SNHD FUNDING POLICY ANALYSIS

Prepared for the Southern Nevada Health District

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Executive Summary

The state of Nevada ranks 50th in public health funding, based on funding from CDC and HRSA) when compared to the rest of the United States, and ranks last in state funding for public health as well.[1]

How does this actually impact our state? There is evidence to suggest that increases to public health spending correlate with decreases in certain preventable mortality rates.[2] However, the complexity of public health makes it difficult to predict how an increase in spending will actually impact the many health problems that affect our community. As of 2016, the national average of public health funding, from two federal funding sources (CDC and HRSA), measures at $95 per capita, while Nevada allocates only $34 per individual.[3] Importantly, the state of Nevada ranks in the bottom half of more than twenty core measures as defined by the United Health Foundation's Annual Report on America's Health Rankings.[4] Furthermore, the Centers for Disease Control and Prevention, one of the two main federal funding sources to the Southern Nevada Health District, has significantly reduced the amount of overall funding that is allocated to the states through grants.[5]

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[1] *2016 Annual Report,* The United Health Found., http://www.americashealthrankings.org/explore/2016-annual-report/measure/Overall/state/NV (last visited 04/19/17).

[2] Glen P. Mays & Sharla A. Smith*, Evidence Links Increases in Public Health Spending To Declines in Preventable Deaths*, Health Affairs (July 21,2011), *available at* http://content.healthaffairs.org/content/early/2011/07/19/hlthaff.2011.0196.full.

[3] *Supra,* note 1.

[4] *Supra,* note 1.

[5] *Grant Funding Profiles, CDC Fiscal Year 2016 Grant Funding By State*, Ctrs. for Disease Control & Prevention, https://wwwn.cdc.gov/FundingProfilesApp/ (last visited 04/19/17).

This policy brief provides an overview of public health funding in the state of Nevada compared to other states in the U.S -- with a focus on the funding to the Southern Nevada Health District; identifies some problems associated with lower funding; considers several policy alternatives aimed at increasing funding; and makes a final recommendation based on the analysis .

The major findings in this policy brief are that:

- The Southern Nevada Health District, like many public health departments, is severely underfunded, compared to the other 49 states and the national average.[6]
- The Southern Nevada Health District, which serves the largest county in the state, receives a disproportionately low amount of funding to support the population when compared to counties of similar size in other states.[7]
- Lower public health funding often correlates with higher mortality rates from certain preventable deaths, including cardiovascular disease, smoking, and drug use.[8] Nevada ranks in the lower 50% of states in the above measures, meaning there are significantly higher rates of death attributable to these causes in Nevada compared to other states.[9] However, this issue is hard to evaluate, and not all studies support this conclusion. There is some evidence that there may be a mixed relationship between public health funding and impacts to health outcomes that varies across communities.[10]

This policy brief assesses four alternative policy options to increase funding: (1) maintaining the status quo, (2) increasing restaurant regulatory fees, (3) focusing on grant writing strategies, and (4) funding a new educational campaign around the current opioid epidemic. To compare these alternatives, the assessment uses three evaluation criteria (1) cost

[6] *Supra*, note 1.
[7] *United States Census 2010, Interactive Population Map,* U.S. Census Bureau, https://www.census.gov/2010census/popmap/ (last visited 04/19/17); *See also supra*, note 1.
[8] *Supra*, note 2.
[9] *Supra*, note 1.
[10] *Supra*, note 2.

to SNHD of pursuing the alternative, (2) likely effectiveness of the strategy in enhancing funding, and (3) the stakeholder perspective on the alternative.

Based on this analysis, this brief recommends a combination of increasing regulatory fees and bolstering grant-writing capabilities. This recommendation utilizes the current SNHD infrastructure, while taking into consideration the rules that govern the funding pipeline, to introduce a more collaborative position that hopes to garner greater funding dollars. If the recommendation is implemented, more funding could be allocated to SNHD through grants from various agencies, which can be used to expand the capabilities of SNHD while also positively impacting the health outcomes of our community.

I. Introduction.

A. Problem Statement:

Allocation of federal and state funding to the Southern Nevada Health District, which likely impacts health outcomes in our community and helps prevent disease, is low relative to other jurisdictions and low to address the community's needs.

B. Background:

For foundational purposes, it is important to understand how public health funding for the state of Nevada is obtained from federal agencies and how this compares to other states in the U.S., the relationship between public health funding and health outcomes, and the state and local sources of funding specific to the Southern Nevada Health District.

1. Public Health Funding in Nevada Compared to the United States

According to the United Health Foundation (UHF), the state of Nevada ranks as the lowest in public health funding per capita in all 50 states, as measured by funding from the Center for Disease Control and Prevention and the Health and Resource Services Administration.[11] UHF has generated annual reports of America's Health Rankings for more than three decades. These reports contain a summary of various health measurements that fall within four central health determinants: behavior, community and environment, policy, and clinical care. These reports utilize data from many major departments of the United States government, including Health and Human Services, Commerce, Education, and the Environmental Protection Agency. According to America's Health Rankings, the US is experiencing a small upward trend in total public health funding. Unfortunately, the state of Nevada is remaining stagnant in this category.[12]

[11] *Supra*, note 1.
[12] *Supra*, note 1.

Nevada, and thus, the Southern Nevada Health District (SNHD), ranks last in the nation when it comes to public health funding dollars.[13] In Nevada, only $34 dollars of state and federal (CDC & HRSA) funding is allocated to public health funding per individual in the state, where the national average lies closer to $95 per capita.[14] In the most heavily populated area of the state of Nevada, Clark County, communities receive governmental public health services from SNHD, the local health department. SNHD had a total revenue of $69 million for the 2016-2017 fiscal year.[15] Contributing 8% of that total are Federal Grants, including those from the CDC and other agencies. With the state population sitting just under 2.9 million people, the CDC awarded more than $26.9 million in grants to Nevada in 2016.[16] Much of this money appears not to go to SNHD, the agency with responsibility for many local public health activities. About $5.45 million of federal funds appear to have gone to SNHD in 2016/17, with another $10.58 million of federal grant funds "passing through" SNHD.[17] While other agencies also require federal funding for other jurisdictions and further allocation to Southern Nevada, SNHD is not receiving appropriate funding considering the relative numbers of people served. This funding problem can lead to unsuccessful prevention efforts in minimizing preventable deaths, injuries, and illnesses, thus increasing the burden of the cost of treatment in the southern Nevada area.[18] Unfortunately, there is insufficient data on how SNHD compares to similar local health districts in other states. However, it is evident that at the state-level, there is a huge discrepancy in allocation of resources (and thus the value) placed on public health between Nevada and other states.

In order to understand what the real funding problem is, it helps to compare the allocation of our state's funds to states with similar population sizes (see Table 1). The state of Utah, where the population is just about 3 million, received a little over $42 million in funding

[13] *Supra*, note 1.
[14] *Supra*, note 1.
[15] *Budget Fiscal Year Ending June 30, 2016,* Southern Nevada Health District (June 19,2016) https://www.southernnevadahealthdistrict.org/download/boh16/20160324-2/viii.draft_budget_20160316.pdf.
[16] *Supra*, note 5; *Supra*, note 15.
[17] *Supra*, note 15.
[18] *Supra*, note 2.

from the CDC in 2016[19] to the State Health Department.[20] Although it is unclear whether funds are further allocated to local health agencies, more federal funding is flowing to public health and Utah and may be reaching localities to potentially address public health issues such as cardiovascular disease, diabetes and cancer.[21] Importantly, Utah consistently ranks higher than Nevada across many public health measures.[22] Because, combined, the state allocates and receives from CDC and HRSA close to $70 per individual for public health funding, more than double Nevada's per capita amount, Utah has been able to maintain a higher average ranking.[23]

Another comparison state, the state of Kansas, received $33.4 million in federal grant funding from the CDC in fiscal year 2016 for its 2.9 million people.[24] With a state population that is equal to that of Nevada, as well as similar funding from the CDC, it is surprising that the average combined state and federal (CDC and HRSA) public health funding dollars per capita is approximately $50 per individual.[25] Even though much of this federal money is brought into the state health departments in both Kansas and Nevada,[26] Kansas represents is a 50% overall increase in public health funding compared to Nevada, perhaps allowing additional state funding sources to address public health needs. This is not to say that federal funding dollars are not reallocated to local health departments in both Nevada and Kansas.

A related issue to consider is how Clark County compares to similar counties in terms of hosting entities directly receiving federal public health dollars (in other words, being the county in which grantees are located). This is a useful measure to consider because the public health system is not limited to governmental public health and also because it provides an additional

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[19] *Supra*, note 5.

[20] *Grant Funding Profiles, Fiscal Year 2016 Grants Summary Profile Report for Utah,* Ctrs. for Disease Control & Prevention (2016), https://wwwn.cdc.gov/FundingProfilesApp/Report_Docs/PDFDocs/Rpt2016/Utah-2016-CDC-Grants-Profile-Report.pdf.

[21] *Supra*, note 1.

[22] *Supra*, note 1.

[23] *Supra*, note 1.

[24] *Supra*, note 5.

[25] *Supra*, note 1.

[26] *Grant Funding Profiles, Fiscal Year 2016 Grants Summary Profile Report for Nevada*, Ctrs. for Disease Control & Prevention (2016), https://wwwn.cdc.gov/FundingProfilesApp/Report_Docs/PDFDocs/Rpt2016/Nevada-2016-CDC-Grants-Profile-Report.pdf.

method to compare Clark County to other localities. Most of the CDC public health dollars allocated to Nevada are granted to entities that are located in Carson City.[27] To compare, the majority of New Mexico's funding from the CDC goes to entities in Bernalillo County, which unsurprisingly, has the largest population of all counties in that state.[28] Since the vast majority of the ~$26 million of annual CDC funding allocated to Nevada goes directly to the State Health Department, it may be worth better understanding how these funds are distributed to address public health needs across the state, including the needs of more heavily populated counties.

Table 1: (using data from the CDC Grant Funding Profiles Summary of 2016)

*These numbers were calculated using the CDC Grant Funding Profiles, By State and the US Census Bureau 2010 County Map. They do not take into account how the CDC grantees may disperse this funding to the other entities.

State	Population size	CDC Funding	CDC Funding Per Capita	Population of Largest County & CDC Direct Allocation to Entities in the Largest County*
Nevada	2,940,058	$29,691,727	$10.09	Clark County- 1,951,269 pop. $2,479,581
Utah	3,051,217	$42,077,878	$13.79	Salt Lake County- 1,029,655 pop. $42,077,878
Kansas	2,907,289	$33,462,867	$11.51	Johnson County- 544,179 pop. $204,957
New Mexico	2,081,015	$38,692,276	$18.59	Bernalillo County - 662,564 $4,499,244

2. How is "public health funding" connected to "better health"?

To contextualize the role public health funding plays in health, it is important to examine the connection between the two. There is an inherent difficulty in measuring the

[27] *Supra*, note 26.

[28] *Grant Funding Profiles, Fiscal Year 2016 Grants Summary Profile Report for New Mexico*, Ctrs. for Disease Control & Prevention (2016), https://wwwn.cdc.gov/FundingProfilesApp/Report_Docs/PDFDocs/Rpt2016/New-Mexico-2016-CDC-Grants-Profile-Report.pdf; *Supra*, note 7.

benefit of public health spending on health outcomes as there is a variation in definitions of public health. Secondly, there is an inherent assumption that improved coordination of services will yield improved outcomes, but it is difficult to appreciate the magnitude of savings. There is also a limitation on how public health expenditures are tracked and thus measuring the resulting improved savings. Generally, public health focuses on preventing disease, prolonging life of individuals and therefore populations, and promoting population health through organized efforts of a community. In order to achieve these goals, public health funding is utilized to control the spread of communicable diseases, identify and implement prevention and early diagnosis strategies, and educate populations on the importance of improved health. [29] Like many public expenditure programs, it is important to understand the "return on investment" of these strategies and focus on programs that lead to beneficial outcomes and avoid utilizing precious resources on programs that are not optimally effective in improving overall better health for the community.

The literature states that about 3% of total national health spending goes to support public health organizations. In 2009, the National Health Expenditure Accounts (NHEA) estimated that there was about $77.2 billion spent on all public health spending, including federal, state and local spending, which resulted in $8,086 in total health expenditures per person and about $251 spent on public health by federal, state, and local governments.[30] The Trust for America's Health (TFAH) has estimated that public health spending by state government in the U.S. from 2009-2010 ranged from a low of $3.40 per capita in Nevada to a high of $171.30 per capita in Hawaii.[31]

However, despite some research, whether more money equals better public health outcomes remains a challenging question. For example, a recent study by Marton et al. titled

[29] *List of Programs*, CDC Foundation, https://www.cdcfoundation.org/what/programs/list (last visited May 10, 2017).

[30] *National Health Expenditures, 2011*, Cntr's for Medicare & Medicaid Serv's, (December, 19, 2011) https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.

[31] Committee on Public Health Strategies to Improve Health; Institute of Medicine, *For the Public's Health: Investing in a Healthier Future* ch. 4 (2012), available at https://www.ncbi.nlm.nih.gov/books/NBK201025/#ref_0365.

"Does More Public Health Spending Buy Better Health?" used a twelve-year panel dataset of Georgia county public health expenditures and outcomes to suggest that increased public health funds leads to increased mortality via several causes, including heart disease deaths.[32] They also found that increasing public health funding leads to increases in morbidity from heart disease.[33] The authors speculated that this finding is due to government funds "crowding out" private investment in public health programs, with the conclusion that these specific programs are not best targeted for public financing.[34]

In contrast, an earlier study published in *Health Affairs*, followed a larger national cohort of communities over a 13-year period and found that mortality rates fell between 1.1% and 6.9% for each 10% increase in local public health spending.[35] These findings show that increases in government spending on public health programs can play a critical role in improving the health of a population and reducing geographic disparities in preventable mortality. It is clear that there are limitations when measuring the cause and effect of public health funding, but it is increasingly important to measure the specific expenditures regarding public health and then linking these dollars to measures of community-level health outcomes. These outcomes, such as preventable deaths and cases of disease, can help the research community estimate health outcomes as a result of public health funding.

3. *What are the sources of SNHD's state & local public health funding and how much does SNHD get from each source?*

SNHD receives funding from sources on both the state and local level.[36] The major revenue sources of SNHD include the property tax allocation from Clark County collected from various jurisdictions and set by state statute; regulatory revenues; fees for services; and other

[32] James Marton et. al, *Does More Public Health Spending Buy Better Health?*, SAGE Journals, (April 13, 2015), available athttp://journals.sagepub.com/doi/full/10.1177/2333392815580750

[33] *Id.*

[34] *Id.*

[35] Glen P. Mays & Sharla A. Smith, *Evidence Links Increases In Public Health Spending To Declines In Preventable Deaths*, Health Aff vol. 30 no. 8 1585-1593 (2011).

[36] *SNHD Comprehensive Annual Financial Report for Fiscal Year Ending June 30, 2016*, Southern Nevada Health District, pg 38, (June 19,2016) http://southernnevadahealthdistrict.org/download/cafr-fy063016.pdf.

intergovernmental revenues from state and federal sources.[37] Other revenue sources--including federal grants received through the state, direct federal grants, and special projects grants--are considered available when cash is received by SNHD.[38]

The four largest sources of funding for SNHD are as follows:

- *General Fund.* All financial resources except those accounted for elsewhere that constitute the general operating fund.
- *Special Revenue Fund.* All grant resources restricted for specific programs.
- *The Bond Reserve Capital Projects Fund.* Resources committed to renovating the new administration building.
- *Capital Projects Fund.* Resources committed or assigned to acquiring or constructing capital assets.[39]

Although created as an independent governmental entity pursuant to Nevada Revised Statute (NRS) Section 439.361, SNHD has no independent taxing authority. It relies on revenue from fees and other governmental sources -- including property taxes allocated to SNHD -- in order to operate. In addition, there are many limitations to the use of SNHD funds and how they are reported. For example, funding for any capital improvement project "must be derived from operating revenue unless capital grant funds are awarded."[40] Likewise, "governmental activities...normally...supported by taxes and intergovernmental revenues, are reported separately from business-type activities, which rely to a significant extent on fees, charges for services, and grants."[41] Table 2 summarizes SNHD's 2016/2017 budget. These sources of fundings and their related limitations should be considered in light of the overall public health funding levels in Nevada discussed above.[42] It is also important to note that the general fund is

[37] *Id.*
[38] *Id.*
[39] *Id.* at 37.
[40] *Id.*
[41] *Id.* at 36.
[42] *Southern Nevada Community Health Assessment, May 2016,* SNHD, pg 16, http://southernnevadahealthdistrict.org/download/boh16/20160526/southern-nevada-cha-081716-wa.pdf.

the source of monies to ensure SNHD to account for emergencies or unexpected revenue declines.[43]

Table 2: (data from SNHD's 2016/2017 Annual Budget)

SOUTHERN NEVADA HEALTH DISTRICT
2016/17 BUDGET
SUMMARY - ALL FUNDS

	Beginning Balance July 1, 2016	Revenues	Expenditures	Transfers	Ending Balance June 30, 2017
GENERAL FUND-Unassigned	$16,511,494	$50,817,742	$(41,005,418)	$(9,193,595)	$ 17,130,223
SPECIAL REVENUE FUNDS					
Federal Grant Funds	-	5,450,151	(6,890,711)	1,440,560	-
Federal Pass-thru Grant Funds	-	10,575,722	(14,121,503)	3,545,781	-
State Grant Funds	-	1,669,939	(2,213,633)	543,694	-
Other Grant Funds	-	1,000	(1,363)	363	-
CAPITAL PROJECT FUNDS					
Building Reserve Fund	69,032	5,000	(225,000)	1,350,639	1,199,671
Capital Project Fund	4,371,636	35,000	(2,180,000)	-	2,226,636
PROPRIETARY FUND					
Laboratory Fund (less depreciation)	-	-	(2,312,558)	2,312,558	-
INTERNAL SERVICE FUND					
Insurance Liability Fund	606,365	5,300	(216,000)	-	395,665
GRAND TOTAL	$21,558,527	$68,559,854	$(69,166,186)	$ -	$ 20,952,195

According to the most recent budget assessment, SNHD's state, federal, and pass-through grant revenue all increased during fiscal year 2016.[44] The Fiscal Year 2016/2017 SNHD budget anticipates about $68.5M in total revenue[45] with about 30% coming through property tax, 27% coming from regulatory fees, 15% coming from pass-thru grants, 15% coming from fees for service and the remaining 10% coming from federal/state/Title XIX grants (Medicaid and CHIP payments),[46] as illustrated in Chart 1 below.

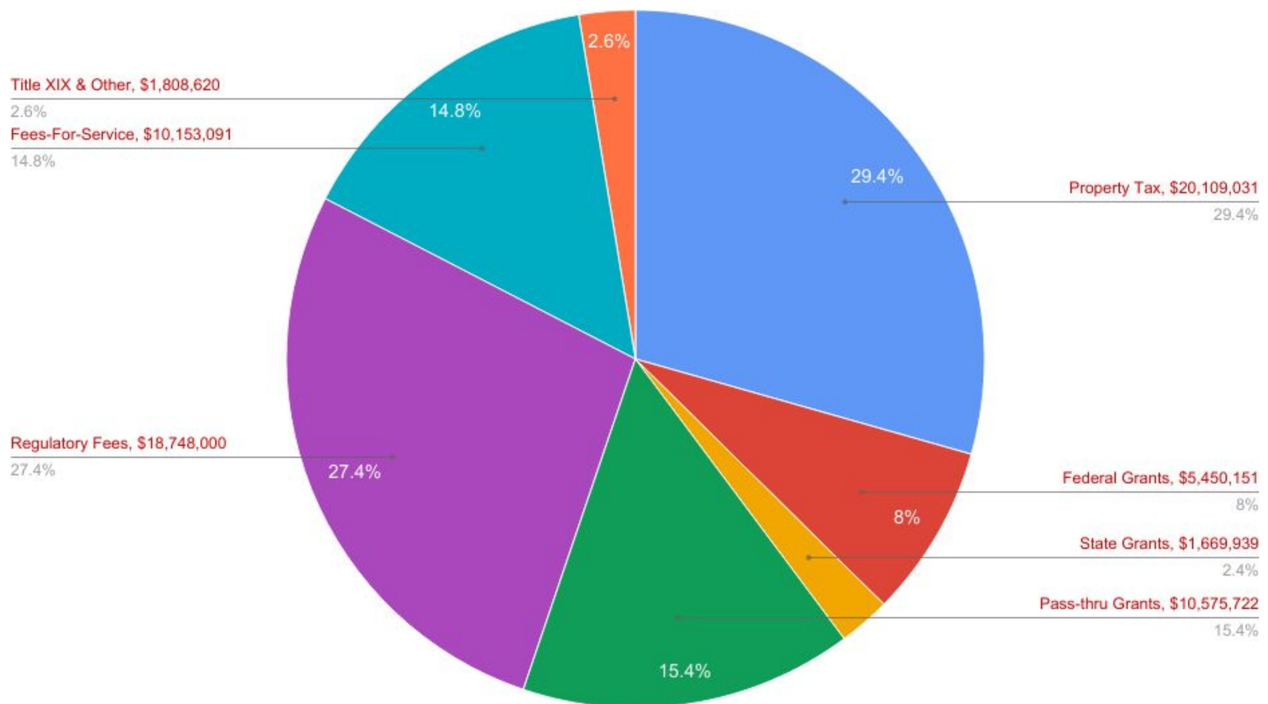
[43] Southern Nevada District Board of Health Audit Committee Meeting, March 15, 2010 at 11 a.m, *available at* http://southernnevadahealthdistrict.org/boh10/0315m.php.

[44] *SNHD Comprehensive Annual Financial Report for Fiscal Year Ending June 30, 2016*, Southern Nevada Health District, pg 25, (June 19,2016) http://southernnevadahealthdistrict.org/download/cafr-fy063016.pdf.

[45] *See supra* Table 2, above.

[46] *SNHD Comprehensive Annual Financial Report for Fiscal Year Ending June 30, 2016*, Southern Nevada Health District, pg 6, (June 19,2016) http://southernnevadahealthdistrict.org/download/cafr-fy063016.pdf.

Chart 1: (using data from the SNHD 2016/2017 Annual Budget)



II. Policy Landscape

Before any policy alternatives aimed at addressing funding for SNHD are recommended, this brief will map out the "policy landscape" by considering stakeholder perspectives and discussing policy history.

A. Stakeholder Analysis

The first step of the policy landscape assessment is the "stakeholder analysis." In this step, we identify the groups with an interest in the implementation and outcome of the policy alternatives. Once the key stakeholders have been identified, we analyzed what motivations and objectives those stakeholders may have regarding public health funding allocation. In this

brief, we have analyzed the perspectives of four key stakeholders: SNHD, the State Health Department, Federal Health Agencies, and the Legislature.

1. SNHD

According to the SNHD mission statement, SNHD's purpose is "to assess, protect, and promote the health, the environment, and the well-being of Southern Nevada communities, residents, and visitors."[47] SNHD fulfills its mission through: "disease prevention, health promotion, environmental health regulations and inspections, and provision of public health nursing services."[48]

SNHD requires a certain amount of funding--regardless of the source--in order to continue its daily operations and special programming.[49] Therefore, at a minimum, from the SNHD perspective, any policy alternative suggested in this analysis must be able to sustain SNHD's current level of funding. However, it would be ideal if the recommended policy could actually *increase* the amount of funding to SNHD, particularly because "funding decisions impact the quality and accessibility" issues.[50] By increasing--rather than maintaining--the amount of funding available, SNHD can continue providing services to Southern Nevada as well as grow and perhaps evolve some of the programs and services offered.

Further, SNHD has expressed interest in opening up avenues for collaboration to improve the community's health, stating:

> "Generating large-scale impact on population health relies on increased cross-sector alignment and collaboration among partner organizations. System activities, such as policy, must be coordinated to efficiently help the community advance towards its health related goals and objectives."[51]

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[47] *General Information,* SNHD, http://southernnevadahealthdistrict.org/general-information.php (last visited 04/19/17).

[48] *Southern Nevada Community Health Assessment, May 2016,* SNHD, pg 1, http://southernnevadahealthdistrict.org/download/boh16/20160526/southern-nevada-cha-081716-wa.pdf.

[49] *See supra* Sec. I.B.3.

[50] *Southern Nevada Community Health Assessment, May 2016,* SNHD, pg 37, http://southernnevadahealthdistrict.org/download/boh16/20160526/southern-nevada-cha-081716-wa.pdf.

[51] *Southern Nevada Community Health Improvement Plan, June 2016,* SNHD, pg 28, http://www.healthysouthernnevada.org/content/sites/snhd/snhd-chip-20160617.pdf.

Accordingly, policy alternatives that encourage collaborative funding and policy reform efforts will be especially useful to SNHD, perhaps particularly in the area of grant funding, which account for a portion of the organization's overall revenue.[52]

2. State Health Department

The Nevada Division of Public and Behavioral Health (DPBH) is a branch of Nevada's Department of Health and Human Services. The division is part of the executive branch of government and is a combination of the previous Health Division and the Division of Mental Health and Developmental Services. DPBH's mission statement is "to protect, promote and improve the physical and behavioral health of the people of Nevada."[53] DPBH has many programs in chronic disease prevention and health promotion to improve the community's health outcomes. Its leadership includes an administrator, chief medical officer, medical epidemiologist, and state epidemiologist.[54] The division is organized into the following four branches, each led by a deputy administrator: Administrative Services Branch, Clinical Services Branch, Community Services Branch, and Regulatory and Planning Services Branch.[55]

As a stakeholder, DPBH values quality public health outcomes for all the residents of the state. As the state body for public health administration, DPBH can achieve its mission only with the needed financial resources, community partners, and infrastructure. Achieving this mission is valuable to the department. There is an incentive for the division to value increased attention to public health because as the amount of attention grows on public health, the division has a greater likelihood of successfully fulfilling its mission because residents and partners become increasingly aware of public health functions and needs. DPBH likely values a good relationship with the governor and larger state administration as the governor recommends the amount of financial support the department should receive from the state in the annual executive budget, which is presented to the state legislature. Finally, the DPBH values a good relationship with the

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[52] *Supra*, note 15.
[53] Nevada Division of Public and Behavioral Health, *Division of Public and Behavioral Health (Dpbh) Overview*, http://dpbh.nv.gov/About/DPBH_Overview/, (last visited May 10, 2017).
[54] *Id.*
[55] *Id.*

community as an increased amount of community engagement not only enhances awareness for critical public health programs, but also engages the community to assist in all public health programs.

DPBH operates many public health programs which include immunization programs, chronic disease management programs, maternal/child/adolescent health and public health informatics & epidemiology to name a few.[56] In order for DPBH to provide these critical programs, they must also have adequate funding. As a public agency, they are reliant on state appropriated funds (as wella s grant dollars) to further the mission of the organization. DPBH works with local public health agencies and other organizations throughout the state. It could thus see the value of increased public health resources at the local level as these collaborative efforts can pay tremendous dividends in the community.[57] In addition, DPBH serves as the local health entity for counties other than Clark and Washoe and therefore has a vested interest both directly and indirectly in resource availability and public health outcomes at the county levels.[58]

3. Federal Health Agencies: Centers for Disease Control & Prevention and the Health Resources & Services Administration

One of the two major federal agencies that provide funding to SNHD is the Centers of Disease Control and Prevention (CDC).[59] It must submit a budget request to Congress annually, which is just a subsection of the executive branch budget submitted by the President of the U.S. that is the precursor to an eventual, passed appropriations bill. This bill highlights federal funding priority areas as determined by the President, but also generates the structure by which federal agencies must operate within.[60] Subsequently, federal agencies like CDC

[56] Nevada Division of Public and Behavioral Health, *Programs*, http://dpbh.nv.gov/Programs/Programs/, (last visited May 10, 2017).

[57] *See generally* Nevada Division of Public and Behavioral Health, *Program Guide 2016* (March 2016), available at *http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/About/Nevada%20Division%20of%20Public%20and%20Behavioral%20Health%20-%20March%202016.pdf*

[58] *Id.*

[59] *Supra*, note 15.

[60] *Funding, Budget*, Ctrs. for Disease Control & Prevention https://www.cdc.gov/budget/index.html, (last visited 04/19/17).

determine what proportion of their individual budgets is available to grant applicants, preferentially funding those that focus on the priority areas selected by the President. While there are many goals of the CDC that focus on protecting the health and safety of Americans, in regards to public health, they are more geared towards building on the current knowledge and contributions that in turn strengthen local, state, and national public health leaders in areas such as the advancement of the science and technology to treat current problems more effectively.[61] In addition, the central framework of the CDC has three top priorities, one of which is to "strengthen public health and healthcare collaboration."[62]

Much of the work done in the last 10 years focuses on increasing access to information through Community Health Improvement navigation systems and surveys that more accurately represent populations while focusing on the health problems they face. A large public health programs launched in 2010 is called the "Winnable Battles."[63] This program focuses on using collaborations with organizations like NACCHO (National Association of County and City Health Officials) and ASTHO (Association of State and Territorial Health Officials) to have a greater impact on public health issues like tobacco, obesity, and health-care associated infections, which can have a large-scale impact on the U.S. health burden.[64]

CDC's fiscal year budget for 2017 is $6.98 billion,[65] including an increase in funding for the prevention and public health section of the total budget.[66] While this is money that will get distributed to all 50 states, it could mean greater accessibility to funds for communities that implement programs with a greater attention to improving public health consistent with CDC priorities. If Nevada, and more specifically SNHD, focus priorities for the local budget toward goals and objectives that align with CDC's focus, it may become easier to secure more CDC funding dollars.

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[61] *About CDC 2: Mission, Role, and Pledge,* Ctrs. for Disease Control & Prevention https://www.cdc.gov/about/organization/mission.htm (last visited 04/19/17).

[62] *Id.*

[63] *Id.*

[64] *Id.*

[65] *Budget Request Overview*, *FY 2017 President's Budget Request*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/budget/documents/fy2017/cdc-overview-factsheet.pdf (last visited 04/19/17).

[66] *Id.*

The second main source of federal funding dollars for SNHD comes from the Health Resources and Services Administration (HRSA).[67] The main focus of HRSA is to protect the health of vulnerable populations, such as children, mothers, and those without access to quality healthcare.[68] Like the CDC, HRSA has five main goals to attain "healthy communities and healthy people." One of these goals focuses on building healthy communities by increasing attention toward collaborative efforts on population and community needs.[69] The fiscal year 2017 budget for HRSA is $10.5 billion.[70] SNHD receives about $2.5 million to its Special Revenues Fund from HRSA, which accounts for about half of the total federal grant funding.[71]

Interestingly, HRSA appears particularly interested in those living with HIV/AIDS, diabetes, and high blood pressure.[72] Importantly, Nevada ranks in the bottom 25% of the nation based on its number of cardiovascular deaths.[73] By focusing on HRSA's interest in decreasing heart disease, Nevada could position itself for greater funding dollars in this area.

4. State Lawmakers

Another important stakeholder on the issue of public health funding is the state legislature. The legislature is comprised of individual members with unique perspectives and priorities. In the aggregate, the legislature, coupled with the administration, determines how to allocate state public health funding. At the same time, in considering public health funding issues, the legislature is balancing Nevada's public health needs with other needs in the state and also considering the availability of overall state revenues. To a large extent, the legislature is also able to control the powers and duties of SNHD as well as provisions of the NRS that, for example, determine SNHD's portion of property tax revenues and certain fee structures.

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[67] *HRSA Strategic Plan FY 2016-2018*, Health Resources and Servs. Admin., https://www.hrsa.gov/about/strategicplan/index.html (last visited 04/19/17).

[68] *Id.*

[69] *Id.*

[70] *Strategic Plan FY 2016-2018*, *HRSA Agency Overview*, Health Resources and Servs. Admin., https://www.hrsa.gov/about/budget/hrsabudgetoverview-2017.pdf (last visited 04/19/17).

[71] *Supra*, note 15.

[72] *HRSA Strategic Plan FY 2016-2018*, Health Resources and Servs. Admin., https://www.hrsa.gov/about/strategicplan/index.html (last visited 04/19/17).

[73] *Supra*, note 1.

B. Policy History

When attempting to craft stronger public health funding policies for SNHD's future, it can be useful to look to the past. Public health funding issues are not particularly new; both SNHD and other jurisdiction's health departments have attempted "a wide range of policies and/or policy solutions...in the months and...years leading up to today."[74] Therefore, "outlining how the problem [of low public health funding] has or has not been addressed"[75] in the past can provide a framework to better understand what policy alternatives should be considered in the future. It is also important to consider this policy history in light of the relationship between prevention and public health outcomes.

1. *Have the levels of funding for SNHD changed substantially?*

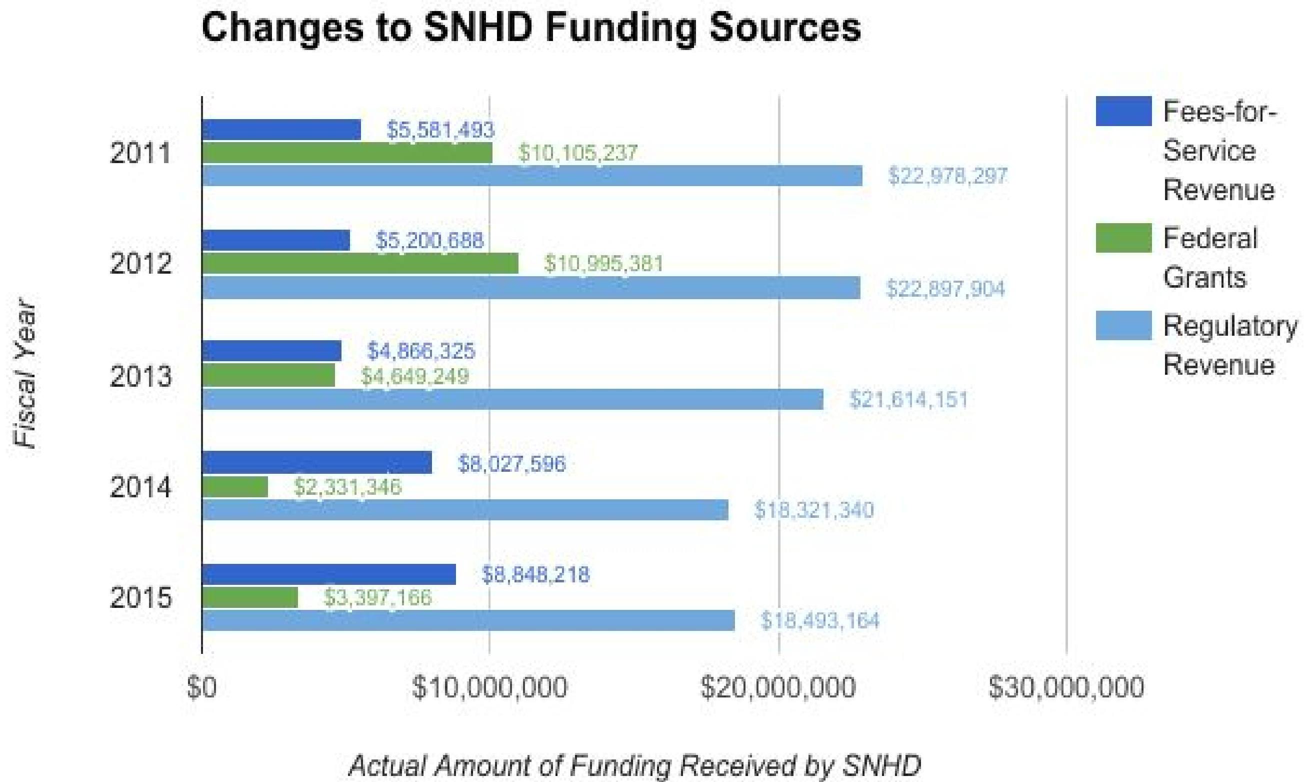
SNHD's funding has been somewhat inconsistent across various funding sources and amounts have fluctuated in recent years depending on the particular source. Chart 2 below provides some examples. As illustrated in Chart 2, Regulatory Revenues,[76] which are typically one of the largest sources of revenue for SNHD, experienced a decrease of almost $4.5 million between fiscal years 2011 and 2015. On the other hand, Fee-For-Service revenues, another one of the larger sources of funding, have modulated up and down.

[74] Moreland-Russell, Sarah; Brownson, Ross C. (2016-01-19). Prevention, Policy, and Public Health (pp. 75-76). Oxford University Press. Kindle Version.

[75] *Id.*

[76] "Regulatory Revenues" include Food Permits, Plan Review Fees, Solid Waste Management Fees, Underground Storage Tank Fees, "Other Permits & Fees", and Emergency Medical Services. *See supra*, note 15, pg 6.

Chart 2: (using data from SNHD's Fiscal Budget Reports for Fiscal Years 2013-2017)



An area that may be of particular note is the area of Special Revenue Funds. Funding in this area goes towards improving or preventing certain specific health issues around Southern Nevada.[77] Although these grants can be incredibly useful tools to improve public health, they are, by nature, somewhat constrained. Often the special grants will have very short grant periods or will be limited in scope as to how the funding may be used. And unlike other sources of funding (tax revenue, federal/state funds), special grants may not be regular or recurring. Therefore, it is difficult to depend on these funds in a long-term, stable capacity. For example, according to the 2016/2017 Fiscal Year Assessment:

> The increase in other [Special Revenue Funds] intergovernmental revenues (excluding the property tax allocation) in the amount of $2,247,572 was due to newly awarded grants such as CDC Partnerships to Improve Community Health, Ryan White B Surveillance, and Ryan White B Intervention and Healthy Start Initiative. Some grant awards were increased such as Ryan White Part A, CDC Public Health Emergency Program, and Ryan White

[77] *Supra*, note 15, pg 15.

Part B Case Management. Various federal and pass-through grant awards also decreased.[78]

Further, SNHD has been the recipient of several special interest grants in recent years. Several of these may be of particular interest to the current goal of *treating chronic disease*. One such grant was from Wholesome Wave to support nutrition incentive programs and to increase access and affordability of fruits and vegetable.[79] The grant was expected to reach more than 120,000 Supplemental Nutrition Assistance Program (SNAP) households in the Las Vegas Valley, permitting SNAP beneficiaries to use SNAP benefits at farmers markets.[80] The grant was intended to expire in September 2016 or until funds ran out.[81] This grant may have been important in improving chronic disease indicators in Clark County.[82]

Another relevant grant was a $2,650,555 award from the Partnerships to Improve Community Health (PICH).[83] The grant, as part of the U.S. Department of Health and Human Services, provided funding to address tobacco use and exposure; poor nutrition; physical inactivity; and lack of access to chronic disease prevention, risk reduction and management opportunities in Clark County.[84] And while the grant has continued to provide funding through fiscal year 2016,[85] the grant restricts the use of funds to the purposes discussed above. It may be useful to keep the restrictive nature of special revenue funds like the Wholesome Wave and PICH grants in mind when considering how the funding to SNHD has fluctuated over time.

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[78] S*NHD Comprehensive Annual Financial Report for Fiscal Year Ending June 30, 2016*, Southern Nevada Health District, pg 21, (June 19,2016) http://southernnevadahealthdistrict.org/download/cafr-fy063016.pdf.

[79] *Health District kicks off grant–funded nutrition incentive program as part of National Nutrition Month*, March 11, 2016 Press Release, available at https://southernnevadahealthdistrict.org/news16/20160311-health-district-kicks-off-grant-funded-nutrition-incentive-program.php.

[80] *Id.*

[81] *Id.*

[82] *Southern Nevada Community Health Improvement Plan, June 2016,* SNHD, pg 22, http://www.healthysouthernnevada.org/content/sites/snhd/snhd-chip-20160617.pdf.

[83] *Southern Nevada Health District Awarded $2,650,555 to Drive Down Chronic Diseases in Clark County*, Press Release, (September 25, 2016) available at https://southernnevadahealthdistrict.org/news16/20160311-health-district-kicks-off-grant-funded-nutrition-incentive-program.php.

[84] *Id.*

[85] *Supra*, note 15, pg 13.

2. *Have there been recent policy-based attempts to increase state & local public health funding for SNHD?*

There is a history of attempts to increase funding to the SNHD. Recently, SNHD clearly indicated its intentions to improve the economic vitality of the organization with its 2016-2019 Strategic Plan. Under this strategic plan, SNHD outlined four goals, the first of which is to strengthen financial sustainability for public health in Southern Nevada and within SNHD. This will be a critical pursuit for SNHD because between 2011 and 2015, its overall revenues fell by about 25%, while the population of Clark County has grown by 5.1% during the same time,[86] consistent with the priorities outlined in the Community Health Improvement Plan.[87]

To achieve the first goal of strengthening financial sustainability of the organization, SNHD has created various performance measures.[88] In its first performance measure, SNHD will deliver three formal performance reviews annually to local and state public health decision-makers to increase knowledge of public health challenges and evidence-based interventions by June 30, 2019.[89] These will include a minimum of two presentations based on the CDC's tobacco and nutrition/physical activity/obesity Winnable Battles. These 9 educational events over a 3-year period will target a wide range of local and state-level stakeholders. The belief is that these presentations will lead to increased knowledge and awareness of the need to improve existing and create new revenue streams to address the public health challenges in our community.[90]

The second objective aimed to improve revenue to SNHD is to create a revenue and contracted services workgroup to provide a plan containing recommendations to increase revenues through billing and/or contracting services.[91] SNHD aims to increase Medicaid

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[86] *2016-2019 Strategic Plan,* SNHD, (June 2016) available at https://southernnevadahealthdistrict.org/download/boh16/20160623/x.accreditation.strategic-plan.pdf.

[87] *Southern Nevada Community Health Improvement Plan, June 2016,* SNHD, pg vi, http://www.healthysouthernnevada.org/content/sites/snhd/snhd-chip-20160617.pdf.

[88] *Supra,* note 86, pgs 11-12.

[89] *Supra,* note 86, pgs 11.

[90] *Supra,* note 86, pgs 11.

[91] *Supra,* note 86, pgs 11.

payments from $1M to about $2M and improve contract revenue from $1M to $2.5M between FY16 to FY19.[92]

The third objective of SNHD's strategic plan to improve revenue is based on the aim of increasing overall grant-based revenue by 15% through the pursuit of local, state, and federal grants that address key health challenges in Clark County.[93] The focus will be on the prioritized CHIP areas of Access to Care and Chronic Diseases.[94] SNHD expects to increase the 2015 grant revenue total of $2.4M to about $2.75M in 2019.[95] Finally, SNHD has set a goal of establishing an interdisciplinary workgroup to develop a report regarding options for increasing revenues and detailing actual cost figures for public health services so the agency can better identify and meet the financial needs of the community.[96] Through a combination of these four activities, SNHD aims to enhance revenues to the organization to meet the increasing needs of the community.[97]

3. How much has Federal funding from CDC and HRSA changed over time?

SNHD has two main federal funding sources, the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA).[98] Over the last 4 years, the total fiscal year budget for the CDC has not changed much, but rather has stayed around 7 billion dollars.[99] The CDC Grant funding to the 50 states has dramatically decreased, however.[100] In 2013, close to $6 billion were accounted for in the grant summaries for all states and the District of Columbia.[101] In 2015, just two years later, the total grant funding was just about $3.5 billion.[102] The most recent report for 2016 indicates there was a smaller, yet still significant decrease of just over $500 million. While there are many possible explanations for

[92] *Supra,* note 86, pgs 11.
[93] *Supra,* note 86, pgs 12.
[94] *Supra,* note 86, pgs 12.
[95] *Supra,* note 86, pgs 12.
[96] *Supra,* note 86, pgs 12.
[97] *Supra,* note 86, pgs 10.
[98] *Supra*, note 15.
[99] *Budget Request Overview*, *FY 2017 President's Budget Request*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/budget/documents/fy2017/cdc-overview-factsheet.pdf (last visited 04/19/17).
[100] *Supra*, note 5.
[101] *Supra*, note 5.
[102] *Supra*, note 5.

these differences, there is a national trend of public health funding reductions, at least in terms of the CDC funding being allocated.

HRSA, on the other hand, has had quite a steady increase in funding from 2000 to the current fiscal year 2016.[103] In 2000, the budget sat at $4.8 billion whereas in 2016, the budget increased to more than $10.5 billion.[104] It is difficult to find a breakdown of the HRSA funding distributed to each state. However, SNHD reports more than $3 million comes from federal funding dollars for the year 2016 (this does not include pass-through grant numbers).[105]

4. What strategies are effective to improve public health outcomes?

Finally, it is worth noting that *preventative health* programs can have a powerful positive impact on overall public health, but have suffered massive funding cuts in recent years. According to one primary care doctor, CUNY public health professor, and Harvard Medical School lecturer, Steffie Woolhandler: "Our health care system is dangerously out of balance; we're spending more and more treating disease but less and less to prevent it....We're breaking the bank paying for hepatitis C and cancer drugs, while drug abuse prevention, needle exchange programs and anti-smoking campaigns are starved for funds."[106]

Moreover, the funding needs for clinical services often increases when funds for preventative programs are reduced.[107] And although their positive returns may take longer to show, preventative programs are relatively "inexpensive and far more cost-effective than clinical treatment when you consider the millions of lives [they] can save or prolong."[108] Accordingly, it may be useful to consider policy alternatives that seek to increase funding to SNHD *by first preventing public health issues like chronic disease or poor access to healthcare.*

[103] *Strategic Plan FY 2016-2018*, *HRSA Agency Overview*, Health Resources and Servs. Admin., https://www.hrsa.gov/about/budget/hrsabudgetoverview-2017.pdf (last visited 04/19/17).
[104] *Id.*
[105] *Supra*, note 15.
[106] Diane Mapes, U.S. public health funding steadily falling, new study shows, Hutch News (Nov. 12, 2015) https://www.fredhutch.org/en/news/center-news/2015/11/Public-health-funding-drop-hurts-prevention.html.
[107] *Id.*
[108] *Id.*

III. Comparing Policy Alternatives

A. Policy Alternatives

Once we have established the policy landscape, we can identify several policy alternatives that may help address the problem of low funding to SNHD. Crucially, these alternatives seek to *address*, not *solve*, the problem of low funding. This distinction is important because "many policy actions are incremental in nature and often will not fully 'solve' a problem, but...will move things along in the 'right' direction."[109]

The four policy alternatives analysed below are:

-**Status Quo**: The first policy alternative is to maintain the status quo by leaving the SNHD funding sources and policies as they currently stand. This policy alternative may be appropriate if 1) it is determined that current funding sources provide sufficient funding to meet SNHD's needs; 2) funding is insufficient, but the time now is not right to act on any specific new policies; or 3) there is not enough information yet to determine what other action is most appropriate and/or feasible.

-**Regulatory Fees**: This policy alternative seeks to marginally increase certain regulatory fees. The premise behind this policy option is that a small, base and per-seat restaurant inspection fee increase could boost revenue to SNHD.

-**Grant Funding**: The third policy alternative is to seek and obtain local, state, and federal special interest grants. This policy alternative is built on the contention that increasing the number of grants that SNHD receives will increase its overall funding levels.

-**Educational Campaign**: The final policy alternative is for SNHD to develop and implement an educational outreach campaign geared toward improving public health in the community.

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[109] Moreland-Russell, Sarah; Brownson, Ross C. (2016-01-19). Prevention, Policy, and Public Health (p. 76). Oxford University Press. Kindle Edition.

B. Policy Alternatives Evaluation Criteria

The merits of the four proposed policy alternatives are assessed in this brief using three evaluation criteria. These criteria were developed through brainstorming, examining SNHD's CHIP and CHA, and applying public health policy theory. Once we identified several possible evaluation criteria, the final three criteria were selected with guidance from Adele Solomon at SNHD. Table 4 summarizes this analysis in Section III.D, below.

-**Cost to SNHD**: This criterion evaluates SNHD's costs in implementing the alternative in terms of time, energy, and money.

-**Effectiveness**: This criterion evaluates whether the proposed policy alternative will likely help address the problem and what the expected returns might be.

-**Stakeholder Perspective**: The final criterion evaluates who is most affected by the alternative, and, for those most directly affected, what the likely benefits and burdens might be.

C. Policy Alternative Analyses

1. Status quo

Description: Any policy comes with an alternative policy of simply maintaining the status quo. Maintaining the status quo essentially means that SNHD would continue to operate using the funding policies and procedures currently in place.

Argument for: The cost of maintaining the status quo is, by definition, a net cost of zero. The current situation, in terms of funding to SNHD, can be separated into two related areas: incomes and expenditures. As discussed in this brief, SNHD currently has multiple sources of funding. This includes, for example, county funding mandated through the Nevada Revised

Statutes, administrative fees and licenses (such as health inspections and food service cards), and taxes on certain businesses (such as a per-table tax on opening restaurants). These are mostly balanced out by the District's expenditures. SNHD's expenditures fall into multiple categories as well. There are operations costs that must be borne, such as salaries for the staff and costs associated with maintaining a physical location (power, water, etc). There are also existing programs that must be funded if they are to continue and/or succeed. Additionally, educational programs, advocacy efforts, and other interventions must also be continuously funded if they are to be successful. For now, the current funding levels of SNHD allows for its continued funding of currently running programs, as well as covering the operations costs associated with the organization. Importantly, however, because some of the revenue can fluctuate (e.g. grant funding), maintaining status quo policies and procedures may ultimately enhance or decrease current revenue levels.

Cost to SNHD: Maintaining the status quo requires no additional cost (in time, energy, or dollars) from SNHD.

Effectiveness: In terms of the financial health of the SNHD (either short or long-term), this alternative is unlikely to increase the funding to SNHD. In that sense, this alternative is not particularly effective at addressing the targeted problem.

Stakeholder perspective: If the status quo is maintained, it is reasonable to believe that SNHD will maintain its currently running programs, subject to continued/level funds via grants, taxes, fees etc. However, this is unlikely to help address any gaps in public health services, programs, or interventions that may be needed to improve health outcomes in Southern Nevada.

Argument Against: While maintaining the status quo requires no additional costs, it is unlikely to net any additional, significant sources of revenue for SNHD.

Cost to SNHD: Although maintaining the status quo garners no extra costs for SNHD, because some sources of SNHD revenue can fluctuate, status quo processes and policies could nonetheless contribute to reductions to future SNHD funding.

Effectiveness: Maintaining the status quo may make it difficult to address new public health needs that may arise in the community. If a new problem requires additional resources, whether it be a deletion, addition, or modification of a program, simply maintaining the status quo cannot deal with this effectively. In addition, maintaining status quo policies and procedures is not likely to improve current public health outcomes in the community, as resources to existing needs will continue to be limited.

Stakeholder perspective: Maintaining status quo policies and current levels of funding is particularly problematic for Southern Nevada community members, including members of vulnerable groups, with public health needs that require additional attention. The status quo also may make it difficult for SNHD to continue to meet the community's needs and respond to new problems or integrate cutting-edge interventions.

Net Assessment: While maintaining the status quo requires no additional costs from SNHD, it is unlikely to net additional sources of revenue. Therefore, this alternative is best for *maintaining* the current funding levels.

2. Grant funding

Description: Another policy alternative is to increase funding to SNHD by increasing the amount of federal, state and local grant dollars that flow to the District.

Argument for: In the event that this alternative is successful (meaning the act of increasing the number and types of grants applied for actually results in more grants being awarded to SNHD), the positive returns would essentially be guaranteed.

Cost to SNHD: SNHD has a human resources department which could easily post grant writer(s) recruitment so time and energy would be a minimal consideration for hiring. There is also a current grant writer, so SNHD is familiar with what the position would entail. The main obstacle for this policy would be the allocation of fiscal

resources. SNHD has a job description for a grant writer, class code 78707, which has an annual salary of $63,000- $83,500. When considering an average benefit load of approximately 30% (health care benefits and Public Employee Retirement System) for public employees in Southern Nevada, the fully burdened salary would range from $82,000- $108,500 per full time equivalent (FTE). Grant writers are typically able to work independently on their work, so additional ancillary staff would not be required. The main consideration would be an internal analysis on how many additional FTEs would be required to add to the current team to obtain the expected financial benefit.

Effectiveness: Additional grant writing resources may be effective at obtaining additional funds, particularly grant writing efforts center on collaborative relationships with healthcare providers in the community. By applying for grants in isolation, SNHD would be limiting the types and amounts of grants for which it may be eligible. Collaborating with healthcare providers (hospitals and clinics) and payors would allow SNHD to extend the application pool with a focus on the prioritized CHIP areas of Access to Care and Chronic Diseases. Many of these organizations are already looking at federal, state and local resources in terms of grants to augment their existing revenue pool and by collaborating with SNHD, this could create a synergistic effect for everyone.

Pursuing a grants strategy is consistent with SNHD's 2016-2019 Strategic Plan. With a diverse population with health care needs in the areas of chronic disease management, primary care and mental health, the Las Vegas Valley could compete for many of these grants. Critical to these grant applications would be a collaboration with healthcare providers and payors, as this relationship would allow SNHD to be even more competitive in the various grant processes.

Additionally, while there must be patience in this process as it takes time for a grant writer to research, write, submit and receive a grant, a successful grants-focused strategy is very likely to increase SNHD revenue.

Stakeholder perspective: There is a tremendous upside in investing in grant writers and community partnerships, as this will allow SNHD to achieve its mission more easily. With this proposal, SNHD and Clark County would be affected most directly as this would give the organization more financial sustainability as well as give them the necessary resources to achieve their public health mission. Furthermore, SNHD could focus on their prioritized CHIP areas of Access to Care and Chronic Diseases and improve health related outcomes in these areas. In addition, community partners may be interested in collaborating with SNHD on mutually-beneficial grant opportunities.

Argument against: Increasing the number of grants applied for does not necessarily guarantee that more grants will be awarded to SNHD. Moreover, this alternative is unlikely to result in immediate positive returns and may require significant time and dollar investment.

Cost to SNHD: There are both direct and indirect costs in implementing this policy. First, this alternative would require SNHD to evaluate its current grants program with an emphasis on determining if it has the requisite number of grant writers and staff within its current structure to increase the quality and quantity of grant applications for federal, state and local grants. If there was a determination that there are not enough resources, SNHD would need to hire the appropriate number of individuals. This would require a recruitment process where SNHD would have to post new positions, interview potential candidates, hire and subsequently train and employ additional individuals. Such hiring requires an allocation of resources, both fiscal and personnel, as you have to have the money and time needed to devote to this type of project and to pay newly hired staff.

Effectiveness: It is difficult to determine the precise return on investment (ROI) of this strategy. Merely applying for more grants does not guarantee that the grants will actually be awarded to SNHD. If SNHD is not awarded additional grants, then this alternative will be fairly ineffective at addressing the problem of low funding.

Stakeholder perspective: There would be a burden on SNHD as it would have to dedicate resources to hire and train grant writers as well as spend time working on collaborative relationships with those in the community. Critical to this policy initiative is to demonstrate that this strategy is an effective utilization of precious resources. Because the "payout" with this alternative is not immediate, it may require in-depth presentations and conversations with the various stakeholders.

Net Assessment: Pursuing additional grant funding is a viable option for SNHD because, although initial costs may be high for SNHD, there may be a good chance for positive returns in the form of increased grant funding. This is especially true if SNHD is not looking for immediate returns. It should be kept in mind, however, that this alternative is not guaranteed to produce increased funding. This may not be an appropriate solution if SNHD is not able to take on any financial risks.

3. Regulatory fees

Description: N.R.S 439.360(5) states that, subject to Clark County Commission's approval, SNHD's Board has the authority to adopt certain regulatory fees. It also declares that such fees must be used to defray related costs such as issuing permits and cannot be distributed to the general revenue fund. One alternative to increase the funding pipeline to SNHD is to alter the current fee schedule and allocate the increased revenue to CHIP priority areas. This may require legislative action to allow for fee increases to be allocated in special circumstances to particular priority areas that are under-funded.

The general fee schedule has not been changed since June 2010.[110] Currently, two of the fees imposed by SNHD are a base and per seat fees on all local restaurant during inspections.[111] This policy alternative would increase both fees by 10%, from $211 to $231 for the base fee and from $2.71 to $2.96 for the per seat fee. This $20 and $0.25 increase, respectively, is based on the premise that more funds could come into SNHD (Priority Area #3). The projected impacted

[110] *Permit and Plan Review Fee Schedule,* S. Nev. Health Dist., http://southernnevadahealthdistrict.org/download/eh/eh-fee-schedule.pdf (last visited 04/19/17).
[111] *Id.*

is presented in Table 3 below. Additional funds could be used to for improvement in CHIP's other two priority areas.

Table 3: SNHD Regulatory Fees Policy Alternative and Projected Impact

Fee Type	Current Fee	Current Total $	Proposed Fee	Projected Total $	Difference
Base	$211.00	$569,700.00	$231.00	$623,700.00	+$54,000.00
Per seat	$2.71	$672.521.73	$2.96	$734,562.48	+$62,040.75

Argument for: Increasing the fees proposed above is a feasible alternative because the increased revenue can be used to fill a new employment position while limiting the individual burden of cost. Importantly, the diverted funds could have a high probability of repayment if used to pursue additional funding.

Cost to SNHD: In undertaking this alternative, SNHD may have to pursue revision of NRS 439.360(5). Also, SNHD's Board would need to discuss all details of the proposed changes to approve this increase. The cost of actually pursuing this strategy is relatively low with respect to money spent. However, this strategy will involve staff time and energy to investigate and pursue the processes to effectively change the fees and allow for funds to be used in SNHD priority areas.

Effectiveness: This strategy, if successfully implemented, could lead to an additional annual revenue of about $120,000 per year. This is an important revenue increase, especially if this new revenue is used to pursue additional funding opportunities by enhancing the grant-pursuing apparatus at SNHD. This policy alternative has the potential to increase the funding pipeline to the health district.

Stakeholder perspective: Local restaurant owners would experience the biggest burden with an increase to the base and per seat regulatory fee. Although it seems unlikely to shutter many restaurants or impose an unfair burden, there may be

potential to pass the additional expense on to patrons. However, the community as a whole would benefit because the money generated by this increase would go directly back into the public health sector to combat various community health problems by way of new programs.

Argument against: This policy alternative could be somewhat burdensome on small local restaurants that have lower profit margins. Also, the fees that have been proposed to increase will generate about $120,000 annually. This reward may not be worth the risk.

Cost to SNHD: To implement this alternative, SNHD would need to change the regulatory fee structure for all local food establishments that contain seats. Given the recent regulatory fee increase on catering services collected by the SNHD, it may be challenging to obtain another fee increase.

Effectiveness: There are a significant number of restaurants (2,700) and seats (248,163) that the $20 and $0.25 increase will be collected on. While these fees are minimal and are estimated to generate just under $120,000 annually using current counts. This is not a significant amount of revenue for an organization the size of SNHD. However, it may cover the cost of one permanent staff member such as a grant writer. Nevertheless, there is no guarantee that a grant writer will be successful at securing additional grant funding.

Stakeholder perspective: Local food establishments will be experiencing an unequal burden due to the increase in regulatory fees, which may cause a backlash from one of the largest industries in the Las Vegas area. Increased fees could also be passed down to patrons or, at worst, expedite the closure of smaller restaurants.

Net Assessment: The state of Nevada and therefore, SNHD, has the lowest allocation of state funding to public health, thus negatively impacting its ability to address community health concerns. By increasing the funding pipeline, there are hopes that positive impacts on public health outcomes (such as decreases in preventable death) will be generated. However, it is very difficult to predict how an increase in regulatory fees at SNHD (generating approximately

$120,000) would impact the overall funding of SNHD and overall health outcomes. Part of this may depend on how this additional funding is used (e.g. to hire a permanent grant writer). It is important to keep SNHD running at full capacity to ensure the community's health as a whole is as great as it can be. Yet, it is imperative that certain businesses, like local food establishments, do not carry a disproportionate burden in comparison to the rest of the community.

4. Educational Campaign

Description: Educational outreach campaigns can be effective preventive health tools.[112] Educational campaigns can take various forms: mass media campaigns; small media, such as videos or printed brochures; interpersonal communication; and comprehensive, community-wide approaches that use multiple health communications, social marketing, and other strategies to improve a variety of behaviors.[113] Therefore, one potential alternative is to create an educational campaign designed to increase the overall health of the Southern Nevada community, thereby reducing the need for funding for clinical and other public health programs. Implementing such a campaign would require funding.

In order to determine how to fund such a campaign, it is necessary to determine the area of interest for the educational campaign. Given that the ultimate goal is to increase community education so that the need for funding to clinical services is decreased, it must be determined which issues need the most attention or currently consume the greatest amount of resources. From that point, current SNHD general funds and/or special grant funds could be used to develop and implement educational outreach programs that will allow the public and healthcare providers to be better informed about areas of public health that currently have high cost impacts to SNHD and Southern Nevada communities.

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[112] Mass media anti-smoking campaigns between 2005 and 2014 were attributed to decreasing number of tobacco users by roughly 20%. Maggie Fox, *'Real Progress': Percentage of U.S. Smokers Plummets, CDC Finds*, NBCNews (Nov. 12, 2015) http://www.nbcnews.com/health/health-news/real-progress-percentage-u-s-smokers-plummets-cdc-finds-n462336?cid=eml_nbn_20151112.

[113] *What Works: Health Communication and Social Marketing*, The Community Guide, available at https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Health-Communication-factsheet-and-insert.pdf(last visited April 20, 2017).

Although any number of topics may be suitable for use in an educational campaign, one recommended area of interest is opioid abuse--particularly prescription opioid abuse. In 2016, SNHD allocated $134,886 from the General Fund to the Substance Abuse Prevention and Treatment Agency.[114] In 2010 in Nevada, the most commonly used drugs in overdose deaths were all opioids: methadone, oxycodone, and hydrocodone.[115] Of those deaths, eighty-five percent were ruled accidental, about 10% as unknown, and 5% as suicides.[116]

Accordingly, other government entities have expressed interest in reducing the number of injuries and deaths resulting from opioid abuse. As part of the 2014 Prescription Drug Abuse Reduction Policy Academy, Nevada established a Taskforce to research prescription drug abuse and related issues including, community education, medical provider education, criminal justice interventions, and screening and treatment.[117] The goal of the Taskforce was "to reduce prescription drug abuse in Nevada by 18% by 2018 by changing attitudes and behaviors of Nevadans through better coordinated efforts and statewide leadership."[118] As such, it is possible that SNHD could implement a collaborative outreach program with another organization because there is a significant government interest in preventing opioid abuse. Additionally, this alternative may be employed in tandem with a grant-seeking alternative since educational outreach may be funded through special grant initiatives.

Given the broad reach of opioid abuse, any educational campaign should take a comprehensive community-wide approach that employs social media, traditional informational brochures, and physician training tools. Social media outreach would be geared toward the opioid users ages 18-45.[119] Traditional brochures warning of the dangers of prescription opioid use and abuse would warn the older demographics of users. These brochures could be posted

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[114] *Supra*, note 15, pg 7.

[115] *Prescription Drug Abuse*, Southern Nevada ubstance Abuse Prevention and Treatment Agency (March, 2012), http://www.leg.state.nv.us/Interim/76th2011/Exhibits/HealthCare/E031312E.pdf.

[116] *Id.*

[117] *State of Nevada Plan to Reduce Prescription Drug Abuse,* National Governors Association Policy Academy on Prescription Drug Abuse Prevention, Pg 3-4, *available online at* http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/State%20of%20Nevada%20Plan%20to%20Reduce%20Prescription%20Drug%20Abuse.pdf (last visited APril 23, 2017).

[118] *Id.*

[119] In 2010, nearly 50% of opioid deaths were individuals ages 18-45. *Id.*

around high-risk areas like doctor's offices and needle exchanges. And finally, this alternative would involve working with the Partnership for Drug-Free Kids to promote the "Search and Rescue Program," developed by the Partnership in collaboration with communications agency Razorfish/Health, to provide opioid prescribers with brief educational videos and other vital resources like Continuing Medical Education courses, CDC guidelines on prescribing opioid medication for chronic pain, and state's Prescription Drug Monitoring Program (PDMP) information to provide data on patients' prescription histories and help prevent "doctor shopping."[120]

Argument for Educational Outreach: Educational outreach programs have proven highly efficient at increasing awareness and improving overall community health in other jurisdictions across the country. Studies following one of the most effective programs, a national 12 week anti-smoking campaign in 2012, indicated as a result of the campaign roughly "1.6 million smokers tried to quit smoking and more than 100,000 likely quit smoking permanently."[121] Further, because any outreach programs would be developed internally, SNHD would be able to tailor the programs almost exclusively to the population's needs and readjust the programs at any point depending on later evaluations.

> **Cost to SNHD:** Some educational outreach programs have proven to be more cost-effective at treating long-term negative effects of public health risks than clinical programs. Further, although it would require assigning SNHD staff to initially work on the program, certain types of outreach programs would not require much SNHD time or energy once development and implementation is complete (though it may require monetary cost to maintain). For instance, printed brochures may be posted in doctor's offices warning of the risk of prescription opioid addiction. Once the initial time and energy has been put into creating the brochures, the only maintenance time/energy costs would likely be ensuring that they remain stocked.

[120] *Prescriber Education Campaign Helps Address National Opioid Epidemic*, Partnership for Drug-Free Kids (Dec. 1, 2016) http://drugfree.org/learn/drug-and-alcohol-news/prescriber-education-campaign-helps-address-national-opioid-epidemic/.

[121] *Public Education Campaigns Reduce Tobacco Use*, Campaign for Tobacco-Free Kids, pg 1 (Jan. 24, 2017) https://www.tobaccofreekids.org/research/factsheets/pdf/0051.pdf.

Effectiveness: As discussed, evidence from across the country support the assertion that certain educational health programs can help improve health outcomes and determinants and reduce the need for funding to clinical programs. This could help address the problem that funding is too low for SNHD's needs because it would decrease the amount of funding needed.

Stakeholder perspective: This alternative would require SNHD staff to develop and implement the programs. However, as discussed above, it is possible to create an outreach program that could be relatively self-sufficient and would require only minimal SNHD involvement (ex. educational brochures, television advertisements, etc). Such a campaign would need to be created in conjunction with healthcare providers, advocates for individuals with mental health and substance abuse issues, and other stakeholders to ensure the campaign were executed in a thoughtful manner.

Argument Against Educational Outreach: This alternative is not likely to yield immediate positive returns and may not be an appropriate alternative if the greatest concern is speed in obtaining short-term results. Further, SNHD has worked with educational programs in the past and has found it can be difficult to effectively determine their success in part because there may be many factors that cause positive results in the subject of the educational program and because it may be challenging to obtain relevant data.

Cost: This alternative would definitely require SNHD to invest initial time, money, and energy into preparing and implementing any programs it develops. Further, it is not a guarantee that any program developed by SNHD will be effective. If the education campaign is ultimately ineffective, then SNHD has spent money and time on a program that has no long-term benefits.

Effectiveness: While history has shown that in some cases educational campaigns can be effective, there is no guarantee that this alternative will produce positive results that will actually reduce the need for future SNHD funding. If that is the case, SNHD would be at a net loss for funds spent to create the programs. This, in turn, would burden SNHD even further than it is already burdened.

Stakeholder Perspective: Although it is likely that the long-term impact to SNHD would not be prohibitively high, there are definitely some costs placed on SNHD (particularly in the initial phases of implementation). Further, due to the "hot-button issue" nature of opioid misuse, it is possible that SNHD might experience a negative reaction from constituents, including healthcare providers and members of the public. Depending on how the educational program is implemented, the risk of a negative reaction could be mitigated. More "invasive" methods of implementation (such as the "Search and Rescue" program) would likely have more backlash.

Net Assessment: Given the potentially high cost-efficiency of this alternative, it is definitely a viable option. It is also a possibility to implement this program in tandem with another alternative, particularly the grant writing alternative. However, although educational programs have proven effective at improving public health in certain instances, it is crucial to consider that this alternative offers no guarantee of success in Southern Nevada. And the act of proving the success of an outreach program is difficult to measure.

D. Policy Alternatives Evaluation Criteria Impact Table

Table 4, below, briefly outlines the relative impact level (low, medium, high) the four policy alternatives would be expected to have across the three evaluation criteria of 1) Cost to SNHD, 2) Effectiveness, and 3) Stakeholder Perspective.

Table 4: Evaluation of the four policy alternatives

	Status Quo	Grant Writing	Regulatory Fees	Educational Campaign
Cost to SNHD	Low	Medium	Low	High
Effectiveness	Medium	High	Low	Medium
Stakeholder Resistance	Medium	Low	Medium	Low

Based on the three evaluation criteria above, the grant writing alternative is expected to be most effective in securing public health funding for SNHD. However, maintaining the status quo would be the least costly to SNHD because the current funding strategy is sustaining the local health district and its current programs. Both the regulatory fee and educational campaign alternatives alone, seem less effective and more costly, respectively.

IV. Final Policy Recommendation: Increased regulatory fees combined with grant writing

Taking the evaluation criteria into consideration, it is the recommendation of this brief that the best policy alternative is to combine the **1) Increased Regulatory Fees** alternative with the **2) Grant Writing** alternative.

The recommended approach is:

1. To begin by increasing the regulatory fees by 10% due to the low cost to SNHD and medium risk of stakeholder pushback.

2. Once fees have been raised, funds may be used to bolster the current grant writing program by hiring another permanent grant writer with a greater focus on collaborative efforts with other health agencies in the Las Vegas area.

This recommended policy, if implemented, has the potential to impact public health outcomes of the local community through increased funding to SNHD. This could be achieved by adding resources to the grant writing team in order to secure more grant funding. Increased grant funds, in turn and over time, could lead to better care of current health issues and also provide opportunities to prevent or limit future public health problems. However, there are some potential drawbacks to this recommendation.

1. It would be necessary to assess whether NRS 439.360 needs modification in order for the funding generated by the fee increases to be allocated to the hiring of a grant writer.
2. A fee increase would need to be approved by SNHD's Board.
3. The amount of money generated by the proposed increase is relatively small (i.e. around $120,000 annually).

4. There are **n**o guarantees that additional resources for grant writing will ultimately secure greater funding dollars.
5. It could be difficult to evaluate whether this policy approach is effective.

Despite these limitations, the final recommendation is still a strong alternative that attempts to improve the current funding situation at SNHD.

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