



District Board of Health Meeting Minutes

Members

Devon Reese, Chair
 Clara Andriola, Vice Chair
 Paul Anderson
 Michael Brown
 Dr. Eloy Ituarte
 Steve Driscoll
 Dr. Reka Danko

Thursday, February 26, 2026
 9:00 a.m.

**Washoe County Administration Complex
 Conference Rooms A & B
 1001 East Ninth Street, Bldg B
 Reno, NV**

1. Roll Call and Determination of Quorum

Vice Chair, Clara Andriola, called the meeting to order at 9:00 a.m.

Members present: Clara Andriola, Vice Chair

Michael Brown
 Dr. Eloy Ituarte
 Steve Driscoll
 Paul Anderson
 Dr. Reka Danko – via Zoom at 9:02 a.m.

Staff present:

Dania Reid, DDA
 Dr. Chad Kingsley
 Erin Dixon
 Dr. Nancy Diao
 Rob Fyda
 Rayona LaVoie
 Scott Oxarart
 Christina Sheppard
 Francisco Vega
 Jack Zenteno
 Dr. Kellie Watkins

Ms. Lawson verified a quorum was present.

2. Pledge of Allegiance.

Dr. Ituarte led the pledge to the flag.

3. Public Comment.

Jamar May stated that his original Mars Mobile Munchies sidewalk stand model was developed as a practical learning opportunity to gain real-world experience before investing in a full mobile food trailer. He explained that his goal has been to build responsibly, gain experience, and scale appropriately. During discussions regarding his permitting, the options presented to him were transitioning to a pushcart model or operating under a full mobile food trailer framework, which is not often affordable for aspiring small business owners. He is requesting clarification regarding the implementation of SB92 and how the term “stand” is interpreted under the sidewalk vendor framework. SB92 establishes sidewalk food vending as a lawful, regulated business activity in Nevada and includes “stand” within the statutory definition of a sidewalk vendor, but does not define what a stand includes. He would like clarification as to the regulatory basis for excluding a limited, commissary-supported stand model and how the term “stand” is interpreted and implemented locally under SB92.

There was one additional comment via eComment, which was shared with the Board and entered into the record, but will not be read.

4. Approval of Agenda.

Steve Driscoll motioned to approve the agenda. Paul Anderson seconded the motion, and the agenda was approved unanimously.

5. Possible approval of January 22, 2026, Draft Minutes.

Mr. Brown moved to accept the consent items, with a second by Mr. Driscoll, and the minutes were approved unanimously.

6. Welcome and Opening.

Dr. Kingsley thanked Erica Olsen with OnStrategy and the staff for the time that was put into preparation for this planning meeting. He also thanked the Board for their support in this process.

Ms. Olsen explained that the meeting was intended as a discussion to obtain Board direction and sentiment regarding organizational priorities for the next three years. The goal was to provide high-level guidance and identify focus areas, informed by community health data, staff feedback, and the organization’s financial position, to support a refresh of the existing strategic plan rather than the development of a new plan. Any proposed updates would be prepared by staff and returned to the Board for future consideration. Materials provided in advance included community health data and organizational information, and the discussion was structured to include both presentations and Board dialogue with flexible timeframes. Planned topics included an overview of the strategic direction and priority-setting process, review of Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) data, health equity considerations, workforce planning and staffing needs, and organizational sustainability and financial health. It was noted that Board action would be required on the proposed budget and that guidance was requested on proposed financial guiding principles. After reading the mission statement, Ms. Olsen stated that no changes were recommended at this time. She also reviewed the structure of the current strategic plan, which is organized around six established priorities—Healthy Lives, Healthy Environment,

Local Culture of Health, Impactful Partnerships, Organizational Capacity, and Financial Stability—that guide organizational outcomes, key performance indicators, and activities. She noted that these priorities would serve as the starting point for discussion, and Board input could result in retaining the priorities or refining elements as part of the strategic plan refresh process.

Dr. Kingsley stated that the current strategic priorities are comprehensive, meaningful, and broadly supported, and he expressed support for maintaining the existing framework while considering opportunities to further strengthen it over the next three years. He described the approach being used to inform development of the next three-year strategic plan, noting that multiple inputs are being used to ensure the plan is data-driven and operationally realistic. These inputs include Community Health Assessment (CHA) data to anchor priorities in identified community needs, Board input to reflect governance direction and policy priorities, a Foundational Public Health Services analysis to assess system capacity and service alignment, evaluation of priority considerations to ensure focus and feasibility, and leadership workshops to apply professional judgment in aligning programs and resources with relevant and sustainable priorities. He noted that these components are intended to support a refreshed strategic plan that is evidence-based and positioned to achieve meaningful impact over the next three years.

Rayona LaVoie described the strategic planning process and the Board's role in providing direction. She explained that information is presented at the retreat to enable the Board to provide input regarding organizational priorities for the next one to three years. Once the Board's priority areas are identified and aligned, staff work within divisions to translate those priorities into actionable plans. The divisions participate in workshops to ensure that outcomes, activities, and performance measures align with the Board's identified priorities, which are then integrated into the organization's performance management system for execution and monitoring. Progress toward Board priorities is reported quarterly through performance reports at DBOH meetings, providing updates on implementation and outcomes. Staff provided an overview of the Foundational Public Health Services (FPHS) framework and Board reporting processes.

Ms. Olsen reported that approximately seven years ago the organization aligned its work with the Foundational Public Health Services model, which identifies the core programs and capabilities that local health departments should maintain to protect community health, including health data monitoring, outbreak and emergency response, food and water safety, chronic disease prevention, maternal and child health services, and the staffing and systems needed to support these functions. She explained that this framework serves as a guiding standard at the local, state, and national levels and is used to evaluate priorities, mission alignment, and service delivery to ensure resources support essential public health functions. Ms. Olsen also reviewed Board reporting practices, including monthly divisional reports with narrative updates and trend data, quarterly performance reports measuring progress toward performance management targets, and the District Snapshot, which is intended to streamline presentation of key data through improved informatics capacity.

Vice Chair Andriola asked if the information is shared with the public.

Dr. Kingsley responded that monthly divisional reports, quarterly performance reports, and the District Snapshot are public records and available to the community. He noted that summary information is also shared during biannual jurisdiction presentations. While the information is accessible, he acknowledged opportunities to improve how data is presented to make it more user-friendly and digestible for the public, including potential enhancements to online dashboards and reporting formats.

Scott Oxarart noted that all major organizational reports, including the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), strategic plan, and Health Equity Plan, are publicly accessible through NNPH's Data Publications and Reports webpage. He also indicated plans to optimize the page by incorporating more visual and graphic elements to improve accessibility and public engagement.

Steve Driscoll complimented staff on the quality of the reports, noting that they are written in clear, understandable language that is accessible to the public. He highlighted that the reports effectively translate technical, medical, and regulatory information without requiring additional clarification, and that staff are responsive and provide timely answers when questions arise. He emphasized the value of the reports as reliable, archivable documents for ongoing reference.

Dr. Kingsley summarized the discussion regarding Board access to information for governance purposes, noting that the Board generally does not experience difficulty obtaining the information needed to fulfill its responsibilities.

7. Presentation and Discussion of the 2026 Washoe County Community Health Assessment (CHA). Review of Community Health Assessment data to inform Board decisions on Northern Nevada's strategic priorities for the next planning cycle, including primary and secondary health outcome data for Washoe County.

Kellie Watkins presented Washoe County's community health assessment, describing the use of population health data and community input to guide evidence-based priorities. The assessment was overseen by a community steering committee and incorporated surveys, focus groups, interviews, and secondary data indicators from multiple sources. Using the Hanlon prioritization method, the analysis identified mental health as the highest priority, followed by access to healthcare, economic stability, and health risk behaviors and early detection. Findings highlighted concerns related to suicide, youth mental health, provider shortages, healthcare navigation challenges, housing instability, cost of living, and preventive health needs. The presentation also noted community strengths, including social connectedness, recreational and outdoor access, cultural diversity, and partnerships with healthcare providers and community organizations.

Kerry Kelly from Renown Health described the Community Health Assessment (CHA) as a joint effort between Renown Health and Northern Nevada Public Health, noting that Renown has conducted similar assessments for approximately 15 years and that the current report was completed collaboratively. Ms. Kelly emphasized the importance of partnerships among healthcare providers, public health agencies, and community organizations to align strategies, reduce duplication of efforts, and improve population health outcomes. She stated that the shared approach helps prioritize prevention, reduce disparities, and guide community

investment, and that the assessment is intended to serve not only as a report but as a coordinated call to action to support long-term community health improvement in Washoe County.

Rayona LaVoie explained how Washoe County translates the Community Health Assessment (CHA) into the Community Health Improvement Plan (CHIP), an actionable framework to address identified community needs and measure progress. Following data collection and analysis, a community forum engages partners to review priorities and provide input. Partners evaluate health topics using five criteria—opportunity, urgency, capacity, leverage, and momentum—to determine where resources can be effectively applied. Current top priorities include mental health, access to healthcare, economic stability, and maternal and child health. While all topics are important, these four represent areas where the community and partners can take immediate, coordinated action to improve health outcomes.

The meeting went into a break at 10:32 a.m. and resumed at 10:42.

Due to the remaining time, items 8 and 9 will be taken from today's agenda and brought back to the Board for the March meeting.

Rayona LaVoie noted the CHA is used in guiding Washoe County's health priorities over the next three years and provides a comprehensive overview of community health, informing where the County and its partners should focus resources and interventions. Community input and board feedback help determine priorities and areas where the County has the capacity to act. Current top priorities identified include mental health, access to healthcare, economic stability, and maternal and child health.

Mr. Anderson asked how the people were chosen for the community survey and what the demographics of the group looked like.

Ms. Watkins noted that demographic breakdown details from the community survey were not included in the presentation, but are available. She explained that the survey was not truly randomized, and a simple statistical review was conducted to assess how closely the respondents reflected the demographics of Washoe County. The analysis indicated some differences from the county's population distribution, including an overrepresentation of women and an underrepresentation of men, as well as challenges in reaching certain racial and demographic groups. She stated that staff considered these findings as lessons learned and will explore strategies to better reach underrepresented populations in future surveys while continuing efforts to promote broad community participation.

Mr. Driscoll asked about the priority list being different from the initial pyramid-shaped list and which one will be used, since they are set up in a different order.

Dr. Watkins clarified that the community health rankings and priorities are derived from multiple data sources, including primary data collected from hundreds of Washoe County residents and secondary data indicators. These inputs are synthesized using the Hanlon prioritization method to generate structured rankings. The priorities presented at the community forum reflected these data-driven results, and forum participants—representing an additional segment of the community—provided further feedback after reviewing the findings. This additional input helped validate and inform the prioritization process; thus, the

list will be used, rather than the pyramid list.

Mr. Anderson asked whether the community stakeholder group included representatives from the Housing Authority, educational participants, and economic development organizations.

Ms. LaVoie described community forum outreach, noting that invitations were extended for about one month to a wide range of partners, including business, academic, nonprofit, housing, managed care, healthcare, and other sectors. Additional outreach was conducted by Renown Health to encourage broad participation. The Community Health Assessment steering committee reviews and vets data indicators to ensure comprehensive representation and appropriate data sources, supporting a holistic assessment of community health.

Mr. Brown appreciated the clarification that this included public safety and law enforcement.

Dr. Diao clarified that the two sets of rankings reflect different processes. Dr. Watkins' chart represented a six-month effort combining primary and secondary data with steering committee input to develop evidence-based priority rankings. The community forum rankings, in contrast, reflected participant perspectives on areas where they believed change was feasible, which accounts for differences between the two lists.

Vice Chair Andriola thanked Dr. Watkins and the team for their work on the community health assessment and acknowledged the extensive data collection and committee contributions. She inquired about representation on the steering committee and suggested potential opportunities to broaden engagement, including participation from additional regional and national organizations. She also encouraged alignment between the Community Health Assessment and the Sequential Intercept Model, noting its relevance across multiple identified priority areas and suggesting increased board awareness of how these frameworks intersect to reduce siloed efforts and strengthen coordinated strategies.

Ms. LaVoie provided an overview of the Sequential Intercept Model, noting that it is supported by the previous Community Health Improvement Plan and the behavioral health system. The model focuses on providing early intervention and support for individuals who interface with the juvenile justice system, aiming to address needs before more intensive or system-level interventions are required.

Vice Chair Andriola emphasized that the Sequential Intercept Model applies to all community members, not just youth, and highlighted the importance of mental health in prevention efforts. She suggested that the board receive a presentation on the model to better understand opportunities for early intervention and treatment, and recommended including Judge Walker as a speaker. Vice Chair Andriola inquired about plans for additional community forums to present and discuss the CHA findings. She suggested that, given the breadth and complexity of the data, future outreach efforts could present the information in focused segments to improve community understanding and engagement. She noted that some identified priorities affect many residents and recommended continued public communication and opportunities for discussion. She enquired about the anticipated release of the assessment results.

Dr. Watkins noted that the goal is for the CHA first draft by June and published shortly thereafter. She noted that the full chart contains extensive data that can be challenging to

synthesize and emphasized the importance of maintaining community engagement and feedback loops, both with partners and internally, to ensure the community can understand the results, see how it affects them, and provide input.

Vice Chair Andriola suggested conducting a “CHA tour” to present the Community Health Assessment to other boards and community groups, highlighting how it intersects with multiple aspects of the community and how stakeholders could help develop solutions. She noted that financial resources could be leveraged to maximize impact. She also shared insights from a recent National Association of Counties legislative conference, including discussions on children’s health, nutrition programs, and legislative opportunities to improve health outcomes. They emphasized the relevance of these topics to the CHA and community-wide efforts.

Dr. Ituarte noted that mental health is closely interconnected with substance abuse, health risk behaviors, and violence prevention and crime, while economic stability influences many other outcomes, including homelessness and access to basic resources. He emphasized that these relationships demonstrate the importance of key priority areas being interconnected and collectively inform where the community should focus its attention and resources.

Ms. LaVoie explained that the CHIP priorities are intended to focus on the top areas where the greatest impact can be achieved over the next three years. While other items, such as health risk behaviors and early detection, will still be addressed, the plan intentionally concentrates on the highest-priority areas to leverage resources, time, and community engagement most effectively.

Mr. Driscoll asked how the priorities identified by the community align with the services currently provided by the health department, and whether there are any gaps or conflicts between community expectations and existing programs.

Ms. LaVoie explained that while the health department may not provide direct services such as therapy, it can support community priorities by investing in infrastructure, convening partners, and addressing systemic barriers. For example, transportation challenges identified in the community survey could be addressed through planning and coordination rather than direct service provision. She emphasized striking a balance between responding to community-identified priorities and staying within the department’s role, noting that facilitating collaboration can lead to impactful outcomes without the department directly delivering all services.

Dr. Ituarte added that the CHA not only informs the health department’s priorities but also guides external agencies and community partners in identifying where services are most needed. By highlighting gaps, the assessment can help stakeholders make strategic decisions, such as locating emergency rooms or other services closer to the populations they serve.

Vice Chair Andriola emphasized that the CHA provides the framework and data to guide priorities but does not place responsibility for service delivery on the health department. Instead, it supports partner organizations in using the information to secure resources, adjust programs, or apply for grants to address community needs. A coordinated outreach effort to share these findings widely would further extend this impact, ensuring that stakeholders responsible for implementation are informed and positioned to respond effectively.

Ms. Olsen suggested that the board review the top four priorities identified through the process and indicate whether they concur with these selections or would like to highlight any additional areas. She noted that staff would use these priorities, along with tools and guidance, to develop an implementation plan, focusing on foundational public health services while supporting other areas through convening or partnership efforts. This discussion was intended to help clarify the distinction between direct services provided by the health department and supportive or secondary roles.

Dr. Ituarte supports maternal and child health as a primary concern, noting that challenges faced by single mothers can contribute to broader issues, including behavioral health, legal involvement, and social instability. He observed that addressing maternal and child health alongside mental health, economic stability, and access to care allows for a more integrated approach, which he believes will yield better long-term outcomes for the community.

Mr. Anderson asked about the relationship between the CHA to the CHIP.

Ms. LaVoie explained that the CHA combines secondary data, primary data from surveys, focus groups, and key informant interviews, and analysis of health indicators to understand community needs and priorities. The CHA identifies areas where organizations can support improvements in health outcomes. The CHIP translates these findings into action by focusing on the top priorities and specifying measurable initiatives, such as the crisis response system, physical activity and nutrition programs, and maternal and child health interventions, in collaboration with community partners.

Dr. Kingsley noted that the most recent CHA added economic stability as a community-identified priority compared with the prior assessment. He explained that, consistent with previous cycles, the CHA informed the development of the CHIP, which guides targeted initiatives.

Mr. Driscoll asked what would keep the team in the advocacy role and not move out of that zone?

Ms. LaVoie explained that foundational public health services provide the core framework for the department's work, and that resource availability guides which priorities the department can directly address. When the department cannot provide direct resources, it identifies community partners to carry out initiatives, while still including those priorities in the Community Health Assessment and reporting progress to ensure transparency and accountability.

Ms. Olsen noted that the five areas identified in the early slides represent the foundational public health services, which serve as the starting point for the department's programming. She explained that priorities directly aligned with these services would continue as core initiatives, while other priorities could be addressed through convening, advocacy, or partnership efforts. She stated that, if the board concurs, staff will use this framework to guide implementation and planning.

Dr. Kingsley shared that the CHA and CHIP are core requirements across the nation for public health agencies and serve as a framework for guiding local initiatives. While the department may not directly provide all services, it can participate in adjacent systems to

help identify opportunities for impact. Collaboration, communication, and strategic resource investment are key to supporting community-wide improvements.

Vice Chair Andriola clarified that she sees these as the prioritized community needs, which reflect the compilation of primary and secondary data, informed by extensive hours of community engagement and analysis. She noted that while some lower-ranked items may be statutorily required, the prioritization focuses on the top areas identified through the assessment. She also emphasized that distinguishing between core responsibilities and areas addressed through partnerships provides clarity for organizational focus and prevents overextension into areas outside the department's role.

Mr. Anderson asked if we routinely check to ensure we haven't gone down a path that a community partner is better suited to address.

Ms. LaVoie explained that the CHIP is presented each year to review initiatives and is frequently assessed for alignment with the department's role. She noted that while the department may not be resourced to provide all services directly, it participates as a convening partner to ensure coordination among stakeholders using the same data to measure health outcomes. The crisis response system was cited as an example, where the department facilitated collaboration without directly providing the service, allowing partners to design and implement the system for Washoe County.

The board members support moving forward with the four identified items – mental health, access to health care, economic stability, maternal & child health, for the next 3-year planning cycle.

8. Presentation and Discussion of the Bay Area Regional Health Inequities Initiative (BARHII) Framework and Assessment findings to support understanding of key health outcome patterns and inform strategic plan discussions.

Item 8 was removed from this agenda and will be presented in the regular March meeting.

9. Presentation and Discussion of the 2025 Public Health WINS survey and data to inform discussions on strategies that support a positive, productive, and resilient public health workforce culture.

Item 9 was removed from this agenda and will be presented in the regular March meeting.

10. Update, discussion, and possible direction regarding the FY27 Northern Nevada Public Health Budget, including revenues, expenditures, and projections.

Jack Zenteno shared that the department currently has 165 of 194.99 authorized positions filled and has managed vacancies strategically to address budget constraints. Expenditures are increasing faster than revenues, primarily due to salaries, benefits, and overhead, which together account for roughly 90% of the budget. Revenue sources include federal grants, state funding, service fees, and county transfers; from 2019 to 2027, these revenues increased modestly but have not kept pace with expenditures, particularly salaries (71% increase), benefits (75%), and county overhead (132%). Health fund reserves have historically offset

shortfalls, but trends indicate reserves may reach minimum levels by 2027–2028. Spending on services and supplies has decreased by approximately 11% to cover personnel and overhead. He highlighted the need for long-term sustainability planning, including strategic use of grants, operational efficiencies, and county support, to maintain fiscal balance while continuing to provide core public health services.

Dr. Kingsley expressed appreciation to the board and county partners for their collaboration in budget review and refinement. He noted that monthly coordination with county budget staff has helped address risks, refine assumptions, and align resources with core services and community priorities. While acknowledging fiscal challenges, he emphasized that the process is manageable, reaffirmed the department’s commitment to protecting public health in Washoe County, and highlighted the importance of continued partnership and data-driven decision-making to maintain sustainability and effectiveness.

Mr. Anderson noted that the budget assumptions rely on anticipated county funding to maintain operations and meet departmental needs. He observed that this support appears to be a key factor underlying the financial projections presented in the budget slides.

Mr. Zenteno explained that ongoing discussions with the county are focused on determining funding needs and allocations, noting that the proposed \$1,000,000 reflects a good-faith effort while awaiting clarity on post-COVID and ARPA funding trends and federal support. He emphasized the complexity of the budget, including offsets and grant-funded programs, and suggested that future adjustments may involve a combination of programmatic changes and infrastructure investments to ensure public health priorities are supported in a challenging fiscal environment. Much of this reflects the most difficult grant environment from the public health perspective in over 20 years.

Vice Chair Andriola suggested that the department consider a priority-based budgeting approach to clearly identify compliance requirements, services it can realistically provide, and any gaps. This framework would support transparent, informed decision-making rather than reactive responses. She emphasized the value of ongoing discussions and briefings outside formal meetings to deepen understanding of assumptions, trade-offs, and funding implications, and to align expectations about departmental responsibilities and capabilities while ensuring effective support for the community.

Mr. Zenteno acknowledged the feedback and noted that a priority matrix has been developed, which can be integrated into the budget process.

Mr. Driscoll raised a question regarding the proposed budget principles, specifically the recommendation to maintain an ending fund balance of at least 17%. He noted that the current budget under consideration projects a 13.9% ending fund balance and asked how the proposed principle would be reconciled with the actual budget, and which would ultimately be approved.

Dr. Kingsley explained that the county’s guidance sets an ending fund balance target of 10% to 17%, and the department selected the high end at 17% as a guiding principle to maintain flexibility for unexpected events, such as public health outbreaks. He clarified that while the current budget projects a balance below this target, the principle serves as a planning tool to inform decisions and highlight the need for adjustments or hard choices to return to the

desired fund balance. The principle is intended to guide the board and staff in budgeting and financial planning.

Vice Chair Andriola asked what the statutorily required fund balance is.

Mr. Zenteno noted that, by policy, it is between 10 and 17%.

Vice Chair Andriola noted that the ending fund balance falls within the statutory range and emphasized the importance of staying within the scope of the current agenda item. She suggested that discussion of the guiding principles be addressed after the next agenda item, and recommended pausing the current item discussion to review the principles first. Legal counsel was consulted to confirm the appropriate process.

Dania Reid noted that the items can be taken out of order, as long as they are noted in the meeting record.

Item 10 will be deferred until after item 11 is presented, discussed, and action taken.

11. Presentation, discussion, and acceptance of NNPH's Guiding Financial Principles to align the Board on long-term sustainability, responsible stewardship, investment strategy, and mission-aligned resource allocation.

Dr. Kingsley presented five proposed guiding principles for the budget, explaining that the principles provide direction for the board and support budget development and management to ensure alignment with board priorities. The board was asked to guide the discussion format by reviewing each principle individually or providing an overview of all five.

Vice Chair Andriola expressed the view that while guiding principles are helpful, she recommends the first item on the proposed list would be more appropriately classified as a policy because it relates to statutory requirements for the ending fund balance. She suggests that this item be agendized separately as a policy reflecting the statutory range of 10% to 17%, while noting that the remaining items on the list could remain as guiding principles. She would respect the board's vote on the matter.

Ms. Olsen explained that the proposed guiding principles were intended to serve as preliminary decision-making guidelines before potentially being formalized as policy. She noted that the first item differs because it reflects a current requirement, and therefore falls outside the scope of experimental or trial principles.

Vice Chair Andriola suggested that, in addition to deferring the first item to a formal policy, the board consider adding a guiding principle focused on priority-based budgeting that incorporates compliance requirements. She noted that guiding principles allow flexibility and do not require the same level of detail as formal policies, but recommended including this concept to inform future budgeting decisions.

Dr. Kingsley provided additional context for the proposed guiding principles, noting that they are intended to help guide decision-making and may eventually inform future policy development. He emphasized the importance of transparency regarding how these principles could translate into real-world impacts. For example, pursuing a goal of 100% cost recovery could result in higher fees for regulated businesses, which may affect small businesses and

the broader local economy. He also noted that independent fee studies conducted at least every five years help ensure that fees remain appropriately aligned with actual costs.

Dr. Kingsley further explained that dedicating \$500,000 to community health investments has been a previous priority under the CHIP, but acknowledged that during periods of fiscal constraint, the board may need to evaluate whether that level of investment remains feasible relative to core service needs. Similarly, the application of priority-based budgeting could require difficult decisions about whether to continue or pause certain lower-priority programs until resources allow reinvestment. He noted that these principles are intended to provide a framework for navigating those types of decisions and ensuring the department moves forward deliberately and transparently, while also committing to regular financial reporting to the board.

Mr. Driscoll recommended replacing “shall” with “may” where the \$500,000 allocation for the CHIP investments is referenced.

Vice Chair Andriola emphasized that, as the board considers principles that could affect programs, fees, or services, it will be important to communicate with the community proactively. She emphasized the value of public education and outreach to explain that any changes are not a reflection of diminished concern for programs such as suicide prevention or mosquito abatement, but rather the result of legal requirements and fiscal constraints that require certain obligations to be met first. She also noted that clear communication would help the community better understand the reasons behind potential decisions and their impacts.

Mr. Brown requested clarification regarding the ending fund balance range referenced and whether the proposed 17% level would apply only to the current fiscal year or as a target for future years.

Vice Chair Andriola responded that she is asking that the item return as a formal policy stating that the ending fund balance range is 10% to 17%, noting that the health fund balance is required by statute.

Item 11 discussion was closed. Moved back to item 10.

Item 10: Mr. Driscoll moved to accept the FY27 Northern Nevada Public Health Budget, including revenues, expenditures, and projections. Mr. Brown provided a second, and the item passed unanimously.

12. Public Comment.

Having no requests for public comment, the public comment period was closed.

13. Board Comment.

Mr. Anderson thanked the staff and all who have been involved in today’s topics.

Vice Chair Andriola expressed appreciation to staff and participants for their work in preparing and presenting the information, noting the effort involved and the importance of helping educate the community, particularly as the organization addresses challenging issues. She also thanked the facilitator for their work and support during the process.

Ms. Olsen noted that the purpose of the discussion today was to obtain high-level direction from the board regarding priorities for the next several years, including community needs and budget focus areas. She stated that the work would remain in draft form so staff could review and process the feedback provided, document requested follow-up items, and incorporate the board's comments before bringing information back to a later meeting.

Dr. Kingsley thanked the board for providing strategic direction at multiple levels and acknowledged the guidance provided to staff in supporting the organization's work. Appreciation was also expressed for staff contributions and for the collaboration with federal and state partners, noting the organization's continued commitment to growth and service to the community.

With no additional comments by the Board, this comment period was closed.

Adjournment.

The meeting adjourned at 12:02 p.m.

DRAFT