**State Community Health Services Advisory Committee (SCHSAC)**
Minnesota Department of Health
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# Funding Formula Recommendations for Public Health Emergency Preparedness

## SCHSAC Public Health Emergency Preparedness Oversight Group

## September 2014

## Contents

*Protecting, maintaining and improving the health of all Minnesotans*

January 6, 2015

Larry Kittelson, SCHSAC Chair
Pope County Commissioner
130 Minnesota Avenue East
Glenwood, MN 56334

Dear Commissioner Kittelson:

Thank you for the State Community Health Services Advisory Committee's (SCHSAC) recommendation to use a new funding formula to distribute the federal Public Health Emergency Preparedness grants from the Minnesota Department of Health to community health boards.

Reallocating resources is difficult work. I appreciate the efforts of the SCHSAC Public Health Emergency Preparedness Oversight Group to develop a new formula based not just on population, but also other factors such as achievement of benchmarks, social vulnerability, and cross-jurisdictional collaboration efforts.

I commend members of the advisory committee who were able to look beyond individual gains and losses to take steps to improve the entire Minnesota local public health system.

Thank you for your work.

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

POPE MINNESOTA
COUNTY

*Enhancing quality of life by providing innovative services for our community every day.*

September 22, 2014

Ed Ehlinger, MD, MSPH
Commissioner
Minnesota Department of Health
625 Robert Street North
St. Paul, MN 55155-2538

Dear Commissioner Ehlinger:

The State Community Health Services Advisory Committee (SCHSAC) recommended a new funding formula to distribute the Federal Public Health Emergency Preparedness Grant (PHEP) from the Minnesota Department of Health (MDH) to community health boards on September 17, 2014. I have been told that MDH intends to apply the new formula to PHEP grants beginning July 1, 2015.

The SCHSAC PHEP Oversight Group spent almost two years researching funding alternatives to the current population-based formula. The group's goal was to correct inequities in funding distribution to improve the preparedness capacity of the entire Minnesota public health system. The final formula was evaluated using the *Funding Principles for PHEP Grant to Community to Health Boards* approved by SCHSAC on September 25, 2013.

Using the new formula to redistribute the same pot of federal PHEP funds results in increased funding for some and decreased funding for others. During the debate over approving the new funding formula, SCHSAC members stated that it is important to advocate for increased state funding for local public health, including preparedness and response.

As SCHSAC chair, I appreciate your continued support for local public health and leadership in seeking additional resources for Minnesota's local public health system.

Sincerely,

Larry Kittelson, 2014 SCHSAC Chair
Pope County Commissioner
Horizon Community Health Board

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# Summary

After approval by the State Community Health Services Advisory Committee (SCHSAC) on September 17, 2014, a revised funding formula will be used to determine the distribution of federal Public Health Emergency Preparedness funds by the Minnesota Department of Health to community health boards.

This new formula will be applied beginning with Budget Period 4 funds, allocated for July 1, 2015-June 30, 2016.

**The funding formula includes the following five factors:**

**A. Base**
**B. Population**
**C. A social vulnerability index**
**D. Benchmarks**
**E. Collaboration**

SCHSAC approved the recommendation that the workgroup review the funding formula effects in one year to determine the impact of the increases and decreases on CHBs' work in public health emergency preparedness.

SCHSAC also recommends that the state to review the state/local split of the Centers for Disease Control and Prevention (CDC) federal PHEP grant, and for the state to support an increase to the Local Public Health Act Grant.

# Background

In 2012, the SCHSAC Public Health Emergency Preparedness Oversight Group (or PHEP Oversight Group) chose to review and possibly revise the funding formula for distributing Public Health Emergency Preparedness grant funds to community health boards. The group sought additional input and included a representative from the Bloomington CHB in the funding formula discussions.

The formula, in place at the time, was primarily population-based, using a base of $19,000 or a per capita amount for counties with larger populations, whichever was greater. There were acknowledged inequities in this formula including that the largest community health board received 19 times more than smallest and some multi-county community health boards with small populations received more that some single counties with larger populations. Those CHBs receiving the base could afford to spend only four hours per week on preparedness duties.

Prior to reviewing the formula and options for change, the PHEP Oversight Group developed funding formula principles to evaluate potential formulas and guide funding decisions. SCHSAC approved the principles at the quarterly meeting held September 25, 2013.

The PHEP Oversight Group researched new factors to include in the funding formulas and calculated hundreds of formula scenarios. After applying the funding formula principles, the PHEP Oversight Group shared the top options with public health directors and CHS administrators in early 2014. At the March 7, 2014, SCHSAC quarterly meeting, the PHEP Oversight Group presented the group's recommendation to change the current PHEP formula to include the following five factors: **base**, **population**, a **social vulnerability index**, **benchmarks**, and **collaboration**. The group sought feedback from SCHSAC and the opportunity to make additional improvements to the proposal, with a final formula being brought to the SCHSAC Executive Committee in early April in order to meet the May 1 application deadline for the Centers of Disease Control and Prevention (CDC). After much discussion, the motion to approve the proposal failed. The population-based PHEP funding formula remained in place. Additionally, the group was charged at the March

SCHSAC meeting to revise their proposal on changes to the PHEP funding formula for community health boards, calculate funding amounts, and seek additional feedback, before making a revised recommendation to SCHSAC.

The PHEP Oversight Group did as charged, revised the formula, and vetted it at regional Local Public Health Association meetings over the summer. At the SCHSAC meeting held September 17, 2014, the PHEP Oversight Group's co-chairs Susan Morris (Isanti-Mille Lacs CHB) and Pete Giesen (Olmsted CHB) presented the recommendations, which included: 1) Change the current PHEP funding formula (applicable to emergency preparedness funding only) to one that included the following five factors to be implemented in Budget Period 4 (July 1, 2015-June 30, 2016); and 2) the PHEP Oversight Group would review the funding formula effects one year after implementation to determine the impact on CHBs' work in public health emergency preparedness, and adjust the weights of the factors in the formula as needed. The co-chairs and OEP staff addressed questions about the caps on increases and decreases, how the formula will be reviewed, and methodology. Members representing the metro region expressed concern that the new formula will result in a net loss to the region. The vote was 35 in favor of approving the recommendation and six opposed, out of a total of 41 eligible votes. Nine CHBs did not cast ballots.

An additional motion was made recommending the state review the state/local split of the CDC federal PHEP Grant and for the state to support an increase to the Local Public Health Act Grant. This motion was approved by SCHSAC.

# PHEP Funding Formula Recommendation to SCHSAC: Approved September 17, 2014

**SCHSAC Public Health Emergency Preparedness Oversight Group**
**Approved by the State Community Health Services Advisory Committee – September 17, 2014**

The PHEP Oversight Group agrees it is time for a change in the PHEP funding formula.

We recommend that SCHSAC approve the following:

**The PHEP Oversight Group/Funding Formula Workgroup recommends that the Public Health Emergency Preparedness (PHEP) formula change from the current base or population (per capita) framework to one that includes the following five factors:**

**A. Base**
**B. Population**
**C. A social vulnerability index**
**D. Benchmarks**
**E. Collaboration**

## Explanation

The PHEP Oversight Group has spent the past year examining the PHEP funding formula. The goal was to develop a revised funding formula for those funds allocated to local health departments. As part of this process, the workgroup developed the funding principles, approved at the September, 2013 meeting to guide the discussion. These principles have been used to measure suggested formulas.

The current formula is primarily population-based, using a base of $19,000 or a per capita amount for counties with larger populations, whichever is greater. There is general agreement that there are inequities in this formula. Three previous funding formula workgroups decided to stay with this formula.

The workgroup identified several elements that could address some of the inequities. However, there remains a finite amount of money awarded from the CDC that can be distributed to local health departments. Changes to the formula will inevitably result in some community health boards gaining funds and others losing funds. To manage the extent of gains and losses, the workgroup recommends that there be a cap on increases and decreases in the awards based on changes to the funding formula. Any increases or decreases on the amount awarded from the CDC are applied across the board to all CHBs.

After considerable discussion and review of many options, the five elements the workgroup members have identified are:

### A. Base

### B. Population

Population remains a significant component of the formula (62.5 percent).

### C. Social Vulnerability Index

The current index to be used in the Budget Period 4's formula was developed by the Centers for Disease Control and Prevention (CDC). The Social Vulnerability Index (SVI)[1] uses U.S. Census data to determine the social vulnerability of every Census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. The SVI ranks each tract on 14 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes.

This Social Vulnerability Index is not perfect, but to date, this is the best comprehensive tool available that attempts to measure social vulnerability and disparities between communities.

### D. Benchmarks

These closely mirror the benchmarks that the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) legislation requires all PHEP funded jurisdictions meet and includes: Completing grant duties, submitting reports by due dates, participation in a site visit, and regional health coalition membership

### E. Collaboration

Based on the cross-jurisdictional work occurring across the state, this focuses on the reality that there is a lot of work to do and insufficient funds to accomplish everything alone. Encouraging jurisdictions to accomplish work together helps address these issues.

The PHEP Oversight Group/Formula Funding Workgroup recommends that the formula be applied for Budget Period 4 (July 1, 2015-June 30, 2016). The PHEP Oversight Group recommends that the workgroup review the funding formula effects in one year to determine the impact of the increases and decreases on CHBs' work in public health emergency preparedness.

* An additional motion was made recommending the state to review the state/local split of the CDC federal PHEP Grant and for the state to support an increase to the Local Public Health Act Grant. This motion was also approved by SCHSAC.

[1] Agency for Toxic Substances and Disease Registry; Centers for Disease Control and Prevention. (Updated May 2013.) *The Social Vulnerability Index (SVI).* Retrieved 9 January 2015 from http://svi.cdc.gov/

# Appendix A. Funding Principles for PHEP Grant to Community Health Boards

**SCHSAC Public Health Emergency Preparedness Oversight Group**
**Approved by SCHSAC – September 25, 2013**

## Intended Use

These funding principles were created by the SCHSAC PHEP Oversight Group and are intended to help guide decision making on funding distribution to local and tribal health departments. It is anticipated that funding decreases will continue, although special funding may also occur when significant incidents occur. The principles are foundational, meaning they represent the key considerations decision makers should reference when determining funding levels.

## Funding Principles

1. All-Hazard emergency preparedness and response has been, is, and will always be a fundamental responsibility of public health.
2. All-Hazard emergency preparedness and response requires all community health boards (CHBs) and tribal health departments (THDs) in Minnesota to be prepared; this is accomplished by using the Public Health Emergency Preparedness capabilities as a framework for assuring capacity, as federal, state, and local funding allows.
3. The same level of response preparedness for each CHB is not expected.
4. Response readiness and capability achievement can and should be accomplished by participating in regional Health Coalitions and partnering with other jurisdictions and disciplines; therefore CHBs are encouraged to plan, exercise, and respond together within their regions.
5. Public health preparedness should focus on the unique roles CHBs/LHDs/THDs have and align with funding levels and capability capacity.

## Caveats

- These principles assume some level of continued federal funding.
- It is recognized that the preparedness funding provided is limited and that there is a considerable amount of work to be completed.
- Efforts will continue to identify scalable grant duties that help move the state forward to meeting the federal capabilities and benchmarks.

## Background: Shifting Focus

Since 2002, there has been dedicated federal funding for public health emergency preparedness activities. Considerable discussion has occurred between MDH and local health departments about funding distribution and work expectations. Many attempts have been made to develop a process for fair and equitable distribution of the funds (e.g., funding formula discussions). Efforts to develop scalable grant duties have also been tried.

Recent shifts in policy and funding at the national level necessitate looking closely at how Minnesota's public health system becomes better prepared to respond. At the same time, Congress demands increased accountability, which imposes an added reporting burden.

In 2011, the Centers for Disease Control and Prevention (CDC) shifted the framework of public health preparedness by introducing the fifteen Public Health Emergency Preparedness (PHEP) Capabilities, based on Homeland Security's Target Capabilities. The CDC also developed an assessment tool, the Capability Planning Guides (CPGs), meant to help identify gaps, priorities, and challenges in order to better focus preparedness work. In 2012, the CDC introduced performance measures, intended to measure achievement of the PHEP capabilities. Concurrently, the Hospital Preparedness Program (HPP) began shifting their framework to focus on Health Coalitions. The Office of the Assistant Secretary for Preparedness and Response also introduced eight Healthcare Preparedness Capabilities, a Capability Planning Guide (CPG) assessment tool, and performance measures. These frameworks support the alignment initiative between the two programs. While there are similarities, each program maintains unique and specific responsibilities.

Formal coalitions are a mechanism for fostering further alignment efforts at the regional level. Healthcare, public health, and other key partners bring their perspectives together to identify mutual planning needs, gaps, and strategies to address them. Conducting risk assessments, working on plans, conducting training and exercises, and evaluating their work on a continual basis allow for efficient use of resources (staff, funding, etc.) and sharing of the burden of preparing, responding, and recovering.

# Foundational Concepts

The concepts described below were agreed upon by the workgroup as foundations for how readiness should be achieved in Minnesota, and they were used to develop the funding principles.

### Inclusivity

Minnesotans expect CHBs and THDs to respond to emergencies that affect communities. There must be a minimum level of response capacity within each CHB and THD; however, every CHB and THD is not expected to have the same capabilities. CHBs and THDs should explore options for achieving comprehensive capabilities through working together, sharing resources, and building partnerships.

### Rationality

Risks for experiencing community emergencies vary across Minnesota due to population composition, geography, and industry, among other factors. Therefore, it is critical to take an all-hazards approach. This approach recognizes that all CHBs and THDs need to engage in at least a certain minimum level of all-hazard emergency preparedness planning.

### Scalability

While all emergencies are local, planning and response capacity should be built by working efficiently with partners based upon a defined assessment and vision. CHBs and THDs should realistically examine their capacity and cooperatively build the systems needed to provide the best level of response and recovery services. Activities, including grant duties, should be directed toward those things that only CHBs and THDs can do, and tiered to recognize the unique abilities of each CHB and THD.

### Sustainability

All CHBs and THDs are responsible, either singly, multi-county or regionally, for contributing to the achievement of the public health emergency preparedness capabilities and developing sustainment processes for maintaining the critical public health capabilities in the case of reduction or elimination of dedicated funding.

### Accountability

All CHBs and THDs actively participate in public health emergency preparedness. While dedicated funding exists for public health emergency preparedness, all CHBs (and all member agencies of CHBs) and THDs will be responsible for contributing to the state's ability to meet federal, state, regional, and local requirements for preparedness.

# Appendix B. March 2014 Initial Recommendation to SCHSAC

**SCHSAC Public Health Emergency Preparedness Oversight Group**
**Proposed March 17, 2014 – Not approved by SCHSAC**

The PHEP Oversight Group agrees it is time for a change in the PHEP funding formula.

**We recommend that SCHSAC approve the following:**

1. **The PHEP Oversight/Funding Formula Workgroup recommends that the Public Health Emergency Preparedness (PHEP) formula change from the current base or population (per capita) framework to one that includes the following five factors:**
    - **A. Base**
    - **B. Population**
    - **C. A social vulnerability index**
    - **D. Benchmarks**
    - **E. Collaboration**

**AND**

2. **That SCHSAC agrees that the PHEP Oversight/Funding Formula Workgroup continue to refine and define the percentages assigned to the five elements, use caps on increases and decreases (due to the funding formula) in funding to minimize funding changes during the transition year, and bring a final recommendation to the SCHSAC Executive Committee in early April.**

## Explanation

The PHEP Oversight Group has spent the past year examining the PHEP funding formula. The goal was to develop a revised funding formula for those funds allocated to local health departments. As part of this process, the workgroup developed the funding principles, approved at the September, 2013 meeting to guide the discussion. These principles have been used to measure suggested formulas.

The current formula is primarily population-based, using a base of $19,000 or a per capita amount for counties with larger populations, whichever is greater. There is general agreement that there are inequities in this formula. Three previous funding formula workgroups decided to stay with this formula.

The workgroup identified several elements that could address some of the inequities. However, there remains a finite amount of money awarded from the CDC that can be distributed to local health departments. Changes to the formula will inevitably result in some community health boards gaining funds and others losing funds. To manage the extent of gains and losses, the workgroup recommends that there be a cap on increases and decreases in the awards based on changes to the funding formula. Any increases or decreases on the amount awarded from the CDC are applied across the board to all CHBs. The vote on the recommendation to bring to SCHSAC was not unanimous. The majority of the workgroup supports the recommendation, but there were two dissenting votes, based on concerns about the Social Vulnerability Index.

After considerable discussion and review of many options, workgroup members have identified five elements:

### A. Base

### B. Population

Population remains a significant component of the formula (60 percent)

### C. Social Vulnerability Index

The current index to be used in the Budget Period 3's formula developed by the University of South Carolina,[2] takes into account 30 factors that have been shown in the literature to affect a community's ability to respond and their resiliency to recover.

It is recognized that this Social Vulnerability Index is not perfect, but to date, this is the only comprehensive tool available that attempts to measure social vulnerability and disparities between communities.

### D. Benchmarks

These closely mirror the benchmarks that the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) legislation requires all PHEP funded jurisdictions meet and includes: Completing grant duties, submitting reports by due dates, participation in a site visit, and regional health coalition membership

### E. Collaboration

Based on the cross-jurisdictional work occurring across the state, this focuses on the reality that there is a lot of work to do and insufficient funds to accomplish everything alone. Encouraging jurisdictions to accomplish work together helps address these issues.

The specific percentages assigned to each element remain under discussion by the workgroup and additional input has been solicited from LHD Directors and CHS Administrators. This is one reason the recommendation asks for SCHSAC's approval to continue to work on the distribution between the elements in the formula. The second reason is because the PHEP Oversight Group/Formula Funding Workgroup recommends that the formula be applied for Budget Period 3 (July 1, 2014-June 30, 2015). For that to happen, CHB allocations must be determined so they can be included in the budget submitted to the CDC with Minnesota's application May 3rd. This also allows MDH to begin processing contracts (if CDC has released final award levels), so work can begin on July 1, 2014.

The PHEP Oversight Group recommends that the workgroup review the transitions effects in one year to determine the impact of the increases and decreases on CHBs' work in public health emergency preparedness.

[2] Hazards and Vulnerability Research Institute; University of South Carolina. (Updated October 2013.) *Social Vulnerability Index for the United States 2006-10.* Retrieved 9 January 2015 from http://webra.cas.sc.edu/hvri/products/sovi.aspx

# Appendix C. July 2014 Fact Sheet

**PHEP Funding Formula Proposal Fact Sheet – July 2014**

The PHEP Oversight Group has been working on a new PHEP funding formula to address the fundamental inequities in the current population-only formula. The proposed formula focuses on the good of the state as a whole as well as ensuring long-term sustainability of emergency preparedness by providing a higher basic level of support for all agencies.

- **Equity**: In the current year, the largest award is 19.5 times the size of the smallest; some multi-county CHBs with small populations get many times more money than one county with a larger population
- **Effort Available for Grant Work**: The 2013-14 base award of $19,000 leaves only about four hours per week for program work after administrative time is subtracted
- **Dimension**: The current formula is based solely on population; CHBs get either the base or a per capita amount, whichever is larger

The revised formula addresses these issues through introducing new funding components, and by using a points system. Points are awarded for specific data factors; the total number of points awarded is variable based on where each CHB falls on the scale. The components are:

- **Base**: Each CHB receives a base award of $8000, plus a dollar amount based on points
- **Population**: 62.5 percent of total awards are based on a CHB's population
- **Social Vulnerability Index (SVI)**: Although CDC assigns counties to quartiles in the interactive map online,[3] the proposed formula breaks CHBs into quintiles to further differentiate vulnerability
- **Benchmarks**: Yes/no measures of performance of grant duties; all CHBs should meet Budget Period 4 measures if they are performing in accordance with their PHEP award contracts
- **Collaboration**: Definitions of levels of collaboration with partners based on principles of cross-border sharing

**How would the formula be phased in?**

The funding proposal includes placing caps on increases (60 percent per year) and decreases (15 percent per year), and phasing in the changes related to the formula over the course of the two remaining years of the federal grant project period (July 1, 2015-June 30, 2017). The 60 percent cap on increases was chosen to provide a substantial bump to those CHBs currently most under-funded, without causing a large increase that might result in staffing challenges. The cap on increases will also provide some money to offset the amounts needed to cap the decreases at 15 percent.

**How will this formula provide more statewide equity?**

In recent years, the largest award has been 16-20 times as large as the smallest one. With the proposed formula, the largest is just over 10 times as great as the smallest award. This provides smaller areas with enough resources to add several hours a week in planning time. In addition, a multi-county CHB with a fairly low combined population no longer receives several times as much grant funding as a single county with a larger population.

**Does this formula also apply to tribal health departments?**

No. Beginning with Budget Period 3, tribal health departments have been offered a new way of choosing what level of participation they want in the PHEP grant, with associated funding levels. In addition, according to the agreement worked out with SCHSAC many years ago, the THD awards come out of MDH's portion of the PHEP grant, not the portion allocated to LHDs.

[3] Agency for Toxic Substances and Disease Registry; Centers for Disease Control and Prevention. (Updated May 2013.) *The Social Vulnerability Index (SVI).* Retrieved 9 January 2015 from http://svi.cdc.gov/

# Appendix D. September 2014 Fact Sheet and Recommendation

**Public Health Emergency Preparedness CHB Funding Formula Proposal Fact Sheet and Recommendation**
**September 3, 2014**

The PHEP Oversight Group was tasked with developing a new PHEP funding formula to address the fundamental inequities in the current population-only formula. The proposed formula focuses on the good of the state as a whole as well as ensuring long-term sustainability of emergency preparedness by providing a basic level of support for all agencies.

**Funding Principles**

The group developed a set of principles to provide a consistent framework against which to measure funding decisions, now and in the future. The intent was to identify those principles fundamental to public health emergency preparedness work in Minnesota. These principles were approved at the September 2013 SCHSAC meeting. The principles recognize that emergency preparedness and response is a fundamental responsibility of public health.

**Current Formula**

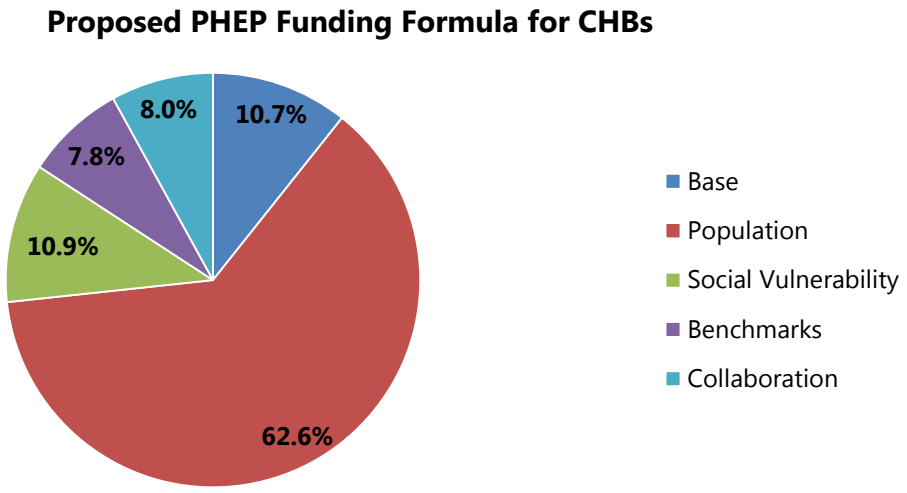
The current formula recognizes the need to conduct preparedness planning in each county-based jurisdiction. Multi-county CHBs have received base funding for each county, resulting in large awards for the four-, five-, or six-county CHBs. In recent years, the largest CHB award has been 16 to 20 times as large as the smallest award.

**Proposed Formula**

The revised formula addresses the funding principles by introducing new funding components. The proposed formula acknowledges the need for county-based planning by adding the counties' Social Vulnerability Index scores, rather than averaging them. Changing the formula will decrease disparities in funding. It will increase capacity for small, stand-alone CHBs by adding several hours each week to preparedness planning. Currently many can only spend four hours each week on this vital responsibility. In addition multi-county CHBs with fairly low combined populations will no longer receive several times more funding as single counties with a larger population.

| Proposed Formula Components | Percent of CHB Award | Explanation |
|---|---|---|
| Base | 10.7% | Each CHB receives a base award of $8,000 |
| Population | 62.5% | Population remains the major funding component |
| Social Vulnerability Index (SVI) | 10.9% | Vulnerable populations face health equity issues and require more assistance during responses. Slightly less than 11 percent of funding is based on how jurisdictions are ranked by the new index from CDC. The CDC SVI replaces the University of South Carolina's SoVI, the index presented to SCHSAC in March. The SVI uses U.S. Census data to rank the social vulnerability of every census tract on 14 social factors (poverty, language, lack of vehicle access, crowded housing, etc.). It can be viewed on CDC's interactive map online (http://svi.cdc.gov) |
| Benchmarks | 7.8% | Just under 8% of funding is dependent on grantees' performance of grant duties; all CHBs should meet Budget Period 4 (2015-2016) measures if they are performing in accordance with their PHEP award contracts |

| Proposed Formula Components | Percent of CHB Award | Explanation |
|---|---|---|
| Collaboration | 8.0% | Eight percent of funding is allocated based on levels of collaboration with partners built around principles of cross-border sharing, as measured by self-assessment with MDH confirmation |




**How would the formula be phased in?**

The funding proposal includes placing caps on increases until the new level is reached (no more than 60 percent per year) and decreases (no more than 15 percent per year), and phasing in the changes related to the formula over the course of the two remaining years of the federal grant project period (July 1, 2015-June 30, 2017). The 60 percent cap on increases was chosen to provide a substantial bump to those CHBs currently most under-funded, without causing a large increase that might result in staffing challenges. The cap on increases will also provide some money to help offset the amounts needed to cap the decreases at 15 percent.

**Recommendation to SCHSAC**

**The PHEP Oversight Group recommends that:**

1. **The Public Health Emergency Preparedness funding formula change from the current framework in which awards to CHBs are the higher of a base amount OR an award based on population (per capita), to a formula that includes the following five factors implemented in budget Period 4 (July 1, 2015-June 30, 2016):**
    - **A. Base award to all CHBs**
    - **B. Population**
    - **C. Social vulnerability index**
    - **D. Benchmarks**
    - **E. Collaboration**
2. **The PHEP Oversight/Funding Formula Workgroup review the funding formula effects one year after implementation to determine the impact of the increases and decreases on CHBs' work in public health emergency preparedness, and adjust the weights of the factors in the formula as needed.**

# Appendix E. PHEP Oversight Group Members

**Oversight Group Membership**

Pete Giesen, Co-Chair (Olmsted)
Susan Morris, Co-Chair * (Isanti-Mille Lacs)
Sharon Braaten (Horizon)
Pam Blixt (Minneapolis)
Robert Einweck (St. Paul-Ramsey)
Jim Gangl (Carlton-Cook-Lake-St. Louis)
Bill Groskreutz * (Faribault-Martin)
Mike Matanich (Stearns County)
Karen Swenson (Brown-Nicollet)
Gloria Tobias (Countryside)
Grant Weyland * (Clay-Wilkin)

* County Commissioners

**MDH Oversight Group Representatives**

Cindy Borgen (Office of Emergency Preparedness)
Jane Braun (Office of Emergency Preparedness)
Becky Buhler (Office of Performance Improvement)
Cheryl Petersen-Kroeber (Office of Emergency Preparedness)

**MDH Oversight Group Staff**

Mickey Scullard (Office of Emergency Preparedness)