DEPARTMENT OF HEALTH

Foundational Public Health Responsibilities Funding Workgroup: Meeting Summary, October 12, 2023

Welcome and opening remarks

Nick Kelley opened the meeting with the following remarks:

- Conversations and presentations at the State Community Health Services Advisory Committee (SCHSAC) retreat challenge us to think about the opportunity shape this funding for the local public health system. Are we propping the old system up? How can we use this opportunity to lean into what we want a new system to look like?
- This work will be the reference point for future work. This is why the workgroup principles are so important. We need to make decisions based on these principles.
- We aren't making decisions in a vacuum. In the coming months, there will also be an opportunity for local public health to tap into the Minnesota Public Health Infrastructure Fund. The Joint Leadership Team is currently consulting with Minnesota Department of Health (MDH) about how those funds might be deployed. These funds provide $6 million per year that can support new delivery models or processes that have the potential to impact multiple jurisdictions.

Background: Funding principles

- Every community health board should get enough to make meaningful progress on Foundational Public Health Responsibilities.
- The funding formula should consider that not everyone has the same opportunity to be healthy across our state.
- The funding formula should help alleviate variation in capacity across our system.

Multi-county community health boards

Historically, some grant funding formulas have included additional funds for multi-county community health boards. Workgroup members discussed the purpose of these funds, the principles guiding workgroup decisions, the purpose and function of multi-county community health boards in our system, and the purpose of a potential multi-county collaboration incentive in the foundational public health responsibilities funding formula.

- Workgroup representatives with current or past experience in multi-county partnerships shared their experiences, and other workgroup members shared input from their regions. The group talked about reporting burden, the legwork and logistics of working across multiple counties, how multi-county

community health boards approach allocating funds across their counties, and the different reasons why jurisdictions do or don't work together.

- There was widespread acknowledgment that multi-county community health boards work better in some places than others. Workgroup members acknowledged the need for a robust discussion to explore the community health board structure of the future, including the strengths and challenges of multi-county community health boards, but that discussion is beyond the scope of this workgroup.
- There was also extensive discussion about how to plan for the future of our public health system, rather than looking to the past.
- The workgroup voted against including a specific multi-county variable in the recommended funding formula, primarily because workgroup members did not see alignment between this approach and the guiding principles developed for this funding. Other reasons included:
    - A multi-county incentive will not make a meaningful difference in our ability to fill in the patchwork of capacity. The workgroup believes a large base will make a more meaningful difference.
    - Other funding sources are available to foster multi-county and cross-jurisdictional collaboration, including the Minnesota Public Health Infrastructure Fund, and no funding source discourages collaboration across jurisdictions.
    - Breaking up small amounts of money even further is not in the interest of small health departments. Money alone does not incentivize collaboration.
    - These new funds allow us to question the things we've always done and do things differently.

The workgroup voted against including specific multi-county variable in the recommended funding formula. The final vote was two in favor and eight against. Two workgroup members reported no preference and would follow the will of the group.

Funding formula recommendation

MDH staff walked through four potential funding formula scenarios that align with the workgroup's principles. Each scenario included a base amount for all community health boards, with the remainder being allocated based on the social vulnerability index and a capacity-based metric.

- Community health boards are assigned to different quartiles based on their vulnerability ranking, which then gets translated into a score that can be used in the formula. For multi-county community health boards, the community health board gets assigned the highest county's vulnerability ranking.
- Operationalizing a capacity metric is difficult; there isn't a good data source to base this metric. The workgroup recommended using a system-level finding from the University of Minnesota cost and capacity assessment to create a capacity measure for the funding formula. **General headline responsibility composite scores of a health department's ability to fully implement foundational public health responsibilities were higher for local health departments serving more than 100,000 people.**
    - There are 39 community health boards with a population under 100,000 and 12 with a population over 100,000. In the case of multi-county community health boards, if the

community health board had one county over 100,000, they were included in the "over 100,000" category.

- Funding formula scenarios were developed by giving a base to each community health board; allocating 60% of the remaining balance based on social vulnerability index score; and dividing the remaining funds among the community health boards serving fewer than 100,000 people.

- The workgroup reviewed scenarios developed around different levels of base funding. That is, they reviewed the range of funding allocations across different social vulnerability index tiers and sizes of population served—the lowest and highest allocations across each category. Adjusting the base funding changes the level of resource left to allocate based on social vulnerability index and capacity. They looked at scenarios based on a base funding amount of $100,000, $115,000, $125,000, and $150,000.
- **Please note: all funding amounts are estimates only and will be refined before distribution of any funding**. Specific funding amounts may vary over time as community health boards move above or below 100,000 population served, as social conditions affecting social vulnerability index rankings change, and as the number of community health board changes.

Option	Low under 100K	High under 100K		Low over 100K	High over 100K
Option 1 ($100,000 base)	$168,913	$225,841		$118,976	$175,904
Option 1 ($115,000 base)	$172,800	$220,548		$130,916	$178,664
Option 1 ($125,000 base)	$175,392	$217,020		$138,876	$180,504
Option 1 ($150,000 base)	$181,871	$208,199		$158,776	$185,104

- After reviewing these scenarios and discussing fit with the workgroup's principles, the workgroup voted to recommend the following funding formula:
- Base funding of $115,000 to each community health board, then allocating 60% of the remaining funds to social vulnerability index and 40% to community health boards serving fewer than 100,000 people. Overall, in this scenario, 59.6% of the funds are allocated to base funding; 24.3% to social vulnerability index; and 16.2% to capacity.
- The workgroup voted unanimously for this scenario. Funding estimates for each community health boards serving more than or fewer than 100,000 people in each social vulnerability index quartile are shown in the table below.

	Base	Capacity	SVI	Total
Under 100,000 population				
SVI 20	$115,000	$41,884	$15,916	$172,800
SVI 40	$115,000	$41,884	$31,832	$188,716
SVI 60	$115,000	$41,884	$47,784	$204,632
SVI 80	$115,000	$41,884	$63,664	$220,548
Over 100,000 population				
SVI 20	$115,000	$0	$15,916	$130,916
SVI 40	$115,000	$0	$31,832	$146,832
SVI 60	$115,000	$0	$47,784	$162,748
SVI 80	$115,000	$0	$63,664	$178,664

SVI = Social vulnerability index

Please direct any questions to your workgroup representatives listed below.

Next steps

The workgroup has three more meetings scheduled. Over the next six weeks, they will discuss if/how the formula should remain consistent over time, recommendations of grant duties, reporting, and other related recommendations (e.g., when/how to reexamine the funding formula).

The next meeting is October 26 at 10:00.

Workgroup membership

Workgroup Co-Chairs

Nick Kelley, LPHA Chair-Elect (nkelley@bloomingtonMN.gov)
De Malterer, Commissioner, Waseca County, and SCHSAC Vice-Chair (de.malterer@co.waseca.mn.us)

Workgroup Members

Bree Allen, SW/SC LPHA, Brown Nicollet CHB (Jaimee Brand, Brown Nicollet CHB, Alternate)
Susan Michels, NE LPHA, Carlton Cook Lake St. Louis CHB
Dave Lieser, Commissioner, Chippewa County, Countryside CHB
Laurie Halverson, Commissioner, Dakota County
Amy Evans, SE LPHA, Dodge-Steele CHB
Susan Palchick, Metro LPHA, Hennepin County Public Health
Ann Stehn, WC LPHA, Horizon Public Health
Chelsie Huntley, Minnesota Department of Health, Community Health Division Director
Marissa Hetland, NW LPHA, North Country CHB
Samantha Lo, Central Region LPHA, Pine County CHB
Joan Lee, Commissioner, Polk County

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