



BUSINESS MEETING AGENDA

Friday, June 9, 2017

1. Call to Order Bill Leake
2. Roll Call by District Bill Leake
3. Proxy Votes Collected per Bylaws Bill Leake
4. Call for Additional Agenda Items (Action) Bill Leake
5. Approval of IADBH Business Meeting Minutes from June 9, 2016 (Action) Bill Leake
6. Ratification of Decisions Made by Trustees During FY17 – TAB 3 (Action) Bill Leake
7. Follow Up Report from the Office of Performance Evaluation Bill Leake
8. General Fund Distribution Formula Bill Leake
9. Millennium Fund Distribution Formula Bill Leake/Maggie Mann
10. Review/Revision of Bylaws (Action) Bill Leake
11. Resolutions (*complete Compendium of Resolutions – Tab 4*) (Action) Bill Leake
 - a. #16-02: Remove Food Establishment License Fee in Idaho Code Tom Dale
 - Trustee Discussion / Plan moving forward
 - b. #16-03: Support Raising the Minimum Age of Legal Access and Use of Tobacco Products
in Idaho to Age 21 Russ Duke
 - Review of 2017 Legislation / Plan moving forward
 - c. #17-01(replacing 15-01): Support Prevention of Excessive Alcohol Use Russ Duke
 - d. #17-02 (replacing 13-02): Prevention of Opioid Drug Overdose through Provider Education Russ Duke
 - e. #17-03 (replacing 14-05): Oppose the Use of Recreational Marijuana in Idaho Carol Moehrle
 - f. #17-04 (replacing 11-01): Support a Tobacco Tax Increase in the State of Idaho Nikki Zogg
 - g. Archival of #14-04: Support Purchasing Healthier Food Options with the Supplemental
Nutrition Assistance Program (Idaho Food Stamps)
12. Association Office Budgets (Action) Nikole Zogg
13. Idaho Association of Counties/IADBH Contract Review (Action) Nikole Zogg
14. SALBOH representative Report Steve Scanlin
15. Adjourn Bill Leake



Public Health
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Idaho Public Health Districts

IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH

Idaho Association of District Boards of Health **Annual Business Meeting Minutes**

Bay 3, Coeur d'Alene Resort

Thursday, June 9, 2016

9:00 a.m. PT

1. Call to Order – Glen Bailey

Chairman Bailey called the Idaho Association of District Boards of Health (IADBH) business meeting to order at 8:50 a.m.

2. Roll Call by District – Glen Bailey

D1: **Present:** Marlow Thompson (Chair); Glen Bailey (Trustee); Allen Banks; Jai Nelson
Proxies: Leslee Stanley

Absent No Proxy: Richard McLandress, MD, Walt Kirby

D2: **Present:** Don Davis (Chair); John Allen (Vice-Chair); Doug Zenner (Trustee); Connie Osborn; Dave McGraw

Proxies: Glenn Jefferson, MD; Jerry Zumwalt

D3: **Present:** Richard Roberge, MD (Chair/Trustee); Tom Dale

Proxies: Larry Church; Lan Smith; Bill Brown; Robert Thomason; Kelly Aberasturi

D4: **Present:** Steve Scanlin (Chair); Elt Hasbrouck (Trustee); Betty Ann Nettleton, RN; Megan Blanksma

Proxies: Ted Epperly, MD, (Vice Chair)

Absent No Proxy: Laura Baker; Jane Young, CRN-P, DNP

D5: **Present:** Linda Montgomery (Chair); Charles Ritter (Vice Chair); Tom Faulkner (Trustee); Terry Kramer; Bob Kunau;

Proxies: Angenine McCleary; Pam Jones; Peter Curran, MD

Absent No Proxy: Cheryl Juntunen, RN

D6: **Present:** Ken Estep (Chair/Trustee); Vaughn Rasmussen (Vice Chair)

Proxies: Steve Hadley; Phil Christensen; Susan Collins; Scott Workman; Jerry Bush; Whitney Manwaring

D7: **Present:** Brian Farnsworth (Chair); Barbara Nelson, MD (Vice-Chair); Lee Staker; LeRoy Miller; Bill Leake (Trustee); Ken Miner;

Proxies: Greg Shenton; Lin Hintze; Kimber Ricks

3. Proxy Votes Collected per By-Laws – Glen Bailey

All proxy votes were collected.

4. Call for Additional Agenda Items – Glen Bailey

MOTION: Tom Faulkner moved to include on the business agenda a Trustee vote on the State appropriation distribution formula. Seconded by Ken Estep

Megan Blanksma asked for point of order. The Trustees should meet as a separate group to make a decision and bring a recommendation back to the entire IAB group.

The Chair ruled the Point of Order was well taken

MOTION: Trustee Faulkner amended his motion: The Trustees resume their Trustee meeting after adjournment of the business meeting to discuss and vote on the State Appropriation Formula. Amended motion seconded by Ken Estep. All were in favor of the motion; motion carried.

All were in favor of approving the agenda as presented.

5. Approval of Minutes from June 4, 2015 – Glen Bailey

MOTION: Doug Zenner moved to approve the June 4, 2015, IADBH Business Meeting minutes as presented; Trustee Tom Faulkner seconded the motion. All were in favor of the motion; motion carried.

6. Association Office Budgets – Nikole Zogg

Nikole Zogg presented the FY17 Association Office Budget and the FY17 Idaho Association of District Boards of Health budget.

MOTION: Ken Estep moved to approve both the Association of Administration budget and the Idaho Association of District Boards of Health (IAB) budget as presented; seconded by Tom Dale. All were in favor of the motion; motion carried.

7. Idaho Association of Counties Contract Review – Nikole Zogg

Nicole Zogg provided an overview of the agreement between the Idaho Association of Counties (IAC) and the Idaho Public Health Districts. It was last signed in 2010. Ms. Zogg reviewed the agreement and there are no new changes.

MOTION: Trustee Doug Zenner moved to sign the contract; second by Betty Ann Nettleton. All were in favor; motion carried.

8. Review of Trustee Response to the Office of Performance Evaluations (OPE) Recommendations - Glen Bailey

Chairman Bailey explained that in March 2015, the Joint Legislative Oversight Committee (JLOC) selected Public Health District financing and in particular the distribution formula for the State general fund appropriation as one of three projects to have the OPE investigate and report back to them on during the legislative session.. OPE completed the investigation and provided a report back to the legislature last session. Included in the study by OPE were recommendations for the Trustees. Chairman Glen Bailey reviewed each of the 6 OPE recommendations and the Trustee response with IAB:

Recommendation 1: The Board of Trustees should consider adopting objectives against which the formula can be measured.

The Trustees adopted two objectives to measure the formula:

1. Assure healthcare services to all 44 counties, and
2. Review formula annually to monitor swings and shifts.

Recommendation 2: The Board of Trustees should consider phasing in over several years any future changes to the formula.

Recommendation 3: The Board of Trustees should consider replacing the county contribution weighted part of the formula with one that distributes state general fund dollars for that part of the formula based directly on 67% of the county contributions.

This will be finalized at the end of today's business meeting.

Recommendation 4: The Legislature should consider developing a separate funding mechanism to make the health district administered regulatory, fee-based programs more self-supporting.

The proposed Resolution to Remove the Food Establishment License Fee in Idaho Code addresses this recommendation.

Recommendation 5: The Legislators should consider commissioning an evaluation to more clearly link funding of districts to actual measures of need more specific to individual programs.

This recommendation was addressed to the Legislature.

Recommendation 6: The Board of Trustees/districts should consider periodically reviewing the indirect cost rate.

The Trustees reviewed the FY 16 the indirect cost rate at their meeting yesterday and will review annually. The next review (FY 17 rate) will be in September at a Trustee meeting.

Dr. Roberge asked why only six of the seven districts responded in writing to the OPE recommendations.

It was explained that all Districts discussed a unified response but District 4 chose not to be included in that response. District 4 provided a verbal response. JLOC has asked OPE to provide a follow-up as to actions taken in response to the recommendations this coming legislative session.

9. State Appropriation Formula Discussion - Glen Bailey

Chairman Bailey explained that in 1993, the Trustees adopted a revised formula as recommended by independent reviewers. The formula was used for about 20 years until public assistance data was no longer available. In FY14, the Trustees dropped the public assistance portion from the formula and adjusted the remaining measures.

Chairman Bailey stated that the Trustee's have discussed and debated the formula including their support for all of the OPE recommendations.

Trustee Doug Zenner stated that at the Trustee meeting yesterday and throughout the year the Trustee's have been talking about the formula, he feels that Trustee Faulkner came up with a solution that provides a compromise, it would freeze the base as it was the prior year and allocate increases based on 67% taxation and 33% population.

Trustee Elt Hausbrouck stated that he doesn't feel the formula is tied to need and that he is concerned that the legislature will eliminate district funding all together.

Trustee Leake reminded everyone that each district has elected a Trustee from their board to represent them in establishing the state formula allocation. He stated need in each District can be tied back to the annual report and the services provided, demonstrating that there is great need in each District for public health services that are unfunded. He emphasized the importance of the Trustee's presenting a unified voice to OPE and the legislators.

MOTION: Commissioner Tom Dale moved that the vote on the formula be delayed and that we make a request to JLOC to commission an independent study. Seconded by Trustee Elt Hasbrouck.

Commissioner Rasmussen stated that the Boards of Health have all had the opportunity over the last year to meet and provide input to their Trustee's on the formula, it is a Trustee issue on how the formula is to be finalized.

Chairman Glen Bailey reviewed Idaho Code 39-411 and 39-425 which define that the authority to develop and administer a formula for allocations of legislative appropriations is the responsibility of the Board of trustees. IC 39-411. "The board of trustees shall develop and administer a formula for the allocation of legislative appropriations." Chairman Bailey stated that the decision on the formula was to be made per Idaho code by the Trustee's. He ruled the original motion as out of order.

Commissioner Tom Dale clarified that the intent of the original motion was not to have the IAB vote on the formula, but rather to recommend to the Trustee's that they do not vote on the formula today.

MOTION: Trustee Hasbrouck moved to recommend to the Trustees that they delay action on the formula and make a request to JLOC that they commission an independent study as recommended by OPE. Seconded by Tom Dale.

Chairman Bailey called for a Roll Call Vote:

District 1:

Marlow Thompson	No
Walt Kirby	Not Present
Glen Bailey	No
Allen Banks, Ph.D.	No
Jai Nelson, RN	No
Leslee Stanley	No (Proxy)
Richard McLandress, MD	Not Present

District 2:

Don Davis	No
John Allen	No
Doug Zenner	No
Connie Osborn	No
Jerry Zumalt	No (Proxy)
Dave McGraw	No
Glenn Jefferson, MD	No (Proxy)

District 3:

Richard Roberge, MD	Yes
Larry Church	Yes (Proxy)
Lan Smith	Yes (Proxy)
Bill Brown	Yes (Proxy)
Robert Thomason	Yes (Proxy)
Kelly Aberasturi	Yes (Proxy)
Tom Dale	Yes

District 4:

Steven F. Scanlin	Yes
Ted Epperly, MD	Yes (Proxy)
Elt Hasbrouck	Yes
Betty Ann Nettleton, RN	Yes
Jane Young, CRN-P, DNP	Not Present
Megan Blanksma	Yes
Laura Baker	Not Present

District 5:

Linda Montgomery	No
Charles Ritter	No
Tom Faulkner	No

Angenie McCleary	No (Proxy)
Bob Kunau	No
Cheryl Juntunen, RN	Not Present
Terry Kramer	No
Pam Jones	No (Proxy)
Peter Curran, MD	No (Proxy)

District 6:

Ken Estep	No
Vaughn Rasmussen	No
Steve Hadley	No (Proxy)
Phil Christensen	No (Proxy)
Susan Collins	No (Proxy)
Scott Workman	No (Proxy)
Jerry Bush	No (Proxy)
Whitney Manwaring	No (Proxy)

District 7:

Lee Staker	No
Barbara Nelson, MD	No
Greg Shenton	No (Proxy)
Lin Hintze	No (Proxy)
LeRoy Miller	No
Brian Farnsworth	No
Ken Miner	No
Kimber Ricks	No (Proxy)
Bill Leake	No

No's: 37; Yes': 12
Motion defeated.

10. Bylaw Revision to Include Objectives for Measuring Formula - Glen Bailey

Chairman Bailey stated that the Trustees recommend that the objectives for measuring the formula be incorporated into the by-laws which are as follows:

Objective 1: Assure delivery of Public Health to residents in all 44 counties.

Objective 2: Review the formula annually to monitor swings and shifts.

Mr. Scanlin stated that proposed amendments to the bylaws should be presented 60 days prior to adoption. Chairman Bailey referred to the bylaws that state that an exception to the 60-day ruling is allowed when the amendment has the majority consent at the annual meeting to allow consideration and that it may be adopted by a two-thirds vote.

MOTION: Tom Faulkner moved that the Association consent to consider bylaw amendments; seconded by Linda Montgomery. All in favor with one opposed. Motion carried.

MOTION: Trustee Doug Zenner moved to include the two objectives for measuring the formula as recommended by the Trustees into Article V, Section D(2), item e.; seconded by Commissioner Rasmussen.

Megan Blanksma asked for clarification on the term “swing and shift”. Trustee Hasbrouck stated that the reference to “all 44 counties” eliminates anything based on need and is strictly on population. Megan Blanksma asked that the reference to “44 counties” be changed to “all seven districts”.

Trustee Zenner withdrew his motion.

11. Resolutions – Glen Bailey

Chairman Bailey stated that District 4 has introduced three resolutions for consideration.

- i. Resolution to Remove Food Establishment License Fee in Idaho Code (16-02)
Steve Scanlin presented the resolution supporting removing the food establishment license fee from Idaho code and allowing districts to set the fees.

MOTION: Trustee Doug Zenner moved to approve this resolution; seconded by Trustee Tom Faulkner. All in favor of resolution; none opposed. Motion carried.

- ii. Support Health Insurance Coverage for Low Income Idahoans (16-01)
Trustee Hasbrouck presented the resolution.

MOTION: Commissioner Dale moved to approve the Resolution to Support Health Insurance Coverage for Low Income Idahoans; seconded by Dave McGraw. All were in favor of the motion with one opposed. Motion passed.

- iii. Resolution to Support Raising the Minimum Age of Legal Access and Use of Tobacco Products in Idaho to Age 21 (16-03)

MOTION: Betty Ann Nettleton moved to approve the Resolution to Support Raising the Minimum Age of Legal Access and Use of Tobacco Products in Idaho to Age 21; seconded by Trustee Doug Zenner. Voice vote with the ayes having it, the motion passed.

- iv. Action Items from D4 for Idaho’s Public Health Districts to Help Close Idaho’s health insurance gap.

Chairman Bailey reviewed the strategies proposed by District IV.

The question was asked if the bylaws need to be amended if the Trustees are going to be asked to carry out the proposed strategies.

Mr. Scanlin explained that the action plan is meant to be recommendations to assist Districts with communication with legislators.

12. State Association of Local Boards of Health (SALBOH) Representative

Chairman Bailey described the responsibilities of the SALBOH representative position. Commissioner Staker was the former SALBOH representative.

MOTION: Ms. Nettleton nominated Mr. Scanlin as the primary SALBOH representative; Mr. Scanlin nominated Dr. Nelson as the alternate. All were in favor.

13. Adjournment of Business Meeting– Glen Bailey

The IAB Business meeting was adjourned at 11:05 a.m.

DRAFT



Public Health
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Idaho Public Health Districts

IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH

Date: December 1, 2016

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson Street
Boise, ID 83720

Dear Director Mohan:

Over the past eleven months, the public health district directors, the Trustees, and the Boards of Health have had multiple discussions regarding the recommendations from the Office of Performance Evaluation's December 2015 study on the *Distribution of State General Fund Dollars to Public Health Districts*. We wanted to take this opportunity to provide you with an update on our actions.

REPORT RECOMMENDATIONS

1. *Board of Trustees consider adopting objectives against which the formula can be measured.*

Action: The Trustees met on February 2, 2016 to discuss OPE's recommendations in more detail. At that time, the following objectives were adopted, which were reaffirmed at the Trustee Meeting held on June 8, 2016: 1) Assure delivery of Public Health to residents in all 44 counties and 2) Review the formula annually to monitor swings and shifts.

2. *Board of Trustees should consider phasing in over several years any future changes to the formula.*

Action: The Trustees discussed this recommendation and in the future, should any changes in the formula be made that result in a significant fiscal impact to one or more districts, consideration will be given to phasing in the changes to formula to minimize the financial impacts.

3. *Board of Trustees consider replacing the county contribution weighted part of the formula with one that distributes state general fund dollars for that part of the formula based directly on 67% of the county contributions.*

Action: In OPE's report, it was suggested that the distribution formula should be simple and effective. While we agree, coming to a consensus of what this looks like has been a challenge. On June 9, 2016, the Trustees voted 5-2 to adopt the following funding formula. This approach was adopted to minimize any significant fiscal impact to any of the districts.

- a) Each District shall receive the same funding % as allocated in the State FY 17 appropriation
- b) Any increase in state appropriation will be divided among the Districts based on the following:
 - 67% based on county contribution
 - 33% based on current population
- c) In years where there is a decrease, each District shall receive the same % as received in prior fiscal year.

Glen Bailey
PHD 1
208.415.5102

Doug Zenner
PHD 2
208.799.3100

Tom Dale
PHD 3
208.455.5315

Elt Hasbrouck
PHD 4
208.375.5211

Thomas Faulkner
PHD 5
208.737.5902

Ken Estep
PHD 6
208.233.9080

Bill Leake
PHD 7
208.522.0310

6. *The Board of Trustees/districts should consider periodically reviewing the indirect cost rate.*

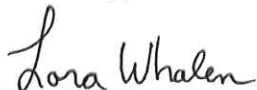
Action: Every year, the health district directors and fiscal officers review their respective indirect cost rates. They are also reviewed during the Legislative Services Office's audits of the health districts. On June 8, 2016, the health districts' Board of Trustees met and collectively reviewed the methodology by which the health districts' indirect rates are calculated as well as the calculated indirect rates of all seven health districts for FY16. The Trustees voted to continue using the current cost allocation methodology (using direct salaries as the denominator). The health districts' indirect rates will be reviewed annually by both the health district staff and Board of Trustees.

Recommendations 4 and 5 were directed to the Idaho Legislature; however, should the Legislature decide to take action on them, we would welcome the opportunity to provide input/feedback to our legislators.

4. *The Legislature should consider developing a separate funding mechanism to make the health district administered regulatory, fee based programs more self-supporting.*
5. *The Legislators should consider commissioning an evaluation to more clearly link funding of districts to actual need.*

Copies of all minutes pertaining to the Trustees' discussion about the OPE report are attached. If you have any questions about any of this information, please feel free to contact Lora Whalen, the current chair of the Idaho Association of Public Health District Directors at lwhalen@phd1.idaho.gov or (208) 415-5102.

Sincerely,



Lora Whalen
Director, Public Health District 1



Glen Bailey
Trustee, Public Health District 1



Carol Moehrle
Director, Public Health District 2



Doug Zenner
Trustee, Public Health District 2



Nikole Zogg
Director, Public Health District 3



Tom Dale
Trustee, Public Health District 3



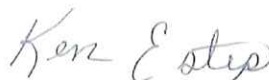
Rene LeBlanc
Director, Public Health District 5



Tom Faulkner
Trustee, Public Health District 5



Maggie Mann
Director, Public Health District 6



Ken Estep
Trustee, Public Health District 6



Geri L. Rackow
Director, Public Health District 7



Bill Leake
Trustee, Public Health District 7



Russ Duke
Director, Public Health District 4



Elt Hasbrouck
Trustee, Public Health District 4

Attachments:

1. February 2, 2016 Trustee Meeting Minutes
2. February 25, 2016 Trustee Meeting Minutes
3. March 24, 2016 Trustee Meeting Minutes
4. June 8, 2016 Trustee Meeting Minutes
5. June 9, 2016 Trustee Meeting Minutes
6. September 22, 2016 Trustee Meeting Minutes
7. October 27, 2016 Trustee Meeting Minutes

**Follow-up report
February 2017**

Distribution of State General Fund Dollars to Public Health Districts

**Office of Performance Evaluations
Idaho Legislature**





Rakesh Mohan
Director

Senator Cliff Bayer (R) and Representative Mat Erpelding (D) cochair the committee.

Office of Performance Evaluations

Created in 1994, the legislative Office of Performance Evaluations (OPE) operates under the authority of Idaho Code §§ 67-457-464. Its mission is to promote confidence and accountability in state government through independent assessment of state programs and policies. The OPE work is guided by professional standards of evaluation and auditing.

Joint Legislative Oversight Committee 2017-2018

The eight-member, equally bipartisan Joint Legislative Oversight Committee (JLOC) selects evaluation topics; OPE staff conduct the evaluations. Reports are released in a public meeting of the committee. The findings, conclusions, and recommendations in OPE reports are not intended to reflect the views of the Oversight Committee or its individual members.

Senators



Cliff Bayer



Mark Harris



Michelle Stennett



Cherie Buckner-Webb

Representatives



Mat Erpelding



Maxine Bell



Caroline Nilsson Troy



Elaine Smith

Follow-up report



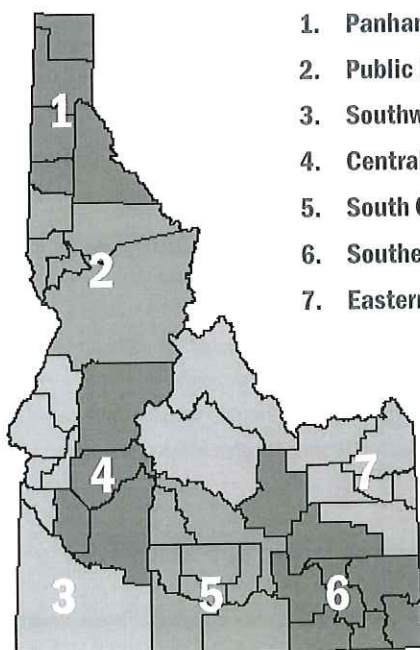
Overview of evaluation

954 W. Jefferson Street,
Suite 202
Boise, ID 83702
Ph. 208.332.1470
legislature.idaho.gov/ope

We released the report *Distribution of State General Fund Dollars to Public Health Districts* in December 2015. The report responded to concerns about recent changes to the formula that distributes state general funds among Idaho's seven public health districts. In fiscal year 2015, 17 percent or \$8.5 million of the districts' \$50.4 million budget came from the state general fund.

Exhibit 1

Idaho's seven public health districts serve all 44 counties.



1. Panhandle Health District
2. Public Health-Idaho North Central District
3. Southwest District Health
4. Central District Health Department
5. South Central Public Health District
6. Southeastern Idaho Public Health
7. Eastern Idaho Public Health

We appreciate the assistance we received from the seven public health districts.

Bryon Welch conducted the study.

Tony Grange conducted the quality control review.

Margaret Campbell copy edited and desktop published the report.

The formula is developed and administered by the Trustees of the Boards of Health, who are either county commissioners or appointed by county commissioners. The formula comprises three differently weighted measures. Of the \$8.5 million appropriated in fiscal year 2015, 67 percent (\$5.7 million) was distributed based on county contributions, 18 percent (\$1.5 million) on district population, and 15 percent (\$1.3 million) on district poverty rates.

Idaho Code § 39-411 gives the Trustees of the Boards of Health the authority to set and change the distribution formula. In fiscal year 2014, the Trustees' changes to the formula caused a shift in distribution. Two districts saw a decrease in state funding from the previous fiscal year despite increases in their county contributions.

Even though the distribution amount a district receives may shift each year depending on changes in the formula measures (population, poverty rates, and amount of county contributions), the Trustees' elimination of one of the formula measures and reweighting of the remaining measures for fiscal year 2014 raised questions from policymakers about the rationale and fairness of the formula.

Idaho's public health districts support 69 categorized programs

9 programs are mandated or delegated to districts, such as environmental health, restaurant inspections, and sewage disposal.

6 programs are considered by districts as core or fundamental to their mission, such as epidemiology, STD testing, and HIV prevention.

18 programs are contracted to districts—the Department of Health and Welfare is the most prevalent contract partner. Other programs not included in the 18 may also involve contracting. Examples include the federal WIC program, immunizations, and fit and fall prevention courses for senior citizens.

36 programs are optional—programs that each local district board has chosen to meet the needs of their districts.

We highlighted several key findings in the report:

The formula was not clearly or consistently linked to district program needs.

Programs with regulatory fees were subsidized with state and county funds and were not subsidized equally.¹

Payment for contract services did not fully cover the cost of some programs and the difference was made up with state and county funds.

Insufficient funding of regulatory programs reduced funding available for other public health services.

The required state match of state general funds to county contributions is 67 percent. In fiscal years 2011–2015, the state match had been much higher than the statutory requirement, slightly more than 100 percent of county contributions.

1. Districts attributed variations in subsidization rates among districts to the number of permits issued, different geographic considerations, and varying time spent issuing permits.

Assessment of status

We assessed the status of recommendations within three categories:



Complete: Measurable steps have been taken to meet the intent, or an approach that diverged from the recommendation has been taken to meet the intent.



In process: Measurable steps have been taken that begins to meet the intent.



No change: No measureable steps have been taken to meet the intent.

Trustees have begun incorporating formula objectives into their bylaws.



We made four recommendations to the Trustees of the Boards of Health and two recommendations to the Legislature. This follow-up report assesses the implementation status of those recommendations: one is completed, two are in process, and three have seen no change. In a few instances, we provided updated information based on fiscal years 2016–2017 data from the districts.

Agency response

We made the following four recommendation to the Trustees of the Boards of Health.

Establish formula objectives

The Trustees may intend to distribute state funds equitably so that districts are provided a fair share to meet their goals; however, objectives of the funding formula are not explicitly articulated. With objectives that are well-defined and measurable, the Trustees would better know when the formula needs periodic adjustment.

Recommendation: The Trustees of the Boards of Health should consider adopting objectives against which the formula can be measured. Then, if the Trustees decide to make changes to the formula, they could determine whether the changes align with the objectives. The objectives would also help with periodic reviews to ensure the formula still meets its intended purposes.

Status: In process

After the report was released, the Trustees incorporated three formula objectives into their bylaws:

Assure delivery of public health to residents in all 44 counties

Review the formula annually

Distribute state funds appropriated for change in employee compensation (CEC) or insurance increases by district full-time equivalents instead of through the formula

The Trustees are creating measures to gauge their ongoing progress in meeting these objectives. By doing so, the Trustees can regularly determine whether the formula is meeting goals and objectives.

Phase in future changes to the formula over several years

Before changes were made to the formula in fiscal year 2014, we found some volatility in funding. After the changes were made, we found notable impact on some districts.

When the state changed vendors for its Medicaid billing in 2010, the change led to major shifts in the estimates of individuals on public assistance, a component used in the distribution formula to determine the amount of state funds a district received.

Exhibit 2 shows how the formula measures have changed over the years. For fiscal year 2014, the Trustees voted to change the distribution formula. They eliminated public assistance enrollment from the formula and changed weights for the three remaining measures. In addition, districts were required to implement this funding change all in one year.

Exhibit 2

The formula's measures and their relative weights have changed twice since the early 1990s.

Measure	Before 1993 (%)	1993-2013 (%)	2014-2017 (%)
County contributions	100	60	67
Population	0	20	18
Poverty rates	0	10	15
Public assistance	0	10	0

Because districts 3 and 4 had the largest percentages of individuals receiving public assistance, this change decreased their state general fund dollars from 2013 levels despite an increase in their county contributions. Overall, the amount of state general fund dollars that district 3 received in 2014 was 2 percent less than the 2013 amount, and for district 4, it was 1 percent less.

Recommendation: To avoid immediate fiscal impact to districts, the Trustees of the Boards of Health should consider phasing in over several years any future changes to the distribution formula.

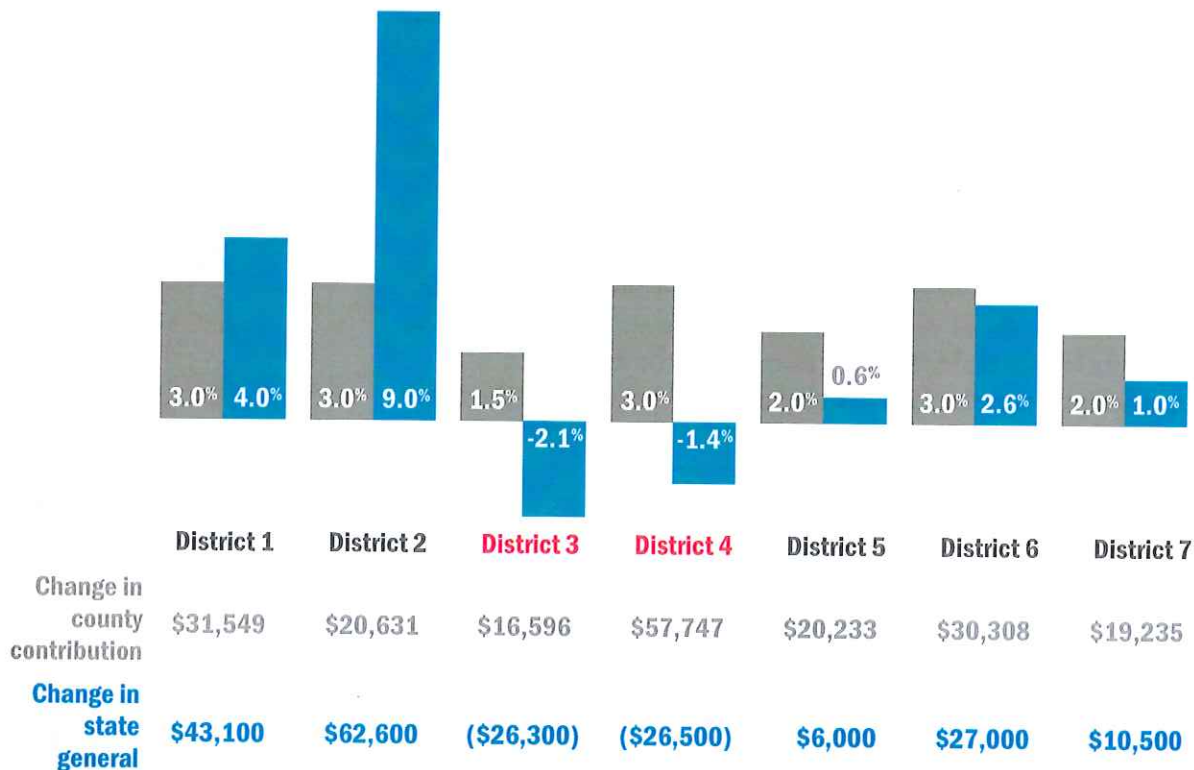
Status: In process

In 2014 the weights for county contributions and poverty rates measures were increased.



Exhibit 3

With 2014 changes to the formula, **state general fund dollars** decreased in **districts 3 and 4** from 2013 levels despite increases in county contributions.



In 2016 the Trustees incorporated an annual review of the formula into their bylaws. This review will look at five-year data trends of general fund distributions. Based on those trends, any changes the Trustees make would be phased in over multiple years so adverse effects to any one district would not be abrupt.

Trustees are making changes to the formula again for fiscal year 2018, which are highlighted in more detail in the next section. The nature of those changes incorporates elements of prior fiscal year distribution amounts to minimize impacts from one fiscal year to the next.

Since the changes to the formula were made by the Trustees in 2014, a district's percentage of the total state general fund appropriation has been fairly close to 2013 levels. In each fiscal year beginning with 2014, the percentage of the total state general fund appropriation a district received, as a result of the formula, has varied from -0.6–1 percentage points when

compared with the percentage a district received in 2013. Similarly, when comparing the three fiscal years before 2013, there was never more than a 0.7 percentage point difference compared to 2013 levels.

Because this recommendation addresses future changes to the formula, we would need to examine the distribution of state funds among districts to determine whether the recommendation has been implemented.

Eliminate weighting of county contributions in formula

Idaho Code § 39-425 states

The matching amount to be included in the request shall be a minimum of sixty-seven percent (67%) of the amounts pledged by each county

When conducting our evaluation, we found that state funds averaged 135 percent of county contributions in fiscal years 2005–2009. In fiscal years 2011–2015, state funds averaged slightly more than 100 percent. Even with a decrease in matching funds, the state general fund appropriation has been substantially greater than the statutorily required 67 percent.

Under the formula, if the state general fund appropriation were ever equal to the minimum in statute, some districts could receive a percentage lower than the 67 percent match of their county contributions. Each district would receive a portion of the available funds only relative to the county contributions for other districts, not to the minimum specified in state code.

Even when state funds are greater than the minimum statutory limit and all districts have seen an increase in their contributions, the formula increases state general fund dollars for some districts at the expense of others. This condition occurs because the formula weights county contributions in combination with poverty rates and population.

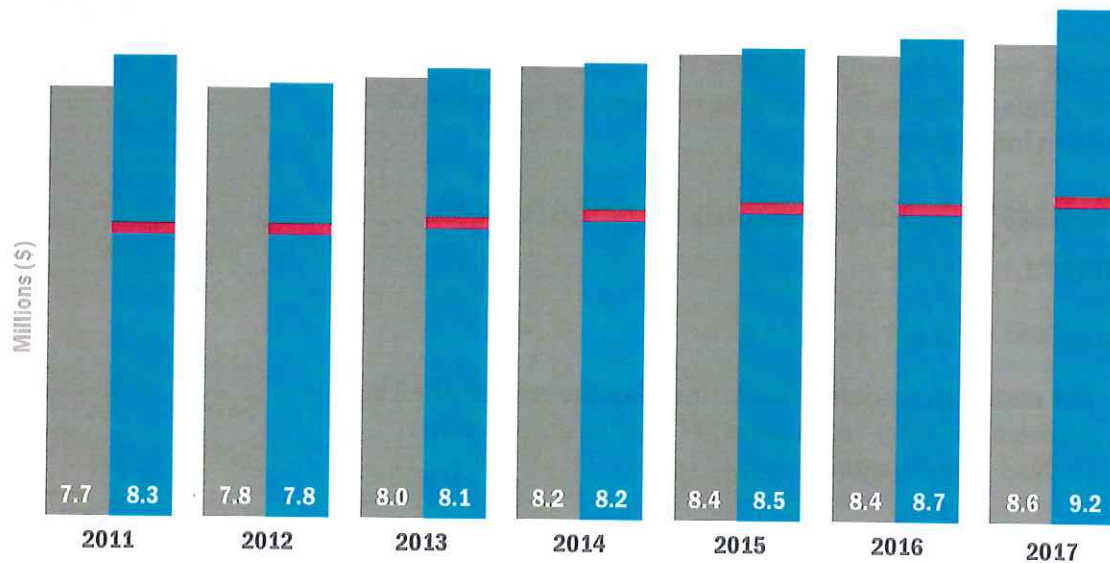
Unweighting the part of the formula for county contributions could change the percentage of general fund dollars that would be available for allocation based on poverty rates and population measures.

Hypothetical scenario:

If the state general fund appropriation were equal to minimum statutory levels, some districts may not receive a 67% match on county contributions.

Exhibit 4

State matching funds exceeded county contributions and were substantially greater than the minimum 67 percent.



Recommendation: The Trustees of the Boards of Health should consider eliminating the part of the formula that weights county contributions and replacing it with one that distributes state general fund dollars for that part of the formula based directly on 67 percent of the county contributions.

Status: No change

The state general fund appropriation has been well above the statutory minimum. As shown in exhibit 4, state general fund appropriations continue to outpace county contributions in fiscal years 2016 and 2017.

In June 2016, the Trustees adopted a new approach to distribute general funds within the formula.

1. If the general fund appropriation is equal to the amount allocated for fiscal year 2017, districts will receive the same funding percentages.

District 1	13.5%
District 2	9.5%
District 3	14.9%
District 4	23.6%
District 5	12.9%
District 6	12.8%
District 7	12.8%
2. When general fund appropriations increase, additional monies will be distributed to districts according to their county contributions (67 percent) and district population (33 percent).
3. When general fund appropriations decrease, each district will receive the same percentage of total state general fund dollars as the prior year.

Beginning in fiscal year 2018, districts will be guaranteed the same percentage of the state general fund appropriation that they received in fiscal year 2017. For example, district 1 received 13.5 percent of the total state general fund appropriation in fiscal year 2017. For fiscal year 2018, if there is no increase, district 1 is guaranteed the same percentage of the total appropriation. If there is an increase, districts are guaranteed at least the dollar amount received in fiscal year 2017.

The formula used in fiscal year 2017 did not eliminate the weighting of the county contributions. Moving forward, districts will continue to receive an amount equal to their district's portion of total statewide county contributions.

With state general fund appropriation levels now outpacing county contributions, none of the districts are receiving less than 67 percent of their county contributions in their district's state general fund distribution. We made this recommendation in the event that if the state general fund appropriation ever decreased to the minimum level, the formula would distribute an amount of state general funds equal to 67 percent of their county contributions.

The Trustees will take a new approach to how state general funds will be distributed in FY 2018.

The Trustees have reaffirmed their commitment to regularly review indirect cost rates.

Simplicity and effectiveness can be used as criteria for evaluating an existing formula.



Unweighting the formula for county contributions would not have significantly changed the amount of state funds a district received in fiscal year 2015. Four districts would have received 0–0.5 percent more in total state funding and three districts would have received 0.3–0.5 percent less. However, this unweighting would ensure that each district received the percentage match of county contributions referenced in statute.

Periodically review indirect cost rates

Indirect costs, such as administrative and IT services, benefit all programs and are part of each district’s core operational infrastructure. Districts use a method for allocating indirect costs based on direct staff salaries for each program. Although district officials acknowledge some challenges to this approach, they said the simplicity of the approach and its rough closeness to capturing actual indirect costs per program made the approach worth retaining.

When indirect charges are based on salaries alone, charges may not align closely enough with actual indirect uses of the programs. There can be many reasons for misalignment, such as variations in use of space, unequal needs for information technology, and differences in longevity and salaries among employees in these programs as compared with staff in more direct, client-based programs.

In our evaluation, we did not find a compelling need for districts to change the base for calculating the indirect rate. However, circumstances may change, especially if recommendations in this report lead to revisions in the formula or funding approach.

Recommendation: The Trustees of the Boards of Health and districts should consider periodically reviewing the indirect cost rate to ensure that the adopted approach reasonably reflects the actual use of indirect resources by program (e.g., costs of the staff, infrastructure, and services). This review should also take into account the tradeoffs between simplicity and effectiveness.

Status: Complete

For fiscal year 2016, the indirect rates among the seven districts still varied, ranging from 27 to 49 percent.

The Trustees have decided to continue to use the cost allocation methodology as they have in the past as well as the methods for determining indirect cost rates. The Trustees will continue to review those rates and methods annually with district staff.

Legislative response

We made the following two recommendations to the Legislature.

Create separate funding mechanism to make regulatory, fee-based programs more self-supporting

Districts have several programs that are regulatory and fee-based. These programs offer permits, licenses, or inspection services, and the affected businesses, governmental entities, or individuals can be required to pay fees for these services. Sewage disposal and restaurant inspections are two programs that are regulatory in nature and collect fees for service.

The programs that regulate these businesses and activities are heavily supported with dollars distributed by the formula. Their reliance on funding support has little or nothing to do with the two need-related measures in the formula—poverty rates and population. Instead, funding support is needed because fees inadequately cover the full cost of operations.

All districts need state and county support for their regulatory programs. If the Legislature were to devise a separate funding mechanism for regulatory, fee-based programs, it could isolate these issues and potentially resolve them, and at the same time avoid a funding competition with other core programs.

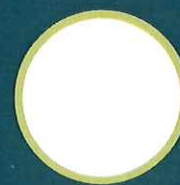
To the extent that regulatory, fee-based programs become more self-supporting, districts can redistribute more county contributions and state general funds to programs that do not receive revenue from regulatory fees.

Devising a separate funding mechanism to make these programs more self-supporting would not add complexity to the formula but would require, at minimum, changes in statute and modifications to the budgeting process. Districts set fees for some programs, such as environmental health, while other fees are established in code.

Recommendation: The Legislature should consider developing a separate funding mechanism to make the regulatory, fee-based programs administered by the health districts more self-supporting. This may include increasing regulatory fees.

Status: No change

If regulatory fees covered more of the cost of programs, state general fund dollars could be used for other core services.



In fiscal year 2016, we continued to see an overall trend in districts' expenditures where state and county funds were being used to offset low revenue in regulatory, fee-based programs, such as food inspection and sewage disposal.

Commission a study linking funding to measures of program need

The two needs-related measures, population and poverty rates, may not allocate funds consistent with actual need.

Districts have discretion to spend funds according to their priorities. Their decisions are not determined by the formula's allocation of funds or by the measures that determine the amount of funds. For example, if a district receives more money because its proportion of citizens in poverty increases, the district is not required to spend proportionally more money on programs that directly benefit those in poverty.

The measures of poverty rates and population are intended to address public health needs. These are broad measures compared with the specific and varied criteria of individual programs.

A key challenge to making the funding formula more effective is to ensure that the allocation of state general fund dollars and county contributions is more clearly linked to need within programs. A major step in making this link would be to separate the regulatory, fee-based programs from the formula.

Addressing need by further changing the formula would require an analysis of the existing array of programs to determine the kinds and amounts of need that are present.

Recommendation: The Legislature should consider commissioning an evaluation to more clearly link funding of districts to measures of need in individual programs.

Status: No change



Reports are available from the OPE website at www.legislature.idaho.gov/ope/ .







Distribution of State General Fund Dollars to Public Health Districts

Follow-up highlights

February 2017

Trustees for the seven district boards of health have begun to formulize objectives and revise the distribution formula.

In fiscal year 2017 districts received the following percentages of **\$9.3 million** in general fund appropriations:

District 1	13.5%
District 2	9.5%
District 3	14.9%
District 4	23.6%
District 5	12.9%
District 6	12.8%
District 7	12.8%



Formula objectives

Trustees incorporated three formula objectives into their bylaws:

Assure delivery of public health to residents in all 44 counties

Review the formula annually

Distribute state funds appropriated for change in employee compensation (CEC) or insurance increases by district full-time equivalents instead of through the formula



New distribution approach

Trustees adopted a new approach to distribute general funds within the formula beginning in fiscal year 2018.

If the general fund appropriation is equal to the amount allocated for fiscal year 2017, districts will receive the same funding percentages.

When general fund appropriations increase, additional monies will be distributed to districts according to their county contributions (67%) and district population (33%).

When general fund appropriations decrease, each district will receive the same percentage of total state general fund dollars as the prior year.



View the report: www.legislature.idaho.gov/ope/





Public Health
Prevent • Promote • Protect

Idaho Public Health Districts

IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH

BYLAWS

ARTICLE I NAME

This Association, approved by members of the seven (7) public health districts of the State of Idaho, shall be called the Idaho Association of District Boards of Health (IADBH).

ARTICLE II PURPOSE

The purpose of this Association shall be:

1. To exchange information among the District Boards of Health.
2. To coordinate policies and programs among the seven (7) public health districts.
3. To pursue new, as well as amend existing public health laws, standards, regulations, and rules to prevent disease, disability, and premature death; to promote healthy lifestyles; and to protect and promote the health and quality of our environment.

ARTICLE III MEMBERSHIP

Membership in the Association shall be limited to members of the seven (7) District Boards of Health of the State of Idaho who are appointed pursuant to Section 39-411 Idaho Code.

The District Directors are ex-officio members of the Association.

ARTICLE IV FINANCING

Funding for the Association shall be provided by the seven (7) public health districts on an equal basis.

ARTICLE V
OFFICERS, TERMS, AND DUTIES of the ASSOCIATION

Section A. Officers

Leadership of the Association will consist of an elected Trustee from each local Board of Health in accordance with Idaho Code 39-411. The leadership of the Association will be referred to as the "Board of Trustees." Officers of the Board of Trustees ~~and~~ shall consist of the following:

1. President of the Association: The President shall be the Trustee from the hosting District where the current year's Annual Meeting will take place.
2. Vice-President: The Vice President shall be a Trustee from the District which hosts the following year's Annual Meeting.
3. Secretary: The secretary shall be the District Director from the District hosting the current year's Annual Meeting. The secretary shall have no vote.
4. ~~Executive Council: The Executive Council will be comprised of a Board of Health member from each health district which has been elected as the health district's Trustee in accordance with Idaho Code 39-411.~~

Section B. Terms

The new President, Vice-President, and Secretary of the Association shall take office at the conclusion of the Annual Meeting and shall serve until the conclusion of the next Annual Meeting. Executive Council members shall serve for the term in which they have been elected by their local Boards of Health.

Section C. Duties of Officers

1. The President of the Association shall:
 - a. Preside at the annual Association meeting and at any special Association meetings.
 - b. Determine the need, dates, times, and location of the annual Association meeting and any special meetings of the Association's Board of Trustees.
2. The Vice-President shall:
 - a. Preside at all meetings of the Association in the absence of or at the request of the President.
 - b. Perform such other duties as may be required.
3. The Secretary of the Board shall:
 - a. Record minutes of the Association and Board of Trustees' meetings.
 - b. Conduct correspondence as directed by the President.
 - c. Send all notices in accordance with these Bylaws.
 - d. Perform such other duties as may be required.

Section D. Duties of the District Trustee and the Board of Trustees

1. The Trustee of each health district shall represent their local Board~~s~~ of Health throughout the year except at the Annual Meeting. This includes providing their Board's position on such laws, standards, regulations, and rules to the Boards of Trustees. As issues arise between the annual Association meetings, decisions of the Board of Trustees shall constitute interim decisions of the Association.
2. The Board of Trustees shall:
 - a. Conduct the affairs of the Association in accordance with the purpose and Bylaws of the Association and directives adopted by the Association.
 - b. Have authority to allocate appropriations from the legislature to the health districts. (IC 39-411)
 - c. Develop and administer a formula for the allocation of legislative appropriations. (IC 39-411)
 - d. In the event a Trustee cannot attend, an alternate Board Member from his/her District shall represent that District at meetings and on conference calls.

Section E. The Association Office shall:

1. Serve as custodian of the Association records.
2. Keep Bylaws current for reference.
3. Have custody of, and be responsible for, all funds and securities of the Association.

Section F. The SALBOH Representative

The SALBOH (State Association of Local Boards of Health) Representative is a Board of Health Member elected by the Association and:

1. Shall serve as the NALBOH (National Association of Local Boards of Health) contact for Idaho's SALBOH.
 2. May attend the annual SALBOH and NALBOH meetings and provide a written summary or an annual report of each meeting to the Association during the annual business meeting. As a representative of the Association, expenses for travel to the annual SALBOH and NALBOH meetings shall be reimbursed by the Association.
 3. Shall serve a three (3) year term and must be reappointed or a new representative appointed at the conclusion of the term.
 4. An alternate representative will be elected by the Association to serve in the absence of the SALBOH Representative.
- 4.5. The health district from which the SALBOH Representative is elected must be a current member of NALBOH.

ARTICLE VI

~~ANNUAL MEETINGS AND SPECIAL MEETINGS~~

Section A. Purpose.

To fulfill the objectives of ARTICLE II of these Bylaws.

Section B. Date and Site of Annual Meeting.

An Annual Meeting of the Association shall be held each year. The location shall be on a rotating basis in each of the seven (7) Health Districts (District 1, 7, 3, 2, 6, 5 and 4). The date and site of the Annual Meeting shall be set by the host district. Invitations and information shall be mailed to the District Boards of Health at least two (2) months prior to the meeting.

Section C. Special Meetings.

Special meetings of the Association may be called by:

1. The Association President or
2. A majority of the members of the Board of Trustees, ~~provided all members are notified not less than seven (7) days before the date of the meeting.~~

Section D. Voting.

Voting at the Annual Meeting and at special meetings shall be limited to the membership in attendance and by proxy of the absent members. Absent members must provide a written proxy to their designee.

Section E. Quorum.

Representation from membership from four of the seven (7) District Boards of Health shall constitute a quorum for the transaction of business at the Annual Meeting and special meetings.

Section F. Open Meeting Requirements.

All meetings of the Association are open to the public and subject to the requirements of Idaho's Open Meeting Law, Idaho Code Chapter 2, Title 74.

ARTICLE VII PARLIAMENTARY AUTHORITY

ROBERT'S RULES OF ORDER NEWLY REVISED shall apply on all questions of procedure and parliamentary law not specified in these Bylaws.

ARTICLE VIII AMENDMENTS

These Bylaws may be amended by a two-thirds (2/3) vote of the Association members, at the Annual Association meeting, when the proposed action has been sent out in the notice of such meeting to all members. Proposed amendments must be submitted to the Association Chair for distribution to the IADBH Bylaws

Association board members at least sixty (60) days prior to the Annual Meeting, for the purpose of giving the seven (7) District Boards of Health notice of the proposed amendments. Exception to this ruling is allowed when the amendment has the majority consent at the Annual Meeting to allow consideration. It may then be adopted by a two-thirds (2/3) vote of the Association members in attendance or by proxy according to ARTICLE VI, Section D. All amendments adopted at the Annual Association meeting shall become effective thirty (30) days following the Association meeting unless otherwise specified.

- 1988 Adopted at the Annual Meeting of IAB.
- 5/93 Adopted by the Board of Trustees on 7/8/93.
- 5/95 Adopted by the Board of Trustees on 5/21/95.
- 5/95 Adopted at the Annual Meeting of the Association on 5/4/95.
- 6/08 Adopted at the Annual Meeting of the Association on 6/30/08.
- 6/10 Adopted at the Annual Meeting of the Association on 6/17/10.
- 5/14 Adopted at the Annual Meeting of the Association on 5/29/2014.

ARTICLE IX RESOLUTIONS

1. Resolutions must be submitted to the Association ~~Chair~~ President for distribution to the Association Board members at least sixty (60) days prior to the Annual meeting, for the purpose of giving the seven (7) District Health Boards ~~of~~ an opportunity to review and comment.
2. Emergency Resolutions, defined as anything that represents a sudden and urgent public health need or anything that is needed to keep the organization moving forward, may be brought up for discussion as long as approved by a two-thirds (2/3) vote of the Association members at any Annual Association meeting.

POTENTIAL CHANGES FOR CONSIDERATION:

Submitted by Bill Leake: Discussion on coordinating and communicating with the Legislature. Having had several discussions with many of the Legislators during this last legislative session, it became clear to me that they are getting conflicting information about how the seven Districts are interacting and our collective goals and objectives. To ensure we continue to get the level of funding we've been getting and if we want to position ourselves to receive any additional funds if needed, we must send a single, consistent message to them. Also, if we are going to have any chance of getting the Food Establishment Inspection fees revised to cover more or all the cost of actually performing the work, we must present not only a perceived but real united front.

Res. 16-02

RESOLUTION TO REMOVE THE FOOD ESTABLISHMENT LICENSE FEE IN IDAHO CODE

WHEREAS, protecting the public from the hazards of food borne illness and disease is a primary function of Idaho's Public Health Districts; and

WHEREAS, the Centers for Disease Control and Prevention estimates that one in six Americans, or 48 million people, get sick from foodborne illnesses every year. Approximately 128,000 of these are hospitalized and 3,000 die¹; and

WHEREAS, foodborne illness poses a \$77.7 billion economic burden in the United States annually², and

WHEREAS, it is well recognized that foodborne outbreaks can be devastating to a food establishment business; and

WHEREAS, the Public Health Districts are committed to providing an appropriate balance between code enforcement and education; and

WHEREAS, the food protection system in Idaho presently meets generally accepted state and national standards; and

WHEREAS, the Public Health Districts are mandated by the Idaho Food Code to perform at least one food safety inspection per year for each licensed food establishment, but current funding is inadequate to cover the cost of this service;

THEREFORE BE IT RESOLVED that the Idaho Association of District Boards of Health supports removing food establishment license fees in Idaho Code and allowing the local boards of health to establish a fee based on the actual cost to deliver the food safety inspection program.

*Adopted by the Idaho Association of District Boards of Health
June 9, 2016*

¹Centers for Disease Control and Prevention. "Estimates of Foodborne Illness in the United States," page last updated January 8, 2014, accessed March 16, 2016, <http://www.cdc.gov/foodborneburden/>.

²Bottemiller, H. "Annual Foodborne Illnesses Cost \$77 Billion, Study Finds, Food Safety News," (January 3, 2012), accessed March 16, 2016. <http://www.foodsafetynews.com/2012/01/foodborne-illness-costs-77-billion-annually-study-finds/#.Vum0BNlrKcN>.

16-03: Resolution to Support Raising the Minimum Age of Legal Access and Use of Tobacco Products in Idaho to Age 21

Res. 16-03

**RESOLUTION TO SUPPORT RAISING THE MINIMUM AGE OF LEGAL
ACCESS AND USE OF TOBACCO PRODUCTS IN IDAHO TO AGE 21**

WHEREAS, Tobacco remains the leading cause of preventable disease and premature death in the U.S., and one of the largest drivers of health care costs¹, and

WHEREAS, Each year approximately 1,800 Idahoans die from tobacco use and 1,100 Idaho youth become new regular, daily smokers, of whom one-third will die prematurely because of this addiction², and

WHEREAS, 95% of current adult smokers began using tobacco before age 21, and the ages of 18 to 21 are a critical period when many experimental smokers transition to regular, daily use³, and

WHEREAS, Adolescents are more likely to obtain cigarettes from social sources than through commercial transactions, and youth who reported receiving offers of cigarettes from friends were more likely to initiate smoking and progress to experimentation³. Raising the legal age of access to 21 would reduce the likelihood that young people would have access to tobacco products through social sources, and

WHEREAS, A growing number of youth and adults are using electronic vapor products, also known as e-cigarettes or electronic nicotine delivery systems (ENDS), which provide a way to deliver the addictive nicotine substance without burning tobacco. In Idaho, e-cigarettes are the most commonly used "tobacco" product among Idaho students: 24.8% of students used an electronic vapor product in the past 30 days and nearly half of all Idaho high school students have used an electronic vapor product at least once during their lifetime⁴, and

WHEREAS, the American Academy of Pediatrics now strongly recommends the minimum age to purchase tobacco products, including e-cigarettes, should be increased to age 21 nationwide⁵, and

WHEREAS, the U.S. Army Public Health Command says soldiers who smoke are less combat ready and take longer to heal and the U.S. Department of Defense is taking steps to ban all tobacco sales on military bases⁶, and

WHEREAS, 131 cities in nine states, and the State of Hawaii have already raised the minimum age of legal access to tobacco products, and several other states are currently considering legislation to do so, and

WHEREAS, Smoking-caused health costs in Idaho total more than \$508 million per year, including more than \$100.5 million in state and federal Medicaid expenditures, and raising the age of legal access to tobacco products to age 21 will likely decrease overall tobacco use rates, which in turn will likely lead to reduced future tobacco-related health care costs², and

WHEREAS, The tobacco industry aggressively markets and promotes its products to continue recruiting young adults as new consumers. Despite legal settlements and laws, the tobacco companies still spend \$9.6 billion per year to market their deadly and addictive products, and they continue to entice and addict America's youth. According to the U.S. Surgeon General, the more young people are exposed to cigarette advertising and promotional activities, the more likely they are to smoke. More than 80% of underage smokers choose brands from among the top three most heavily advertised⁷, and

WHEREAS, The Institute of Medicine concluded that raising the age of legal access to tobacco products to 21 years of age will likely prevent or delay initiation of tobacco use by adolescents and young adults, immediately improve the health of adolescents and young adults, improve maternal, fetal, and infant health outcomes, and substantially reduce smoking prevalence and smoking-related mortality over time. The Institute of Medicine also predicted that raising the age now to 21 nationwide would result in approximately 249,000 fewer premature deaths, 45,000 fewer deaths from lung cancer, and 4.2 million fewer years of life lost for those born between 2000 and 2019⁸.

THEREFORE, BE IT RESOLVED, that the Idaho Association of Boards of Health supports raising the minimum age of legal access and use of tobacco products, including electronic vapor products, in Idaho to 21 years of age. District public health staff will actively engage in local and statewide efforts to support this public health policy.

1 – U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. (http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm) Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

2 – The Toll of Tobacco in Idaho. (2015). Retrieved from www.tobaccofreekids.org.

3 – Knox, B. (2016). Increasing the Minimum Legal Sale Age for Tobacco Products to 21. Retrieved from www.tobaccofreekids.org.

4 – Idaho State Department of Education, Idaho Youth Risk Behavior Survey. (2015). Retrieved from <https://sde.idaho.gov/student-engagement/shared/2015-Youth-Risk-Behavior-Survey-Results.pdf>.

5- American Academy of Pediatrics, Julius B. Richmond Center of Excellence. Tools and Information, Tobacco 21. Retrieved from <http://www2.aap.org/richmondcenter/Tobacco21.html>.

6 – U.S. Army. Stand-To! Edition November 20, 2012. Retrieved from <http://www.army.mil/standto/archive/issue.php?issue=2012-11-20>.

7 – Tobacco Industry Marketing. Retrieved from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/marketing/index.htm.

8 – Institute of Medicine. Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products. Washington, D.C: The National Academies of Press, 2015. doi: 10.17226/18997.

*Adopted by the Idaho Association of District Boards of Health
June 9, 2016*

RESOLUTION SUPPORTING PREVENTION OF EXCESSIVE ALCOHOL USE

WHEREAS, excessive alcohol use includes binge drinking (five or more drinks during a single occasion for men and four or more drinks in a single occasion for women), underage drinking, drinking while pregnant, and alcohol impaired driving¹; and

WHEREAS, recognizing that children who consume alcohol before age 15 are four times more likely to develop alcohol dependence at some point in their lives versus children who abstain from alcohol until they are 21¹; and

WHEREAS, excessive alcohol use still continues to play an important role in unintentional injuries, homicides, and suicides which are the leading causes of death among youth²; and

WHEREAS, recognizing that alcohol use is implicated in at least one-third of sexual assault and acquaintance or “date” rape cases among teen and college students²; and

WHEREAS, alcohol is more likely to be a factor in violence where the attacker and victim know each other (such as domestic violence). Two-thirds of victims who were attacked by an intimate partner (including a current or former spouse, boyfriend, or girlfriend) reported that alcohol had been involved, whereas only 31% of victimizations by strangers are alcohol-related³; and

WHEREAS, reports by the Center on Alcohol Marketing and Youth revealed that underage youth are heavily exposed to alcohol advertising on radio, in magazines, and on the Internet²; and

WHEREAS, recognizing the Idaho Youth Risk Behavior Surveillance Survey found that in 2013⁵, 28⁷% of high school students had at least one drink of alcohol during the 30 days prior to the survey⁴; and

WHEREAS, recognizing that in 2015, 15.5% of one in five (18%) Idaho students engaged in binge drinking (defined as having five or more drinks in a row) during the 30 days prior to completing the survey⁴; and

WHEREAS, excessive drinking results in 437 deaths and 12,311 years of potential life lost each year in Idaho⁵.

WHEREAS, the beer tax in Idaho was last changed in 1961 and is ranked 38th out of 50 states^{6,7} and,

WHEREAS, the wine tax in Idaho began in 1971 and has not been changed since then and is ranked 36th out of 50 states^{6,7}.

THEREFORE BE IT RESOLVED, that the Idaho Association of District Boards of Health support the best practice recommendations to decrease excessive alcohol use by raising state excise taxes on alcohol; restricting access to alcohol through increased compliance checks and responsible beverage service programs; and increasing community mobilization efforts to assess problems and resources needed to combat underage drinking. The proceeds collected from the tax shall be dedicated to substance abuse prevention or treatment programs.

1 Preventing Drug Abuse and Excessive Alcohol Use. National Drug Prevention Strategy, National Drug Council, May 2014.

2 Reducing Underage Alcohol Consumption. American Public Health Association Policy Statement, November 9, 2004.

3 Alcohol and Crime Fact Sheet. National Council of Alcoholism and Drug Dependence, Inc. <https://ncadd.org/learn-about-alcohol/alcohol-and-crime>. Accessed on February 25, 2015.

4 Centers for Disease Control and Prevention. 2013 Youth Risk Behavior Survey. Available at: www.cdc.gov/yrbs. Accessed on January 22, 2015.

5 Centers for Disease Control and Prevention. Prevention Status Reports 2013: Excessive Alcohol Use—Idaho. Atlanta, GA: US Department of Health and Human Services; 2014.

6 <https://tax.idaho.gov/i-1021.cfm>. Accessed on April 18, 2017

7 <http://www.tax-rates.org/idaho/excise-tax>. Accessed on April 18, 2017

Res. 17-02 (replaces 13-02)

RESOLUTION CONCERNING THE PREVENTION OF OPIOID DRUG OVERDOSE THROUGH PRESCRIBER EDUCATION

WHEREAS, sales of prescription opioids in the U.S. nearly quadrupled from 1999 to 2014¹; and

WHEREAS, in 2012, healthcare providers wrote 259 million prescriptions for painkillers, enough for every American adult to have a bottle of pills²; and

WHEREAS, during 2015, drug overdoses accounted for 52,404 U.S. deaths, of those, 63.1% involved an opioid¹; and

WHEREAS, overall, more Americans die every year from drug overdoses than they do in motor vehicle crashes, making nonprescription use of opiates now the second most common cause of substance abuse disorder in the U.S.⁶; and

WHEREAS, as a result, prescription drug abuse prevention is a top priority for the Centers for Disease Control and Prevention; and

WHEREAS, per 100 people, Idaho healthcare providers prescribed 86 painkiller prescriptions in 2012⁴; and

WHEREAS, Idaho ranked 35th in the nation in 2014 for nonmedical use of prescription pain relievers among persons aged 12 years and older³; and out of the 35 states for which data are available, Idaho ranked 7th in high school students ever using prescription drugs without a doctor's prescription³; and

WHEREAS, in 2013, an Idahoan died every 39 hours from drugs, more than tripling the drug-induced death rate since 2000⁵; and

WHEREAS, Idaho Public Health Districts are responsible to promote and protect the health of Idaho citizens; and

WHEREAS, Idaho Public Health Districts provide services to individuals and families who are affected by prescription drug abuse;

THEREFORE BE IT RESOLVED that Idaho Public Health Districts seek opportunities to collaborate with stakeholders such as the Office of Drug Policy, Idaho Department of Health and Welfare, and institutions of higher education, as well as other pertinent community organizations, to prevent the misuse and abuse of prescription drugs. The Idaho Public Health Districts will provide prescriber education on the opioid epidemic and encourage active use of Idaho's Prescription Monitoring Program (PMP).

1. Centers for Disease Control and Prevention. [Increases in Drug and Opioid-Involved Overdose Deaths -- United States, 2010-2015](#). MMWR 2016; 65(50-51);1445–1452.
2. Centers for Disease Control and Prevention: Vital Signs: Opioid Painkiller Prescribing --- United States, July, 2014
3. Idaho Office of Drug Policy (2016). Substance Abuse Prevention Needs Assessment, Idaho.
4. IMS, National Prescription Audit (NPA™), 2012.
5. Idaho Vital Statistic. (2013)
6. Centers for Disease Control and Prevention: Leading Causes of Death – United States 1999-2015.

Res. 17-03; Updated from Res. 14-05

RESOLUTION TO OPPOSE THE USE OF RECREATIONAL MARIJUANA IN IDAHO

WHEREAS, recreational marijuana places a significant strain on our health care system, and poses considerable danger to the health and safety of the users themselves, their families, and our communities. Marijuana use, particularly long-term, chronic use that began at a young age, can lead to dependence and addiction (i); and

WHEREAS, recreational marijuana use is associated with addiction,(ii) respiratory illnesses,(iii) and cognitive impairment.(iv); and

WHEREAS, studies also reveal that marijuana potency has almost tripled over the past 20 years,(v) raising serious concerns about implications for public health – especially among adolescents, for whom long-term use of marijuana may be linked with lower IQ (as much as an average 8 point drop) later in life.(vi); and

WHEREAS, scientific research shows that legality increases the availability and acceptability of drugs, as we see with alcohol and tobacco – which far outpaces the use of illegal drugs.(vii);and

WHEREAS the U.S. Drug Enforcement Administration recently refused to downgrade marijuana from its federal status as a Schedule I controlled substance (ix) and the DEA and Food and Drug Administration’s decision is consistent with major medical organizations including the American Medical Association, which states, “cannabis is a dangerous drug and as such is a public health concern; and the sale and possession of cannabis should not be legalized (AMA, 2013).” (x); and

~~WHEREAS, increased consumption leads to higher public health and financial costs for society. Addictive substances like alcohol and tobacco, which are legal and taxed, already result in much higher social costs than the revenue they generate. The cost to society of alcohol alone is estimated to be more than 15 times the revenue gained by their taxation.(viii);~~

THEREFORE, BE IT RESOLVED, that the Idaho Association of District Boards of Health oppose the recreational use of marijuana, and support the Idaho Office of Drug Policy’s position that components of the marijuana plant should be evaluated by the same rigorous, scientific FDA process through which every legal medication in our country is tested. because the recreational use of marijuana would increase the availability and use of illicit drugs, and pose significant health and safety risks to our population.

Adopted by the Idaho Association of District Boards of Health
May 29, 2014

- (i) Anthony, JC, Warner, LA, and Kessler, RC (1994) Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants: Basic Findings from the National Comorbidity Survey, *Experimental and Clinical Psychopharmacology* 2(3):244-268.
- (ii) Anthony, JC, Warner, LA, and Kessler, RC (1994) Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants: Basic Findings from the National Comorbidity Survey, *Experimental and Clinical Psychopharmacology* 2(3):244-268.
- (iii) Polen MR, Sidney S, Tekawa IS, Sadler M, Friedman GD. Health care use by frequent marijuana smokers who do not smoke tobacco. *West J Med* 158(6):596–601, 1993. Available at <http://www.ncbi.nlm.nih.gov/pubmed/8337854>
- (iv) Meier et al., “Adolescent-onset cannabis and neuropsychological health.” *Proceedings of the National Academy of Sciences*. [August 27, 2012].
- (v) Mehmedic, Zlatko, et al., “Potency Trends for Δ^9 -THC and Other Cannabinoids in Confiscated Cannabis Preparations from 1993 to 2008.” *Journal of Forensic Sciences*, Vol. 55, No. 5. [September 2010].
- (vi) Meier et al., “Adolescent-onset cannabis and neuropsychological health.” *Proceedings of the National Academy of Sciences*. [August 27, 2012].
- (vii) Substance Abuse and Mental Health Services Administration. *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*. U.S. Department of Health and Human Services. [September 2012].
- ~~(viii)~~ [Ellen E. Bouchery, Henrick J. Harwood, Jeffrey J. Sacks, Carol J. Simon, Robert D. Brewer. *Economic Costs of Excessive Alcohol Consumption in the U.S., 2006*. American Journal of Preventive Medicine—November 2011 \(Vol. 41, Issue 5, Pages 516–524, DOI: 10.1016/j.amepre.2011.06.045\). Available: \[http://www.ajpmonline.org/article/S0749-3797\\(11\\)00538-1/fulltext\]\(http://www.ajpmonline.org/article/S0749-3797\(11\)00538-1/fulltext\)](#)
- ~~(ix)~~ [Johnson, C. \(2016\) DEA rejects attempt to loosen federal restrictions on marijuana. NPR.](#)
- ~~(viii)~~(x) [American Medical Association House of Delegates \(1-13\), Council on Science and Public Health Report 2. “AMA Policy Statement on Cannabis, H-95.998.” November 19, 2013. P. 6.](#)

Tobacco

~~17-04 11-00~~: Resolution to Support a Tobacco Tax Increase in the State of Idaho
Updated from Res. ~~11-01~~, 07-01 and 10-02

Res. ~~17-04 11-00~~; Updated from Res. ~~11-00~~, 10-02, & 07-01

RESOLUTION TO SUPPORT A TOBACCO TAX INCREASE IN THE STATE OF IDAHO

WHEREAS, cigarette smoking remains the leading cause of preventable disease and death in the United States and in Idaho. Annually 1,8500 Idahoans die from smoking-attributable deaths (1), (2); and

WHEREAS, ~~1,200~~800 Idaho youth will become new smokers each year and ~~24~~30,000 Idaho youth that are alive today will die from smoking (3,4); and

WHEREAS, Idaho's cigarette tax ranks ~~42nd~~-45nd in the nation (57 cents/pack), is lower than all of the surrounding states, and is substantially lower than the average cigarette tax per pack in non-tobacco producing states at \$1.57 per pack (5); and

WHEREAS, Idaho spends ~~319~~-508 million in smoking-attributable medical costs and ~~333~~-433 million in smoking-attributable lost productivity costs annually (~~23~~); and

WHEREAS, numerous economic studies in peer-reviewed journals have documented that cigarette tax or price increases reduce both adult and youth smoking (6), and

WHEREAS, every state that has significantly raised its cigarette tax has enjoyed substantial increases to state revenues despite the fact that cigarette tax increases reduce state smoking levels (7), and

WHEREAS, state funding levels for comprehensive tobacco prevention and control programs are sorely inadequate to support effective and sustained tobacco control efforts (~~28~~):

THEREFORE, BE IT RESOLVED, that the Idaho Association of Boards of Health supports ~~an initiative to increase~~ing the tobacco tax ~~by at least \$1.25 per pack and equivalent for other tobacco products to enhance comprehensive tobacco prevention, and control efforts to reduce youth and adult tobacco use rates, and decrease the tax burden derived from tobacco-attributable expenditures by offsetting tobacco-related medical care.~~

*Adopted by the Idaho Association of District Boards of Health
June 2007; Revised June 2010; Revised June 2011*

- 1 – U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012. Accessed on April 12, 2017. U.S. Department of Health and Human Service. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*, Atlanta, GA: Centers for Disease Control and Prevention; 2010
 - 2 – Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2014*. Accessed on April 12, 2017. U. S. Department of Health and Human Services and Centers for Disease Control and Prevention. *Sustaining State Programs for Tobacco Control, Data Highlights 2006*.
 - 3 – Campaign for Tobacco Free Kids. *Toll of Tobacco in the United States*. December 22, 2016. www.tobaccofreekids.org. Accessed on April 12, 2017. Youth Risk Behavior Survey, 2009.
 - 4 - Campaign for Tobacco Free Kids. *Key State-Specific Tobacco Related Data and Rankings*. December 22, 2016. www.tobaccofreekids.org. Accessed on April 12, 2017.
Campaign for Tobacco Free Kids. *Key State-Specific Tobacco Related Data and Rankings*. January 9, 2007. www.tobaccofreekids.org
 - 5 - Campaign for Tobacco Free Kids. *State Cigarette Excise Tax Rates and Rankings*. December 22, 2016. www.tobaccofreekids.org. Accessed on April 12, 2017.
Campaign for Tobacco Free Kids. *State Cigarette Excise Tax Rates and Rankings*. August 3, 2010. www.tobaccofreekids.org
 - 6 - Campaign for Tobacco Free Kids. *Raising Cigarette Taxes Reduces Smoking, Especially Among Kids*. January 18, 2017. www.tobaccofreekids.org. Accessed on April 12, 2017. Campaign for Tobacco Free Kids. *Raising Cigarette Taxes Reduces Smoking, Especially Among Kids*. November 10, 2009. www.tobaccofreekids.org
 - 7 - Campaign for Tobacco Free Kids. *Tobacco Tax Increases are a Reliable Source of Substantial New State Revenue*. December 23, 2013. www.tobaccofreekids.org. Accessed on April 12, 2017. Campaign for Tobacco Free Kids. *Tobacco Tax Increases are a Reliable Source of Substantial New State Revenue*. December 19, 2008. www.tobaccofreekids.org
 - 8 - Centers for Disease Control and Prevention. *Tobacco Control State Highlights, 2010*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010. Accessed on April 12, 2017.
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Res. 14-04

**RESOLUTION TO SUPPORT PURCHASING HEALTHIER FOOD OPTIONS WITH
THE IDAHO SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM
(IDAHO FOOD STAMP)**

WHEREAS, obesity continues to be a leading cause of preventable disease and death in the United States and in Idaho. In Idaho, 27% of adults are obese while 62.3% of adults are either overweight or obese¹; and

WHEREAS, 29% of Idaho third grade students were classified as overweight or obese in 2011-12², and 23% of ninth through twelfth grade Idaho high school students were classified as overweight or obese; and

WHEREAS, 82.5% of Idaho adults do not eat the minimum recommended servings of fruits and vegetables each day¹ and only 19% of ninth through twelfth grade Idaho high school students ate fruits and vegetables five or more times during the seven days prior to completing the Youth Risk Behavior Survey³; and

WHEREAS, limited access to healthy, affordable foods and increased consumption of sugary drinks and less nutritious foods contributes to an increase in obesity rates; and

WHEREAS, U.S. medical costs associated with obesity in 2008 were estimated at \$147 billion⁴; and

WHEREAS, there is no single or simple solution to address the obesity epidemic, however experts recommend a collaborative approach utilizing policy and environmental strategies; and

WHEREAS, as reported by the Idaho Department of Health and Welfare, the Supplemental Nutrition Assistance Program (SNAP), helps low-income families buy food. Approximately 13.6% of Idaho's state population is enrolled in SNAP as of February 2014⁵; and

WHEREAS, the State of Idaho does not have a policy regarding promotion of healthy food choices for those participating in SNAP.

THEREFORE IT RESOLVED, that the Idaho Association of Local Boards of Health supports and encourages enactment of policies that improve access and encourage choice of healthier food options for individuals utilizing SNAP as one strategy to address rising obesity rates.

*Adopted by the Idaho Association of District Boards of Health
May 29, 2014*

Archived June 9, 2017

¹ Idaho Behavioral Risk Factors: Results from the 2011 Behavioral Risk Factor Surveillance System. Boise, Idaho

Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics, 2011.

² Division of Public Health, Bureau of Community and Environmental Health. Idaho 3rd Grade Body Mass Index

(BMI) Assessment 2011-2012 School Year: Idaho Department of Health and Welfare.

³ Centers for Disease Control and Prevention. 2011 Youth Risk Behavior Survey. Available at: www.cdc.gov/yrbs. Accessed on March 6, 2014.

⁴ Finkelstein, EA, Trogon, JG, Cohen, JW, and Dietz, W. Annual medical spending attributable to obesity: Payer and service-specific estimates. *Health Affairs* 2009; 28(5): w822-w831.

⁵ Idaho Department of Health and Welfare. Food Stamps Participation by County. Available at: www.healthandwelfare.idaho.gov/foodcashassistance/FoodStamps/tabid/90/Default.aspx. Accessed on March 6,

Association Office - FY2017 Estimate & FY2018 Budget

SUMMARY OBJECT					
CODE	SUMMARY OBJECT	FY 17 BUDGET	FY 17 ESTIMATE	FY 18 BUDGET	Description
1501	SALE OF SERVICES	-	-	-	
1701	SALE OF GOODS	-	-	-	
1901	SALE LAND BLDG EQUIP	-	-	-	
2001	FED GRANTS & CONTRIBS	-	-	-	
2101	ST GRANTS & CONTRIBUTIONS	-	-	29,475	Assessment
2501	INTEREST	-	-	-	
2701	RENT AND LEASE INCOME	-	-	-	
3601	MISCELLANEOUS REVENUE	-	724	-	NACCHO ck/SACCHO mbrshp rebate
3601	CASH BALANCE AT 5/31/17	-	35,945	-	
3999	DISTRICT FUNDS	-	-	-	
Total Revenue		-	36,669	29,475	
5000	INDIRECT COST	-	-	-	
5001	COMMUNICATION COSTS	500	90	125	Conference calls
5051	EMPLOYEE DEVELOPMENT COSTS	750	350	350	Idaho Association of Counties Mbrshp
5101	GENERAL SERVICES	-	-	-	
5151	PROFESSIONAL SERVICES	12,750	16,650	12,750	Idaho Assoc of Counties/Mediators
5201	REPAIR & MAINT SVCS	15,500	15,000	15,000	Network of Care (Trilogy)
5251	ADMINISTRATIVE SERVICES	-	-	-	
5301	COMPUTER SERVICES	-	132	-	Charge from SE Health District
5351	EMPLOYEE TRAVEL COSTS	2,300	1,000	1,000	Trustee meeting dinner
5401	ADMINISTRATIVE SUPPLIES	-	-	-	
5451	FUEL & LUBRICANTS COSTS	-	-	-	
5551	COMPUTER SUPPLIES	-	-	-	
5601	REPAIR & MAINT SUPPLIES	-	-	-	
5701	SPECIFIC USE SUPPLIES	-	-	-	
5751	INSURANCE	-	-	-	
5851	UTILITY CHARGES	-	-	-	
5901	RENTALS & OPER LEASES	-	-	-	
5961	MISC EXPENDITURES	250	250	250	Admin Rule Expense
Total Operating Expenditures		32,050	33,472	29,475	
Total Expenditures		32,050	33,472	29,475	
Total Revenues Less Total Expenditures		(32,050)	3,197	-	
Total District Funds		-	-	-	
Less Total Indirect Costs		0	0	0	
Budgeted District Funds		0	0	0	

IADBH - FY2017 Estimate & FY2018 Budget

SUMMARY					
OBJECT					
CODE	SUMMARY OBJECT	FY 17 BUDGET	FY 17 ESTIMATE	FY 18 BUDGET	Description
1501	SALE OF SERVICES	-	-	-	
1701	SALE OF GOODS	-	-	-	
1901	SALE LAND BLDG EQUIP	-	-	-	
2001	FED GRANTS & CONTRIBS	-	-	-	
2101	ST GRANTS & CONTRIBUTIONS	-	-	-	
2201	CTY/CO GRTS & CONTR	-	-	-	
2501	INTEREST	-	-	-	
2701	RENT AND LEASE INCOME	-	-	-	
3601	MISCELLANEOUS REVENUE	11,200	7,075	16,400	FY18-Sponsorships & registration fees
3601	CASH BALANCE AT 5/31/17	-	599	-	
3999	DISTRICT FUNDS	-	-	-	
Total Revenue		11,200	7,674	16,400	
5000	INDIRECT COST	-	-	-	
5001	COMMUNICATION COSTS	150	-	-	
5051	EMPLOYEE DEVELOPMENT COSTS	-	-	-	
5101	GENERAL SERVICES	-	-	-	
5151	PROFESSIONAL SERVICES	1,000	100	2,000	IAB guest speaker
5201	REPAIR & MAINT SVCS	-	-	-	
5251	ADMINISTRATIVE SERVICES	400	-	-	
5301	COMPUTER SERVICES	-	-	-	
5351	EMPLOYEE TRAVEL COSTS	7,000	-	-	
5351	EMPLOYEE TRAVEL COSTS	-	-	12,000	FY18-Host IAB Conference
5351	EMPLOYEE TRAVEL COSTS	-	1,532	-	FY16 Meal for IAB Conference
5351	EMPLOYEE TRAVEL COSTS	-	4,000	-	FY17 IAB Conference Dinner
5401	ADMINISTRATIVE SUPPLIES	-	300	-	Office supplies for IAB Conference
5451	FUEL & LUBRICANTS COSTS	-	-	-	
5551	COMPUTER SUPPLIES	-	-	-	
5601	REPAIR & MAINT SUPPLIES	-	-	-	
5701	SPECIFIC USE SUPPLIES	-	-	-	
5751	INSURANCE	-	-	-	
5851	UTILITY CHARGES	-	-	-	
5901	RENTALS & OPER LEASES	2,150	900	2,400	Bus/table rental for IAB conference
5961	MISC EXPENDITURES	500	1,200	-	Recognition
Total Operating Expenditures		11,200	8,032	16,400	
Total Expenditures		11,200	8,032	16,400	
Total Revenues Less Total Expenditures		-	(358)	-	
Total District Funds		-	-	-	
Less Total Indirect Costs		0	0	0	
Budgeted District Funds		0	0	0	

**AGREEMENT
BETWEEN THE
IDAHO ASSOCIATION OF COUNTIES
AND THE
IDAHO PUBLIC HEALTH DISTRICTS**

THIS AGREEMENT updated the 1st day of October 2016 by and between the IDAHO ASSOCIATION OF COUNTIES (hereafter "IAC"), and the IDAHO PUBLIC HEALTH DISTRICTS (hereafter "Health Districts").

WHEREAS, IAC is a non-profit corporation organized under the laws of the state of Idaho, owned and operated by Idaho's forty-four counties, and whose counties participate in the funding of Idaho's seven public health districts; and

WHEREAS, the Public Health Districts are created by the laws of the state of Idaho;

WHEREAS, the Public Health Districts function under the direction of the Idaho Association of District Boards of Health;

NOW, THEREFORE, for and in consideration of the mutual promises and agreements contained herein, the parties hereto agree as follows:

DUTIES OF IDAHO PUBLIC HEALTH DISTRICTS

1. The Executive Council of the Idaho Association of District Boards of Health shall designate a liaison for IAC to coordinate and work with prior to and during the annual Idaho Legislative Session.
2. The liaison for the Health Districts shall notify IAC of issues that require tracking, monitoring, lobbying and/or testifying on behalf of the Health Districts.
3. The Health Districts shall provide Board of Health members and local public health staff necessary to testify or otherwise contact legislators on public health issues.
4. The Health Districts, through the finance office at District 3, shall pay the sum of \$12,000.00 to IAC for the services set forth below. Payments shall be made as follows: January 31, the sum of \$3,000.00; February 28, the sum of \$3,000.00; March 31, the sum of \$3,000.00; and April 30, the sum of \$3,000.00. Payments shall be sent to the IAC office at 3100 S. Vista Ave., Suite 200, Boise, ID 83705.
5. The Health Districts shall meet with IAC for strategic planning of yearly legislative issues prior to the IAC legislative planning meeting.
6. The Health Districts shall designate two contact persons to serve as ex-officio Members of the IAC Health and Human Service and the Energy, Environment, and Land Use committees.

7. The Health Districts shall provide all funds as may be necessary for IAC to manage and pay for a designated lobbyist at the request of the Health Districts.

DUTIES OF IAC:

1. IAC shall designate staff for purposes of monitoring, and at the discretion of IAC, lobbying and or testifying on behalf of public health issues.
2. IAC shall monitor and advise of actions that may impact the Idaho Legislative Session and the actions of the Idaho Legislature and report to the Health Districts' contact person on those actions affecting public health issues. IAC shall advise of the necessity for action including testimony, lobbying, or making contacts by members of the Health Districts. ["Monitoring" may include but not be limited to reviewing germane committee schedules, legislation, and other activities to determine if there is an impact on public health issues.]
3. IAC shall provide in their regular Legislative Bulletin a highlighted or defined section, which reports on the Health Districts issues during the Idaho Legislative Session.
4. IAC shall meet from time-to-time as may be required with the Health Districts and its Board of Trustees to address issues related to the Legislative Session.
5. In the event that the Health Districts have need to work on legislative issues that are in conflict with IAC and/or IAC policies, IAC will inform the Health Districts of such conflict and the Health Districts will remove such issue from this contract oversight and deal with the issue at the Health District level.
6. IAC, with the advice and consent of the Idaho Association of District Boards of Health, may designate an outside lobbyist to assist with lobbying for public health legislative issues. The management and fiscal oversight for this person will be provided through IAC and reimbursed by the Association office.

TERM:

This Agreement shall commence on October 1, 2016 and shall continue on an annual basis until either party has given notice to terminate the contract prior to October 1 of each year.

AMENDMENTS:

Amendments to this Agreement, including the performance of additional services for new or special projects by the Idaho Public Health Districts and the costs associated with them, shall be agreed to in writing and made a part of this Agreement.

IN WITNESS WHEREOF, the parties have signed this Agreement the date above written, pursuant to approval by the Board of Directors of IAC and the Trustees of the Health Boards.

IDAHO ASSOCIATION OF COUNTIES

By: *Daniel G. Chadwick*
Daniel G. Chadwick
Executive Director

IDAHO ASSOCIATION OF DISTRICT HEALTH BOARDS

By: *Bill Leake*
Chair: *Bill Leake*