Board of Health Meeting
Thursday, February 24, 2022, 10:00 a.m.
13307 Miami Lane, Caldwell, ID 83607

Public comments specific to an agenda item for the February 24, 2022 Board of Health meeting can be submitted at https://www.surveymonkey.com/r/BoH02242022 or by mail to: SWDH Board of Health, Attn: Administration Office, 13307 Miami Lane, Caldwell, ID, 83607. The period to submit public comments will close at 10:00 a.m. on Wednesday, February 23, 2022.

***Meeting Format** : In-person attendance at the meeting will be limited. Anyone unable to attend the meeting in-person is invited to view the meeting on their own device through live streaming available on the SWDH You Tube channel.

Agenda

A = Board Action Required		**G =Guidance**	**I = Information item**
10:00	A	Call the Meeting to Order	Chairman Bryan Elliott
10:02		Pledge of Allegiance	
10:04		Roll Call	Chairman Bryan Elliott
10:07	A	Request for Additional Agenda items; Approval of Agenda	Chairman Bryan Elliott
10:10	A	Approval of Minutes – January 25, 2022	Chairman Bryan Elliott
10:15		In-Person Public Comment	
10:30	I	Open Discussion	Board Members
10:40	A	Preventing Adolescent Pregnancy in SW Idaho: Reducing the Risk Curriculum	Charlene Cariou
11:05	I	Introduction of New Employees	Division Administrators
11:10	I	January 2022 Expenditure and Revenue Report	Troy Cunningham
11:20	A	Fiscal Year 2022 Budget Revision – State Appropriation	Troy Cunningham
11:30	A	Request for Proposal Process for Financial Statement Provider	Troy Cunningham
11:40		Break	
11:50	I	Clinic Services Update	Josh Campbell
12:05	I	Public Health Emergency Preparedness Information Sharing	Ricky Bowman
12:20	A	Sub-Surface Sewage Fee Update	Colt Dickman
12:40	I	Executive Council Update	Nikki Zogg, Georgia Hanigan
12:45	I	Director's Report	Nikki Zogg
		Millennium Fund Update	
		House Bill 316 Update	
		Legislative Update	
1:00		Adjourn	

NEXT MEETING: Tuesday, March 15, 2022, 10:00* a.m.

*Winter hours in effect

BOARD OF HEALTH MEETING MINUTES
Tuesday, January 25, 2022

BOARD MEMBERS:
Georgia Hanigan, Commissioner, Payette County – present via Zoom
Lyndon Haines, Commissioner, Washington County – present
Keri Smith, Commissioner, Canyon County – present via Zoom
Kelly Aberasturi, Commissioner, Owyhee County – present via Zoom
Viki Purdy, Commissioner, Adams County – present
Sam Summers, MD, Physician Representative – present
Bryan Elliott, Commissioner, Gem County – present

STAFF MEMBERS:
In person: Nikki Zogg, Katrina Williams, Josh Campbell, Colt Dickman, Sarah Price, Charlene Cariou, Mitch Kiester

Via Zoom: Troy Cunningham, Ashley Anderson, Doug Doney, Chuck Washington, Ricky Bowman, Robin Doney

GUESTS: Tricia Hebdon, Idaho Department of Fish and Game, and members of the public attended the meeting.

CALL THE MEETING TO ORDER
Chairman Bryan Elliott called the meeting to order at 10:02 a.m.

PLEDGE OF ALLEGIANCE
Meeting attendees participated in the pledge of allegiance.

ROLL CALL
Commissioner Aberasturi – present via Zoom; Dr. Summers – present; Chairman Elliott – present; Commissioner Hanigan – present via Zoom; Commissioner Purdy – present; Commissioner Haines – present; Commissioner Smith – present via Zoom.

REQUEST FOR ADDITIONAL AGENDA ITEMS; APPROVAL OF AGENDA
Nikki asked to remove the Clinic Services Update agenda item due to Josh Campbell's availability. This topic will be carried over to the February agenda.

MOTION: Commissioner Haines made a motion to accept the agenda with the requested change. Dr. Summers seconded the motion. All in favor; motion carries.

APPROVAL OF MINUTES – NOVEMBER 16, 2021
MOTION: Commissioner Haines made a motion to approve the December 14, 2021 Board of Health meeting minutes as presented. Commissioner Smith seconded the motion. All in favor; motion passes.

IN-PERSON PUBLIC COMMENT

Members of the public attended the meeting and provided in-person public comment. Topics included vaccine safety and Reducing the Risk (RTR) curriculum. Concerns about permission slips for the curriculum being presented in classrooms were discussed.

Board members asked whether an opt-in system for students to receive the RTR curriculum can be implemented. Nikki will add this topic to the February meeting agenda. Commissioner Purdy asked if it is possible to request a copy of the Reduce the Risk curriculum. Nikki will provide that the curriculum to Board members in advance.

OPEN DISCUSSION

Board members participated in open discussion. Commissioner Purdy asked for the names of the legislative review panel for the Citizen Review Panel. Nikki responded that there is a legislative oversight committee for the Citizen Review Panel and will provide the names to Commissioner Purdy.

INTRODUCTION OF NEW EMPLOYEES

Division administrators introduced new staff and Nikki introduced Colt Dickman, Environmental and Community Health Services Division Administrator.

DECEMBER 2021 EXPENDITURE AND REVENUE REPORT

Troy Cunningham, SWDH Financial Manager, presented the December 2021 Expenditure and Revenue Report. Troy explained that the agency is about halfway through the fiscal year and the agency is on target. Revenues are on target; personnel expenditures and operating expenditures are down slightly.

FISCAL YEAR 2022 BUDGET REVISION REQUEST

Troy Cunningham presented a Fiscal Year 2022 Budget Revision Request. Troy explained that during development of the fiscal year budget, program managers and division administrators use historical information to make projections. Revisiting budget status part-way through the fiscal year allows projections to rely on the data from the first part of the fiscal year.

Halfway through Fiscal Year 2022, Troy explained that SWDH revenues have increased slightly due to some new grants as well as receipt of Coronavirus Financial Advisory Committee (CFAC) funds. The CFAC funds are reimbursement for costs incurred in Fiscal Year 2021. Expenditures decreased slightly primarily due to decreased personnel expenditures attributed primarily to high vacancies particularly in the clinic services division.

The overall budget shift is $283,648. Troy explained that in his work with state agencies and other agencies the budget revision is intended to help staff dealing with budget processes to develop more focused projections.

Commissioner Aberasturi asked whether SWDH will continue to follow the state budget process or move to align more with county timeline and processes. Troy explained that the current SWDH budgeting process will remain the same and will remain on the state cycle. There has been no conversation to move to the county fiscal year.

MOTION: Commissioner Smith made a motion to approve the Fiscal Year 2022 Budget Revision Request as presented. Commissioner Haines seconded the motion. All in favor; motion passes.

BOARD COMMITTED FUNDS

Troy Cunningham explained that reimbursement funds from the CFAC (Coronavirus Financial Advisory Committee) have been received. These dollars were initially expended as district dollars for COVID response expenses in Fiscal Year 2021 in the amount of $488,314 and then reimbursed following the completion of a very lengthy reimbursement process for the CFAC. The reimbursement funds were received in Fiscal Year 2022 rather than Fiscal Year 2021. Troy sought input from divisions regarding proposed expenditures of funds. Using that input, Troy proposed the Board commit the funds as follows: facility improvements of $138,000; 27th pay period funds of $129,314; county collaboration projects of $70,000, mobile clinic/events unit of $130,000; employee development and engagement of $20,000; and an EKG machine of $1,000.

Commissioner Aberasturi asked for clarification of facility improvements as the state is strict about taxpayer dollars sitting unused. Nikki explained that the facility improvement fund represents dollars set aside to fund needed building improvements such as roofing. The district does not have access to the state's building fund and cannot levy taxes; therefore, the district needs to save for larger building improvement or replacement projects.

MOTION: Commissioner Smith made a motion to approve the designation of Board committed funds as presented. Commissioner Purdy seconded the motion. All in favor; motion passes.

EMPLOYEE RETENTION UPDATE

Sarah Price presented an update on employee retention and explained our agency's efforts to recruit and retain. Last time Sarah spoke, there was a 33% employee turnover rate. Since that time, the turnover rate has dropped to 14% between August 2021 – December 2021 largely aligning with the 5% merit-based increase. Sarah highlighted some increased costs of living including increased housing and fuel. Sarah evaluated the 12 separations that have been processed and surveyed them to see their reasons for leaving. Of those, 1 retirement, 1 returned to education, and 10 left for better paying jobs.

In addition to the 5% merit-based increase provided, SWDH is working to better communicate benefits of the jobs to help increase recruitment and retention, has developed and pushed out a pulse survey assessing and addressing burnout, and has implemented flexible hybrid remote/onsite schedules.

CHRONIC WASTING DISEASE (CWD) UPDATE

Tricia Hebdon, Idaho Department of Fish and Game Wildlife Health Program Coordinator, provided information to Board members regarding chronic wasting disease (CWD). Chronic wasting disease is an infectious disease caused by a prion that affects deer and elk and was first identified in Idaho in 2021. This topic is relevant to public health because the disease is deadly to deer and elk herds, which are a food source for people. There is also concern that CWD has the potential to jump species and impact humans as has been seen with other prion diseases. The disease can infect animals for several years and is highly contagious through direct nose to nose contact and is also shed in urine and feces. The prion can also exist in the environment and be picked up by susceptible animals; therefore, it is vitally important that carcasses be disposed of in a place that reduces the risk of the disease spreading. Idaho Fish and Game is working to identify landfills across the state to be carcass disposal sites. Pickles Butte and Clay Peak are two landfills within SWDH's boundaries that are potential disposal sites for infected carcasses. She provided information about how to better design landfills to receive these materials and explained that areas with clay-based, non-porous soils are the best places to dispose of affected carcasses.

SEWAGE PROGRAM FEES

Mitch Kiester, SWDH Program Manager, presented a request for a sub-surface sewage fee. He provided background information and explained that when a subsurface sewing application is submitted, the applicant has one year from the time of application is initiated to convert it to a permit. The permit is them good for a one-year period and the the individual has one year to have the system installed and finalized by one of the SWDH inspectors. If either of these deadlines pass without a request for a renewal, the customer is required by Idaho rule to reapply for the application or permit. This information is very clearly conveyed, in writing, during the application process. Sometimes there are extenuating circumstances that delay the process, and the customer can pay $100 to renew the application or permit for an additional year if less than a year has passed since the date of issue.

Mitch proposed allowing SWDH to implement a new fee called a no test hole/no site evaluation and if an individual has an application or permit that has expired the existing data in most instances can be used to reissue a permit at half the original cost to rewrite the permit, conduct trench investigations, site evaluations if needed, and finalize the application.

This new fee would allow the customer to pay 50% of the original fee. Currently, a customer is expected to pay the full cost if the application or permit have expired. Board members discussed how to accommodate customers who are conducting groundwater monitoring that takes longer than a year. Mitch clarified that a permit is not issued until the groundwater monitoring is complete.

Commissioner Purdy has some questions about why we need to ask for another partial fee. Mitch clarified the process of test hole fee, permit fee, and the one-year limit for that permit fee. He explained that the IDAPA (Idaho Administrative Procedures Act) is being followed with these permit expiration dates. Commissioner Purdy discussed Adams County's short building window.

MOTION: Commissioner Haines made a motion to approve the requested no test hole/no site evaluation permit.

The motion was not seconded.

Commissioner Hanigan asked if there is an opportunity to set up a liability account for those permits that have not been set up yet? Troy explained that there is a potential to allow pursuing a liability account. Troy can reach out to his peer at other health districts to see if they use this ability.

Commissioner Purdy voiced non-support of the no test hole permit fee of $425 and suggested paperwork could be completed for less than $425. Nikki asked if Commissioner Purdy would like to propose a different fee.

Commissioner Haines supports allowing a fee to save the customer money. If a customer has the knowledge to complete the process within a year, there is some responsibility on the customer's part to initiate the renewal if the application or permit are at risk of expiring. He stated that an explanation of the costs involved would be helpful.

Commissioner Aberasturi is hesitant to go forward with any fee approval without going through legal first if the IDAPA fee process is not followed. He stated that by law the health district cannot make money off of a fee and can only cover costs.

MOTION: Commissioner Purdy made a Motion to make it a $100 fee to renew an expired permit for an additional one-year period.

The motion was not seconded.

Dr. Summers asked if this matter needs to be discussed with legal counsel first. Commissioner Hanigan concurs that a more in-depth look and review to analyze what can and cannot be done in fee setting is appropriate. Commissioner Haines asked for a more detailed breakdown of what goes into the $450 fee renewal and for an answer to whether we can legally add a new fee.

MOTION: Commissioner Haines made a motion to request a more detailed breakdown of where the $450 comes from and to ask legal counsel if we can add a new fee. Dr. Summers seconded the motion. All in favor; motion passes.

Nikki asked for clarification on what to seek from legal counsel. Board members asked Nikki to clarify that the one-year period is fixed and is in the Idaho Administrative Procedure Act (IDAPA) rules and that our fee calculations ensure we are not making money on that fee. Nikki noted there is precedence for this in at least one other health district.

YOUTH BEHAVIORAL HEALTH

Nikki Zogg, District Director, provided an update on efforts to address gaps and needs surrounding youth behavioral health. Nikki explained some of the funding options and asked for feedback. Nikki has visited with District 4 and they may be interested in participating. The next steps would be to formalize the support services and develop a roadmap to move from planning to implementation. She explained the goal is not to run a youth crisis center but recognize the need for youth behavioral health services in our community and work with community partners to leverage the resources necessary to fill the gaps and address the needs. Nikki asked for guidance from board members on how to best proceed.

Board members discussed existing resources including the Behavioral Health Board (BHB). There are several folks serving on the BHB who are attending the youth crisis services community meetings.

CLINIC SERVICES UPDATE

This presentation will be postponed to a future Board of Health meeting date.

DIRECTOR'S REPORT

Department of Health and Welfare Memorandum of Understanding (MOU)

Nikki Zogg presented a draft intended to replace language on delegation of authorities between the departments and the districts. The agreement specifically addresses the communicable disease control, food protection, and public pool inspection programs. The health districts and the districts' legal counsel have been involved in these conversations and with the negotiations of these agreements.

State Controller's Office Memorandum of Understanding

The directors and legal counsel have been involved in the development of this MOU as well to be consistent with the agreements currently in place. The agreements with the State Controller's Office

(SCO) are for them to provide payroll, accounting, and billing services. The biggest change is the SCO is moving to a new electronic system called Luma. Nikki explained the changes to sick leave and vacation.

Legislative Update
There has not been a lot of legislative activity so far in the session. The Governor's budget recommendation regarding Millenium fund appropriation for public health districts is that the allocation of funding be cut completely out of health district budgets. The potential financial impact of this recommendation is over $700,000 statewide, and approximately $130,000 to SWDH.

Strategic Plan Update
Nikki asked commissioners to provide input on the services they would like to see as SWDH works to update its strategic plan. She has sent a survey link out and asked Board members to respond.

Letter to Governor/COVID Response
Several months ago, Nikki sent a letter on behalf of the board to Governor Little requesting a different statewide approach to the pandemic response. Following the initial letter to the Governor, there was both written and verbal conversations between Nikki and the Department of Health and Welfare and Idaho Office of Emergency Management. However, there was no resolution or closure on the matter. Nikki asked if the board would like any further follow-up and the board provided guidance that it was not necessary.

Commissioner Purdy asked about the tobacco program and whether SWDH is doing anything to curb the vaping among youth. She noted that Governor Little took a big campaign donation from Juul and asked whether the tobacco cessation program will be eliminated. Nikki is unsure of how the tobacco cessation program funding will be impacted if the millennium fund appropriation is removed. One additional resource for funding might be a telecommunications fee for the 9-8-8 resource.

There being no further business the meeting adjourned at 1:44 p.m.

Respectfully submitted: Approved as written:

Nikole Zogg	Bryan Elliott	Date: February 22, 2022
Secretary to the Board	Chairman	

Preventing Adolescent Pregnancy in SW Idaho

Reducing the Risk Curriculum

Charlene Cariou, MHS, CHES®, CPH

Community Health Program Manager

Impact of Adolescent Pregnancy

Teenage parents:

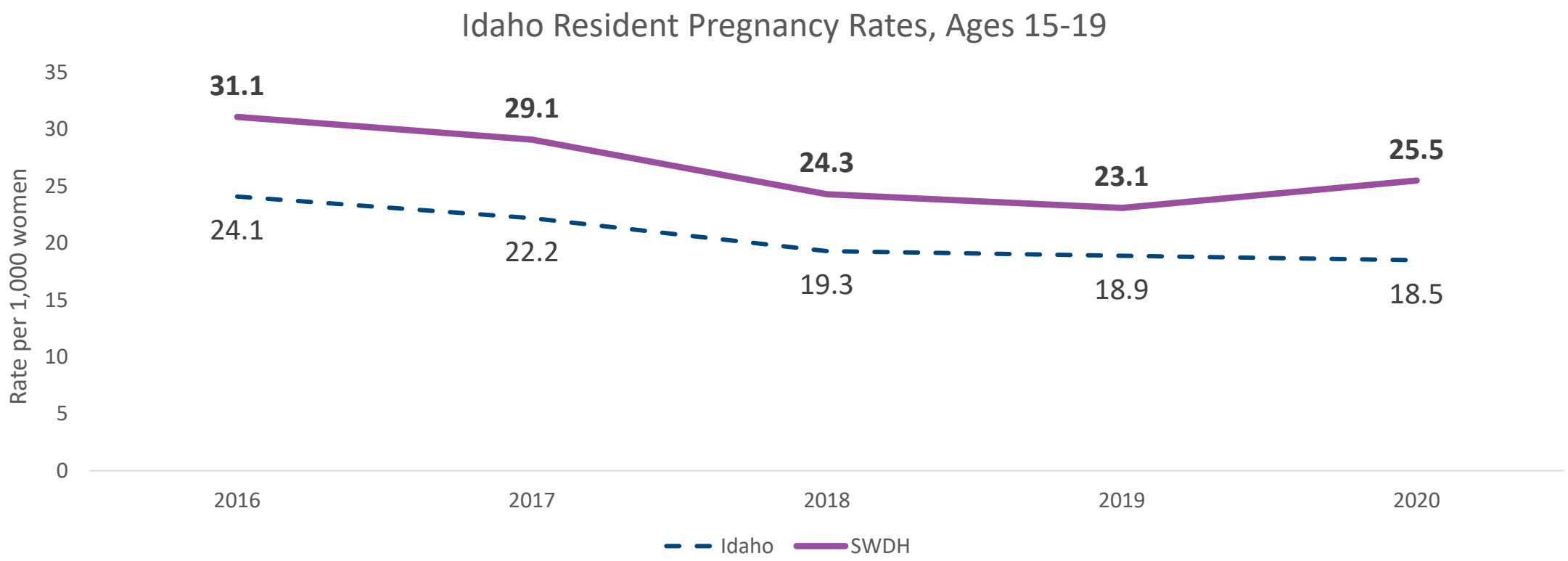
- Decreased graduation
- Increased drop out

Children of teenage parents:

- Low birth weight
- Less prepared for school
- Chronic health conditions
- Low school achievement
- Teenage parents

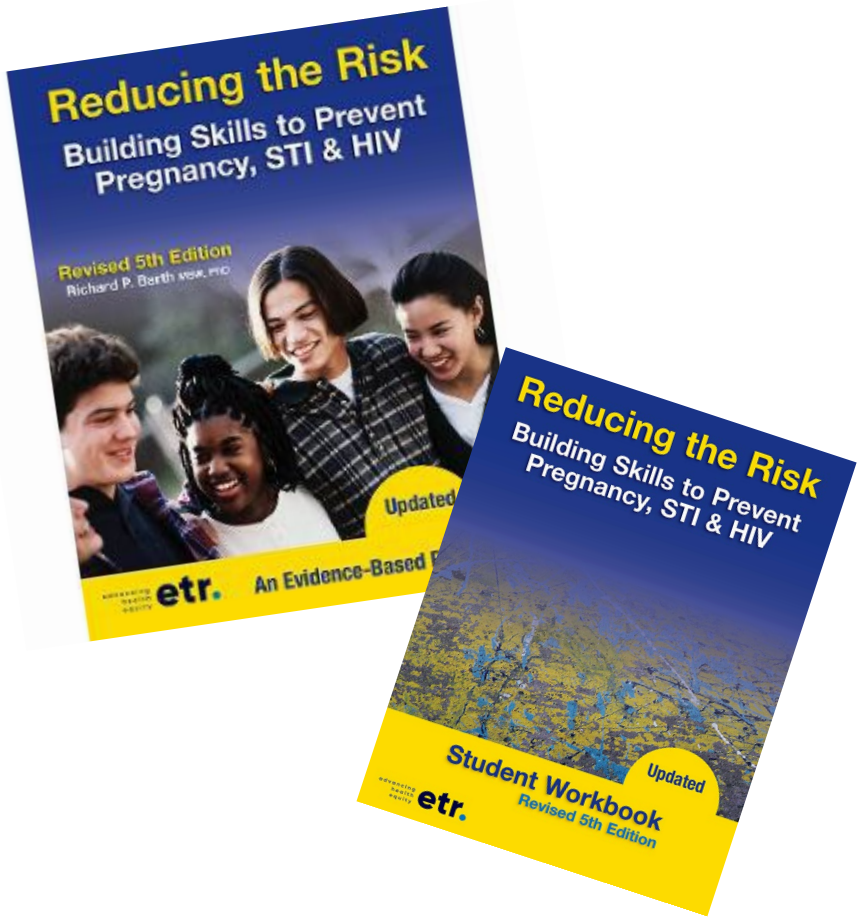
Sources: Covington, Peters, Sabia, & Price, 2011; Fletcher & Wolfe, 2012
Youth.gov - https://youth.gov/youth-topics/pregnancy-prevention/adverse-effects-teen-pregnancy#_ftn
Perper K, Peterson K, Manlove J. *Diploma Attainment Among Teen Mothers. Child Trends, Fact Sheet* Publication #2010-01: Washington, DC: Child Trends; 2010.

SWDH has higher teenage pregnancy rates than Idaho overall



Source: *Idaho Vital Statistics – Natality*, Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics, February 2022.

Reducing the Risk (RTR) – Program Overview



- Students in Grades 8-12
- 16 lessons
- Facilitated by SWDH Health Education Specialist
- Focus on:
  - Refusal skills
  - Delay tactics and alternative actions

RTR Classes

Risk & Protective Factors

Prevent teenage pregnancy, HIV, and other STIs

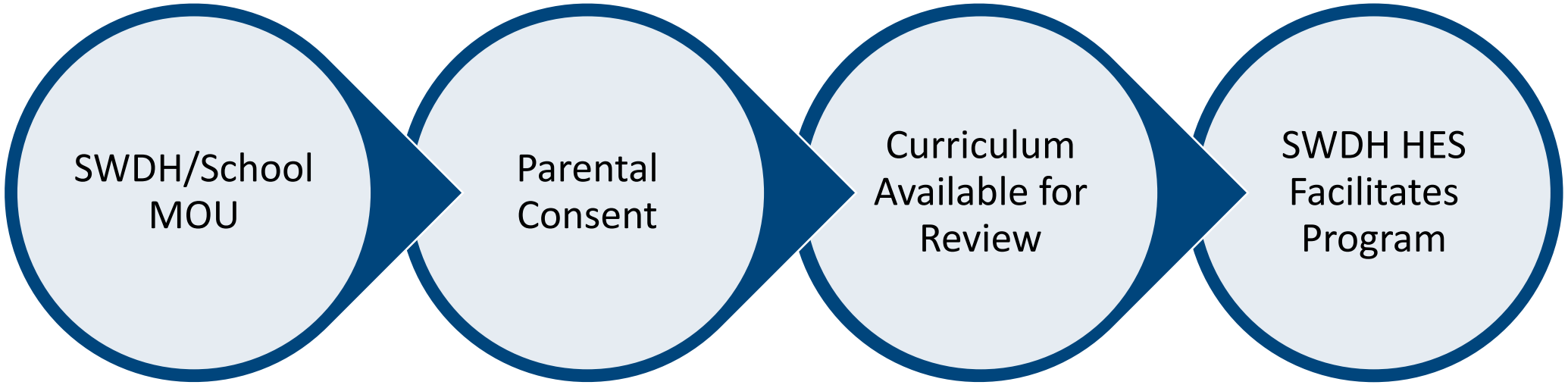
Increased parent-child communication

As a result of participating in RTR, students will be able to:

- Evaluate the risks and lasting consequences of becoming an adolescent parent or becoming infected with HIV or another STD.
- Recognize that abstaining from sexual activity or using contraception are the only ways to avoid pregnancy, HIV and other STD.
- Conclude that factual information about conception and protection is essential for avoiding teen pregnancy, HIV and other STD.
- Demonstrate effective communication skills for remaining abstinent and for avoiding unprotected sexual intercourse

Source: https://www.etr.org/ebi/programs/reducing-the-risk/

RTR Implementation at SWDH



- Number of cohorts
- Grade level
- Obtaining parental consent
- Process for curriculum review

- (Opt-in/Opt-out)

- Program Overview, entry surveys completed
- Lessons 2-3x/week
- Exit surveys completed

As a result of this program, youth report being much more likely to…

53%

…Resist or say no to peer pressure

46%

…Think about consequences before making a decision

53%

…Better understand what makes a relationship healthy

34%

…Talk with their parent, guardian, caregiver about things going on in their life

Source: Idaho Department of Health and Welfare, 2022. *SWDH Reducing the Risk participant exit surveys, FY21.*

As a result of this program, youth report being much more likely to…

58% …resist or say no to someone you are dating or going out with if they pressured you to participate in sexual acts, such as kissing, touching private parts, or sex

Source: Idaho Department of Health and Welfare, 2022. *SWDH Reducing the Risk participant exit surveys, FY21.*

How might SWDH help to...

- Increase confidence and communication skills to refuse or delay sexual activity
- Increase knowledge of contraception and protection methods
- Decrease adolescent pregnancy

...among youth in your communities?

Questions?

Charlene.Cariou@phd3.Idaho.gov

SOUTHWEST DISTRICT HEALTH

BUDGET REPORT FOR FY2022

Cash Basis | **Jan-22** | **Target 58.3%**

Fund Balances	FY Beginning	Month Ending	Change	
General Operating Fund	$ 65,977	$ 159,424	$ 93,448	
Millennium Fund	$ -	$ 77,947	$ 77,947	
LGIP Operating	$ 3,187,262	$ 4,470,976	$ 1,283,714	
LGIP Vehicle Replacement	$ 99,692	$ 99,766	$ 73	
LGIP Capital	$ 1,299,174	$ 1,299,174	$ -	
LGIP Facility Improvements	$ -	$ -	$ -	*Will move $138,000 from LGIP Operating
LGIP 27th Pay Period	$ -	$ -	$ -	*Will move $180,814 from LGIP Operating
Total	**$ 4,652,106**	**$ 6,107,287**	**$ 1,455,182**	*State GF, CFAC, Committed*

Income Statement Information		YTD	This month
(Less CFAC Funds)	**Net Revenue:**	**$ 5,662,593**	**$ 636,059**
	Expenditures:	$ (5,828,793)	$ (769,784)
	Net Income:	**$ (166,201)**	**$ (133,725)**

Revenue

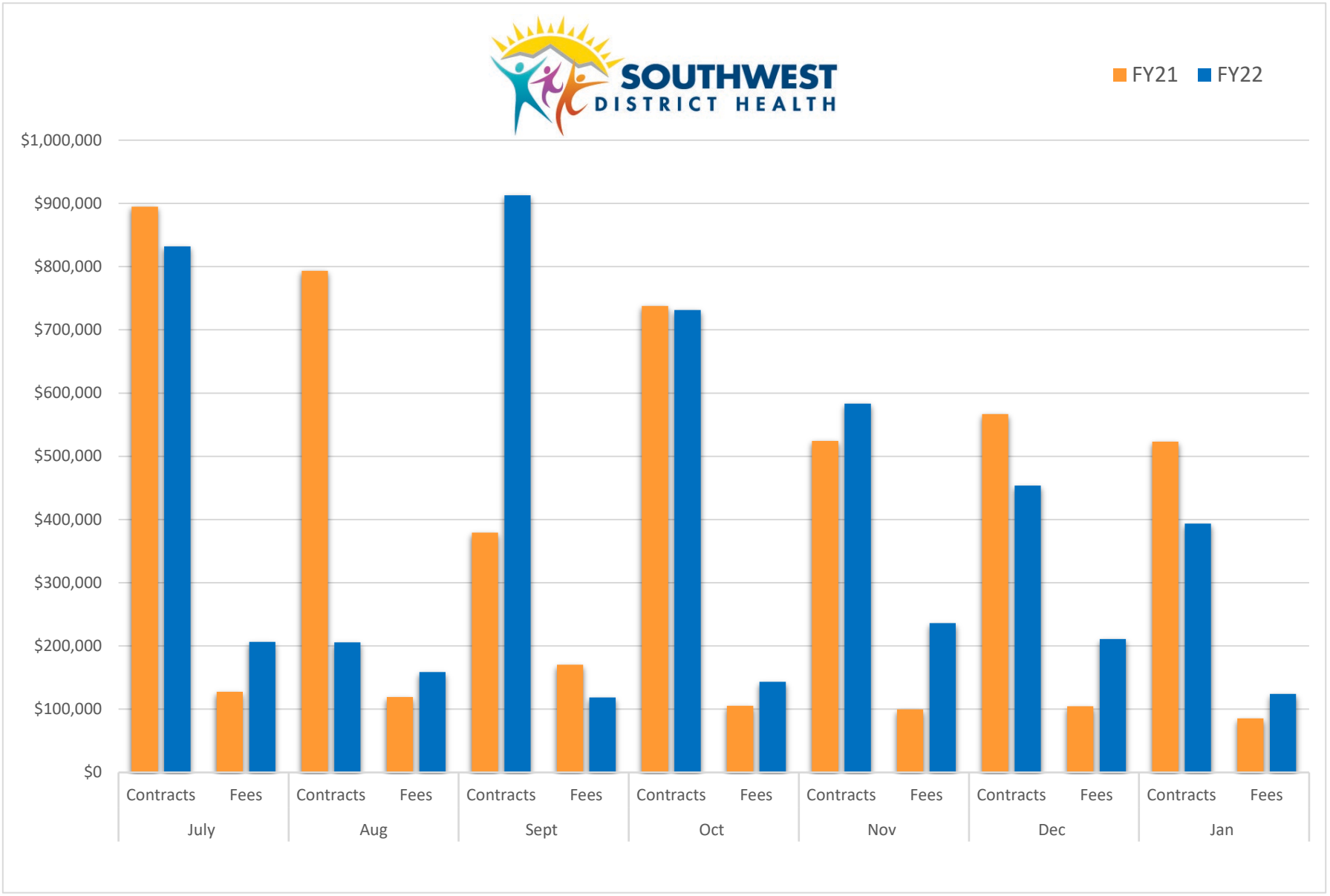
	Board of Health	Admin	Clinic Services	Env & Community Health	General Support	Buildings	Crisis Center	Total	YTD	Total Budget	Percent Budget to Actual
State GF Appropriations	$ -	$ 502,650	$ -	$ -	$ -	$ -	$ -	$ 502,650	$ 1,005,300	$ 1,005,300	100%
County Contributons	$ -	$ 116,825	$ -	$ -	$ -	$ -	$ -	$ 116,825	$ 817,773	$ 1,892,992	43%
Fees	$ -	$ -	$ 14,358	$ 109,653	$ -	$ 240	$ -	$ 124,251	$ 1,198,843	$ 1,789,138	67%
Contracts	$ -	$ -	$ 171,925	$ 145,147	$ -	$ -	$ 76,442	$ 393,515	$ 4,112,919	$ 6,678,142	62%
Sale of Assets	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 20,000	0%
Interest	$ -	$ 545	$ -	$ -	$ -	$ -	$ -	$ 545	$ 3,787	$ 6,780	56%
Other	$ -	$ -	$ -	$ 924	$ -	$ -	$ -	$ 924	$ 17,585	$ 337,833	5%
Monthly Revenue	$ -	$ 117,370	$ 186,283	$ 255,724	$ -	$ 240	$ 76,442	$ 636,059	$ 6,150,907	$ 11,730,185	52.4%
Year-to-Date Revenue	$ -	$ 1,309,874	$ 1,477,337	$ 2,880,099	$ 7,706	$ 2,159	$ 473,732	$ 6,150,907	REVISED DIRECT		
Budget	$ -	$ 2,659,939	$ 2,661,838	$ 5,379,032	$ 22,968	$ 4,713	$ 1,001,695	$ 11,730,185	REVISED DIRECT		
		49.2%	**55.5%**	**53.5%**	**33.5%**	**45.8%**	**47.3%**	**52.4%**			

Expenditures

	Board of Health	Admin	Clinic Services	Env & Community Health	General Support	Buildings	Crisis Center	Total	YTD	Total Budget	Percent Budget to Actual
Personnel	$ 628	$ 18,061	$ 196,324	$ 276,974	$ 81,717	$ 10,226	$ 3,063	$ 586,993	$ 4,418,289	$ 7,931,388	56%
Operating	$ 523	$ 4,701	$ 49,768	$ 33,083	$ 15,770	$ 23,507	$ 56,585	$ 183,938	$ 1,395,934	$ 2,681,386	52%
Capital Outlay	$ -	$ -	$ -	$ (1,147)	$ -	$ -	$ -	$ (1,147)	$ 14,570	$ 359,209	4%
Trustee & Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 62,500	0%
Monthly Expenditures	$ 1,151	$ 22,762	$ 246,092	$ 308,911	$ 97,487	$ 33,733	$ 59,648	$ 769,784	$ 5,828,794	$ 11,034,483	52.8%
Year-to-Date Expenditures	$ 7,190	$ 170,386	$ 1,884,594	$ 2,364,494	$ 700,768	$ 242,883	$ 458,479	$ 5,828,793	REVISED DIRECT		
Budget	$ 11,488	$ 393,405	$ 3,495,444	$ 4,336,867	$ 1,262,098	$ 698,100	$ 837,081	$ 11,034,483	REVISED DIRECT		
	62.6%	**43.3%**	**53.9%**	**54.5%**	**55.5%**	**34.8%**	**54.8%**	**52.8%**			

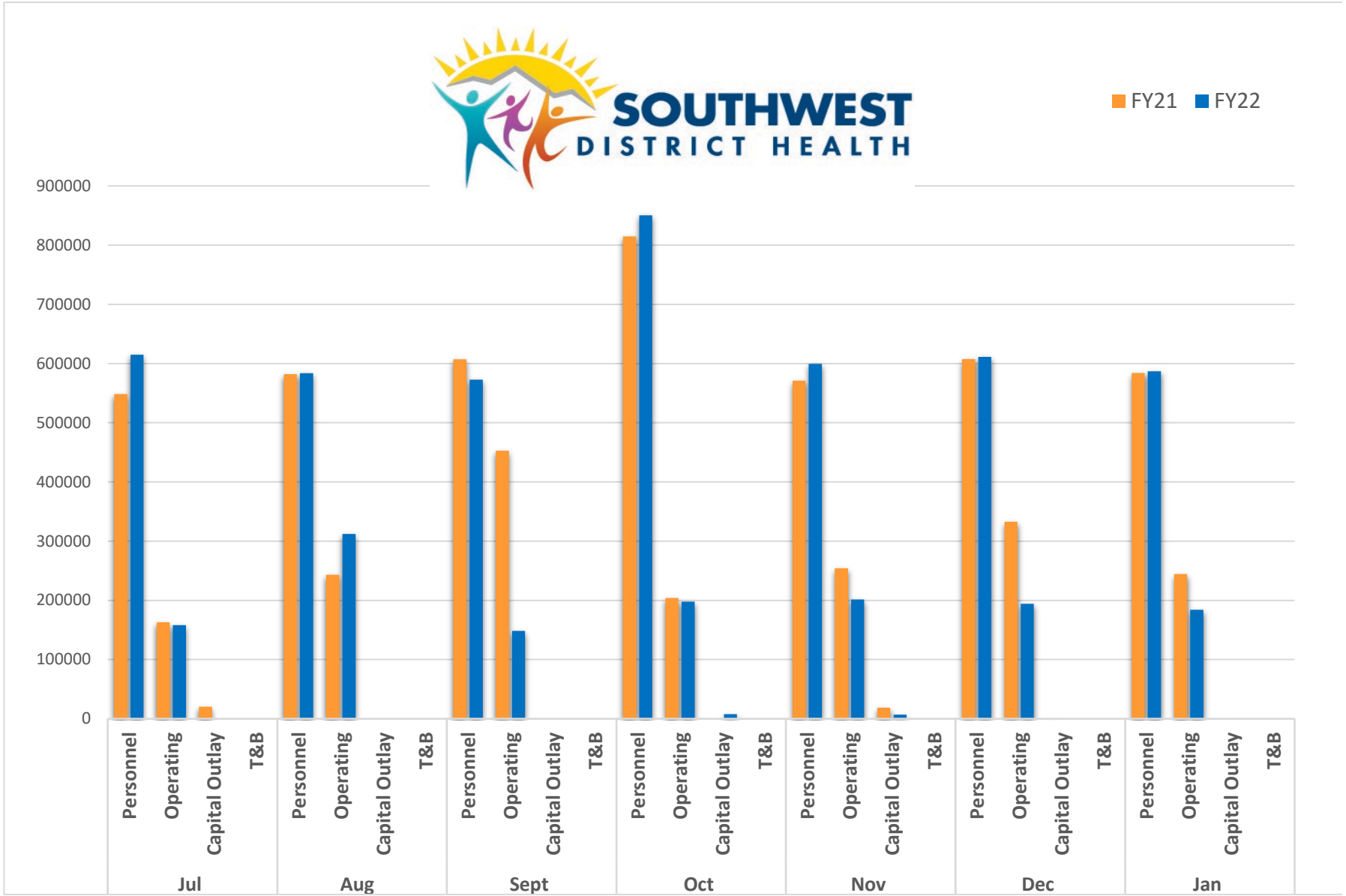
YTD REVENUES with Prior Year Comparison

Jan-22



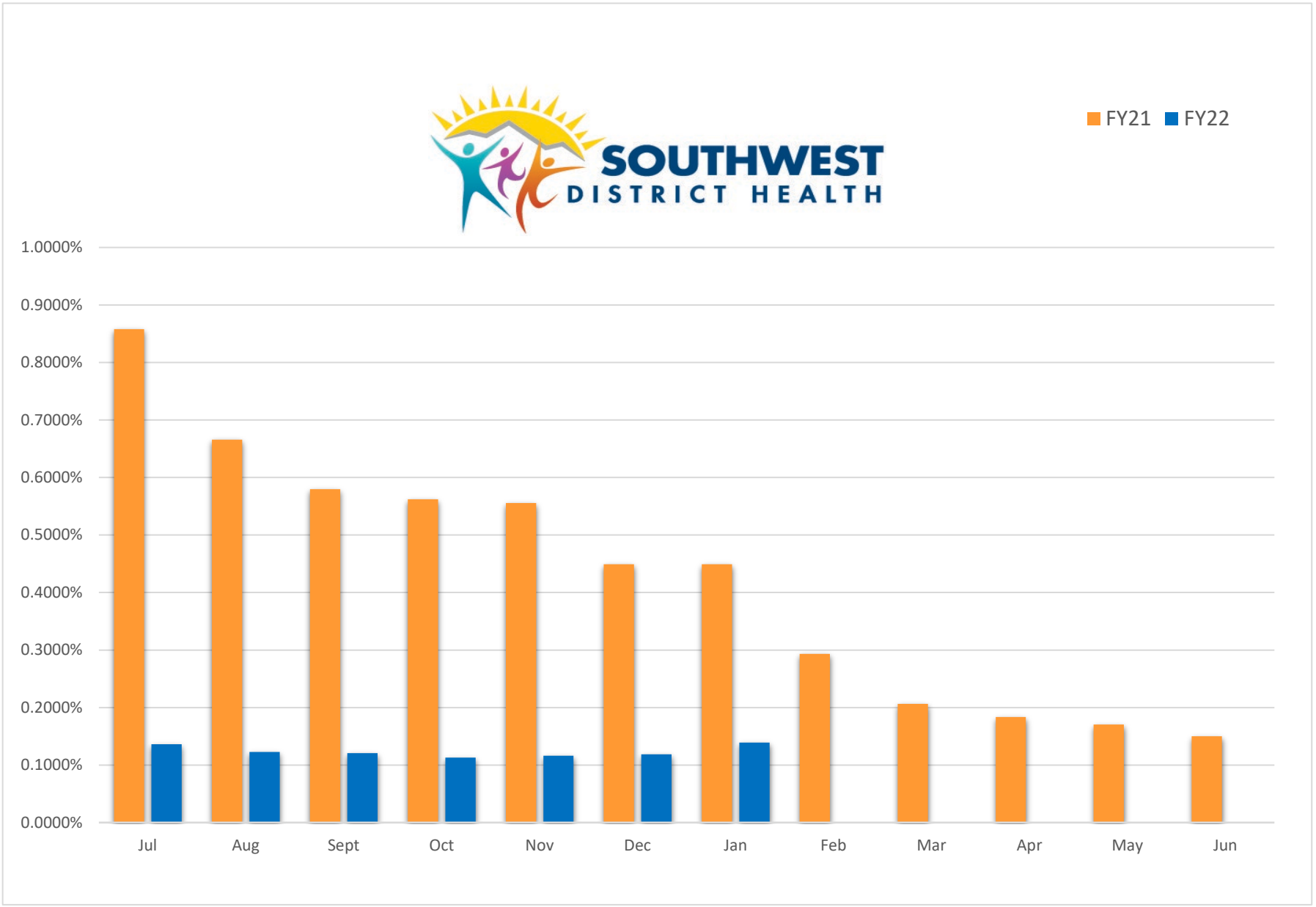
YTD EXPENDITURES with Prior Year Comparison

Jan-22



YTD Investment Yield with Prior Year Comparison

Jan-22



Southwest District Health
Summary of Restricted and Committed Funds - FY 2022

Restricted Funds - Third party restricted by contract, grant, or donation terms
Committed Funds - Committed by the Board of Health for a specific purpose

Fund Balances as of last prior month reported

	Restricted Funds	Committed Funds
Behavioral Health Board	$ 5,766.73	
Parents as Teachers	$ 117,087.79	
Citizen's Review Panel	$ 20,440.95	
Kresge Grant	$ -	
COVID Incentive grant*	$ 25,735.98	
Crisis Center (CFAC)	$ 28,571.00	
Personnel Updates		$ -
Weiser Project		$ 1,000.00
Clinic Medical Supplies/Equipment		$ 1,622.44
EH Employee Training		$ 5,000.00
EH A/V Equipment		$ 2,380.00
EH Vehicle		$ 33,790.00
EH Security		$ 7,500.00
County Collaborations		$ 70,000.00
Mobile Clinic/Events Unit		$ 130,000.00
Employee Development & Engagement		$ 20,000.00
EKG Machine		$ 1,000.00
27th Pay Period *Will move to LGIP as approved*		$ 180,814.00
Facility Improvements *Will move to LGIP as approved*		$ 138,000.00
**Not program funds and must be spent by Mar 1, 2022*	$ 197,602.45	$ 591,106.44

Southwest District Health
FY2022 Budget Revision Request

July 1, 2021 through June 30, 2022

District Summary	FY2021 Budget	FY2022 Budget	FY2022 Revision		FY2022 Change
REVENUE					
Fees	$1,715,979	$1,874,852	$1,789,138		-$85,714
Contracts	$4,152,338	$5,194,475	$5,637,794	*	$443,319
County Funds	$1,401,892	$1,401,892	$1,401,892		$0
County Funds HB316 Mar - June **	$0	$491,100	$491,100		$0
State Appropriation	$1,442,900	$985,800	$1,005,300		$19,500
Millennium Fund Appropriation	$129,500	$130,000	$124,500		-$5,500
Interest	$80,000	$50,000	$6,780		-$43,220
Sale of Land, Buildings & Equip	$20,000	$20,000	$20,000		$0
Other	$14,986	$24,000	$135,485		$111,485
Carry-Over Funds	$70,027	$169,000	$158,459		-$10,541
Board Committed Reserve	$12,900	$90,000	$43,889		-$46,111
Total Revenue	$9,040,522	$10,431,119	$10,814,337		$383,218
EXPENDITURES					
Salary & Wage	$4,657,914	$5,733,833	$5,474,514		-$259,319
Employee Benefits	$2,117,263	$2,631,858	$2,402,865		-$228,993
Operating Expenses	$2,080,545	$1,743,528	$1,883,504		$139,976
Capital Outlay	$184,800	$197,400	$359,209		$161,809
Trustee Benefits *(Pass-thru funds)*	$0	$124,500	$62,500		-$62,000
Total Expenditures	$9,040,522	$10,431,119	$10,182,592		-$248,527
CRISIS CENTER					
Contract Revenue	$1,520,000	$1,083,289	$915,848		-$167,441
Expenditures	$1,520,000	$1,083,289	$851,891		-$231,398
GRAND TOTALS					
Revenues	**$10,560,522**	**$11,514,408**	**$11,730,185**		**$215,777**
Expenditures	**$10,560,522**	**$11,514,408**	**$11,034,483**		**-$479,925**
		Difference	**$695,702**		
		Less CFAC Commitment	**-$488,314**		
		Less Anticipated Crisis Carryover	**-$63,957**		
		Potential Carryover FY23	**$143,431**		
			OVERALL BUDGET CHANGE		**-$264,148**

*** = includes CFAC reimbursements**

	FY21 Budget	FY22 Budget	FY22 Revision
FTEs	97.1	116.7	116.7
COVID		12.0	15.0
BASE		104.7	101.7

3. **Albertson Card purchases**
The Albertson credit card may be used to purchase refreshments for authorized district-sponsored meetings that are at least three hours in length. A printed meeting agenda is required when checking out the Albertson card from the receiving clerk. The card must be checked out immediately prior to making the purchase. The card and receipt must be returned to the receiving clerk immediately after the purchase is made. The card may not be "passed off" to another employee. A sign-in sheet from the meeting must be provided to the receiving clerk within 24 business hours after the conclusion of the meeting.

4. **Standing Purchase Orders**
4.1. Standing POs are in force for the fiscal year they are originated. Each standing PO must be reviewed prior to being used in subsequent years by the employee responsible for the PCA the PO is being billed to. If the standing PO details have changed, a new PO shall be issued or an update provided by the division responsible. The district director or their designee must approve all standing POs. The purchasing office shall be notified if a standing PO is no longer valid.
4.1.1. When purchasing items for maintenance or housekeeping needs, the store receipt must be turned into the purchasing office within 24 business hours of the purchase.

5. **Meal and Refreshment purchases**
POs for meetings involving refreshments or meals must include a printed copy of the agenda before they are processed. Attendance or sign-in sheets and receipts for purchases at a store or restaurant must be provided to support the invoice payment. SWDH adheres to the guidelines as provided by the State Travel Policy and Procedures for meals and refreshments. Any exceptions must be approved by a division administrator, financial manager, or district director.

6. **Training or education classes**
Registration for attendance at paid training or education sessions that do not entail travel outside the local area and do not include an overnight stay, will be authorized using a PO. All POs for training or education must be approved by the division administrator. Registration instructions must be followed and attached to the PO. The originating division is responsible for the registration after the PO is processed.

7. **District Vehicle Repairs**
POs for repair of district-owned vehicles will be initiated by the fleet manager. Preventive maintenance for district-owned vehicles are covered via standing POs. Examples of preventative maintenance includes overall inspection of the vehicle, changing engine oil, replacing filters, windshield wipers, and batteries, etc.

8. **Photocopy Machine Supplies**
The district has maintenance agreements for all photocopy machines that are leased or owned by SWDH. IT staff are responsible for software upgrades, photocopier service orders, and maintenance. The receiving clerk is responsible for ordering all toner cartridges or supplies.

9. **Spending Authority and Bid Process**
9.1. The district has a spending authority up to $9,999 per individual purchase without going through a competitive bid process.

9.2. SWDH shall receive three price quotes (if three vendors are available) for all purchases between $10,000 and $100,000. Any purchase of $100,000 or more must be submitted through the Department of Administration for review and approval.
9.2.1. Documentation of the price quotes must be attached to the purchase order. All price quote documentation will be attached to the electronic PO and retained per Legislative rules.
9.2.2. Only the district director or their designee is authorized to sign and approve POs for individual purchases between $2,501 and $100,000.

10. **Receiving Procedures**
10.1. All shipments, with the exception of vaccine, shall be delivered to the purchasing office where the items will be checked against the packing slips and purchase orders.
10.2. The receiving clerk will notify the PO originator of the delivery once the items are processed and ready for pickup.

CS Needs Assessment and Next Steps

Thursday, February 24, 2022

Needs Assessment Review

Questions

1. Describe your position in 1-2 sentences.
2. Why do you work at Southwest District Health?
3. What do you need, that you currently don't have, to do your job well?
4. Strengths of your program, the division, and/or district?
5. Weaknesses of your program, the division, and/or district?
6. Opportunities we are missing as a program, division, and/or district?
7. Threats from the outside for your program, the division, and/or district?
8. Anything else you feel like I should know about?

Needs Assessment Review—cont.

of people surveyed = 23 (anyone that signed up on the Doodle poll)

# of respondents for each program

- WIC—3
- Administrative Support—2
- Primary Care Clinic—7
- NFP—3
- PAT—2
- Satellites—3
- Oral Health—2
- Front Office--1

Why do you work at SWDH?

1. To help/serve others (moms, babies, kids, underserved, and town I live in)--18 (78%)

2. Believe in the effectiveness of the specific program for which I work (WIC and NFP)--4 (17%)

3. Supports my personal life (good retirement, flexible with family needs, needed part-time job)--4 (17%)

What do you need?

1. More qualified staff (medical, dental, NFP, PAT)--7 (30%)

2. IT items/infrastructure (computers and improved internet)--6 (26%)

3. Other items (30%)
    - Supplies specific to program—3
    - Marketing for programs—2
    - Training in EH—2

Strengths?

1. Staff that work here are passionate about the mission—9 (39%)

2. Strong sense of community/teamwork--7 (30%)

3. The work/services that we provide are missional (serve the underserved and the community)--7 (30%)

Weaknesses?

1. Inconsistency across division—11 (48%)
   a. In either having or knowing policies and procedures—4
   b. In knowledge of resources other programs provide, roles and responsibilities within program, or when things are or are not available—7

2. Staffing shortages, especially for full-time, qualified clinic positions—7 (30%)

3. 3-way tie
   a. Poor communication--5 (22%)
   b. Lack of training—5 (22%)
   c. Inefficient (too many people involved in decision making, too many steps to get things done)--5 (22%)

Opportunities

1. Many like-minded organizations to partner with—9 (39%)
2. Marketing in the community through established outreach events—8 (35%)
3. Growing population needs our services—7 (30%)

Threats

1. Lack of knowledge or bad reputation in the community—10 (43%)

2. Others doing what we do (primary care and oral health prevention for kids)--6 (26%)

3. Other employers pay more, especially for clinical positions—5 (22%)

Next Steps—Crawl, Walk, Run

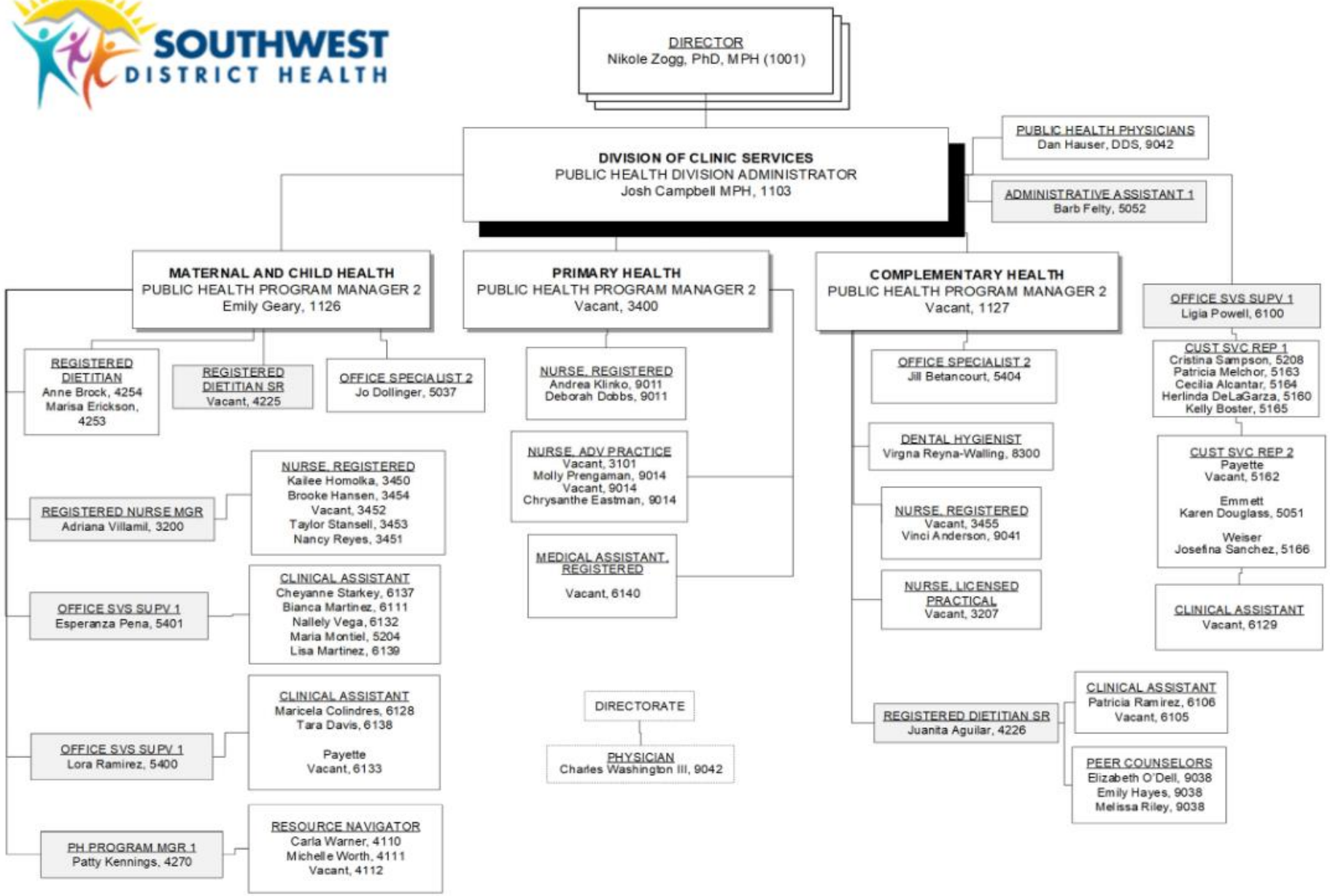
Crawl--Stabilization

1. Establish clarity and consistency in:
   a. Roles and responsibilities
   b. Policies and procedures
   c. Scope of services and availability

2. Measure what we are doing—establish baseline

3. Hire and equip qualified staff
   - 4 Cs—Competent, Committed, Compassionate, Character
   - Provide consistent training for new staff

SOUTHWEST DISTRICT HEALTH



SOUTHWEST DISTRICT HEALTH

Walk--Integration

1. Establish processes and structure for interagency referrals and measure success.

2. Establish relationships for partner agency referrals and measure success.

Run--Expansion

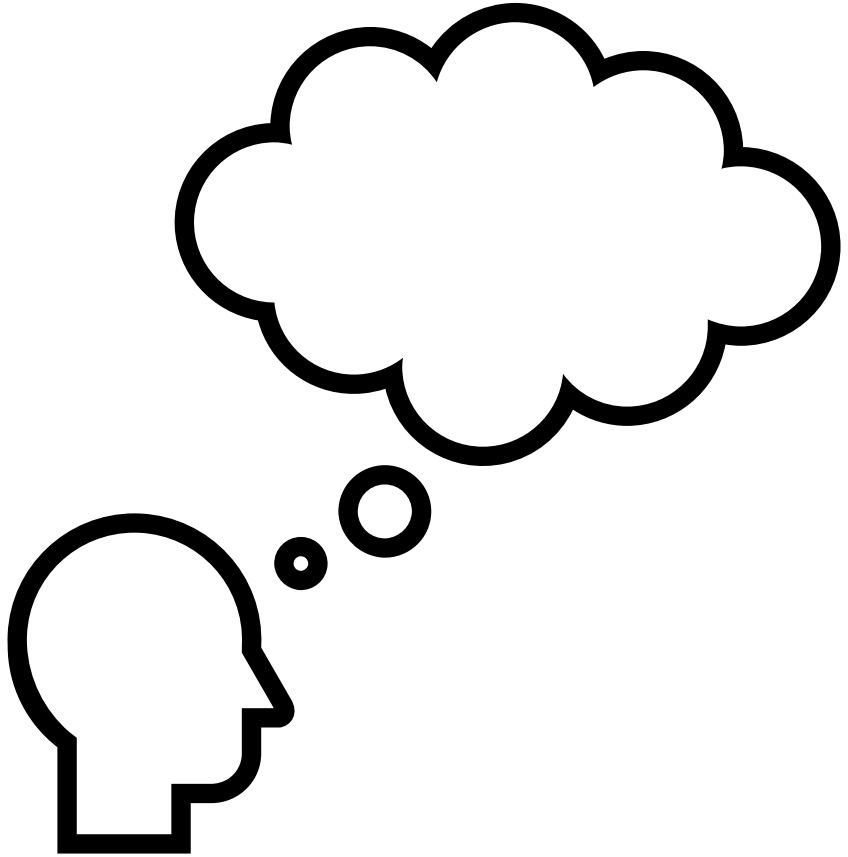
1. Identify and implement services we should be offering, but currently are not. AKA—Develop new programs.

2. Eliminate or modify services that are no longer needed by the community or unsustainable.

Support a cultural of empowerment, accountability, trust, and grace

- Empower each other to make decisions within scope at all levels
- Hold each other accountable to program goals
- Trust each other with assigned areas
- Give each other grace when we mess up, hear each other out (escalation process)

QUESTIONS?

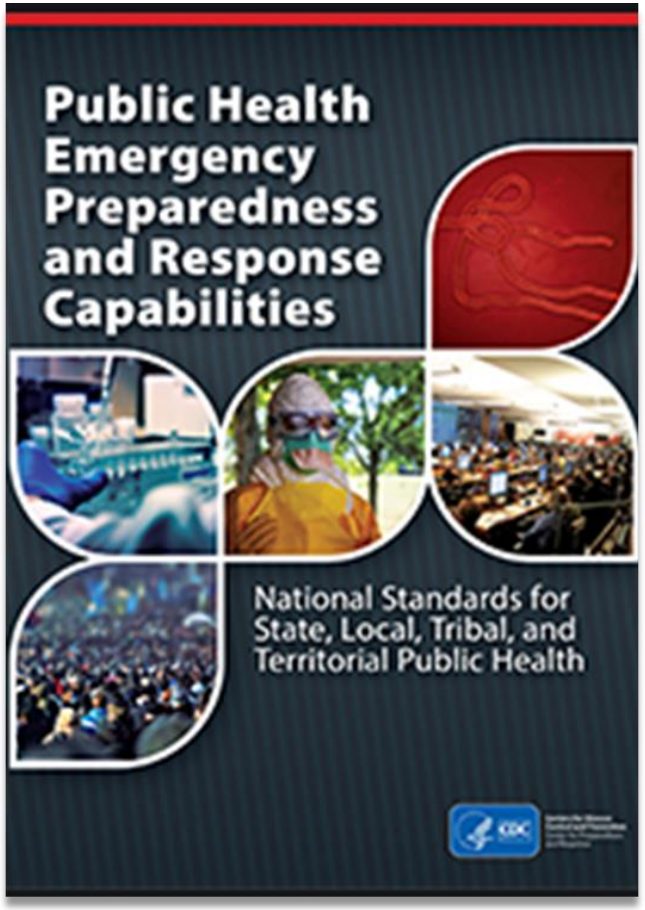


Public Health Emergency Preparedness and Epidemiology Response Information Sharing

Southwest District Health Board of Health Meeting

February 24, 2022

Capabilities Based Program



Capability 6 – Information Sharing

Definition: Information sharing is the ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, tribal, and territorial levels of government and the private sector.

Reference: https://www.cdc.gov/cpr/readiness/00_docs/CDC_PreparednesResponseCapabilities_October2018_Final_508.pdf

Information Sharing

- State Communications On-call Phone
  - 24/7 accessibility
  - 8 staff rotation
  - Examples of calls – Hazardous Materials, Disease Reporting, etc.

Information Sharing

- SWDH Information Sharing Platforms:
  - Epidemiology reporting line
  - Southwest District Health Website
  - HIPPA compliant platform - Netsfere

- State Information Sharing Platforms:
  - Health Alert Network (HAN) – Department of Health and Welfare
  - Idaho Resource Tracking System – Department of Health and Welfare
  - Volunteer Idaho – Department of Health and Welfare
  - WebEOC – Idaho Office of Emergency Management

Internal Communications

- call-em-all messaging
- Emergency notification call down trees
- Government Emergency Telecommunications (GETS)
- Wireless Priority Service (WPS)
- Base Station Radio
- HAM Radio and VHF radio functionality

At-A-Glance: Capability Definitions, Functions, and Summary of Changes

Capability 1: Community Preparedness

Definition: Community preparedness is the ability of communities to prepare for, withstand, and recover from public health incidents in both the short and long term. Through engagement and coordination with a cross-section of state, local, tribal, and territorial partners and stakeholders, the public health role in community preparedness is to

- Support the development of public health, health care, human services, mental/behavioral health, and environmental health systems that support community preparedness
- Participate in awareness training on how to prevent, respond to, and recover from incidents that adversely affect public health
- Identify at-risk individuals with access and functional needs that may be disproportionately impacted by an incident or event
- Promote awareness of and access to public health, health care, human services, mental/behavioral health, and environmental health resources that help protect the community's health and address the access and functional needs of at-risk individuals
- Engage in preparedness activities that address the access and functional needs of the whole community as well as cultural, socioeconomic, and demographic factors
- Convene or participate with community partners to identify and implement additional ways to strengthen community resilience
- Plan to address the health needs of populations that have been displaced because of incidents that have occurred in their own or distant communities, such as after a radiological or nuclear incident or natural disaster

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Determine risks to the health of the jurisdiction
- Function 2: Strengthen community partnerships to support public health preparedness
- Function 3: Coordinate with partners and share information through community social networks
- Function 4: Coordinate training and provide guidance to support community involvement with preparedness efforts

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Defines at-risk individuals as people with access and functional needs that may be disproportionately impacted by an incident or event, and provides parameters to identify those populations
- Highlights Americans with Disabilities Act (ADA) requirements in jurisdictional public health preparedness and response plans
- Accentuates the importance of community partnerships, including tribes and native-serving organizations in public health preparedness and response activities
- Promotes integration of community partners to support restoration of community networks and social connectedness to improve community resilience

Capability 2: Community Recovery

Definition: Community recovery is the ability of communities to identify critical assets, facilities, and other services within public health, emergency management, health care, human services, mental/behavioral health, and environmental health sectors that can guide and prioritize recovery operations. Communities should consider collaborating with jurisdictional partners and stakeholders to plan, advocate, facilitate, monitor, and implement the restoration of public health, health care, human services, mental/behavioral health, and environmental health sectors to at least a day-to-day level of functioning comparable to pre-incident levels and to improved levels, where possible.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Identify and monitor community recovery needs
- Function 2: Support recovery operations for public health and related systems for the community
- Function 3: Implement corrective actions to mitigate damage from future incidents

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Highlights the need to define the jurisdictional public health agency recovery lead and support role
- Supports the National Disaster Recovery Framework (NDRF)
- Promotes integration of community partners to support community recovery and restoration
- Emphasizes engagement of community partners to access hard-to-reach populations to ensure inclusive communications that meet the needs of the whole community

Capability 3: Emergency Operations Coordination

Definition: Emergency operations coordination is the ability to coordinate with emergency management and to direct and support an incident or event with public health or health care implications by establishing a standardized, scalable system of oversight, organization, and supervision that is consistent with jurisdictional standards and practices and the National Incident Management System (NIMS).

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Conduct preliminary assessment to determine the need for activation of public health emergency operations
- Function 2: Activate public health emergency operations
- Function 3: Develop and maintain an incident response strategy
- Function 4: Manage and sustain the public health response
- Function 5: Demobilize and evaluate public health emergency operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Distinguishes the need to identify and clarify the jurisdictional ESF #8 response role based on incident type and characteristics
- Incorporates the National Health Security Strategy and Crisis Standards of Care for public health activation
- Emphasizes the importance of supporting development of mission-ready packages (MRPs) for mutual aid and understanding the Emergency Management Assistance Compact (EMAC)

Capability 4: Emergency Public Information and Warning

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Activate the emergency public information system
- Function 2: Determine the need for a Joint Information System
- Function 3: Establish and participate in information system operations
- Function 4: Establish avenues for public interaction and information exchange
- Function 5: Issue public information, alerts, warnings, and notifications

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Promotes the need to leverage social media platforms for issuing emergency public information and warnings
- Clarifies conditions for establishing a virtual Joint Information Center and Joint Information System
- Includes content to identify and reach populations at risk to be disproportionately impacted by incidents and those with limited access to public information messages

Capability 5: Fatality Management

Definition: Fatality management is the ability to coordinate with partner organizations and agencies to provide fatality management services. The public health agency role in fatality management activities may include supporting

- Recovery and preservation of remains
- Identification of the deceased
- Determination of cause and manner of death
- Release of remains to an authorized individual
- Provision of mental/behavioral health assistance for the grieving

The role also may include supporting activities for the identification, collection, documentation, retrieval, and transportation of human remains, personal effects, and evidence to the examination location or incident morgue.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Determine the public health agency role in fatality management
- Function 2: Identify and facilitate access to public health resources to support fatality management operations
- Function 3: Assist in the collection and dissemination of antemortem data
- Function 4: Support the provision of survivor mental/behavioral health services
- Function 5: Support fatality processing and storage operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Clarifies importance of identifying the public health agency role in fatality management and describes potential fatality management lead, advisory, and support roles
- Aligns the fatality management definition to the existing federal definition as recommended by the U.S. Department of Health and Human Services (HHS), Disaster Mortuary Operational Response Team (DMORT)
- Updates resources to improve coordination, accuracy, and timeliness of electronic mortality reporting

Capability 6: Information Sharing

Definition: Information sharing is the ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, tribal, and territorial levels of government and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to all levels of government and the private sector in preparation for and in response to events or incidents of public health significance.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Identify stakeholders that should be incorporated into information flow and define information sharing needs
- Function 2: Identify and develop guidance, standards, and systems for information exchange
- Function 3: Exchange information to determine a common operating picture

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Increases alignment to public health surveillance and data strategies
- Emphasizes the need to implement data security and cybersecurity
- Emphasizes the need to decrease reporting time and increase collaboration by expanding use of electronic information systems, such as electronic death registration (EDR), electronic laboratory reporting (ELR), and syndromic surveillance systems

Capability 7: Mass Care

Definition: Mass care is the ability of public health agencies to coordinate with and support partner agencies to address, within a congregate location (excluding shelter-in-place locations), the public health, health care, mental/behavioral health, and human services needs of those impacted by an incident. This capability includes coordinating ongoing surveillance and public health assessments to ensure that health needs continue to be met as the incident evolves.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Determine public health role in mass care operations
- Function 2: Determine mass care health needs of the impacted population
- Function 3: Coordinate public health, health care, and mental/behavioral health services
- Function 4: Monitor mass care population health

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Incorporates content for accommodating individuals with access and functional needs within general population shelters
- Includes considerations for registration of individuals requiring decontamination or medical tracking in the event of an environmental health incident
- Coordinated content with the HHS Assistant Secretary for Preparedness and Response's (ASPR) Health Care Preparedness and Response Capabilities

Capability 8: Medical Countermeasure Dispensing and Administration

Definition: Medical countermeasure dispensing and administration is the ability to provide medical countermeasures to targeted population(s) to prevent, mitigate, or treat the adverse health effects of a public health incident, according to public health guidelines. This capability focuses on dispensing and administering medical countermeasures, such as vaccines, antiviral drugs, antibiotics, and antitoxins.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Determine medical countermeasure dispensing/administration strategies
- Function 2: Receive medical countermeasures to be dispensed/administered
- Function 3: Activate medical countermeasure dispensing/administration operations
- Function 4: Dispense/administer medical countermeasures to targeted population(s)
- Function 5: Report adverse events

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Revises the Capability 8 title, definition, and content to account for both the dispensing and the administration of medical countermeasures, such as vaccines, antidotes, and antitoxins
- Adds content and resources to account for potential radiological or nuclear exposure
- Broadens the network of dispensing and administration sites to include pharmacies and other locations

Capability 9: Medical Materiel Management and Distribution

Definition: Medical materiel management and distribution is the ability to acquire, manage, transport, and track medical materiel during a public health incident or event and the ability to recover and account for unused medical materiel, such as pharmaceuticals, vaccines, gloves, masks, ventilators, or medical equipment after an incident.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Direct and activate medical materiel management and distribution
- Function 2: Acquire medical materiel from national stockpiles or other supply sources
- Function 3: Distribute medical materiel
- Function 4: Monitor medical materiel inventories and medical materiel distribution operations
- Function 5: Recover medical materiel and demobilize distribution operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Broadens the cold chain management guidance to include all aspects of storage and handling
- Expands recovery activities to incorporate proper handling and disposal of infectious, hazardous, or contaminated materiel and waste
- Accounts for security and inventory management tasks that occur throughout the entire distribution process

Capability 10: Medical Surge

Definition: Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the health care system to endure a hazard impact, maintain or rapidly recover operations that were compromised, and support the delivery of medical care and associated public health services, including disease surveillance, epidemiological inquiry, laboratory diagnostic services, and environmental health assessments.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Assess the nature and scope of the incident
- Function 2: Support activation of medical surge
- Function 3: Support jurisdictional medical surge operations
- Function 4: Support demobilization of medical surge operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Emphasizes the need to define public health agency lead and support roles within medical surge operations
- Eliminates use of the term "HAvBED" because the term is no longer promoted by the Hospital Preparedness Program (HPP) and focuses instead on "situational awareness" and "health care systems tracking" as an overarching theme
- Emphasizes the need to identify and clarify the jurisdictional ESF #8 response role in medical surge operations based on jurisdictional role and incident characteristics

Capability 11: Nonpharmaceutical Interventions

Definition: Nonpharmaceutical interventions are actions that people and communities can take to help slow the spread of illness or reduce the adverse impact of public health emergencies. This capability focuses on communities, community partners, and stakeholders recommending and implementing nonpharmaceutical interventions in response to the needs of an incident, event, or threat. Nonpharmaceutical interventions may include

- Isolation
- Quarantine
- Restrictions on movement and travel advisories or warnings
- Social distancing
- External decontamination
- Hygiene
- Precautionary protective behaviors

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Engage partners and identify factors that impact nonpharmaceutical interventions
- Function 2: Determine nonpharmaceutical interventions
- Function 3: Implement nonpharmaceutical interventions
- Function 4: Monitor nonpharmaceutical interventions

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Focuses on collaboration by expanding suggested partners for implementing nonpharmaceutical interventions
- Supports establishment of community reception center processes to enhance ability to respond to radiological and nuclear threats
- Highlights management of mass gatherings (delay and cancel) based on all-hazards scenarios

Capability 12: Public Health Laboratory Testing

Definition: Public health laboratory testing is the ability to implement and perform methods to detect, characterize, and confirm public health threats. It also includes the ability to report timely data, provide investigative support, and use partnerships to address actual or potential exposure to threat agents in multiple matrices, including clinical specimens and food, water, and other environmental samples. This capability supports passive and active surveillance when preparing for, responding to, and recovering from biological, chemical, and radiological (if a Radiological Laboratory Response Network is established) public health threats and emergencies.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Conduct laboratory testing and report results
- Function 2: Enhance laboratory communications and coordination
- Function 3: Support training and outreach

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Updates Laboratory Response Network (LRN) requirements
- Incorporates LRN-chemical requirements
- Prioritizes cooperation, coordination, and information sharing with LRN laboratories, other public laboratories, and jurisdictional sentinel laboratories

Capability 13: Public Health Surveillance and Epidemiological Investigation

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes. It also includes the ability to expand these systems and processes in response to incidents of public health significance.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Conduct or support public health surveillance
- Function 2: Conduct public health and epidemiological investigations

- Function 3: Recommend, monitor, and analyze mitigation actions
- Function 4: Improve public health surveillance and epidemiological investigation systems

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Increases alignment to public health surveillance and data strategies
- Strengthens surveillance systems for persons in isolation or quarantine and persons placed under monitoring and movement protocols
- Emphasizes syndromic surveillance and data collection to improve situational awareness and responsiveness to hazardous events and disease outbreaks, for example, participation in CDC's National Syndromic Surveillance Program BioSense Platform

Capability 14: Responder Safety and Health

Definition: Responder safety and health is the ability to protect public health and other emergency responders during pre-deployment, deployment, and post-deployment.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Identify responder safety and health risks
- Function 2: Identify and support risk-specific responder safety and health training
- Function 3: Monitor responder safety and health during and after incident response

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Incorporates the need to securely manage responder data
- Improves responder on-site management, tracking, in-processing, and out-processing
- Reprioritizes hierarchy of control and promotes the alignment of responder safety and health control measures, for example, personal protective equipment (PPE), with jurisdictional risk assessment findings

Capability 15: Volunteer Management

Definition: Volunteer management is the ability to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support the jurisdictional public health agency's preparedness, response, and recovery activities during pre-deployment, deployment, and post-deployment.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Recruit, coordinate, and train volunteers
- Function 2: Notify, organize, assemble, and deploy volunteers
- Function 3: Conduct or support volunteer safety and health monitoring and surveillance
- Function 4: Demobilize volunteers

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Addresses the need to monitor volunteer safety, risks, and actions during and after an incident
- Strengthens and clarifies volunteer eligibility considerations, such as medical, physical, and emotional health, during the volunteer selection process
- Promotes use of Emergency Responder Health Monitoring and Surveillance™ (ERHMS™)

Septic Fee Discussion Continued from Jan Board Meeting

- The Board asked two questions when they were presented with the No Test Hole/Site Evaluation Fee:
  - Can we legally assign this fee?
    - Legal Counsel has advised us that we are well within our legal bounds to assign this fee
  - Are we charging customers twice for this service?
    - This question is no longer applicable after we developed an alternative option.
- After further review, we feel that it will be better for the customers and SWDH if we instead, extend the septic permit from 12-months, to 18-months.

Septic Fee Discussion Continued from Jan Board Meeting cont.

- We are asking the Board to consider extending the length of our septic permits, from 12-months, to 18-months
  - This would give a customers at least 2.5 years to complete their application and permitting process
  - This would greatly reduce cost and conflict for customers which are not able to complete their systems within the current 12-month permit
    - Estimated 40-60 permits expire each year
  - We would like to caveat this with no extensions or grace periods as those are built into the extended permit length
- We have discussed with other health districts, and we will be the second district to do this
- We have already obtained approval from DEQ to extend our permits to 18-months

Septic Permit Decision

Option A (keep it the same)

- 12-month permit for $850
- Total time to complete application and permit ~24 months
- Permit can be renewed for 12-months “before expiration date”
- $850 “reapplication cost if permit expires”

Potentially develop conflict with customers who do not feel like they should have to pay an additional $850 to finish their septic install after their permit expires

Option B (18-month permit)

- 18-month permit for $850
- Total time to complete application and permit ~30 months
- Permit can be renewed for 12-months “before expiration date”
- No variances or grace periods for this permit expiration date
- $850 “reapplication cost if permit expires”

Potentially develop conflict with customers when our permit lengths are inconsistent with other health districts

Option C (No Test Hole/ Site Evaluation Fee)

- 12-month permit for $850
- Total time to complete application and permit ~24 months
- Permit can be renewed for 12-months “before expiration date”
- No variances or grace periods for this permit expiration date
- $425 “reapplication cost if permit expires”

Potentially develop conflict with customers who feel they should not have to pay when SWDH is not doing as much work to complete their permit

CONFIDENTIAL LEGAL MEMORANDUM

DATE: **August 14, 2017**

TO: **Mike Kane**

FROM: **Kristen Atwood**

RE: **Food Establishment Act Fees**

FILE: **Southwest District Health (#1300.00)**

Notice: This is confidential legal research, advice, and work product governed by the Attorney-Client Privilege and the Attorney Work Product Doctrine. This information is not intended or permitted to be used for public disclosure and is intended solely for confidential use.

Issue: Whether Southwest District Health (SWDH) is permitted to charge fees not enumerated in the Food Establishment Act.

Idaho Code § 39-1607 states that the Department of Health and Welfare's regulatory authority may charge a fee "for licensing a food establishment…[f]ees collected for licensing a food establishment shall be used by the designated regulatory authority for funding a portion of the food safety inspection program."

Idaho Code § 39-414(11) permits the district board of health the power to "establish a charge whereby the board agrees to render services to or for entities other than governmental or public agencies for an amount reasonably calculated to cover the cost of rendering such service."

The administrative rules governing health district fees note that:

> [t]he public health districts are statutorily responsible for providing health services to the public. The public health districts are also statutorily entitled to adopt fees and charges for the services they render. The public health districts therefore find that it is reasonably necessary to adopt these rules to enable them to charge fees for the services they render in order to protect the public health, safety, and welfare, and to comply with the requirements of federal, state, and local laws, rules, and regulations.

IDAPA 41.02.01.000.

In addition, pursuant to Idaho Code § 39-414(11), the health district is allowed to "establish reasonable charges or fees for services rendered to the members of the public in an amount calculated to cover the cost of rendering such services." IDAPA 41.02.01.010. Further,

> Each public health district may adopt charges or fees for services provided consisting of screening, education, consultation, record keeping, evaluation, assessment, referral, permitting, inspection, survey, and treatment as appropriate in the physical health, environmental health, health education, and other programs which they administer including, but not limited to, adult health, AIDS/HIV, child health/adolescent health, communicable diseases, day care, immunization, perinatal services, primary care, reproductive health, risk reduction, school health, sexually transmitted diseases, training and continuing education, monitoring and inspection programs, public health information records development and maintenance, and such other health-related programs which serve specific beneficiaries or which address specific legal responsibilities as may be approved by the respective district board of health from time to time.

IDAPA 41.02.01.011.

Although the Food Establishment Act does not explicitly state that the district may charge fees other than those set forth in § 39-1607, § 39-414(11) and the accompanying administrative rules permit the district to charge additional fees so long as those fees are reasonable, are for services rendered to the public and are in an amount to cover the cost of rendering the services. IDAPA 41.02.01.011 provides a long list of services for which a district may charge a fee, and then concludes that list with "such other health-related programs which serve specific beneficiaries or which address specific legal responsibilities as may be approved by the respective district board of health from time to time."

As explained by Ms. Zogg, when a food facility is ready to open, it submits a plan and the district reviews that plan. The district would like to continue charging the food facility for that review. The district would also like to charge food establishments for attending training at the health district. Both of these examples fall directly in the services set forth in IDAPA 41.02.01.011.

Based on the statues and rules cited above, as long as the district is only charging fees to cover the cost of the plan review and the cost of providing the training, these fees would be permissible.

From: Mike Kane <mkane@ktlaw.net>
Sent: Thursday, February 3, 2022 10:57 AM
To: Nikole Zogg <Nikole.Zogg@phd3.idaho.gov>; Douglas Doney <Douglas.Doney@phd3.idaho.gov>
Subject: Your question re fees

Thank you for your clarification of the issue. You have asked:

In follow-up to my conversation with you last week about setting fees, I was able to listen to the conversation at the board meeting and I think I have a good handle on their questions now.

- *According to 39-414.11 - PHDs can set fees for an amount reasonably calculated to cover the cost of rendering such services.*
- *According to IDAPA 58.01.03.005.08 & 09 - applications and permits are valid for one year.*
- *In an situation where an application or permit expires, can a PHD:*
    - *charge the full fee to restart the process even if some of the work has already been completed and doesn't need to be repeated?*
    - *charge a fee lesser than the original amount to cover the anticipated cost to complete the work once a new application/permit is submitted?*
    - *charge a fee at all to restart the process since presumbly the original fee covered the entire cost even it wasn't accomplished within the period outlined by IDAPA?*

The board was particularly interested in the last bullet item. They're concerned we could potentially make a profit by charging a fee that doesn't connect to a new service. I assume that there would be some additional cost to restart the process on our end, albeit our team does think that the in most cases the field work that has been completed would not need to be repeated.

When a board engages in fee setting, it looks to the work involved at a macro level, as each individual case will have different costs associated with it. Taking up the potential costs, the board must put together a fee that it estimates will cover costs to the district based upon generic information. In so doing, the fee is based upon a "best guess" as to what the costs are in most situations. This is allowed for in 39-414, since it speaks to "an amount reasonably calculated to cover the cost…"

Based upon the information you have provided, the original fee was designed to cover the entire cost and if no work at all is required to simply renew the permit, then no fee should be charged. However, it is intuitive that your staff will be required to do something to deal with the renewal process that would ordinarily not be required, even if that is only clerical or administrative. So if the staff is able to estimate the amount of cost to the district by calculating how much time and work is involved in the renewal process, that would be a reasonable basis to set a fee.

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Legislative Update – February 24, 2022

Bill number	Title	Brief Description	Impact	Status
HB491	Personal medical information	This bill amends and adds to existing law to provide for the protection of personal medical information.	May impact SWDH's ability to provide a safe working environment and meet infection prevention and control standards for clinic settings.	Printed and referred to Ways & Means
HB502	Immunization registry, opt-in	This bill amends existing law to provide for voluntary opt-in into the immunization registry and removes language about providing reminders to parents of children in the registry.	SWDH receives calls daily requesting copies of immunization records from the registry. Changing the process to an opt-in and removing reminders would be a disservice to those we serve who choose to vaccinate their children, would likely result in children receiving multiple vaccinations to prevent the same illness, and would add administrative burden to district staff and impact customer service.	Printed and referred to Ways & Means
HB515 & HB516	Public health districts & the state personnel system	HB515 Clarifies that public health district employees are not part of the state personnel system. HB516 Allows Public Health Districts to establish a personnel system to support rates of pay for appointments, promotions, demotions, and separations and to perform such other personnel actions as are needed.	None – clean up language introduced by DHR following HB316 in 2021.	Both House bills are currently on the 3rd reading calendar in the House.
HB604	Immunization, proof, government	This bill prohibits proof of vaccination or negative laboratory test result for a communicable disease to be hired by the state or any political subdivision.	May impact SWDH's ability to provide a safe working environment and meet infection prevention and control standards for clinic settings.	Printed and referred to State Affairs on 2/11.

HB631	No mask mandates	This bill prohibits the State of Idaho, a political subdivision of the state or any officer of the state from mandating the use of a face mask or other facial covering to slow the impact of an infectious disease. Should it become law, this means that public health districts could not, in the future, require a mask to impede the spread of a contagious disease.	May impact SWDH's ability to run the region's only tuberculosis clinic and provide a safe environment in our clinic settings when persons with infectious diseases enter for care or treatment. SWDH serves pregnant women, newborns, infants, and persons with compromised immune systems in our clinic settings.	This bill will now move to the Senate.
HCR029	Adverse Childhood Experiences – ACES	A resolution to combat childhood trauma by recognizing the impact of ACEs, Adverse Childhood Experiences, and their long-term consequences. The resolution also encourages the implementation of evidence-based interventions and practices, which are proven to be successful in identifying risk and helping children and adults suffering from trauma-related disorders develop resiliency and tools to heal.	Supports SWDH's efforts and efforts of community partners to implement programs and services that aim to prevent ACEs and build resilience.	Adopted by the Senate on 2/18
SB1234	Dental hygienists	Removes the requirement for dental hygienists to hold a license with an extended access dental hygiene endorsement.	May assist SWDH in providing preventative oral health care in rural communities without a dentist present.	This bill has moved to the House.
SB1260	Insurance – contraception supply	Adds to existing law to provide that health benefit plans and student health benefit plans covering prescription contraception must provide reimbursement for a six-month supply except under certain circumstances.	Would reduce risk for unplanned pregnancy, reduce patient cost for additional medical visits, and address access to provider issues often seen in rural communities.	This bill has moved to the House.
SB1287	Rural Nurse Loan Repayment Fund	This legislation, referred to as the "Rural Nursing Loan Repayment Fund" under Title 39, Chapter 59, would allocate to a fund to pay educational debts for nurses committing to practice in designated rural health shortage areas and critical access hospitals in Idaho. Payments	May assist SWDH in recruiting/retaining nursing staff in our rural communities.	The bill is currently on the floor of the Senate for a vote.

		would be capped at $25,000 per year up to a maximum of $75,000 per qualified applicant.		
SB1328	Telehealth, patient relationship	This legislation amends existing law to clarify interactions that qualify as telehealth services sufficient to establish a prescriber-patient relationship, adding the exchange of information that does not occur in real time.	Allows for new technology to be used to expedite prescribing for patients with an established provider outside of an in-person setting. This bill would benefit clients and patients of SWDH who experience transportation barriers or live in rural or remote communities.	Bill printed on 2/15.