Snohomish County/Health District Merger Issues Analysis

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Forward

This report would not have been possible without the help of many, many people. I want to thank everyone who graciously agreed to take time to be interviewed (Appendix A). Their knowledge and helpfulness was invaluable. There are also many employees of Snohomish County who were not interviewed but were willing to very quickly respond to questions. They too deserve thanks. I often needed clarification regarding a point, a fact regarding finances, or where to find a document and I always got the assistance I needed. Some of these Snohomish County employees were Brain Haseleu, Roger Moller, Annie Cole, and Susan Neely.

One thing that was mentioned by many of the interviewees was the talent and dedication of Health District staff. The staff truly wants to provide quality public service and protect the public’s health. And from all accounts, they do a great job. I was often told how they go the extra mile to resolve customer problems. I also want to single out four staff whom I frequently queried for help—Peter Mayer, Teri Mitchell, Judy Chapman, and Dan LeFree.

Finally, a word about the use of this report. The Scope of Work required me to “Preliminarily identify operational and financial issues and areas needing more detailed analysis.” I want to stress that this is a preliminary analysis. While I believe it does a good job of outlining these issues, it is certainly possible that my information was not complete or that I have misinterpreted certain items. It is essential that the subject matter experts of the County and District review it before any major changes in the current situation are made. Put another way, I believe the report is a good map, but the map is not the territory. Good decisions require that the territory be explored by the experts and the map corrected if need be.
# SNOHOMISH COUNTY/HEALTH DISTRICT MERGER ISSUES ANALYSIS

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Executive Summary

Introduction

Changes in the Focus of Public Health

Public health’s focus has shifted from direct provision of medical services to broader efforts to effect “wellness”. This approach is termed “population based”. Public health is increasingly seen as playing a key role in mobilizing people to address community needs. These efforts are not directed at individuals but society as a whole.

One reason for this change is the feeling that it is simply too expensive for public health to provide direct services. A second is the belief that medical care is only responsible for about 20% of health. The other 80% is related to the physical environment, socio-economic factors, and individual behaviors. A third reason is that with the passage of the Affordable Care Act insurance became more broadly available. The Snohomish Health District has been moving away from direct services for years for all these reasons.

Fiscal Overview

Since the 2008 recession, the Snohomish Health District has faced serious financial difficulties. Revenues have dropped by over 18% while expenses have increased with inflation. The number of employees has decreased from 227.44 FTEs to 137.3 FTEs.

Fund balance is expected to decline, reaching a negative number in 2022. The picture is bleaker when $4.5 million in deductions the District makes against fund balance are taken into account. At the same time, the District’s financial situation has improved in recent years. The six-year forecast shown in the 2013 through 2016 budgets all projected significantly less fund balance in 2017 than there is. This improvement is in spite of the fact that deductions taken against fund balance were increased in 2015 and 2017.

Snohomish County is also experiencing difficult financial times. While in a stronger position than the District, the County has reduced funding from its high point in 2009.

Issues Needing Consideration

Legal Process

The process for converting the Snohomish Health District (an independent entity) to a part of Snohomish County government is not entirely clear. The key issue is what happens to District
assets if it is dissolved. When other special purpose districts are dissolved the assets must be sold, debts paid, and the surplus distributed to the school districts. Without District assets it would be difficult for the County to take over the District’s public health responsibilities.

**Taxing Authority/Dedicated Revenues**

Some interviewees expressed the wish that the District had dedicated funding. The most likely source would be passage of a levy lid lift. It was generally felt that the likelihood of passage would be negatively impacted if the Health District were no longer an independent agency. If the desire is to seek dedicated funding it may not make sense to consider merger.

**General Workforce Issues**

It is likely that in a merger the County would make most Health District employees County employees. Extensive bargaining with the three District unions and at least one County union would be necessary. Potentially contentious issues include pay dates, how to deal with existing leave balances, years of service, seniority, etc.

**Insurance Benefits Costs**

Both agencies provide medical, dental, and vision insurance for their employees. It is assumed that the unions would advocate for the best plan and equality for employees. A comparison of District benefits costs with County costs shows that if District employees were offered the County plan costs would increase by over $600,000 per year.

The Health District also has an aging employee base. Over half are over 55 years of age. It would be necessary to discuss with the County’s insurance broker what the likely impact on rates would be.

Finally, there are other insurance benefits which differ between the two agencies. It would be necessary to negotiate life insurance, basic Accidental Death & Dismemberment (AD&D), and Long Term Disability Insurance and their related costs.

**Salaries**

If the County merged with the District it is inevitable that at some point job classifications would be reviewed. In an attempt to get a high level sense of what that impact might be Snohomish County Human Resources looked at a number of Health District job descriptions. Six were identified that seemed relatively close matches for County jobs.
Starting and top step salaries were compared. In all six cases the starting salaries were higher for the comparable County jobs. In four of the six the top step salaries were higher. It should be noted that in two of the cases the County jobs, while roughly comparable, had a higher level of work responsibility.

Salary schedule structures also differ, with a different number of steps. This would need to be negotiated and might impact costs.

Finally, the County currently does not provide for Health District COLAs and health insurance increases. Were a merger to take place it would need to fund both every year.

**Deferred Compensation**

While both jurisdictions offer Deferred Compensation, only the County offers a $.50 match per $1.00 of contributions up to 1% of the employee’s monthly base salary. District employees would expect to receive this benefit. The District also has two instead of one provider. The County would likely need to negotiate this change.

**Contract Differences**

In addition to wages and benefits there are many other contract issues that would need to be resolved. No attempt was made to analyze differences in the details of contract language dealing with grievances, union activities, management rights, recruitment, etc. A number of areas which might have financial impacts are listed below.

- **Bilingual pay**—District employees are eligible for it. County employees are not.
- **Holiday pay**—County employees receive a higher overtime rate on Thanksgiving Day and Christmas Day
- **Trial Service Periods**—District trial service periods are half the length of those at the County.
- **Longevity Pay**—Health District employees receive it. County employees do not.
- **Annual Leave**—Although somewhat the same, District employees receive more leave in the first two years of employment. Then until year 22, County employees receive fractional amounts more per year. Beginning at year 22 District employees once more receive significantly more leave.
- **Sick Leave**—Cash out provisions vary based on when Health District employees were hired. While difficult to compare due to differences, cash out provisions appear more generous in the District contracts.
Contract Expiration Dates—All District contracts expire at the end of 2017. The County AFSCME contract includes a 2.5% COLA in 2018 and expires at the end of that year.

Capital Issues

The Health District presents itself as having significant capital needs. Snohomish County Department of Information Services (DIS) estimated that slightly over $215,000 was needed to address depreciation on Health District technology. The network system and various software systems may also need upgrading. It was reported in 2015 that all Health District fleet vehicles had exceeded their anticipated useful life. Other items such as data input, new business cards, signage, fleet labels, phone numbers, etc. would also all need to be addressed in a merger.

Rucker Building

The Health District owns the building it occupies on Rucker Ave. McKinstry performed a building assessment in 2015 which identified over $2.3 million in needed improvements. Additionally, the building has more space than the District needs. The District is considering selling the building “as is” to avoid the cost of upgrades and “right size” their space. Current estimated value is $8.5 million.

The ownership of the building is complex. All cities and the County contributed to the purchase. They were told they would have an ownership interest but legal documents were never completed. If one assumes that each city has an ownership interest equal to its contribution the cities share would be 13%, with the remaining ownership resting with the District. These issues would need to be clarified prior to any assumption of Health District responsibilities by Snohomish County.

Fund Balance Issues

Snohomish County and the Snohomish Health District have different policies for fund balance. The District’s 2017 fund balance is just under $6.7 million. However, by policy it reserves from this amount $4.5 million for an Emergency Reserve, a Working Capital Reserve, and Compensated Absences.

The County reserves no such amounts from its fund balance. Were the County to take over the District’s responsibilities the County’s fund balance policies would apply. Depending on the disposition of the Rucker Building fund balance might fall from just under $6.7 million to as low as roughly $4.2 million.
The most likely scenario would appear to be that these amounts would be added to the County’s fund balance. The County has a current fund balance of slightly over 10%, with a goal of 11%. The fund balance would likely increase to approximately either 11% or 12% following a merger.

**Legal Liability/Risk Management**

Health District insurance compares favorably with that of Snohomish County. The District’s coverage limit amount is 40% of the much larger County’s. The District has low deductibles and a good claim history. The cost of the insurance premium is also low—$138,040/year. It is possible that the County would prove a more attractive target and that claims would increase following merger. If a merger occurred, the County should consider keeping the current insurance package for the new Health Department.

Potential liabilities associated with the Rucker Building would include hazardous materials, seismic status, fire and security systems, and other similar issues.

**Affordable Care Act (ACA)**

One major factor in the shift in public health from providing direct services to population based services was the passage of the ACA. The theory is that direct services are better provided by an individual’s “medical home” which they obtain through insurance.

In February of 2014 the Herald reported that 22,000 Snohomish County residents had obtained insurance through the Medicaid expansion. The possible impact of repeal needs to be considered.

Most interviewees did not believe that the focus of public health should change if the ACA is repealed. A number did, however, believe that there might be some cases where public health might have to step back in. They also believed there would be significant pressure on public health to once again provide direct services.

**Culture**

While no detailed look at the two work cultures was made, interviewees volunteered the difference between the two regarding customer service. The County focuses on technology: internet access, web lookups, phone trees, etc. The District focuses on the personal: short lines to see people, phones answered by people directly, no need for appointments, etc. These cultures would need to be meshed.
Perceived Advantages of Merger

Positive Impacts on Health District Workforce

Health District personnel, while having mixed feelings about the merger idea, saw it as increasing their possibilities for advancement. They also believed the merger would address the District’s financial issues. Being part of the County was seen as adding “depth” to the pool of expertise that could be drawn upon. Finally, with a work force which is over 50% age 55 and older, recruitment is an important issue. District employees saw recruitment as easier if the County were to take over the District’s responsibilities.

Accountability

A number of interviewees felt that the current structure of the Health Board did not create clear lines of accountability. It was felt that with the County in charge accountability would clearly lodge with the County Executive and Council. There would also be funding alignment since funding primarily comes from the County. Lastly, Health District and County priorities would be aligned.

Ability to Influence Policy

There were a number of interviewees who felt that by becoming part of the County, public health would increase its influence and visibility. This would make it more successful at mobilizing the community around issues and consequently achieving its goals.

Efficiency

There were numerous comments by interviewees regarding economies of scale and efficiencies that might result from merger. Both the possibility of service and “back office” efficiencies were mentioned. At the same time, interviewees cautioned not to overestimate the cost savings. Most County interviewees indicated they could not absorb new workload without new staff. It would also be necessary to evaluate the overhead costs of both the Health District and the County to make sure that higher overhead would not eat up any savings.

Elimination of Silos

Both agencies were perceived to have silos of services. Many interviewees felt that synergies might be created if the organizations were merged. Human Services, Mental Health, the built environment, and septic permits were all mentioned as areas which might benefit. At the same
time, while communication might be improved, it is unlikely that silos could be completely eliminated.

**Perceived Disadvantages of Merger**

**Bureaucracy**

Snohomish County was perceived as much more bureaucratic than the Health District. The District was described as nimble and able to quickly address issues. This is particularly important in a health emergency where time is critical.

**Loss of Public Health Focus**

A number of interviewees were concerned that public health would get lost in the larger County organization. Visibility would be less and the County might not make public health a priority. The importance of a strong, independent Health Officer was also stressed, with concerns expressed that the role would be damaged by being part of the County.

**Politicization**

Fears were expressed that public health policy, which is currently insulated from political pressures, would become subject to politics. In addition to subjecting policy debates to more political involvement there are areas of oversight public health exercises over the County. Septic, clean water, and solid waste were all mentioned. There were fears that with the County performing oversight on itself there might be pressures to ignore public health concerns.

**Competition for Funding**

County revenues are constrained. In taking over the District’s responsibilities the County would receive no revenues beyond what the District currently has. County departments expressed concerns that they would face budget cuts to fund public health. Conversely, other interviewees feared that public health would face cuts to fund other County priorities.

**Other Potential Disadvantages**

Concerns were expressed that direct medical services provided by the District would be difficult to integrate within the County structure. There were also concerns that significant staff resistance would develop due to staff of both organizations fearing loss of jobs.
Structure Following Merger

Department/Division

The primary reason perceived by interviewees for moving the Health District into the County as a department or division was the fear that breaking it up would lose the public health focus. A related perception was that keeping public health as one unit kept the Health Officer as the visible face of public health. There were also concerns that existing synergies in the District would be lost if broken up.

Variety of Departments

Those who favored separating District functions into various County departments saw it as aligning District functions with County structures. This in turn would lead to synergies and improved customer service. The example most often cited was the opportunity to make septic permits “one-stop shopping”. Various matches for District functions with County departments were suggested.

As noted earlier, concerns were mentioned over oversight issues. If District functions were located in the County departments they oversaw, these concerns would be heightened. However, two of the counties surveyed for this report do locate these functions together. While working, this was reported to sometimes lead to the sense that the public health function has become part of development activity.

Transition Option

A number of interviewees suggested moving the Health District initially as a unit and then after a period of years breaking parts off to other County departments. It was felt this would provide a smoother transition.

Role of Cities

Interviewees had mixed views. Some felt it was important to continue a role for cities (perhaps advisory) because they provided valuable input and many public health programs are implemented within their boundaries. Others felt there was no need for the cities to play a role in the absence of city financial contributions. It was believed that if the role of cities was eliminated the cities were unlikely to contribute.
Hybrid Option

Another option discussed would be to keep the Health District a separate entity but contract with the County for “back office” services. In this way savings from a merger might be realized without the merger. The County currently provides some “back office” services to junior taxing districts.

Concerns were raised about the practicality of such contracting with some services, particularly legal, Human Resources, and communication. It would also be necessary to review County overhead costs to see if they were higher than those of the District.

Opportunities

Space

A number of County interviewees mentioned lack of space for employees as a problem for the County. The District has excess space at the Rucker Building. It might be possible for the County to contract for space at the Rucker Building. Parking issues would need to be addressed.

Co-Location of Septic Permitting

The availability of space in the Rucker Building would make it possible to co-locate County employees involved in septic permits with the District’s employees. Both better customer service and coordination would result. Other counties (King and Kitsap) have tried such an approach. The possibility of moving additional County land use services to the Rucker Building could also be considered.

Clarification of Health District Mission

A significant number of interviewees felt there was a need for the District to clarify its mission, whether or not merger occurred. It was not felt that the Board, District leadership, and employees had a shared vision.

This was not a call for drafting a new mission statement. Rather, it is important for the District to develop a clear rationale, particularly for changes in programs. If the rationale is to move toward population based services, then new programs must be clearly population based. If it is to save money, then significant financial savings must be realized. If it is to fill a community service gap, that goal needs to be clearly stated. Decisions about program changes do not always have this kind of clarity of purpose.
Conclusion

A recommended process for decision making is:

- Determine if there is a desire to obtain taxing authority for the Health District. If the answer is “yes” proceed no further.
- Review financial issues. If taking over the Health District does not enhance the District’s financial situation it does not make sense to proceed.
- If financial issues are positive, consider policy issues.
- If policy issues are resolved consider the legal process, future structure, and role of the cities.
- If the decision is at any point made to not merge, consider the possibilities of the County providing “back office” services and of locating some services at the Rucker Building.
- In all cases, proceed to clarify the Health District’s mission as soon as possible.
Introduction

Changes in the Focus of Public Health

In recent years significant changes have taken place within the public health community. Several persons interviewed stressed that the focus has moved away from actual clinical care to other areas. One interviewee referenced the concept below to illustrate the point.

In this view, actual health care is only 20% of the reason people are healthy. The physical environment accounts for another 10%. As important as both together are healthy behaviors by individuals. And finally, 40% is based on socio-economic factors such as education, employment, income, family/social support, and community safety. One interviewee expressed the view that the focus for public health needs to be on “health and wellness” in all its aspects. This new version of public health “emphasizes cross-sector environmental, policy and systems level actions that directly affect … all the determinants of health.” (presentation by Patrick O’Carroll, Senior Advisor to the Assistant Secretary of Health)

This approach is often referred to as “population based”. It focuses on prevention of health problems. Indeed prevention of health problems has always been a key role of public health. Clean water, proper handling of sewage, and safe food are examples of traditional population based health policy. Instead of dealing with individuals, these policies address the health of the community as a whole.

In recent years public health has expanded the definition of population based services. Public health agencies have encouraged exercise, become involved in land use decisions (walkability),
addressed second hand smoke, discouraged alcohol and tobacco use, and other activities that are not directed at individuals, but at society as a whole.

There is not agreement between public health agencies regarding what is and is not “population based”. Interviews were conducted with representatives of nine public health agencies within Washington State and while there was agreement on the need to focus on population based services, views of what that meant varied. In one case, the public health agency felt that the Nurse Family Partnership, which involves direct one-on-one service, was a good example of a population based program. Other agencies specifically rejected that view. Some defined population based services in ways that went far beyond traditional public health (see sidebar).

All see public health having a key role in mobilizing the community. As one interviewee put it, public health is the “leading convener and planner”.

While all public health agencies interviewed continue some direct services, most view these services as exceptions to the general thrust of where public health is headed. *Foundational Public Health Services: A New Vision for Washington State* (written under the leadership of the Washington State Department of Health in 2015) referred to foundational public health services including direct services only when “…governmental public health is the only or primary provider of the service…” (p. 4).

Aside from the policy reasons why public health is shifting from direct services a number of interviewees mentioned financial reasons. There is a perception that it is simply too expensive for public health agencies to provide direct services. A frequent view is that there are other private and community entities who can perform direct services more economically and efficiently. At the same time, it is recognized that much of the funding for public health is directed at specific program outcomes which involve direct services.
Locally, the Snohomish Health District has been making this shift for several years for both policy and financial reasons. The immunization clinics have been closed, the Nurse Family Partnership has been transitioned to ChildStrive, the clinic for Sexually Transmitted Diseases has been closed, and discussions are currently underway regarding the future of First Steps and Women, Infants, and Children Nutrition Program (WIC). The District’s view of the future is reflected in the 2014 Strategic Plan Update on page 13:

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

One important impetus for the shift in focus by the Snohomish Health District was the adoption of the Affordable Care Act in 2010. Supported and Sustainable: The Future of Public Health in Snohomish County noted that the closing of the Health District’s immunization clinics “…is now feasible because of the Affordable Care Act making health care insurance more widely available.” (p. 3)

Within the public health community there is wide agreement that medical care is best provided from a “medical home”. A medical home is defined by Wikipedia as “a team-based health care delivery model led by a health care provider that is intended to provide comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes”.

Without insurance, such an approach is impossible. With insurance, it is the best way to assure good medical care outcomes. Being able to move out of direct medical care allows public health to focus on the 80% of the determinants of public health.

A key aspect of population based public health is the ability to have, and use, good data. The Snohomish Health District has access to data that the private sector cannot access due to privacy and legal reasons. The District can do analysis and present its conclusions to the private sector who can then use the information. Several interviewees, both public and private sector, spoke of the importance of Health District data. It helps local agencies apply for grants and determine what issues to focus efforts on.
Fiscal Overview

When interviewees were asked to identify the primary challenges facing the Snohomish Health District by far the most common answer was lack of financial resources. Certainly, financial issues are a key driver in the discussion of whether or not the county should absorb the Health District.

Since the 2008 recession the Health District has experienced significant budget cuts. In 2009, Health District revenues totaled just over $19,000,000. In the 2017 budget revenues total slightly less than $15,500,000. In addition to the 18.4% decrease in gross revenues, costs (salaries, benefits, etc.) have also increased in this 8 year period, exacerbating the impacts of the revenue decrease on the Health District.

The District has adapted to this decrease in revenues in a number of ways, but most significantly by eliminating staff and programs. The 2009 budget had a total of 227.44 FTEs. The 2017 budget includes 137.3 FTEs, a decrease of nearly 40%.

The District has also looked for new revenues. In 2017, for the first time since the 1990s, cities are contributing to the Health District budget. Additionally, Snohomish County in 2017 increased its per capita contribution. These new revenues are shown below:

<table>
<thead>
<tr>
<th>Total city per capita contribution</th>
<th>$405,210</th>
</tr>
</thead>
<tbody>
<tr>
<td>New County per capita contribution</td>
<td>$ 24,790</td>
</tr>
<tr>
<td>Total new dollars</td>
<td>$430,000</td>
</tr>
</tbody>
</table>

It should be noted that the above only shows new County per capita. Total per capita contribution by Snohomish County is $653,200.

The impact of these new dollars is unclear. In the Snohomish Health District’s Public Health Per Capita Funding: Frequently Asked Questions it states:

Then there are also more targeted programs and services that we are either currently providing, or have plans to provide, that are specific to the cities/communities. That is where we believe the cities’ funding is best utilized….we intend to work with each city to determine what their biggest priorities are and where we can provide support. (p. 2)
Insofar as the funds are used for new services, they will not improve the Health District’s overall financial position.

As reported in the 2017 Snohomish Health District Budget, the District’s long term fiscal outlook is not positive. The table below from the 2017 budget shows the difference between revenues and expenses and the impact on fund balance.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Resources Less Expenses</th>
<th>Beginning Fund Balance</th>
<th>Available Fund Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$117,201</td>
<td>$6,832,518</td>
<td>$6,949,719</td>
</tr>
<tr>
<td>2017</td>
<td>($251,029)</td>
<td>$6,949,719</td>
<td>$6,698,690</td>
</tr>
<tr>
<td>2018</td>
<td>($673,889)</td>
<td>$4,796,509</td>
<td>$4,122,620</td>
</tr>
<tr>
<td>2019</td>
<td>($904,366)</td>
<td>$3,218,253</td>
<td>$2,078,675</td>
</tr>
<tr>
<td>2020</td>
<td>($1,139,579)</td>
<td>$2,078,675</td>
<td>$699,053</td>
</tr>
<tr>
<td>2012</td>
<td>($1,379,622)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>($1,624,592)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Available Fund Balance in 2017 represents just over 40% of 2017 expenditures. However, a formatting change in the 2017 budget makes these numbers appear far more positive than previous budgets. In previous budgets a number of items were subtracted from the fund balance to yield “Undesignated Fund Balance”. Making the same adjustments to 2017 reduces the fund balance by $4,500,000 (not including any capital expenditures) leaving a fund balance of $2,198,690 (13.3% of expenditures). By District policy the same $4,500,000 would need to be subtracted from each subsequent year’s fund balance.

While not positive in the long run, the financial position of the Health District has improved over the last few years. Health District leadership and staff have made difficult decisions and managed carefully in order to improve the fiscal outlook. The chart below shows the fund balance for 2017 as projected in the budget adopted in each year shown.

<table>
<thead>
<tr>
<th>Year</th>
<th>Fund Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>($353,177)</td>
</tr>
<tr>
<td>2014</td>
<td>$896,083</td>
</tr>
<tr>
<td>2015</td>
<td>$1,589,000</td>
</tr>
<tr>
<td>2016</td>
<td>($747,124)</td>
</tr>
<tr>
<td>2017</td>
<td>$2,198,690</td>
</tr>
</tbody>
</table>

In the 2013 budget a fund balance deficit of $353,177 was projected in 2017 as opposed the current projected fund balance surplus of $2,198,690. Additionally, in 2015 a new yearly deduction was added to the fund balance total—compensated absences, which is the value of leave owed to employees. In 2015 this amount was $1,798,000 (for 2017 the amount is $1,900,000). In 2017 another deduction to the fund balance total was added when the working capital deduction was increased from 30 to 45 days (and increase of nearly $600,000). The fact that 2017 now shows a positive fund balance in spite of these additional deductions is a testimony to the District’s prudent fiscal management over the last few years.
One factor in the District’s negative financial picture is the level of funding from Snohomish County. The 2009 Health District Budget, adopted as the 2008 recession was beginning, was the high point of both Health District revenues and of County contributions in gross dollars. The chart below compares 2009 and 2017.

<table>
<thead>
<tr>
<th>Year</th>
<th>County contribution</th>
<th>Health District Revenues</th>
<th>County Contribution as percent of revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$3,253,203</td>
<td>$19,176,471</td>
<td>16.96%</td>
</tr>
<tr>
<td>2017</td>
<td>$2,277,990</td>
<td>$15,439,853</td>
<td>14.75%</td>
</tr>
</tbody>
</table>

In gross dollars, the Health District is receiving roughly $1,000,000 less per year. As a percentage of total revenues Snohomish County’s contribution has declined less significantly, dropping by slightly over 2%.

This decline in funding is partially offset by separate County funding for the Nurse Family Partnership (NFP). Until 2012 the NFP was a part of the Health District and fully funded by it. Beginning in 2012 the Health District cut the program and urged the County to take over funding. The program was transitioned to ChildStrive, who runs the program today and will receive slightly over $400,000 in 2017 from Snohomish County to support it.

The Health District is not alone in facing financial difficulties since the 2008 recession. Snohomish County has also faced a challenging financial situation. While Snohomish County’s General Fund revenues have risen since 2009 (increasing from $206,445,311 to $237,593,592), the increases have not matched increases in costs.

Although Snohomish County’s position is better than that of the Health District it is still difficult. Numerous persons interviewed commented on the County’s financial position and wondered if it was financially wise for the Health District to tie its fiscal health to the County. It was noted that the property tax, a key county revenue, is capped at a 1% per year increase. Continued city annexations will erode sales tax revenues. Current law suits over sales tax could reduce those revenues significantly. One person commented that they did not see an advantage to linking two organizations with financial challenges.
Issues Needing Consideration

Legal Process

Public health services are primarily provided at the county level. Three basic models are used. The most popular is having public health as a county department. Twenty four of Washington’s thirty nine counties use this model. The second most popular is a health district. In this case one or more counties form an organization independent of county government, although counties usually provide significant financial resources and are part of the governing structure. The district is then responsible for public health in the region. These health districts may be multi-county (there are three) or single county (there are six). Snohomish County has a single county Health District. There are also two joint city/county health districts. Washington state law allows for the city/county structure when there is a city within the county that has a population of 100,000 or more.

It should be noted that Snohomish County is responsible for insuring that public health is addressed within the county. RCW 70.05.035 states that “In counties with a home rule charter, the county legislative authority shall establish a local board of health…” This local board may be the County Council, acting as a board of health, or another body created by the Council. It may govern either a county department or a public health agency. But Snohomish County must create the board and organization.

Since it seems unlikely that Snohomish County would respond to the dissolution of the Health District by trying to create a new district, the following discussion assumes the creation of a County department of health. The same considerations, however, would exist were a new district to be created.

The process whereby Snohomish County would take over the provision of public health services in Snohomish County is not entirely clear. The two options are:

- Snohomish County withdraws from the Snohomish Health District and creates a health department within Snohomish County government.
- The Snohomish Health District dissolves and Snohomish County must create a health department within Snohomish County government.

Withdrawal from the Health District has certain requirements. At least six month’s notice must be given and the withdrawal can only take place at the end of a calendar year. Upon withdrawal the County “…shall immediately establish a health department or provide health services which meet the standards …promulgated by the state board of health” (RCW 70.46.090).
There is no clear guidance within state law for what then happens to the Health District. Does it continue to exist if it chooses to? Is it obligated to dissolve? And if dissolved, what process would be followed regarding the assets?

The Health District can petition the court system to be dissolved. Were such a petition to be granted (either as a result of County withdrawal or as part of a mutually agreed dissolution and County assumption), Snohomish County would then be required to create a health department. But would the assets of the current Health District automatically become the County’s?

The answer is unclear. When other special purpose districts are dissolved the assets must be sold, debts paid, and any surplus is then given to the county school districts. Since any County assumption of the District’s public health responsibilities would likely be predicated upon the County using the current District’s assets this could create a problem.

It is possible that an agreement could be made prior to the dissolution which transferred the assets upon dissolution to the County. It would also need to be determined what consideration the District would receive for the assets to establish a binding agreement. It is possible that the agreement to take on the District’s responsibilities would be an adequate consideration. It would be prudent to also obtain agreement from the various school districts that they would not seek any assets. Since dissolution would be granted by the courts it would be crucial to make sure all legal issues were clearly addressed.

**Taxing Authority/Dedicated Revenues**

Several interviewees mentioned the difficulties the Health District faces due to the lack of a dedicated fund source. The most likely scenario which leads to dedicated tax revenues is passage by the voters of a levy lid lift. While generally for a limited number of years it would provide guaranteed funding for that period of time. This is the route Seattle and King County have taken with a number of social service issues like housing and education.

If there is a desire to pursue this option the impact of dissolving the Health District and creating a Health Department must be considered. Those who discussed this issue were generally in agreement that the likelihood of passage was significantly greater if the District was still a separate, independent entity. It was felt that voters would be more reluctant to vote additional money for a County department due to the fear that the money would not in the end be used for public health.

Another consideration is that a levy lid lift would use up Snohomish County’s “banked” levy capacity. Moreover, this potential banked capacity can be used for a permanent tax increase. A
levy lid lift would use up that capacity for a temporary tax. Unless the county were willing to use its banked capacity in this manner it would not be possible to place the issue on the ballot.

It would likely be possible to place a law and justice sales tax increase on the ballot and dedicate part of the funding for public health. However, the same voter concern regarding possible diversion would likely occur.

**General Workforce Issues**

Any assumption of the Health District’s responsibilities involves significant labor related issues. Before going into some detail regarding wages, benefits, and contracts there are several general observations that need to be made.

It is assumed in the following analysis that if the County took over the District’s public health responsibilities it would also desire to take over the Health District staff and programs. Certainly the County would make some changes but to avoid disruption in service delivery it would be necessary to make most of the Health District employees County employees.

The issues surrounding such a move would need to be bargained. The Health District has three unions: the Washington State Nurses Association, the American Federation of State, County, and Municipal Employees, and the Professional and Technical Employees. Snohomish County has many unions, at least some of which would need to be bargained with. The largest, AFSCME, would almost certainly need to be bargained with.

One interviewee mentioned that they had been present at one of the initial meetings between King County leadership and the unions to discuss the Metro merger. Issues similar to those Snohomish County would face in an assumption of Health District responsibilities and employees existed in the Metro merger. At one point in that meeting one of the labor representatives announced that labor intended to look at every contract any bargaining unit had and insist on the best language of all the contracts.

The discussion that follows of various contract issues assumes that the same approach would be taken by labor in a Snohomish County/Health District merger. Certainly, these items would need to be negotiated. But in assessing the impacts of the merger it needs to be remembered that it is unlikely any labor group would without resistance accept less than they have now, or less than other employees had.

Pay dates is one issue that would have to be addressed. Snohomish County pays on the 7th and 22nd of each month. The Health District pays on the 8th and 23rd. Both organizations pay for the same pay period (1st through 15th and 16th through the end of the month). In the event that the
pay date falls on a weekend or holiday the District pays on the next business day. However, Snohomish County issues pay checks on the business day prior to the weekend or holiday.

While these differences may appear minor, they would have to be negotiated. When the County changed pay dates several years ago there were lengthy negotiations involved and compensation was paid to employees. Given that the County pays earlier than the District (and assuming the County would desire to make former Health District employees pay periods conform to existing County standards) such negotiations might be easier than those the County experienced earlier.

Other potentially contentious issues are how existing leave balances, years of service, seniority, etc. would be counted. In an informal conversation with the County AFSCME union they indicated that while they would wish to be fair to the former Health District employees, all these issues would need to be negotiated.

Finally, the processing of over 100 new employees would have an impact on a variety of County departments. Human Resources and Payroll, for example, would have additional one-time costs separate from whatever on-going costs were created.

**Insurance Benefits Costs**

It is reasonable to assume that if Snohomish County brings in the Health District’s employees the unions will seek to place the employees in the most favorable insurance plan. Both agencies provide medical, dental, and vision insurance.

Snohomish County and the Snohomish Health District deal with medical costs in two different ways. Snohomish County is self-insured; the Health District purchases insurance at monthly rates from the Public Employees Benefits Board (PEBB). Consequently, a perfect “apples to apples” comparison is not possible. It is possible, however, to develop the approximate financial impact of Snohomish County taking over Health District employees.

Of the 136 Health District employees, 21 waive their right to insurance. Therefore the number of persons insured is 115. A per employee average cost can be computed by determining what the Health District pays for each employee (it varies by plan and number of dependents) and adding those costs. The average per employee cost is $1,055 per month (see Appendix B for worksheet).

Since Snohomish County is self-insured, the computation must be done differently. When a department is budgeting for a new employee the Snohomish County Finance Department instructs the department to budget $1,495 per month for medical, dental, and vision insurance for each employee. While the actual cost may go up or down dependent on claim history, it seems reasonable to compare these two numbers.
The average difference in cost per employee is $440 per month or $5,280 per year. If one assumes that the 115 Health District employees currently receiving insurance benefits were to move to the County plan the cost of health insurance would increase over what the Health District currently pays by $607,200 per year.

Another factor which would need to be looked at is the potential impact on Snohomish County rates of including the Health District workforce. Snohomish County is self-insured. Generally, rates will go down if a healthier group of employees is added, or up if a less healthy group of employees is added. Generally, health costs rise as the age of employees rise. Slightly over half of the members of the Snohomish Health District employee group are over 55 years of age. It is recommended that before any action to assume the Health District is taken that the County’s insurance broker is consulted regarding possible impacts.

Both agencies also provide their employees with life insurance, including basic Accidental Death and Dismemberment (AD&D). The way each agency provides the insurance is sufficiently different that no financial comparison will be attempted. Note in particular that the Health District benefit is based on salary while the county is based on coverage. The two methods are described below:

**Snohomish Health District:**

- $0.15 per $1,000 of salary (as of Dec 31 year prior)
- Maximum of $150,000 (Non-reps, PTE EH and EH supervisors)
- Maximum of $48,000 (WSNA, AFSCME, PTE APHU)

**Snohomish County:**

- $0.105 per $1,000 of coverage for Life
- $.03 per $1,000 of coverage for AD&D
- $40,000 of coverage for Life and AD&D (AFSCME, Non-Reps, Teamsters LE Support, Clerks)
- $40,000 coverage for Life and $20,000 coverage for AD&D (Teamsters Corrections Support, Corrections Guild, IAFF, Teamsters Corrections Sgt/Lts, Teamsters, Corrections Supervisors)
- $60,000 of coverage for Life and ADD (DSA, SOMT)

Snohomish County also provides all employees except DSA, SOMT, and IAFF with Long Term Disability Insurance for which it pays 0.438% of covered payroll.
Salaries

Should the county take over employees of the Health District it is inevitable that job classifications at some point will be reviewed. While it is impossible to fully understand the impacts without a level of detail which is beyond the scope of this project, an attempt was made to assess possible impacts.

A selection of job descriptions was obtained from the Health District and then submitted to Snohomish County Human Resources. They were asked to do an initial, high-level review to see what Snohomish County job classifications might match. Six positions were determined to have a close enough match for some salary comparisons.

It needs to be noted that there are significant differences between the salary schedules in terms of structure. These differences will need to be further evaluated for the financial impact.

For four of the positions reviewed the Health District schedule includes either 7 or 8 steps while the county positions include 5. Were the county salary structure to be adopted for former Health District employees they would rise to the top step earlier. Additionally, the steps are implemented differently. In all cases a new employee (unless special circumstances were present) would begin on step 1. Health District employees advance to step 2 after 6 months and then advance yearly. County employees advance to the next higher step yearly.

Below is a comparison for the four positions. Each shows the starting step, top step, and percentage the county monthly pay rate is over or under the Health District’s monthly pay rate. In the last two examples (Health District Administrative Assistant and Executive Assistant) Snohomish County Human Resources indicated that the Snohomish County positions, while somewhat comparable, also reflected a lower level of work responsibility.

<table>
<thead>
<tr>
<th>Position</th>
<th>HD Payroll Analyst</th>
<th>Co Payroll Tech 3</th>
<th>Snohomish County % under or over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Step</td>
<td>$3,956</td>
<td>$4,616</td>
<td>16.68%</td>
</tr>
<tr>
<td>Top Step</td>
<td>$5,301</td>
<td>$5,614</td>
<td>5.90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position</th>
<th>HD Program Assistant II</th>
<th>Co Recording Assistant</th>
<th>Snohomish County % under or over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Step</td>
<td>$3,254</td>
<td>$3,443</td>
<td>5.81%</td>
</tr>
<tr>
<td>Top Step</td>
<td>$4,361</td>
<td>$4,187</td>
<td>(5.35%)</td>
</tr>
</tbody>
</table>
As can be seen, while it is not always the case, generally the county wage rates are higher.

For the other two positions the Health District schedule included either 7 or 8 steps, while the County structure included 15. The 15 step County salary schedule includes the potential for a merit increase every six months. While this has not been the practice in recent years, were the employee to consistently receive merit increases they would reach the top step in seven years instead of fifteen. The Health District again has an increase to step 2 at six months and then yearly advancement after that. The comparison of the two positions is below.

The county positions in these last two examples are significantly higher than Health District positions. Again, it must be remembered that Human Resources did a quick analysis. A full classification study might yield significantly different results.

One final item that must be considered is the impact of future COLAs and insurance increases for former Health District employees if the County assumed the Health District’s responsibilities. Currently, Snohomish County provides the Health District with a relatively static amount of
funding per year. The County does not include additional funding to address COLA and insurance increases. Were the County to merge with the Health District it would need to address both every year.

Deferred Compensation

While both Snohomish County and the Health District offer deferred compensation programs the County provides for an employer match and the Health District does not. Snohomish County provides a $.50 match per $1.00 of contributions up to 1% of the employee’s monthly base salary. It seems likely that Health District employees who became County employees would also receive this benefit. Without extensive analysis a solid estimate is not possible, but it seems likely that the impact would be tens of thousands of dollars or more.

The Health District also has different deferred compensation providers (Nationwide and Washington State Deferred Compensation). Snohomish County has an exclusive relationship with Nationwide. It is possible that making the change to bring Health District employees into the County system of Nationwide only would require negotiations.

Contract Differences

In addition to wages and insurance benefits there are many other contract provisions which would be relevant. This analysis made no attempt to delve into the details of contract language dealing with grievances, union activities, management rights, recruitment, etc. Such an analysis would be wise prior to any decision to proceed with the merger. The focus of this report is on contractual items are most likely to have a financial impact. The following are some areas of difference between the County and Health District contracts.

Bilingual Pay

- All Health District Contracts provide for:
  - $50 per month for employees who have demonstrated the ability to communicate in a foreign language
  - $100 per month for employees who are certified interpreters
  - Such pay will only be paid when the ability to use the particular language is a preferred qualification for the position.
- County contracts do not have this provision

Holiday Pay

- County AFSCME employees receive holiday pay plus double time on Thanksgiving Day and Christmas Day
- Health District employees receive holiday pay plus time-and-a-half on Thanksgiving Day and Christmas Day

**Trial Service Periods:**
- Most Health District contracts provide for a six month trial service upon hiring
- AFSCME contract provides for a twelve month trial service except in certain circumstances.

**Longevity Pay**
- All Health District contracts provide for longevity pay:
  - $30 per month after 10 years
  - Additional $30 per month after 15 years
  - Additional $30 per month after 20 years
  - Additional $30 per month after 25 years
- County AFSCME has no provision for longevity pay

**Annual Leave**
The chart below compares the annual leave earned at the Health District with that earned in the AFSCME contract at the county.

<table>
<thead>
<tr>
<th>Health District-Years of Service</th>
<th>County-Years of Service</th>
<th>Vacation earned in days</th>
<th>Vacation earned in days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>Year 1</td>
<td>12</td>
<td>10 1/2</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 2</td>
<td>13</td>
<td>12.05</td>
</tr>
<tr>
<td>Year 3-5</td>
<td>Year 3-5</td>
<td>15</td>
<td>15.065</td>
</tr>
<tr>
<td>Year 6-9</td>
<td>Year 6-9</td>
<td>18</td>
<td>18.0775</td>
</tr>
<tr>
<td>Year 10-11</td>
<td>Year 10-11</td>
<td>21</td>
<td>21.0913</td>
</tr>
<tr>
<td>Year 12-13</td>
<td>Year 12-13</td>
<td>22</td>
<td>22.0863</td>
</tr>
<tr>
<td>Year 14-15</td>
<td>Year 14-15</td>
<td>23</td>
<td>23.1088</td>
</tr>
<tr>
<td>Year 16-17</td>
<td>Year 16-17</td>
<td>24</td>
<td>24.1038</td>
</tr>
<tr>
<td>Year 18-21</td>
<td>Year 18-24</td>
<td>25</td>
<td>25.1</td>
</tr>
<tr>
<td>Year 22+</td>
<td>Year 25+</td>
<td>30</td>
<td>28.1125</td>
</tr>
</tbody>
</table>

Although there is significant similarity in the middle years, the Health District starts with a higher number of vacation days (12 v 10.5) and ends with a higher number of vacation days (30 v. 28.1125). The Health District vacation schedule also reaches the top end quicker (top end at 22 years instead of 25 for the county).

In addition, Health District employees can accumulate up to 320 hours of vacation. County AFSCME employees can only accumulate up to 240 hours. Upon separation both Health District and AFSCME employees can cash their
leave out, but because of the ability to accumulate more it is possible for Health District employees to cash out a larger balance.

**Sick Leave**

While both the Health District and County sick leave systems provide for the earning of eight hours per month, they are structured quite differently. Consequently, a side-by-side comparison is difficult. Additionally, there are minor differences between the Health District contracts. A summary of the provisions of each system is below. Please note that for simplicity’s sake certain minor differences between Health District contracts are not shown.

- **Health District:**
  - Upon separation the employee can cash sick leave out
    - Cash out rate depends on the date of hire and years of service
    - No cash out prior to 7 years of service
    - Hired prior to 1/1/2015
      - 7-14 years—25% of value
      - 15+ years—50% of value
      - No maximum cash out amount
    - Hired after 1/1/2015
      - 7+ years—25% of value up to a maximum of 1,000 hours
    - If employee has over 600 hours, can convert leave earned in preceding 12 months to cash (20% of value) or annual leave (25% of value)
    - Upon death compensated for 100% of leave balance

- **County AFSCME:**
  - Upon separation the employee can cash sick leave out
    - Cash out rate depends on years of service, ranging from 40 hours with 5-10 years to 192 hours with 20 years or more with no deduction in value
    - Upon termination if 65 and 20 years of service receive 10% of the remaining balance
    - Retirees may convert any remaining sick leave at the rate of 100 hours for one month of medical coverage up to a maximum of 12 months
  - No mention of payment upon death
**Contract Expiration Dates**

Snohomish County has a contract with AFSCME running until the end of 2018. All Health District contracts expire at the end of 2017. The County AFSCME contract provides for a COLA of 2.5% in 2018, which Health District employees would likely expect as the minimum in any negotiations.

**Capital Issues**

In general, the Snohomish Health District presents itself as having extensive capital needs. The following analysis is based on reported needs, without a detailed independent examination of the capital needs of the District.

Information technology is an area of particular concern. In one case a Health District employee reported she did not use certain of the District’s financial software, not trusting it and believing that Excel was superior.

In the past year the Health District and County have been in the process of negotiating a contract under which the County would provide the District with Information Technology services. A contract is now in place for basic support. During discussions regarding a more robust support contract various Health District systems were reviewed. Snohomish County Department of Information Services (DIS) produced an estimate of slightly over $215,000 as necessary to cover depreciation on Health District technology and allow it to be placed within the County’s equipment replacement cycle.

Major Health District software systems might also need significant financial investment. The Finance system is currently undergoing an upgrade and would not need any additional improvement at this time. County DIS believes it is likely that the Health District network system would need to be upgraded or replaced.

In Environmental Health there are needs for upgrades, some of which will be paid for with a fee surcharge currently in place. Whether the surcharge is adequate for all necessary upgrades is not clear. Users would like the ability to submit septic plans electronically (currently not available). It would also be useful to be able to access the DAVE system (all old septic as-builds) on-line. It is instructive that for Health District staff to access the County’s AMANDA system it was necessary for County Planning and Development Services to pay for the hardware and give it to the Health District.

Another consideration is the conversion of Health District data (financial, employee, etc.). There is a belief on the part of many Health District and County interviewees that data imports to the County systems would be relatively easy. There were some interviewees, however, who
cautioned that this conversion might be more difficult than anticipated. Certainly, costs would increase significantly if data had to be manually inputed.

District employees have reported that the fleet is aging and in need of replacements. The 2015 Operations and Maintenance Capital Request stated:

“The District fleet includes 43 vehicles, all exceeding the anticipated useful life of 6 years… The District’s Capital Improvement Plan anticipates slowly replacing older, higher mileage vehicles,” (p. 3)

In the event the County decides to move forward with a merger Fleet Management should review the age and condition of all Health District vehicles.

Finally, while small items in themselves, any merger may require new business cards, signage, fleet labels, phone numbers, etc.

**Rucker Building**

The Health District owns the building on Rucker Avenue. There are issues involving the building including maintenance needs, excess space, the possible sale, and ownership.

The maintenance needs of the building are significant. McKinstry performed a building assessment in July of 2015. While other issues were also identified, the primary needed improvements and their costs are:

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVAC replacement</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Electrical and Wifi upgrades</td>
<td>$162,000</td>
</tr>
<tr>
<td>Misc. painting, etc.</td>
<td>$145,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,307,000</strong></td>
</tr>
</tbody>
</table>

The 2017 Health District budget included funding for the building improvements shown below:

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVAC replacement</td>
<td>$1,048,181</td>
</tr>
<tr>
<td>Carpeting replacement</td>
<td>$105,000</td>
</tr>
<tr>
<td>Parking lot security</td>
<td>$100,000</td>
</tr>
<tr>
<td>Customer service counter replacements</td>
<td>$150,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,403,181</strong></td>
</tr>
</tbody>
</table>
The improvements programmed in the 2017 budget come with caveats. The customer service counter improvements are to be further refined before proceeding. The other three items are all on hold pending a final decision on selling the Rucker Building.

As noted earlier, the Health District’s staff has declined by nearly 40% since 2008. As a result, the building has more space than the District can use. Additionally, the large atrium, while an amenity, is not the most efficient use of space. In 2016 the Health District approached the County to discuss the possibility of a loan for necessary improvements which might make space in the building more attractive to potential tenants. The Health District does have one tenant, the IRS, which provides over $200,000 per year in revenues to the District.

On November 28, 2016, the Health District Real Estate Committee met to discuss the possible sale of the building. The District would then either lease or purchase space which was more closely in line with its space needs. Further, the large capital improvements being considered could then be deferred, with the building being sold “as is”. At that meeting they were presented with a report by Workman Real Estate Services which valued the building at $8,500,000 in its current condition.

Any decision on the sale must be deferred until ownership issues are cleared up. The Rucker Building was purchased in 1990 for $5,150,000 with the assistance of an interlocal agreement (ILA) to finance the purchase. Snohomish County, 20 cities, and the Snohomish Health District all were part of the ILA. In addition, while Mukilteo was not a party to the ILA, it was assessed the same per-capita contributions for the financing of the building as the other entities.

A down payment was made of $1,174,270. The down payment was shared by the Health District, Snohomish County, and the cities. The balance was financed through a loan from Snohomish County. When the loan was paid off in 1995 the amounts contributed by each of the groups over the six year period was:

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health District</td>
<td>$6,403,719</td>
</tr>
<tr>
<td>Snohomish County</td>
<td>$1,438,288</td>
</tr>
<tr>
<td>Cities</td>
<td>$1,096,342</td>
</tr>
<tr>
<td>Mukilteo</td>
<td>$64,596</td>
</tr>
</tbody>
</table>

Mukilteo is listed separately because it was not a part of the ILA, but did make the same payments as the ILA members. All figures are from the spreadsheet attached to the agenda of the Real Estate Committee meeting on November 28, 2016.

While the ILA did not specifically address the topic of shared ownership the District told all the parties at the time that they would each own an interest in the building. In 1995, just prior to the
completion of the ILA (which expired when the loan was paid in full) the Board of Health adopted Charter Article VIII. The Article appears to provide for a legal mechanism whereby the various local governments could be reimbursed in the event the building was sold or “…Snohomish County assumes sole responsibility for public health governance as provided by law…” (Charter, p. 8)

The second provision, addressing as it does the possibility of Snohomish County taking over the District’s responsibilities, is very relevant to this report. However, following the adoption of Article VIII, there is no evidence that any of the legal steps to establish ownership interests of any of the participants in the purchase were taken.

The Snohomish Health District has paid all insurance, utilities, maintenance, repairs, and capital improvements for the building for over twenty years. It should also be noted that Snohomish County quit claimed its share of the building to the Health District in 1996 and some of the cities may have done the same.

Given the above, it is clear that the legal ownership of the building is unclear. If one assumes, however, that each entity has an ownership equal to its participation in the purchase, the following percentages of ownership would exist:

<table>
<thead>
<tr>
<th>Entity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health District</td>
<td>87.1%</td>
</tr>
<tr>
<td>Cities</td>
<td>12.2%</td>
</tr>
<tr>
<td>Mukilteo</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Note that the above shows Snohomish County’s equity as part of the Health District’s share in light of the 1996 quit claim. The chart also shows an ownership share for Mukilteo, although since the city did not sign the ILA, the ownership could be questioned.

**Fund Balance Issues**

Snohomish County and the Snohomish Health District treat fund balance in very different ways. These differences create a number of issues which will have to be addressed in the event the County assumes the Health District’s responsibilities.

For 2017, the Health District has a fund balance of $6,698,690 (after deducting $251,029 to cover the shortfall in 2017 between expenses and revenues). However, the Health District reserves parts of that balance for other uses. These reserve amounts for 2017 are shown below.
The remaining balance, however, needs to be evaluated in light of the capital improvements planned for 2017. As noted in the Capital Issues section of this report the District plans on $1,403,181 in capital improvements in 2017 if the building is not sold. The remaining balance is $795,509.

Were the County to take over the Health District it can be assumed that its fund balance policies would apply. The County maintains a fund balance of about 10% of the previous year’s revenues, which is approximately $23,000,000. It includes no deductions for an Emergency Reserve, Working Capital, or Compensated Absences (although the last is noted in the County’s Comprehensive Annual Financial Report).

Neither approach is “wrong” or “right”. They are simply different ways of doing things based on the differences between the two agencies. As a smaller organization with no dedicated tax revenues it is reasonable for the Health District to structure its fund balance in this manner. Snohomish County, with $23,000,000 in fund balance available and dedicated tax revenues, can reasonably take a different approach. Snohomish County’s practice is to treat fund balance as including these funds for emergencies and revenue shortfalls.

The question then is what use would the County make of the Health District’s fund balance in the event of a merger. Depending on the decision regarding the Rucker Building, a deduction to fund balance might be necessary. If the building were not sold, the $1,403,181 in capital improvements would need to be made. Additionally, it may be necessary to compensate the cities for their share of the building equity. The earlier analysis placed the potential percentage of ownership at 12.9% (all cities including Mukilteo) of an $8,500,000 building making the payout $1,096,500. The remaining fund balance would be $4,199,009.

If the Rucker Building were sold, it is unlikely any deductions would be necessary. Certainly the capital improvements to the building would not be made. Any potential reimbursement to the cities would likely come from the proceeds of the sale.

In either case, between $4,199,009 and $6,698,690 would be available for use. It would be questionable to use one-time funds for operating expenses. It is possible that the money could be
used for other one-time capital expenses. However, it seems the most likely scenario would be to add it to Snohomish County’s fund balance total.

As noted earlier, Snohomish County’s current fund balance is slightly above 10%. The County has a goal of increasing the amount to 11%. The impact of adding these additional amounts to the fund balance would be to increase it between 0.8% and 1.8%.

Consequently, if following merger the County decided to keep the building, the fund balance would be increased to approximately 11%. If the County decided to sell the building, the fund balance would be increased to approximately 12%. In either scenario the County would achieve its goal of a fund balance of 11%. While there are other ways these funds could be used, this seems the likeliest outcome.

**Legal Liability/Risk Management**

The question of how taking over the Health District’s responsibilities would impact the County’s potential liability and risks needs to be examined. The Health District carries all coverages that the County does with the exception of pollution coverage. Total dollar amount of coverage is $20,000,000, compared to $50,000,000 for the much larger County. The Health District’s insurance has relatively small deductibles—$10,000 is the highest.

Its claim history is also relatively good. No claims were filed in 2011-2014. Three claims have been filed against its insurance since. For the period 2009-2017 the total Gross Reserve associated with claims is less than $900,000, or an average of less than $100,000 per year. This compares favorably with the County’s experience.

The District’s insurance costs are also low. Premium cost is $138,040 per year. If a merger occurred, the County should consider keeping the current insurance package for a new Health Department.

However, once the Health District was part of the County it is possible it would become a more likely target of claims. A larger organization, with deeper pockets, might be more likely to be sued. It is also possible that persons who would hesitate to sue a public health agency would not hesitate to sue the County.

Additionally, there may be financial liabilities associated with the Rucker Building. The County would want to ascertain what hazardous materials might be in it, what its seismic status is, whether it had adequate fire and security systems, and other similar issues.
Affordable Care Act (ACA)

One important factor in the shift in the focus of public health discussed earlier in this report was the passage of the Affordable Care Act. The Snohomish Health District has cited the increased number of Americans with health insurance as a key consideration in a number of recent decisions it has made to move away from direct client services. In the 2014 Strategic Plan Update it noted:

> With health insurance more widely available to every U.S. citizen, it is becoming more possible for the District’s current clients to access comprehensive medical services through providers in the community. (p. 5)

The District sees care as being more efficient, comprehensive, and cost-effective when carried out through a “medical home”. There is general agreement in the public health community with this approach. Congress recently considered repeal and replacement of the ACA. While currently on hold, there is no doubt there is significant Congressional interest in still pursuing this goal. The Congressional Budget Office (CBO) evaluated the original House proposal. The CBO projected the number of people losing health insurance this year if the proposed bill had passed to be 14,000,000. Any consideration of the County assuming the Health District’s responsibilities will need to assess this possibility.

Interviewees who are involved in the provision of or policy planning of health care were asked their views. There is widespread agreement that if the Medicaid expansion of the ACA goes away there will be an explosion of the uninsured. The Community Health Center of Snohomish County is one provider of health care to low income Snohomish County residents. They alone reported that 8,000 of their clients were part of the Medicaid expansion. The Herald reported on February 22, 2014, that over 22,000 Snohomish County residents were newly covered by Medicaid. That number may well have grown since.

Most interviewees did not believe repealing the ACA should change the focus of public health. Not only do they believe that it is not financially feasible for public health to fill such a gap but they also believe it is not the proper focus for public health. The proper role for public health would be to work with community agencies and providers to encourage them to provide services, not provide them itself.

That said, interviewees also believed there might be some cases where the need would be so great that public health would have to step in. A number indicated that there would be a great deal of public pressure to provide direct services once again.
Another concern raised by several interviewees was the danger of rural areas being particularly hard hit. Urban areas have more clinics, pharmacies who provide shots, etc. While this may not be as significant a problem in Snohomish County (where urban areas are 30-60 minutes from most rural areas), the possibility of significant rural impact and related pressure for public health to provide services should be considered.

**Culture**

One aspect of any merger that will be a challenge is making the two work cultures mesh. No effort was made in this report to study culture per se. However, in the process of interviewing people some interesting comments were made about the attitudes toward customer service in the two organizations.

A number of interviewees touted the customer service aspects of their organization while criticizing the other as not customer oriented. This is because the County and Health District seemed to have different focuses for customer service. Snohomish County interviewees tend to focus on technology: customers can look things up on-line, there are efficient phone trees to route customers to the right person, materials can be submitted electronically, etc. Health District interviewees focus on the personal: short lines to immediately see someone, people answering the phone directly, no need for appointments, etc.

One interviewee who works with both agencies made similar points, agreeing with both views. Internet access is a real plus at the County which makes this individual’s job easier. At the Health District customers can just drop in to talk to someone (making their job easier) while the County often requires an appointment. The personal relationships with customers are better at the Health District for these reasons.

These comments are not designed to criticize either customer service model. Partly it is a natural function of size: the larger County organization is of necessity more structured and has more access to technology. Further, a relatively small number of interviewees addressed the issue of customer service. However, in any merger care should be taken to take the best of both.

**Perceived Advantages of Merger**

**Positive Impacts on Health District Workforce**

Health District employees who were interviewed, while having mixed feelings about a merger, were very positive about how it would impact their employment situation. One area in particular that was focused on was that of potential advancement. Snohomish County, with both a larger
number of jobs and more varied responsibilities, was viewed as providing many more opportunities to move to a higher paying job and/or switch career tracks.

Health District staff also expressed exhaustion with the constant pressure of budget cuts. One employee indicated they had left a job they enjoyed after being placed on a layoff list for multiple years in a row. It needs to be remembered that whenever layoffs happen at the Health District a complex “bumping” system must be implemented. Consequently, laying off a few people can impact the jobs of many more employees as employees with more seniority “bump” employees in entirely different areas.

District staff saw merging with Snohomish County as creating a stable financial situation which would end these problems. Given the County’s own financial issues that is clearly not a certainty, but it was generally perceived that way.

Several interviewees referenced the budget pressure as also creating difficulties in recruiting new staff. This is of particular concern given that over 50% of the current workforce is 55 years old or older. There will be a major need to hire new employees in the next decade. It can be difficult to get the best possible applicants to apply when it is well known that the financial position of the agency is precarious. It was believed by these interviewees that merging with the county would alleviate the recruitment problem.

A final issue is that of “depth” of experience. This problem was identified as not a problem for individuals but for the organization. It is an inevitable consequence of size. The Health District currently receives basic technology support under a contract with Snohomish County. It has interest in expanding the scope of the contract. While Health District IT staff is quite competent, the limited number of staff means that the range of expertise is significantly less than that of the County. Similarly, Health District Human Resources is currently interviewing companies for building maintenance services, an area with which they have little experience, because the Health District does not have a Facilities Department. Human Resources is also in charge of Risk Management and Fleet. The ability to access the larger workforce with greater “depth” of expertise, was seen by a number of interviewees as a key benefit of merger.

Accountability

A number of interviewees indicated that the current Health Board structure does not create clear lines of accountability. Board members represent their cities or the county. They are chosen based on city and county elections, for positions that have no clear connection to public health. If the County took over the Health District, the Executive and County Council would clearly be responsible for public health decisions.
It was also noted that in the current structure two-thirds of the Board are from cities who, until this year, had provided no funding. Even now the city contribution is a comparatively small portion of the budget. Budget decisions have been made in the past based on the votes of Board members who had no “skin in the game”. With the County Council acting as the Health Board there would be funding alignment, with the same people who were responsible for funding public health making the decisions regarding it.

From the County’s perspective, it would also align Health District priorities with County priorities. One interviewee reported that as the opioid crisis grew the County approached the Health District for support. The response was that District was very interested but would need to finish creating rules and policies around vaping before focusing on opioids. This interviewee believed that if the District had been part of the County structure a more timely response would have been made.

**Ability to Influence Policy**

As was discussed in the “Changes in the Focus of Public Health” section of this report, public health is increasingly focusing on being the “leading convener and planner”. Mobilizing multiple groups in society is a key strategy. A number of interviewees felt that being part of Snohomish County government would enhance the Health District’s ability to play this role.

Partially this is a function of size. The Health District is a comparatively small agency and not well recognized by the general public. People are confused as to what it does, particularly in terms of some of the areas associated with population based public health (walkways and gun safety for example). Snohomish County is seen to have more visibility and clout.

One individual argued that the County could bring Boeing and other major employers to the table to discuss health issues while it was much more difficult for the District. The belief is that by becoming part of Snohomish County public health would become more visible in the community, have a louder voice, build broader coalitions, and be more successful in achieving its goals.

**Efficiency**

There were numerous comments by interviewees about the possibility of economies of scale and efficiencies that might result from the County taking over the Health District. A common theme was that there are almost always overlaps in bureaucracies and that this was especially true when discussing two totally separate agencies.
On the service side, synergies between drug and alcohol programs, mental health and jail services, water quality, and septic permitting were items that were specifically mentioned. There were also a number of generic mentions of overlap between the people the County (particularly Human Services) serves and those the Health District serves. It was felt that duplications or misaligned services could be avoided by a merger. It was also noted that the assessment function of the county could be enhanced by having direct access to the Health District’s assessment unit.

One area that was discussed by almost all interviewees was the possibility of savings in the “back office” functions like Human Resources, Finance, Accounts Payable, Payroll, Fleet, Technology, and other administrative functions. There was disagreement regarding which functions might make sense.

Many respondents also cautioned that the cost savings should not be overestimated. County interviewees generally indicated they could not just absorb the additional workload. One example given was that if the Health District had four staff doing a task, the department could probably do it for them with three more people. The key take away is that it was unlikely that whole functions could be eliminated at the Health District and provided by the County without significant (although slightly less than the combined total) new staff. This subject will be further explored in later discussion of the possibility of a “Hybrid Option” (see page 48).

One interviewee, who had been directly involved in the transitioning of service from the Health District to a private provider also noted that it was more cost effective at the private provider. Their perception was that overhead costs at the Health District were higher than at the private provider. This observation raises the need to carefully analyze the overhead costs of the County compared to the Health District. If general overhead costs are higher at the County, savings from economies of scale might be lost to the higher overhead. If general overhead costs are lower, the savings would be compounded.

**Elimination of Silos**

Many of the interviewees commented on the opportunity to end silos of services. While related to the issues discussed above regarding efficiencies, this subject was prominent enough to deserve specific discussion.

Both the Health District and Snohomish County were perceived as having silos. Not only were services between the two organizations seen as separate, but even the services within each agency were seen as siloed. It was recognized that attempts were made by both to work across the silo-related boundaries but it was believed this would be improved by merging the two.
Human Services was often mentioned as an example where synergies might be created by the merger. There might be advantages to a medical continuum, particularly for early childhood services. By having First Steps, Head Start, ECAP, etc. under a single agency which included public health, services to clients might be more effectively delivered. King County was cited as an example of how being in the same agency allowed programs to more easily borrow from each other’s expertise.

Mental health was another area mentioned. While Medicaid and emergency mental health services are provided by a third agency, the North Sound Behavioral Health Organization, these services are closely integrated and monitored by Snohomish County. The Health District is perceived to have little connection to mental health services, which are clearly a key component of the overall health of the public. Making the Health District a part of Snohomish County government might address this disconnect.

There are also perceived advantages in terms of broader population based health needs. The built environment—parks, safe walkways, housing—are all County issues. But from a population based perspective, they are all also public health issues. By combining both elements in the same agency it is likely that more collaboration on these issues would take place.

A specific area that was often mentioned was the coordination of septic permits between the Health District and County Planning and Development Services. While the two do work together (witness the provision of a computer and AMANDA access by the County), customers have to go to the Health District for part of the septic process and to the County for the other. It would be far more convenient if the customer could go one place and complete the process.

One particular item that was mentioned by several interviewees was how the Health District’s (and to a lesser degree the County’s) funding streams contributed to silos. Much of the Health District’s funding comes in the form of grants for specific purposes. Programs must sometimes be designed to meet grant requirements rather than be fully integrated into other programs in what might be a more effective manner.

One leader of a non-profit mentioned how even in his relatively small agency (30 employees) silos exist. It needs to be remembered that while it is very possible to improve communication, it is unlikely that silos can be completely eliminated.
Perceived Disadvantages of Merger

Bureaucracy

Snohomish County is seen as significantly more bureaucratic than the Snohomish Health District. This perception is partially based on size and partially on the experience of Health District staff. Examples were cited of the District negotiating agreements with the County which took a year or longer. It was also mentioned that turnaround on legal issues is much quicker at the Health District.

Conversely, the Health District is portrayed by some interviewees as nimble. When an issue comes up the response is very quick. Nimbleness is particularly important when dealing with health emergencies. By their nature, these emergencies cannot be anticipated. As one interviewee put it “public health issues pick you”. Yet also by their nature, public health emergencies require quick, effective responses. The District’s response to H1N1 (one interviewee described it as one of the best in the country) was cited a number of times as an example. Whether the County could have responded as quickly was considered questionable.

One interviewee indicated that one of the most pressing needs of the Health District was to become more efficient. They doubted that becoming part of the County would accomplish that goal.

Loss of Public Health Focus

A number of interviewees were concerned that public health would get “lost” or “swallowed up” as part of the much larger County. There were concerns that the Health District would lose public visibility and have a harder time leading on important issues as a result. One interviewee also indicated that the Health District’s independence allowed it to move in certain circles related to health that it might not be able to access as part of the County.

Another concern was how much of a priority public health would be for the County. Currently, public health is the only priority of the Health District. But as part of the County, the leadership (Executive and Council), would have many other priorities as well. In a public health emergency would the focus be on it or on a bargaining crisis, development issue, or other county priority? If there were a mumps outbreak would the County communication staff focus on that issue or the new economic development initiative of the Executive or Council?

Directly related to these concerns was the concern that public health needs a strong, independent voice. That voice currently is the Health Officer. As an employee of the County, that independence would be significantly less. One of the advantages mentioned above was the
opportunity to align Health District priorities with those of the County. Yet the opposite is also true—it might be a disadvantage for the Health District to no longer be able to independently set public health priorities without reference to the County.

One final point was raised. One interviewee felt that public health policy was highly specialized and that the County simply did not have the relevant expertise.

**Politization**

Following directly from the fear of loss of independence is the fear that public health issues would be politicized. Due to the indirect nature of the current Health District Board (members are elected to other offices and then serve as one duty on the Board) the District is shielded in many ways from electoral politics. Were public health to become the direct responsibility of the elected County Executive and Council the possibility for electoral politics and public health to become intertwined becomes more significant.

Public health could be impacted in several ways. Campaigns might focus on efforts to change septic rules, loosen food safety requirements, prohibit needle exchanges, or other health policy. While these kinds of issues still get addressed in the Board setting today, there is a distance from the political. That distance may disappear with the assumption of Health District functions by the County.

Related are concerns about the areas in which the Health District currently provides oversight of the County. The Health District has oversight of whether or not closed landfills are being properly maintained to protect public health. Fixes to problems with landfills can be very expensive. Interviewees worried that as part of the County public health might not adequately pursue problems or even be pressured to ignore them.

Under the current system both the County and Health District have a role in the granting of a permit for a septic system. Interviewees expressed fears that political pressure might be applied to the public health process to either grant or deny septic permits. And when a septic system fails, would the County be willing to red tag a house? And if it did, would pressure come to bear to change that decision?

Similarly, clean water issues, insofar as they relate to failed septic systems, is a Health District issue. Concerns were expressed that losing the oversight function of a separate Health District might lead to politicization of these decisions.
Lastly, local groups opposed to development often believe that the County does not adequately enforce environmental laws and regulations now. It needs to be considered what the public perception would be if these functions were placed entirely under County control.

**Competition for Funding**

A number of interviewees noted that County revenues were already constrained. In taking over the Health District, Snohomish County would be accepting new responsibilities and liabilities with no revenues beyond what the Health District already possesses. Indeed, it is possible the County would lose the revenue which the cities have promised for 2017 if the merger occurred.

Interviewees were concerned that in the event of a budget shortfall the County would not continue to fully fund public health. And if not, what public health programs would be cut? Today the Health District controls its own destiny to some extent. While in many ways it does not determine its own revenues, it does control how it spends them. This independence would be lost with the merger.

Interestingly, some County interviewees expressed the opposite concern. In a budget shortfall would existing County services be cut to provide funding for public health? They felt there was more than enough competition for County funds currently. Several County interviewees indicated they saw no or little advantage to the County to any merger.

**Other Potential Disadvantages**

A number of interviewees felt that certain Health District services would be difficult to integrate with the County structure. WICS, food safety, the Refugee Health Program, dental, communicable disease, epidemiology, and emergency preparedness were all mentioned. In general, those services with the closest ties to direct medical services were seen as most difficult.

Two interviewees who had been through mergers indicated that there might be significant resistance by Health District (and possibly County) staff who feared losing their jobs. Communication would be essential to reduce employee fears as much as possible.

**Structure Following Merger**

**Department/Division**

All interviewees were asked how they felt the merger should be structured in the event it took place—Health Department, Health Division, or broken up between a variety of departments.
Opinions were divided. However, in most cases interviewees saw little difference between the department and division options so both will discussed together in this section.

The primary reason for bringing the Health District in as a department/division was that breaking pieces up into other County departments would result in a loss of the public health focus. There was a feeling that an entity that constantly focuses on public health was necessary. There was also a high level of concern that existing Health District synergies would be lost.

For example, it was reported that now if the Communicable Disease Division receives a report of *e.coli* employees can simply walk it over to Environmental Health which can follow up with restaurants who might be involved. This might become more problematic if Communicable Disease was in Human Services and restaurant enforcement were with the Auditor.

Another concern was that it was important that the Health Officer be the visible face of public health. It was felt that this was facilitated by having a health department or division. At the same time a number of interviewees also discussed how a health department should be led. Most felt that the department should have an administrator who was not the Health Officer. The direction the Health District is currently taking to separate the two was seen as positive.

If moved to the County as a division instead of a department, the general consensus was that it should be placed under Human Services. It was felt that there was significant overlap between what public health and the Human Services Department do.

There was also some feeling that moving to the County would already be a significant change and shock to the organizational system of the Health District. Breaking it up and placing different parts in different County departments was seen as much more disruptive. There were concerns that in doing so existing structures and processes would be lost or confused with the result that backlogs would result.

Interviewees discussed the possibility of moving functions currently being performed by existing County departments to a newly created Health Department. While respondents were interested in the concept, there was no clear pattern of suggested movements. It should be noted, however, that both Health District and County interviewees mentioned that the County might want to consider making use of the Health District’s assessment personnel.

It must be noted that this discussion concerns Health District services to the public. It is assumed that in the event of the County assuming the Health District “back office” functions would be taken over by existing County departments.
Variety of Departments

Interviewees who favored separating Health District functions saw a number of benefits to that approach. It would align Health District functions with County departments. Placing subject matter experts together was seen as a way to create synergies that would be efficient.

Separating Health District functions was also seen as a way to make services more consumer friendly. For example, septic permits could truly be a “one-stop shopping” situation. Additionally, it was mentioned that moving the Health District into the County intact would simply preserve existing management and silos. One interviewee with experience in mergers stated that cost savings were only achieved if the organizations were truly integrated.

There was also discussion of what Health District functions might go to which County departments. Some of the ideas suggested are listed below:

- Vital Statistics—Auditor or Medical Examiner
- Food Permits—Auditor
- Restaurant Inspection—Auditor or Planning and Development Services
- Landfills—Solid Waste
- Septic—Planning and Development Services
- WIC, First Steps—Human Services
- Emergency Preparedness—Department of Emergency Management

As noted earlier, there were concerns raised over the potential for problems with oversight should the Health District be taken over by the County. During the course of this project nine other counties were contacted. Six have Health Departments and two have Health Districts. Since the two districts are separate organizations they do not have to worry about conflicts regarding oversight issues.

Conflicts in the other six can manifest in two ways. First, as discussed in the section on “Politicization", there is the danger of other elements in the local government pressuring the Health Department to approve or disapprove a project for reasons that have little to do with public health. This issue has already been discussed adequately.

Second, however, is the possibility that the oversight functions are not within the Health Department but within the very department being overseen. The two most often cited concerns were with placing solid waste and/or septic functions in a non-health department setting. Two of the nine counties contacted have the public health septic functions within their development
departments (Pacific and Grays Harbor). In addition, until approximately four years ago, Cowlitz did the same.

Combining in this way is usually done because of a desire to provide “one-stop shopping” for persons who are seeking septic permits. Some interviewees did report that when all septic functions were in the land development department there was a sense that the public health officials were acting as land development regulators rather than public health protectors. One of the reasons that Cowlitz County moved the public health functions back to the Health Department was this perception.

Interestingly, all solid waste functions are under the supervision of the Health Department in Whatcom County.

**Transition Option**

A third option was discussed by some interviewees: moving the Health District into the County structure intact but then after several years considering moving some functions into existing County departments.

It was felt that this allowed for the least disruption of the Health District culture, structure, and workforce. The act of moving to the County would in itself be a shock to the system. By moving the District intact it would reduce that shock. It would then also be possible to spend several years evaluating what might make sense to transfer to other departments, creating a smoother transition.

**Role of Cities**

One of the key questions that arises should the County take over the Health District’s responsibilities is what role the cities should play. The response from interviewees was mixed.

One group clearly thought it was important for the cities to continue to have at least an advisory role (some felt it should be more than advisory). It was often mentioned that eliminating the city role would result in the cities no longer continuing the per capita contributions that began in 2017. It was also felt that cities provided valuable input regarding public health issues and programs in their local jurisdictions. Further, many health programs are actually implemented
within city boundaries and therefore city input would be useful. (See sidebar for how King County addresses this issue.)

A number of interviewees mentioned that if the cities continued to have a role the size of the board needed to be smaller. It was felt that the current 15 member board was unwieldy and difficult to work with.

Other interviewees felt that without a financial contribution there was little need or sense to continue a role for cities. They did not see a significant downside to no more city participation.

On a related note, most interviewees felt the existing Public Health Advisory Council should be continued in some form.

**Hybrid Option**

Another option which was discussed with interviewees was a hybrid approach: keep the Health District as a separate entity but have Snohomish County provide “back office” services on a contract basis. In this way some of the perceived savings from merger might be achieved without ending the Health District’s independence. As noted earlier, the County is currently providing information technology and fleet maintenance services under a similar model. Additionally, the issue discussed earlier of depth of experience would be addressed.

During the course of preparing this report one interviewee mentioned that in the 1980’s the Health District was actually located on the County campus in a County building. It was also reported that at that time the County provided payroll, information technology, fleet, and perhaps other services to the Health District. Grant County does something similar by providing space and building maintenance as a contribution toward public health.

Snohomish County currently provides some “back office” services to junior taxing districts. Some of those services...
include payroll and accounts payable. The same model could be applied to the Health District.

There was general agreement that this model would work for most “back office” functions. However, a few interviewees raised red flags about certain functions. The three functions most often mentioned as difficult to contract out were legal services, Human Resources, and communication.

At first glance legal services would appear to be easy. As one interviewee put it “the law is the law”. The argument against contracting out legal services was two-fold. First, public health legal services need to be very nimble. If a health emergency of some sort arises it is necessary to quickly move. Second, there is a perception by some Health District employees that the County Prosecutor’s office is not aggressive enough in pursuing violations.

One interviewee pointed out that since having the right employees is key to being able to deliver on core competencies it was necessary to keep Human Resources in-house. Another whose agency is actually involved in providing HR services to another party indicated that it was sometimes difficult and confusing.

Communication seemed to some problematic because it was crucial, especially during a health emergency. There was a feeling that contracted communications services might lack the necessary expertise and not be available when needed due to other assignments.

The issue of the services not being dedicated to public health was one drawback to contracting any services mentioned by several interviewees. There was concern that if there were a conflict of need between the County and the Health District that County needs would come first. The issue of accountability—would services be available when needed—would need to be addressed.

The issue of payment would also need to be addressed. There are two basic models of cost recovery—marginal and full costs. Marginal costs only cover the direct costs of providing the additional service. The potential advantage to using the marginal cost model is that at no direct cost to the County the Health District could presumably receive services for a reduced rate.

The marginal cost model is not, however, used by the County currently with junior taxing districts (JTDs). Instead a version of full cost recovery is used. For several years there was no inflation adjustment for the costs charged to the JTDs so costs are not fully compensated. Nevertheless, were the County to use a different cost recovery model for the Health District than for the JTDs it is likely that the JTDs would object.

The most important consideration in whether or not this option would work is what the cost would be. As mentioned earlier there is some reason to suspect that overhead costs at the County
might be higher than at the Health District. This would need to be carefully studied to be sure that cost savings would actually accrue to the Health District.

Finally, if implemented, it would be important to have a plan in place to quickly and clearly communicate what was happening. One private sector interviewee who had experienced a similar contracting out process stated that employees would become very anxious about their jobs. Without certainty and clarity the best employees would start immediately looking for other jobs.

**Opportunities**

**Space**

During the interview process several County personnel mentioned that a key issue if the County took over the Health District’s responsibilities would be space. In their view the County was running out of space for new employees and would not be able to accommodate the additional Health District employees. It was also mentioned that the Rucker Building might, in the event of merger, provide a solution to some space needs of the County.

As the chart below shows, vacant space in the Rucker Building equals nearly 8,700 square feet. In addition, the Atrium, while a pleasant feature, is not configured to be easily used. That could be changed resulting in additional usable space.

<table>
<thead>
<tr>
<th>Basement (42 parking spaces, generator, &amp; storage)</th>
<th>Total</th>
<th>Used</th>
<th>Common/ Conf Areas</th>
<th>Leased</th>
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<th>Usable Atrium Space</th>
<th>Non-Usable</th>
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<td>10,728.52</td>
<td>10,692.85</td>
</tr>
</tbody>
</table>

Assuming the space concerns reported are significant enough, it is possible the County could rent additional space at the Rucker Building. The County could address its needs while providing a revenue stream to the Health District.

An alternative option would be to negotiate an agreement with the Health District in which the County would pay for building improvements and/or repairs. In return, the District would
provide space rent free. The potential advantage to this approach is that REET dollars might be able to be used for the capital investment. General Fund dollars might not be necessary.

One potential drawback to this proposal is that a number of interviewees mentioned parking as an issue. In addition to the 42 parking spaces shown in the chart above in the basement there are a total of 26 spots in the lot behind the building and 22 spots across the street. The County would need to evaluate if there was a need for more parking and, if so, how to address that need.

Co-Location of Septic Permitting

Directly related to the space available at the Rucker Building is the possibility of co-locating Health District and County septic permitting staff. The necessary County employees could be relocated to the Rucker Building. This would create a clear customer service improvement because they would not have to go back and forth between the Rucker Building and County campus. Additionally, by being located next to each other, closer coordination between the two agencies would be possible.

A similar approach has been used by two of the counties surveyed for this report. In Kitsap County the Health District stations an employee at the county’s building department for one-half day each week to help with septic permit coordination. At one point, when the county was providing half of the funding (the position is entirely funded by the Health District now), the employee was there one-half day every day.

In King County, the 2016 budget provided for a Health District employee to be located part of the time in the building department. Before the year was over the employee went back to working full time for the Health Department. The perception was that the person assigned continued to primarily do other Health Department work and did not adequately address septic needs.

The Health District’s 2014 Strategic Plan Update includes “Initiative 2: Improve Environmental Health Business Practices”. It suggests:

…District staff might be co-located in other County offices, continuing to provide Health District expertise and rigor on permit review, and also working alongside staff who are also performing permitting duties. Of particular interest is the current use of District staff in processing septic and drainfield plans associated with single-family residential construction, review and permitting of interior remodels of schools, and permitting of food service establishments. (p. 18)
If a decision was made to move County septic permitting staff to the Rucker Building, it might also be wise to look at other areas such as those listed above. Indeed, it is worth noting that by rough estimates Snohomish County Planning and Development Services permitting staff currently use approximately 8,500 square feet. Current vacant space at the Rucker Building is over 8,600 square feet. It might be worth evaluating moving the entirety of PDS permitting to the Rucker Building.

**Clarification of Health District Mission**

A significant number of interviewees referenced the need for the Health District to clarify its mission. To be successful at delivering public health services, whether as an independent district or as part of the County, clarity of purpose is essential.

Comments by persons in the private and non-profit sector are instructive. One private sector interviewee stated that they had looked at the website and saw lots of services but no focus of effort. A non-profit head noted that the funding shortfalls meant that the Health District needed to define what is essential to accomplishing its goals. A third stated that it was not clear what business the Health District was in—what were the key goals?

A step in this process would be to look at what is currently available in the community and seek not to duplicate it. As one individual noted, the private sector is constantly adapting to markets and so must public health.

The Health District has made an effort to identify services being provided in the community that duplicate Health District services. Good examples of this are First Steps and WIC. But the District has struggled to implement its plans for these programs. Partially, this is a result of not clearly defining the rationale for change.

The history of First Steps in the last few years is illustrative of this point. First Steps is a traditional Health District program, having been offered by the District (and many other public health agencies) for many years. It is highly popular and seen to have produced significant positive results. The program is described in the 2017 Budget:

First Steps is a Washington state program for pregnant and postpartum women and infants to age one year. The goal of the program is to provide services as early in a pregnancy as possible in an effort to promote positive pregnancy and parenting outcomes. First Steps assists women with targeted risk factors—mental illness, alcohol and substance abuse, smoking, domestic violence, hypertension, or diabetes—in order to deliver full term, healthy infants….First Steps is a preventive
health service that supplements medical coverage for Medicaid eligible women. (p. 47)

Services are provided by public health nurses, a behavioral health specialist, and nutritionists. Clients are referred to other services through the state Department of Social and Health Services such as Basic Foods, Temporary Assistance to Needy Families, and Child Support Enforcement. The program also connects clients with resources for medical and dental care, housing and energy assistance, drug and alcohol treatment, smoking cessation, food banks, childcare, ECEAP, and Head Start.

Since at least 2014 District administration has been discussing ending the program. First Steps is expensive at a time when the District is financially stressed. Following the 2008 recession the County began funding roughly three-quarters of the First Steps program with mental health sales tax funds. That funding began to be phased out in 2015 and is now gone.

First Steps is also available in the community from two other non-profit providers, Sea Mar and Step by Step. Sea Mar has indicated a willingness to take over provision of services from the Health District in those parts of the county where they operate. Further, the provision of direct one-on-one client services clashes with the District’s stated goal of moving toward population based services. Many other public health organizations in Washington State have moved away from providing First Steps.

In preparing the 2015 budget, Health District Administration proposed a one-time draw down of fund balance to continue First Steps while efforts were made to identify community partners to take the service over. By March of 2016 the District was presenting a plan to the Board of Health for the transitioning of the program to other providers by January of 2017. That plan stated:

WIC and First Steps are no longer services where the Health District is uniquely qualified, nor are they aligned with the future vision of public health in Snohomish County. (SR 16-019, p. 6)

The plan’s goal was to transition services to other providers and begin a new program called “Healthy Starts”.

53
The plan was not implemented. Discussions of transitioning First Steps again occurred in conjunction with the 2017 budget deliberations. First Steps continues to be funded through the end of 2017.

The Board has not been willing to move forward with the plan. It is difficult to obtain public support for eliminating a program (even if the argument is that it is being transitioned to another provider) which is popular and serves vulnerable pregnant women and their babies. But lack of a clear rationale may be another factor.

One of the stated reasons is the need to end direct client services and move toward population based programs. Yet the proposal to substitute “Healthy Starts” is not clearly population based. While there is a new emphasis on coalition building (which would be a population based strategy) there is also an emphasis on providing direct services, just in a group setting. (see sidebar)

One Boardmember who opposed the change indicated they did not believe the services could be as effectively delivered in a group setting. What is significant about this comment is they saw the change primarily as impacting the manner in which the District delivered direct services. They did not see the change as eliminating direct services. At least with this Boardmember, the program was not seen as population based.

Was the rationale the funding shortfall? While this analysis has focused on First Steps, WIC and First Steps are closely integrated in the Health District’s delivery model. In the materials presented with the 2016 plan the financial analysis below was presented:

**POPULATION BASED SERVICES**

One interviewee who represented a service delivery agency made some interesting observations regarding population based services when discussing the proposed Healthy Starts program.

- Working with families in shelters or at other agencies (even in groups) to provide information on alcohol or drugs, proper nutrition, the importance of breastfeeding, etc. is direct service. Training the employees of those agencies to provide the information themselves is population based. Additionally, coming from the agency personnel the family already knows makes it more likely to be accepted and more sustainable in the community in the long run.

- Sending a nurse to a home to talk about nutrition is direct service to address obesity. Working with schools on health food and physical activity is population based.
There is no question that the cost of Healthy Starts is lower, as is the number of FTEs needed for the program. But the revenue lost by moving to Healthy Starts is near $1.8 million. Consequently, in the end the net savings to the Health District is just over $61,000 per year. As a percentage of the total cost of WIC and First Steps the savings are only 1.6%. And as a percentage of total 2016 expenditures it only amounts to 0.3%. While saving money is always laudable, it is difficult to justify such a significant change in services for such paltry financial savings.

Nothing in this analysis is intended to be a criticism or endorsement of First Steps, WIC, or the Healthy Starts programs. Nor is it intended to advocate for or against the District’s provision of these services. Rather it is intended to provide an example of a significant service change (which may indeed be a positive and necessary step) without a clear rationale.

This serves as an example of why a number of interviewees had no clear vision for where the Health District was headed. For example, one interviewee indicated that they perceived the District as getting rid of “old” programs to make way for “trendy” new ones. They did not see a broad, policy rationale.

It is important that the District and its Board clarify the mission. This does not mean writing a new mission statement. It means reaching agreement on the criteria that will be applied when evaluating existing and potential future programs.

It also does not mean that if the District is seeking to move toward population based services that only those services may be offered. There may be cases where direct services will be provided by the District because no other provider is available.

But it does mean that when the District proposes service changes the rationale needs to be clear. If the rationale is financial, there need to be clear financial benefits. If the rationale is to move toward population based services, any new programs should clearly be population based. If the rationale is that there is another provider of these direct services in the community and the

Table: WIC & First Steps vs. Healthy Starts

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<th>WIC &amp; First Steps</th>
<th>Healthy Starts</th>
<th>Change</th>
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District wishes to meet an unmet need for other direct services, this should be clearly stated. But clear criteria and direction need to be established.

A number of interviewees stressed the need to insure that the Board, the administration, and the employees have a shared vision. This is a necessary step whether the District remains independent or becomes part of the County.

One final note related to Health District decisions to transition services to other agencies. Two interviewees had some experience with such transitions and stressed that the planning time for such a transition should ideally be one year. That is one year from the time the agreement is reached between the Health District and the other agency. Shorter timelines were seen as making a seamless transition for the clients very difficult.

Conclusion

It is clear that there are many issues to examine when considering whether or not Snohomish County should take over the responsibilities of the Snohomish Health District. This report serves as a preliminary identification and review of many of these issues. As noted earlier, subject matter experts should be consulted to further flesh out these matters.

The final part of this report suggests a process for decision making. An outline is provided below:

- Determine if there is desire to obtain taxing authority or a special levy for the Health District. If the answer is “yes”, it is most likely unwise to proceed with a merger.

- If the answer is “no”, then proceed to:
  - Review financial issues. If taking over the Health District’s responsibilities does not enhance the District’s financial situation it does not make sense to proceed. Key issues to consider include:
    - Difficulty of bargaining
    - Costs of insurance benefits
    - Salaries
    - Other contract differences
    - Capital costs
    - Fund Balance
    - Rucker Building
    - Legal liability and risk management
    - Affordable Care Act
    - Efficiency/overhead costs
• If financial matters can successfully be addressed, policy issues need to be resolved. Key policy issues include:
  o Agency culture and impacts on Health District workforce
  o Possibility of increased accountability
  o Potential elimination of silos
  o Impact of bureaucracy
  o Potential loss of public health focus
  o Potential politicization
  o Competition for funding
  o Potential use of Health District space

• If policy issues have been resolved favorably, the next steps would be to consider:
  o The legal process. Confirm that the District, County, and School Districts are in agreement on how to proceed.
  o Structure
  o Role of the cities

• If at any point a decision not to merge the two organizations is made, it would then be necessary to consider:
  o Should the County provide “back office” services to the Health District?
  o Should County septic (and/or other services) be provided at the Rucker Building?

Separate from this decision process is the need to clarify the Health District’s mission. That activity seems necessary and important regardless of the final decision. It can take place at any time and should not be delayed.
APPENDIX A

INTERVIEW LIST

John Amos, Former Interim Finance Director, Snohomish County
Jason Biermann, Emergency Management Director, Snohomish County
Chris Bischoff, Environmental Health Manager, Health & Human Services, Cowlitz County
Judy Chapman, Project Manager, Snohomish Health District
Jeff Clarke, General Manager, Alderwood Water and Wastewater District
Annie Cole, Human Resources Director, Snohomish County
Amy Beth Cook, Superintendent, Lake Stevens School District
Christine Cook, Councilmember, Mukilteo
Eric Cooper, Medical Director for Snohomish County EMS
Jane Dale, Food Safety Manager, Quality Food Centers
Regina Delahunt, Director, Health Department, Whatcom County
Chris DesRosier, Director, Health & Human Services, Cowlitz County
Trever Esko, Chief Information Officer, Snohomish County
Bob Farrell, Chief Executive Officer, Community Health Center of Snohomish County
Scott Forslund, Director, Snohomish County Health Leadership Coalition
Adrienne Fraley-Monillas, Councilmember, Edmonds
Nancy Furness, Director of Communicable Disease Control & Emergency Preparedness, Snohomish Health District
Gary Goldbaum, Director and Health Officer, Snohomish Health District
Keith Grellner, Administrator, Kitsap Public Health District
Becky Guadamud, Deputy PA, Snohomish County
Brent Hackney, President, Brent Hackney Designs
Will Hall, Surface Water Director, Snohomish County
Kurt Hilt, Councilmember, Lake Stevens
Karolyn Holden, Director of Public and Social Services, Grays Harbor County
Shawn Humphreys, Deputy Director, Community Development, Pacific County
Nathan Kennedy, Finance Director, Snohomish County
Jefferson Ketchel, Division Director, Environmental Health, Snohomish Health District
Ken Klein, former Councilmember, current Executive Director, Snohomish County
George Kosovich, Assistant Superintendent, Verdant Health Commission
Kathy Lambert, Councilmember, King County Council
Dan LeFree, Accounting Supervisor, Snohomish Health District
Sam Low, Councilmember, Snohomish County
Peter Mayer, Deputy Director, Snohomish Health District
Steve McGraw, Chief Executive Officer, Senior Services of Snohomish County
Allen Melnick, Community Public Health Director/Health Officer, Clark County
Matthew Miller, Staff Representative, Washington State Council of County and City Employees
Keith Mitchell, Risk Manager, Snohomish County
Barb Mock, Director, Planning and Development Services, Snohomish County
Jeff Nelson, Director, Environmental Health, Grays Harbor County
Heather Oie, Operating Manager, Medical Examiner, Snohomish County
Afsaneh Rahimian, Preventive Health Services Director, Sea Mar
Sharyl Raines, Controller, Accounting/Finance Management Division, Snohomish County
Jeff Rasmussen, Councilmember, Monroe
Jeff Roe, Chief Executive Officer and President, Premera Blue Cross
Terry Ryan, Councilmember, Snohomish County Council
Cecilia Saldana, Maternity Support Services/Program Manager, Sea Mar
Daniel Selove, Chief Medical Examiner, Snohomish County
Charlene Shambach, Director of Community Health, Snohomish Health District
Preston Simmons, Chief Executive Officer, NW Washington Region, Providence Health & Services
Dennis Smith, President and Chief Executive Officer, United Way of Snohomish County
Teri Smith, Human Resources Manager, Snohomish Health District
Torney Smith, Administrator, Spokane Regional Health District
Jim Steinruck, Health Administrator, Tulalip Tribes
Carolann Swartz, former Commissioner, Grant County
Brian Sullivan, Councilmember, Snohomish County
Vanessa Timmons, Senior Budget Analyst, Snohomish County
Ty Trenary, Sheriff, Snohomish County
Gina Veloni, Nurse Family Partnership Program Manager, Childstrive
Mary Jane Brell Vujovic, Director, Human Services, Snohomish County
Carloyn Weikel, Auditor, Snohomish County
Hanna Welander, Nurse Representative, Washington State Nurses Association
Jim Welsh, Executive Director, Childstrive
Brenda White, Legislative Liaison, Snohomish County PUD
Brant Wood, Snohomish County PUD #1, 2016 Chair, Public Health Advisory Council
Maria Wood, Administrator, King County Board of Health
Kyoko Matsumoto Wright, Councilmember, Mountlake Terrace
Stephanie Wright, Councilmember, Snohomish County
Sarah Zabel, Chief Operating Officer, Swedish Edmonds
Carl Zapora, Superintendent, Verdant Health Commission
Matt Zybas, Solid Waste Director, Snohomish County

Thanks also to the union members of the Washington State Nurses Association, American Federation of State, County and Municipal Employees, and Professional and Technical Employees who met with me to share their insights.
## APPENDIX B

### BENEFITS WORK SHEET

<table>
<thead>
<tr>
<th>Snohomish Health District</th>
<th>Medical Plans - All Employees by Plan/Coverage 2017</th>
<th># of Employees</th>
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<th>Cost per employee dental and vision</th>
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<tbody>
<tr>
<td>Employee Only</td>
<td>1</td>
<td>$640.16</td>
<td>$58.05</td>
<td>$698.21</td>
<td>$698.21</td>
</tr>
</tbody>
</table>

### WAIVED

<table>
<thead>
<tr>
<th></th>
<th># of Employees</th>
<th>Employee Only</th>
<th>Child(ren)</th>
<th>Spouse</th>
<th>Family</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

**Grand Total**: 120 employees

Average cost per employee: $1,055.32