders, published a report “Washington State Public Health Transformation Assessment Report”. (BERK, 2018) It contains the results of a statewide survey that calculated the level of funding necessary to implement FPHS statewide. In 2019, the Steering Committee published functional definitions for six foundational programs and six foundational capabilities. Each program and capability are further defined by a set of activities. (WA Department of Health, 2019)

There is a strong linkage between Public Health Accreditation Board standards and measures and FPHS services and capabilities. It is anticipated in late 2025 that an updated and expanded set of definitions will be released requiring our assessment to be revisited as part of on-going alignment.

## Methodology

The Washington Foundational Public Health Services Functional Definitions Manual, Version 1.4 (2019) was provided to department senior leaders. Key leaders with programs and capabilities related to their scope of responsibility were subsequently interviewed and tasked with self-assessing the Department’s current capacity and expertise for each of the three hundred defined FPHS activities.

Self-assessment was completed between June and September 2024 using the identical rating scale developed for the 2018 statewide transformation assessment survey (BERK, 2018). Each FPHS activity was rated on a Likert scale of 1 to 5 for capacity and expertise. 1 means that the activity is not currently provided; 3 indicates that the basic level of service is provided and that there is a meaningful gap in skills and knowledge; and 5 means that we are fully meeting the requirements of the activity.

Capacity	Value	Expertise
Not currently provided.	1	Not currently provided.
↓	2	↓
Able to provide the basics as at a lower level of service.	3	There is meaningful gap in skills & knowledge.
↓	4	↓
Fully meets requirements.	5	Fully meets requirements.

# Foundational Public Health Services and Capabilities – Assessment



## Results

The full assessment for each Foundational Public Health Services activity is available in Appendix B. The average score presented in Table 2 is for those activities associated within each foundational program and capability.

**Table 2:** Foundational Public Health Capabilities Self-Assessment Results, 2024

Foundational Program or Capability	Capacity (Average)	Expertise (Average)
A. Vital Records	5.0	5.0
B. Environmental Health	2.6	3.2
C. Prevention and Control of Communicable Disease and Other Notifiable Conditions	3.9	4.3
D. Maternal/Child/Family Health	2.5	2.6
E. Access/Linkage with Medical, Oral and Behavioral Health Care Services	2.3	2.4
F. Chronic Disease, Injury and Violence Prevention	2.7	2.7
G. Assessment (Surveillance and Epidemiology)	2.9	3.0
H. Emergency Preparedness	3.3	3.1
I. Communication	4.7	4.6
J. Policy Development and Support	1.9	3.6
K. Community Partnership Development	2.4	3.4
L. Business Competencies	3.0	3.4

For over half of the foundational services, Snohomish Health Department does not have the capacity to provide a basic level of service and in only one area does the Department fully meet the requirements defined in foundational public health definitions.

- The foundational programs that scored the highest for capacity and expertise are:
  - vital records;
  - prevention and control of communicable disease; and
  - communication.
- Mirroring the results of the accreditation standard review, the areas that scored lowest for capacity are:
  - access/linkage with medical, oral and behavioral health care services;
  - community partnership development; and
  - policy development and support.
- Maternal/child/family health and chronic disease, injury and violence prevention also scored low for expertise. This signals a need for staff training and mentorship in these areas to allow the current staff capacity to reach the level of expertise expected to provide foundational services to Snohomish County.

# Foundational Public Health Services and Capabilities – Assessment



## Recommendations

Significant investments in both capacity and expertise are needed for Snohomish Health Department to deliver a foundational level of public health services to the residents of Snohomish County. When asked what is needed to allow the Department to fully meet requirements in both capacity and expertise, staff reported:

- additional staff, in certain programs,
- staff training and capacity building, and
- improved systems and infrastructure.

The next step to fulfilling foundational public health services in Snohomish County is to create a plan and timeline for incremental staff additions, training and infrastructure improvements that will move the Department towards the goal of providing the range of foundational services.

# CSTE Framework for Improving Applied Epidemiology – Assessment



## Background

The Council of State and Territorial Epidemiologists (CSTE) is a national organization whose aim is to advance public health epidemiologic capacity. *Framework for Improving Applied Epidemiology* (draft, 2022) aims to assist state, local, territorial, and tribal health departments as they improve their epidemiology capacity to achieve public health transformation. The Framework provides a broad outline of the scope of applied public health epidemiology and serves as a tool to assess organizational practices and identify priority needs to support, sustain, and enhance epidemiology capacity.

The Framework has five categories and 38 subcategories. Each subcategory contains minimum standards, examples of best practices, and measures for evaluation.

Note: As of April 2025, the Framework has not been finalized or published by CSTE. Public Health – Seattle & King County, who is using it for a similar assessment, provided a copy.

## Methodology

The *Framework for Improving Applied Epidemiology during Public Health Transformation* was provided to the Health Officer, Epidemiology and Informatics Manager, and epidemiology staff to review. Staff self-assessed the national standard compared to existing epidemiology resources and capabilities in Snohomish County as of 2023.

# CSTE Framework for Improving Applied Epidemiology – Assessment



## Results

The department is not meeting minimum recommendations in most subcategories identified in the framework. The framework includes 38 subcategories or rather service areas for epidemiology. Four are state-level roles in Washington. Of the remaining 34 service areas, the department is not meeting minimum requirements in 76 percent (26) of the subcategories (Table 3). The full assessment for each category & subcategory is available in Appendix C.

**Table 3:** Epidemiology and Informatics Capabilities Self-Assessment Results, 2023

Categories	Subcategories	Meets Standards
Epidemiology Service	Case Surveillance	State
	Risk Factor Surveillance	No
	Syndromic Surveillance	State
	Hospitalization Surveillance	No
	Birth Surveillance	No
	Mortality Surveillance	No
	Environmental Public Health Hazards Surveillance	No
	Vaccination Coverage Surveillance	No
	Injury Surveillance	No
	Chronic Disease Surveillance	No
	Maternal & Child Health Surveillance	No
	Community Health Assessment	Yes
	Monitoring Health Status	No
	Disease Investigation	Yes
	Outbreak Detection	Yes
Outbreak Investigation	Yes	
Chronic Environmental Health Studies	No	
Capabilities	Data Collection/Reporting	State
	Data Sharing/Interoperability	State
	Data Analysis	No
	Data Visualization	No
	Date Dissemination	No
	Data Standards	No
Roles	Policy Development	No
	Health Status Improvement	Yes
	Identification of Health Disparities	No
	Health Equity Achievement	No
	Pandemic Preparedness	No
	Program Evaluation	No
Evidence-Based Practice	Yes	
Infrastructure/ Organization	Staffing	No
	Funding	No
	Epidemiology Program Areas	No
	Internal Connectivity/Organization	No
	External Connectivity	Yes
Characteristics	Population Focus	Yes
	Timeliness of Data Collection, Analysis, Interpretation & Dissemination	No
	Flexibility/Ability to Address Emerging Issues	No

# CSTE Framework for Improving Applied Epidemiology – Assessment



## Results (cont.)

Themes across topic areas not meeting minimum standards are, insufficient:

- epidemiology staffing,
- informatics infrastructure for public health,
- data access, and
- epidemiology staff involvement in projects from their start and throughout their life cycles.

Snohomish Health Department is meeting minimum standards in a few key areas, most notably in communicable disease investigation and response.

A further analysis of staffing capacity compared to national and state level were conducted as means to understand the challenges in achieving minimum standards. (Table 4) Snohomish Health Department Epidemiology and Informatics team has five epidemiologists to serve a population of ~845,000 (0.6 epidemiologists/100,000 population). The CSTE minimum standard as outlined in the framework is five epidemiologists/100,000 population, although discussions with CSTE make it uncertain if this standard applies to home rule jurisdictions.

An informal survey of Washington local health jurisdictions that serve a similar population size revealed that they employ 1.3 to 2.8 epidemiologists/100,000 population.

**Table 4:** Epidemiologists per 100,000 population, 2023

National	State	Snohomish County
5	1.3 – 2.8	0.6

The department would need 11 epidemiologists to attain the lowest ratio (1.3/100K) identified in Washington State, and 19 epidemiologists to reach 2.8 epidemiologists/100,000 population.

## Recommendations

Like previous assessments provided, significant investments in capacity are needed for the department to provide minimum informatics and epidemiology services. Opportunities for improvements with immediate benefit include staffing and data modernization and interoperability.

The CSTE framework should be reviewed annually to provide direction for areas requiring additional investments.

# Funding & Staffing Level Comparisons Across Local Health Jurisdictions



## Background

As Warren Buffet once said, “Price is what you pay. Value is what you get.” For public health, the single largest expenditure is staffing. The value received is captured by the department’s ability to provide minimum services and capabilities as defined by Public Health Accreditation Board, Foundational Public Health Services, and the Council of State and Territorial Epidemiologists. For an assessment of those capabilities and services see previous sections of this report.

Public health financing is complex, with local health departments heavily dependent on federal, state, local, and grant funding. This assessment seeks to capture a view into the local portion of the public health funding equation.

## Methodology

Local health jurisdictions (LHJs) with 2023 population estimates of 500,000 to 999,000 were identified within Washington State and in other states. Within Washington, eligible local health jurisdictions are Tacoma-Pierce, Clark and Spokane. King County, has a population exceeding two million and is non-comparable.

Out-of-state comparisons were chosen based on 2023 population estimates of 500,000 to 999,000 and their geography. All are counties next to a major metropolitan area as Snohomish County is next to the Seattle/King County metropolitan area.

Following identification each local health jurisdiction was contacted and requests were made to for the same data:

- size of the 2024 operating budget,
- allocation of general fund from the county, and
- number of full-time equivalents (FTE).

All the Washington state LHJs responded with the requested information. After multiple inquiries, several out-of-state local health jurisdictions did not respond. In those instances, information was obtained through publicly available reports and budget documents.

# Funding & Staffing Level Comparisons Across Local Health Jurisdictions



## Results

Table 5 shows a comparison of in-state LHJs. Snohomish County's funding includes both general fund and funds allocated from a local sales tax option for behavioral health. Despite differences in the size of budgets, Snohomish County's population to FTE ratio is significantly higher than any other comparable LHJ.

**Table 5:** LHJ Local Revenue Comparison, WA counties with population of 500,000 – 999,000, 2024

2024 Budget	Snohomish County	Tacoma-Pierce County*	Clark County	Spokane Regional Health District
Operating Revenue	\$35,761,681	\$59,472,125	\$22,158,484	\$54,778,818
Funding from local county revenue	\$3,263,959	\$3,781,075	\$1,986,055	\$2,071,723
Population est. (2023)	859,800	946,300	527,400	554,600
Total FTE	197	349	157	270
Population per FTE	4,397	2,711	3,359	2,054
Local Contribution per capita	\$3.80	\$4.00	\$3.76	\$3.74
<i>*TPHD aggregates 24-25 budget figures, i.e. 2024 equals 50% of total for biennium.</i>				

Comparable out-of-state LHJs serve counties of similar population and have similar size operating budgets. In addition, each is a suburban county near a large metropolitan area. Notably, the financial contributions per capita are much higher than surveyed Washington State LHJs. It is assumed that these states have differing taxing and revenue options for local governments than those available in WA or different mechanisms for funding public health. This makes a local funding comparison challenging across states. Total budget size is comparable and provides a better measure of the financial health of the LHJ. Despite the funding differences, the population served per FTE remains the highest in Snohomish County. (Table 6)

**Table 6:** LHJ Local Revenue Comparison, counties with population of 500,000 – 999,000, 2024

2024 Budget	Snohomish County	Washington County, OR*	San Joaquin County, CA*	Macomb County, MI	El Paso County, CO
Operating Revenue	\$35,761,681	\$30,827,754	\$53,090,001	\$42,487,200	\$27,705,852
Funding from local county revenue	\$3,263,959	\$9,718,568	\$15,158,942	\$21,291,500	\$7,912,001
Population est. (2023)	859,800	598,865	793,229	875,900	744,215
Total FTE	197.05	151	221	268	197
Population per FTE	4,397	3,966	3,589	3,268	3,778
Local Contribution per capita	\$3.80	\$16.22	\$19.11	\$24.31	\$10.63
<i>*2023-2024 Fiscal Year</i>					

# Funding & Staffing Level Comparisons Across Local Health Jurisdictions



Another method of benchmarking the fiscal health of the Snohomish Health Department is the National Association of County & City Health Officials (NACCHO) survey of local health departments. It is conducted every three to four years to gather data on the capacity of our local public health system across the nation. The 2022 National Profile of Local Health Departments is useful to compare the Snohomish Health Department to health departments across the country that serve similar size communities. (Cunningham, et al., 2024) A few salient measures are described here and shown in Table 7.

- Local health departments serving populations of 500,000 – 999,999 have an average of 4.3 FTEs per 10,000 people. Using this as a common metric, Snohomish Health Department would need to be staffed at 370 FTEs.
- Local health departments serving populations of 500,000 – 999,999, report a median annual expenditure per capita of \$49. Snohomish Health Department’s 2024 budget figure is \$41 per capita, placing us well below the median of health departments across the country.

**Table 7:** Median revenue & expenditure comparison with national benchmark, populations of 500,000 – 999,999

Budget	NACCHO (2022)	Snohomish County (2024)
Per capita expenditure	\$49	\$40
Per capita revenue	\$46	\$41
FTEs per 10,000 (population)	4.3	2.3

## Recommendations

This point-in-time analysis exists in a changing landscape, and work continues to evolve with Snohomish County leadership and the Snohomish County Board of Health to diversify public health funding for stability.

Comparisons to local health jurisdictions in Washington and across the United States having similar characteristics to Snohomish County shows that the health department is understaffed based on a population to FTE ratio. Additional funding will be needed to provide the staffing and programming that is comparable to other local health jurisdictions serving similar sized jurisdictions in Washington and other states.

A deeper dive into funding sources for local health jurisdictions is warranted to understand how others are supporting more robust staffing models. Using gathered information, a five-year plan for increasing and diversifying funding to support additional staff and provide more comprehensive public health services for Snohomish County residents should be developed.

# Equity Review of Current Practices, Standards and Capacity



## Background

One of the *Snohomish County 2024 High Level Goals* is, “Ensuring our work is accessible and equitable.” Strategies aimed at moving the county’s commitment to equity forward was central to the development of the *Strengthening Public Health Policy Recommendations*. As directed, the gold standard evaluation must include an equity inclusion review around the current standards, practices, and capacity to engage in such work.

An additional separate recommendation was made as part of the policy recommendation. This recommendation states, “Take immediate measures to address the needs of Snohomish County’s systematically excluded communities.”

Taken together, the assessment and the actions decided in the separate recommendation are intended to guide the department’s equity work.

## Methodology

A request for proposals was publicized through the Snohomish County Purchasing Portal in fall 2023 and a contract awarded to The Upstream Group, LLC in December 2023. Contract finalization occurred in May 2024.

The contracted scope of work detailed a comprehensive equity review of the Health Department, including an assessment of the Department’s capacity to engage in broader and sustained equity work in the future. The assessment consisted of a review of internal documents relating to equity within the Department and key informant interviews.

Interviews were conducted with staff leaders at the Health Department and in the County Executive’s Office, members of the Community Equity Advisory Board (an external department board) and the Equity & Trauma-Informed Leadership Team (an internal department committee comprised of staff committed to advancing equity and trauma-informed practices).

The final assessment was completed in September 2024.

## Results

The results of this “Gold Standard” evaluation show that despite chronic under-investment the staff are constantly striving to serve the residents of Snohomish County with quality public health services.

The full report with attachments is available in Appendix D.

Key themes of the department’s organizational culture as stated in the report:

- 1. *Transitioning culture.***  
Snohomish Health Department’s overall organizational energy still feels transitory. Some areas of the Department are still catching up after a rushed transition while trying to understand and adapt to unfamiliar county policies and new culture. The Department is settling but still hasn’t completely, with a mix of lingering emotions including feeling behind with the transition, overwhelmed by another new thing, traumatized by the change, and weary of the future. At the county level, the Office of Social Justice is newly staffed and will increasingly provide an opportunity for the Health Department to connect to enterprise equity efforts.
- 2. *Assimilation culture.***  
Snohomish Health Department (SHD) strives to be an inclusive organization, but the organization lacks readiness and capacity for conversations that push against the status quo or disrupt systems of oppression. The implicit workplace norms remain aligned with an assimilation mindset. Although employees may be publicly encouraged to share feedback, pressure exists to adapt to dominant culture norms. Assimilation culture most disproportionately impacts underrepresented groups and employees with intersectional identities.

# Equity Review of Current Practices, Standards and Capacity



### 3. ***Inconsistency in DEI knowledge and practice.***

There is a varying level of applied knowledge and understanding of the meaning of equity and how it differs from the concept of equality. Applying an equity lens into daily practice is intermittent and ad-hoc across Snohomish Health Department programs, and this is also true across county departments. There is a need for more tailored and consistent approaches to integrating an equity and community-informed lens into decision-making, programmatic opportunities, and the regulatory functions of public health.

### 4. ***Presence of white supremacy culture characteristics (and efforts to challenge them).***

Many aspects of white supremacy culture are inherent to and built into governmental agencies, structures, and systems. While some characteristics arose during this assessment, so did examples of SHD challenging these characteristics and building new systems and processes toward a relational culture.

- **Urgency:** Can appear in response to emerging issues or tight deadlines (e.g., grant cycles) and is often connected to a larger system outside of SHD control. Impacts of work urgency can and should be assessed to identify whether frontline staff and community partners carry a disproportionate burden. Urgency can also appear through a pressure to quickly advance equity initiatives or community engagement efforts. Although well intentioned and aligned with the Department's equity goals, this can become harmful if the urgency perpetuates power imbalances or impacts employee/community well-being in the process.
- **Fear:** Although culture is shifting, some participants have observed a lingering resistance or fear to speak up and challenge the status quo.
- **Quantity or quality:** Often arising within public health's data and epidemiological responsibilities, SHD is limited by the same quantitative-centric approaches structures. However, very positive examples were shared of valuing qualitative information and community stories to fill in data gaps, demonstrating commitment toward a more balanced and relational approach.
- **Paternalism:** Some with decision making power may hold that close or, more commonly, not understand the power they hold. SHD decisions that impact employees do not always involve those impacted, and the same is true for external-facing decisions that impact communities. However, in both realms, progress is currently being made to advance toward shared power.

### 5. ***Growth and DEI learning mindset.***

There is a desire to create space to have the necessary and sometimes difficult conversations, center and share lived experiences and build affinity amongst SHD employees. The commitment to advancing equity was shared by all participants, with nearly everyone sharing the recent Orange Shirt Day event that was employee-led and leadership-supported.

# Equity Review of Current Practices, Standards and Capacity



## Recommendations

The report details 36 recommend actions spanning twelve focus areas. Recommendations range from communications, data, policies, and workforce development. An additional four cross-cutting recommendations focused on existing or emerging efforts:

- **County's Office of Social Justice**, including adoption and alignment with current/future pro-equity efforts around hiring, contracting, and other areas.
- **Community Equity Advisory Board**, including alignment with Community Equity Advisory Board recommendations.
- **Equity and Trauma-informed Leadership Team (ETILIT)**, including support for and resourcing of ETILT recommendations.
- **Strategic Planning**, including integrating equity into strategic goals and metrics.

# References



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**SNOHOMISH  
COUNTY**   
HEALTH DEPARTMENT

# **GOLD** **STANDARD** — **EVALUATION REPORT** **2025**

Appendix A: Results of PHAB Pathways Standards Review

Data presented was collected September through December 2023

Domain & Measure	Description	2024 Department Status
<b>Domain 1: Assess and monitor population health status, factors that influence health, and community needs and assets.</b>		
Measure 1.1.1	Develop a community health assessment.	Partial
Measure 1.2.1	Collect primary non-surveillance data.	Partial
Measure 1.2.2	Participate in data sharing with other entities.	Yes
Measure 1.3.1	Analyze data and draw public health conclusions.	Yes
<b>Domain 2: Investigate, diagnose, and address health problems and hazards affecting the population.</b>		
Measure 2.1.1	Maintain surveillance systems.	Partial
Measure 2.1.3	Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards.	Yes
Measure 2.2.5	Maintain & implement a risk communication plan for communicating with the public during a public health crisis or emergency.	Yes
Measure 2.2.1	Maintain a public health emergency operations plan (EOP).	Partial
Measure 2.2.2	Ensure continuity of operations during response.	Outdated
Measure 2.2.6	Maintain & implement a process for urgent 24/7 communications with response partners.	Yes
Measure 2.2.7	Conduct exercises and use After Action Reports (AARs) to improve preparedness and response.	Partial
<b>Domain 3: Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.</b>		
Measure 3.1.1	Maintain procedures to provide ongoing, non-emergency communication outside the health department.	Partial
Measure 3.2.2	Implement health communication strategies to encourage actions to promote health.	Yes

Appendix A: Results of PHAB Pathways Standards Review

Domain & Measure		2024 Department Status
<b>Domain 4: Strengthen, support, and mobilize communities and partnerships to improve health.</b>		
Measure 4.1.2	Participate actively in community health coalition (s).	Partial
<b>Domain 5: Create, champion, and implement policies, plans, and laws that impact health.</b>		
Measure 5.1.2	Examine and contribute to improving policies & laws.	No
Measure 5.2.2	Adopt a community health improvement plan.	No
Measure 5.2.4	Address factors that contribute to specific populations' higher health risks and poorer health outcomes.	No
<b>Domain 6: Utilize legal and regulatory actions designed to improve and protect the public's health.</b>		
Measure 6.1.4	Conduct enforcement actions.	Yes
<b>Domain 7: Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy.</b>		
Measure 7.2.1	Collaborate with other sectors to improve access to social services.	No
<b>Domain 8: Build and support a diverse and skilled public health workforce.</b>		
Measure 8.1.2	Recruit a qualified and diverse health department workforce.	No
Measure 8.2.1	Develop a workforce development plan that assesses workforce capacity and includes strategies for improvement.	Outdated
Measure 8.2.2	Provide professional and career development opportunities for all staff.	Partial

Appendix A: Results of PHAB Pathways Standards Review

Domain & Measure	Description	2024 Department Status
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<b>Domain 9: Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.</b>		
Measure 9.1.1	Establish a performance management system.	No
Measure 9.1.5	Implement quality improvement projects.	Partial
Measure 9.2.1	Identify and use applicable research and practice-based information for program development and implementation.	Partial

<b>Domain 10: Build and maintain a strong organizational infrastructure for public health.</b>		
Measure 10.1.2	Adopt a department-wide strategic plan.	No
Measure 10.2.2	Maintain a human resource function.	Yes
Measure 10.2.3	Support programs and operations through an information management infrastructure.	Yes
Measure 10.2.4	Protect information and data systems through security and confidentiality policies.	Yes
Measure 10.2.6	Oversee grants and contracts.	Yes
Measure 10.2.7	Manage financial systems.	Partial
Measure 10.3.3	Communicate with governance routinely and on an as-needed basis.	Yes
Measure 10.3.4	Access and use legal services in planning, implementing, and enforcing public health initiatives.	Yes
Measure 10.2.1	Manage operational policies including those related to equity.	Partial

**Yes** = meets the documentation requirements

**No** = does not currently have any portion of the required documentation for the measure

**Partial** = currently meets some, but not all, of the documentation requirements

**Outdated** = documentation exists, and it would need to be updated to meet accreditation standards

## Appendix B: Foundational Public Health Services Assessment & Analysis

Data presented was collected June through September 2024

Program & Capability	Capacity	Expertise
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### A. Vital Records

- |  |   |   |
|--|---|---|
| 1. In compliance with state law and in concert with local, state and national groups, assure a system of vital records. (Centralized activity – currently provided by DOH)   |   |   |
| 2. Provide certified birth and death certificates in compliance with state law and rule.   |   |   |
| a. Register records of deaths that occur in the local jurisdiction, using the state’s Electronic Death Registration System (EDRS). Review records for compliance with state laws, rules and policies.  | 5 | 5 |
| b. Provide guidance and training to individuals responsible for death records registration including LHJ deputy registrars, medical examiners, coroners, funeral directors, physicians, and other health care professionals that certify death certificates.   | 5 | 5 |
| c. Issue certified copies of birth and death records for events that occurred in any Washington jurisdiction using the state vital records system.   | 5 | 5 |
| d. Assist applicants for birth and death certificates with the documents needed to submit amendments or corrections to the State vital records office including parentage acknowledgments, so that clean documents are submitted to DOH, as well as the follow- up to submissions ensuring satisfactory final disposition. | 5 | 5 |

### B. Environmental Public Health

1. Provide timely, state and locally relevant and accurate information statewide and to communities on environmental public health issues and health impacts from common environmental or toxic exposures.

#### Data and Data Systems and Analysis

- |  |   |   |
|--|---|---|
| a. Collect and maintain environmental and human health data to support environmental public health functions at the local and state level, including built environment, chemical, radiological and biological hazards.   | 3 | 3 |
| b. Analyze, interpret and share environmental public health data including data pertaining to the built environment and health inequities.   | 2 | 2 |
| c. Develop and implement protocols for information sharing between public health, health care providers (including veterinarians), Tribal Nations, other local, state and federal agencies and the public to reduce environmental exposure and disease transmission. Include protocols for confidentiality as appropriate. | 2 | 2 |
| d. As appropriate, prepare data files to share and make available to researchers and other stakeholders.   | 2 | 2 |

Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
<u>Reporting, Communications, and Policy</u>		
e. Provide the public, regulated facilities and stakeholder organizations effective and timely communication of environmental public health hazards and protection recommendations, such as media releases and public health advisories.	4	4
f. Measure the impact of environmental hazards on the health of the public, including health inequities. Produce and share periodic/routine reports of diseases or other impacts linked to environmental public health issues	1	1
g. Inform decision makers of potential and actual environmental impacts to public health based on data and published reports.	3	3
h. Use data and evidence-based practices to facilitate development of environmental public health policy, systems and environmental change initiative, including those designed to promote health equity.	2	2
<u>Prepare for Future Data Needs</u>		
i. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and geographic information systems (GIS) to meet user’s requests.	2	1
j. Develop and adapt data systems as needed.	2	2
2. Identify statewide and local community environmental public health assets and partners, and develop and implement a prioritized prevention plan to protect the public’s health by preventing and reducing exposures to health hazards in the environment, seek resources and advocate for high priority policy initiatives.		
a. Provide subject matter expertise to inform policy, system and environmental change, program design and communications that inform decision makers, providers, the public and stakeholders about environmental public health risks.	3	4
b. Identify, develop, engage and maintain local strategic partnerships to prevent and control environmental public health risks.	4	4
c. Identify, develop, engage and maintain strategic partnerships with statewide associations, government agencies and statewide organizations to prevent and control environmental public health risks.	3	4
d. Identify, engage and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovation.	1	3
e. Work with partners to develop a prioritized control plan addressing important environmental public health risks.	1	3
f. Work with partners to advocate for high priority policy, system and environmental change initiatives regarding environmental public health and seek funding to implement evidence-based or innovative additional important services (AIS)prevention and control initiatives.	1	3
g. Develop action plans for environmental public health emergencies.	5	5
h. Coordinate and/or provide surge capacity staffing for cross-jurisdictional environmental public health emergency response.	5	5

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
<ul style="list-style-type: none"> <li>i. State Department of Ecology and Washington State Department of Agriculture). Document implementation of regulations for mandated public health programs.</li> </ul>	3	3
<ul style="list-style-type: none"> <li>3. Conduct environmental public health investigations, inspections, sampling, laboratory analysis and oversight to protect food, recreational water, drinking water and liquid and solid waste systems in accordance with local, state, and federal laws and regulations.</li> </ul>		
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>a. Develop environmental public health regulations per local, state and federal mandates.</li> </ul> </li> </ul>	4	4
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>b. Develop, implement and enforce laws, rules, policies and procedures for maintaining the health and safety of retail food service inspections and shellfish monitoring, that address environmental public health concerns.</li> </ul> </li> </ul>	3	5
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>c. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of recreational water facilities, including through pool and swimming beach health and safety inspections and water quality sampling and testing, that address environmental public health concerns.</li> </ul> </li> </ul>	5	5
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>d. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of drinking water including through source water protections, water system design review, water system inspections, water quality testing and oversight and plan review to ensure water adequacy, that address environmental public health concerns.</li> </ul> </li> </ul>	2	3
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>e. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of wastewater and facilities, including onsite septic design and inspections, wastewater treatment and reclaimed water, that address environmental public health concerns.</li> </ul> </li> </ul>	3	5
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>f. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of solid waste and facilities, including hazardous waste streams (e.g. animal waste, solid waste permitting and solid waste inspections), that address environmental public health concerns.</li> </ul> </li> </ul>	5	5
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>g. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of schools, including through education and plan review that address environmental public health concerns.</li> </ul> </li> </ul>	5	5
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>h. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of temporary worker housing, that address environmental public health concerns.</li> </ul> </li> </ul>	1	1
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>i. Develop, implement and enforce laws, rules, policies and procedures for ensuring the health and safety of transient accommodations, including through camp inspections, that address environmental public health concerns.</li> </ul> </li> </ul>	1	1

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
j. Utilize scientific methods and best practices, when indicated, to collect environmental samples and human specimens for laboratory analysis to confirm or rule out disease presence. This includes packaging in conformance with DOT and USPS requirements and shipping to a certified laboratories for analysis.	5	5
k. Develop, implement and enforce laws, rules, policies and procedures for ensuring compliance with smoking in public places laws, that address environmental public health concerns.	5	5
l. Implement environmental public health regulations including licensing, inspection, public notification and enforcement actions.	4	5
m. Educate individuals and organizations on the meaning, purpose and benefit of public health laws and how to comply.	4	5
n. Conduct or assist with outbreak investigations that have an environmental public health component.	4	5
o. Conduct timely investigation of complaints related to mandated environmental public health programs.	3	5
p. Maintain and implement protocols and systems to ensure confidentiality of protected health information throughout inspection, investigation, reporting and maintenance of data.	5	5
q. Maintain expertise and provide consultation to other local and state agencies and the general public.	3	4
r. Evaluate implementation of environmental public health regulations and disease control investigations and response, and use findings to improve processes and procedures.	3	4
4. Identify and address priority notifiable zoonotic conditions (e.g. those transmitted by birds, insects, rodents, etc.), air-borne conditions and other public health threats related to environmental hazards.		
a. Develop and implement environmental public health regulations, including licensing, investigations, inspections, containment/mitigation, correction and enforcement, per local, state and federal mandates.	3	4
b. As needed, develop and implement plans to identify and respond to emerging zoonotic diseases (e.g. Zika), exposures related to pesticides and other emerging environmental public health issues.	1	3
c. Coordinate containment or mitigation of environmental public health hazards (e.g. air quality and exposures to toxic substances) with other government departments and stakeholders.	3	4
d. Conduct outreach and provide guidance on the occurrence, prevention and control of zoonotic diseases to Local Health Jurisdictions (LHJs), Washington State Department of Agriculture and Fish and Wildlife, veterinarians and others.	2	3
e. Maintain expertise and provide consultation to other local and state agencies and the general public about best practices related to vector control.	3	3
f. Coordinate and/or provide surge capacity staffing for cross-jurisdictional environmental public health emergency response.	1	3

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
5. Protect the population from unnecessary radiation exposure in accordance with local, state and federal laws and regulations		
<u>Licensing and oversight of permitted sources (Centralized activities currently provided by DOH)</u>		
a. Develop environmental public health regulations for radioactive sources per state and federal mandates.	1	1
b. Develop and implement policies and procedures for regulated facility inspections and investigations related to exposure to harmful radioactive sources.	1	1
c. Implement environmental public health regulations including registration, licensing, inspection and enforcement actions.	1	1
d. Document implementation of radiation regulations.	1	1
e. Evaluate implementation of radiation regulations and use findings to improve processes and procedures	1	1
f. Maintain and implement protocols and systems to ensure confidentiality throughout inspection, investigation, reporting and maintenance of data.	1	1
g. Coordinate environmental public health efforts with federal and state partners (e.g. CDC, FDA, USDA, EPA, the Nuclear Regulatory Commission (NRC), Washington State Department of Ecology and Washington State Department of Agriculture).	1	1
h. Provide consultation and technical assistance to LHJs, other agencies and the general public.	1	1
<u>Shared Responsibilities at Department of Health and Local Health</u>		
i. Conduct timely investigation of complaints related to radioactive sources.	1	1
j. Maintain a trained and equipped radiation emergency response team(s) for radiological emergencies. Ensure external first responders and local health responders have received sufficient training. Educate, train, exercise, and evaluate staff at the WA DOH. Coordinate and integrate with local public health	1	1
k. Monitor and study radiation levels in the environment air, water, soils, foods and vegetation for possible health effects.	1	1
l. Radon monitoring, awareness, outreach and education.	1	1
6. Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes.		
a. Maintain relationships with partners in economic development, transportation, parks and land use agencies.	4	5
b. Understand and participate in land use, transportation, natural resources and other planning processes.	4	5
c. Provide technical assistance to planning agencies and community stakeholders to integrate standard environmental public health practices that prevent/reduce high risk for harmful environmental exposures to humans or disease transmission.	3	5

Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
d. Anticipate, analyze and communicate about changes in public health risk and benefits resulting from changes to the built and natural environment and potential impacts of climate change through the collection, analysis and interpretation of health and environmental public health data.	3	5
e. Provide input on potential health and equity impacts of projects, plans, programs or policies to ensure healthy and sustainable built and natural environments.	3	5
f. Document and evaluate integration of standard environmental public health practices into programs and planning processes that prevent high risk for harmful environmental exposures or disease transmission.	3	5
7. When additional important services are delivered regarding environmental public health, assure that they are well coordinated with foundational services.		
a. Identify and support relationships, interdependencies, and coordination needs between the foundational program and related AIS.	3	3
b. Leverage foundational program activities and funding to support identification and implementation of related AIS and vice versa.	3	3

**C. Prevention and Control of Communicable Disease and Other Notifiable Conditions**

1. Provide timely, statewide, locally relevant and accurate information statewide and to communities on prevention and control of communicable disease and other notifiable conditions.

Data and Data Systems and Analysis

a. Collect and maintain communicable disease, other notifiable conditions and immunization data to support prevention and control of communicable diseases and other notifiable conditions at the state and local level.	3	5
b. Develop and maintain up-to-date electronic statewide Immunization Information System (IIS). (Centralized activity – currently provided by DOH)	N/A	N/A
c. Conduct data entry, validation / clean-up and maintenance as needed to ensure data quality.	3	5
d. Access, analyze, and use immunization data to inform evidence-based interventions.	3	3
e. Develop and implement protocols for data and information sharing between public health, health care providers (pharmacists and veterinarians when appropriate), other local, state and federal agencies and the public to reduce disease transmission and increase immunization rates. Include protocols for confidentiality as appropriate.	4	5
f. Ensure that health care providers, pharmacists, school officials and the public are educated about the statewide IIS and how to enter, maintain and access correct data, as appropriate to ensure data quality.	4	5

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
g. Analyze, interpret and share communicable disease, other notifiable conditions and immunization data, including data pertaining to inequities.	3	4
<u>Reporting, Communications, and Policy</u>		
h. Measure the impact of communicable disease and other notifiable conditions and immunization rates on the health of the public, including priority populations.	3	4
i. Ensure health care facilities, health care providers, veterinarians and laboratories are educated about notifiable conditions requirements including the need for timely and accurate reporting and how to report.	4	5
j. Maintain capacity to prioritize and respond to data requests and as appropriate, prepare data files to share and make available to researchers and other stakeholders.	4	5
k. Produce and share periodic/routine reports of communicable disease and other notifiable conditions and immunization rates.	3	5
l. Inform decision makers of potential and actual impacts to public health based on communicable disease and other notifiable conditions data, immunization rates and published reports.	3	5
m. Provide the public, regulated facilities, health care facilities, health care providers and stakeholder organizations effective and timely communication about protection recommendations for communicable disease and other notifiable conditions while balancing the need to protect personal health information.	5	5
n. Use data, evidence-based practices and community input to facilitate development of public health policy, systems and environmental change initiatives for communicable disease, other notifiable conditions and immunization rates, including those designed to promote health equity.	3	3
<u>Prepare for Future Data Needs</u>		
o. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and GIS to meet user's requests.	3	3
p. Ability to develop and adapt data systems as needed.	3	3
2. Identify statewide and local community assets for the control of communicable diseases and other notifiable conditions, develop and implement a prioritized control plan addressing communicable diseases and other notifiable conditions and seek resources and advocate for high priority prevention and control policies and initiatives regarding communicable diseases and other notifiable conditions.		
a. Provide subject matter expertise to inform policy, system and environmental change; program design and communications to decision/policy makers, providers, the public and stakeholders about communicable disease and other notifiable condition risks.	4	4

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
<ul style="list-style-type: none"> <li>b. Identify, develop, engage and maintain <u>local</u> strategic partnerships with health care facilities, health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others to prevent, control and mitigate risks from communicable disease and other notifiable conditions.</li> </ul>	4	4
<ul style="list-style-type: none"> <li>c. Identify, develop, engage, and maintain strategic partnerships with <u>statewide</u> organizations, associations, and government agencies to prevent, control, and mitigate risk from communicable disease and other notifiable conditions.</li> </ul>	4	4
<ul style="list-style-type: none"> <li>d. Identify, develop, engage and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovations related to disease prevention, control and mitigation.</li> </ul>	3	3
<ul style="list-style-type: none"> <li>e. Work with partners to develop a prioritized control plan(s) addressing important communicable disease and other notifiable conditions, and immunization rates, as needed.</li> </ul>	3	3
<ul style="list-style-type: none"> <li>f. Work with partners to advocate for high priority policy, system and environmental change and other initiatives regarding communicable diseases and other notifiable conditions.</li> </ul>	2	2
<ul style="list-style-type: none"> <li>3. Promote immunization and use of the statewide immunization registry through evidence-based strategies and collaboration with schools, health care providers and other community partners to increase immunization rates.</li> </ul>		
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>a. Provide subject matter expertise to inform policy, systems and environmental change, program design, and communications to decision/policy makers, providers, the public and stakeholders about vaccine preventable disease and immunizations.</li> </ul> </li> </ul>	3	3
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>b. Ensure that health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others are educated about vaccine- preventable diseases, immunizations and use of the statewide immunization registry called the Immunization Information System (IIS).</li> </ul> </li> </ul>	4	4
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>c. Develop, implement, and enforce laws, rules, policies and procedures related to immunizations per local, state and federal mandates and guidelines (e.g. school/work exclusion, isolation and quarantine).</li> </ul> </li> </ul>	2	2
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>d. Identify, develop, engage and maintain <u>local</u> strategic partnerships with health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others to use evidence-based strategies that are culturally and linguistically appropriate to increase immunization rates in children and adults and in communities that are disproportionately impacted by low immunization rates.</li> </ul> </li> </ul>	4	4

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
e. Identify, develop, engage and maintain strategic partnerships with <u>statewide</u> organizations, associations and government agencies to use evidence-based strategies that are culturally and linguistically appropriate to increase immunization rates in children and adults and in communities that are disproportionately impacted by low immunization rates.	3	3
f. Identify, develop, engage, and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovation regarding immunizations.	3	3
g. Work with partners to develop a prioritized plan addressing important immunization issues.	3	3
h. Work with partners to advocate for high priority policy, system, and environmental change initiatives regarding immunizations.	3	2
4. Ensure disease surveillance, investigation, and control for communicable disease and notifiable conditions in accordance with local, state and federal mandates and guidelines.		
a. Notify health care providers, laboratories and health care facilities within the jurisdiction about the requirements related to notifiable conditions.	4	5
b. Establish and maintain 24/7 access to receive and respond to case reports in a timely manner according to Washington Administrative Code (WAC) and Revised Code of Washington (RCW) timeframes.	5	5
c. Maintain written protocols and procedures for conducting investigations of suspected or identified public health problems/hazards including investigation steps, responsible parties, timelines, handling and submission of specimens, communication with the public health lab and coordination with other applicable agencies. These should address in addition how the principal health care provider will be notified, the use of prophylaxis, the process of exercising legal authority for disease control, internal and external communication.	5	5
d. Utilize scientific methods and best practices, when indicated, to collect environmental samples and human specimens for laboratory analysis to confirm or rule out disease presence. This includes packaging in conformance with DOT and USPS requirements and shipping to a certified laboratories for analysis.	5	5
e. Receive case reports and other identifiable data from a variety of providers and laboratories and other reporters.	5	5
f. Include protocols to ensure confidentiality of protected health information throughout inspection, investigation, reporting and maintenance of data.	5	5
g. Develop and maintain a system/process to communicate rapidly with health care providers during public health emergencies.	5	5
h. Evaluate disease control investigations and response and use findings to improve response processes and procedures.	3	4

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
<ul style="list-style-type: none"> <li>i. Provide consultation and technical assistance to other local and state agencies and the general public. Provide disease-specific and technical expertise regarding epidemiologic and clinical characteristics of diseases of public health significance to health care professionals, veterinarians, and others. Advise health care practitioners about evidence-based practices for communicable disease and other notifiable conditions diagnosis, treatment, control and prevention.</li> </ul>	5	5
<u>Disease Surveillance and Investigation</u>		
<ul style="list-style-type: none"> <li>j. Develop, implement and enforce laws, rules, policies and procedures related to the investigation and control of communicable diseases and other notifiable conditions per federal, state and local mandates and guidelines (e.g. school/work exclusion, isolation and quarantine).</li> </ul>	5	5
<ul style="list-style-type: none"> <li>k. Monitor occurrence and distinguishing characteristics and trends of communicable diseases and other notifiable conditions to identify outbreaks and other emerging events (e.g. disease clusters, source and geographical region).</li> </ul>	4	5
<ul style="list-style-type: none"> <li>l. Conduct or assist with outbreak investigations that have a communicable disease or other notifiable condition component. Maintain outbreak response and control protocols, including accessing resources and assistance after normal work hours.</li> </ul>	5	5
<ul style="list-style-type: none"> <li>m. Conduct timely investigation of complaints related to communicable disease or other notifiable conditions, including ensuring capacity to identify and respond to rare or previously unidentified infections (conditions for which formal protocols do not yet exist) or novel modes of transmission. Maintain capacity (including a system/process) for prioritization and respond to investigate cases and control disease outbreaks within the jurisdiction, in collaboration with partners.</li> </ul>	4	4
<ul style="list-style-type: none"> <li>n. Maintain a tracking log of all case reports and investigations.</li> </ul>	5	5
<u>Specific Conditions of Public Health Importance</u>		
<ul style="list-style-type: none"> <li>o. Provide partner notification services for newly diagnosed cases of syphilis, gonorrhea, Hepatitis C and HIV, according to Centers for Disease Control and Prevention (CDC) guidelines.</li> </ul>	5	5
<ul style="list-style-type: none"> <li>p. Provide surveillance, disease investigation and control (including partner services and linkage to curative treatment) for Hepatitis C, according to CDC guidelines.</li> </ul>	3	3
<ul style="list-style-type: none"> <li>q. Maintain adequate expertise and resources to ensure the identification and appropriate treatment of individuals who have latent tuberculosis (TB) infection and active tuberculosis, including the provision of directly-observed therapy for active TB according to CDC guidelines.</li> </ul>	3	5
<ul style="list-style-type: none"> <li>r. Provide education to and coordinate with health care providers to ensure appropriate screening, reporting and treatment of TB.</li> </ul>	5	5
<ul style="list-style-type: none"> <li>s. Maintain the ability to identify and provide education for a community provider willing to treat latent TB.</li> </ul>	5	5
<ul style="list-style-type: none"> <li>t. Conduct timely contact investigation for all active pulmonary TB cases per state guidelines.</li> </ul>	5	5

Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
u. Review overseas medical records and chest radiographs on all class B immigrants; if needed, perform additional evaluation to ensure active disease is ruled out.	3	5
v. Maintain access to consultation with a public health physician with experience in diagnosis and treatment of TB as well as contact investigations.	5	5
<u>New and Emerging Conditions and Emergencies</u>		
w. Develop and implement plans to identify and respond to emerging infectious diseases (e.g. Severe Acute Respiratory Syndrome [SARS], Middle East Respiratory Syndrome [MERS] and Ebola).	4	5
x. Coordinate communicable disease and other notifiable conditions public health efforts with Tribal Nations and federal and state partners (e.g. CDC, U.S Food and Drug Administration [FDA], U.S. Department of Agriculture [USDA], U.S. Environmental Protection Agency [EPA], Washington State Department of Ecology and Washington State Department of Agriculture).	4	5
y. Ensure the ability to recognize instances of potential biological terrorism and conduct and coordinate appropriate investigations, laboratory testing, and management of exposed persons in collaboration with first responder and law enforcement agencies.	5	5
z. Develop action plans for communicable disease and other notifiable conditions emergencies.	5	5
aa. Develop, maintain and coordinate to provide surge capacity to other public health agencies during emergency events or large outbreaks.	3	5
bb. Develop and maintain plans for the allocation of scarce resources and medical countermeasures in the event of an emergency or outbreak in collaboration with the regional health care system.	4	4
5. Ensure availability of governmental public health laboratory services for disease investigations and response, and reference and confirmatory testing related to communicable diseases and notifiable conditions. (Centralized activity – currently provided primarily by DOH with support from Public Health – Seattle-King County)		
6. When additional important services are delivered regarding prevention and control of communicable disease and other notifiable conditions, ensure that they are well coordinated with foundational services.		
a. Identify and support relationships, interdependencies and coordination needs between the foundational program and related additional important services (AIS).	5	5
b. Leverage foundational program activities and funding to support identification and implementation of related AIS and vice versa.	5	5

**D. Maternal/Child/Family Health**

1. Provide timely, statewide and locally relevant and accurate information statewide and to communities on emerging and ongoing maternal, child and family health trends, taking into account the importance of childhood adversity and health inequities.

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
<u>Data and Data Systems and Analysis</u>		
a. Anticipate future data needs, track new methods of data collection and technology, explore new data sources, identify new uses of data and suggest technological, data architecture, staffing and resource solutions to meet data needs and improve effectiveness and efficiency.	3	3
b. Develop and implement protocols for data and information sharing between public health, health care providers, Tribal Nations, other local, state, and federal agencies and the public. Include protocols for confidentiality as appropriate.	3	3
c. Analyze, interpret and share public health data regarding the status of maternal, child and family health including trends and data pertaining to risk factors and social and health inequities.	3	3
d. Collect and maintain data on health outcomes for preconception, prenatal, natal and postnatal care; childhood, maternal and family health (e.g. Pregnancy Risk Assessment and Monitoring System [PRAMS] and maternal and child death reviews) to support public health functions at the state and local level, including risk factors and demographic information.	3	3
<u>Reporting, Communications, and Policy</u>		
e. Maintain capacity to prioritize and respond to data requests and as appropriate, prepare data files to share and make available to researchers and other stakeholders.	3	3
f. Monitor knowledge, attitudes, behaviors and health outcomes related to maternal, child and family health and risk factors by using data provided by the state or by conducting surveillance locally.	3	3
g. Produce and share periodic/routine reports on the status of the health of mothers, children and families as well as risk factors that impact their health.	2	2
h. Inform decision makers of potential and actual impacts to maternal, child and family health and contributing factors based on data and published reports.	2	2
i. Provide the public, health system partners and stakeholder organizations effective and timely communication about recommendations to protect and improve maternal, child and family health.	3	3
j. Use data, emerging science (e.g. neuroscience, epigenetics, Adverse Childhood Experiences, resilience) and evidence-based practices to facilitate development of public health policy, systems and environmental change initiatives to protect and improve maternal, child and family health, including those designed to promote health equity.	2	2

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
<u>Prepare for Future Data Needs</u>		
k. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and GIS to meet user's requests.	3	3
l. Develop and adapt data systems as needed.	3	3
2. Identify local maternal, child, and family health community assets, develop a prioritized prevention plan using life course expertise and an understanding of health inequities, seek resources and advocate for high priority policy initiatives.		
a. Identify, disseminate and promote emerging and evidence-based information about interventions in the preconception, pregnancy and early childhood periods that optimize lifelong health and social-emotional development.	2	2
b. Make training opportunities available in social determinants of health and the health impact of prenatal and early childhood experiences.	3	3
c. Identify and promote the use of innovative strategies related to childhood adversity and interventions based on evidence-based or promising practices.	4	4
d. Provide subject matter expertise to inform policy, systems and environmental change, program design, and communications to decision makers, providers, the public and stakeholders about maternal, child and family health risks and protective factors.	2	3
e. Identify, develop, engage and maintain local strategic partnerships with health systems and social service systems, schools, child care centers, businesses, neighborhoods, parents, caregivers and others to strengthen and support families and reduce sources of child and family stress.	2	3
f. Identify, develop, engage and maintain strategic partnerships with statewide organizations, associations and government agencies to address adverse impacts to mothers, children and families.	3	3
g. Identify, develop, engage, and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovation.	2	2
h. Engage and support diverse community members and other partners to develop and implement prioritized plans for addressing important maternal, child and family health risks, taking into consideration the impact of social and physical environments on health and well-being.	3	3
i. Work with partners to advocate for high priority policy, system, and environmental change initiatives regarding maternal and child health and seek funding to implement evidence-based or innovative prevention initiatives.	2	2
3. Assure mandated newborn screening done by the state public health lab to test every infant born in Washington to detect and prevent the developmental impairments and life-threatening illnesses associated with congenital disorders that are specified by the State Board of Health. (Centralized activity – currently provided by DOH)		

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
4. When additional important services are delivered regarding maternal, child and family health, assure that they are well coordinated with foundational services.		
a. Identify and support relationships, interdependencies, and coordination needs between the foundational program and related additional important services (AIS).	1	1
b. Leverage foundational program activities and funding to support identification and implementation of related AIS and vice versa.	1	1
<b>E. Access/Linkage with Medical, Oral and Behavioral Health Care Services</b>		
1. Provide accurate timely, statewide and locally relevant information statewide and to communities on the medical, oral and behavioral health care system.		
<u>Data and Data Systems and Analysis</u>		
a. Collect and maintain data to support public health at the state and local level (e.g. Health Professional Shortage Areas [HPSA] and other data).	2	2
b. Access, analyze, interpret and share data about health care, including disaggregating data to identify inequities.	3	3
c. Collect and maintain health care provider and facility licensing, inspection and enforcement data to support public health at the state level.	N/A	N/A
d. Develop and implement protocols for data and information sharing between public health, health care providers, health care systems, Tribal Nations, other local, state, and federal agencies and the public. Include protocols for confidentiality as appropriate.	4	4
e. As appropriate, prepare data files to share and make available to researchers and other stakeholders.	1	1
<u>Reporting, Communications, and Policy</u>		
f. Produce and share periodic/routine reports of health care access and regulation of health care providers and facilities.	2	2
g. Inform decision makers of potential and actual impacts to the health of the public based on data and published reports.	3	3
h. Provide the public, regulated facilities and stakeholder organizations with effective and timely communication of recommendations for medical, oral and behavioral health care and ensuring public safety.	2	3
i. Use data and evidence-based practices to facilitate development of public health policy, systems and environmental change initiatives for medical, oral and behavioral health care and public safe, including those designed to promote health equity.	2	2
<u>Prepare for Future Data Needs</u>		
j. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and GIS to meet user's requests.	2	3

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
k. Ability to develop and adapt data systems as needed.	2	2
2. Participate actively in local, regional and state level collaborative efforts regarding medical, oral and behavioral systems planning to improve health care quality and effectiveness, reduce health care costs and improve population health.		
a. Continuously work with local and state partners to improve health care quality and effectiveness, reduce health care costs and improve population health. Identify evidence-based interventions and promising practices for population health, especially those that are upstream and preventative. Share information with partners and the public on these interventions.	2	2
b. Collaborate with partners in finding funding for these interventions.	2	2
c. Evaluate progress on health care quality and effectiveness, reduction of health care costs and improving population health at the state and local level every three to five years. Use findings to improve intervention strategies with partners.	2	2
d. In concert with local, state and national health care providers and groups, develop and implement prioritized plans for assuring access to specific clinical services of public health importance, such as family planning, key services for pregnant women and their infants (e.g. maternity support and Women, Infants, and Children [WIC]) and sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) testing and treatment; appropriate follow-up for positive newborn screening test (e.g. referrals to the Children with Special Health Care Needs [CSHCN] program) and positive blood lead levels; seek resources and advocate for high priority policy initiatives.	2	3
e. Provide subject matter expertise to inform policy, systems and environmental change, program design, and communications to decision makers, providers, the public and stakeholders about relevant public health risks. This includes building understanding of social determinants of health, risk and protective factors and the value of prevention and early upstream intervention to improve population health and reduce costs.	3	3
f. Identify, develop, engage and maintain local strategic partnerships with health and behavioral health systems, community groups, social services, criminal justice, education system and others to increase access to services of public health importance.	3	3
g. Identify, develop, engage and maintain strategic partnerships with statewide organizations, associations and government agencies to increase access services of public health importance.	3	3
h. Work with partners to develop a prioritized plan addressing increased access to high priority public health services.	3	3
i. Work with partners to advocate for high priority policy, system, and environmental change initiatives regarding access to high priority public health services and seek funding to implement evidence-based or innovative prevention and disease control initiatives considered FPHS.	3	3

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
j. Identify, develop, engage and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovation.	3	3
k. Work with local health care systems to address health care shortages and emergent health care gaps.	2	2
3. Improve patient safety through inspection and licensing of health care facilities and licensing, monitoring and discipline of health care providers. (Centralized activity – currently provided by DOH)		
4. When additional important services are delivered regarding medical, oral and behavioral health, assure that they are well coordinated with foundational services.		
a. Identify and support relationships, interdependencies, and coordination needs between the foundational program and related additional important services (AIS).	1	1
b. Leverage foundational program activities and funding to support identification and implementation of related AIS and vice versa.	1	1

### F. Chronic Disease, Injury and Violence Prevention

1. Provide timely, state and locally relevant and accurate information statewide and to communities on chronic disease (including behavioral health), injury and violence prevention.

#### Data and Data Systems and Analysis

- |  |   |   |
|--|---|---|
| a. Collect and maintain data (including risk factors and demographic information) on chronic disease, injuries and violence to support public health functions at the state and local level.   | 2 | 2 |
| b. Analyze and interpret, and share public health data regarding chronic disease, injuries and violence including trends, data pertaining to risk factors and inequities.  | 2 | 2 |
| c. Develop and implement protocols for data and information sharing between public health, health care providers, Tribal Nations, other local, state, and federal agencies, and the public to reduce chronic disease, injuries and violence. Include protocols for confidentiality as appropriate. | 3 | 3 |
| d. Measure the impact of chronic disease, injuries and violence on the health of the public, including priority populations.   | 3 | 4 |
| e. As appropriate, prepare data files to share and make available to researchers and other stakeholders.   | 2 | 2 |

#### Reporting Communications and Policy

- |   |   |   |
|---|---|---|
| f. Monitor knowledge, attitudes, behaviors and health outcomes related to chronic disease, injuries, and violence and risk factors by using data provided by the state or by conducting surveillance locally. | 3 | 3 |
| g. Inform decision makers of potential and actual impacts to public health from chronic disease, injuries, and violence based on data and published reports.  | 3 | 3 |
| h. Produce and share periodic/routine reports of rates of chronic disease injuries, and violence as well as risk factors and inequities.  | 3 | 3 |

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
i. Provide the public, regulated facilities, and stakeholder organizations effective and timely communication about recommendations to prevent chronic disease, injuries and violence.	3	3
j. Use data and evidence-based practices to facilitate development of public health policy, systems and environmental change initiatives for preventing chronic disease, injuries and violence, including those designed to promote health equity.	3	3
<u>Prepare for Future Data Needs</u>		
k. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and geographic information systems (GIS) to meet user's requests.	3	3
l. Develop new and adapt existing data systems as needed.	3	3
2. Identify state and local chronic disease (including behavioral health), injury and violence prevention community assets; develop and implement a prioritized prevention plan and seek resources and advocate for high priority policy initiatives to reduce statewide and community rates of chronic disease, injury and violence.		
a. Provide subject matter expertise to inform policy, systems and environmental change, program design, and communications to decision makers, providers, the public and stakeholders about chronic disease, injury and violence risks.	3	3
b. Develop a community asset map that identifies state and local strategic partnerships, including academic institutions and/or research centers.	3	3
c. Identify, develop, engage and maintain local and statewide strategic partnerships with organizations, associations and government agencies, academic institutions and/or research centers to advance evidence-based practice and innovation to prevent chronic disease, injuries and violence.	3	3
d. Work with partners to review, update and implement a prioritized plan of best and emerging practices aligned with state and national guidelines to address important chronic disease, injury and violence risks and Healthy People6 federal guidelines objectives.	3	3
e. In concert with local, state and national local health community partners, develop and implement prioritized plans for assuring access to specific chronic disease, behavioral health, injury and violence prevention programs and services of public health importance, such as: Reducing rates of tobacco use through activities to reduce youth initiation, increase cessation and reduce secondhand smoke exposure; Increase statewide and community rates of healthy eating and active living; and Seek resources and advocate for high priority policy initiatives.	3	3
f. Work with partners to advocate for policy, system and environmental change initiatives regarding chronic disease, injury and violence prevention.	3	3

Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
g. Seek funding to implement evidence-based or innovative prevention initiatives.	3	3
h. Periodically evaluate progress on reducing rates of chronic disease, injuries, violence and contributing risk factors and use findings to improve prevention strategies.	3	3
3. When additional important services are delivered regarding chronic disease, injury and violence prevention, assure that they are well coordinated with foundational services.		
a. Identify and support relationships, interdependencies and coordination needs between the foundational program and related additional important services (AIS).	1	1
b. Leverage foundational program activities and funding to support identification and implementation of related AIS and vice versa.	1	1

**G. Assessment (Surveillance and Epidemiology)**

1. Ability to collect sufficient data and develop and maintain electronic information systems to guide public health planning and decision making at the state, regional and local level:

Foundational data include (but are not limited to):

- Behavioral Risk Factor Surveillance System (BRFSS),
- Healthy Youth Survey (HYS), and
- Vital statistics.

Foundational information systems include:

- Washington Disease Reporting System (WDRS),
- Washington Electronic Lab Reporting System (WELRS), and
- Selected clinical data systems (e.g. Comprehensive Hospital Abstract Reporting System [CHARS] and Community Health Assessment Tool [CHAT]).

Data and Data Systems and Analysis

a. Assure access to public health informatics capability.	2	3
b. Develop and implement policies and procedures to standardize and promote best practices related to data systems, analytic methods and tools to promote data quality, accuracy and timeliness statewide.	2	2
c. Maintain ability to collect primary data and share it with Tribal Nations and governmental public health authorities.	1	1
d. Develop and maintain up-to-date electronic information systems for public health surveillance for statewide notifiable disease reporting and investigation (e.g. WDRS).	5	5
e. Develop and maintain up-to-date electronic information systems for public health surveillance for statewide notifiable disease reporting from laboratories (e.g. Public Health Reporting of Electronic Data [PHRED]).	N/A	N/A
f. Develop and maintain up-to-date electronic information systems for public health surveillance for statewide collection of selected clinical data sets such as real-time Emergency Room, sentinel outpatient and hospitalization records and hospital discharge data (e.g. CHARS).	3	3

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
g. Develop and maintain up-to-date electronic information systems for public health surveillance online data analysis of individual data sets and online compilation and analysis of multiple health-related data sets to support governmental agencies in understanding the health of communities and people (e.g. CHAT).	4	4
h. Ensure collection of behavioral data via the BRFSS (annual) and HYS (biennial), including as appropriate: <ul style="list-style-type: none"> <li>▪ Work with partners to design survey questions and parameters within the funds available.</li> <li>▪ Oversee contracts to administer the survey.</li> <li>▪ Coordinate the data collection.</li> <li>▪ Prepare data for independent analyses by stakeholders.</li> </ul>	N/A	N/A
<u>Reporting, Communications, and Policy</u>		
i. Ensure access to shared data between Tribal Nations and governmental public health authorities that pertain to the health status of the population they serve.	1	1
j. Provide training and technical assistance to local health jurisdictions and community partners on the use of foundational data for assessment.	3	3
<u>Prepare for Future Data Needs</u>		
k. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and GIS to meet user's requests.	3	4
l. Develop and adapt data systems as needed.	3	3
2. Ability to access, analyze, use and interpret data, including:		
<ul style="list-style-type: none"> <li>▪ U.S. Census,</li> <li>▪ Vital Statistics,</li> <li>▪ Notifiable condition data,</li> <li>▪ Selected clinical data sets including Comprehensive Hospital Abstract Reporting System (CHARS),</li> <li>▪ Behavioral Risk Factor Surveillance System (BRFSS),</li> <li>▪ Healthy Youth Survey (HYS),</li> <li>▪ Basic community and environmental health indicators, and</li> <li>▪ Financial data.</li> </ul>		
a. Develop and implement policies and procedures to standardize and promote best practices related to data systems, analytic methods and tools to promote data quality, accuracy and timeliness.	3	3
b. Analyze data, prepare and publish standardized reports and report on specific topics as needed. Assure accuracy of data and interpretation.	3	3
c. Produce summaries on key indicators of community health, which include information about social determinants of health.	3	3

Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
d. Provide and use the results of health data analysis (including inequities) to develop culturally appropriate recommendations regarding public health policies, processes, programs or interventions.	3	3
e. Facilitate the sharing of data, resources and expertise through partnerships and relationships.	3	3
f. Maintain 24/7 access to public health surveillance system. Maintain and implement written processes and/or protocols to collect surveillance data from multiple sources and to review and analyze those data, and report out the data, including how they are collected.	3	3
g. Assist agency leadership with identification of health priorities and policies based on data analysis, scientific literature, best practices and promising practices.	3	3
h. Provide scientific and epidemiologic expertise to support leadership.	3	3
i. Provide technical assistance to other governmental public health entities and partners regarding access, use, analysis and interpretation of data related to protecting and improving the public’s health.	3	3
j. Include protocols for confidentiality as appropriate, and assure consistency in adherence to data sharing agreements and security policies.	4	4
k. Prioritize and respond to information and data requests and translate data into information and reports that are valid, statistically accurate and readable by the intended audiences.	3	3
3. Ability to conduct a comprehensive community or statewide health assessment and identify health priorities arising from that assessment, including analysis of health disparities and the social determinants of health.		
a. Conduct a comprehensive state health assessment (SHA) every three to five years in conjunction with the governmental public health system and other statewide partners.	N/A	N/A
b. Conduct a local and/or regional comprehensive community health assessment (CHA) everett three to five years in conjunction with community partners.	4	3
c. Develop a state health improvement plan (SHIP) in conjunction with the governmental public health system and other statewide partners.	N/A	N/A
d. Develop a local and/or regional community health improvement plan (CHIP) in conjunction with community partners.	2	2

**H. Emergency Preparedness (All Hazards)**

1. Ability to develop emergency response plans for natural and man-made public health hazards, train public health staff for emergency response roles and routinely exercise response plans.
  - a. Maintain written procedures for Emergency Support Function 8 – Public Health & Medical (ESF8) in the State or County Comprehensive Emergency Management Plan (CEMP) and/or the Public Health Response Plan.
 

5	3
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## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
b. Develop and sustain local and state-level emergency response teams to provide surge capacity in the areas of environmental public health, epidemiology and surveillance, medical countermeasures response, incident command, radiological response, health care response and emergency medical services (EMS) response. Ensure teams are rostered, trained and exercised annually.	3	3
c. Develop and sustain local and statewide mutual aid and partnership agreements with and among governmental public health system and Tribal Nations pharmacies, health care organizations, private sector, community organizations and other state agencies.	2	2
d. Develop and maintain a public health preparedness training and exercise plan. <ul style="list-style-type: none"> <li>• Conduct training and exercise on the jurisdiction’s ESF8 response plans, public health plan and policies for staff who serve in the agency or jurisdiction Emergency Operations Center (EOC).</li> <li>• Ensure training addresses how the ESF8 response and public health response is coordinated within the jurisdiction’s incident command system.</li> <li>• Write after action reports (AARs) documenting lessons learned from exercises. Identify corrective actions and track progress in completing those actions.</li> </ul>	4	4
<ul style="list-style-type: none"> <li>• Conduct training and exercise on the jurisdiction’s ESF8 response plans, public health plan and policies for staff who serve in the agency or jurisdiction Emergency Operations Center (EOC).</li> </ul>	2	3
<ul style="list-style-type: none"> <li>• Ensure training addresses how the ESF8 response and public health response is coordinated within the jurisdiction’s incident command system.</li> </ul>	2	3
<ul style="list-style-type: none"> <li>• Write after action reports (AARs) documenting lessons learned from exercises. Identify corrective actions and track progress in completing those actions.</li> </ul>	4	3
e. Train appropriate public health emergency response staff on information management systems used by public health and emergency management agencies.	3	3
f. Maintain a continuity of operations plan (COOP) for the agency. Plans include definition and identification of essential services, line of succession, written delegation of authority for select critical positions and protocols for temporarily discontinuing specific functions to sustain critical services.	1	3
g. Plan or participate in, and document, annual emergency preparedness exercises. Include community partners such as schools, hospitals, emergency management, first responders, community organizations and organizations serving priority populations in exercise design and implementation.	3	3
2. Ability to lead the Emergency Support Function 8 – Public Health & Medical and/or a public health response for the county, region, jurisdiction and state.		
a. Develop, train and exercise a decision-making protocol to support agency leadership in making policy-level decisions during public health incidents.	2	3
b. Develop and maintain strategic partnerships with local agencies, non-profit organizations, private sector, health care organizations, state agencies and associations to support public health preparedness, recovery and resilience efforts.	3	3
c. Define roles and responsibilities of public health leaders in establishing short-term and long-term community recovery goals.	1	1

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
3. Ability to activate and mobilize public health personnel and response teams; request and deploy resources; coordinate with public sector, private sector and non-profit response partners and manage public health and medical emergencies utilizing the incident command system.		
a. Establish and maintain a process for 24/7 access, including coverage and availability, for urgent public health issues.	4	4
b. Maintain an emergency notification system (e.g. WASECURES, E911 Dispatch, or similar system) and include all critical public health response and leadership positions, and essential partners as appropriate, as registered users.	3	3
c. Conduct routine staff notification exercises, evaluate results, address issues and make improvements.	2	2
d. Maintain procedures for requesting assistance during disasters from the local or state Emergency Operations Center (EOC) and mutual aid partners.	2	2
e. Use the incident command system to:		
• Determine objectives to address the health needs of those affected,	4	4
• Develop situational assessments to determine the functionality of critical public health operations, critical health care facilities, critical infrastructure, and the number of ill, injured, and deceased,	4	4
• Identify and allocate resources to address public health needs,	4	4
• Return to routine operations, and	4	4
• Write after action reports documenting lessons learned from real life activations of plans. Identify corrective actions and track progress in completing those actions.	4	4
f. Maintain and exercise procedures and agreements with health care, private sector and community partners to request, receive, distribute and dispense medical countermeasures for statewide and community-wide public health incidents.	2	2
4. Ability to communicate with diverse communities across different media, with emphasis on populations that are disproportionately challenged during disasters, to promote resilience in advance of disasters and protect public health during and following disasters.		
a. Maintain and annually exercise procedures and various tools to inform the public of threats to health and safety in a manner that is culturally and linguistically appropriate.	4	4
b. Create and maintain templates for news releases and social media posts for categories of public health hazards.	4	4
c. Work with community leaders, partners, and organizations serving priority populations to communicate public health and health care preparedness, recovery and resilience efforts.	2	2

Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
<b>I. Communication</b>		
1. Ability to engage and maintain ongoing relations with local and statewide media.		
a. Develop and maintain a media relations plan and policies for leveraging media in communicating with the public effectively.	5	5
b. Build and maintain relationships with media outlets.	5	5
2. Ability to develop and implement a communication strategy, in accordance with Public Health Accreditation Standards, to increase visibility of public health issues. This includes the ability to provide information on health risks, healthy behaviors and disease prevention in culturally and linguistically appropriate formats for the various communities served.		
<u>Communications Strategy</u>		
a. Develop and implement a communication plan that includes strategies that describe the role and responsibilities of public health, including the mission and value.	4	4
b. Apply health education and behavior change principles and audience research and analysis to develop communication strategies and plans. This includes using data about the demographics of the general community and specific populations to tailor communication to specific audiences, such as policy makers, stakeholders, local public health authorities, health care providers, the public and specific population groups.	3	3
c. Maintain a list of staff or contractors who provide interpretation, translation or other specific communication services.	5	5
d. Upon request, provide technical assistance to programs and LHJs on the development of communication plans and strategies.	5	4
e. Make health information accessible by using communication channels preferred by target audiences, including a public-facing website, social media platforms, text messaging and other mobile platforms.	5	4
f. Provide a notification system for public health updates or advisories and a 24/7 contact numbers for reporting health emergencies.	5	5
g. Support ongoing public interaction by ensuring that communications allow for two-way communications with the public (e.g. contact information, surveys, comment boxes, phone, social media and community engagement meetings).	4	4
h. Evaluate the effectiveness of communications efforts using tools such as web analytics, surveys or polls. Adjust communications and communications strategies accordingly.	5	5
i. Inform and/or coordinate communications between LHJs, state government, national organizations and federal agencies, including the Centers for Disease Control and Prevention.	5	5
<u>Regular and Ongoing Communications</u>		
j. Provide routine communications to the public.	5	5

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
k. Maintain an up-to-date public website and social media platforms (e.g. Twitter, Facebook and blogs, etc.) that can provide public health information, as part of regular monitoring and responding to community concerns, both routinely and during an emergency.	5	5
<u>Emergency Communications Response</u>		
l. Have, test, use and maintain an emergency communication plan with defined policies and procedures.	4	5
m. Establish or participate in an alert network or similar system to receive and issue alerts 24/7.	5	5
<b>J. Policy Development and Support</b>		
1. Ability to develop basic public health policy recommendations. These policies must be evidence-based, or, if innovative/promising, must include evaluation plans.		
a. Identify and incubate locally-appropriate, evidence-based policy, systems and environmental change strategies to improve health outcomes or innovative/promising strategies using an established policy change framework that includes problem identification, policy analysis, strategy and policy development, policy enactment, policy implementation and policy evaluation.	3	5
b. Develop a strategic policy agenda that includes specific strategies to improve public health at the system level. The plan should contain strategic policy priorities and goals and should align with other plans (e.g. health improvement plan, strategic plan) but can also include policy goals not related to other plans if appropriate.	2	3
c. Monitor emerging public health issues, conduct policy analysis and develop policy positions in concert with local, state and national partners.	3	5
d. Take a leadership role for communication about how policy changes may impact health.	1	3
e. Access literature, journals and research on evidence-based policy options.	2	5
2. Ability to work with partners and policy makers to enact policies that are evidence-based (or are innovative and/or promising and include evaluation plans) and that address the social determinants of health and health equity.		
a. Coordinate local, state and federal public health policy agendas where appropriate to intentionally advance health equity.	2	5
b. Develop and implement the strategic policy agenda through agency/organization policy, new/revised public health programs, development/proposal of guidelines, rules, regulations or laws that used evidence-based or innovative/promising practices with a focus on eliminating health, racial, income, geographic and other inequities.	1	4
c. Analyze, interpret and respond to proposed policy, and, if enacted, implement local, state and federal policy changes. Describe the impact on public health and health equity.	3	4

Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
d. Coordinate within the governmental public health system and with federal agencies and other partners on policies that affect public health and health equity.	3	4
e. Provide support (e.g. information sharing and technical assistance) to policy leads working in local organizations and, upon request, participate in policy initiatives including those that include multiple organizations.	1	4
f. Provide access to public health law consultation and technical assistance (e.g. state attorney general and legal technical assistance groups).	1	1
g. Analyze pending legislation, estimate costs for new work, provide data and information as requested by lawmakers and testify on proposed policy changes if appropriate.	3	4
h. Review existing laws and work with governing entities and elected/appointed officials to update as needed.	2	4
i. Monitor and/or track policies under consideration by the regulatory authority, elected officials, government officials and/or other entities that set policies and practices that impact public health.	3	4
j. Evaluate implemented policies to determine whether policy goals were met and use findings to improve and/or revise policies.	1	3
3. Ability to utilize cost-benefit information to develop an efficient and cost-effective action plan to respond to the priorities identified in a community and/or statewide health assessment.		
a. Access resources to develop and/or make available economic analyses (e.g. cost and/or risk of non-investment, return on investment) for proposed policy changes at the local and/or state level.	1	2
b. Ensure access to experts to evaluate the social and economic impact of public health policies (e.g. contracts with economists, if needed).	1	2

**K. Community Partnership Development**

1. Ability to create and maintain relationships with diverse partners, including health-related national, statewide, and community-based organizations; community groups or organizations representing populations experiencing health inequity; private businesses and health care organizations; Tribal Nations and local, state and federal government agencies and leaders.
  - a. Create and maintain relationships with and convene cross-sector and cross-cultural stakeholders to establish shared local or statewide priorities, identify a common vision and values and build partnerships to develop and implement coordinated activities to address priority public health issues, with attention to health equity.
 

	3	4
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  - b. Evaluate the effectiveness of cross-sector and cross-cultural partnerships in a culturally appropriate way, including evaluating DOH or LHJs as partners. As part of evaluation efforts, address successes, lessons learned, recognized barriers to such collaboration and strategies to overcome these barriers.
 

	1	3
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Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
2. Ability to select and articulate governmental public health roles in programmatic and policy activities and coordinate with these partners.		
a. Convene public health and cross-sector and cross-cultural partners to promote health and address public health issues and health equity.	4	4
b. Coordinate policy agendas with partner organizations to advance cross-cutting, strategic goals.	1	3
c. Engage affected communities in developing policy and conducting community/state health assessments and developing health improvement plans to ensure efforts to leverage community resources are community-oriented and culturally-appropriate.	3	3

**L. Business Competencies**

1. Leadership Capabilities. Ability to lead internal and external stakeholders to consensus and action planning (adaptive leadership) and to serve as the public face of governmental public health in the community.		
a. Provide leadership and managerial oversight to the agency.	4	3
b. Engage in public health policy development, discussion and adoption with local, state and national policy makers to help define the strategic direction of public health initiatives.	3	4
c. Lead collaborations with external and cross-sector partners to develop a vision for a healthy community.	2	2
d. Develop and implement a governmental public health authority-specific strategic plan to guide resource allocation for strategic priorities.	2	3
e. Convene members of the governmental public health system and partners to create opportunities to work together to improve the public’s health.	2	2
f. In collaboration with partners and stakeholders, set the strategic direction and goals for the governmental public health system in Washington.	4	4
2. Accountability and Quality Assurance Capabilities. Ability to uphold business standards and accountability in accordance with local, state, and federal laws, regulations and policies and to align work with national and Public Health Accreditation Standards.		
a. Develop and implement written operations policies and procedures, including organizational charts.	3	3
b. Develop and implement policies and procedures that relate to identification and resolution of ethical issues.	3	2
3. Quality Improvement Capabilities. Ability to evaluate programs and continuously improve processes.		
a. Use performance management, quality improvement tools and coaching to promote and monitor organizational objectives and sustain a culture of quality.	4	2
b. Develop and maintain performance standards, including goals, targets and performance measures.	2	2

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
c. Collect, maintain and analyze longitudinal data on defined performance measures.	3	4
d. Collect, maintain and analyze feedback from customers.	4	3
e. Use performance data to inform quality improvement and program planning.	2	2
f. Communicate goals, targets and performance measures to governmental public health, elected officials and the public.	3	3
g. Generate regular progress reports that analyze data and communicate performance results.	2	3
h. Assist public health programmatic staff and content experts with the development and collection of performance measures used to monitor performance over time.	2	3
i. Provide subject matter expertise to programs, agencies and partners regarding: <ul style="list-style-type: none"> <li data-bbox="391 777 1192 840">▪ Meaningful milestones, performance measures, targets and goals for which the appropriate level and frequency of data is available.</li> <li data-bbox="391 848 1175 911">▪ Monitoring, evaluating, analyzing and reporting on performance measures.</li> </ul>	2	2
<ul style="list-style-type: none"> <li data-bbox="391 924 1097 987">▪ Use of quality improvement methods and other tools and techniques, such as Lean, to improve performance.</li> <li data-bbox="391 995 1127 1058">▪ Use of financial data, as appropriate, in program evaluation, program design, organization and delivery.</li> <li data-bbox="391 1066 1192 1197">▪ Literature and resources on the efficiency and effectiveness of alternate structures or processes for delivering services, including published program evaluations and related evidence-based research.</li> </ul>	2	2
j. Evaluate the efficacy and efficiency, including the financing, organization/structure and delivery of public health policies, programs, strategies, interventions and processes using a variety of evaluation approaches and frameworks.	1	1
k. Produce summaries describing the impact of public health policies, programs and strategies on health outcomes, including economic analyses, when appropriate.	1	1
4. Information Technology Capabilities. Ability to develop, maintain and access electronic health information to support operations and analyze health data. Ability to support, maintain, and use communication technology.		
a. Develop and maintain public health system-wide and local technology and resources that supports current and future public health practice needs including ability to collect public health surveillance data, conduct robust analyses and make results available to the public.	3	4
b. Use and disseminate protocols based on best practices to ensure privacy and protection of personally identifiable and/or confidential health information in data systems and information technology.	4	4
c. Develop, use and maintain communication technologies needed to interact within the agency and externally with partners and the public.	4	4

## Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
d. Develop and maintain agreement(s) between governmental public health and other data providers to share data relevant to public health.	4	4
5. Human Resources Capabilities. Ability to develop and maintain a competent workforce, including recruitment, retention and succession planning functions; training; and performance review and accountability.		
a. Assure access to staff with the necessary knowledge, skills and abilities to perform the essential functions of governmental public health with ongoing access to training and supervision.	3	3
b. Support overall workforce development by providing resources to improve the skills, capabilities and leadership of the public health workforce.	3	3
c. Develop public health leaders to effectively support and manage the workforce from hire to retire.	2	2
d. Develop and maintain a human resources manual or set of human resources policies and procedures.	1	3
e. Provide or have access to adequate human resources support, including recruitment, retention, succession planning, training, performance review and other necessary human resource activities to meet program needs.	2	3
f. In governmental public health authorities with staff represented by collective bargaining units, develop and maintain productive relationships with collective bargaining units; engage in collective bargaining negotiations as appropriate and ensure access to labor relations expertise as needed.	4	4
g. Develop and implement a workforce development plan that identifies needed technical and/or informatics skills, competencies and/or positions. Include action plans for recruiting, hiring and/or developing existing staff to meet the needs of and reflect the ethnic, linguistic and cultural aspects of the population served.	1	3
h. Coordinate, or perform when necessary, assessments of leadership and organizational capabilities to understand capacity, identify gaps and develop strategies to address gaps.	1	1
i. Support leaders and employees in understanding equity principles and using inclusionary practices in all aspects of workforce management and workforce culture.	2	3
6. Fiscal Management, Contract and Procurement Capabilities. Ability to comply with federal, state and local standards and policies.		
a. Develop and maintain financial management and procurement manuals documenting organizational policies and procedures.	4	4
b. Establish and maintain budgeting, billing, contracting and financial system(s) in compliance with local, state and federal standards and policies.	5	4
c. Produce and monitor an effective governmental public health authority-specific budget.	3	5

Appendix B: Foundational Public Health Services Assessment & Analysis

Program & Capability	Capacity	Expertise
d. Provide financial management, contract and procurement services, including maintaining records, in accordance with generally accepted accounting principles (GAAP), governmental accounting standards board (GASB) or other compliance requirements.	3	5
e. Ensure access to auditing services to evaluate financial management practices and transparency around collection of revenues and disposition of expenditures.	5	5
f. Conduct sound financial analyses to inform decisions about policies, programs and services.	4	5
<b>7. Facilities and Operations. Ability to procure, maintain and manage safe facilities and efficient operations.</b>		
a. Maintain safe, secure and clean facilities in compliance with all relevant laws.	5	4
b. Develop plans for future facility and space requirements that align with operational needs.	4	4
c. Plan for, acquire and maintain fleet vehicles.	5	5
d. Ensure compliance with local, state and federal laws concerning facility accessibility.	5	5
<b>8. Legal Capabilities. Ability to access and appropriately use legal services in planning and implementing public health initiatives.</b>		
a. Provide or have access to legal services and analysis to support development and enforcement of public health rules, regulations, policies and legislation.	4	4
b. Advocate to and collaborate with governing bodies, including boards of health, county commissioners and the governor and state legislature.	3	4

Capacity	Value	Expertise
Not currently provided.	1	Not currently provided.
↓	2	↓
Able to provide the basics as at a lower level of service.	3	There is a meaningful gap in skills & knowledge.
↓	4	↓
Fully meets requirements.	5	Fully meets requirements.

## Summary, Framework for Improving Applied Epidemiology during Public Health Transformation.

Data in this report is accurate as of December 2023.

Please note that the Council of State and Territorial Epidemiologists (CSTE) Framework was never published by CSTE, due to challenges presented by the COVID-19 pandemic. However, the framework was useful in helping the Snohomish County Health Department better understand areas where investment was needed.

### Key Findings from CSTE Framework Assessment

- **The Snohomish County Health Department Epidemiology team is extremely under-resourced.**

The health department Epidemiology and Informatics team currently had only 5 Epidemiologists to serve a population of ~860,000 (0.6 Epidemiologists/100,000 population).

- One lead Epidemiologist (expertise in communicable disease, but works on projects across the entire scope of the team); 3 Epidemiologist 2 staff (one with Maternal and Child Health expertise, one with opioid expertise and one with mapping expertise); and one Epidemiologist 1 staff (works on a variety of topic areas)
- The CSTE minimum standard as outlined in the framework is 5 Epidemiologists/100,000.
- Per discussion with Epidemiology managers at WA LHJs of similar population size, other LHJs have 1.3-2.8 Epidemiologists/100,000. To get to 1.3 Epidemiologists/100,000 population, Snohomish would need a total of 11 Epidemiologists.
- Other LHJs also have essential infrastructure to support the work of Epidemiologists and other staff, such as project management and administrative support. Such support is currently extremely limited at SHD.

- **The Snohomish County Health Department is NOT meeting minimum recommendations in most topic areas.**

- The framework includes 38 major topic areas. Four of these are state roles in Washington. Of the 34 remaining topic areas, the department is *not* meeting minimum CSTE requirements in 26 (76 percent).
- A common theme across topic areas for which the department is *not* meeting minimum standards is lack of epidemiology staffing, lack of any informatics infrastructure for public health, lack of data access, and lack of involvement of epidemiology staff early in and throughout project life cycles.
- The Snohomish County Health Department is meeting minimum standards in a few key areas, most notably in communicable disease investigation and response. Even though the department is meeting minimum standards in communicable disease, additional epidemiology staffing is needed to allow for deep dives into topic areas including tuberculosis, sexually transmitted infections, and vaccine preventable disease.

## Epidemiology Services

### Case Surveillance

**Status:** Not rated, this is a state role.

CSTE	Snohomish County Health Department
<b>Minimum Standards</b>	
Majority of laboratory reports for reportable diseases provided to state in accordance with local reporting requirements (i.e., immediate, 1-2 days, 3-5 days depending on the condition)	This was not assessed. State DOH does track case reporting timeliness.
Cases classified according to CDC NNDSS case definitions	Yes
Case surveillance data maintained in a surveillance database that includes case investigation questionnaires for each condition	Yes, WDRS and PHIMS (state systems)
<b>Best Practices</b>	
Electronic laboratory reporting via HL7 messaging utilizing LOINC and SNOMED Codes in realtime	State DOH role
Total number of cases of each reportable condition identified	Yes, monthly and ad hoc reports run.
Total number of laboratory reports received identified	This was not assessed. State DOH does track proportion of lab results that come in elect
Percent of laboratory reports that were received electronically	Unable to influence, state role in ELR onboarding and management
<b>Measure</b>	
Percent of laboratory reports that were received electronically	Unable to influence, state role in ELR onboarding and management

Note: Maintenance and improvement of the ELR system is a Washington state responsibility.

Risk Factor Surveillance

**Status:** Not meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Established risk factors routinely collected and analyzed in major surveillance systems	No. While SHD has access to state notifiable condition systems, as well as state/national surveys like HYS and BRFSS, SHD does not routinely analyze health outcomes by risk factors due to lack of Epidemiology capacity.
Best Practices	
Data for multiple conditions reported by risk factor to highlight relationship between risk factor and multiple outcomes	No
Measure	
Number and percentage of surveillance systems that capture risk factors associated with health outcomes	Did not enumerate systems. Main systems are for notifiable conditions (WDRS, PHIMS) as well as work around opioid surveillance (data from hospitals and others about overdose and related topics). At present limited data regarding most other topics are available/analyzed routinely. Aside from some opioid related data and notifiable condition data we have little to no data access locally for other health related conditions/factors including chronic diseases of all types, immunization data, environmental health factors, social determinates of health. We rely almost exclusively on state data which is inadequate to reasonably identify health disparities due to small numbers.

Syndromic Surveillance

**Status:** Not rated, this is a state role.

CSTE	Snohomish County Health Department
Minimum Standards	
Emergency departments (Eds) and Urgent Care Centers (UCC) within the jurisdiction send Meaningful Use Compliant HL7 messages to the health department in near-real time	Yes, state role in maintaining ESSENCE
Best Practices	
100% of Eds and UCC within the jurisdiction send Meaningful Use Compliant HL7 messages to the health department in near-real time	State responsibility
Measure	
Percentage of Eds and UCC sending Meaningful Use Compliant HL7 messages to the health department	State responsibility

Hospitalization Surveillance

**Status:** Not meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Hospital inpatient and emergency department discharge data with demographics, diagnoses, procedures, length of stay and outcomes, in addition to administrative data; available by quarter, within 90 days of the quarter’s end	No. SHD has access to ESSENCE. Beyond this, data are very limited. There is special surveillance for opioid related health issues. SHD is working to gain access to administrative data, but does not currently have access.
Capacity in an emergency situation to monitor hospital admissions and bed utilization daily	SHD does have access to ESSENCE and partnerships with local hospitals to track these topics .However, most staff have minimal experience with using ESSENCE. Skill development in accessing and analyzing ESSENCE data is needed.
Best Practices	
Availability of administrative, demographic, and clinical data on ambulatory surgery, hospital observation stays and outpatient services	ESSENCE available, but most Epidemiology staff have limited training and knowledge of how to formulate queries and utilize and troubleshoot the system. Additional upskilling for ESSENCE is needed. SHD is working on gaining access to administrative data, but will need extensive improvements to data storage infrastructure and staffing to successfully gain access and be able to use the data
Linkage of hospital discharge data sets with other data, such as laboratory results, vital statistics, emergency medical services, and syndromic surveillance data	This is not routinely done, except on a case-by-case basis for notifiable condition surveillance
Direct access to hospital electronic medical records for surveillance purposes	No. SHD has access to EMRs, but usage is allowed only for notifiable condition case investigation. Usage for surveillance purposes, including for notifiable condition surveillance, is not allowable under our existing data sharing agreements.
Measure	
Discharge data are available within 90 days of the end of the quarter	No. SHD has access to CHARS (state system for inpatient hospitalization data) but this is very delayed.
Daily admission and utilization data are operational within 3-7 days	SHD does have access to ESSENCE data. We have CHARS (state hospitalization data system) access but this is delayed. SHD does not have access to administrative data. Even with the existing data systems, there is not sufficient Epidemiology capacity to fully utilize the systems.

Birth Surveillance

**Status:** Not meeting

CSTE	Snohomish County Health Department
Minimum Standards	
<p>Data derived from birth certificates are regularly used to help set public health program priorities for mothers and infants, to evaluate the effectiveness of programs to improve pregnancy and birth outcomes, and to monitor the frequency of adverse birth and pregnancy outcomes.</p>	<p>This is not done. SHD Epidemiology team does not have access to birth certificate data, except for very limited data from the state generally available several years after the fact. Epidemiology Manager is exploring enhanced partnership with SHD vital records team as well as will pursue data sharing with state vital records to ensure timely birth certificate data</p>
Best Practices	
<p>Linked birth and infant death files are available for analysis within 6 months of the end of each calendar year (for example, 2020 births linked to deaths occurring in 2020 or 2021, available by mid-2022)</p>	<p>Not available. Only very limited data (from CHAT system, which is aggregate and deidentified) available to SHD, generally a few years after the event.</p>
Measure	
<p>Linked birth and infant death files are available</p>	<p>This is a major gap. SHD does not have timely access to state birth and death records. Access is generally several years behind, and is limited to what is available in CHAT (community health assessment tool, a WA DOH product that provides only limited variables generally several years behind). Crucial to make improvements to this area.</p>

Mortality Surveillance

**Status:** Not meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Data derived from death certificates are regularly used to help set public health program priorities, evaluate the effectiveness of disease prevention and treatment programs, and identify fatal cases of select reportable diseases for priority follow-up	No, death certificate data are not regularly used. Mortality data are used in overdose surveillance, but not for most other health conditions. SHD does have a child death review coordinator, but this role is not within the Epidemiology team. Deaths associated with notifiable conditions are tracked by the state. SHD Epi team has extremely delayed access to death certificate data (generally only has aggregated deidentified data from CHAT available a few years after the event).
Majority of mortality records provided electronically to state within 10 days	State role
Notifiable condition case data and mortality records routinely linked	Yes, this is done at the state level for communicable disease cases (unclear about STI and Hepatitis)
Official mortality surveillance is death certificate-based	No. SHD has access to CHAT (state aggregate deidentified data system) but data are several years late
Best Practices	
Data from death certificates are available in real time and tabulated by any mention of causes of current public health interest, without waiting for assignment of underlying cause, in an analytic environment such as ESSENCE, within 7 days from date of death	Unclear, state role
Centralized medical examiner database exists for the state	This is not routinely done, except on a case-by-case basis for notifiable condition surveillance
Measure	
Proportion of reportable diseases/conditions with established linkage with death data	State role in WA.
Time to linkage of death data with reported disease/condition	State role
Percentage of total mortality records provided electronically to NCHS within 10 days	State role

Note: This is a major gap. SHD does not have timely access to state birth and death records. Access is generally several years behind, and is limited to what is available in CHAT (community health assessment tool), a WA DOH product that provides only limited, aggregate data generally several years after the event.

Environmental Public Health Hazards Surveillance

**Status:** Not meeting

CSTE	Snohomish County Health Department
Minimum Standards	
State environmental public health priorities are addressed by conducting projects that analyze and translate data and information to support public health actions that can improve environmentally related health outcomes	No. SHD Epidemiology team not routinely integrated into EH work. Efforts are in beginning stages to enhance coordination between Epidemiology team and EH, but capacity issues are a challenge.
Best Practices	
Science and policy challenges related to the timely accessibility, analysis, and dissemination of sub-county data relevant to environmental public health are prioritized and addressed	Unclear
The surveillance of heat-related illness exists	No
Biomonitoring laboratory capacity in response to identified exposures	No
Measure	
Environmental data such as groundwater contaminants, drinking water contaminants, and air pollutants are monitored and assessed as to their impact on human health	No. At present there is minimal Epidemiology involvement with EH projects. Room for growth in this area, which requires additional Epidemiology capacity and a cross-agency commitment to partner early on in project life cycle.

Vaccination Coverage Surveillance

**Status:** Not meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Vaccination coverage for the jurisdiction is monitored using national data sources (e.g., immunization surveys)	No. Limited ability to do this given capacity issues (lack of Epidemiology staffing) and challenges with state immunization data
Best Practices	
Vaccination coverage for the jurisdiction is monitored using the jurisdictional Immunization Information System (IIS)	Not routinely, due to capacity issues as well as very hard to use IIS data.
Vaccination coverage data is used to identify and address disparities in vaccination rates in the jurisdiction's population	Not routinely, but attempting to begin this work. Challenges due to capacity issues as well as state data being hard to use.
An IIS that supports interoperability across jurisdictions and bidirectional communication with other health data systems (e.g., Electronic Medical Records, case surveillance systems, etc.) is maintained	State role in maintenance of IIS.
Measure	
Proportion of the population participating in the jurisdictional IIS	IIS is a state platform. SHD does have access to IIS, but data are very hard to work with (out of date, incomplete, not de-duplicated). This makes it difficult to understand immunization gaps in SHD and what strategies would work to close them. IIS is not integrated into other data systems (this is a state role). There is a fledging project in beginning stages to understand immunization gaps in Snohomish. Improved informatics infrastructure and staffing would improve our ability to use IIS and other data systems that may store immunization data. At present, even if IIS was a perfect system, we do not have adequate Epidemiology and Informatics capacity to meaningfully use the data.

Injury Surveillance

**Status:** Not meeting

CSTE	Snohomish County Health Department
Minimum Standards	
<p>External causes of morbidity and mortality surveillance using administrative hospital discharge and death certificate data exists</p>	<p>No. SHD is working to gain access to administrative datasets (all payer claims database). Significant upgrades to informatics data infrastructure are required to gain access to all payer claims data (we do not have the infrastructure to host the system at SHD). We also need staffing support to maintain infrastructure and interface to extract data into meaningful data sets. SHD Epidemiology team access to death certificate data is extremely limited (aggregate, deidentified data several years late).</p>
Best Practices	
<p>Use of additional data sources for intentional and unintentional injury surveillance such as medical examiner records, violent death surveillance, workers compensation claims data, state OSHA data, syndromic surveillance, health information exchanges, motor vehicle crashes, law enforcement records, emergency medical services records, trauma registry, overdose reporting, and poison control data (NPDS)</p>	<p>Most of these data sources are not utilized. SHD does have ties with the medical examiner, but ME records are not used for injury surveillance at present. SHD does have syndromic surveillance access, and is just beginning to look at these data for injury surveillance. More extensive data sources are utilized for opioid related surveillance, but not for surveillance in most other topic areas. Extensive room for improvements in using data sources listed above. Access to most of these sources has not yet been sought out.</p>
Measure	
<p>Number of injury-related conditions under surveillance by category occupational, intentional, and unintentional</p>	<p>Surveillance for opioid related illness and injury is underway. Surveillance for other injury causes is very limited at present.</p>

Note: A new Epidemiologist on the team is beginning to look at main causes of injury morbidity and mortality, with the goal of development of an injury and mental health data dashboard.

Chronic Disease Surveillance

**Status:** Not meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Hospital discharge, death certificate and risk factor surveillance data are all used to track chronic disease	No. SHD does not have timely or complete access to death certificate data, and does not have any capacity in chronic disease surveillance at present.
Best Practices	
Access to electronic medical records for ongoing surveillance	SHD has some access to EMRs, but access is strictly for notifiable condition case investigation.
Measure	
The health department routinely adds questions of local interest to the BRFSS	No

Note: At present, there is very limited capacity for chronic disease surveillance at SHD. There is NO surveillance for diseases such as cancer, heart disease, stroke, asthma, or diabetes (to list a few top causes of morbidity and mortality in the US). It is unclear what if any program work exists on these topics (likely extremely minimal/none). A new Epidemiologist 2 position focusing on chronic disease and built environment will be recruited in early 2024. Lack of any surveillance for chronic disease is a major gap.

Maternal and Child Health Surveillance

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
<p>Data derived from birth certificates are regularly used to help set public health program priorities for mothers and infants, to evaluate the effectiveness of programs to improve pregnancy and birth outcomes, and to monitor the frequency of adverse birth and pregnancy outcomes</p>	<p>No, this is not done. The CHA did identify that access to prenatal care is a priority in Snohomish, but birth certificate data are not available to the Epidemiology team except as aggregate, limited datasets several years after the event (via state system CHAT). Access to timely birth certificate data is a crucial area that must be pursued.</p>
Best Practices	
<p>Maternal mortality and child fatality review processes are in place and are regularly used to improve health policy</p>	<p>Yes, SHD does have a child death review coordinator. However, the child death review coordinator is not a member of the Epidemiology and Informatics team; we are working to enhance collaborations across teams so that programmatic work and Epidemiology support are more integrated.</p>
Measure	
<p>The health department routinely adds questions of local interest to the PRAMS and YRBS</p>	<p>SHD is involved with the WA Healthy Youth Survey, a survey similar to YRBS that is utilized in WA middle and high schools. SHD does not however add questions to PRAMS and YRBS.</p>

Community Health Assessment

**Status:** Meeting

CSTE	Snohomish County Health Department
<b>Minimum Standards</b>	
Health department Epidemiologists provide support for data collection, analysis, and presentation of community health assessments	Yes, a CHA was completed in 2022. However, the CHA utilized almost exclusively aggregate state data that were a few years old. The CHA contained minimal local specific data and was mostly based on available state data and qualitative interviews with community members There is a need to identify next steps for the CHIP process.
<b>Best Practices</b>	
Health department Epidemiologists support nontraditional community health assessments such as those at the sub county level or for racial/ethnic groups	No, there was limited data available for sub county regions and for different populations including racial/ethnic groups. The CHA showed data on the county-level.
<b>Measure</b>	
A survey of public or private entities for evaluation of data provision and assistance exists	No
Health department Epidemiologists are actively involved in preparing or presenting community health assessments	Yes, SHD Epidemiologists have presented on the CHA in various venues.

Monitoring Health Status

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
An electronic vital statistics system that allows for real-time monitoring of birth and death certificate data	No, this does not exist. SHD Epidemiology team has extremely limited and very delayed access to birth and death records
Participation in the Behavioral Risk Factor Surveillance System, with capacity and resources to include questions of local interest	No local questions added
Capacity to utilize hospital discharge data sets, claims data and other sources for health indicators (diagnoses, utilization, treatment, etc.)	SHD is in process of attempting to gain access to administrative datasets (all payer claims database). In order for us to access these data significant investments in relevant informatics infrastructure would be required. The state does maintain the CHARS discharge dataset, but these data are limited and generally very delayed. Some hospital data are utilized for opioid surveillance
A syndromic surveillance system that provides real-time data on events of interest	Yes, ESSENCE is utilized for opioids as well as some communicable disease. SHD Epidemiology team is working to utilize ESSENCE for other topic areas too, including injury. However, capacity to utilize ESSENCE is very limited on the team; team members will benefit from additional training and skills development in usage of ESSENCE. Being able to access existing training resources and enhance staff proficiency with ESSENCE will necessitate additional staffing.
Best Practices	
Capacity to do ongoing surveys of health status in the jurisdiction	SHD has access to state surveys. There are some local surveys related to opioid use topics, but in general not for other topics. Most data utilized by SHD is aggregate, years' old state data. SHD has minimal local-specific data, which makes assessments by subgroup, including race/ethnicity, language, socioeconomic status and other factors virtually impossible. This means that SHD is not able to close health disparity gaps, as we lack data to understand which communities are most impacted by various health issues. This creates a severe issue when trying to ensure that equity is a cornerstone of our work.

Appendix C: CSTE Framework

CSTE	Snohomish County Health Department
Capacity for rapid assessments of health status for specific purposes	ESSENCE could be used for surveillance of a variety of topics, but need to expand on expertise and ability to have standing queries that can monitor baselines (like for chronic disease, smoke related illness). Enhancing our ability to utilize ESSENCE will require.
Capacity to link surveys with specimen collection to assess health and environmental exposures in a sample of the population	No, does not exist (except for notifiable condition case investigation).
Access to electronic medical records for ongoing and cross-sectional assessments of population health	No. SHD has some access to EMRs, but this is strictly for notifiable condition case investigation purposes.
Access to social media data for indications of population attention to specific syndromes or conditions	No, not done.
<b>Measure</b>	
Preliminary birth and death data available within one week of events	No, birth and death data are not available from the state for several years after the event, and even then only limited data are available. Improving this is critical.

Disease Investigation

Status: Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Case surveillance data maintained in a surveillance database that includes case investigation questionnaires for each condition	Yes, PHIMS and WDRS (state systems)
Public health laboratory capacity for processing primary specimens and pathogen characterization in support of epidemiologic investigations	Yes, state role (PHL)
Best Practices	
Disease or condition group specific questionnaires including questions about disease- specific risk factors, exposures, symptoms, and required public health actions (e.g., exclusion for work, quarantine, etc.) as applicable for the condition or condition group	Yes, within WDRS and PHIMS. However, with these being state systems SHD ability to influence improvements is very limited. At present SHD has one lead epidemiologist who has a background in communicable disease; this person compiles weekly and monthly communicable disease reports, leads projects across all topic areas (not just communicable disease), and performs ad hoc analyses and investigations relating to time sensitive and high priority communicable disease topics. Other similarly sized WA LHJs have ~6 epidemiologists solely focused on communicable disease; Snohomish has one who also splits time on a large variety of other topic areas (and five epidemiologists total across all topics). Additional communicable disease Epidemiology capacity, to focus on such critical topics as tuberculosis, sexually transmitted infections and immunization uptake and gaps, is needed
Measure	
Percent of case investigations that are eligible for interview (e.g., include useable contact information, are not institutionalized, etc.)	Not assessed, as epidemiology team does not routinely perform case interviews except in special circumstances (this work routinely is done by DIS and RN staff).
Percent of cases that were attempted for interview	Not assessed.
Percent of cases that were reached for interview	Not assessed.
Percent of cases that were reached for interview within 24 hours of receipt by the health department (or different timing depending on the disease)	Not assessed.

Outbreak Detection

Status: Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Understanding of baseline case rates for conditions based on the state, region, time of year,etc	Yes, monthly and ad hoc notifiable condition case reports compiled.
Routine review of case surveillance data for case rates higher than the baseline/expected rates for a given place and time.	Yes, monthly and ad hoc notifiable condition case reports compiled. At present SHD has one lead Epidemiologist who has a background in communicable disease; this person compiles weekly and monthly communicable disease reports, leads projects across all topic areas (not just communicable disease), and performs ad hoc analyses and investigations relating to time sensitive and high priority communicable disease topics. Other similarly sized WA LHJs have ~6 Epidemiologists solely focused on communicable disease; Snohomish has one who also splits time on a large variety of other topic areas (and five Epidemiologists total across all topics). Additional communicable disease Epidemiology capacity, to focus on such critical topics as tuberculosis, sexually transmitted infections and immunization uptake and gaps, is needed
Coordination with partners (e.g., hospitals, healthcare providers, etc.) to detect and report outbreaks to health departments	Yes, SHD does have strong ties with healthcare organizations in the county and has regular communication with such facilities about trends and urgent events
Routine review of disease investigation data to detect outbreaks associated with a commonrisk factor or exposure	Yes
Best Practices	
Use of statistical tools (e.g., SAS, R, SaTScan, ArcGIS) to compare current disease rates to expected disease rates by condition at varying levels of geography	Sub-county analyses are done for some conditions, such as respiratory virus reporting. However, with added Epidemiology capacity such analyses could be performed routinely across notifiable conditions.
Measure	
Total number of outbreaks detected by review of routine case surveillance/disease investigation data	Not assessed
Total number of outbreaks reported by healthcare providers and other partners	Not assessed for the purposes of this report, but this is compiled by the state annually.

Outbreak Investigation

Status: Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Following outbreak detection, investigation into total number of cases and/or contacts, common source	Yes
Capacity to assign sufficient trained staff to accomplish investigation in a timely fashion	<p>No. Additional Epidemiology staff focused on communicable disease are needed. At present SHD has one lead Epidemiologist who has a background in communicable disease; this person compiles weekly and monthly communicable disease reports, leads projects across all topic areas (not just communicable disease), and performs ad hoc analyses and investigations relating to time sensitive and high priority communicable disease topics. Other similarly sized WA LHJs have ~6 Epidemiologists solely focused on communicable disease; Snohomish has one who also splits time on a large variety of other topic areas (and five Epidemiologists total across all topics). Additional communicable disease Epidemiology capacity, to focus on such critical topics as tuberculosis, sexually transmitted infections and immunization uptake and gaps, is needed.</p> <p>While this CSTE framework assessment is focused on Epidemiology capacity, an assessment of DIS/investigator/communicable disease nurse staffing may be valuable. That is, what is the best practice or minimum standard for how many investigators (DIS, nurse, etc) an LHJ should have per quantity of notifiable conditions reported? SHD does have an extremely small communicable disease investigative team given the population size and communicable disease case burden</p>
Best Practices	
Disease specific response (, e.g., for enteric diseases, identification and traceback of commonly consumed food items; for respiratory diseases, identification of common exposures or risk factors and recommendations for quarantine)	Yes, this does occur even given the small staffing. Additional support needed however. SHD has one Epidemiologist with communicable disease expertise; this is far below staffing levels at other LHJs of a similar population size.
Measure	
Percentage of detected outbreaks investigated	Not assessed

Chronic and Environmental Health Studies

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
There is an Epidemiologist dedicated to designing and completing chronic disease and environmental health studies	No. SHD has essentially no chronic disease Epidemiology capacity. SHD is planning to hire a chronic disease/built environment Epidemiologist in 2024, but at present there is no one focused on this topic area. Epidemiology involvement in EH projects is minimal at present
Best Practices	
Health department staff have routinely published scientific papers on chronic and environmental disease studies	No
Measure	
A dedicated Epidemiologist who designs and completes chronic disease studies and/or environmental health studies exists in the health department	No

## Capabilities

### Data Collection/Reporting

**Status:** Not rated, this is a state role.

CSTE	Snohomish County Health Department
<b>Minimum Standards</b>	
Centralized, secure, unitary, person-based data system for disease reporting and investigation case management in the jurisdiction, with access shared securely by state and local health departments	Yes, state role (WDRS and PHIMS for notifiable condition surveillance, which are state systems)
Electronic laboratory reporting of pertinent, positive test results	Yes, state system
Regulations or rules allowing for reporting and investigation of outbreaks of any sort and novel conditions	State role in WAC revision
Geocoding of all case reports entered in surveillance systems	No
<b>Best Practices</b>	
Real-time integration of electronic death files with the surveillance system	No, death data are generally available only in aggregate several years after the events
Integration of the child and adult immunization registry with the surveillance system	More timely data are utilized for opioid surveillance
Direct access to information authorized for collection for surveillance and investigation from electronic medical records with integration into a surveillance and case management system (electronic case reporting)	No, state role in development of eCR
A longitudinal case management system integrated into the surveillance system	No
Electronic laboratory reporting with additional reporting of negative test results or other supportive laboratory results that assist with case classification	Variable, state issue (relating to WAC)
<b>Measure</b>	
Completeness of data in select fields for reportable conditions	Did not assess – state role
Proportion of laboratories or laboratory results received via electronic laboratory reporting	Did not assess – state role

CSTE	Snohomish County Health Department
Proportion of reported cases with usable geocoding	Geocoding not available in PHIMS or WDRS, but would be useful if included (state role in making modifications to these systems)

Data Sharing/Interoperability

**Status:** Not rated, this is a state role.

CSTE	Snohomish County Health Department
Minimum Standards	
Centralized, secure, unitary, person-based data system for disease reporting and investigation case management in the jurisdiction, with access shared securely by state and local health departments	Yes, SHD has access to WDRS and PHIMS (state systems) for communicable disease.
Best Practices	
Direct access to information authorized for collection for surveillance and investigation from electronic medical records with integration into a surveillance and case management system (electronic case reporting)	State role in development of eCR modalities; eCR does not exist at present
Measure	
Percentage of opportunities resulting in successful sharing/interoperability	Extensive room for improvement in data sharing and interoperability, such as having timely birth and death records. However, WDRS and PHIMS do exist and are state maintained (hence marking this as state role).
The existence of secure, centralized, unitary, person-based data system for disease reporting and investigation case management in the jurisdiction with access shared securely by state and local health departments	Yes, PHIMS and WDRS.

Data Analysis

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Automated data linkage processes exist	No
Best Practices	
Data is routinely analyzed at the sub-county level by percentage in poverty or by income level	No
Data is routinely analyzed by urbanization/rurality level	No. Some reports, such as COVID report, show a map of cases by zip code but this is not generally done across topic areas.
Measure	
Data is routinely analyzed by race/ethnicity, gender, and geographic level	Routinely, no. Some reports (such as COVID report, opioid report) show data by race/ethnicity, gender and geographic region but this is not done routinely across topic areas.

Data Visualization

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
<p>Data derived from multiple surveillance information and related systems (e.g., vital statistics, health surveys, reportable diseases, hospital admission data, syndromic surveillance data, vaccine coverage data) are readily accessible for display in a single environment with similar tools, supporting both preprogrammed reports (for frequent questions) and customized queries</p>	<p>No, this does not exist.</p>
<p>Public health agency provides data in a format that is easily understood and can be used to inform public health policy and drive population health improvement</p>	<p>Variable. There are some regularly updated public facing reports/dashboards (like COVID report, opioid reports). However, due to capacity issues there is minimal/no reporting/visualization for most public health topic areas.</p>
Best Practices	
<p>Displays and query capabilities are developed in close consultation with both technical and non-technical users of the displays and queries</p>	<p>No, room for improvement. There are some reports/displays that are public facing and which have been vetted with stakeholders, but this is not generally done. Reports and visualizations exist for only a handful of public health topic areas given lack of capacity.</p>
Measure	
<p>Public health agency displays data in a format that is easily understood and can be used to inform public health policy and drive population health improvement on its website</p>	<p>Variable, some reports (such as COVID and opioid) are integrated as Tableau dashboards, but this is not routinely done across topic areas.</p>

Data Dissemination

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Epidemiology products are published by the health department at least monthly onaverage	Overall, no. Some reports, like COVID report, are weekly whereas others (notifiable condition case counts) are monthly and others (such as opioid dashboard) are quarterly or less. Reports/dissemination plans for other topic areas are largely completely absent due to lack of capacity.
Best Practices	
An up-to-date web health data query system is used by both health department Epidemiologists and the public	No this does not exist
Measure	
Number of Epidemiology products published by the health department in the last 6months	Not enumerated

Data Standards

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
A data release standard exists which provides for confidentiality while not overlyinterfering with data use and access	Data release standards do not exist; Epidemiology team is actively working to identify standards and develop documentation.
Best Practices	
A standard exists for collecting and presenting data by race/ethnicity across the health department	Standard does not exist; Epidemiology team is actively working to identify standards and develop documentation. However, capacity for this work is limited.
Measure	
Data release standard is in existence at the health department which specifically defines when numbers and/or rates are too small to be released publicly	Standard does not exist; Epidemiology team is actively working to identify standards and develop documentation.

## Roles

### Policy Development

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Provide and use the results of health data analysis to inform public health policies	No. Epidemiology team not generally involved in policy work at SHD. The Epidemiology and Informatics team was moved to the Office of the Director to help improve cross-collaboration on policies, so potential for improvement.
Best Practices	
Epidemiologists are engaged in analyzing the impact of various policy options and recommending specific public health policies based on those analyses	Not consistently occurring at present. Epidemiology staff are included in the opioid MAC group, and Epidemiology staff are providing analyses relating to STI direct services. However, room for growth in incorporating epidemiologic analyses for policy decision making.
Measure	
Data are used to recommend and inform public health policy	Unclear. Epidemiology team not generally involved in policy work at SHD. Possible room for enhanced collaboration.

Health Status Improvement

**Status:** Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Epidemiologists and Epidemiology products are critical to the prioritization of health problems for health status improvement efforts – data, not just stakeholder opinion, inform selection of priorities	Somewhat. Epidemiology team was involved in the CHA, which did identify key prioritization areas. However, next steps of process (CHIP) in development. In general, likely extensive room for enhanced collaboration in this topic area.
Best Practices	
Epidemiologists help lead a regular review of jurisdiction health status which is used to update health status priorities	Yes, CHA published in 2022. However, CHA was somewhat limited in scope and data available. Room for enhanced capacity with more robust staffing and collaboration.
Measure	
Within the last 2 years, health department Epidemiologists led a review of jurisdiction health status data which was used to update health status priorities	Yes, CHA published in 2022. However, data used in the CHA were largely from state/national surveys. Minimal local data were available/included.

Identification of Health Disparities

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Data are routinely collected, analyzed, and presented by available demographic (as available by data source: age, sex, race, ethnicity, gender identity, education, income, insurance status) and geographic strata (sub-state)	No. For some limited analyses data are presented by these demographic factors (eg COVID report, some opioid reporting). However, for most reports demographic factors are not assessed. This is due both to limited access to such data, small numbers (and lack of an agreed upon small numbers release guideline) and lack of Epidemiology capacity.
Best Practices	
Information on health disparities is reported and visualized into meaningful charts and maps	Overall not done, except for a few reports such as COVID report and some opioid reporting. Opportunities exist for enhancement
Visualizations on health disparities are presented alongside text highlighting major take-aways for data-driven action	Overall not done, except for a few reports such as COVID report and some opioid reporting. Opportunities exist for enhancement
Measure	
The health department routinely presents data by available demographic and geographic strata	This is done for a few reports. Room for improvement in this arena. Reports that include demographic factors and that look at smaller geographies are time consuming and complex, and require dedicated Epidemiology time; this highlights the need for enhanced Epidemiology capacity development (additional staff who are able to specialize in topic areas and provide the level of granularity necessary to drive public health advancement).

Health Equity Achievement

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Jurisdiction works to collect, analyze, and visualize data on health disparities No.	This is a goal but not routinely accomplished given lack of capacity and need to improve data access and availability.
Jurisdiction routinely complete needs assessments, including qualitative data collection on populations experiencing health disparities and/or systemic injustice	No. Some work in limited topic areas such as opioids, but not routinely done.
Best Practices	
Jurisdiction works collaboratively with populations that experience disparities to identify ways to reduce disparities and improve health	No. Possibly some work on this for opioids and in the COVID report, but in general no.
Jurisdiction uses data to identify local policy improvements to reduce health disparities and share information publicly	Unclear. Epidemiology team not generally involved in policy.
Measure	
Jurisdiction works collaboratively and on a routine basis with at least one population experiencing disparities in that jurisdiction	Unclear. Need for enhanced cross-collaboration between Epidemiology team and program-specific work across the department.

Pandemic Preparedness

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
<p>Epidemiologists ensure jurisdictional capacity to meet public health and emergency preparedness capabilities for surveillance and epidemiological investigation (which include conduct or support public health surveillance, conduct public health and epidemiological investigations, recommend, monitor, and analyze mitigation actions, and improve public health surveillance and epidemiological investigation systems)</p>	<p>No. Communicable disease Epidemiology capacity is extremely limited. SHD has one Epidemiologist with communicable disease expertise; this person works across a variety of topic areas. In the event of another pandemic, SHD does not have adequate epidemiologic capacity. Epidemiology capacity is very limited compared to neighboring LHJs and jurisdictions of a similar population size.</p>
Best Practices	
<p>Preparedness-focused Epidemiologists that not only ensure surveillance and epidemiological investigation capacity, but who also provide data collection, analysis, and interpretation to support preparedness plan development and planning activities across the 15 preparedness capabilities to improve future responses</p>	<p>There is no preparedness focused Epidemiologist.</p>
Measure	
<p>Number of preparedness-focused Epidemiologists</p>	<p>Zero. There is one lead Epidemiologist who has expertise in communicable disease, but an all hazards preparedness focused Epidemiologist does not exist. There is a new emergency preparedness manager; the Epidemiology manager will work to collaborate on needed initiatives.</p>

Program Evaluation

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
<p>Epidemiologists support program evaluation activities within the agency by providing data collection, analysis, interpretation, and dissemination expertise</p>	<p>Overall, no. Epidemiology staff are well integrated into a few program areas (communicable disease, opioids, childhood blood lead), but not involved in the vast majority of work of the department due to lack of staffing. Additional Epidemiologist capacity is needed, as well as education of SHD supervisors and staff about the role of Epidemiologists, best practices for when to involve Epidemiologists, and importance of integration of Epidemiology into grants and projects in the early stages of their development. A project planning and grants management framework, to include the importance of Epidemiology and program evaluation and to write Epidemiologist work into funding sources, is needed across the department. Inclusion of Epidemiologists early in project life cycles is imperative.</p>
Best Practices	
<p>Epidemiologists receive formal training in program evaluation</p>	<p>Variable, some staff have received training on this as part of their graduate education and others have received some trainings on the job while employed at SHD or at previous places of employment.</p>
Measure	
<p>Proportion of program evaluations that consulted an agency Epidemiologist</p>	<p>Did not assess. Most programs in SHD have minimal involvement with the Epidemiology team, given that there are only five total Epidemiologists and two of these were hired within the last year.</p>
<p>Proportion of Epidemiologists with formal training in program evaluation</p>	<p>Unclear, as some MPH programs do provide program evaluation education.</p>

Evidence-based Practice

Status: Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Health departments should have a protocol in place to request peer-reviewed literature and have the literature available within 72 hours	Yes, WA DOH has a program by which to request literature.
Epidemiologists should disseminate lessons learned from their work to the larger applied Epidemiology community	Variable. Epidemiology team has not routinely attended conferences due to capacity constraints, but working to improve this. Some on the team have contributed to peer reviewed publications; working with team to submit abstracts to conferences and to write up more work for publication
Best Practices	
Epidemiologists have access to the peer-reviewed literature within 24 hours	Yes, via state DOH
Epidemiologists regularly submit abstracts, present at conferences detailing their applied Epidemiology experiences, and publish their work	No, room for improvement. Actively encouraging Epidemiologists to submit abstracts to local, state and national conferences
Measure	
Average time to access peer-reviewed literature	Access to many journals is near immediate due to WA DOH access program

## Infrastructure/Organization

### Staffing

**Status:** Not Meeting

CSTE	Snohomish County Health Department
<b>Minimum Standards</b>	
Every health department should have a minimum of 5 Epidemiologists per 100,000 population to provide basic public health services	SHD has 5 Epidemiologists/860,000 population, or 0.6 Epidemiologists/100,000.
Every health department should offer routine professional development activities to every Epidemiologist	Room for improvement. Due to capacity constraints, many staff are not able to take advantage of trainings offered through state, academic partners and others. Need for additional Epidemiologists to allow adequate staffing, so that staff can specialize and become experts in their fields, and so staff can take advantage of training opportunities.
Every health department should provide dedicated and protected time for Epidemiologists to participate in training and communities of practice to ensure the highest quality Epidemiology activities	No, in the past this has not existed. Manager actively encourages staff to attend trainings and communities of practice, but in reality this is difficult to accommodate given under-staffing.
Informaticians are available to support Epidemiology projects	At present, there are zero informaticians. Planning to hire informatician position in 2024.
<b>Best Practices</b>	
To achieve public health transformation, every health department should have at least 8 Epidemiologists per 100,000 population	No, currently have 5 Epidemiologists/860,000 (or 0.6/100,000).
Every health department should offer cross-training across infectious and non-infectious topics to improve response capabilities and awareness of public health partners	By necessity some Epidemiology team members are cross trained, but given time constraints depth is limited. Highlights need for additional staffing to ensure minimum work products can be completed.
Dedicated informaticians are integrated into Epidemiology teams and projects	No such positions exist at present; plan to hire first ever informatician in 2024.
<b>Measure</b>	
Number of Epidemiologists per 100,000 population	5/860,000 (or 0.6 per 100,000)

Funding

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
<p>Funding is available for core Epidemiology services</p>	<p>No. SHD Epidemiology and Informatics team is severely understaffed, with at present only 5 Epidemiologists to serve a population of 860,000 (plans to have 8 Epidemiologists in 2024, which is still severely under the needed staffing levels). There is currently no informatics staffing of any kind (plan to hire first such staff member in 2024). Epidemiology team is not routinely written into grants or project workplans at present. Need for a program planning and grant management infrastructure at SHD to ensure that Epidemiology and evaluation is written into projects at their inception.</p>
Best Practices	
<p>Funding for Epidemiology program staff is incorporated across all health department budgets</p>	<p>No. Need to include Epidemiologists in the visioning of projects, as well as write these staff into budgets at FTEs commensurate with the time commitments involved.</p>
<p>Non-categorical state funding for Epidemiology is available and allows for investigation of emerging issues</p>	<p>Unclear.</p>
Measure	
<p>Existence of non-categorical state funding for Epidemiology is available and allows for investigation of emerging issues</p>	<p>Funding of Epidemiology program staff has been variable over time; need for inclusion of Epidemiologists in grants and projects across all stages of the grant and project life cycle.</p>

Epidemiology Program Areas

Status: Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Health departments should have Epidemiologists in the following program areas: infectious disease, maternal and child health, chronic disease, injury, environmental health, preparedness, informatics, vital statistics, substance use, occupational health, oral health, mental health, and genomics	No. SHD has five total Epidemiologists across all topic areas in the entire health department. Additional staff are needed to allow for the necessary breadth and depth of expertise.
Epidemiologists should receive on-the-job training rooted in the Applied Epidemiology Competencies (AECs) to reflect public health practice	Not currently occurring.
Best Practices	
Health departments should have a lead Epidemiologist in every program area	No. There is one lead Epidemiologist for all of SHD who helps guide projects across all topic areas in the entire health department. This one lead Epidemiologist is also the communicable disease Epidemiology main point of contact. Ideally we would have multiple Epidemiologists covering different topics areas in communicable disease (STI vs immunizations vs TB vs other notifiable communicable conditions) plus additional other lead Epidemiologists for other topic areas.
Epidemiologists should receive training on methodologies and evidence-based practices to support the use of innovative approaches to improve data quality, timeliness, utility, and value	Variable. While training is a priority for the Epidemiology manager, current staff are spread thin.
Measure	
The percentage of CSTE Epidemiology program areas with at least one health department Epidemiologist	SHD does not have enough Epidemiologists to meet the need. There is one lead Epidemiologist who has special expertise in communicable disease, one assessment Epidemiologist 2 who in practice focuses on opioid related topics, one Epidemiologist 2 who primarily focuses on elevated childhood blood lead and other MCH related topics, one newer Epidemiologist 2 who has special expertise in mapping, and one Epidemiologist 1 who assists with various projects. SHD does not have adequate Epidemiology coverage to focus on all needed program areas that could benefit from epidemiological expertise.

Internal Connectivity/Organization

**Status:** Not Meeting

CSTE	Snohomish County Health Department
<b>Minimum Standards</b>	
State Epidemiologist coordinates closely with other governmental public health leaders across the state/territory, including those in information management, informatics, and public health programs	State role (State Epidemiologist). Assessment of not meeting the standard is based on the items below, which are local roles.
<b>Best Practices</b>	
Public health agency IT plans are informed by Epidemiology practice needs	Not occurring. Ad hoc and minimal communication between Epidemiology team and county IT. Room for growth. There are no informatics staff at SHD at present.
Public health agency has an active team of subject matter experts, Epidemiologists, data scientists, informaticians, and communications experts that work together to create data visualizations and information	Not occurring. SHD has no data scientists or informaticians.
<b>Measure</b>	
Public health agency has active process for coordination among Epidemiologists	Somewhat. Epidemiology team is very small (5 Epidemiologists and one program assistant) so coordination is somewhat straightforward.
Public health agency has active coordination between Epidemiologists, IT, informatics, and public health programs	No. There is no informatics capacity at SHD. IT services seem siloed from other work. Connections between Epidemiologists and program staff is variable, and for most programs very limited given dearth of Epidemiology time availability.

External Connectivity

**Status:** Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
<p>Epidemiologists coordinate closely with community leaders and academic partners to provide public health applied epidemiologic expertise</p>	<p>Variable, but upward trajectory. Marking as meeting for the purposes of this framework. Affiliation agreements between SHD and various local academic partners are underway (agreements needed to be renegotiated given move to county processes). New Epidemiology manager holds an affiliate faculty appointment with University of Washington Department of Epidemiology, and does intend to bring students to SHD for practicum projects/thesis projects etc. Role of Epidemiologists with community leaders varied depending on projects. Given capacity constraints, Epidemiology team has limited involvement with programs.</p>
Best Practices	
<p>Epidemiologists participate in developing and implementing collaborativestate/community health assessments and improvement plans</p>	<p>Epidemiology team heavily involved in CHA process; CHIP next steps to be determined.</p>
Measure	
<p>Health department Epidemiologists work closely with the Health Official to provide epidemiologic expertise on complex public health issues</p>	<p>Yes, to the greatest extent possible given capacity constraints for Epidemiology team.</p>

## Characteristics

### Population Focus

**Status:** Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
<p>Most Epidemiology activity at the health department is focused on populations and subpopulations rather than individuals</p>	<p>Yes, focus of Epidemiology work is on population health as a whole. Marking this section as meeting the minimum standard for the purpose of this framework. Notifiable condition work does focus on individuals, but the goal is to protect overall public health.</p>
Best Practices	
<p>Data is routinely analyzed and disseminated in a timely fashion by the health department for the following populations: by race/ethnicity, gender and sexualorientation, poverty/income, subcounty, occupation, and urbanization</p>	<p>Variable. Some reports (such as COVID report and some opioid reporting) do provide demographic breakdowns to the extent possible, but routinely data for most topic areas are not assessed by subpopulation (and in fact limited data exist for most other topic areas). This is an area for growth that can be accommodated with additional epidemiologic capacity.</p>
Measure	
<p>Data is routinely analyzed and disseminated in a timely fashion by the health department for at least 4 of the following 6 populations: by race/ethnicity, gender andsexual orientation, poverty/income, subcounty, occupation, and urbanization</p>	<p>No, this is not done routinely.</p>

Timeliness of Data Collection, Analysis, Interpretation and Dissemination

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Data are collected within the jurisdiction’s required timeframes (e.g., 24 hours, 72hours, etc. of the health event)	Not assessed. Reporting timeframes for notifiable conditions are tracked by the state.
All major surveillance datasets are analyzed with data disseminated within one yearafter the end of data year	No. SHD has very limited access to most datasets, and access that does exist (for e.g. for birth and death records) is generally very limited (aggregate, deidentified data only) and years delayed.
Best Practices	
Data are collected through automated processes that allow for the timely analysis, interpretation, and dissemination of data	No.
All major surveillance datasets are analyzed with data disseminated within 6 monthsafter the end of data year	No.
Measure	
Percentage of major surveillance datasets that are analyzed with data disseminatedwithin one year after the end of the data year	Unknown. SHD has deficits in access to state data (birth and death records). Regular reports of notifiable condition and opioid related data occur regularly (weekly for COVID report, monthly for notifiable condition case counts, quarterly for opioid dashboard). Data access and reporting for most other topics is highly variable and generally extremely limited. For example, the CHA was completed in 2023 using data from 2022 and before.

Flexibility/Ability to Address Emerging Issues

**Status:** Not Meeting

CSTE	Snohomish County Health Department
Minimum Standards	
Sufficient non-categorical funding is available to allow investigation of emerging issues	Unclear. There is a need for an agency wide grants management initiative.
Best Practices	
Surveillance of health effects of climate change exists	No. This does not exist.
Measure	
The health department has assured that surveillance of the health effects of climate change is conducted	No, there is no such work



# Equity Review & Assessment

## Phase 1: Summary Report

**Prepared for the Snohomish County Health Department**  
October 2024

# Table of Contents

<b>Context and opportunity</b> .....	<b>3</b>
<b>Approach and methodology</b> .....	<b>4</b>
Audiences and qualitative instruments .....	4
Equity and cultural humility review .....	5
Summary of the current state Key themes of SHD’s organizational culture .....	6
<b>Priority areas of focus</b> .....	<b>9</b>
1. <b>Access/accessibility for people with disabilities</b> .....	<b>10</b>
2. <b>Communications</b> .....	<b>11</b>
3. <b>Community engagement and partnerships</b> .....	<b>12</b>
4. <b>Contracting equity</b> .....	<b>14</b>
5. <b>Data equity</b> .....	<b>16</b>
6. <b>Employee inclusion and belonging</b> .....	<b>17</b>
7. <b>Grants and program development</b> .....	<b>19</b>
8. <b>Language access</b> .....	<b>20</b>
9. <b>Organizational policies, procedures, and change</b> .....	<b>23</b>
10. <b>Policy (external)</b> .....	<b>24</b>
11. <b>Workforce development and training</b> .....	<b>25</b>
12. <b>Workforce diversity</b> .....	<b>27</b>
<b>Recommendations</b> .....	<b>29</b>
1. Access for people with disabilities .....	29
2. Communications .....	29
3. Community engagement and partnerships.....	30
4. Contracting equity (and risk assessment).....	30
5. Data equity .....	30
6. Employee inclusion and belonging .....	30
7. Grants and program development .....	31
8. Language access.....	31
9. Organizational policies, procedures, and change.....	31
10. Policy (external) .....	31
11. Workforce development and training .....	32
12. Workforce diversity .....	32

## Context and opportunity

The Snohomish Health Department (SHD) is at a critical point in its equity journey, due to several factors:

- The recent transition from an independent health district to a health department, under the county government structure.
- The COVID-19 pandemic's impact on community relationships, funding opportunities, and growing emphasis on reducing health disparities and related systemic inequities.
- New executive leadership, including a new department director and health officer.
- Workforce demographics shifts, including younger employees entering the workforce and more seasoned ones leaving or retiring.
- Confluence of several equity-focused initiatives and contracts across the department.

While organizational changes and transitions can carry a high level of uncertainty for leadership and employees alike, they also present a unique opportunity for SHD to pause, step back, and reassess organizational readiness to intentionally lead with equity across all programs, policies, and practices. SHD is well positioned to authentically integrate equity throughout all layers of the organization due to an activated executive and senior leadership; engaged workforce; and an intentional focus on integrating principles of equity into strategic priorities.

SHD has two critical pro-equity infrastructures already in place that are, and can continue to be, leveraged to advance the organization along its journey:

1. More internal facing: Equity and Trauma-Informed Leadership Team (ETILT)
2. More external facing: Community Equity Advisory Board (CEAB)

While an activated leadership, engaged internal workforce, and committed community partner network collectively signal a high level of commitment to advancing equity throughout SHD, there are other critical infrastructure pieces and resources needed to operationalize equity in more visible, tangible, and sustainable ways.

Phase 1 of this equity review and assessment focuses on the **current state** of equity-driven work and priorities at SHD. Key themes and insights from this phase will be used to inform Phase 2 of the project.

## Approach and methodology

Drawing heavily on The Upstream Group’s strong background in public health systems thinking, health equity expertise, organizational DEI leadership, qualitative research, and program assessment, we leveraged a mixed qualitative methods approach to uncover:

- A deep understanding of the current state of equity-driven work, efforts, and capabilities at SHD.
- Existing barriers to advancing/operationalizing equity as experienced by employees and upheld by institutional policies, systems, and practices.
- Opportunities to further advance and better position equity-driven strategies and actions within the organization.

Additionally, we leveraged and learned from parallel and complementary projects including the department’s strategic planning efforts. This allowed us to limit over-surveying employees for similar information and identify equity connection points between these related areas of work.

Focus group and key informant interview questions were structured to solicit input regarding:

- Perceptions about SHD’s culture of inclusion and belonging, particularly for employees of color and those who belong to other historically marginalized identities.
- Perceptions of how well SHD incorporates the voices of employees into equity/DEI initiatives.
- Areas of organizational barriers and resistance to move equity work forward.
- Opportunities to make SHD a more diverse, inclusive, and equitable organization.

## Audiences and qualitative instruments

Method and format	Audience
Key informant interviews (Virtual)	<ol style="list-style-type: none"> <li>1. Department Director</li> <li>2. Health Officer</li> <li>3. Deputy Director</li> <li>4. Prevention Services Division Director</li> <li>5. Environmental Health Division Director</li> <li>6. Senior HR Specialist</li> <li>7. HR Specialist</li> <li>8. Prevention Services Division Assistant Director</li> <li>9. Health Equity Policy Analyst</li> </ol>

Method and format	Audience
	10. Executive Director for County Executive’s Office 11. Chief of Staff to County Executive 12. Chief DEI Officer at County Executive’s Office
Focus group (Virtual)	ETILT Committee members
Survey (Anonymous, online)	ETILT Committee members who couldn’t participate in the focus group
Observation (Virtual)	Community Equity Advisory Board meeting, to observe Board dynamics and DEI strategic planning efforts

## Equity and cultural humility review

We conducted a review of the following SHD documents as provided by leadership using an equity and cultural humility lens:

- Snohomish Health Department 2022 Community Health Assessment
- Snohomish County Health Department DEI Survey Results
- A Board of Health Resolution “Supporting Equity and Inclusion in Public Health within Snohomish County” from July 2020
- A Policy Brief on “Strengthening Public Health”
- Report titled “Snohomish COVID Equity Project”
- A PowerPoint report on the findings of an equity review done by the consulting group Racing to Equity through the Department’s Advancing Health Literacy grant
- Language access document
- Community Engagement interviews

In addition, we reviewed the following documents due to their relevance in advancing equity:

- Strategic planning – draft goals
- Strategic planning – priority areas
- Strategic planning – SWOT analysis

Each review assessed the following areas:

- Overall potential equity impacts.
- Any disproportionate impacts on historically marginalized groups.
- Strengths and opportunities to advance equity.
- Gaps and recommendations to remedy inequities.

# Summary of the current state

Key themes of SHD's organizational culture

## 1. *Transitioning culture*

SHD's overall organizational energy still feels transitory. Some areas of the department are still catching up after a rushed transition while trying to understand and adapt to unfamiliar county policies and new culture. SHD is settling but still hasn't completely, with a mix of lingering emotions including feeling behind with the transition, overwhelmed by another new thing, traumatized by the change, and weary of the future. At the county level, the Office of Social Justice is newly staffed and will increasingly provide an opportunity for SHD to connect to enterprise equity efforts.

## 2. *Assimilation culture*

SHD strives to be an inclusive organization, but the organization lacks readiness and capacity for conversations that push against the status quo or disrupt systems of oppression. The implicit workplace norms remain aligned with an assimilation mindset. Although employees may be publicly encouraged to share feedback, pressure exists to adapt to dominant culture norms. Assimilation culture most disproportionately impacts underrepresented groups and employees with intersectional identities.

## 3. *Inconsistency in DEI knowledge and practice*

There is a varying level of applied knowledge and understanding of the meaning of equity and how it differs from the concept of equality. Applying an equity lens into daily practice is intermittent and ad-hoc across SHD programs, and this is also true across county departments. There is a need for more tailored and consistent approaches to integrating an equity and community-informed lens into decision-making, programmatic opportunities, and the regulatory functions of public health.

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*"People want to help be part of the change. We are cultivating equity champions."*

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#### 4. *Presence of white supremacy culture characteristics (and efforts to challenge them).*

Many aspects of white supremacy culture are inherent to and built into governmental agencies, structures, and systems. While some characteristics arose during this assessment, so did examples of SHD challenging these characteristics and building new systems and processes toward a relational culture.

- **Urgency:** Can appear in response to emerging issues or tight deadlines (e.g., grant cycles) and is often connected to a larger system outside of SHD control. Impacts of work urgency can and should be assessed to identify whether frontline staff and community partners carry a disproportionate burden. Urgency can *also* appear through a pressure to quickly advance equity initiatives or community engagement efforts. Although well intentioned and aligned with the department's equity goals, this can become harmful if the urgency perpetuates power imbalances or impacts employee/community well-being in the process.
- **Fear:** Although culture is shifting, some participants have observed a lingering resistance or fear to speak up and challenge the status quo.
- **Quantity or quality:** Often arising within public health's data and epidemiological responsibilities, SHD is limited by the same quantitative-centric approaches structures. However, very positive examples were shared of valuing qualitative information and community stories to fill in data gaps, demonstrating commitment toward a more balanced and relational approach.
- **Paternalism:** Some with decision making power may hold that close or, more commonly, not understand the power they hold. SHD decisions that impact employees do not always involve those impacted, and the same is true for external-facing decisions that impact communities. However, in both realms, progress is currently being made to advance toward shared power.

#### 5. *Growth and DEI learning mindset.*

There is a desire to create space to have the necessary and sometimes difficult conversations, center and share lived experiences and build affinity amongst SHD employees. The commitment to advancing equity was shared by all participants, with nearly everyone sharing the recent Orange Shirt Day event that was employee-led and leadership-supported.

## ☆☆ Equity in practice ☆☆

The Maternal and Child Health program realized much of the focus, understandably in the name, was on mom and baby. The program began asking questions: how do we bring in fathers? Grandparents?

The program renamed itself to Children and Families. This is a great first step toward creating a more inclusive program.

The TB and STI programs are meeting their clients where they are and responding to community-identified needs food, rent, gas payments, and more. Recognizing the growing Spanish-speaking population in Snohomish County, the team has embarked on a journey to learn Spanish together to better serve the community.

Old job postings sometimes have outdated requirements. A department employee within the epidemiology and informatics team identified an unintentional, and for most irrelevant, employment barrier in many postings: the requirement to be able to lift 50 lbs. This is a great example of identifying barriers and removing them.

The Environmental Health Division is getting ready to update their entire regulatory code. Recognizing the code may have unintentional consequences when implemented, the Division hired a community engagement team member to gather community feedback on the proposed update. This is a strong example of proactively involving and incorporating community voices in policy development efforts.

The pandemic provided the department a unique opportunity to think about how they were reaching priority communities with limited information access. Working with key community partners, SHD co-created their health information and vaccine distribution strategy.

## Priority areas of focus

This assessment looked at the current state of organizational equity across 12 key domains. While there are several domains that are reflective of organizational equity practices, the Upstream Group focused on the following based on SHD's organizational structure, authority, and scope.

1. Access/accessibility for people with disabilities
2. Communications
3. Community engagement and partnerships
4. Contracting equity
5. Data equity
6. Employee inclusion and belonging
7. Grants and program development
8. Language access
9. Organizational policies, procedures, and change
10. Policy (external)
11. Workforce development and training
12. Workforce diversity

As **one** tool to complement the analysis from the assessment process, The Upstream Group used the [Continuum on Becoming an Anti-Racist, Multicultural Institution](#) to provide a quick glance at the department's current state across these 12 domains. No tool is perfect, and there are some aspects of this continuum that are outdated. However, it withstands many years of application and provides a more step-based visual to advance towards becoming an anti-racist and multicultural institution.

Please note that the following assessment captures a high-level status view and doesn't account for the nuanced differences in levels that very often exist across different areas of an organization on a small, more program-to-program level.

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*"To be able to advance this work, we have to be able to sit in difficult spaces."  
– SHD employee*

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## 1. Access/accessibility for people with disabilities

Exclusive	<b>Passive</b>	<b>Symbolic change</b>	Identity change	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why passive – symbolic change?

SHD may limit or exclude people with disabilities from equitable employment opportunities or external services inadvertently by not having comprehensive accessibility practices in place. This is a characteristic of the passive level on the continuum.

SHD is implementing training related to employee accommodations and has proactively sought a grant opportunity to advance accessible communications. These efforts are characteristic of the symbolic level, and if institutionalized appropriately, could advance the department toward identity change.

### Pulse: Current state details

- Although this is an area that is still nascent for the department, there is also strong desire and interest in addressing barriers and advancing access for people with disabilities.
- In the 2023 employee DEI survey, only 49% of respondents were aware of the process to request accommodations. In partnership with Human Resources (HR), work is underway to provide accommodations in the workplace, including during job interviews.
- Additionally, it was noted that training is being offered to SHD employees on understanding individual rights and pathways to accommodations in the workplace.
- In the 2022 Community Health Assessment, SHD had an opportunity conduct an interview with a member of the d/Deaf community. However, they were unable to secure ASL interpretation services, which led to the critical community voice not being represented in the assessment.
- A grant opportunity from the State Department of Commerce has offered a pathway on how to communicate effectively with individuals with intellectual and developmental disabilities.

## 2. Communications

Exclusive	Passive	<b>Symbolic change</b>	Identity change	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why symbolic change?

SHD recognizes and tailors communications to some elements of diversity. However, the Department needs an increased commitment to further expand cultural relevancy and linguistic accessibility to reach priority communities and multicultural audiences more effectively.

### Pulse: Current state details

- Overall, communications is an area within SHD that needs more attention, support and action. It is one of the critical access pathways to advance organizational equity and reach audiences and communities in ways that are culturally and linguistically responsive.
- There was a suggestion to improve existing communications campaigns to reach multicultural audiences more effectively and in culturally responsive ways. Related, there was an expressed desire to see new thought leadership at the helm of this work and hire new staff to fill critical vacant positions, including by using an equity lens during the hiring process.
- While social media posts and media releases are important tactics to reach audiences more generally, SHD’s communications tactics need to be more comprehensive and inclusive of the communities and audiences it serves, especially people of color who account for 30% of the population.
- Similarly, SHD’s website could strongly benefit from being more accessible by transitioning to a multilingual site for communities and audiences who speak languages other than English and Spanish.
- The Snohomish COVID Equity Project report offers tactical recommendations to address website accessibility and user testing to improve access for those who speak a language other than English or rely on assistive technology. The report also offers recommendations for improving social media content to meet the needs of BIPOC and/or RIM (refugee, immigrant, and migrant) community members who are most impacted by health inequities and likely to access SHD’s social media platforms for timely and accurate health information.

- In terms of internal communications, ETILT has played a key role in sharing all-staff communications to commemorate monthly cultural observances.
- There has been a shift in the perception of transparency in leadership communications. In 2023 as part of the staff DEI survey, only 50% of respondents said they are “kept well informed by senior management about the strategic direction, plans, and progress of the organization.” All participants involved in this assessment spoke to the change observed in the Department director and noted that he is very vocal about inclusion and belonging, while practicing an open-door communication style.

### 3. Community engagement and partnerships

Exclusive	Passive	Symbolic change	<b>Identity change</b>	Structural change	Fully inclusive, anti-racist, multi-cultural
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#### Why identity change?

SHD falls in the identity change level because they are beginning to develop accountability to priority communities through the Community Equity Advisory Board (CEAB). However, there remain institutional structures limiting the ability to share power more fully with community.

#### Pulse: Current state details

- There is heightened energy and enthusiasm across SHD around the CEAB. The Board is viewed by many as a bright spot along the department’s community-facing equity journey. It is also a tangible way for SHD to center community voices, perspectives, lived experiences and wisdom to help advise the department on critical issues.
- Several leaders shared a recent and challenging issue involving the food licensing team and members of the West African community in Lynwood. While the issue revealed structural gaps related to departmental forms and procedures, translation services and community engagement, it also provided an opportunity for SHD leadership to address community concerns more directly and seek the advice of/loop back with the CEAB.

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*“This is the first time anyone has cared to go. The community felt heard and appreciated. If we do learn from these lessons, things should go better.”*

*– Community partner*

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- While the CEAB structure is advancing organizational equity, leaders also agreed that the Board needs to move beyond an advisory role/symbolic committee to providing more strategic direction on department processes and practices.
- The level and depth of community engagement and partnerships vary from program to program and even project to project.

For the **County's opioid response**, people with lived experiences are providing input into various products and services so they are more audience informed and sensitive to their unique context.

The **Community Navigator Program** in the Prevention Services Division was highlighted as another successful example of responding to community needs in culturally resonant and authentic ways. However, finding stable funding is an ongoing challenge as grant-based financing is not sustainable longer term.

The **Tuberculosis (TB) Prevention Program** also applies community-centered tactics, such as conducting exit interviews with patients to understand their experience and improve program practices to make them more culturally informed.

For the **County's Orange Shirt Day event**, local tribes and tribal communities were invited to attend. Although the overall event was seen as a success, tribal partner response was low, potentially illustrating an opportunity area for stronger relationships.

- There is a strong desire to compensate community members for their time, counsel and perspectives, no matter the program or project need. For example, it was noted that community members were reimbursed for their participation during the SHD's most recent Community Health Assessment (CHA) process, which led to a more representative county sample versus when community members have been asked to volunteer to share their input in the past. That said, there is an opportunity to institutionalize some of these community-centered practices and policies at the County level.
- Even though demographic data is limited and not disaggregated to the level that is preferable to meaningfully represent the BIPOC community, for example, the CHA was nevertheless lifted as a strong example where qualitative research and storytelling was front and center. Storytelling affords an opportunity for community members to share their experiences in ways that are culturally authentic and reflective of their preferences, context, and needs, while also highlighting their barriers to meaningfully participate in SHD programs.

- SHD was also transparent in the CHA about communities who were not represented in the assessment, with a committed desire to improve community participation and inclusion for the next CHA. Communities that were identified as not represented include members of the Tulalip Tribes, Sauk-Suiattle Tribe, and Stillaguamish Tribe; Russian community members; Ukrainian community members; people who are d/Deaf or head of hearing; older adults; and members of the community who speak a language other than English.
- SHD is actively working on a community engagement tool that includes reflection questions about how the County can more actively share power WITH community in ways that are equitable and center co-creation. It is also a way assess who from the community is missing and who might be overburdened.

## 4. Contracting equity

Exclusive	<b>Passive</b>	<b>Symbolic change</b>	Identity change	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why passive and symbolic change?

SHD falls in the passive level because there is not currently a large-scale effort to advance contracting equity. Contracting policies and practices continue to maintain bureaucratic power structures, enforce barriers, and perpetuate inequities. Many contracting systems result from passive acceptance and compliance with burdensome source funding requirements, although this isn't a unique challenge for the department or county.

However, there is broad understanding of the barriers current systems create to achieving a shared goal of more equitable contracting practices. There are intentional efforts to carry out some starting strategies around this work. Efforts for micro service agreements and community compensation show symbolic changes the department and county are making toward become a multi-cultural institution.

### Pulse: Current state details

- There is strong consensus that equity in contracting and procurement is an area that deserves much needed attention. This is especially true for circumstances when smaller organizations and businesses are unable to fairly compete or participate in competitive county funding opportunities, primarily because larger organizations often have more knowledge of contracting processes and more resources to complete polished applications. Additionally, affinity bias may unintentionally influence contract manager and evaluator decisions, inadvertently defaulting to the same entities they are comfortable or familiar working with.
- Some barriers are more structural. For example, smaller organizations and businesses are structurally marginalized due to burdensome insurance requirements. Additionally, opportunities funded through federal dollars can be complex and out of reach due to the foundational requirements. Within the department, the perception is that the county structure has made the overall contracting process more risk-averse, and this sentiment was shared by several leaders.
- At the county level, risk-based discussions involve assessing the potential *risk for* smaller organizations who may be newer to governmental contracting. Especially when it comes to less flexible funds, there is fear of passing along too much risk—without accompanying it with technical assistance—and set smaller organizations' up for a potential, future audit.
- Both the department and county are concerned about how risk impacts smaller community organizations and businesses. While assessing overall contracts-related risk is prudent and necessary to protect the county against liability, it can inadvertently be counterproductive to equitable contracting practices. Additionally, unnecessary barriers—or lack of transparency around funding source-initiated requirements—may erode community trust.
- There are positive advancements toward contracting equity at both county and department levels. The county has figured out how to work with others through micro service agreements and recognize more work is needed to ensure equitable access to larger grants. The department has initiated a community of practice for contracting across the county where compensation for community participation is receiving much needed attention and traction for a more sustainable, countywide solution.

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*Most of our systems are embedded in county government, and most of those systems are not easy to change.*

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## 5. Data equity

Exclusive	Passive	<b>Symbolic change</b>	<b>Identity change</b>	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why symbolic and identity change?

SHD is between symbolic and identity change because they are carrying out inclusive data practices where feasible (for example, gathering qualitative information) and are committed to improving data equity through disaggregation and other best practices.

### Pulse: Current state details

- An area of greatest need, as identified by several participants, is data disaggregation. SHD has received guidance from the Washington State Department of Health on the level and specificity of data disaggregation based on small numbers. Related, staff aren't able to publicly share data and would like to find a way to do so that respects both community preference and data integrity.
- There is opportunity to revamp the small numbers data guidance in partnership with WSALPHO, including supporting more race and ethnicity options and social determinants of health data across healthcare systems, where access to electronic health records (when adequately filled out) can provide deeper insights into patient and community-level indicators.
- It was noted that the Community Health Assessment (CHA) isn't as quantitatively representative of the population and could be enhanced to better capture the diversity of the county residents. However, the CHA was recognized for its efforts to include qualitative information to fill in quantitative data gaps and more holistically share community stories and experiences.
- The Strengthening Public Health Policy Brief outlines six recommendations, with one solely focused on enhancing the Department's informatics and epidemiological analytic capacity. Improved data collection and analytics can help the Department better serve BIPOC and RIM (refugee, immigrant, and migrant) communities. This is aligned with the Department's equity commitments and efforts to close disparity gaps. Additionally, increasing server capacity to obtain access to all-payers claims data to conduct more effective chronic disease surveillance and monitoring at a population level.

- This will help answer some of these questions: Who are our priority populations? What data do we have? Who is missing from the data? How do we work with community partners to validate and affirm community-level data?
- It was also shared that traditional public health data systems and structures are white-culture dominant, along with some indication of interest in decolonizing public health data within the county. As such, maintaining strong community relationships is critical to help inform that process.

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*“Surveillance & data – we believe we are the experts.”*

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## 6. Employee inclusion and belonging

Exclusive	Passive	<b>Symbolic change</b>	Identity change	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why symbolic change?

SHD is at the symbolic change level because it has made formal announcements to support multicultural diversity and is carrying out intentional inclusivity efforts. To move to identity change, the department will need to lead with a racial equity lens and take intentional steps toward becoming an anti-racist institution.

### Pulse: Current state details

- While there is recognition of improvement in this domain, particularly due to the efforts of ETILT, there is still room for growth.
- It was noted that employee experience is a key priority in the new strategic plan, while some teams like the Maternal and Child Health and Tuberculosis Prevention programs are already finding ways to connect through creative team building opportunities.

- More recognition of cultural and other monthly observances internally has brought much needed attention to key celebrations and traditions mostly unfamiliar to SHD employees (for example, Orange Shirt Day—that recognizes the colonial legacy of Indian residential school system). That said, it was also noted that more work is needed in this space to embrace cultural differences and celebrate the inherent diversity and intersectionality of SHD employees.
- There is also a need to define and have shared agreement on terms like employee inclusion and belonging so there's common and consistent understanding across all team members.
- Exit interviews have been conducted and reviewed across the county, finding that employees of color haven't stayed because they feel like they don't belong.
- The staff DEI survey conducted in the second quarter of 2023 illustrated equity gaps in all questions that were cross-tabulated.
  - About 90% of men, women, and white respondents agreed that employees respect each other. This was true for 80% of respondents of color.
  - 71% of respondents of color agree that all parts of their identity and background they present at work are accepted, compared to 91% of white respondents.
  - 77% of straight respondents agree that they feel like they belong in the County compared to 33% of LGBTQIA+ respondents.
  - For all DEI readiness questions, 16-20% of respondents were uncomfortable discussing key topics including ageism, disability, neurodivergence, Indigenous identities, LGBTQIA+ identities, sexism, and racism.
- While many employees have prior/past trauma from earlier experiences in their workplace within the Department, there are signals of positive change. In particular, the Department Director and other senior leaders are moving SHD in the right direction to make the environment more open, transparent, inclusive and a safe place to belong. It was noted that these actions are going a long way in rebuilding trust among junior and newer team members.
- Even with remote employees, there is a concerted effort to create connectedness among team members across many levels of the Department, including through innovations in using technology.
- Employees are also provided the opportunity to share their perspectives, ideas, issues, and concerns and feel heard. To that end, an employee satisfaction and engagement survey will be conducted in 2025, and results will be disaggregated by key employee demographics, including race and ethnicity, sexual orientation, and gender identity, to name a few.

- ETILT participants shared that in general SHD employees value diversity and are respectful towards and inclusive of all colleagues. And while ETILT communicates monthly to honor holidays and cultural celebrations that are historically underrepresented, there is still space for more intentional and strategic efforts to make the Department more inclusive.

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*“People want to speak up and challenge the status quo. But they don’t want to challenge if that challenge means repercussions.”*

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- It was noted that the County offered BIPOC caucuses earlier in the year, but SHD staff are unaware of what the Department specifically has done/is planning to do to cultivate a culture of inclusion and belonging for employees of color. Some suggested that in addition to providing more spaces for all staff learning, employees of color should be offered additional resources and supports given the disproportionate burden they often experience in the workplace due to implicit bias, prejudice, and discrimination.

## 7. Grants and program development

Exclusive	Passive	<b>Symbolic change</b>	Identity change	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why symbolic change?

SHD is in symbolic change for integrating equity into grants and program development because there are some examples of intentional inclusiveness efforts—for example, engaging community partners in the application process and writing them into a grant opportunity. However, integrating equity and community priorities into grants and programs isn’t an institutionalized practice and the Department still maintains a pattern of control, even if unintentionally or unconsciously, as the ultimate decision-maker related to these opportunities.

**Pulse: Current state details**

- 85% of SHD is grant funded, providing a critical opportunity area for integrating equity into practice.
- For recent grant and program development efforts, SHD has integrated a stronger equity component with the intention to keep advancing work in this area.
- The most consistent related effort is writing a partner into a new grant opportunity. SHD does this to some degree and there is an opportunity to increase it. This practice can decrease some of the more common barriers related to contracting.
- There is a desire to move towards co-creating proposals rather than asking community partners to support or attach their (organization’s) name to a pre-determined direction.
- The county and department have used recent large investments from federal funding as an opportunity to respond to community needs and priorities.

## 8. Language access

Exclusive	Passive	Symbolic change	<b>Identity change</b>	Structural change	Fully inclusive, anti-racist, multi-cultural
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**Why identity change?**

SHD is in identity change for language access because there is growing understanding of the lack of language access as a barrier to effectively reach multilingual audiences and deliver linguistically accessible services. However, SHD has not yet assessed linguistic accessibility more holistically across the Department and developed structures that would allow for full participation in SHD services and programs (a critical component to structural change).

**Pulse: Current state details**

- SHD recently wrapped up a three-year grant from U.S. Department of Health and Human Services that focused on health equity, language access, and health literacy. There is a commitment to continue the work that was started under this initiative.
- SHD has a language access plan that agency and division leadership are both committed to updating in 2025.

- There are some language access supports in place including use of translation and interpretation services. However, it was noted that there are some barriers and challenges to procuring language access services because of the limited number of approved contractors at the county level. Current, there is not an enterprise-wide language access policy.
- Key data from the Language Access Assessment Report and Recommendations illustrated the severity of the barriers experienced by communities.
  - Survey respondents said that the language they speak influenced their ability to:
    - Find a COVID-19 testing site (41.1%)
    - Find a COVID-19 vaccination site (41.0%)
    - Get a COVID-19 vaccination once I found a place that provided vaccinations (44.1%)
    - Find information related to COVID-19 specific to my needs (48.6%)
    - Get resources to deal with the impacts of COVID-19 (48.5%)
  - Additionally, in the same report, only 7% of SHD staff reported using an interpreter every time they communicated with individuals who spoke a language other than English.
- If language access created barriers during COVID when language access was more at the forefront, resourced, and prioritized, one could assume at least the same percent of the community would face barriers to other critical public health services and information.

*“Language access is equally essential during times of public health crises as it is in in the day-to-day activities of the Health Department. Between the beginning of 2019 and the end of 2020, the Health Department’s expenditures on translation and interpretation tripled. This growth was crucial to providing equitable care to communities that were disproportionately impacted by COVID-19 – primarily Black and brown communities. While this growth from the COVID-19 response reflects a leap in the right direction towards achieving more equitable access, there are still gaps in language access across areas of work that must be addressed.”*

**– Language Access Assessment & Recommendations Report**

- Areas of the organization vary on whether they provide language services pro-actively—which is needed to truly address language barriers—or reactively, which requires a community member to request language services to receive them.

- On the internal side, many shared the benefit of dual language pay and increased recruitment of employees who are bilingual and/or multi-lingual.
- There is agreement SHD can benefit from enhancing translation and interpretation services for clients and customers whose primary language is not English, while also creating internal policies to assist SHD staff in responding to the needs of non-English speaking community members more effectively.
- According to the Office of Financial Management (OFM) Limited English Proficiency (LEP) population estimates from 2021, there are 16 languages in Snohomish County that meet the “Safe Harbor Threshold” for Title VI/Language Access compliance.

**Table: 2021 OFM LEP population estimates, Snohomish County**

Primary Language	Number of Students	% of All Students in County	Estimate of Language Speakers	Newly listed since 2016
Amharic	432	0.40%	1,110	
Arabic	1,134	1.04%	2,688	
Cambodian	277	0.25%	1,042	
Chinese-Mandarin	707	0.65%	1,852	
Hindi	492	0.45%	1,437	Y
Korean	1,001	0.92%	2,593	
Marshallese	311	0.29%	1,773	Y
Punjabi	415	0.38%	1,212	
Russian	1,615	1.48%	3,828	
Spanish	12,172	11.17%	43,819	
Tagalog	361	0.33%	1,112	
Tamil	339	0.31%	990	Y
Telugu	573	0.53%	1,673	Y
Ukrainian	1,137	1.04%	2,695	
Urdu	312	0.29%	1,092	Y
Vietnamese	1,574	1.44%	5,336	

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*“Language access – a very simple idea that has been really challenging to implement agency-wide. We don't have an enterprise-wide language access policy. If you can't even interact with your government, how are you going to get services?”*

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## 9. Organizational policies, procedures, and change

Exclusive	<b>Passive</b>	<b>Symbolic change</b>	Identity change	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why passive – symbolic change?

SHD is between passive and symbolic change. Due to the recent transition under the county structure, SHD has less of an active role in driving organizational policies and procedures. SHD inherits policies, practices, and power structures. These characteristics are detailed with the passive, or “club” institution, level.

However, within its area and limitations of influence, SHD is striving to advance more equitable policies, procedures, and organizational change efforts and has recruited staff with diverse lived experiences and strong DEI commitments to ETILT and other critical roles. These efforts fall under examples of a multicultural institution currently working through the symbolic change level.

### Pulse: Current state details

- SHD has been in a challenging transition period related to internal policy. The Department had a rushed, six-month transition to the county structure. HR focused on getting employees settled and established in county systems. Moving under the county structure meant adopting county policies, especially related to HR, and contracting.
- It was noted that SHD can have Department-specific policies if they don’t contradict county policies. SHD staff make up about 200 of the 3,000 total county employees. Departments vary in their own approaches to operationalizing equity and the county structure is—for the most part—decentralized.
- There are early discussions to improve feedback and engagement efforts during policy development and revision efforts, including ensuring review by the ETILT committee. Additionally, there is interest in bringing policies that may have external impacts to CEAB or other community spaces for review.
- Current effort is to learn the county policies, identify gaps within the county policies, and prioritize what SHD can and should address.

- ETILT members shared that not surprisingly, the transition to integrating all departmental policies, procedures and services into the County structure has been challenging. Participants shared that in the prior “District” structure, they had the ability to design their own policies and procedures and be more intentional about integrating a DEI lens throughout.
- A key recommendation in the Strengthening Public Health Policy Brief to Take immediate measures to address the needs of Snohomish County’s systemically excluded communities is to work with the Office of Social Justice to develop an equity review tool to guide in reviewing current health department policies and inform the creation of new health department policies.

## 10. Policy (external)

Exclusive	Passive	Symbolic change	<b>Identity change</b>	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why identity change?

By instituting a new process to bring policies to the Community Engagement Advisory Board (CEAB), the SHD took a meaningful step toward sharing power and beginning to develop accountability to racially oppressed communities.

### Pulse: Current state details

- SHD invested in a health equity-focused policy position within their policy and partnerships section.
- New SDH policies are brought to the Community Equity Advisory Board for feedback, and current efforts are underway to ensure this is more systematic.
- SHD has not yet engaged in participatory budgeting processes, but the 2027-2028 budget process would be the next ideal opportunity. Budgets are a financial expression of an organization’s policy priorities.
- Some areas of the organization are unaware of how and when to engage CEAB, which may lead to missed opportunities for CEAB to inform both large- and small-scale policy efforts.

- It was noted that SHD has chosen not to make an overarching equity statement and/or declaration of racism as a public health crisis until systems, structures, policies, and practices are in alignment. This demonstrates awareness of the differentiation between meaningful and performative actions.
- Status quo culture creates resistance to holistically implementing equity into all policies. In the more regulatory areas and functions of the Department, for example, the perception is that the approach to current work—and rules or code that guide it—cannot be changed. Further, there is a misconception that such regulations are applied equally and impact all communities equally.

## 11. Workforce development and training

Exclusive	Passive	<b>Symbolic change</b>	Identity change	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why symbolic change?

SHD views itself as an organization with “open doors” to employees, but the workplace and organizational culture does not yet fully support conversations that challenge the status quo. There are strong threads of an assimilation culture and continuing patterns of paternalism. SHD does not currently sponsor anti-racism training, which is a critical component of identity change.

### Pulse: Current state details

- There is a shared interest to prioritize workplace development, onboarding, and employee training related to DEI principles and philosophy. Currently, there is not a specific training plan in place related to advancing organizational equity. There are minimum training requirements that touch on adjacent topic areas including discrimination and harassment.
- There is excitement for some recent, current, and future equity-focused training and learning opportunities.
  - *Recent:* An outside speaker presented on inclusive language, which was well received. SHD employees asked good questions and were engaged.
  - *Current:* Key equity practitioners and leaders are going through training on targeted universalism.

- *Future:* Equity training will be rolled out to senior leadership as a cohort and then the Department is considering offering to supervisors as well.
- At the county level, training and learning efforts have concentrated on the cabinet level, although there is a recognized need to go deeper into all levels and reach the frontlines.
- The development of staff competencies has been identified as a priority area that reach beyond diversity and inclusion and prioritize topics related to racial equity. A current effort is underway to develop competencies for all supervisors and staff and then offering training for those competencies.
- ETILT committee participants also shared that SHD employees could benefit from a stronger foundation of DEI principles, knowledge, and skills as part of new employee onboarding and an overall training program for all employees.
- ETILT participants noted that SHD's foundation hasn't been fully addressed or realized. There is a sense that most employees would be unsuccessful in stating the department's values around diversity, equity, and inclusion consistently.

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*“At what point do I push anti-racist work? I don't think the organization is ready”*

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## 12. Workforce diversity

Exclusive	Passive	<b>Symbolic change</b>	Identity change	Structural change	Fully inclusive, anti-racist, multi-cultural
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### Why symbolic change?

SHD has made and continues to work toward official policy pronouncements regarding multicultural diversity and there is an expanding view of diversity to include other socially oppressed groups (for example, people who speak languages other than English). However, SHD has not yet made steps toward practicing anti-racism (as detailed in identity change).

### Pulse: Current state details

- There is a shared goal of having SHD workforce reflect the people they serve, and a consensus that workforce diversity has been increasing in recent years. The workforce has also shifted toward a younger demographic with the current average SHD employee age being 31 years.
- With a stronger DEI focus at SHD, newer hires tend to be in a different place around conversations related to equity, justice, and fairness.
- Human Resources has several best practices in place that support workforce diversity including name redaction on interview applications and offering dual language pay. Hiring dual language employees has increased at SHD and is seen as success, although opportunities remain to increase hiring for language skills. It was noted that language skills are not consistently included as a preferred qualification – although beneficial to any position – and could be especially beneficial in some of SHD’s more outward or community-facing positions like food inspectors, who speak the languages of the communities.
- However, a few challenges were shared related to an overall, comprehensive workforce diversity strategy:
  - Although Snohomish County is becoming more racially and ethnically diverse, the overall community is still predominately white (72.8% - Census). Data is easier to find for overall community demographics rather than the communities most directly served by the health department, which would be a more ideal metric for measuring representation.

- Currently all jobs are posted on county platforms, but there is a lack of capacity and resources for posting to more community-oriented job boards. The free resources SHD has utilized don't generate candidates and leads. There is a desire and commitment to reach outside the traditional scope. Some interest exists in improving academic partnerships to increase interest among public health students of color and leveraging community navigators/public health ambassadors for community outreach about employment opportunities.
- The County largely directs HR activities, which has made it difficult for SHD to rethink job descriptions and position requirements (for example, related to criminal background checks and educational attainment).
- There are current efforts to integrate workforce diversity strategies into HR's internal strategic plan and active efforts to integrate an equity statement into job postings.
- The County has a new policy they would like to implement to ensure that employees are doing implicit bias training and integrating other best practices into the process. There has been pushback from some Departments, including SHD.
- ETILT committee members shared that there is a desire for county, board, and council leadership to show greater support in creating a more diverse and representative workforce, especially to counter some of the open resistance experienced by some employees.
- Participants also noted that the Department is currently attracting several candidates who reflect the communities and audiences SHD serves. This is especially true for candidates with critical language skills.
- Related, the Department has a more diverse and representative workforce now as compared to the last five years.
- Some participants have witnessed the prioritization of internal hires or past SHD employees for positions that could have received more consideration for persons with greater lived experiences for the subject matter or health topic. There is concern that while some candidates from historically marginalized identities may lack specific qualifications for a position, there is also the sense that the hiring team is actively seeking and encouraging prospective candidates they are familiar with to apply.
- There is interest in becoming more proactive in "getting the word out" about new job openings. Partnering with local colleges and other academic institutions to provide public health internships/practicum opportunities was also suggested to introduce the Health Department as a potential workplace to students early in their public health journey.

# Recommendations

## *To move toward broader equity-driven work*

We have provided our top three recommendations for tangibly advancing equity within SHD's 12 DEI priority areas. All recommendations reflect the results of the equity assessment and existing and emerging best practices. These recommendations will serve as the starting point for Phase 2 of this assessment.

1. Access/accessibility for people with disabilities
2. Communications
3. Community engagement and partnerships
4. Contracting equity
5. Data equity
6. Employee inclusion and belonging
7. Grants and program development
8. Language access
9. Organizational policies, procedures, and change
10. Policy (external)
11. Workforce development and training
12. Workforce diversity

## 1. Access for people with disabilities

- a) Assess access for individuals with disabilities to health information, services, and programs.
- b) Incorporate American Sign Language (ASL) into language access efforts.
- c) Integrate accessibility best practices into in-person and virtual public meetings, convenings, and events.

## 2. Communications

- a) Ensure all communications are audience-informed, accessible, and tailored to their specific cultural context and unique needs.
- b) Create and implement an Equity Style Guide that provides clear guidance on using appropriate language when identifying and communicating with and about historically marginalized/systemically excluded communities.
- c) Integrate language access into comprehensive communication plans and platforms.

### 3. Community engagement and partnerships

- a) Harness the power and expertise of the Community Equity Advisory Board to its full potential by identifying opportunities to move beyond advisory and toward shared decision making power.
- b) Create an inventory of SHD's community engagement infrastructure and build new partnerships to bridge representation gaps.
- c) Institutionalize compensation for community member participation and expertise as a standard practice.

### 4. Contracting equity (and risk assessment)

- a) Right-size contracts to reduce unintended barriers for small businesses and community organizations to compete.
- b) Conduct a risk tolerance assessment through an equity lens to identify leadership's appetite for any risk introduced through pro-equity and anti-racist contracting strategies.
- c) Explore opportunities to provide technical assistance to organizations and businesses new to governmental contracting.

### 5. Data equity

- a) Continue data disaggregation efforts to meaningfully understand underlying or hidden health inequities and disparate outcomes.
- b) Validate data sources and overall data collection approaches, analysis, and presentation with communities historically mis/underrepresented in public health data.
- c) Institutionalize the practice of complementing quantitative data with qualitative information and community-informed narratives and community-led storytelling.

### 6. Employee inclusion and belonging

- a) Explore employee resource/affinity groups (ERGs) as an organizational investment in employee inclusion and belonging.
- b) Activate leadership to continue support for employee-driven/led DEI efforts (following the success of Orange Shirt Day).
- c) Create a work environment that fosters psychological safety, transparency, and trust.

## 7. Grants and program development

- a) Leverage CEAB for community review of grant opportunities and program plans.
- b) Co-create grant applications with community partners when feasible/appropriate.
- c) Integrate community compensation, language access, accessibility services, and related “DEI costs” into grant applications and project timelines.

## 8. Language access

- a) Develop a comprehensive Language Access Plan to ensure access to vital health and other information in the county’s top languages, using OFM’s LEP Population Estimates.
- b) Develop tools, trainings, and resources to ensure adoption and implementation by staff including, but not limited to, translation prioritization processes and training to procure and work with interpreters.
- c) Assess the linguistic accessibility of all information pathways using a customer journey map.

## 9. Organizational policies, procedures, and change

- a) Develop a process for ETILT review of all internal policies and procedures, leveraging the Office of Social Justice’s future equity review tool.
- b) Provide opportunities for employee feedback and contributions to organizational policies, procedures, and change efforts.
- c) Identify gaps within county policies that have the greatest equity impacts or opportunities for SHD’s work.

## 10. Policy (external)

- a) Develop a process for consistent CEAB review of all external policies.
- b) Engage priority/most impacted communities on future department budget priorities.
- c) Implement a cross-Department equity assessment tool to identify disproportionate impacts among priority communities through policies, procedures, codes, and regulations.

## 11. Workforce development and training

- a) Create a comprehensive and consistent onboarding experience, which grounds new employees in SHD's equity commitments and practices.
- b) Implement DEI competencies for all employees and set up systems for measuring growth.
- c) Develop a DEI learning pathway for all employees tailored to position responsibilities and role, in partnership with Human Resources.

## 12. Workforce diversity

- a) Add language skills as a preferred qualification in all job postings, with a goal of hiring dual language employees in all top county languages.
- b) Conduct employee diversity assessments at the Division or Program level to identify representation gaps.
- c) Develop a DEI promotion and retention strategy with meaningful and supported pathways into management and leadership positions, especially for employees of color and those belonging to other historically marginalized identities.

### Cross-cutting recommendations:

Moving toward broader equity-driven work can be most effective, efficient, and impactful when you're able to leverage existing or emerging efforts. Four key opportunity areas for alignment and partnership are:

1. **County's Office of Social Justice**, including adoption and alignment with current/future pro-equity efforts around hiring, contracting, and other areas.
2. **Community Equity Advisory Board**, including alignment with CEAB recommendations.
3. **Equity and Trauma-informed Leadership Team**, including support for and resourcing of ETILT recommendations.
4. **Strategic Planning**, including integrating equity into strategic goals and metrics.

