

Snohomish Health District

2013 ADOPTED BUDGET

Gary Goldbaum, MD, MPH
Director | Health Officer



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HEALTH DISTRICT
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Snohomish Health District 2013 Adopted Budget

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Board of Health- Snohomish Health District

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City of Stanwood



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City of Snohomish



Councilwoman
Patsy Cudaback
City of Monroe

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**SNOHOMISH HEALTH DISTRICT
RESOLUTION OF THE BOARD OF HEALTH
RESOLUTION NUMBER: 12-37**

12-37

RESOLUTION SUBJECT: ADOPTION OF THE 2013 BUDGET

WHEREAS the 2013 Snohomish Health District Budget was developed during an extended and ongoing period of unusual uncertainty about the funding sources relied upon by the District for its programs, and

WHEREAS the 2013 Snohomish Health District Budget relies on \$962,559 in Fund Balance to balance expenditures with revenues and anticipates the District to develop and implement an agency transition plan to align future operations and budget within its allocated resources, and

WHEREAS the Board of Health has adopted operating guidelines which provide for it to approve total and program staffing numbers, and

WHEREAS the base 2013 compensation levels (salaries and wages) of non-represented regular employees include a cost of living adjustment (COLA) to final year 2012 salaries and wages, the same as granted to AFSCME and PTE union employees in their collective bargaining agreements covering the 2013 year which is an increase of 1.5% effective January 1, 2013, and

WHEREAS the Board of Health has directed staff to maintain a minimum fund balance (Resolution 11-19) in order to maintain reserves over the next few years, and

NOW THEREFORE, pursuant to the authority granted to the Snohomish Health District Board of Health in RCW 70.46 and in the Charter of Snohomish Health District:

- A. The Board of Health does hereby adopt the 2013 Snohomish Health District General Fund Budget, authorizing expenditure of funds during calendar year 2013 in the amount of \$17,170,636 and authorizing total staffing of 164 FTEs.
- B. The Board of Health does hereby adopt the 2013 Snohomish Health District Public Health Emergency Preparedness and Response Fund Budget, authorizing expenditure of funds during calendar year 2013 in the amount of \$717,868 and authorizing total staffing of 5.1 FTEs.

ADOPTED this 11th day of December, 2012.

ATTEST:

Dave Somers, Chair
Board of Health

Gary Goldbaum, MD, MPH
Health Officer and Director

About Snohomish County

Snohomish County is located on Puget Sound, between Skagit County to the north, King County (and Seattle) to the south and Chelan County to the east. Covering 2,090 square miles, it is the 13th largest county in total land area in Washington and 3rd most populated county in the state. A significant portion of the Mt. Baker-Snoqualmie National Forest is also in Snohomish County and it's the second most visited national forest in the country.



The total population of Snohomish County was estimated to be 717,000 as of April 1, 2011, according to the Washington State Office of Financial Management. This includes a total unincorporated population estimate of 304,435 (42% of total county population) and a total incorporated (city) population estimate of 412,565 (58% of total county population). Along with many other recognized communities, there are twenty cities and towns in Snohomish County with the largest city, and seat of county government, being Everett, population 103,100.

Snohomish County's varied topography ranges from saltwater beaches, rolling hills and rich river bottom farmlands in the west to dense forest and alpine wilderness in the mountainous east. Glacier Peak, at 10,541 feet, is the highest point in Snohomish County and one of the highest in Washington State. Sixty-eight percent of the county land area is forest land, 18% is rural, 9% is urban/city and 5% is agricultural.

Protecting the Public's Health

In Washington State, responsibility for public health protection is shared among the State Board of Health, Washington State Department of Health, and the 35 local health jurisdictions covering the 39 counties. The State Board of Health provides a citizen forum for the development of public health policy in Washington State, and is responsible for outlining the state's priority health goals and recommended strategies for use in preparing budgets and requesting legislation. The Board also exercises regulatory authority in a variety of public health areas, including drinking water, immunizations, school safety, and food handling.

The state Department of Health is responsible for the preservation of public health, monitoring health care costs, maintaining minimal standards for quality in health care delivery, and the general oversight and planning for all the state's activities. Responsibility for governance of local public health boards is placed solely with counties or groups of counties which may form health districts. State law also requires Counties to bear the cost of public health services within the District.



The **Snohomish Health District**, an independent special purpose district, was created in 1959 as the municipal corporation responsible for public health in

Snohomish County. A health district is all the territory consisting of one (or more) counties organized pursuant to the provisions of RCW 70.05 and RCW 70.46. Snohomish Health District's service area is contiguous with Snohomish County's boundaries.

A 15-member Board of Health has supervision over all matters pertaining to the preservation of life and the health of people, including policy and budget development. All five Snohomish County Council members sit on the Board of Health, together with ten city council members or mayors representing the 20 incorporated cities and towns in the county. Public meetings of the Board of Health are held monthly.

State law also requires each local board of health to appoint a licensed, experienced physician as the local health officer who serves as the executive secretary to, and administrative officer for the local board of health. **Gary Goldbaum, MD, MPH**, serves as the **Director and Health Officer** of the Snohomish Health District. Dr. Goldbaum subsequently hires and manages staff and resources in support of the agency's mission.

The Snohomish Health District provides a wide range of programs and services that protect and promote the public health with particular focus on preventing injury and disease. In addition to annual funding from Snohomish County, revenues are derived from federal and state grants, intergovernmental revenues and license/permit fees.

The operational divisions include **Environmental Health, Communicable Disease Control, and Community Health**.

The **Environmental Health Division** issues permits for all food vendors, public and semi-public swimming pools, on-site septic systems, small public water systems, and solid waste disposal facilities. Environmental health specialists regularly inspect food establishments,

Snohomish Health District

Vision

Healthy Lifestyles. Healthy Communities.

Mission

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

Strategic Directions

Assure provision of basic health services to protect the population's health and safety.

Support healthy lifestyles and environments for the prevention of chronic disease and injury.

Create support for stable and adequate public health funding.

Expand partnerships to share resources and responsibility for the public's health.

Improve the quality of and access to information and education about disease and injury prevention across the community.

Leverage technology to broaden community outreach and to improve the public's health.

Increase public involvement in public health policy and direction.

Source: Snohomish Health District Strategic Plan (July 2009)

swimming pools, and solid waste facilities, and help home owners keep their on-site septic systems in good working order. Environmental health specialists also evaluate and respond to complaints about garbage accumulations, failing septic systems, potential toxins in the environment, contaminated wells, vermin, and other potential public health risks. Health educators ensure that all food workers are educated about food safety and have been issued food worker cards valid throughout Washington State.

The **Communicable Disease Control Division** works to prevent and control communicable disease in Snohomish County and the North Puget Sound region through disease surveillance, outbreak response, education, vaccination, disease contact investigation, and preparedness activities. Transmission of communicable diseases, including food-borne illness, is controlled by prompt reporting and extensive disease investigation to identify and contain outbreaks. The Tuberculosis (TB) control program treats active TB cases and investigates case contacts. The immunization clinic vaccinates all ages for protection against vaccine preventable diseases. Travelers meet with nurses for in-depth counseling about destination health risks, and appropriate vaccinations and medications to prevent disease during travel. Other clinical services include perinatal hepatitis B monitoring for hepatitis B positive women and infants and TB skin tests. The HIV/AIDS program provides HIV counseling, testing, outreach education (including harm reduction and prevention counseling), and referral services. Public health interventions and health education for the community, providers, and hospitals are an essential part of disease control efforts. The Division also coordinates activities to ensure that the community is prepared for public health emergencies.

The **Community Health Division** focuses on improving the health of families and children. The First Steps, Early Intervention, and Children with Special Health Care Needs services support these aims. Home and clinic visits to families with high-risk pregnancies and children help to ensure the best possible environment for the critical time of early childhood. Some of these children and families are also seen in the Women, Infants and Children (WIC) Nutrition Program, which is designed to improve the health of pregnant, breastfeeding and postpartum women, infants and children up to

Snohomish Health District

Guiding Principles

Prevention

Prevention of disease is the most effective way to protect the health of the public.

Information

Access to accurate information by clients, community and staff is necessary to promote and protect health.

Confidentiality

We will respect privacy and will use or disclose confidential information only as authorized or permitted.

Effectiveness

We will pursue the highest value in public health services by using best practices, evidence-based practices and scientific knowledge.

Assurance

We will work to assure access to quality services that promote and protect health.

Learning

We are a learning organization that encourages creativity, learning from both successes and failures, and staff enrichment to achieve the SHD mission.

Shared Responsibility *Public health is a shared responsibility of government, community, and the individual.*

age 5. The program offers nutrition counseling, provides nutritious foods, promotes breastfeeding, and makes referrals to other health care providers.

The Healthy Communities efforts strive to reduce factors associated with cardiovascular, lung, and dental disease, cancer, and diabetes. These diseases often have associations with tobacco use, poor diet and physical inactivity as well as smoking and obesity. Work is aimed at tobacco cessation, enforcement of laws regarding smoke-free workplaces, training and technical assistance to community agencies and healthcare providers regarding oral health practices and issues, school based dental sealants, and fluoride varnish. Influencing organizational practices and community policies are means by which health issues are addressed.

The Assessment services provide data that assists public health programs and community agencies to better understand the particular health needs of local populations and prioritize prevention activities. Collection and analysis of data from multiple sources and production of reports for use by the Health District and the community occur.

As the local vital records registrar, the Vital Records service issues certified copies of birth and death certificates.

Administrative support functions include **Executive Leadership, Human Resources, Information Services, Business Office** and **Communications**.

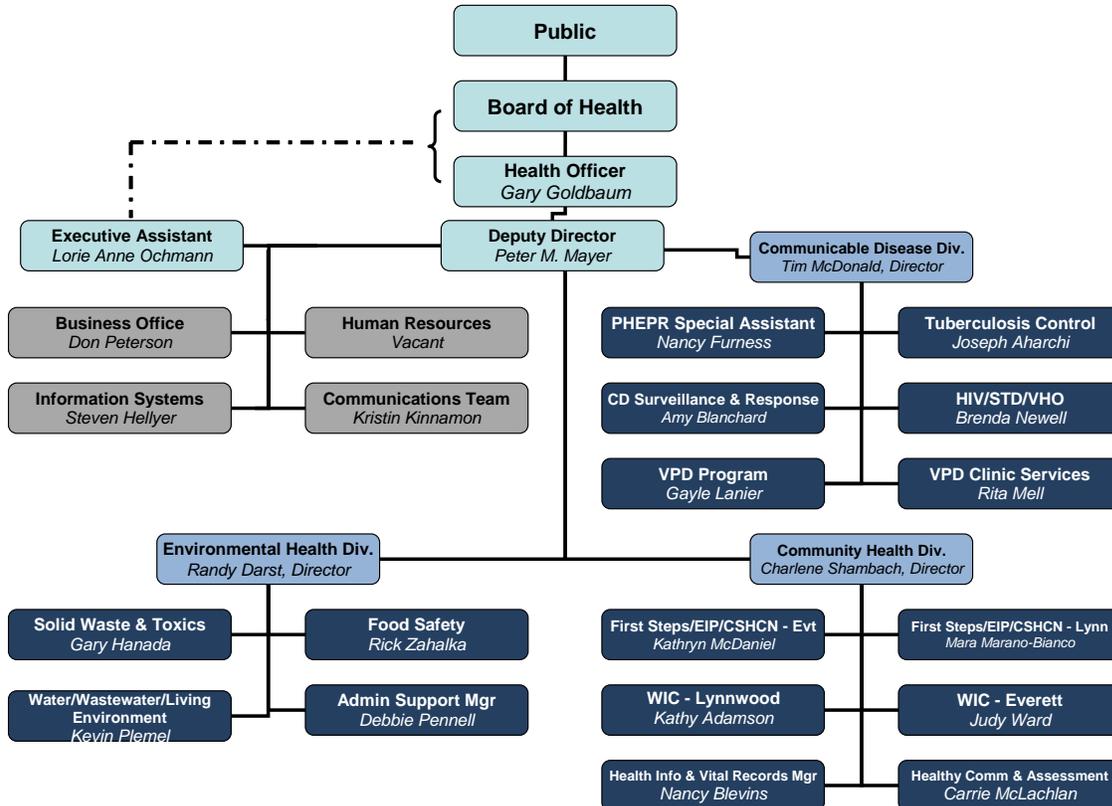


Figure 1. Current SHD Organizational Structure

Strategic Planning

The Snohomish Health District (SHD) undertook the development of a strategic plan in 2009 that provides both near and long term guidance to policy makers, managers, and the Board of Health. The process involved and engaged the community to a greater extent than ever before with the intent of securing broad and insightful community involvement and building a cadre of community leaders who will be advocates for public health and will partner with SHD to improve community well-being.

Drawing from the perspectives of community stakeholders the following vision for 2020 was recommended to guide the Snohomish Health District.

In 2020, Snohomish County will be the healthiest community in Washington State and its residents will aspire to lead still healthier lives.

Snohomish Health District will play a critical role in improving the health of the community by preventing illness and injury through:

- **Protecting The Public's Health**
 - Providing public health services that no other organization is authorized to provide and/or is able to provide.
- **Demonstrating Leadership**
 - Implementing community assessment to monitor progress, offering and educating about best practices in the prevention of illness and injury, and working to shape public policies in areas that affect the health of the public.
- **Offering Partnership**
 - Seeking, creating, and willingly participating in partnership with both public and private agencies to use community resources well in the prevention of disease and injury.
- **Providing Value**
 - Carrying out our work in ways which are innovative, effective and use resources wisely.
- **Education and Promotion**
 - Communicating what it means to be actively seeking to be a healthier community and healthier individual, while deepening the public's understanding of the role and importance of public health in their daily life.

To move towards the health vision for Snohomish County, the Snohomish Health District is pursuing seven strategic directions over the next five to ten years. The first two delineate the programmatic directions:

- I. Assure provision of basic public health services to protect the population's health and safety.

- II. Support healthy lifestyles and environments for the prevention of chronic disease and injury.

The remaining strategic directions provide the primary means by which the programmatic directions will be achieved:

- III. Create support for stable and adequate public health funding.
- IV. Expand partnerships to share resources and responsibility for the public's health.
- V. Improve the quality of and access to information and education about disease and injury prevention across the community.
- VI. Leverage technology to broaden community outreach and to improve the public's health.
- VII. Increase public involvement in public health policy and direction.

The Strategic Plan serves as a guide for decision making both near term and long term policy, and financial and programmatic decisions. It provides a road map for the District in the challenging years to come.



Budget Message

Gary Goldbaum, MD, MPH

Director | Health Officer

2012 brought both new challenges and opportunities. The pertussis epidemic that started in the fall of 2011 hit full force in the winter of 2012, requiring the full attention of our communicable disease staff. An outbreak of tuberculosis in late fall has further taxed resources. However, these events have also afforded opportunities to better connect with health care providers and other community partners. We are especially proud of our

successes promoting pertussis vaccination, through mass vaccination clinics and the postcard sent to every Snohomish County household.

The health care environment changed throughout the year, with much happening at both the state and federal levels. Although health care reform is proving complicated, it is also encouraging new connections between the medical and public health communities. To investigate reports of communicable diseases, Health District staff can directly access electronic health records (EHRs) at Providence Regional Medical Center Everett; we hope to access EHRs at other sites soon. To address rising health care costs, a group of local community leaders from the health, education, non-profit, and business worlds are committing to population-based prevention activities that will augment the Health District's effort to develop and implement a community health improvement plan.

The economy has improved slowly, but federal, state, and local government revenues have generally continued to decline. Despite this, public health funding from all levels of government has been sustained to this point. Today we see opportunities for possible new funding to support targeted activities, especially working with Verdant Health Commission in south county.

2013 will bring new challenges and opportunities. Both the state and federal budgets are likely to shrink. State and federal legislators have supported public health in the past, but the need to more adequately fund education may lead to future reductions in state support and a divided Congress may cut Federal funding for foundational public health activities such as promoting immunizations or planning for emergencies.

We will continue to face new and re-emerging infectious diseases such as West Nile virus and meningitis caused by a rare fungus. New tobacco products and settings such as electronic cigarettes and hookah bars will challenge our ability to reduce tobacco use. Inadequate physical activity and poor nutrition will challenge our ability to reverse the obesity epidemic and its sequelae of diabetes, heart disease, cancer, and degenerative joint disease.

Health care reform will escalate, complicating our ability to be reimbursed for some services while affording new opportunities to transition some clinical services to the medical community.

The population will get older, bringing new public health challenges—who thought pertussis should be a concern of adults? Our own workforce will be impacted, with much institutional memory and expertise lost as many employees retire.

The state's public health system will continue a two-decade-long effort to become more effective and efficient. Building on statewide performance objectives first introduced in the 1990s and constantly revised since, the Washington State Department of Health and local health jurisdictions have developed an Agenda for Change that defines what public health must provide in every community and sets priorities for efforts to move the entire state forward. This agenda could influence funding priorities and will certainly shape the state's expectations of local public health performance. At the same time, a national accreditation effort affords us an opportunity to prove our accountability. Beyond adopting new ways of doing business to better address evolving health issues while minimizing costs, responding to these external forces will also require new approaches, such as increasing our emphasis on constant assessment and continuous quality improvement.

The Health District is facing extraordinary challenges and possible opportunities amidst difficult economic times. Nevertheless, public health is a core government service to assure that every community has a healthy future. Employers cannot thrive without a healthy and safe workforce. Schools cannot teach students who are home ill. Families cannot reach their potential if they struggle with health problems. The Health District plays a vital role in all of these areas.

The adopted 2013 budget holds true to our commitment to provide the essential public health services that the public deserves while also addressing the need to keep the Health District financially healthy. We draw on the General Fund to maintain current activities during 2013. However, we will work closely with the Board of Health to develop a balanced budget for 2014. This allows time for thoughtful process, process informed by our local community health improvement plan and the statewide Agenda for Change. It also allows time to work with the community and staff on activities that may transition out of the Health District.

We live in a time of many changes, challenges, and opportunities. With the Board's support, we will confront those changes, overcome the challenges, and embrace the opportunities.

Introduction

The Snohomish Health District's budget serves a number of essential functions. The budget is more than a "checkbook" posting of adopted revenues and expenditures. It is a financial plan for the year and also looks out over a six year horizon, to better assess planned income and expenses in a fiscally responsible manner. It is a policy plan, guiding and assuring the District's long-term financial health. And, most importantly, it is a detailed description of the goods and services for which the agency and its Board will be held accountable. It documents the "social contract" between the citizens and their government.

The budget also serves in a broader policy context. It draws upon many Board decisions and discussions that precede it, and it will leave a legacy of policy influence for future budgets—helping to give the agency's finances long-term stability and continuity.

Six Year Financial Forecast

Consistent with best financial management practice, a new tool has been added to help guide agency financial planning. A 6-year financial forecast has been developed to help document known as well as anticipated or assumed fluctuations impacting both revenues and expenditures. Implementing such a tool aids in the documentation and understanding of changing funding formulas as well as potential trends, so that near term financial decision making can be more informed. The ultimate goal of the tool is to assist in developing a more stable and sustainable financial plan, able to withstand the occasional turbulence associated with state and federal funding

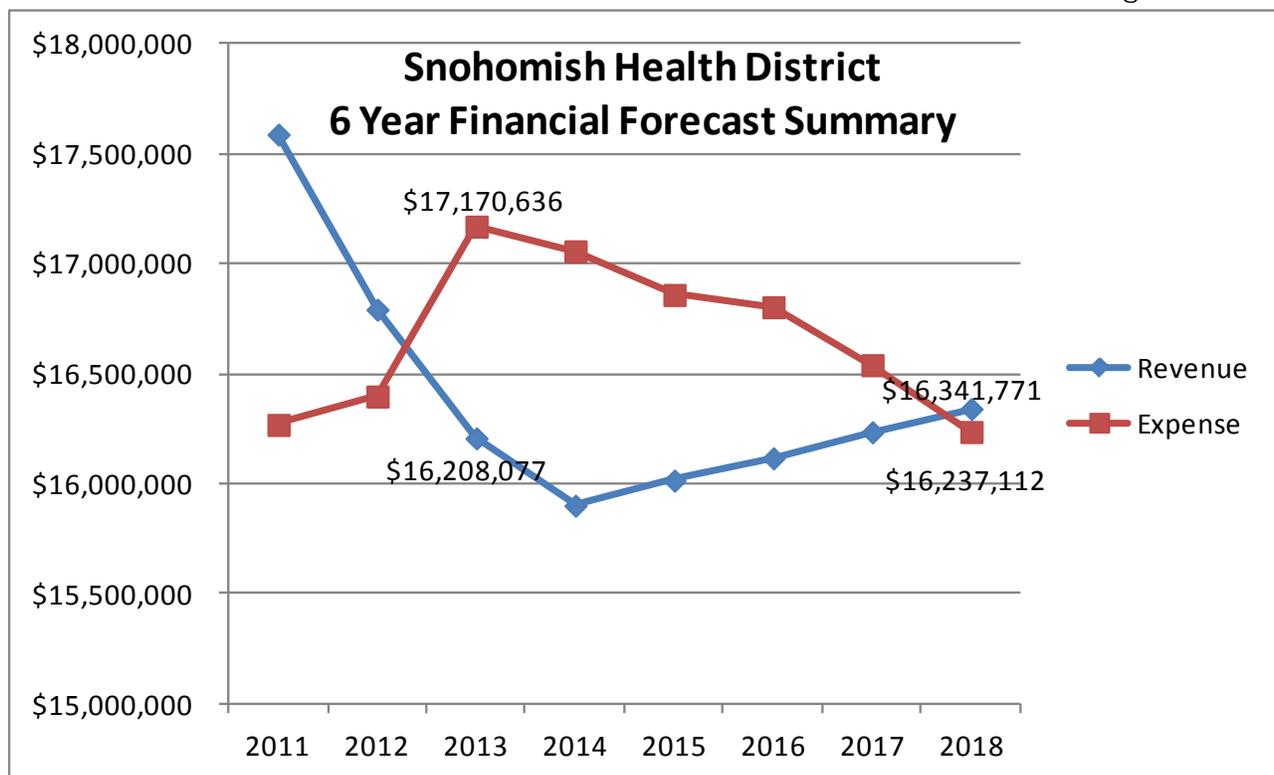


Figure 2. Snohomish Health District: 6 Year Financial Forecast Summary

reductions as well as ensure the agency is living within its means over the long term.

The forecast also provides a more deliberate assessment of the agency's financial health and enables a review of key financial management assumptions. While the Board has had some prior deliberations regarding setting aside reserves for contingencies, accrued liabilities, repair/replacement of technology and building systems and maintaining adequate resources for an emergency, the financial forecast can help ensure appropriate and sufficient funds are preserved to maintain a healthy financial foundation.

2013 Budget Summary

The following table summarizes General Fund revenues and expenditures for 2010 (actual), 2011 (budget), 2011 (actual), 2012 (budget), 2012 (projected) and adopted 2013.

	2010 Actual	2011 Budget	2011 Actual	2012 Budget	2012 Projected	2013 Proposed
Revenues	\$ 19,152,418	\$ 17,714,731	\$ 17,588,946	\$ 16,425,768	\$ 16,792,982	\$ 16,208,077
Expenses	\$ 16,921,867	\$ 17,413,301	\$ 16,269,194	\$ 16,239,983	\$ 16,398,514	\$ 17,170,636
Balance / (Deficit)	\$ 2,230,551	\$ 301,430	\$ 1,319,752	\$ 185,785	\$ 394,468	\$ (962,559)

Table 1. SHD Revenue and Expense History

Over the past several years, the District's General Fund has contributed to the growth of fund balance. Contributing factors included restrictions in spending, influx of federal H1N1 and emergency preparedness funds. The 2012 budget anticipated a year end surplus of \$185,785, however this sum is anticipated to grow to approximately \$394,000 largely as a result of unanticipated grant funding and an accounting adjustment transferring Region III HIV/Aids fund balance. This surplus revenue will be applied toward ending fund balance and subsequently carried over as beginning fund balance in 2013.

However, the 2013 adopted budget anticipates that operational and capital expenses will be greater than revenue by over \$960,000 and thus, require use of fund balance to balance the budget.

Funding

Washington State law gives primary responsibility for the health and safety of Washington residents to county governments. Funding of local public health is a shared responsibility among federal, state, and local governments. LHJs combine funds from the county general fund, fees charged for services rendered, categorical state and federal funds for specific contracted programs or services, and flexible state general funds to assure the public's health.

SHD Primary Revenue Sources

The primary revenue sources supporting the District's operations consist of licenses and permits, intergovernmental transfers, charges for services and miscellaneous revenue.

License and permit revenues

include charges for the issuance of licenses and permits to engage in certain activities because of certain health and safety hazards which might arise in the absence of regulation. Typically licenses are accompanied by inspection of the premises. License and permit fees cover the costs of administration and inspection. License and permit fees are generated within the Environmental Health Division for food vendors, public and semi-public swimming pools, on-site septic systems, small public water systems and solid waste disposal facilities. Regular inspections occur of food establishments, swimming pools and solid waste facilities.

Intergovernmental revenues include grants (state and federal), entitlements, shared revenues and payments for goods and services provided by one government to another. The Snohomish Health District will rely on \$2,253,200 in General Fund support from Snohomish County conveyed via an intergovernmental transfer (Intergovernmental- Snohomish County).

In December 2008, the Snohomish County Council approved Ordinance 08-154 "Authorizing a Sales and Use Tax to Provide for Operation or Delivery of Chemical Dependency or Mental Health Treatment and Therapeutic Court Programs and Services". A 1/10th of 1% county-wide sales tax is collected and distributed to a number of local agencies and organizations annually to achieve specific policy goals. The Snohomish Health District is anticipated to receive \$900,000 in funding to reduce the incidence and severity of chemical dependency and/or mental health disorders in adults and youth; reduce the number of individuals with chemical dependency and/or mental health disorders using costly interventions such as hospitals, emergency rooms or jails; support linkages with other county efforts; provide outreach to underserved populations; and provide culturally appropriate service delivery.

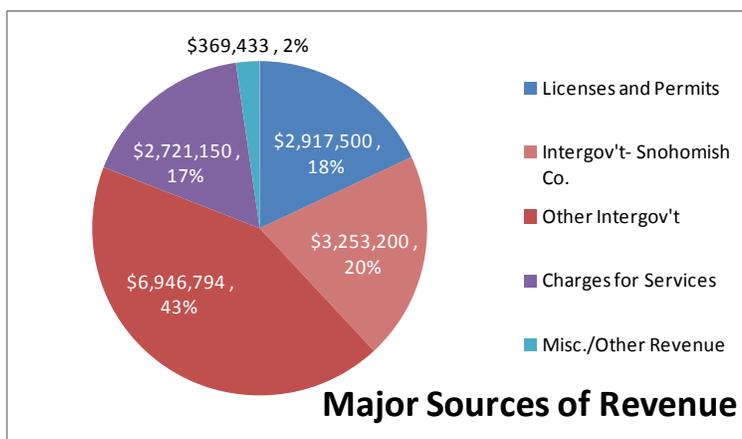


Figure 3. Major revenues by source

Federal grants provide significant resources to support agency programs or activities, such as immunizations, STD control, Medicaid Administrative Match, maternal infant services, Women & Infant Children (WIC), pregnant and parenting teens and women, drinking water, emergency readiness and response and more.

State grants also provide local capacity to address a variety of public health programs including immunizations, HIV, youth tobacco, drinking water, local source control, on-site sewage, early intervention, dental and more.

“Flexible” state General Funds are also conveyed to local health jurisdictions via three primary mechanisms (See Appendix B) to address a variety of public health services-

- Local Capacity Development Funds (LCDF) are used by each LHJ to participate in and improve performance on public health standards and in the area of greatest public health need;
- Blue Ribbon Commission/5930 Funds do not represent a program unto itself, but rather funding to enhance LHJ’s performance to address statewide priorities, which include stopping communicable diseases before they spread and reduce the impact of chronic disease. Specific performance measures include increasing the number of childhood immunizations given, more timely and complete communicable disease investigations, and increasing efforts to stop the obesity epidemic;
- Motor Vehicle Excise Tax (MVET) Replacement Funds- Following voter approval of the tax-limiting Initiative 695, the legislature in 2000 voted to repeal the MVET. During the same session, the legislature appropriated an amount from the state general fund that restored 90% of the lost public health funds. During the 2001 session, the legislature again made up 90% of the difference and has made an equal appropriation, without adjustments for inflation or population growth, in each biennium since.

Charges for services include fees associated with goods and services delivered to clients, customers, permittees and others. SHD charges for some communicable disease related services including refugee health, immunizations, vaccine/preventable disease, travel and some TB related services. In addition, community health related service charges include First Steps clinic based services, dental/oral health, and vital records related services. Environmental health related service charges include public/private water supplies, solid waste, liquid waste and food program activities. SHD also provides solid and hazardous waste management related services to Snohomish County via a fee for services Interlocal Agreement. Tasks include monitoring and inspecting County and non-County owned facilities, responding to complaints and taking enforcement actions, educating and coordinating prevention activities and providing performance reports on such activities.

Primary Expenditures

As a service oriented agency, the vast majority of expenditures are associated with staffing and labor related costs. The District has the pleasure of employing an experienced staff with many longtime veteran employees, many of which are at the maximum salary step.

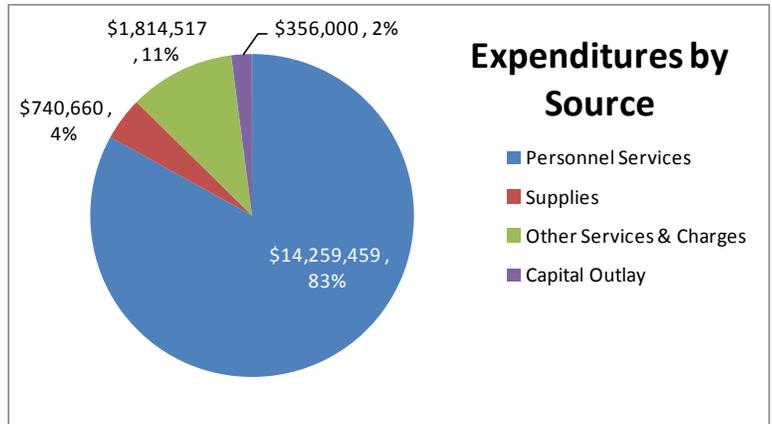


Figure 4. Major expenditures by source

Fund Balance

The District has maintained an 'unbudgeted' fund balance over the course of many years, derived when revenues have exceeded expenditures for various unanticipated reasons.

Based upon a variety of known costs as well as assumptions regarding future revenues and expenses, the agency is anticipated to fall below its minimum fund balance target of \$2 million in 2017. (This presumes the elimination of vacant positions associated with a conservative 3% attrition forecast).

Year	Ending Fund Balance
2012	\$ 5,651,480
2011	\$ 3,694,958
2010	\$ 3,528,160
2009	\$ 1,297,609
2008	\$ 1,517,405
2007	\$ 4,841,410

Table 2. Annual Ending Fund Balance (General Fund)
(Source: SHD Annual Audited Financial Statements)

While the agency is anticipated to align its anticipated expenditures with presumed revenues over the six year forecast period, the fund balance is significantly reduced and further erodes the ability to adequately address liabilities (accrued employee liabilities) and the many potential contingencies (repair/replacement of technology and building systems and maintaining adequate resources for an emergency).

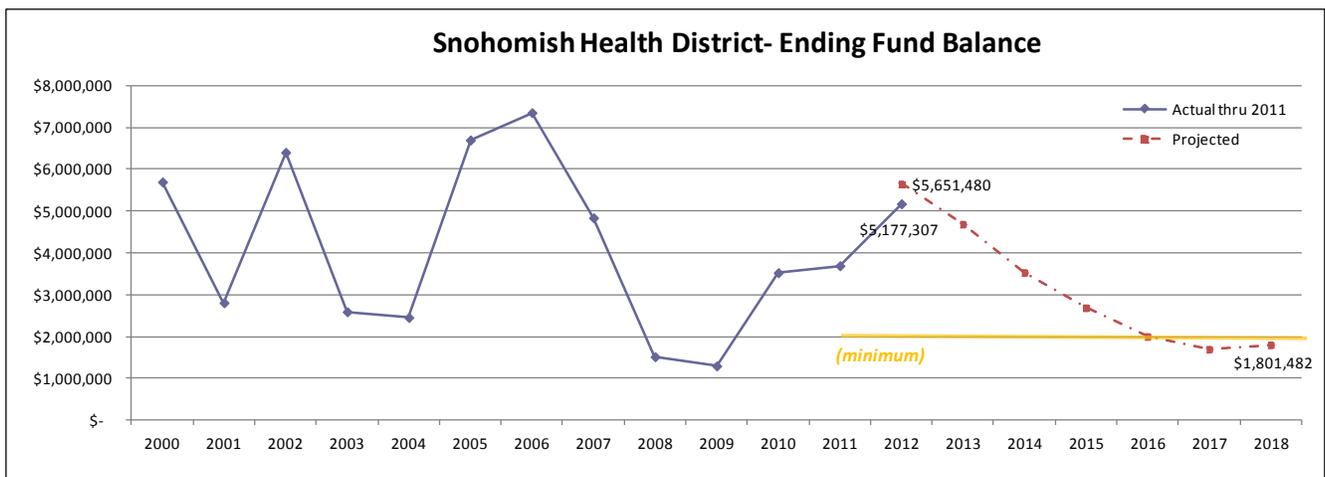


Figure 5. Ending Fund Balance (General Fund)

Several years ago, the Board decided that the fund balance was excessively large and directed District staff to budget it for expenditures rather than seeking increased revenue from certain existing sources. The plan was underway when the region experienced the beginning of the current recession, accelerating and exacerbating the reduction in the size of the fund balance. Table 2 and Figure 5 illustrate the history of the fund balance in recent years, using Ending Fund Balance as a common reference point (*Source: SHD Annual Audited Financial Statements*).

In July 2011, the Board of Health adopted Resolution 11-19: Setting a Minimum Fund Balance Target which established a policy on the appropriate level of fund balance to guide future budgets. The minimum fund balance target was established at \$2 million so as to protect the financial viability of the District, provide financial liquidity through fluctuations in spending cycles (including emergencies) and assure that the agency is able to continue its programs to serve the public without interruption.

In late 2011, the Board also adopted Resolution 11-37: Use of Fund Balance in 2012 which directed the Health Officer to maintain at least a minimum Fund Balance of \$4 million in 2012 as a result of extended and ongoing unusual uncertainty about the primary funding sources relied on by the agency. With the adoption of this policy, the Board intended to maintain existing programs to the extent possible while working to avoid making abrupt major programmatic and staffing changes over the next three years.

Entering into 2013, the projected Beginning Fund Balance will be approximately \$5,651,480- over \$3.6 million above the agency minimum policy level of \$2 million. However, the 2013 adopted budget includes utilizing over \$960,000 in fund balance to balance the budget- largely as a result of reduced state and federal revenues and increased labor costs.

Significant fund balance remains to address uncertainty associated with state and federal funding sources, persistent volatility in the economy and the slow economic recovery process now underway. With the adoption of Resolution 11-37, the Board intended to utilize fund balance to help absorb revenue cuts over a longer period and avoid utilizing these one-time funds in a single year.

Assumptions

The 2013 adopted budget and six year forecast assume certain increases and decreases in revenues and expenditures, subject to decisions by the Board of Health, funding agencies and State and Federal agencies. The most significant assumptions include:

- **Expenditures**
 - Contracts with three labor units (Association of Federal, State, County and Municipal Employees (AFSCME Local 1811), Professional and Technical Employees Local 17- Allied Health Professionals Unit (AHPU) and PTE Local 17- Environmental Health Specialists (EHS) were negotiated in 2011 for the 2012-2014 period. These included a Cost of Living Adjustment (COLA) of 1.5% for 2013. The Board of Health also approved a similar COLA for non-represented staff. Negotiations will be commencing in December 2012 for the fourth bargaining unit, Washington State Nurses Association (WSNA), as their contract period concludes in December 2012. Specific budgetary impacts associated with the total cost of compensation are unknown at this time;
 - Step increases are factored into staffing costs for those eligible to receive them;
 - Required employer paid increases of 1.98% for the Public Employee Retirement System (PERS);
 - Assumed increases in health/medical insurance costs (.0045%) was factored by applying projected increases to the current coverage selection by employee group (i.e. "single"; "married"; "family");
 - Assumed under-spent "savings" of approximately 1.75% within the salary/benefits budget associated with delays in filling vacant positions, leave without pay, starting salaries less than outgoing ending salaries, etc.)

- **Revenues**
 - A modest increase in license/permit fee activity of 2%. No fee increases in Environmental Health.
 - A 50% reduction (\$270,350) in Medicaid Administration Match (MAM) is reflected in this adopted budget. As of this draft, the actual reduction is unknown. MAM provides financial reimbursement for outreach to residents with no or inadequate medical coverage, explaining the benefits of Medicaid, assisting residents in applying and linking residents with Medicaid covered services they need;
 - State funding appears to be stable for 2013 based upon the State's biennial 2012-13 budget. However, the 2013 Legislature may take action associated with the 2013-14 biennial budget process that could affect revenues to the agency between July 1 and December 31. State funding is conveyed to Local Health Jurisdictions (LHJ's), like Snohomish Health District, via several mechanisms (See Revenues and Appendix B sections for greater detail), including:

- Blue Ribbon Commission/5930 Funds-
2013 Anticipated Appropriation to SHD: \$375,688
- Local Capacity Development Funds-
2013 Anticipated Appropriation to SHD: \$795,824
- Local Government Assistance (MVET)-
2013 Anticipated Appropriation to SHD: \$2,108,000

- **Uncertainties**

- Federal sequestration- the process of making automatic budget cuts to federal government programs- was included as a budget reduction enforcement mechanism in the Budget Control Act of 2011. It will take effect in 2013 unless the U.S. Congress passes legislation to postpone it or finds other ways to reduce the federal deficit. The sequester will affect federal public health programs as well as state and local health agencies. Local agency impact may be a reduction as great as \$390,000. However, no reduction is reflected in this adopted budget due to so many uncertainties regarding the federal budget;
- Agenda for Change- An action plan (See Appendix C) has been developed by the Washington State Department of Health and local public health agencies that provides strategic guidance in responding to the rapidly changing environment- whether new preventable disease challenges, health care reform, diminishing resources or helping residents live safer and healthier. The plan defines "Foundational Public Health Services" - what must be present everywhere for the public health system to function anywhere. In addition, strategic priorities are identified for the future. Shifts in Federal and State funding are anticipated as a result of the Affordable Care Act and to better align with the Agenda for Change. It's too early to accurately predict what or how these anticipated funding changes might affect the Snohomish Health District and its services, but the agency will help operationalize them locally in 2013.

Staffing Levels

As part of the agency's transition planning efforts, staffing assignment and alignment will be assessed in light of anticipated attrition over the six year planning horizon. While the 2013 budget reflects no attrition, it's anticipated there will be staff turn-over and subsequent position vacancies. This will enable the agency flexibility as it develops its transition plan and begin aligning staff resources with core foundational services.

As was noted earlier, the agency's workforce reflects long-time tenure and as such, many are nearing normal retirement age. In mid-2011, an analysis highlighted the following characteristics:

65+ years old	5
60-64	37
55-59	41
50-54	30
45-49	24
40-44	12
35-39	22
30-34	13
25-29	5

So out of 189 employees at that time, 83 (44%) were within ten years of normal retirement age, and half of those were within five years. This means that the District will be transitioning over the next 5-10 years by critically evaluating its services, identifying foundational/core services and strategically filling some vacancies, but not all.

The Washington State Department of Health and local health jurisdictions have collaborated in developing an "Agenda for Change" planning document that defines what public health must provide in every community and sets priorities for efforts to move the entire state forward. In 2013, the Health District will relate the Agenda to Snohomish County- developing a transition plan to guide what programs and services will be provided, how the services will be delivered and to what level of service. This will certainly shape staffing decisions in the short and long term.

The following Table 3 summarizes program level staffing for each SHD Division in 2012 and 2013. Positions are noted in full-time equivalents (FTE's).

Division/Program	2012 Budget	2012 Mid-year Adj	2012 Year End	2013 Proposed
Communicable Disease * See also PHEPR funds below	41.025		41.950	41.950
Immunization	12.310		12.310	13.750
Sexually Transmitted Diseases	3.610		3.110	3.800
Tuberculosis	8.800		8.900	8.700
HIV/AIDS	5.415		5.540	3.850
Refugee Health	2.290		2.290	2.050
Other Diseases	6.100		6.100	7.300
CD Administration	2.500	0.700	3.700	2.500
Community Health	52.550		52.900	52.900
Maternal and Infant Care	19.400	1.000	18.150	18.150
Oral Health	0.200	0.500	0.900	0.900
Children w/Special Health Care Needs	2.150		2.150	2.150
Women, Infants & Children (WIC)	15.100		15.000	15.000
Child Abuse	1.050		1.200	1.200
Assessment/Chronic Disease	8.300		8.700	8.700
Vital Records	3.750		4.000	4.000
CH Administration	2.600		2.800	2.800
Environmental Health	43.750		43.550	43.550
Drinking Water	1.350		1.070	1.070
Solid Waste & Toxics	10.250		10.500	10.500
Septic/Land Use	7.600		6.620	6.620
Food Safety	16.500		17.650	17.650
Living Environment	3.300		3.010	3.010
EH Administration	4.750		4.700	4.700
District Administration	19.200		20.500	20.500
Administration	11.400		10.700	10.700
Information Services	5.000		5.000	5.000
Rucker Building	0.800		0.800	0.800
Communications	2.000		4.000	4.000
General Fund Total	156.525	2.200	158.900	158.900
PHEPR Fund	5.200		5.100	5.100
Health District, all funds	161.725	163.925	164.000	164.000

Table 3. SHD Staffing Levels Summary

Looking to the Future

As was the case entering 2012, many factors will shape the future public health system- whether uncertainty regarding federal sequestration, regulatory changes associated with universal health care, or shifts and reductions in grant funds. The Agenda for Change (See the Appendix C), provides strategic guidance in helping shepherd a new era for public health programs and services. The identification of “foundational” services, development of strategic priorities and reforms to businesses processes provides necessary guidance to the State and local health jurisdictions in further evolving an affordable, sustainable and effective service delivery model.

Preventing communicable disease and other health threats, fostering healthy communities and environments and new partnerships with the health care system are top priorities.

The 2013 adopted budget draws on the agency’s fund balance- \$962,559, but prudence dictates that ongoing operational reliance on dwindling fund balance is neither sustainable nor advisable. The focus in 2013, will be better balancing the agency’s costs with available revenues, while maintaining reasonable reserves for emergencies and other liabilities. This is particularly important as existing revenue sources diminish further amidst new and changing public health needs in a slow economic recovery.

Source and Use of Funds- Six Year Financial Forecast

	Actual 2011	Projected 2012	Proposed Budget 2013	Projected 2014	Projected 2015	Projected 2016	Projected 2017	Projected 2018
Beginning Fund Balance	\$ 3,528,159	\$ 5,098,087	\$ 5,651,480	\$ 4,688,921	\$ 3,532,769	\$ 2,688,796	\$ 2,001,787	\$ 1,696,823
Fund Balance Transfer		\$ 158,925						
Revenues								
Licenses and Permits	\$ 2,658,259	\$ 2,763,060	\$ 2,917,500	\$ 2,975,850	\$ 3,035,367	\$ 3,096,074	\$ 3,157,996	\$ 3,221,156
Intergovernmental	\$ 12,042,287	\$ 10,877,029	\$ 10,199,994	\$ 9,835,722	\$ 9,835,722	\$ 9,820,722	\$ 9,820,722	\$ 9,805,722
Charges for Services	\$ 2,642,600	\$ 2,731,827	\$ 2,721,150	\$ 2,721,150	\$ 2,775,573	\$ 2,831,084	\$ 2,887,706	\$ 2,945,460
Misc. Revenue	\$ 245,800	\$ 421,066	\$ 369,433	\$ 369,433	\$ 369,433	\$ 369,433	\$ 369,433	\$ 369,433
Total Revenues	\$ 17,588,946	\$ 16,792,982	\$ 16,208,077	\$ 15,902,155	\$ 16,016,095	\$ 16,117,314	\$ 16,235,857	\$ 16,341,771
Expenditures								
Personnel Services	\$ 13,548,417	\$ 13,759,066	\$ 14,259,459	\$ 13,992,058	\$ 13,872,966	\$ 13,744,455	\$ 13,406,224	\$ 13,025,766
Supplies	\$ 937,658	\$ 726,639	\$ 740,660	\$ 760,658	\$ 781,196	\$ 802,288	\$ 823,950	\$ 846,196
Other Services & Charges	\$ 1,669,517	\$ 1,839,809	\$ 1,814,517	\$ 1,863,509	\$ 1,913,824	\$ 1,965,497	\$ 2,018,565	\$ 2,073,067
Capital Outlay	\$ 113,602	\$ 73,000	\$ 356,000	\$ 442,083	\$ 292,083	\$ 292,083	\$ 292,083	\$ 292,083
Total Expenditures	\$ 16,269,194	\$ 16,398,514	\$ 17,170,636	\$ 17,058,308	\$ 16,860,068	\$ 16,804,323	\$ 16,540,822	\$ 16,237,112
Net Operating Revenue	\$ 1,319,752	\$ 394,468	\$ (962,559)	\$ (1,156,153)	\$ (843,973)	\$ (687,009)	\$ (304,964)	\$ 104,659
Ending Fund Balance	\$ 4,847,911	\$ 5,651,480	\$ 4,688,921	\$ 3,532,769	\$ 2,688,796	\$ 2,001,787	\$ 1,696,823	\$ 1,801,482
Committed Reserves								
Operating Capital	\$ 1,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000
Total Committed Reserves	\$ 1,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000
Assigned Reserves								
Technology and Equipment	\$ -	\$ -	\$ -	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000
5930 Funds	\$ 152,953	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Assigned Reserves	\$152,953	\$0	\$0	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000
Undesignated Fund Balance	\$ 3,694,958	\$ 3,651,480	\$ 2,688,921	\$ 1,482,769	\$ 638,796	\$ (48,213)	\$ (353,177)	\$ (248,518)

A Reader's Guide to the Budget

Each year, the Board of Health formally adopts a single budget figure for the District's General Fund budget: the total approved expenditure amount. However, the Budget is developed by programs within Divisions.

A key factor in understanding the District's Budget is the complexity of its funding sources, as described more fully beginning on page 18. Programs are supported by local, state, and federal grants, some of which are dedicated or restricted to specific programs (such as HIV/AIDS or dental care), with others more flexible. Some activities charge fees for services or for licenses, such as restaurant permits, food handler cards, or fees for copies of birth or death certificates. The clinics charge fees for administering immunizations and other services, although these depend, in part, on the client's income level.

Because of the many sources of revenues, and the way many are tied to particular projects, the budget sheets that follow are organized by Division and program, and identify funding sources for each.

The budget sheets also document the allocation of administrative indirect and overhead costs for the purpose of grant billing.

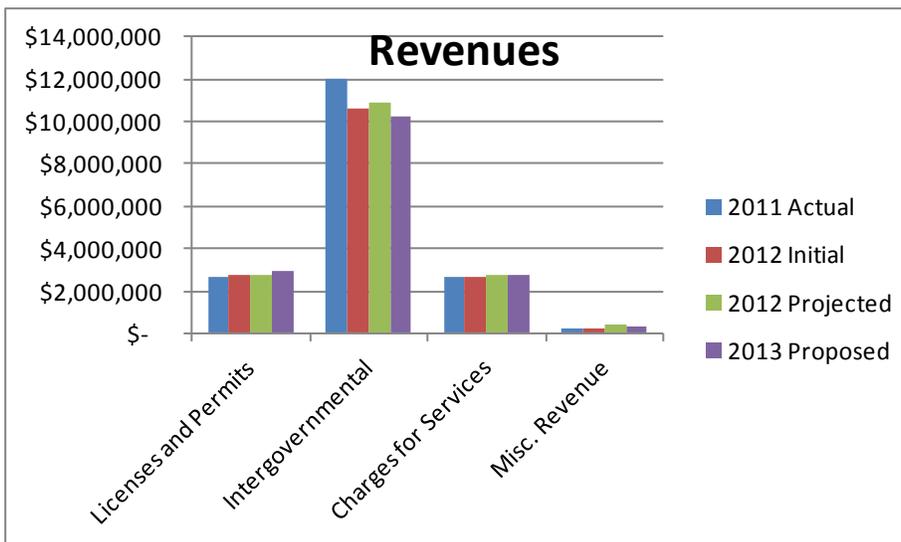
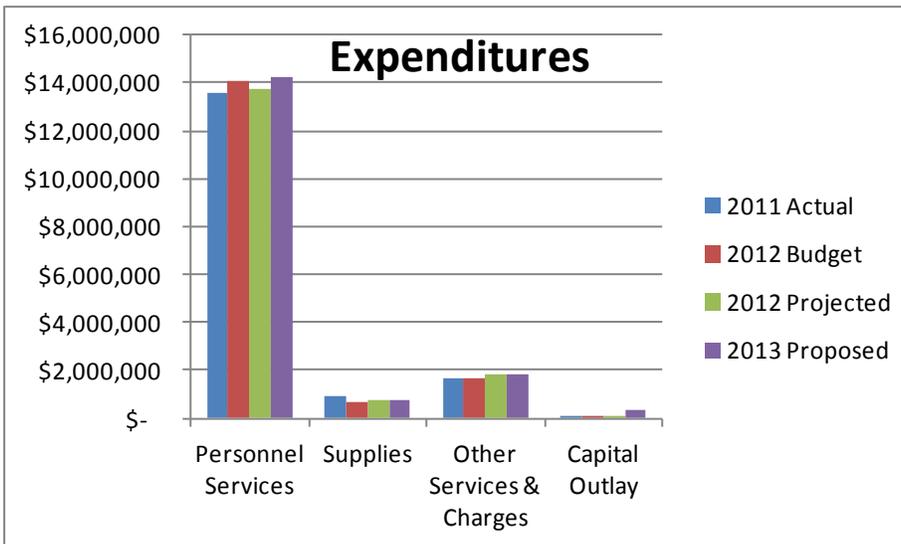
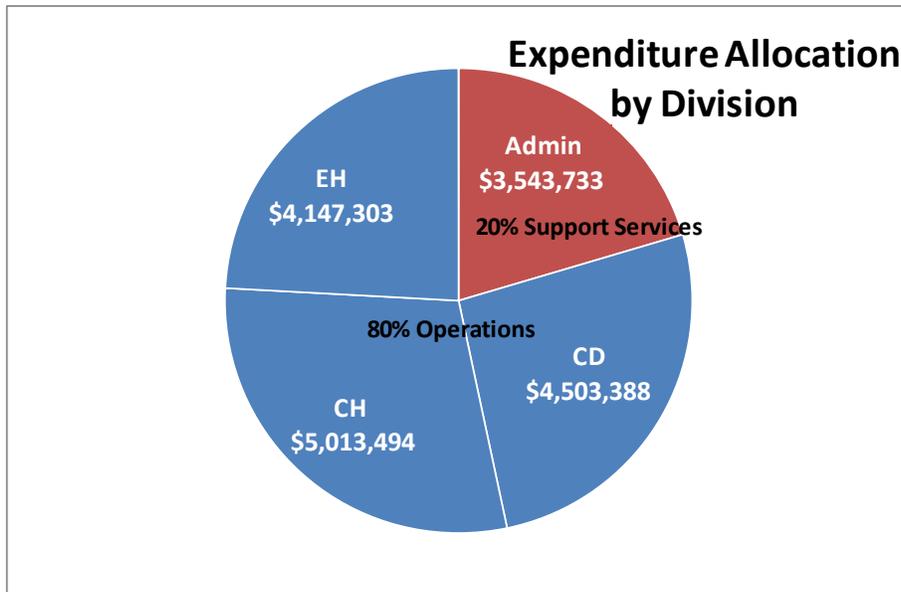
NOTE:

The spreadsheets detailing revenues for each Division include a column immediately to the right of the revenue sources. That column indicates the general source of the funding, which is important information as the District anticipates possible funding cuts from local, state, and federal sources. The letters denote the following:

- D:** District funding. Includes fees programs charge for services, interest on investments, lease payments made by federal agencies for use of the Rucker Building, etc.
- C:** County funding. Funds provided by Snohomish County Government, including the Solid Waste MOU.
- S:** State funding.
- F:** Federal funding. Includes revenue from federal sources that passes through state programs to the District.

General Fund Expenditure and Revenue Summary by Division

EXPENDITURES: Grants	SHD TOTALS	Admin	CD	CH	EH
Personnel Services	\$ 4,415,243	\$ -	\$ 614,883	\$ 3,043,219	\$ 757,142
> Projected Underspending	\$ (77,267)	\$ -	\$ (10,760)	\$ (53,256)	\$ (13,250)
Supplies	\$ 25,975	\$ -	\$ 9,650	\$ 11,825	\$ 4,500
Other Services & Charges	\$ 215,104	\$ -	\$ 3,000	\$ 166,904	\$ 45,200
Capital Outlay	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotals	\$ 4,579,055	\$ -	\$ 616,772	\$ 3,168,692	\$ 793,592
EXPENDITURES--Non-Grants	SHD TOTALS	Admin	CD	CH	EH
Personnel Services	\$ 10,098,201	\$ 2,130,410	\$ 3,160,271	\$ 1,548,985	\$ 3,258,536
> Projected Underspending	\$ (176,719)	\$ (37,282)	\$ (55,305)	\$ (27,107)	\$ (57,024)
Supplies	\$ 714,685	\$ 243,910	\$ 360,250	\$ 59,325	\$ 51,200
Other Services & Charges	\$ 1,599,413	\$ 813,413	\$ 421,400	\$ 263,600	\$ 101,000
Capital Outlay	\$ 356,000	\$ 356,000	\$ -	\$ -	\$ -
Subtotals	\$ 12,591,581	\$ 3,506,450	\$ 3,886,616	\$ 1,844,803	\$ 3,353,711
DIVISION SUBTOTAL	\$ 17,170,636	\$ 3,506,450	\$ 4,503,388	\$ 5,013,494	\$ 4,147,303
OVERHEAD					
Overhead charged to other Funds	\$ 166,933				
Overhead Cost Allocation			\$ 1,100,625	\$ 1,225,294	\$ 1,013,598
TOTALS			\$ 5,604,013	\$ 6,238,789	\$ 5,160,901
REVENUES					
	SHD TOTALS	Admin	CD	CH	EH
Licenses and Permits	\$ 2,917,500	\$ -	\$ -	\$ -	\$ 2,917,500
Intergovernmental: Grants	\$ 6,776,944	\$ 3,289,512	\$ 644,746	\$ 2,270,936	\$ 571,750
Intergovernmental: Other	\$ 3,423,050	\$ 3,153,200	\$ 122,600	\$ 147,250	\$ -
Charges for Services	\$ 2,721,150	\$ -	\$ 796,875	\$ 737,875	\$ 1,186,400
Misc. Revenue	\$ 202,500	\$ 202,500	\$ -	\$ -	\$ -
Revenues Subtotal	\$ 16,041,144	\$ 6,645,212	\$ 1,564,221	\$ 3,156,061	\$ 4,675,650
TRANSFERS					
> Non-General Fund Overhead	\$ 166,933				
> Transfer to Fund Balance	\$ -				
> Transfer between Divisions	\$ -	\$ (6,645,212)	\$ 3,528,665	\$ 2,692,692	\$ 423,855
TOTAL	\$ 16,208,077	\$ -	\$ 5,092,886	\$ 5,848,753	\$ 5,099,505
Budget Balance / (Deficit)	\$ (962,559)				



ADMINISTRATION

Peter M. Mayer | Deputy Director | Chief Operating Officer

Overview

The Administration group provides **overall direction and management for District staff, as well as support activities for the Divisions**. It includes the Health Officer, who has specific duties within the community under state law, and the Deputy Director, who serves as the District's Chief Operating Officer. These two translate decisions by the Board of Health into program direction and operating guidelines for the Divisions.

Within Administration is the **Business Office**. This staff maintains and operates the Rucker Building and the Lynnwood clinic. It collects revenues from the District's many funding sources, and processes payments to vendors. Service contracts, payroll for all District employees, budget development and management, and all accounting are handled by this group.

Human Resources staff provide expert professional assistance and guidance to the agency on human resources programs, employee health and safety, performance management, employee relations, labor relations, and organizational development issues.

The **Information Systems** group acquires and manages and maintains the District's data systems. This includes assuring that every employee has the appropriate technology including computers, software, printing and communications capabilities necessary to efficiently conduct their work. I.S. insures the agency's systems are secure, redundant and legally compliant with client/patient health record laws. In addition, they support the agency in responding to public health emergencies.

The **Communications** team, formed in 2012, consolidates many of the agency's internal and external communications activities, including marketing and public relations, graphic design, event planning and implementation, media relations, and employee communications. The team continues to develop standardized tools, templates and design standards to more effectively deliver public health messages to the public, including emergent risk and emergency situations.

It is important to note that many operational costs of the Divisions are budgeted in Administration rather than being paid by each work unit. This includes computer/technology costs, vehicles, printing, and office space and utilities. These expenses are distributed to the various programs on a pro rata basis for the purpose of grant billing; however, they are initially budgeted in Administration.

Capital Projects

The 2013 adopted budget includes several capital outlay items, including:

- Replacement of Environmental Health inspection and records management systems (Est. \$200,000). Currently, the Division uses a variety of software tools for food safety management, billing, permitting, time accounting, complaint

tracking, filing septic as-builts and septic inspections. The project objective is to consolidate up to 5 existing applications to one primary web-based business application with on-line modules for public access. Annually, the Division permits and inspects approximately 3,087 retail food facilities, 1,100 temporary event vendors, 480 swimming pool/spa facilities, and 150 Solid Waste Handling Facilities. Additionally, the Division annually completes approximately 500 individual sewage disposal system applications and issues 430 permits and responds to approximately 1,890 sewage and solid/hazardous waste complaints. Approximately 17,600 financial transactions are completed annually. Staff are exploring regional and hosted solutions to reduce costs and improve functionality and maintenance/support.

- Implement Rucker Building space plan improvements (Est. \$100,000). In 2012, staff engaged outside design expertise to develop plans and specifications enabling more efficient and effective work space configuration in the Rucker Building. This appropriation enables improvements to the facility, including furnishings, fixtures and equipment to support the consolidation of work functions throughout the building.
- Other technology and projection systems improvements (Est. \$56,000). Adopted improvements to the agency's Emergency Operations Center (EOC) include improved projection systems and monitors and incident tracking tools, as well as projection improvements to other conference and meeting spaces, including the agency's auditorium.

Administration Budget- Expenditures

2013					
Administration Budget					
> Expenditures					
EXPENDITURES: Grants	Admin TOTALS	Admin/Bus.	Info Svcs	Rucker Bldg	Comm. Team
Personnel Services	\$ -				
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -
Other Services & Charges	\$ -	\$ -	\$ -	\$ -	\$ -
Capital Outlay	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotals	\$ -	\$ -	\$ -	\$ -	\$ -
EXPENDITURES--Non-Grants	Admin TOTALS	Admin/Bus.	Info Svcs	Rucker Bldg	Comm. Team
Personnel Services	\$ 2,130,410	\$ 1,197,335	\$ 500,392	\$ 51,208	\$ 381,475
Supplies	\$ 243,910	\$ 100,580	\$ 124,830	\$ 14,500	\$ 4,000
Other Services & Charges	\$ 813,413	\$ 473,600	\$ 84,473	\$ 203,540	\$ 51,800
Capital Outlay	\$ 356,000	\$ 100,000	\$ 256,000	\$ -	\$ -
Subtotals	\$ 3,543,733	\$ 1,871,515	\$ 965,695	\$ 269,248	\$ 437,275
ADMIN SUBTOTAL	\$ 3,543,733	\$ 1,871,515	\$ 965,695	\$ 269,248	\$ 437,275
Indirect		\$ -	\$ -	\$ -	\$ -
TOTALS	\$ 3,543,733	\$ 1,871,515	\$ 965,695	\$ 269,248	\$ 437,275
SHD Overhead	\$ -				
ADMIN Total	\$ 3,543,733	\$ 1,871,515	\$ 965,695	\$ 269,248	\$ 437,275

Administration Budget- Revenues

2013						
Administration Budget						
> Revenues						
REVENUES		Admin TOTALS	Admin/Bus.	Info Svcs	Rucker Bldg	Comm. Team
Licenses and Permits		\$ -	\$ -	\$ -	\$ -	\$ -
Intergovernmental: Grants		\$ 3,289,512	\$ 3,289,512	\$ -	\$ -	\$ -
Intergovernmental: Other		\$ 3,153,200	\$ 3,153,200	\$ -	\$ -	\$ -
Charges for Services		\$ -	\$ -	\$ -	\$ -	\$ -
Miscellaneous Revenues		\$ 202,500	\$ 6,500	\$ -	\$ 196,000	\$ -
Revenues Subtotal		\$ 6,645,212	\$ 6,449,212	\$ -	\$ 196,000	\$ -
Expenditure Total (from above)		\$ 3,543,733	\$ 1,871,515	\$ 965,695	\$ 269,248	\$ 437,275
<i>Surplus/(Deficit)</i>		<i>\$ 3,101,479</i>	<i>\$ 4,577,697</i>	<i>\$ (965,695)</i>	<i>\$ (73,248)</i>	<i>\$ (437,275)</i>
<i>[To/(From) other programs]</i>						
LICENSES AND PERMITS		\$ -	\$ -	\$ -	\$ -	\$ -
> None						
INTERGOVERNMENTAL: Grants		\$ 3,289,512	\$ 3,289,512	\$ -	\$ -	\$ -
> State Local Capacity Funds	S	\$ 795,824	\$ 795,824			
> State DOH Other CC--5930 fund	S	\$ 375,688	\$ 375,688			
> State--Local Gov. Assist.	S	\$ 2,108,000	\$ 2,108,000			
>Quality Improvement Grant	S	\$ 10,000	\$ 10,000			
INTERGOVERNMENTAL: Other		\$ 3,153,200	\$ 3,153,200	\$ -	\$ -	\$ -
> County Contribution	C	\$ 3,153,200	\$ 3,153,200			
CHARGES FOR SERVICES		\$ -	\$ -	\$ -	\$ -	\$ -
> None		\$ -				
MISCELLANEOUS		\$ 202,500	\$ 6,500	\$ -	\$ 196,000	\$ -
> Investment earnings	D	\$ 6,000	\$ 6,000			
> other misc. revenue	D	\$ 500	\$ 500			
> Rucker Building leases	D	\$ 196,000			\$ 196,000	\$ -

COMMUNICABLE DISEASE CONTROL DIVISION

Tim McDonald, MPH | Division Director

Overview

The burden of **prevention of the spread of communicable diseases** such as pertussis, influenza, measles, rubella, mumps, viral hepatitis infections, HIV, STDs, and tuberculosis has been the focal point of public health systems for decades. The Communicable Disease Division at Snohomish Health District (SHD) provides many services to prevent and control communicable disease in Snohomish County utilizing the tools of **surveillance, outbreak response, education, vaccination, and preparedness** activities. Some diseases such as HIV, hepatitis C and or TB have no available vaccines and therefore their control and prevention rely heavily on communicable disease control division services including counseling, direct treatment, and isolation or quarantine. The Division explains public health interventions and disseminates health education messages to the broad community, health care providers, hospitals, schools, childcare facilities, nursing home facilities, laboratories, veterinarians, and the media to enhance disease control efforts. Issues which will require innovative emphasis in 2013 include:

The persistence of pertussis epidemic

The pertussis outbreak began in 2011 and through communicable disease surveillance was identified as an epidemic in the last half of 2011, months before an epidemic was declared at the state level. Over 700 cases have been confirmed and new pertussis reports continue daily. One infant has died from this vaccine-preventable disease and over the past year ten infants were hospitalized. Many children and adults have experienced lengthy and severe illness. Each pertussis case is investigated, close contacts are identified, and follow up counseling on the disease is provided. Communicable Disease staff work closely with medical providers to assure all high risk contacts (infants, pregnant women and health care providers) receive antibiotic prophylaxis to prevent them from becoming ill with pertussis. We are preparing for a resurgence of pertussis through the fall of 2012 and winter of 2013.

Tdap clinics and pertussis focused community outreach will continue

To protect the most vulnerable, the CD Division will continue to collaborate with community partners to host Tdap clinics for adults, the most important reservoir of the disease. Childcare facilities are being targeted by the Child Care Outreach program to receive information on the recommendations for vaccination. Over the past year, community partners stepped up to fund vaccine purchase and a vaccine reminder

2013 At-a-Glance

Controlling and treating pertussis

Increased community outreach to treat those most vulnerable

Improving adult immunization rates and record keeping

Controlling active TB cases through prevention

Expanded Hepatitis C screening for older adults

postcard mailed to 275,000 households in Snohomish County to inform citizens about the epidemic and the Tdap vaccine recommendations. We anticipate more community partner collaboration. Twenty-one private pharmacies continue to be committed to vaccinating low income and uninsured adults through a patient assistant program in partnership with SHD.

Adult immunizations in Snohomish County will continue to be an issue

The low percentage of Snohomish County adults who had been vaccinated with a Tdap booster is a significant contributing factor to the pertussis epidemic. This epidemic highlights the importance of adult vaccination, not just to protect the individual adult but more importantly to provide protection for the entire community through “herd Immunity”. Unlike childhood vaccinations there is no community based infrastructure supporting immunization among adults. Priorities for our division include: building community capacity to vaccinate adults, addressing vaccine hesitancy among all ages, and assuring that immunizations are tracked in a uniform immunization information system.

TB prevention through treatment of active TB cases- disease complexities

Patient diagnosis, treatment, case management, and investigation of contacts are the cornerstone of TB Control and Prevention in Snohomish County. Treatments for patients with complex medical conditions, i.e. diabetes or cancer, and new emerging forms of TB have been challenging throughout the world and here in Snohomish County. While we have been able to treat three multi drug resistant (MDR) TB cases during the past two years, the rate and the number of MDR TB cases worldwide are continuing to increase. Therefore we anticipate more MDR TB cases with other underlying medical conditions in 2013 for Snohomish County resulting in increases in the costs of care. We have addressed some of the expense of the MDR cases by contracting with Public Health Seattle King County Pharmacy making us eligible for the 340 B pharmacy subsidy program. However the savings in pharmacy costs are being overshadowed by increases in the complexity and duration of the patient care for these challenging TB cases.

Hepatitis C screening

Based on studies of risk the CDC has developed a new recommendation to screen all babies born between 1945 and 1965 for Hepatitis C. This newly identified risk group, baby boomers, raises a concern for those who cannot afford to be tested. Currently the Division provides an outreach program which targets populations at greatest risk for Hepatitis C for screening and counseling. Staff identify where the clients congregate such as correctional facilities, treatment centers, and community gathering locations. No new outreach intervention has yet been developed to address the newly identified risk group.

Communicable Disease Control Division- Expenditures

2013									
Communicable Disease Budget									
> Expenditures									
EXPENDITURES: Grants	CD TOTALS	CD Admin	Immun.	STDs	TB	HIV/AIDS	Refugee	Other Com. Dis.	
Personnel Services	\$ 614,883	\$ -	\$ 196,052	\$ -	\$ 59,757	\$ 359,074	\$ -	\$ -	
Supplies	\$ 9,650	\$ -	\$ -	\$ -	\$ -	\$ 9,650	\$ -	\$ -	
Other Services & Charges	\$ 3,000	\$ -	\$ -	\$ -	\$ -	\$ 3,000	\$ -	\$ -	
Capital Outlay	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Subtotals	\$ 627,533	\$ -	\$ 196,052	\$ -	\$ 59,757	\$ 371,724	\$ -	\$ -	
EXPENDITURES--Non-Grants	CD TOTALS	CD Admin	Immun.	STDs	TB	HIV/AIDS	Refugee	Other Com. Dis.	
Personnel Services	\$ 3,160,271	\$ 271,768	\$ 1,037,532	\$ 365,450	\$ 676,135	\$ -	\$ 183,403	\$ 625,983	
Supplies	\$ 360,250	\$ 6,500	\$ 256,000	\$ 3,000	\$ 85,000	\$ -	\$ 5,000	\$ 4,750	
Other Services & Charges	\$ 421,400	\$ 114,000	\$ 54,000	\$ 12,500	\$ 195,000	\$ -	\$ 30,000	\$ 15,900	
Capital Outlay	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Subtotals	\$ 3,941,921	\$ 392,268	\$ 1,347,532	\$ 380,950	\$ 956,135	\$ -	\$ 218,403	\$ 646,633	
DIVISION SUBTOTAL	\$ 4,569,453	\$ 392,268	\$ 1,543,584	\$ 380,950	\$ 1,015,892	\$ 371,724	\$ 218,403	\$ 646,633	
Division Indirect		\$ -	\$ 144,954	\$ 35,774	\$ 95,400	\$ 34,908	\$ 20,510	\$ 60,724	
TOTALS	\$ 4,569,453		\$ 1,688,538	\$ 416,723	\$ 1,111,292	\$ 406,631	\$ 238,912	\$ 707,356	
SHD Overhead	\$ 1,100,625		\$ 406,711	\$ 100,374	\$ 267,672	\$ 97,944	\$ 57,546	\$ 170,378	
Division Total	\$ 5,670,078		\$ 2,095,248	\$ 517,098	\$ 1,378,964	\$ 504,575	\$ 296,458	\$ 877,734	

Communicable Disease Control Division- Revenues

2013									
Communicable Disease Budget									
> Revenues									
REVENUES		CD TOTALS	CD Admin	Immun.	STDs	TB	HIV/AIDS	Refugee	Other Com. Dis.
Licenses and Permits		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Intergovernmental: Grants		\$ 644,746	\$ -	\$ 140,301	\$ 26,880	\$ 83,090	\$ 394,475	\$ -	\$ -
Intergovernmental: Other		\$ 122,600	\$ 122,600	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Charges for Services		\$ 796,875	\$ -	\$ 520,525	\$ -	\$ 16,000	\$ -	\$ 260,350	\$ -
Miscellaneous Revenue		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Revenue Subtotal		\$ 1,564,221	\$ 122,600	\$ 660,826	\$ 26,880	\$ 99,090	\$ 394,475	\$ 260,350	\$ -
Expenditure Total (from above)		\$ 5,670,078	\$ -	\$ 2,095,248	\$ 517,098	\$ 1,378,964	\$ 504,575	\$ 296,458	\$ 877,734
Surplus/(Deficit)		\$ (4,105,857)	\$ 122,600	\$ (1,434,422)	\$ (490,218)	\$ (1,279,874)	\$ (110,100)	\$ (36,108)	\$ (877,734)
LICENSES AND PERMITS									
> None		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INTERGOVERNMENTAL: Grants									
> Immunizations--Gen. Ops		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
> FA317 Immun-CC	F	\$ 33,143		\$ 33,143					
> Child Immun. Activities Fed.	F	\$ 107,158		\$ 107,158					
> STD Control	F	\$ 26,880			\$ 26,880				
> Medicaid Match--TB		\$ -							
> TB Control-elimination-CC	F	\$ 83,090				\$ 83,090			
> HIV Project C-CC	S	\$ 34,475					\$ 34,475		
> 2012 HIV-CC	S	\$ 360,000					\$ 360,000		
INTERGOVERNMENTAL: Other									
> CD--Medicaid Match	F	\$ 122,600	\$ 122,600						
CHARGES FOR SERVICES									
> Refugee Health	D	\$ 260,350						\$ 260,350	
> Child Immunizations	D	\$ 60,000		\$ 60,000					
> Adult Immunizations	D	\$ 136,000		\$ 136,000					
> Immun TST & Reads	D	\$ 88,525		\$ 88,525					
> VPD /Community	D	\$ 2,000		\$ 2,000					
> Travel Services	D	\$ 234,000		\$ 234,000					
> TB	D	\$ 16,000				\$ 16,000			
MISCELLANEOUS									
		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

COMMUNITY HEALTH DIVISION

Charlene Shambach, RN, MA, MSN | Division Director

Overview

This Division **stresses preventive care programs**. It **promotes health** through educational outreach, oftentimes working with the poorest and most vulnerable members of the community. Staff convenes and facilitates coalitions and partnerships to improve health and services. Best practices and evidence based strategies are shared with local partners in forums such as the annual Oral Health Summit for dental professionals.

One focus of the Division is on **parent/child health**. Studies show that such programs can pay major dividends in the long-term health of infants, and in helping to break the cycle of poverty in families. Staff provides services to low-income and vulnerable families in our Everett and Lynnwood clinics and in home settings throughout the county. Parent child health programs focus on:

Pregnancy/Post-Pregnancy: Staff assesses risks for preterm labor, prenatal complications, mental health issues such as postpartum mood disorder, and substance use. They provide guidance on proper nutrition, avoiding tobacco smoke, alcohol and other drugs, support systems, breastfeeding, birth control, and oral health. Women are linked to medical and dental care, substance use counseling and other community resources.

Infants and Children: Staff works to promote optimal nutrition, supportive parent child interactions, and healthy growth and development. They assess the risk of child neglect, injury and disease and provide guidance on proper nutrition, preventive medical/dental services, and caring for infants and children- including those with special health care needs. Families are linked to medical and dental care and available community resources.

Another important area of emphasis is the development of healthy communities through support of tobacco free living, healthy eating, and active living. Tobacco remains the number one health threat in this nation. With the growing burden of factors associated with cardiovascular, lung and dental disease, cancer, and diabetes, prevention of chronic disease is an essential role for public health. Changes in individual behaviors as well as changes in public policies and community norms to support these behavior changes are complicated and need to include efforts along a continuum. This range of services includes direct client support and education in programs such as the Women, Infant, and Children (WIC) program as well as addressing the built environment with policy development focused on increasing access to

2013 At-a-Glance

Development of a new Community Health Improvement Plan

Implementation of electronic death records system

Promotion of breastfeeding

healthy food and physical activity. Addressing oral health services includes assessing the health status of Snohomish County children and the dental professional system capacity to meet the need. A referral network is maintained that will accept low-income individuals as new dental patients.

New to the Community Health Division are the Assessment services, which **collect, analyze, interpret, and distribute data and health information**. These data are used by the Health District and community stakeholders to identify emerging patterns of morbidity and mortality, increase awareness regarding issues, educate policymakers and the public, prioritize needs, target populations for services, plan programs, mobilize communities, develop policies, measure impact, and obtain resources. Assessment provides consultation to Health District programs in scientific methods, including survey design, sampling, data collection, mapping, editing technical information, and interpretation. Involvement in quality improvement and program evaluation to guide Health District planning will occur in 2013.

Vital records (formerly known as vital statistics) is another service that is now located within the Community Health Division. It provides a critical service to the public through the **issuance of birth and death certificates**. Certified birth and death records are required for many purposes including legal name changes, paternity affidavits, and coordination with the Medical Examiner to record accurate causes of death and issuance of burial permits.

Division programs are supported with local, state, and federal funds. Fees, Snohomish County, the state Department of Health, the state Department of Social and Health Services, and several federal sources are the primary contributors.

2013 Initiatives and Issues, include:

Development of a Community Health Improvement Plan

In 2013, a major initiative will include creating a Snohomish County Community Health Improvement Plan (CHIP). The CHIP will build upon the Snohomish County Community Health Assessment (CHA), which was conducted in 2012 and included gathering and analyzing data on 69 community health indicators. Data analyses for the assessment reviewed prevalence rates, trends and whether health goals were met by Snohomish County residents. The indicators will be used to determine priority health issues for Snohomish County. Once priority health issues are determined, Snohomish Health District will facilitate a community process that involves community leaders in exploring possible interventions, developing a plan for action, and making commitments leading to improved health of Snohomish County residents.

As with the Community Health Assessment, the Health District's Public Health Advisory Council will serve as the Steering Committee for this work and provide continuous review and direction to Snohomish County Health District staff.

Initiation of the Electronic Death Registration System in Snohomish County

Vital Records plans to implement the Electronic Death Registration System (EDRS) in Snohomish County in order to move from paper to electronic filing of death records.

Developed by the Washington State Department of Health, EDRS will streamline the death registration process, improve the quality of the death data collected, and improve communication among those who file death records in the county. EDRS is designed to be used by all of the parties involved in approving a death record: the funeral director, the medical certifier, the medical examiner, and the Health District deputy registrars. Among the benefits of EDRS are:

- Physicians can quickly initiate a death record and file it from any computer with web access;
- Funeral directors can save time by collecting physician signatures electronically instead of obtaining them in person and can receive the burial permit electronically instead of in person at the Health District;
- Families can obtain death certificates faster because delays with paper processing will be reduced; and
- Department of Health can track and monitor public health trends with accurate and timely cause-of-death reporting.

Promoting Breastfeeding

Helping mothers to breastfeed and breastfeed longer is a health priority of the Women, Infant, and Children (WIC) Program. The 2012 rate of mothers that start breastfeeding is over 86% in the Health District's WIC/First Steps Clinics, which is well above the national average of 75%.

Trained staff that include certifiers, nutritionists, lactation consultants, and public health nurses employs a wide range of activities directed at changing behavior, including one-on-one counseling, group classes and support groups, and referrals to appropriate health and social services. Staff strives to help pregnant mothers plan for breastfeeding and supports them from the initiation until breastfeeding is well established. The WIC First Steps Clinics have completed the second year of the breastfeeding peer counseling program in partnership with Pregnancy Aid. Peer counselors provide more frequent and informal support to the mother to ensure successful breastfeeding. WIC is able to loan mothers breast pumps so they can continue breastfeeding even if they return to work or school. In 2012, the WIC First Steps Clinics celebrated National Breastfeeding Month by sponsoring a Breastfeeding Tea for clients and community members.

Assisting mothers to breastfeed is an important obesity prevention effort. Breastfed children are less likely to suffer from childhood obesity. Mothers who breastfeed lose their pregnancy weight gain more quickly.

Community Health Division- Expenditures

2013									
Community Health Budget									
> Expenditures									
EXPENDITURES: Grants	CH TOTALS	CH Admin	Matern./Inf.	Oral Health	CSHCN	WIC	Assess/Chronic	Child Abuse	Vital
Personnel Services	\$ 3,043,219	\$ -	\$ 1,435,644	\$ 91,346	\$ -	\$ 1,353,612	\$ 46,534	\$ 116,083	\$ -
Supplies	\$ 11,825	\$ -	\$ 3,000	\$ 460	\$ -	\$ 5,000	\$ 3,165	\$ 200	\$ -
Other Services & Charges	\$ 166,904	\$ -	\$ 77,000	\$ 29,328	\$ -	\$ 21,000	\$ 36,666	\$ 2,910	\$ -
Capital Outlay	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotals	\$ 3,221,948	\$ -	\$ 1,515,644	\$ 121,134	\$ -	\$ 1,379,612	\$ 86,365	\$ 119,193	\$ -
EXPENDITURES--Non-Grants	CH TOTALS	CH Admin	Matern./Inf.	Oral Health	CSHCN	WIC	Assess/Chronic	Child Abuse	Vital
Personnel Services	\$ 1,548,985	\$ 286,066	\$ 118,586	\$ 7,307	\$ 224,616	\$ -	\$ 664,964	\$ -	\$ 247,445
Supplies	\$ 59,325	\$ 52,100	\$ 300	\$ 125	\$ 950	\$ -	\$ 1,350	\$ -	\$ 4,500
Other Services & Charges	\$ 263,600	\$ 186,500	\$ 16,800	\$ 8,000	\$ 16,300	\$ -	\$ 29,500	\$ -	\$ 6,500
Capital Outlay	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotals	\$ 1,871,910	\$ 524,666	\$ 135,686	\$ 15,432	\$ 241,866	\$ -	\$ 695,814	\$ -	\$ 258,445
DIVISION SUBTOTAL	\$ 5,093,858	\$ 524,666	\$ 1,651,331	\$ 136,566	\$ 241,866	\$ 1,379,612	\$ 782,180	\$ 119,193	\$ 258,445
Division Indirect		\$ -	\$ 189,617	\$ 15,681	\$ 27,773	\$ 158,417	\$ 89,815	\$ 13,687	\$ 29,676
TOTALS	\$ 5,093,858		\$ 1,840,948	\$ 152,247	\$ 269,639	\$ 1,538,028	\$ 871,995	\$ 132,879	\$ 288,122
SHD Overhead	\$ 1,225,294		\$ 442,828	\$ 36,622	\$ 64,860	\$ 369,963	\$ 209,753	\$ 31,963	\$ 69,306
Division Total	\$ 6,319,152		\$ 2,283,776	\$ 188,869	\$ 334,499	\$ 1,907,991	\$ 1,081,748	\$ 164,842	\$ 357,428

Community Health Division- Revenues

2013									
Community Health Budget									
> Revenues									
REVENUES	CH TOTALS	CH Admin	Matern./Inf.	Oral Health	CSHCN	WIC	Assess/Chronic	Child Abuse	Vital
Licenses and Permits	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Intergovernmental: Grants	\$ 2,270,936	\$ -	\$ 248,283	\$ 73,000	\$ 279,763	\$ 1,544,614	\$ 58,026	\$ 67,250	\$ -
Intergovernmental: Other	\$ 147,250	\$ 147,250	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Charges for Services	\$ 737,875	\$ -	\$ 350,000	\$ 35,600	\$ 2,275	\$ -	\$ -	\$ -	\$ 350,000
Miscellaneous Revenues	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Revenue Subtotal	\$ 3,156,061	\$ 147,250	\$ 598,283	\$ 108,600	\$ 282,038	\$ 1,544,614	\$ 58,026	\$ 67,250	\$ 350,000
Expenditure Total (from above)	\$ 6,319,152	\$ -	\$ 2,283,776	\$ 188,869	\$ 334,499	\$ 1,907,991	\$ 1,081,748	\$ 164,842	\$ 357,428
Surplus/(Deficit)	\$ (3,163,091)	\$ -	\$ (1,685,493)	\$ (80,269)	\$ (52,461)	\$ (363,377)	\$ (1,023,722)	\$ (97,592)	\$ (7,428)
LICENSES AND PERMITS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
> None	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INTERGOVERNMENTAL: Grants	\$ 2,270,936	\$ -	\$ 248,283	\$ 73,000	\$ 279,763	\$ 1,544,614	\$ 58,026	\$ 67,250	\$ -
> Community Based Prevention	F \$ 33,729						\$ 33,729		\$ -
> PCHS Maternal Infant	F \$ 428,546		\$ 148,783		\$ 279,763				
> Preg & Parenting Teens & Women	F \$ 99,500		\$ 99,500						
> WIC-breast feeding promo	F \$ 36,686					\$ 36,686			
> WIC-breast feeding Counseling-CC	F \$ 7,578					\$ 7,578			
> Youth Tobacco	S \$ 24,297						\$ 24,297		
> Primary Prev. Early Intervention	S \$ 67,250							\$ 67,250	
> ABCD Dental Grant	S \$ 23,000			\$ 23,000					
> Access to Adult Dental Services	C \$ 50,000			\$ 50,000					
> WIC	F \$ 1,500,350					\$ 1,500,350			
INTERGOVERNMENTAL: Other	\$ 147,250	\$ 147,250	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
> Medicaid Match	F \$ 147,250	\$ 147,250							
CHARGES FOR SERVICES	\$ 737,875	\$ -	\$ 350,000	\$ 35,600	\$ 2,275	\$ -	\$ -	\$ -	\$ 350,000
> First Steps Clinic Based	D \$ 350,000		\$ 350,000						
> Dental -CC	D \$ 30,000			\$ 30,000					
> Oral Health Summit	D \$ 5,600			\$ 5,600					
> Work First	D \$ 2,275				\$ 2,275				
> Vital Stats	D \$ 350,000								\$ 350,000
MISCELLANEOUS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
> None	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

ENVIRONMENTAL HEALTH DIVISION

Randy Darst | Division Director

Environmental Health is an essential element in protecting the public's health. Improvements in sanitation, drinking water quality, food safety and disease vector control have been central to the significant improvement in quality of life and longevity experienced over the last hundred years. This Division largely **focuses on population-based public health activities that address chemical, physical, and biological factors external to a person that can potentially affect health.** Such factors can include air, food, and water contaminants; toxic chemicals; disease vectors; and safety hazards. Environmental Health programs impact and protect nearly everyone living in and visiting Snohomish County.

One very broad area is the **food safety inspection and education program.** Environmental Health Specialists inspect all retail food service establishments within the cities, towns, and unincorporated county on a regular basis including restaurants, grocery stores, school kitchens, and temporary event facilities. They make sure food handlers are trained and permitted; provide coaching on proper food handling techniques during facility inspections; investigate complaints and illnesses associated with food establishments; and review plans for new and remodeled food service facilities.

Other staff are part of the land development approval process. They **inspect and approve private drinking water wells and septic drain field systems** to ensure that ground and surface water will not be contaminated; they respond to concerns about drinking water and complaints about failing septic systems; work with homeowners to ensure timely repair of septic system failures; and they educate the public about proper system operation and maintenance. Additionally, this section works with other agencies and groups such as the Stillaguamish Clean Water District to protect and improve water quality in collaborative and coordinated projects. With regards to individual drinking water wells the program assures protection of users from the naturally occurring arsenic that is commonly found in Snohomish County by maintaining one of the more aggressive and forward thinking drinking water standards review programs for these wells.

The Solid Waste program **permits and inspects solid and moderate risk waste handling and disposal sites** to assure that waste is handled safely and to protect against impacts to surrounding areas. Environmental health specialists provide assistance to small businesses about best management practices for their waste streams and educate the public in schools, fair booths and community presentations on handling solid and hazardous wastes. They also investigate complaints about illegal dump sites, excessive trash accumulations, improper hazardous waste handling and disposal

2013 At-a-Glance

New Environmental Health Software

Expanded use of Technology

Improvements to Septic System Operations and Maintenance

practices, contaminated sites including illegal drug labs; all of which can endanger the public health by creating exposure to toxic substances and attracting disease-carrying rodents, insects, and other vectors.

Staff from this Division are also charged with making **routine health and safety inspections at schools and reviewing plans for school construction and remodel projects**. The mandated inspections of schools results in routine detection and elimination of health and safety issues protecting the tens of thousands of students, staff and visitors to these community facilities. Staff review plans for public and semi-public swimming pools and spas and inspect them to ensure conditions are safe and sanitary. Maintenance issues are a common occurrence at these facilities and staff work closely in not only gaining compliance, but also educating the responsible maintenance individuals on preventing future violations.

Environmental Health charges fees for most of its services, and is largely self-supporting. For example, septic system owners and restaurants must pay for their permits, as do food handlers. The Division also receives funding through an Interlocal Service Agreement with the County Solid Waste Division, as well as funding grants and contracts with partner agencies such as State Department of Ecology, State Department of Health, and Snohomish County Surface Water Management.

Environmental Health work plan for 2013 includes:

- **Expanded use of new technology in the food safety program**
- **Planning for and implementing new Environmental Health software**
- **Implementing a new onsite sewage system Operation & Maintenance regulation**

New Environmental Health Software

Currently the Environmental Health Division uses a variety of software tools for food safety management, billing, permitting, solid waste program time accounting, facility inspections, complaint tracking, septic inspections, and storing septic as-builts and maintenance reports. The Division uses a variety of commercial off the shelf packages that have been customized for the business functions they serve and have developed internally two web applications to exclusively serve septic system as-builts and septic system operation and maintenance inspection reporting for the Water Waste Water program.

The Division is looking to replace our current use of various software and databases with a comprehensive and integrated Environmental Health Software system to manage all environment programs including on-site sewage, water recreation, private and public drinking water, solid and hazardous waste, school safety monitoring, and retail food safety evaluations as well as manage complaints and incidents. The core function of the software will be the ability to conduct inspections and electronically document those inspections in the field on a remote device, track data and run reports. This will help ensure timely and accurate data collection and quicker public access. Historical data will also be available to inspectors electronically at the time of the inspection, thus

improving the inspectors' efficiency and effectiveness in the field. The system will allow entry of and on-line access to all applicable scanned and electronic documents including: permit applications, inspections, septic system as-builts, photographs, and permits. The system will manage permitting and all financial transactions associated with application reviews, permitting and other fees and a public portal will be implemented to allow the general public and regulated businesses to submit applications, file complaints, conduct file reviews and pay fees on-line.

Expanded use of Technology

The Food Program is replacing 5 year old field computers with state-of-the-art tablet computers. The field tablet allows for direct script entry of inspection data and observations and efficiently converts the written script into easily read typed reports. The program is also changing the inspection process by e-mailing inspection reports rather than leaving a paper copy. After the inspection, the report is easily e-mailed to multiple recipients such as the owner, manager, corporate office or others as desired by the food service establishment owner.

Implementing Septic System Operation and Maintenance Regulation.

The Board of Health recently adopted septic system maintenance provider rules and regulations that were developed in collaboration with septic industry partners. Formal program implementation will begin during the final months of 2012 with full program implementation during 2013.

Environmental Health Division- Expenditures

2013							
Environmental Health Budget							
> Expenditures							
EXPENDITURES: Grants	EH TOTALS	EH Admin	Drink. Water	Solid Waste	Septic/Land Use	Food	Living Env.
Personnel Services	\$ 757,142	\$ -	\$ 7,173	\$ 585,712	\$ 161,223	\$ 3,033	\$ -
Supplies	\$ 4,500	\$ -	\$ -	\$ 4,500	\$ -	\$ -	\$ -
Other Services & Charges	\$ 45,200	\$ -	\$ -	\$ 45,000	\$ 200.00	\$ -	\$ -
Capital Outlay	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotals	\$ 806,842	\$ -	\$ 7,173	\$ 635,212	\$ 161,423	\$ 3,033	\$ -
EXPENDITURES--Non-Grants	EH TOTALS	EH Admin	Drink. Water	Solid Waste	Septic/Land Use	Food	Living Env.
Personnel Services	\$ 3,258,536	\$ 413,551	\$ 107,317	\$ 403,410	\$ 491,419	\$ 1,559,360	\$ 283,479
Supplies	\$ 51,200	\$ 40,000	\$ 200	\$ -	\$ 5,000	\$ 5,000	\$ 1,000
Other Services & Charges	\$ 101,000	\$ 10,000	\$ 30,000	\$ -	\$ 20,000	\$ 40,000	\$ 1,000
Capital Outlay	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotals	\$ 3,410,736	\$ 463,551	\$ 137,517	\$ 403,410	\$ 516,419	\$ 1,604,360	\$ 285,479
DIVISION SUBTOTAL	\$ 4,217,577	\$ 463,551	\$ 144,690	\$ 1,038,622	\$ 677,842	\$ 1,607,393	\$ 285,479
Division Indirect		\$ -	\$ 17,866	\$ 128,250	\$ 83,701	\$ 198,483	\$ 35,251
TOTALS	\$ 4,217,577		\$ 162,557	\$ 1,166,872	\$ 761,542	\$ 1,805,876	\$ 320,731
SHD Overhead	\$ 1,013,598		\$ 39,067	\$ 280,431	\$ 183,019	\$ 434,001	\$ 77,080
Division Total	\$ 5,231,175		\$ 201,623	\$ 1,447,303	\$ 944,562	\$ 2,239,877	\$ 397,811

Environmental Health Division- Revenues

2013								
Environmental Health Budget								
> Revenues								
REVENUES		EH TOTALS	EH Admin	Drink. Water	Solid Waste	Septic/Land Use	Food	Living Env.
Licenses and Permits		\$ 2,917,500	\$ -	\$ -	\$ 70,000	\$ 470,000	\$ 2,150,000	\$ 227,500
Intergovernmental: Grants		\$ 571,750	\$ -	\$ 21,500	\$ 360,000	\$ 187,250	\$ -	\$ 3,000
Intergovernmental: Other		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Charges for Services		\$ 1,186,400	\$ -	\$ 70,000	\$ 762,400	\$ 140,000	\$ 144,000	\$ 70,000
Miscellaneous Revenues		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Revenue Subtotal		\$ 4,675,650	\$ -	\$ 91,500	\$ 1,192,400	\$ 797,250	\$ 2,294,000	\$ 300,500
Expenditure Total (from above)		\$ 5,231,175	\$ -	\$ 201,623	\$ 1,447,303	\$ 944,562	\$ 2,239,877	\$ 397,811
Surplus/(Deficit)		\$ (555,525)	\$ -	\$ (110,123)	\$ (254,903)	\$ (147,312)	\$ 54,123	\$ (97,311)
LICENSES AND PERMITS		\$ 2,917,500	\$ -	\$ -	\$ 70,000	\$ 470,000	\$ 2,150,000	\$ 227,500
> Food handler permits	D	\$ -						
> Restaurant permits	D	\$ 2,150,000					\$ 2,150,000	
> Facility permits	D	\$ -						
> Solid Waste Gen Ops	D	\$ -			\$ -			
> Solid Waste Grant--facilities	D	\$ 70,000			\$ 70,000			
> Liquid Waste	D	\$ 470,000				\$ 470,000		
> Camps	D	\$ 2,500						\$ 2,500
> Water sports--pools	D	\$ 225,000						\$ 225,000
INTERGOVERNMENTAL: Grants		\$ 571,750	\$ -	\$ 21,500	\$ 360,000	\$ 187,250	\$ -	\$ 3,000
> Sanitary Surveys-grp A-CC	S/F	\$ 7,500		\$ 7,500				
> Water Well Construction-DOE	S	\$ 14,000		\$ 14,000				
> Solid Waste Grant-Facilities	S	\$ 92,000			\$ 92,000			
> Stilligumish Clean Water		\$ 49,500				\$ 49,500		
> MRA Prevention	F	\$ 80,000				\$ 80,000		
> Site HazArd Grant-Init Invest.	S	\$ 130,000			\$ 130,000			
> Local Src Control Spec Prtns-DOE	S	\$ 138,000			\$ 138,000			
> Small OSS LHJ Contracts-CC	S	\$ 60,750			\$ -	\$ 57,750		\$ 3,000
> EHP Shellfish-CC	S	\$ -						\$ -
INTERGOVERNMENTAL: Other		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
> None								
CHARGES FOR SERVICES		\$ 1,186,400	\$ -	\$ 70,000	\$ 762,400	\$ 140,000	\$ 144,000	\$ 70,000
> EH Admin		\$ -						
> Public/Private Water Supplies	D	\$ 70,000		\$ 70,000				
> Solid Waste - Gen. Ops	D	\$ 5,000			\$ 5,000			
> Solid Waste/County MOU	C	\$ 754,000			\$ 754,000			
> Solid Waste grant--facilities	D	\$ 3,000			\$ 3,000			
> Decontamination-Drug Mfg	D	\$ 400			\$ 400			
> Living Environment	D	\$ -						\$ -
> Pools	D	\$ 15,000						\$ 15,000
> Schools	D	\$ 55,000						\$ 55,000
> Liquid Waste	D	\$ 140,000				\$ 140,000		
> Food Program (plan reviews, etc)	D	\$ 144,000					\$ 144,000	
MISCELLANEOUS		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
> None		\$ -						

PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE FUND (PHEPR)

SHD created the Public Health Emergency Preparedness and Response team within the Communicable Disease Division 11 years ago, following the September 11, 2001, attack on the World Trade Center and the subsequent anthrax attacks. Initially funded through general funds, the program has been maintained since mid-2002 in a separate, dedicated fund with federal funding through the Centers for Disease Control and Prevention (CDC). The PHEPR team's responsibilities are to **plan, exercise, and prepare SHD to be ready to respond to local public health emergencies, including disease outbreaks, storms, earthquakes, and other natural or manmade disasters.**

The 2013 PHEPR Budget of \$717,868 comes from three funding sources—CDC base funding, Cities Readiness Initiative, and Healthcare Preparation from the Assistant Secretary for Preparedness and Response (ASPR). The current contract for the three funding sources is awarded through June 30, 2013. The 2013 budget is based upon stable federal funding through December 2013.

PHEPR Fund	2011	2012	2013
Revenues	\$999,856	\$741,037	\$717,868
Expenditures	\$999,856	\$741,037	\$717,868
Balance	\$0	\$0	\$0

The PHEPR team consists of four full-time and two part-time employees, for a total of 5.1 FTE. PHEPR activities in 2013 will include:

1. **Facilitating the revision of community plans for alternate care facilities with local and regional healthcare partners.**
 - Alternate Care Facilities will serve as triage and patient holding areas during an event causing extreme catastrophic loss of healthcare capability in order to relieve pressure on local healthcare systems, so that acute care facilities can concentrate on providing medical care to the most seriously ill or injured patients.
2. Participating on a state-level committee to **develop Operations plans for medication distribution through local pharmacies during an emergency response.**
 - SHD will partner with local pharmacies to help distribute emergency medications or vaccinations during an emergency response. In worst-case scenario, mass distribution of medications to our entire population needs to be completed within 48 hours.

3. **Aligning regional Strategic National Stockpile procedures with King and Pierce Counties** and making preparations for a regional exercise in 2014.
- Snohomish, King, and Pierce Counties work closely together as the metropolitan area to plan and exercise mass antibiotic distribution to the counties' entire population within 48 hours.
 - A regional exercise in 2014 will test the plans and procedures across all three counties.

2013			2013		
Emergency Preparedness Fund Budget			Emergency Preparedness Fund Budget		
> Expenditures			> Revenues		
EXPENDITURES: Grants	EMERG. TOTALS	Emerg.	REVENUES	EMERG. TOTALS	Emerg.
Personnel Services	\$ 511,555	\$ 511,555	Licenses and Permits	\$ -	\$ -
Supplies	\$ 1,500	\$ 1,500	Intergovernmental: Grants	\$ 717,868	\$ 717,868
Other Services & Charges	\$ 37,880	\$ 37,880	Intergovernmental: Other	\$ -	\$ -
Capital Outlay	\$ -	\$ -	Charges for Services	\$ -	\$ -
Subtotals	\$ 550,935	\$ 550,935	Miscellaneous Revenues	\$ -	\$ -
			Revenue Subtotal	\$ 717,868	\$ 717,868
EXPENDITURES--Non-Grants	EMERG. TOTALS	Emerg.	Expenditure Total (from above)	\$ 717,868	\$ 717,868
Personnel Services	\$ -		Surplus/(Deficit)	\$ (0)	\$ (0)
Supplies	\$ -				
Other Services & Charges	\$ -		LICENSES AND PERMITS	\$ -	\$ -
Capital Outlay	\$ -	\$ -	> None	\$ -	
Subtotals	\$ -	\$ -			
EMERGENCY SUBTOTAL	\$ 550,935	\$ 550,935	INTERGOVERNMENTAL: Grants	\$ 717,868	\$ 717,868
Division Indirect	\$ -	\$ -	> CDC Base Grant	F \$ 523,250	\$ 523,250
TOTALS	\$ 550,935	\$ 550,935	> Cities Readiness Initiative	F \$ 156,343	\$ 156,343
SHD Overhead	\$ 166,933	\$ 166,933	> Health Care Coalition	F \$ 38,275	\$ 38,275
Project Total	\$ 717,868	\$ 717,868	> Homeland Security--Med. Plan.	F \$ -	\$ -
			INTERGOVERNMENTAL: Other	\$ -	
			> None	\$ -	
			CHARGES FOR SERVICES	\$ -	\$ -
			> None	\$ -	
			MISCELLANEOUS	\$ -	\$ -
			> None	\$ -	

Appendix A**Snohomish Health District
Resolution of the Board of Health****11-19****Resolution Number:** 11-19**Resolution Subject: SETTING A MINIMUM FUND BALANCE TARGET**

WHEREAS the Snohomish Health District operates primarily through its General Fund, which takes in revenues from various fees, grants, and other sources, and

WHEREAS maintaining an adequate fund balance in its General Fund is an important aspect to protecting the financial viability of the District, providing financial liquidity through fluctuations in spending cycles including emergencies, and assuring that it is able to continue its programs to serve the public without interruption, and

WHEREAS setting a minimum fund balance target will provide District staff with guidelines for budgeting and planning program expenditures, and will provide the Board with an important tool for evaluating budget proposals, and

WHEREAS District staff have analyzed annual fund balance cycles as the potential for funding through crises;

NOW THEREFORE the Board of Health hereby resolves as follows:

Section 1. The Snohomish Health District should maintain a fund balance of at least two million dollars at all times, including at its normal low point in early December.

Section 2. District staff shall propose annual budgets that project an ending fund balance for each year of at least two million dollars.

Section 3. At any point that District staff forecasts that short term conditions may reduce the fund balance below the set minimum amount, they shall notify the Board in advance of reaching that level and discuss the reasons for the lowered fund balance, any options to avoid doing so, and whether steps need to be taken to prevent such an occurrence.

Section 4. At any time that the staff proposes an annual budget in excess of twenty million dollars, the Board shall consider whether to change the minimum fund balance amount so as to continue to maintain a fund balance of at least ten per cent of the annual budget.

Section 5. This policy shall take effect on July 15, 2011.

Adopted this 12th day of July, 2011.

ATTEST:*Signature on file**Signature on file*

 Mark Lamb, Chair
Board of Health

 Gary Goldbaum, MD, MPH
Health Officer and Director

Appendix B

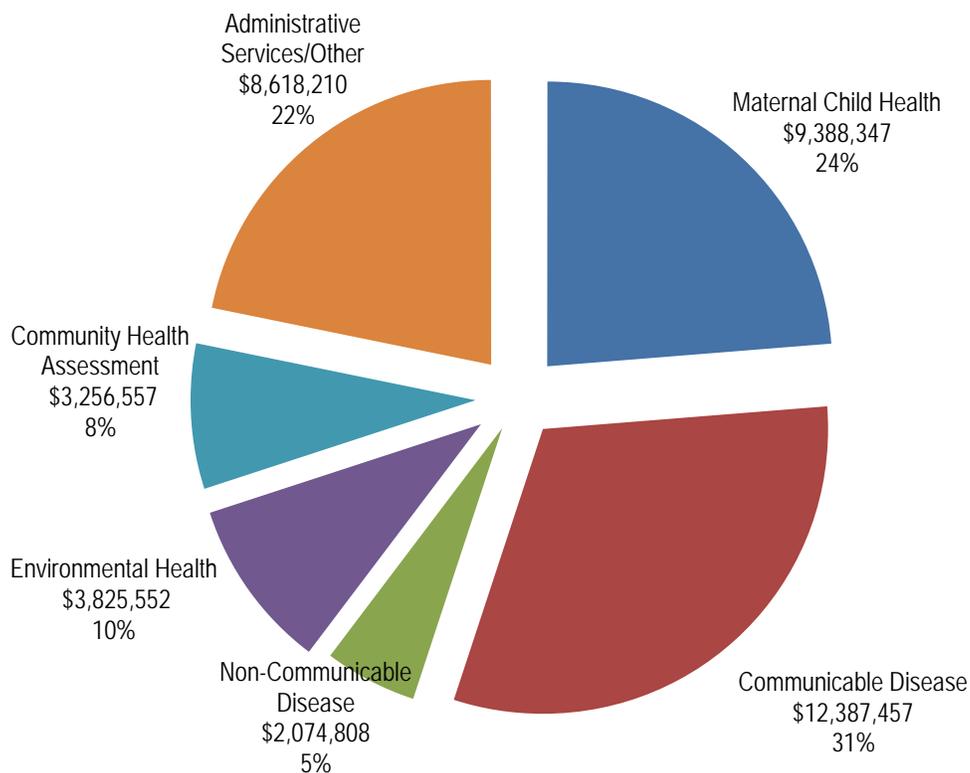
Summary of State Flexible Funding for Local Health Jurisdictions

Fund Name	Year Started	Biannual Amount	Distribution Formula	Requirements / Accountability	How Each Fund Was Used Statewide (Source: BARS Data, 2010)
Local Capacity Development Fund (LCDF)	1993	\$16 million/biennium	Per legislative budget proviso Base + per capita	Performance-based Contract – 2010-2011 - participate in Standards Review and use the funds where needed most. 2012 – use the funds to conduct a community health assessment, community health improvement plan, agency strategic plan, and/or to implement elements of the plans Report in BARS	<ul style="list-style-type: none"> • 24% Community Health Assessment • 24% Maternal and Child Health • 20% Administrative Services • 11% Chronic Disease • 9% Communicable disease • 6% Environmental Health • <u>6%</u> Other <p>100%</p>
MVET / I-695 Backfill	2000	\$48 million/biennium	90% of MVET revenue received by each local agency	Use the funds where needed most. Report in BARS	<ul style="list-style-type: none"> • 35% Maternal & Child Health • 19% Communicable Disease • 16% Administrative Services • 14% Environmental Health • 10% Other • 3% Community Health Assessment • <u>3%</u> Chronic Disease <p>100%</p>
5930 / Blue Ribbon Commission Funds	2007	\$20 million / biennium	Per legislative budget proviso Base of \$100,000 per local agency + per capita	Performance-based Contract – use the funds to improve the following, in rank order: 1. Increase the uptake of vaccines 2. Improve the investigation of communicable disease. 3. Develop and implement interventions to address obesity. Report in BARS	<ul style="list-style-type: none"> • 57% Communicable Disease • 18% Immunizations • 8% Community Health Assessment • 6% Chronic Disease • 5% Administrative Services • 3% Maternal and Child Health • 3% Other • <u><1%</u> Environmental Health <p>100%</p>
	2009	\$16 million/biennium			
	2011	\$10 million/biennium			

Diagram 2: For Each Fund - Accountability

Fund	Statewide Annual Amount	Focus / Accountability
MVET	\$24M	<ul style="list-style-type: none"> • BARS reporting
LCDF	\$8M	<ul style="list-style-type: none"> • BARS reporting • Participate in standards review • QI Plan • Community Health Assessment • Community Health Improvement Plan • Agency Strategic Plan
5930	\$10 \$8 \$5	<ul style="list-style-type: none"> • BARS reporting • Vaccine ordering • Shots recorded in ChildProfile • Communicable disease reported and investigated timeline and completely • Reduce chronic disease

Diagram 3: Funds in Aggregate – How Used Statewide
From 2010 BARS Data



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

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

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

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

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

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

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

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

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

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

Engrossed Second Substitute House Bill 5930 – The 2006 Washington State Legislature passed Engrossed House Concurrent Resolution (EHCR) 4410 and created the Joint Select Committee (JSC) on Public Health Funding. The JSC was a bipartisan study committee of the House and Senate, tasked with studying the persistent shortfall in public health funding. In response to the committee's request for information, local and state public health officials developed and presented a report titled *Creating a Stronger Public Health System: Setting Priorities for Action* (labeled "Statewide Priorities" on the committee's web site

<http://www.leg.wa.gov/jointcommittees/PHF/Pages/default.aspx>). The report ordered a list of priorities "for the next investment in public health" as follows:

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

The committee unanimously concluded that "the lack of a stable source of funding provided specifically for public health services has eroded the ability of local health jurisdictions to maintain a reliable statewide system that protects the public's health." It recommended that the state "provide additional funding in the amount of approximately \$50 million annually during the 2007-2009 biennium, as an initial

investment” and that a “dedicated account for public health revenues” be established. Finally, it recommended that these actions be considered “the first step in what must be continuing state and local efforts to fund the public health system at a level that provides the capacity to effectively deliver the five core functions.”

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

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

<http://www.doh.wa.gov/hip/products/5930/overview.htm>

Budgeting, Accounting and Reporting Systems (BARS) Data

The State Auditor’s Office collects information from local government via the *Budgeting, Accounting and Reporting System* (BARS)

<http://www.sao.wa.gov/EN/ClientSupport/FinancialReporting/LGS/BarsManuals/Pages/default.aspx>. DOH uses information from BARS to produce reports on revenue and expenditures for each LHJ and local public health in the aggregate. This report can be found at http://www.doh.wa.gov/a-z_topics/r.htm under *Revenue Reports*.

Appendix C
Agenda for Change- Action Plan 2012 Summary

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Agenda for Change Action Plan

FOR WASHINGTON'S PUBLIC HEALTH NETWORK

SUMMARY

2012

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the Agenda for Change**



Collaboration

THE FUTURE OF PUBLIC HEALTH



A growing and changing population, new and resurgent diseases, and a severe funding crisis all make for a challenging future for Washington's public health network. While public health agencies on the state and local levels have seen major cutbacks, our communities are faced with significant health problems that impact people today and will likely affect the health of our state for generations.

Obesity, diabetes, and tobacco use are just a few examples of the health issues that are taking a huge toll on the people of Washington. About 95 percent of health spending goes toward treatment and health care, yet we know that how and where we live have the biggest influence on our health. That's why the work of public health agencies is so important. Preventing unhealthy behaviors and replacing them with healthy habits can drive down chronic disease rates and improve quality of life. Making it easier in local communities to access medical care, get fresh fruits and vegetables, and live an active lifestyle can help people live longer and save on health care costs.

The combined efforts of local, state, and federal health agencies have made major strides, but there's much more to do. The partners in Washington's governmental public health network realize we can't do it all. To protect and improve the public's health into the future, we must build a plan that sustains our past successes, confronts our emerging challenges, and uses the resources we have as efficiently and effectively as possible.

Washington's Public Health Improvement Partnership is working to plan for, guide, and strengthen our future public health network. The partnership includes local and state public health leaders, local boards of health and tribal nations, the state Board of Health, the American Indian Health Commission, and the federal Department of Health and Human Services. Together, this comprehensive group has produced an "Agenda for Change Action Plan." The plan provides the guidance needed to ensure that we continue to protect and improve the health of people in Washington state in spite of the many challenges.

The following is a summary of the vision, strategies, and steps to move toward a valued and effective 21st Century public health network that will help everyone in our state have a better chance for a long and healthy life.

Thank you for taking an interest in the Agenda for Change and the important work of making Washington a safer and healthier place to live, work, and play.

Mary C. Selecky

Washington State Secretary of Health

Regina Delahunt

Director of Whatcom County Health Department

Co-Chairs, Public Health Improvement Partnership

The Agenda for Change

AN ACTION PLAN



Washington state's public health network has long been recognized as a national leader. The state Department of Health collaborates with a network of local public health agencies and tribes to protect every resident. Today, Washington continues that tradition of leadership by providing this Agenda for Change. This is a strategic framework that responds to a rapidly changing environment, such as new preventable disease challenges, health care reform, and diminishing resources, and helps everyone in our state have a better chance for a long, healthy and economically productive life. A successful public health network keeps Washingtonians safer and healthier, reduces health care costs, and improves the productivity of our workforce so we can continue to be competitive now and into the future.

Planning for the Future

The landscape for health is changing across the nation. Thanks to successes in public health and federal, state, local, and tribal funding commitments, communicable diseases such as tuberculosis and influenza are no longer the leading causes of death. People now become ill and die early from preventable chronic diseases like diabetes and heart disease that result from tobacco use, poor nutrition and lack of physical activity. Public health approaches will help solve this new challenge if we align our resources and competencies to match.

Implementation of the Affordable Care Act brings new opportunities for expanding insurance coverage and access to care for some of our most vulnerable populations. It provides states the ability to define essential health benefits. Ultimately, it allows the health care system to reform its business practices while ensuring better collaboration with partners — as a means to slowing the increase in health care costs, improving the experience of care and improving the health of populations.

We are also living in a time when resources are scarce and competitive. Public health agencies at the state and local levels have seen major cutbacks over the past several years, compromising our ability to protect and improve the health of our communities.

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The Agenda for Change

AN ACTION PLAN

continued from page 2

With the Agenda for Change, our state can be **at the forefront of responding** to this changing landscape by transforming our public health network through three approaches:



- 1 Foundational Public Health Services Ensure** every resident in Washington can access a foundational set of public health services, no matter where he or she lives. The Agenda for Change introduces a new concept: residents can access a foundational set of capabilities and programs supported by adequate and predictable funding. These foundational services are necessary but not sufficient. Just like the foundations of buildings support the larger structure, the public health foundational programs support other standalone federal or fee supported programs, like WIC, emergency preparedness and response, food safety inspections, and diabetes prevention.
- 2 Strategic Priorities Prioritize** our work so the public health network is working together to confront emerging challenges. The Agenda for Change helps us focus on the most important elements of preventing communicable disease and other health threats, fostering healthy communities and environments, and partnering with the health care system.
- 3 Transform Business Processes Reform** how we do business. Just as the health care system is changing through health care reform to better meet current challenges, the public health network must also undergo reform. This includes taking steps to ensure our workforce has the necessary skills and competencies to address new challenges, adopting the best of both private and public sector management into our operations, and developing a long-term strategy for predictable and appropriate levels of financing.

Committing to Health Equity and Eliminating Health Disparities

All Washingtonians should have the opportunity to live long, healthy lives regardless of geography; education; income level; race; ethnicity; sexual orientation; or physical, mental, or emotional abilities. While data shows improvements overall, there are groups of people suffering from health problems above and beyond the population as a whole; as well as getting care and services that are lower quality, if they are receiving them at all. It is difficult to comprehend and painful to acknowledge that not everyone has an equal opportunity for a long, healthy, enjoyable life. Achieving health equity is a public health priority as local public health agencies, tribes, and the state work to identify health disparities and implement strategies to eliminate them.

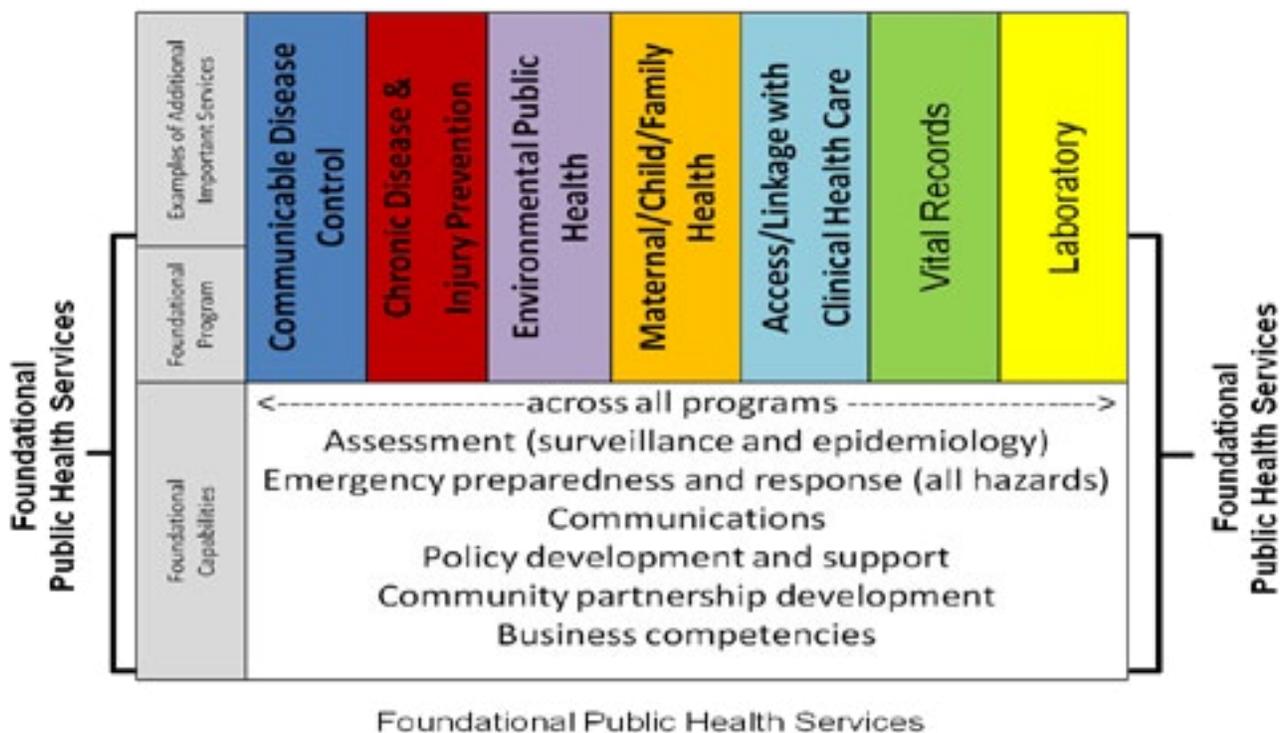
Foundational Public Health Services

Public Health Services for Every Community

Similar to other public safety (fire and law enforcement), public utilities (power, water) and infrastructure services (roads, sewer), a minimum level of public health capabilities and programs must be in place everywhere to protect and improve the overall health of the state. No matter where they live, residents of our state should be able to rely on the governmental public health network to deliver foundational services that protect all Washingtonians.

Health insurance plans describe their minimum benefits package – defining the services available to everyone who has that plan. Similarly, the Foundational Public Health Services defines the public health services that no community should be without, regardless of how the services are provided. It includes:

- » **Foundational Capabilities** like community health assessments, communications, policy development, community partnerships, emergency preparedness, and modern business practices.
- » **Foundational Programs** like communicable disease control; chronic disease and injury prevention; environmental public health; maternal, child and family health; linking with clinical health care; vital records; and laboratory services.



continued on next page

The Foundational Public Health Services **define what must be present** everywhere for the public health system to function anywhere.

- ➔ **GOAL** Develop sustainable public health financing statewide so that all residents have access to a foundational set of services that protect and improve their health.
- **Objective** Develop a scalable cost model for Foundational Public Health Services that can be adjusted for different population sizes and geographic locations.
- **Rationale** A foundational level of capabilities and programs are needed everywhere to protect and improve the overall health of the state. No matter where they live, all residents of our state should be able to rely on the governmental public health network to detect and remedy hazards to the health of the public, deliver a foundational set of services that protect their health, and meet specific standards.
- **Strategies**
 - » **Develop** a list of foundational capabilities and programs that should be available in every community. The list will not indicate who or how the services should be delivered.
 - » **Using** a representative sample of counties, identify the cost of delivering the foundational services statewide.
 - » **Develop** a funding model that accounts for these costs.

While the Foundational Public Health Services defines the basic services to protect and improve health that people rely on government to provide, it does not define a vision for the future of public health in Washington. That vision is articulated in the strategic priorities to follow.

Strategic Priorities



Priorities for the Future

The following strategic priorities build on the strengths of the decentralized public health network in Washington by supporting local solutions to local issues. Having statewide priorities enhances our ability to work together with essential partners, resulting in the most impact for the investment and effort. This plan will move the public health network toward increased consistency in business practices and will fulfill public expectations for consistent services from government across the state. It will improve efficiency and make the best use of our available resources. The three priorities are:

- **1 Preventing Communicable Disease and Other Health Threats**
- **2 Fostering Healthy Communities and Environments**
- **3 Public Health Partnering with the Health Care System**

Preventing Communicable Disease and Other Health Threats

Preventing people from getting sick from communicable disease is **foundational to the work** of public health agencies. We do this by assuring safe drinking water and food, providing immunizations, monitoring disease, and investigating outbreaks.



Preventing communicable disease is as important at home as it is in the developing world. The recent whooping cough epidemic in Washington shows that **we must be vigilant** in our efforts, embrace improvements in how we do our work and modernize our systems to ensure effectiveness. We must be able to respond effectively to new disease threats like we did successfully with H1N1 flu, SARS, and Mad Cow disease. **Our efforts are vitally important** to the health of the whole population of Washington state.

➔ **GOAL** Implement the most effective and important elements of prevention, early detection, and swift responses to protect people from communicable diseases and other health threats.

— **Objective 1** Increase immunization rates for all age groups.

Strategies

- » **Improve** our understanding of immunization coverage in Washington state by enhancing the completeness and quality of data entered in the Washington Immunization Information System (adults and children).
- » **Identify** and implement evidence-based practices to improve immunization coverage rates. Emphasize immunizations that provide the greatest impact to the health of people in Washington.

— **Objective 2** Standardize and prioritize communicable disease tracking, monitoring and response.

Strategies

- » **Prioritize** the activities that are most critical to protect the public's health
- » **Establish** evidence-based statewide recommendations for identifying and controlling communicable diseases.

— **Objective 3** Develop, maintain and integrate a data collection system for communicable disease tracking, monitoring, and response.

Strategies

- » **Modernize** our data systems for disease tracking, monitoring, and response.
- » **Increase** capacity to receive electronic laboratory reporting of communicable diseases through a health information exchange.
- » **Implement** an updated secure communication alerting system to send urgent messages from public health agencies to community partners.

Fostering Healthy Communities and Environments

Governmental public health agencies work to protect and improve people's health **throughout the course of their life**, from healthy childhoods to living well as older adults. As we learn more about how childhood illness and trauma can affect someone for a lifetime, new evidence shows a strong connection between a woman's health *before* becoming pregnant and the health of her child.



While some factors that impact health are out of a person's control, behaviors are not. **People make choices every day** that impact their health, like what to eat, how active to be, and whether or not to use tobacco. These choices are largely influenced by where you live, work, play, and go to school.

Not everyone has an equal opportunity to make healthy choices. **Success means making changes** to our communities and environments so that everyone can choose to live a healthy life.

➔ **GOAL** Prevent illness and injury, and promote health equity through sustainable, population-based changes in communities.

— **Objective 1** Implement policy, environmental, and system changes that give all babies a planned, healthy start in life.

— **Strategies**

- » **Connect** uninsured and underinsured women to preconception, prenatal, and postnatal care services.
- » **Collaborate** with health care providers to support women carrying babies to full-term.
- » **Improve** access to safe and healthy food for low-income women and families.
- » **Help** women quit using tobacco before and during pregnancy.
- » **Support** breastfeeding mothers in child care settings, hospitals, and worksites.

— **Objective 2** Implement policy, environmental, and system changes that prevent or reduce the impact of Adverse Childhood Experiences, such as abuse and neglect on children and families.

— **Strategies**

- » **Link** low-income families to programs that provide social and parenting support (examples include: home visiting and nurse-family partnerships).
- » **Screen** young children for developmental and social-emotional issues, and connect them with appropriate community services.
- » **Give** children safe and healthy meals (including snacks and beverages) in schools, child care settings, and after-school programs.
- » **Provide** opportunities for physical activity before, during, and after school and in child care settings.
- » **Prevent** youth from using tobacco products.

— **Objective 3** Implement policy, environmental and system changes that help adults make healthy choices for themselves and their families.

— **Strategies**

- » **Promote** affordable, healthy food and beverage options at worksites, colleges, hospitals, and other venues.
- » **Offer** free or low-cost physical activity opportunities in communities and worksites.
- » **Include** healthy design concepts when planning communities.
- » **Provide** smoke-free multi-unit housing.
- » **Link** people to quality tobacco cessation services (like the Tobacco Quitline).
- » **Protect** employees, customers, patrons, and others from secondhand smoke.

PRIORITY 3

Public Health Partnering with the Health Care System

A recent report from The Institute of Medicine argues that much can be gained by bringing primary care and public health together to improve individual, community, and population health. **Washington must act on new opportunities** presented through health care reform to bridge the divide between the two disciplines with a shared goal of improved health.



Health care today in **Washington faces many challenges**: the disease burden has shifted to chronic diseases, health care costs are rising and are unsustainable, and health care reform will increase the number of people with insurance, further challenging the health care delivery system.

Public health and health care providers can **respond to these challenges** by finding innovative ways to work together, jointly placing emphasis on preventing health problems *before* they become hard to treat and expensive. They can also team up with a broad range of community partners to set local priorities for improving health.

Public health agencies can contribute valuable information about health problems, they can help communities address the disparities in health among different groups of people, and they can help promote the use of prevention practices that have been shown to get results.

- ➔ **GOAL** Improve access to quality, affordable, and integrated health care that incorporates routine clinical preventive services and is available in rural and urban communities alike, by effectively and strategically partnering with the health care system.
- **Objective 1** Provide more information about the community's health care system and the health of local communities.
- **Strategies**
 - » **Improve** knowledge about the health status of the community.
 - » **Improve** information about the capacity of the health care delivery system within the community.
 - » **Increase** information about how people use the health care system in the community.
- **Objective 2** Engage community leaders with a shared interest in improving health to identify and address community health problems. Mobilize resources and strategies to improve the health of the community, especially among populations affected by health disparity.
- **Strategies**
 - » **Convene** interested parties to develop community health needs assessments. This includes connecting hospitals, consumers, behavioral health, primary care, specialty care, and dental care services.
 - » **Convene** interested parties to share information about the health of the community so that problems can be identified and potential solutions achieved.
- **Objective 3** Promote and adopt the use of evidence-based clinical preventive services and patient-centered health homes as a way to assure that needed care is well-coordinated.
- **Strategies**
 - » **Improve** provider use of evidence-based clinical preventive services like screening tests, counseling, immunizations, and medications used to prevent disease.
 - » **Increase** the availability and use of patient-centered health homes so that patients receive the benefits of access to care, preventive services, and continuity of care.



Partners are Essential

Keeping our communities healthy is not the job of one agency alone; many organizations influence the health and wellness of the people they serve. Public health agencies throughout the state are continually working with partners. An important role of the public health network is to convene community groups to help define and address local health problems. This is especially vital with populations experiencing disparities.

We can also help our partners understand the relationship of health to their agency's mission. Examples of partners and possible actions they might take include:

Child care and early learning centers

» Example: Adopt healthy food and beverage procurement guidelines

Community employers and businesses

» Example: Provide physical activity opportunities for employees

Community organizations

» Example: Participate in forums to learn about the health status of the community and identify policies to improve health

Health care system (payers, providers, hospitals)

» Example: Work with local health agencies and the Washington State Department of Health to improve completeness of Washington Immunization System data

Housing authorities, non-profit housing organizations, property management organizations, and landlords

» Example: Educate residents on the health risks of secondhand smoke and the benefits of quitting tobacco

Schools, colleges, and universities

» Example: Work with local health agencies to promote immunization and improve coverage

State and local government agencies

» Example: include healthy community design elements in comprehensive plans

Tribes and The American Indian Health Commission

» Example: Increase capacity to use policies, systems, and environmental changes when addressing health issues

Next Steps

IMPLEMENTING THE AGENDA FOR CHANGE



With Foundational Public Health Services and strategic priorities now defined in the Agenda for Change, we're ready to implement. To make these strategies a reality, we will focus on workforce development, modify business practices for maximum impact, and identify long-term, sustainable financing for programs and services.

The future work of public health agencies must include retraining their workforce so they have the skills and competencies to meet today's challenges. Recruitment, selection, and retention strategies must be implemented to address skills gaps in health equity, policy change, social media, and communications.

The Agenda for Change also calls on Washington's public health network to **transform its business practices** and reprioritize its work by:

— **Working** with policymakers to set and prioritize specific health outcomes, and establish ways to measure them.

— **Streamlining** performance and accountability measures on public health actions that lead to the achievement of the prioritized health outcomes.

— **Committing** fully to quality improvement by striving to meet state and national public health standards.

— **Organizing** a more cost-effective public health network to achieve prioritized health outcomes.

— **Applying** the best of private and public sector management techniques to the operation of each of our programs.

— **Critically** evaluating and reprioritizing our limited resources, and better defining roles and responsibilities among the overlapping government authorities and jurisdictions.

— **Modernizing** and sustaining capabilities to collect, analyze, and share information, that policy makers, health agencies, and the public can use to make Washington a healthier place to live. Implementation of the Affordable

Care Act brings new opportunities for expanding insurance coverage and access to care for some of our most vulnerable populations. It also provides states the ability to define essential health benefits, and ultimately, it allows the health care system to reform its business practices while ensuring better collaboration with partners.

Our challenge and opportunity in public health is to do no less.

Health is important to all of us, yet we have limited government resources so we must use them wisely. Like police and fire services, people expect government to consistently and reliably provide public health services for all. The Agenda for Change Action Plan describes our vision for the future of public health in Washington state and how we will achieve it. We look forward to working with policy makers and partners as we implement the vision and strategies in this document.

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Photos provided by the Washington State Department of Health, the Rudd Center for Food Policy and Obesity, and Bigstock.

For more information visit: www.doh.wa.gov/hip

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