Iowa's Local Governmental Public Health System: Results of the 2023 Local Public Health Systems Survey

July 31, 2024

Kelly Garcia
Director

Dr. Robert Kruse
Division Director, Public Health

IOWA Health and Human Services

Table of Contents

Acknowledgements

Governor Kim Reynolds
Lieutenant Governor Adam Gregg

Kelly Garcia, Director, Iowa Department of Health and Human Services
Dr. Robert Kruse, State Medical Director, Division of Public Health, Iowa Department of Health and Human Services

Report Contact Information:
Marisa Roseberry, MPA
Chief, Performance Bureau
Administration Division, Iowa Department of Health and Human Services
marisa.roseberry@hhs.iowa.gov
515-322-1925

Erin Barkema, MPH
HHS Systems Development Coordinator, Performance Bureau
Administration Division, Iowa Department of Health and Human Services
erin.barkema@hhs.iowa.gov
515-829-0515

The Iowa Department of Health and Human Services wishes to thank Iowa's local Public Health Administrators and their staff for completing the 2023 Local Public Health Systems Survey.

Suggested Citation:
Division of Public Health. (2024, May). *Iowa's local governmental public health system: Results of the 2023 local public health systems survey*. Iowa Department of Health and Human Services, Division of Public Health. http://hhs.iowa.gov/lphs

Overview

This report provides an overview of Iowa's local public health system and results of the qualitative and quantitative data collected through the fourth annual Local Public Health Systems Survey.

Information from this report can be used by a variety of audiences to not only gain a better understanding of the local governmental public health system, but to also inform planning activities for future public health initiatives. Iowa HHS intends to continue public health system assessment activities, through the collection of data from local public health administrators and HHS program staff, annually.

Survey Methodology

In the summer and fall of 2023, HHS staff developed the 2023 Local Public Health Systems Survey questionnaire. The questionnaire focused on the following areas:

- Local boards of health
  - Board membership,
  - Board member background, and
  - Board service.
- Local public health agencies
  - Infrastructure (including workforce, revenue and expenses, and foundational capabilities),
  - Service delivery, and
  - Cross-jurisdictional sharing.

The questionnaire was emailed to the administrator of the recognized local public health agency in each county in November 2023. Survey responses were collected using the survey tool Cognito. Additional information was clarified through correspondence with specific local public health administrators. There was a 100% response rate for the 2023 survey (n=94).

Data were also collected from HHS programs, vial email or shared Google documents, to provide additional context about service delivery within the local governmental public health system. The data collected is not all inclusive of programming that takes place at the local level. For the purposes of this report all data, unless otherwise noted, are for state fiscal year 23 (SFY23: July 1, 2022 – June 30, 2023).

The following are limitations of this report:

1. The survey required the input of local public health administrators. Local boards of health or other public health staff were not surveyed.
2. One-third of Iowa's local environmental health departments are included in the data. This is because the majority of environmental health departments are organized separately from the recognized local public health agency.
3. Data about public health funding was sought at a high level but conclusions are difficult to draw as counties track and account for funds using different graphs of accounts and financial management systems.

4. Administrators were not asked to do a formal review of their ability to meet the foundational public health capabilities but instead were asked to self-identify their agency's ability to meet general requirements.
5. Influenza vaccine data may be based on an underestimation of the total number of influenza vaccine doses in SFY23. Reporting to IRIS is not mandatory for all healthcare providers so doses administered may not be reported to IRIS or may be listed as historical on a record if it was entered by another healthcare provider at a later date.
6. Data collected were self-reported; local public health administrators may have answered the questions differently. Clarification was provided for select questions within the survey questionnaire.

Comparisons of statewide data collected by Iowa HHS – Division of Public Health (DPH) over the past four state fiscal years (SFY20, SFY21, SFY22, and SFY23) can be found in Appendix A. Some data may not be available for each fiscal year as new questions were added with each iteration of the survey.

In addition to examining data at the state level, all 99 counties were sorted into one of eight structures. Structure-level data in five areas (workforce, services provided, foundational capabilities, revenue and expenses, and cross-jurisdictional sharing) were compiled and analyzed. Where relevant, data were further broken down by population. This analysis, found in the standalone LPH structures document, can be used to compare both similarities and differences within each structure and across structures.

Iowa's Public Health System

Public Health Systems

Public health systems are commonly defined as all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction. This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services (Centers for Disease Control and Prevention, 1994).

Iowa's public health system includes, but is not limited to:

- public health agencies at the state and local levels,
- environmental agencies and organizations,
- healthcare providers,
- public safety agencies,
- human service and charity organizations,
- education and youth development organizations,
- recreation and arts-related organizations, and
- economic and philanthropic organizations.

Iowa's Governmental Public Health System

Iowa's governmental public health system consists of three main sets of partners:

The Iowa Department of Health and Human Services and the Council on Health and Human Services: The Council on Health and Human Services advises or makes recommendations to the Governor, General Assembly, or Director of the Department of Health and Human Services.

The State Hygienic Laboratory: The State Hygienic Laboratory serves all of Iowa's 99 counties through disease detection, environmental monitoring, and newborn and maternal screening.

Local Boards of Health and Recognized Local Public Health Agencies: The local governmental public health system consists of local boards of health (with assistance from local boards of supervisors) and recognized local public health agencies. As the groups that work most closely with people within their communities, these partners are typically front-line staff who provide services; advise policy development; enforce rules, regulations, or laws; or support and implement local public health efforts.

Local Boards of Health

Iowa is a decentralized, home rule state with 99 county boards of health (BOH). This means each local board of health has jurisdiction over the public health matters within its designated geographic area. Iowa Code Chapter 137.104 states, "local boards of health have the following powers and duties:

A local board of health shall:

a) Enforce state laws and rules and lawful orders of the state department.
b) Make and enforce such reasonable rules and regulations not inconsistent with the law and the rules of the state board as may be necessary for the protection and improvement of the public health.
c) Employ persons as necessary for the efficient discharge of its duties.

A local board of health may:

a) Provide such population-based and personal health services as may be deemed necessary for the promotion and protection of the health of the public and charge reasonable fees for personal health services.
b) Provide such environmental health services as may be deemed necessary for the protection and improvement of the public health and issue licenses and permits and charge reasonable fees in relation to the construction or operation of nonpublic water supplies or private sewage disposal systems.
c) Engage in joint operations and contract with colleges and universities, the state department, other public, private, and nonprofit agencies, and individuals or form a district health department to provide personal and population-based public health services.
d) By written agreement with the council of any city within its jurisdiction, enforce appropriate ordinances of the city relating to public health."

Prioritization of public health services is necessary as local boards of health fulfill their roles of resource stewardship and oversight. Local boards of health must continually evaluate the need to increase or decrease programs or services based on the availability of funding, the board of health's mission and vision, and community needs.

520

People served on their
local board of health in SFY23

BOARD MEMBERSHIP

Although membership varies from board to board, there are minimum requirements that each board must meet. Each local board of health must consist of at least five members including one member licensed to practice in the state of Iowa as a physician, a physician assistant, an advanced registered nurse practitioner, or an advanced practice registered nurse. While most boards consist of five members, there were twelve boards of health that had seven members in SFY23. One board of health had six members.

All members of the local board of health are volunteers and are appointed by the county board of supervisors. Sixty-two new members were appointed to a local board of health during SFY23, a 7% increase in board of health turnover from SFY22. Members serve a three-year term. The appointment of subsequent terms is at the discretion of the board of health (per board policies) and the local board of supervisors.

BOARD MEMBER BACKGROUND

Iowa Administrative Code 641.77.4(1) states, “members should have experience or education related to the core public health functions, essential public health services, public health, environmental health services, personal health services, population-based services, or community-based initiatives.”

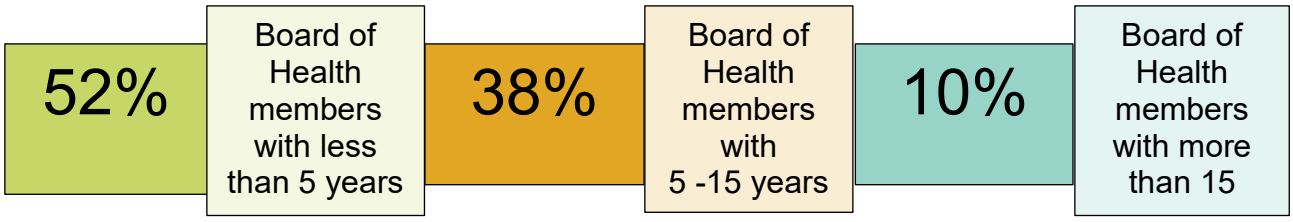
The table below illustrates the various backgrounds of Iowa’s board of health members. Of the 520 members in SFY23, local public health administrators reported that 150 members (approximately 29%) are retired. This is an 11% increase in retired members from SFY22.

Table 1: SFY23 Professional background data highlights an increase of 11% in retirement by local BOH members from SFY22

Member Background	Number of BOH Members
Professional - medical	275
Elected officials	55
Education	33
Professional	31
Animal Science/Veterinarian	25
Managers/administration	23
Farmer	14
Other	12
Self-employed	11
Finance	9
Legal	7
Service	7
Clerical	5
Sales	4
Religious	2
Craftsperson	1

BOARD SERVICE

Each board of health is led by a chairperson. The average years of service reported by administrators for board of health chairs was 12 years.
For all other board of health members, the average number of years served was 6.6. The breakdown of years of service for board of health members who did not serve as the chair during SFY23 is as follows:



LOCAL PUBLIC HEALTH STRUCTURES

The phrase, “No two counties are alike” is often used when describing Iowa’s complex local governmental public health system. There are three main ways in which counties in the system can be categorized: 1) how the board of health assures the provision of services (e.g., employs staff or contracts for services); 2) whether the recognized public health agency provides home health services; and 3) the level of home health services provided. Using these three variables, counties can be sorted to better understand how they compare to other counties with the same structure. All 99 counties were placed in one of eight structures and additional data (workforce, services provided, foundational capabilities, revenue and expenses, and cross-jurisdictional sharing) were reviewed to better understand and explain the complexity of the local governmental public health system. The eight structures are as follows:

- **Structure A:** The board of health directly employs staff and is the governing body for the recognized local public health agency. The agency provides population-based activities and services only - home health is not provided by county staff nor offered through a contract with an outside agency.

- **Structure B:** The board of health directly employs staff and is the governing body for the recognized local public health agency. The agency provides population-based activities and services only. Home health is not provided by county staff but is provided through a contract with an outside agency (the contracted agency may be a non-profit, health system-based or county government-based agency).

- **Structure C:** The board of health directly employs staff and is the governing body for the recognized local public health agency. The agency provides population-based activities and services and some home health services. Additional home health services are provided through a contract with an outside agency (the contracted agency may be a non-profit, health system-based or county government-based agency).

- **Structure D:** The board of health directly employs staff and is the governing body for the recognized local public health agency. The agency provides population-based activities and services and home health services.

- **Structure E:** The board of health contracts for services and a board of directors or board of trustees is the governing body for the recognized local public health agency. The agency provides population-based activities and services only - home health is not offered through a contract with an outside agency.

- **Structure F:** The board of health contracts for services and a board of directors or board of trustees is the governing body for the recognized local public health agency. The agency provides population-based activities and services only. Home health is not provided by staff at the recognized local public health agency but is provided through a contract with an outside agency (the additional contracted agency may be a non-profit, health system-based or county government-based agency).

- **Structure G:** The board of health contracts for services and a board of directors or board of trustees is the governing body for the recognized local public health agency. The agency provides population-based activities and services and some home health

services. Additional home health services are provided through a contract with an outside agency (the additional contracted agency may be a non-profit, health system-based or county government-based agency).

- **Structure H:** The board of health contracts for services and a board of directors or board of trustees is the governing body for the recognized local public health agency. The agency provides population-based activities and services and home health services.

In SFY23, two boards of health (Adams County and Audubon County) contracted for services with another board of health of a contiguous county. Responses for those counties were incorporated into the respective responses of the lead recognized local public health agency's responses.

To note: In SFY23, the structure of three of the four counties that previously met the criteria for Structure G changed. Those counties were included in the appropriate structure type for this fiscal year. Only one county met the criteria for Structure G in SFY23. To maintain confidentiality, that county's responses were moved to the next most relevant structure type.

Seven structure documents were created for this fiscal year. For further details on each structure, refer to the LPH structure document. Where relevant, data were broken down, analyzed, and reported by rural, micropolitan, and metropolitan counties.

ORGANIZATION OF PUBLIC HEALTH AGENCIES

Due to the home rule nature of public health in Iowa, a number of factors play a role in how services are provided at the local level:

Population:

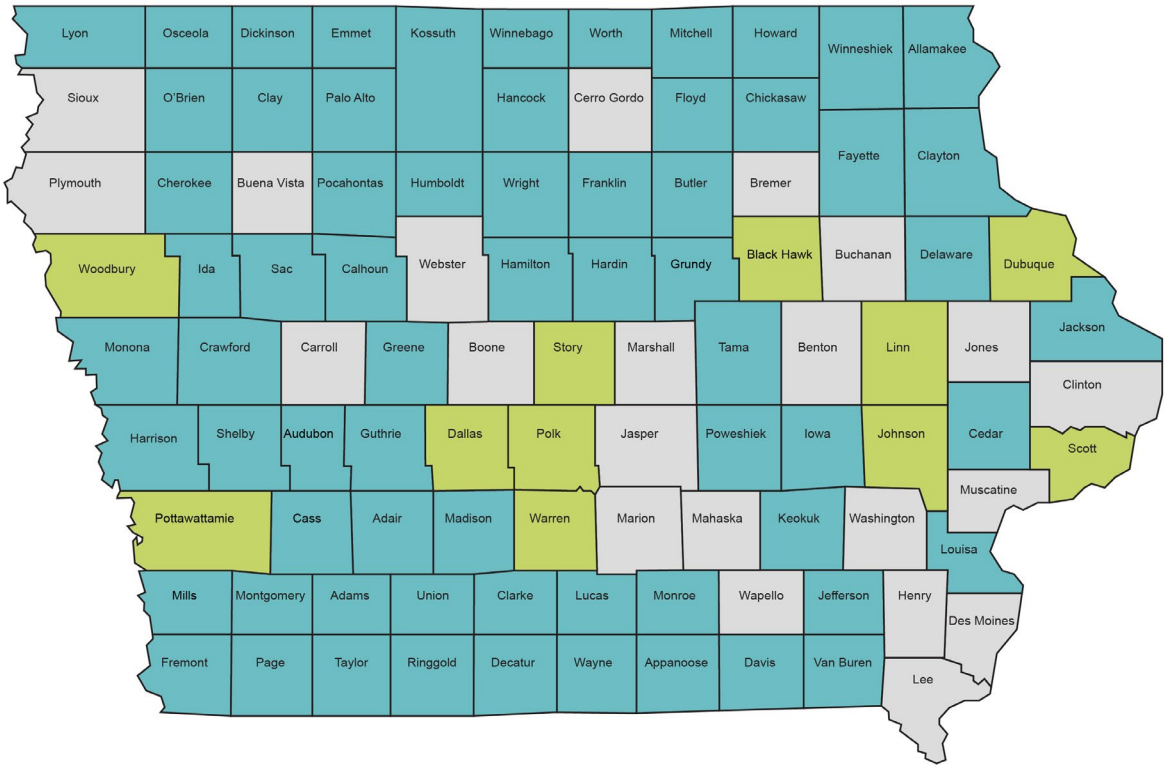
The number of residents in a county and the resources available to serve those individuals can impact the type and level of services needed.

Figure 1 illustrates the public health service provision type for each county: 66 rural, 22 micropolitan and 11 metropolitan counties

Figure 1

Map Key:

- Rural (fewer than 20,000 people)
- Micropolitan (20,000-49,999 people)
- Metropolitan (more than 50,000 people)



Public Health Service Provision:

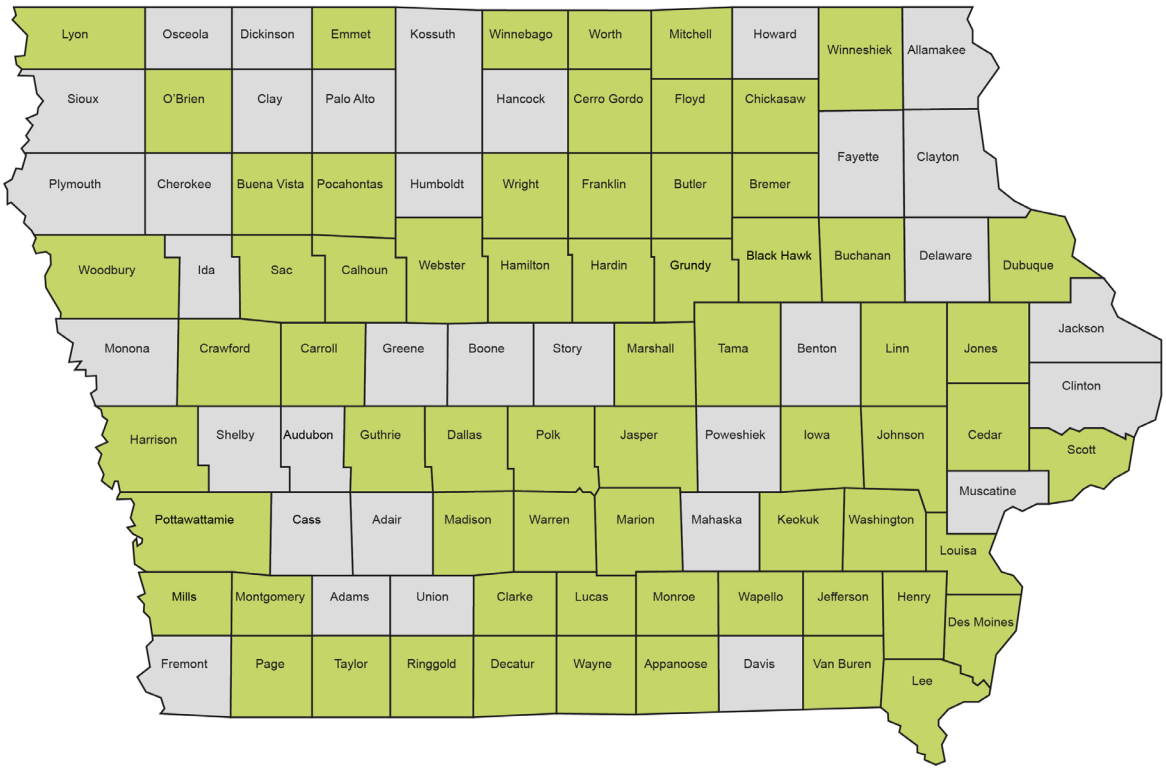
Iowa Code Chapter 137 allows boards of health to either directly employ staff or contract with outside agencies to provide personal and population-based public health services. In SFY23, there were 65 counties in which the board of health directly employed public health staff. When a board of health employs staff, they serve as the governing entity for the local public health agency and has oversight of agency operations. The agency is typically a department within the county's government structure.

In counties where the board of health contracts with an outside agency for personal health services, population-based services, or both, the board of health serves in an advisory capacity but remains the primary contractor for many state issued grants. The outside agency's board of directors or board of trustees serve as the agency's governing body; they have oversight of the outside agency's operations.

Figure 2: Map of Iowa counties illustrating 65 counties in which the board of health employs public health staff

Map Key:

- Counties directly public health staff health staff
- Counties contract for public health services



Individual County Needs - Environmental Health:

Iowa Code Chapter 137 gives boards of health the authority to provide such environmental health services as may be deemed necessary for the protection and improvement of the public health, and issue licenses and permits and charge reasonable fees in relation to the construction or operation of nonpublic water supplies or private sewage disposal systems. Environmental health activities and services can include:

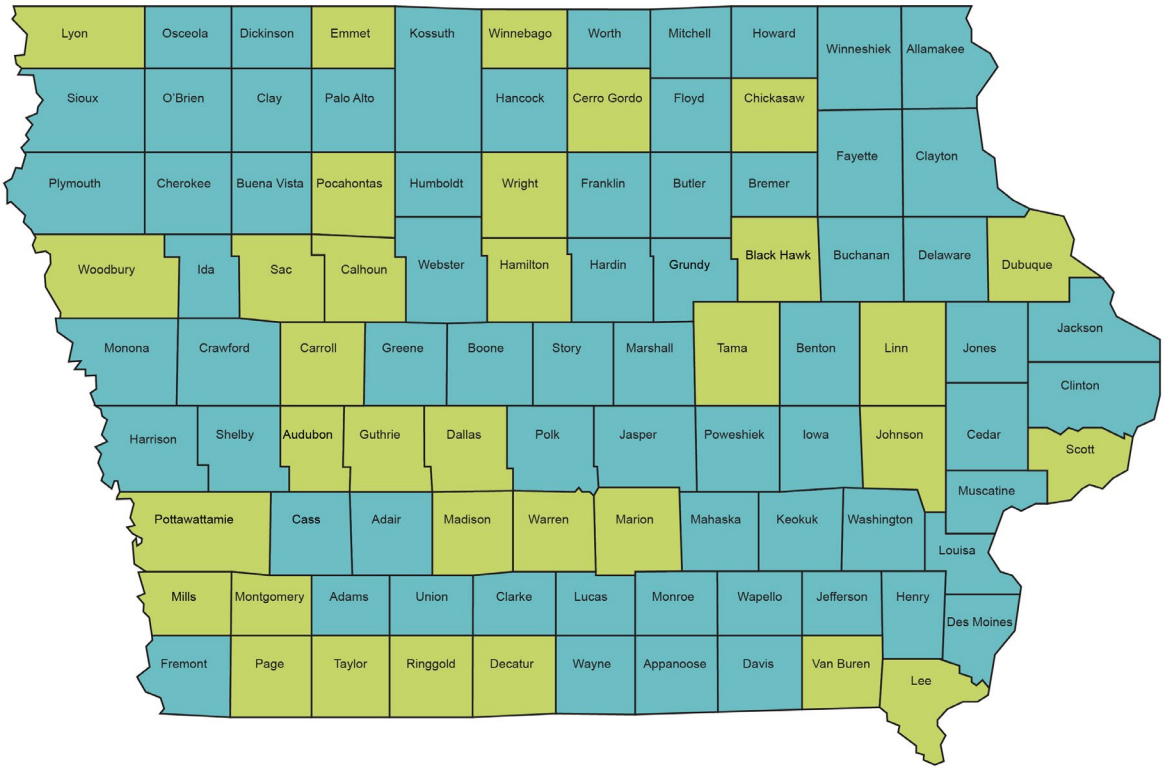
- providing private water well services
- providing private sewage disposal (septic) system services
- conducting safety inspections (e.g., inspect tattoo parlors, food establishments, registered aquatic facilities, homes, hotels and motels, private sewage disposal systems, or tanning facilities);
- receiving and addressing environmental health related complaints); or
- providing education on environmental health related topics.

Environmental health staff are either directly employed by the recognized local public health agency, are a county employee but are not employed by the local public health agency, or are contracted through an agreement between the local board of health and an outside agency. The map below illustrates the environmental health staff type for each county. In SFY22 and SFY21, 34 and 31 counties respectively employed environmental health staff through the recognized local public health agency.

Figure 3: Map of Iowa counties illustrating 33 counties in which environmental health staff were directly employed by the recognized local public health agency

Map Key:

- **Counties directly employing environmental health staff**
- **Counties NOT directly employing environmental health staff**



Boards of health must assess both population health and personal health needs within their county. Then, based on those needs and available funding, allocate resources to protect and improve the health of the people in their counties. The graph below illustrates the percentage of work focused on non-population health services for the past fiscal year. Of the 80 recognized local public health agencies that provided non-population health services in SFY23, 34 (43%) spent half or more of their time providing said services.

Individual County Needs - Home Health:

Iowa Code Chapter 137 gives boards of health the authority to provide personal health services (i.e. home health) and charge reasonable fees for personal health services. Home health services can include:

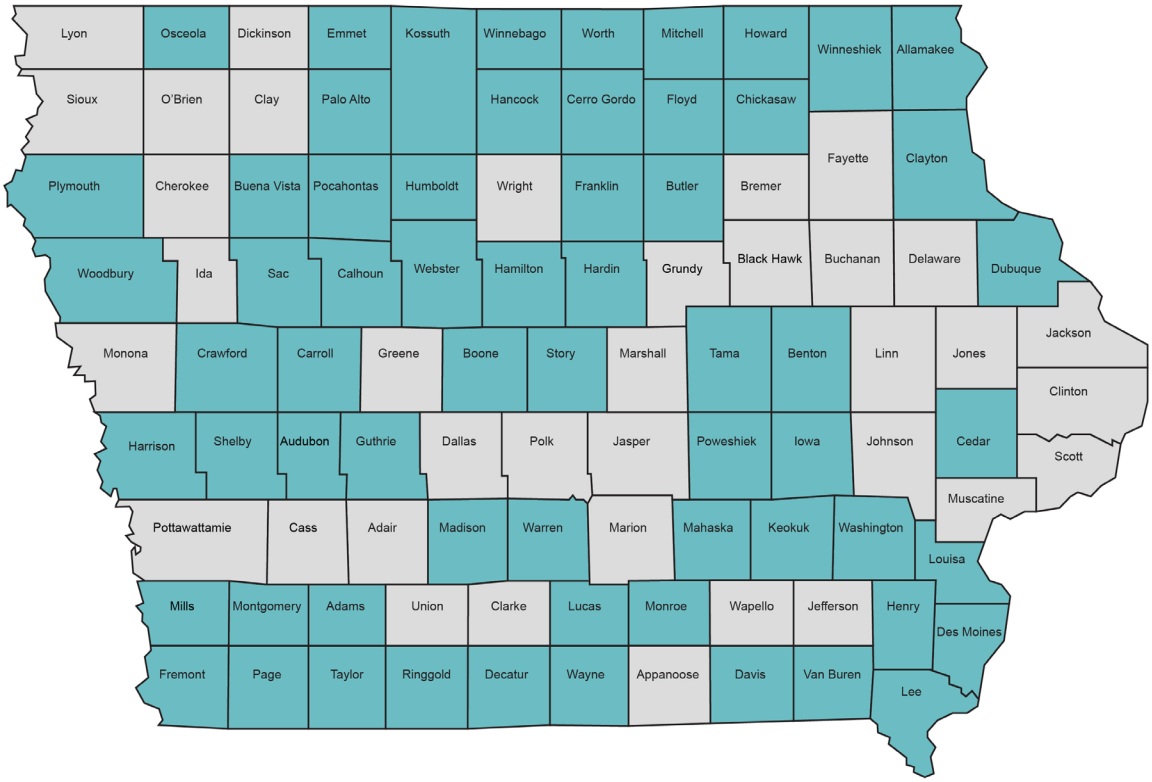
- assessing an individual's needs within their home,
- providing homemaker services to consumers who, due to the absence, incapacity or limitations of the usual homemaker or caregiver need assistance to remain in their home,
- providing home care aide services under the direction of nursing and/or medical staff,
- providing skilled nursing services for the acutely ill, or to those individuals with a chronic condition that if left unmonitored would potentially become an unstable condition, or
- providing nursing services to help clients manage chronic conditions (e.g., medication and medical supply management).

The level of home health services provided by a county varies based on community needs, the presence of other home health agencies in the county, and funding. Community needs play a significant role in determining the level of services provided in each county. In some counties there are no home health agencies outside of the local governmental public health system to provide services. In other counties, for-profit home health agencies only serve those individuals who have health insurance, or the outside agency only provides specific services. In those counties, boards of health provide home health services as a gap filler for their communities. In SFY23, 77 counties provided home health services either directly or through a contract with an outside agency, as shown in the map below.

Figure 4: Map of Iowa counties highlighting those counties whose boards of health provided home health services

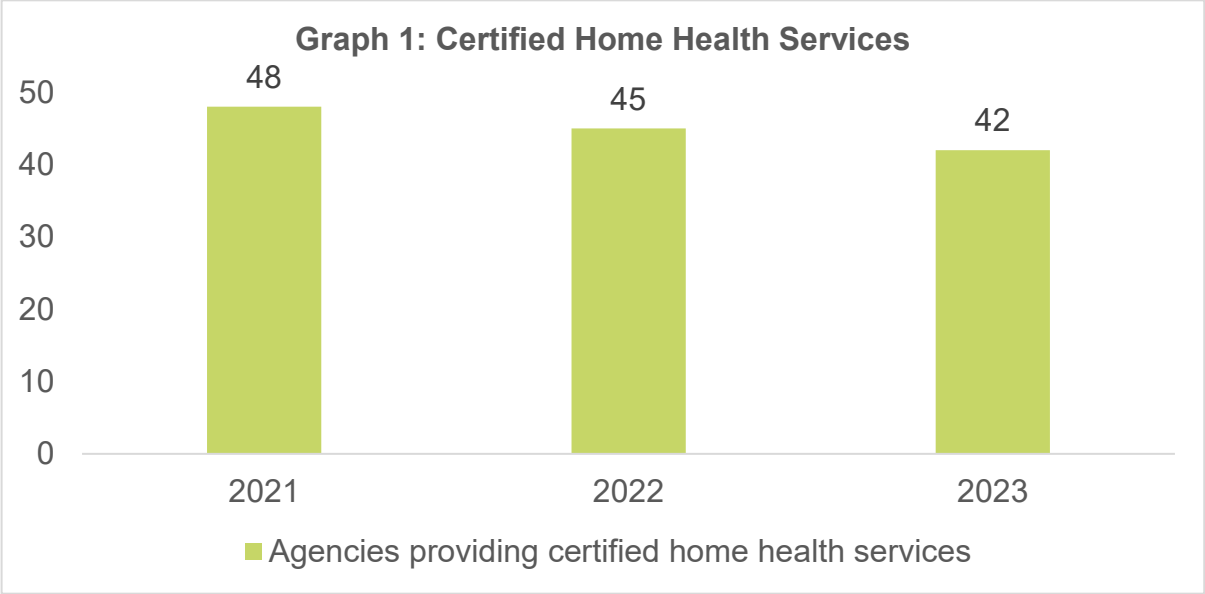
Map Key:

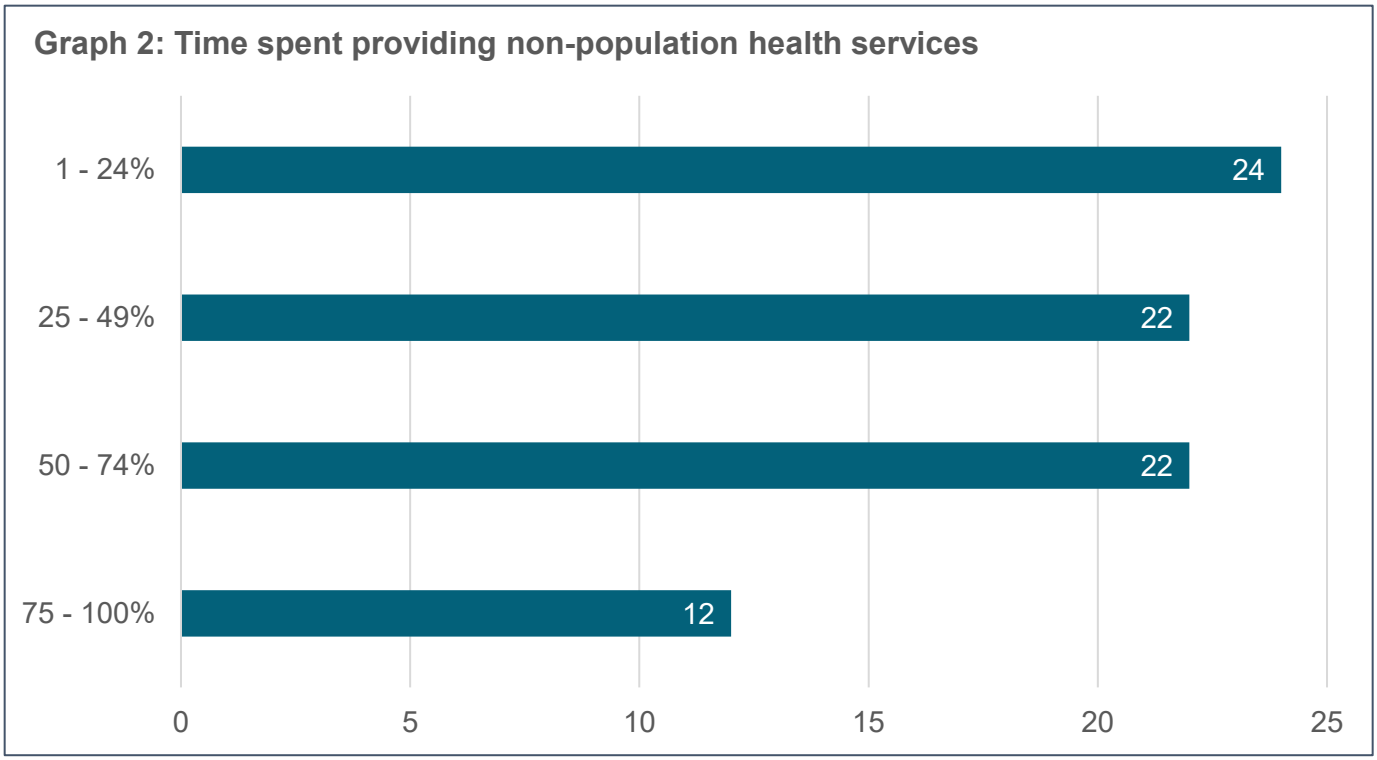
- County provided home health services directly/through agency
- County provided home health services through outside agencies (for profit/specific services)



Funding is also a factor when looking at the level of services provided. Home health agencies can maintain a certified status with private and public insurances (Medicare and Medicaid) to bill for home health services. Of the 61 recognized local public health agencies that provided home health in SFY23, 42 provided certified services, which has continued to decrease from prior years as seen in the graph below. Counties in which boards of health provide home health may choose to provide certified services or can provide decertified services (home health services governed by internal policies). Those that provide certified services typically provide a full menu of home health services to a higher volume of clients. Decertified agencies rely solely on county and state tax dollars to pay for home health services and either provide a full menu of services to a smaller number of clients or provide specific services (e.g. just home care aide or homemaker services) to a larger number of county residents.

> **Certified Status**
> requires agencies to follow rules and regulations for each insurance provider and receive revenue through claims to insurance providers in addition to county tax dollars





Note: Of the 80 recognized local public health agencies that provided non-population health services in SFY23, 43% spent half or more of their time providing said services.

Local Public Health Agencies

Administrators were asked questions about their agencies' business practices in three main areas. These areas included infrastructure, service delivery, and cross-jurisdictional sharing.

Results from each of the three areas are described in detail below and represent the responses given by the administrators of the recognized local public health agencies in Iowa.

The responses for counties who contract with another local public health agency were consolidated into a single agency response.

Local Public Health Infrastructure

"The following infrastructure categories were included in the 2023 Local Public Health Systems Survey:

- workforce,
- revenue and expenses, and
- foundational capabilities.

WORKFORCE

The heart of Iowa's public health system is the public health workforce. Administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency; this included permanent full-time, permanent part-time, and temporary staff. As a whole, there were 1,143 FTEs (for 1,290 employees across all 97 agencies) at the end of SFY23. This was a 6% decrease in FTEs from SFY22.

The minimum number reported for an agency was 1.2 FTEs; the maximum number reported was 64.1 FTEs.

Population size was not a factor in determining the number of FTEs for an agency. The table below provides information about FTEs as they relate to county population. The average number of FTEs has decreased from SFY20 to SFY23 for both rural and micropolitan counties. Although the average number of FTEs looks to be proportionate to the population size, there are significant ranges for each population category.

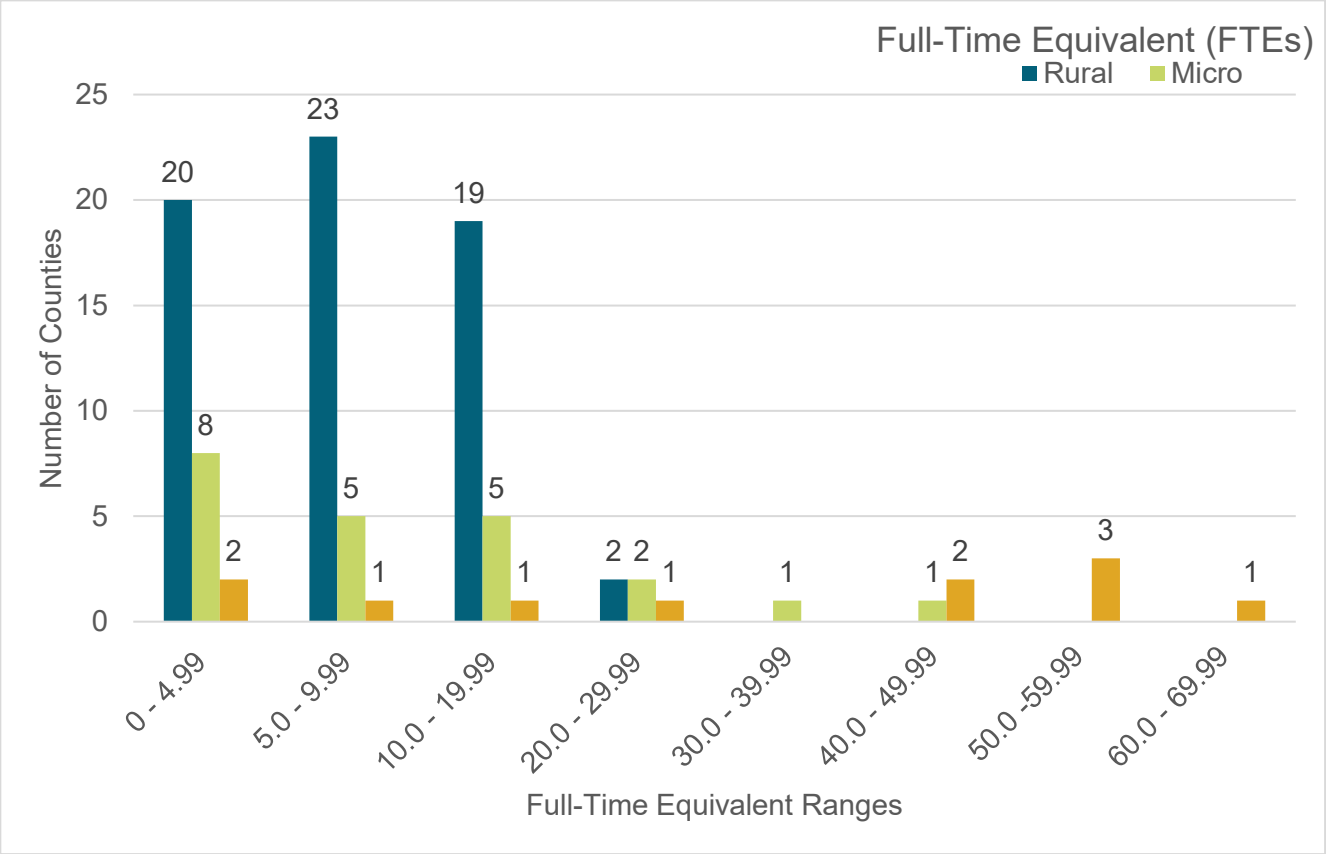
Table 2: Agency workforce data from SY20 to SFY23 show a decrease in average number of FTEs across rural and micropolitan counties

Fiscal Year	Average Number of FTEs Rural (n = 63)	Range of FTEs Rural (n = 63)	Average Number of FTEs Micropolitan (n = 22)	Range of FTEs Micropolitan (n = 22)	Average Number of FTEs Metropolitan (n = 11)	Range of FTEs Metropolitan (n = 11)
SFY20	8.9	0.9 - 25.1	15.0	1.2 - 41.9	32.4	2.8 - 62.7

SFY21	9.1	1.0 - 24.3	14.7	1.0 - 43.5	37.6	3.5 - 98.0
SFY22	8.2	1.2 - 23.4	13.2	1.0 - 39.6	37.4	3.5 - 64.1
SFY23	8.2	1.2 – 21.3	11.6	1.5 – 42.3	33.1	3.0 – 64.1

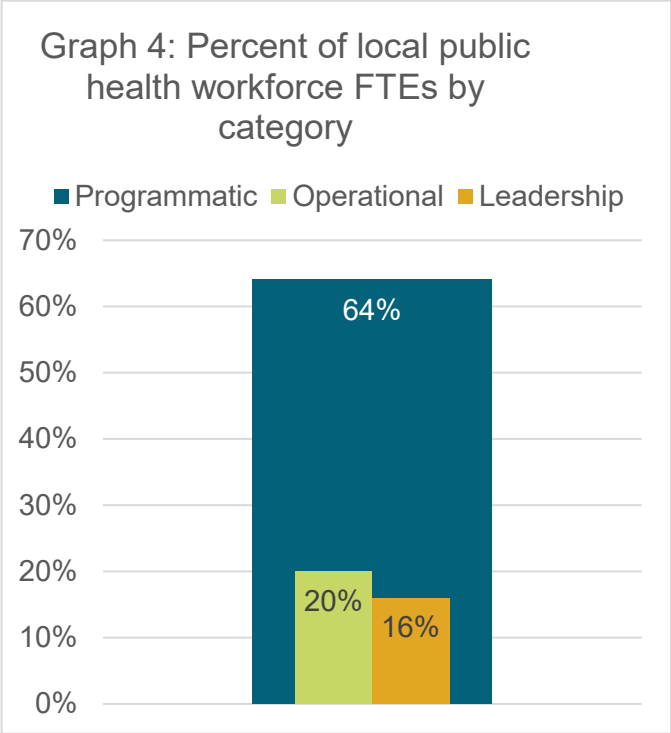
As demonstrated in both the table above and the graph below, there is great variability in the number of FTEs in agencies across the state. For some counties, capacity to serve their population is minimum. Over half of the 22 micropolitan agencies reported less than 10.0 FTEs and two metropolitan administrators reported less than 5.0 FTEs.

Graph 3: A majority of the recognized public health agencies employed less than 20.0 FTEs



In addition to reporting the total number of FTEs, administrators were asked to provide a breakdown of their agency's FTEs for 20 different roles. Those roles were assigned to one of three categories:

- Leadership: the agency administrator and additional agency leadership
- Operational functions business, finance, information technology, and administrative staff, as well as public information professionals
- Programmatic: staff in a variety of areas providing activities and services to Iowans



Workforce – Agency Administration:

The position of local public health administrator is an important and vital role. Local public health administrators are responsible for the day-to-day operations of their agencies, work closely with boards of health to meet the needs of the residents in their counties, and are the face of public health in their communities. Depending on the size and structure of the local public health agency, an administrator may have several different responsibilities. These responsibilities may include:

- shaping and implementing the strategic vision for public health in their county,
- supervising and evaluating the work of staff,
- developing the annual budget and monitoring revenue and expenses,
- establishing and maintaining working relationships with other county officials and public health partners, and
- evaluating agency and administrative services.

In SFY23, there were 97 local public health administrators serving Iowa's 99 counties. In southwest Iowa, one administrator oversaw services for Taylor and Adams counties and one administrator oversaw services for Guthrie and Audubon counties. In eastern Iowa, one administrator oversaw services for Clinton and Jackson counties.

Administrator turnover over the past fiscal year decreased. There were seven new local public health administrators in SFY23; compared to 22 new administrators in SFY22, 12 in SFY21 and 16 in SFY20. Significant time goes into orienting new administrators both by state and local staff, signaling the critical nature of retention to continuity of operations.

59% of local public health administrators have been in their position ***less than five years.***

Workforce – Local Public Health Staff:

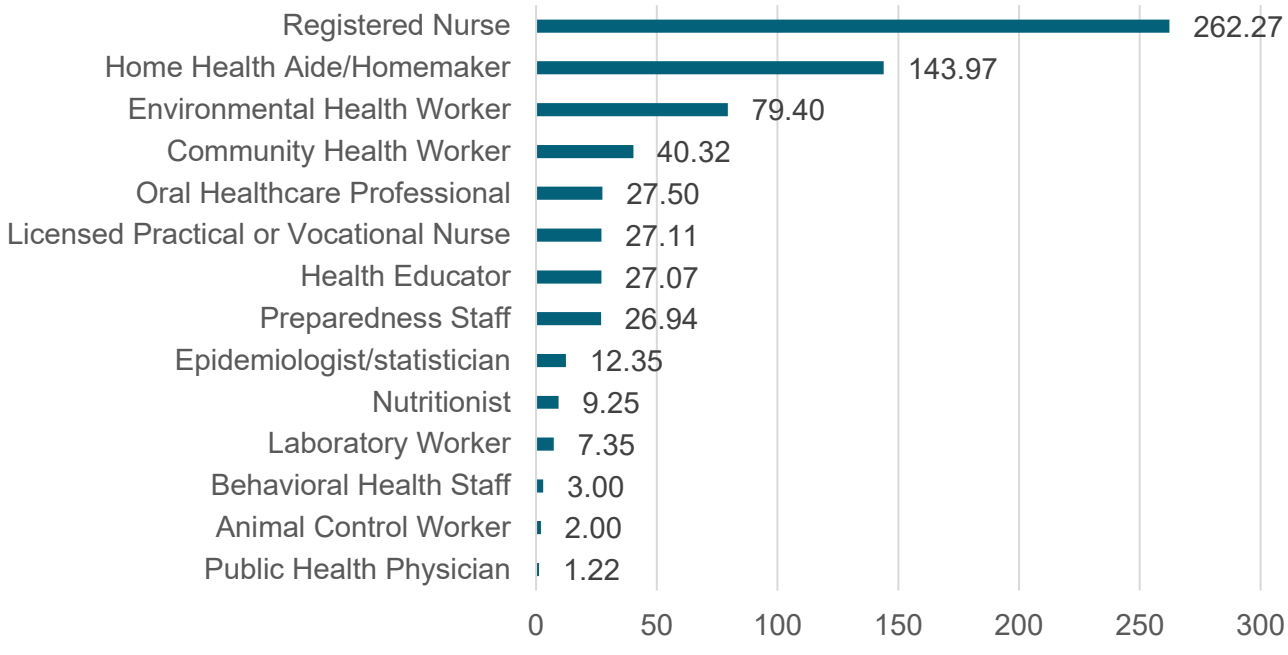
Local public health staff work to deliver the 10 Essential Public Health Services:

- assess and monitor population health status, factors that influence health, and community needs and assets,
- investigate, diagnose, and address health problems and hazards affecting the population,
- communicate effectively to inform and educate people about health, factors that influence it, and how to improve it,
- strengthen, support, and mobilize communities and partnerships to improve health,
- create, champion, and implement policies, plans, and laws that impact health,
- utilize legal and regulatory actions designed to improve and protect the public's health,
- assure an effective system that enables equitable access to the individual services and care needed to be healthy,
- build and support a diverse and skilled public health workforce,
- improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement, and
- build and maintain a strong organizational infrastructure for public health.

Job titles and classifications vary from agency to agency, but the roles staff fill are generally the same across the state. The graph below illustrates the number of FTEs for the 14 roles in the programmatic category for workforce. Forty-three percent of FTEs in this category were Registered Nurses, Licensed Practical Nurses, or Vocational Nurses.

Environmental health workers represented 12% of programmatic staff. This number only includes environmental health workers employed by recognized local public health agencies.

Graph 5: Number of FTEs by programmatic category



The remaining local public health FTEs fall in the operational functions category. The total number of FTEs and the corresponding percentages for the four roles in this category were reported as follows:

- Office and administrative support staff – 132.8 FTEs (65%)
- Business and financial operations staff – 60.3 FTEs (30%)
- Public information professional – 6.8 FTEs (3%)
- Information systems specialist – 3.0 FTEs (1%)

Administrators were asked to identify the positions that were most difficult to fill. The top two position categories were Registered Nurse (33 responses) and Nursing Aide/Home Health Aide/Homemaker (23 responses). The next highest categories were Health Educator (5 responses) and office and administrative support staff (5 responses).

Workforce – Contracted Staff and Interns:

In addition to full and part-time staff, public health agencies may utilize contracted staff or interns to increase capacity and complete the work necessary to meet the needs of their communities. In SFY23, 23% of administrators responded that they contracted for personnel and 24% used interns to help collect and analyze data or develop and implement public health activities.

Workforce – Succession Planning:

Succession planning is “a deliberate and systematic effort by an organization to ensure leadership continuity in key positions, retain and develop intellectual capital for the future, and encourage individual advancement” (Rothwell, 2010, p. 6). Administrators were asked about the extent the recognized local public health agency is implementing three specific components of succession planning.

Decrease in local public health staff turnover between SFY23 (210 individuals) and SFY22 (256 individuals)

- 37% responded that they had identified high-potential employees (someone with the ability, engagement, and aspiration to rise to and succeed in more senior, critical positions); a significant increase since SFY22.
- 16% of administrators said they have developed high potential employees
- 18% said they have written documentation that describes work of critical importance to the agency.

Workforce - Barriers and Emerging Issues:

Administrators were asked to report the challenges and emerging issues their agency encountered in SFY23. Workforce related barriers were reported by 47% of local public health administrators. They included:

- limited staff serving in multiple roles,
- staff time and availability,
- lack of public health staff,
- staff turnover, and
- difficulty recruiting qualified applicants for open positions.

Emerging workforce related issues were noted by 23% of administrators. Those issues included:

- increased workload of staff,
- mental health issues of staff,
- staffing shortages,
- recruitment and retention of staff including the lack of competitive compensation and benefits,
- lack of volunteers, and
- number of local public health administrators approaching retirement.

REVENUE AND EXPENSES

Budgeting is a complex business practice as both revenue and expenses can come from a variety of sources. “The sustainability of the governmental public health system depends on the financial health of state and local public health agencies. This is a challenge because public health programs and services are often provided in fiscally strapped environments (e.g., government revenue declines, budget reductions, economic recessions, unfunded mandates)” (National Association of County and City Health Officials). Budgets from one public health agency are difficult to compare to another public health agency.

Revenue:

Several possible revenue sources are available to support public health activities and services at the local level. They can include, but are not limited to:

- County tax dollars (designated by the county Board of Supervisors)
- Donations
- Fees for services
- Federal grants or programs and Foundations or private grant opportunities

- Public health insurance (Medicare or Medicaid)
- Private health insurance
- State grants or programs

Revenue varies from county to county based on the level of activities and services provided, the way in which the county is structured, the amount of financial investment by the county board of supervisors, among other factors. Counties that provide a wide variety of public health activities and services have revenues larger than counties that provide minimal public health activities and services because of the grants and other resources they seek out to meet community needs. Counties that provide certified home health services typically demonstrate higher revenue compared to counties that are decertified because they typically provide home care to more clients and are also able to bill both public and private health insurances for services. Lastly, counties that serve as the lead contractor for a multi-county service area have higher revenue; however, those funds are not solely dedicated to activities and services within the lead county. The lead county for a multi-county service area oversees contract funds and deliverables, but subcontracts a large portion of what shows as their revenue out to other public health partners in the service area to provide public health activities and services.

$42,524,774

Amount invested in public health by Iowa's boards of supervisors in SFY23; an increase of $985,982 from SFY22.

Annually, boards of supervisors (BOS) discuss county funding needs with boards of health and local public health agencies. The amount of county tax dollars invested in public health varies from county to county. Some counties receive the amount of funds needed to cover predicted shortfalls between anticipated revenue and expenses for a fiscal year; while other counties receive a set, fixed amount of funds each fiscal year.

The table below shows the amount of county tax dollars allocated to support local public health efforts in SFY23. Two counties reported receiving no support from their county board of supervisors.

Table 3: 47% of Iowa's recognized local public health agencies received less than $200,000 from their board of supervisors in SFY23.

BOS Allocation	Number of Counties	BOS Allocation	Number of Counties
Less than $100,000	18	$750,000 - $999,999	3
$100,000 - $149,999	14	$1,000,000 - $1,999,999	3
$150,000 - $199,999	14	$2,000,000 - $2,999,999	3
$200,000 - $249,999	9	$3,000,000 - $3,999,999	1
$250,000 - $499,999	22	$4,000,000 - $4,999,999	1
$500,000 - $749,999	9		

(Note: The revenue for the two counties that contract for services with a contiguous county or agency appears in lead county's budget).

Administrators were asked to provide their agency's total revenue, including the amount of county tax dollars allocated by their board of supervisors, for SFY23. Revenue for 97 counties totaled $91,448,274. There was a 26% decrease in revenue from SFY22 to SFY23.

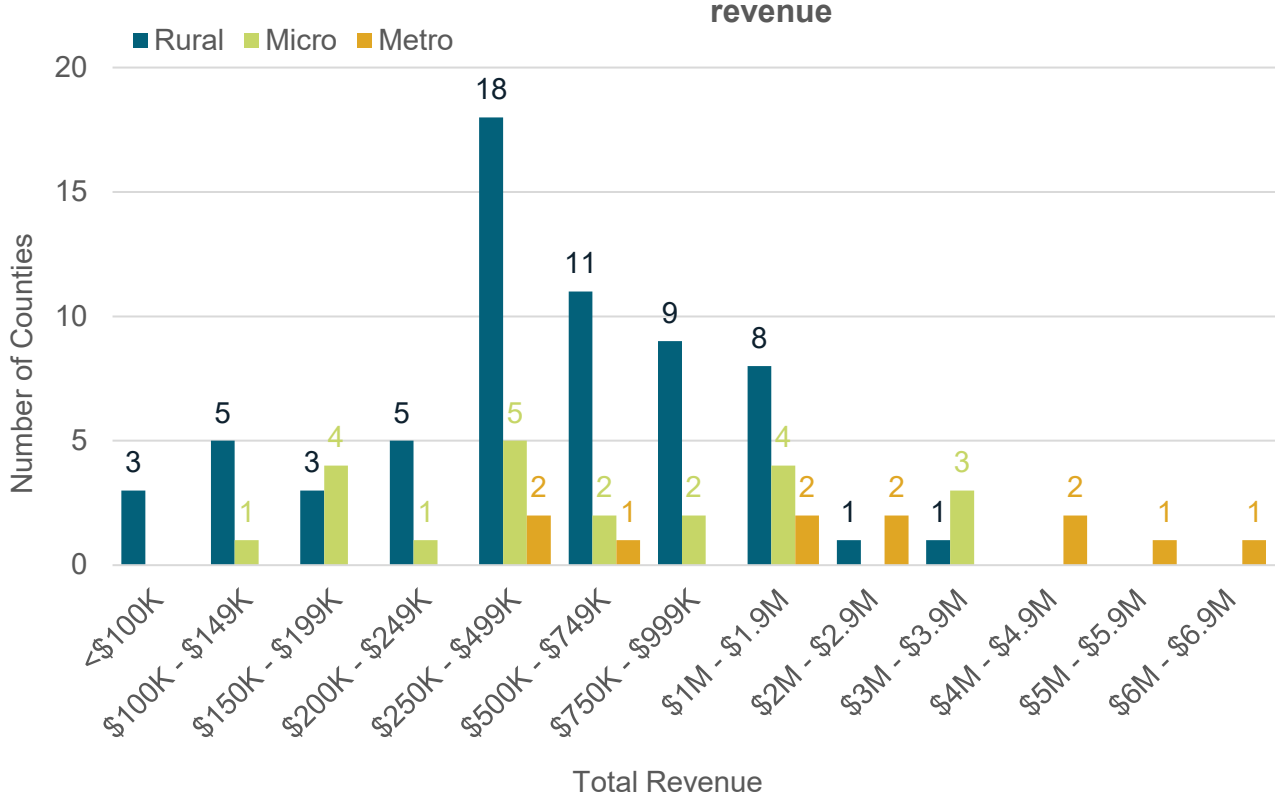
Population is not a determining factor for revenue for counties. The graph below illustrates total revenue broken down by rural, micropolitan, and metropolitan counties.

Rural Counties: Eighteen of the 64 counties fall within the $250,000 - $499,999 category for revenue; with three counties in the less than $100,000 category and one in the $3,000,000 - $3,999,999 category.

Micropolitan Counties: Four of the 22 counties fell within the $150,000 - $199,999 category for revenue; four counties fell in the $1,000,000 - $1,999,999 category, three in the $3,000,000 - $3,999,999 category, and one in the $100,000 - $149,999 category.

Metropolitan Counties: One of the 11 counties fell within the $6,000,000 - $6,999,999 category for revenue, with two counties in the $250,000 - $499,999 category. The agency that reported the most revenue in SFY23 was not the most populous county in the state.

Graph 6: Number of rural, micro, and metro counties by total revenue



Expenses:

Although most expenses for a local public health agency come from salaries and fringe, there are several other necessary expenses over the course of a fiscal year, including:

- travel and training,
- equipment and supplies,
- operational overhead,
- dues and fees,

- subcontracts, or
- contracted providers (including internal operations support such as human resources and IT and external services such as physical therapy (PT), occupational therapy (OT), or speech therapy).

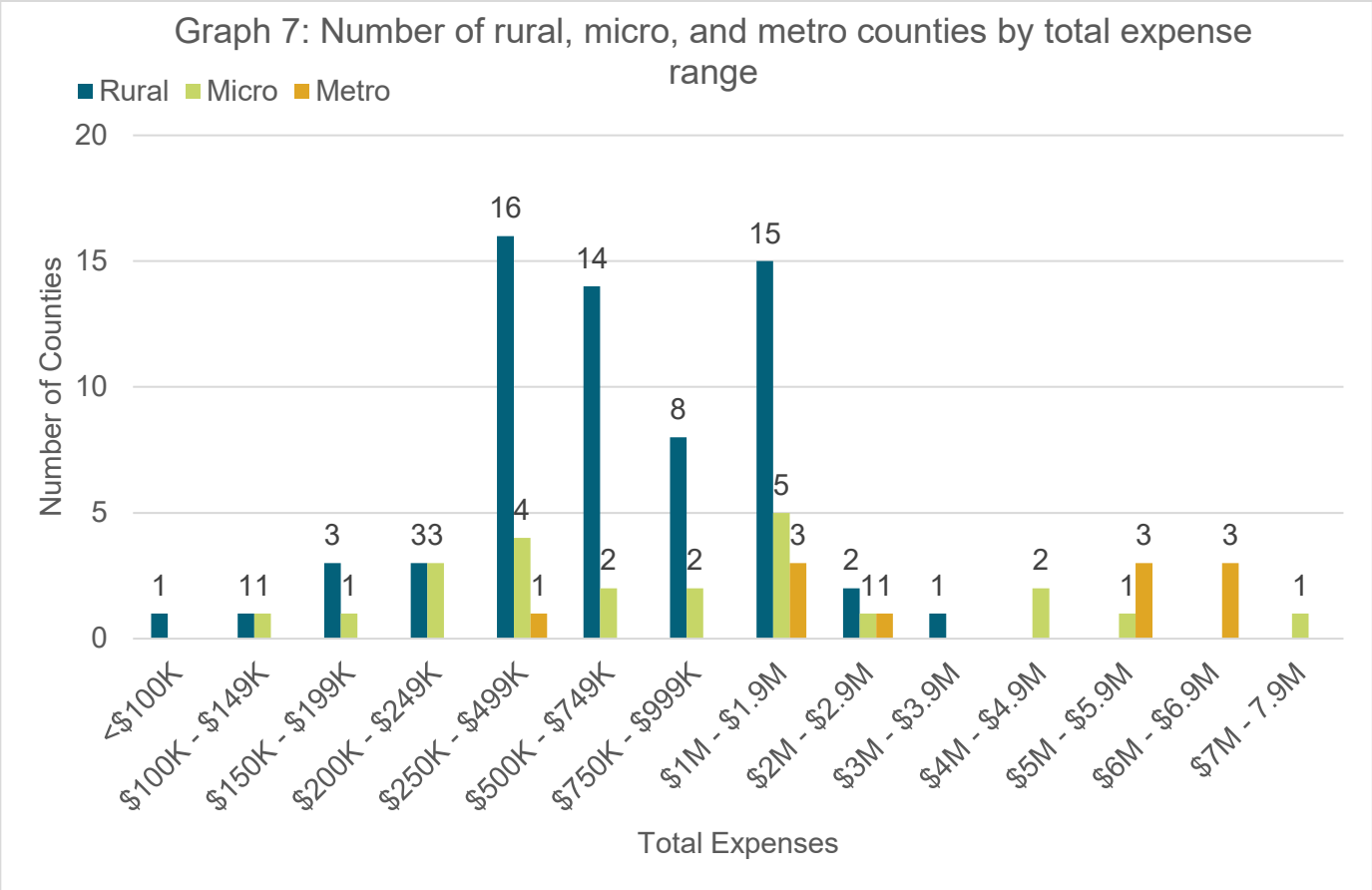
Administrators were asked to provide their total expenses for SFY23. One county did not report expenses for this past fiscal year. Expenses for 97 counties totaled $125,334,992. (Note: The expenses for the two counties that contract for services with a contiguous county appears in the lead county's budget). This amount was a 4% increase in expenses from SFY22 to SFY23.

The graph below illustrates total expenses broken down by rural, micropolitan, and metropolitan counties.

Rural Counties: Sixteen of the 64 counties reported expenses in the $250,000 - $499,999 category; with one county in the less than $100,000 category and one in the $3,000,000 - $3,999,999 category.

Micropolitan Counties: Nine of the 22 counties reported expenses less than $499,999. Five counties fell in the $1,000,000 - $1,999,999 category. One administrator reported between $100,000 - $149,999 in expenses and one reported between $7,000,000 - $7,999,999.

Metropolitan Counties: This graph shows the expense ranges for the 11 metropolitan counties in Iowa. Expenses for six of the 11 counties were greater than $5,000,000; for one county, expenses were less than $499,999. The agency that reported the highest expenses in SFY23 was a micropolitan county.



Expenses vary based on the level of services provided within the county, staffing levels, the county structure, and other factors:

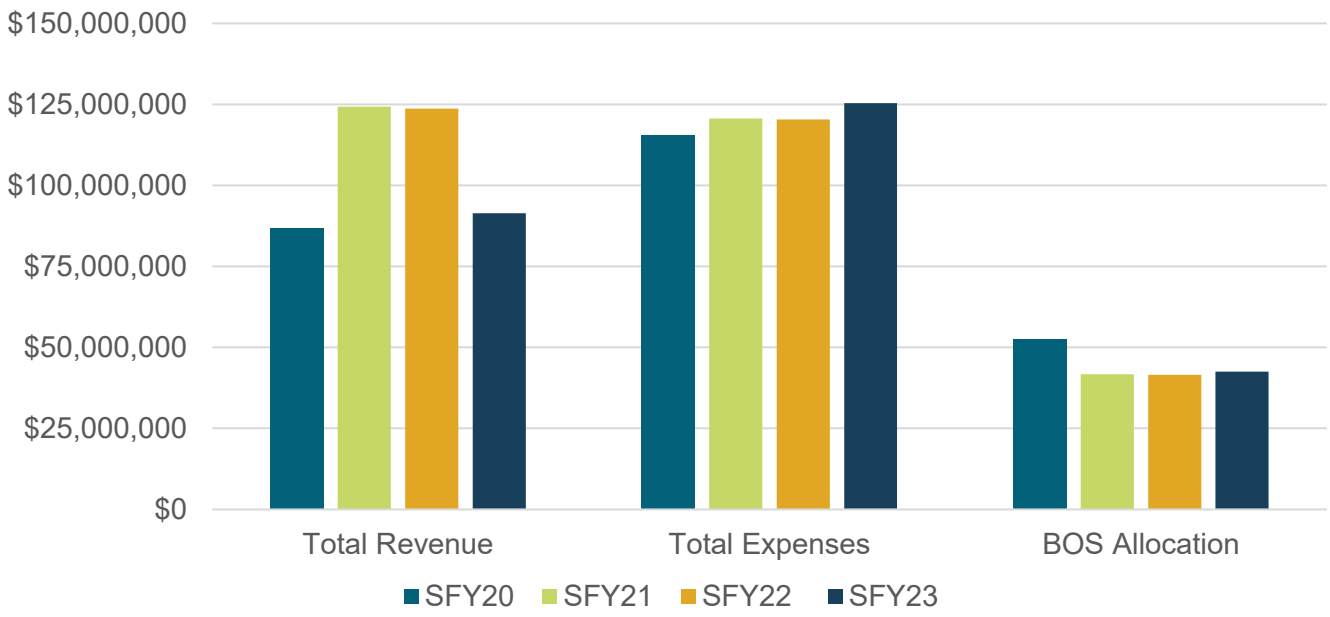
- Counties that provide a wide variety of population health activities and services employ more staff than those counties that provide minimal population health.
- Counties that provide certified home health services provide care to more clients than those counties that are decertified, thus needing more staff to serve an increased number of clients.
- Certified home health agencies are required to meet the comprehensive needs (speech, PT or OT) of clients; this is generally accomplished through contracted staff.
- Contracted operations support also varies from county to county. Some counties are able to utilize other staff within their governing structure to provide operations support, while others must contract with outside service providers for those services. Outside operations support is typically more expensive than support received internally.
- Lastly, counties that serve as the lead contractor for a multi-county service area have higher subcontracting expenses as they work with other public health partners in the service area to provide population health activities and services.

Revenue and Expenses – Annual Totals:

The graph below compares annual revenue, expenses and board of supervisor (BOS) allocation for the past four fiscal years. The comparisons show an increase in revenue from SFY20 to SFY22. Public health agencies were called to safeguard the public's health in a way very few people have witnessed during the COVID-19 pandemic. This increased ask of public health was supported by COVID relief funds in SFY21 and SFY22. There was a significant decrease in revenue for SFY23. Revenue and expense amounts reported by

administrators in both SFY21 and SFY22 indicated a positive balance as a whole at the end of each fiscal year. Based on administrator responses, there was a shortfall of $33,886,718 in SFY23. Board of supervisor financial investment for activities and services decreased from SFY20 to SFY21 and has remained status quo for the last three fiscal years.

Graph 8: Annual Finance Comparisons



Revenue and Expenses - Barriers and Emerging Issues:

Administrators were asked to report the challenges and emerging issues their agency encountered in SFY23. Finance related barriers were reported by 56% of local public health administrators. They included:

- insufficient state funding,
- decrease in grant funding from Iowa HHS for many grant programs,
- lack of flexible funding,
- lack of resources/funding to support efforts to address issues, meet needs, and expand population health initiatives,
- increase in the cost of living and providing services while also experiencing a decrease in funding, and
- Managed Care Organization (MCO) reimbursement challenges for services provided.

Emerging finance related issues were noted by 7% of administrators. Those issues included:

- economic instability,
- funding for local public health,
- flexible infrastructure funding,
- funding to hire staff, and
- inflation costs for the community.

FOUNDATIONAL CAPABILITIES

The Foundational Public Health Services, a nationally recognized framework for governmental public health, was developed in 2013 to define a minimum package of public health capabilities and programs that no jurisdiction can be without. Administrators were asked to report the level in which their agency is able to meet 29 capabilities. To better understand the infrastructure needs of local public health agencies, the capabilities have been grouped into five categories (see the yellow boxes below).

Agency Operations

- Workforce development
- Strategic plan
- Emergency operations plan
- Financial management system
- Grant and contract oversight
- Performance management system
- Quality improvement (QI) program
- QI activities

Data

- Community Health Assessment
- 24/7 surveillance system
- Data analysis and conclusions
- Fact sheets of data to support improvment planning
- Confidentiality policies

Partnerships

- Collaborative work through partnerships
- Health improvement plan implemented in partnership with others
- Access to legal counsel
- Implement strategies to increase access to care services

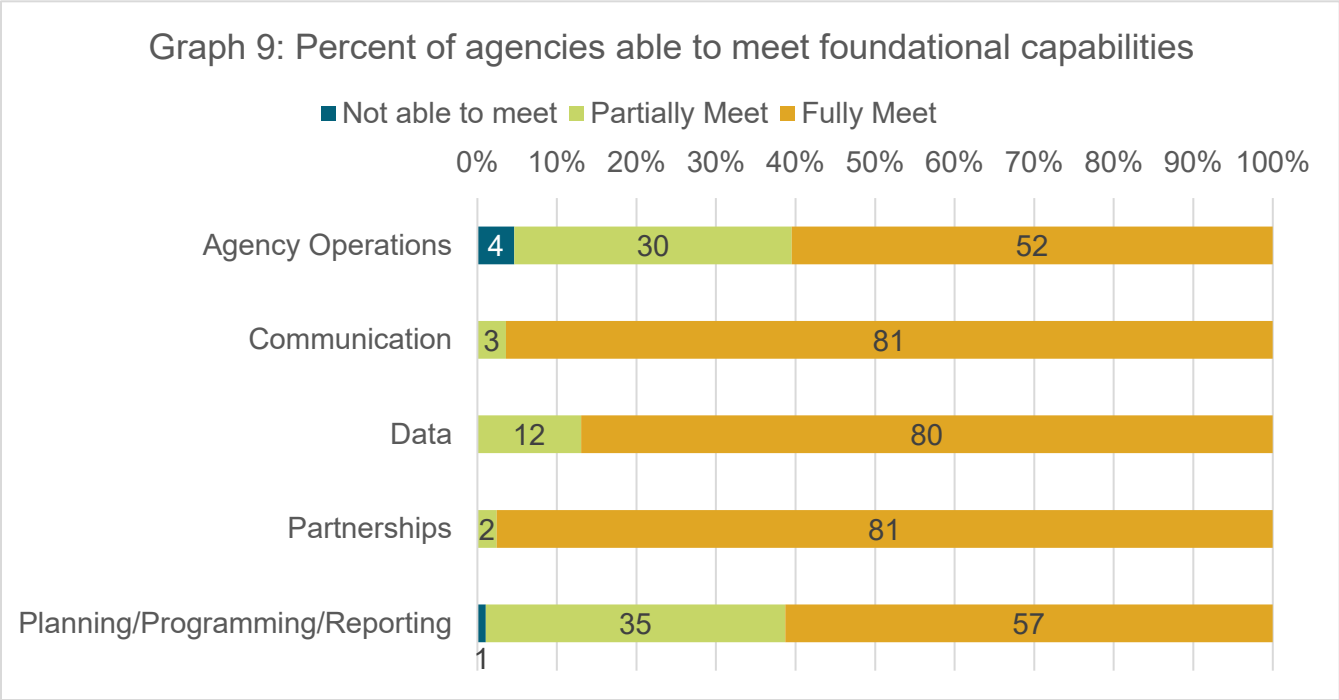
Communication

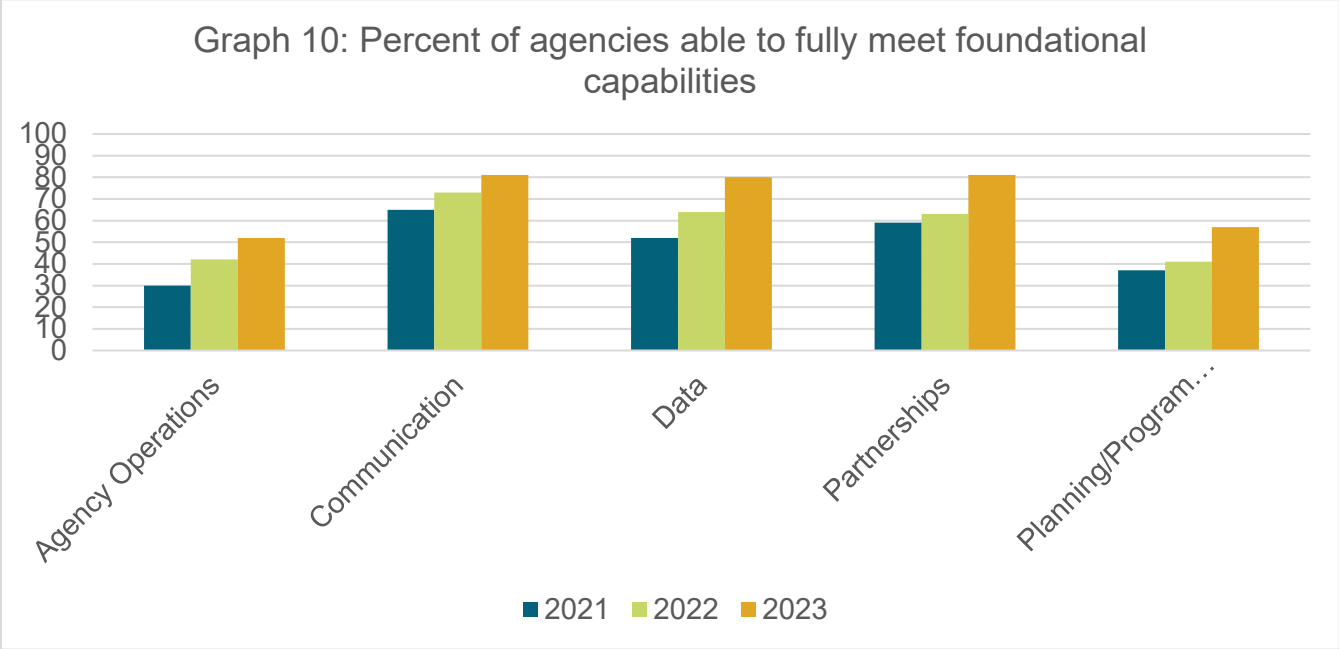
- Communication procedures
- Information available to the public
- Procedures and protocols for routine and emergency situations
- Communicate with Boards of Health about responsibilities and important health issues
- Communicate with governing entity about performance

Planning/Programming/Reporting

- Efforts that contribute to higher health risks and poorer outcomes
- Community health improvement plan
- Implement culturally competent initiatives
- Monitor and revise health improvement plan
- Complete After Action Reports

The graph below shows local public health agencies' ability to meet each infrastructure category.





Communication, Data, and Partnerships were the strongest categories for SFY23. Administrators reported being less able to meet the capabilities in the Agency Operations and Planning/Programming/Reporting categories. The overall goal would be for every agency to appear in blue in each of the five categories.

Iowa HHS has emphasized the importance of healthy equity for the past several years. Health equity is "the attainment of the highest possible level of health for all people. It means achieving the environmental, social, economic and other conditions in which all people have the opportunity to attain their highest possible level of health" (Iowa

Department of Health and Human Services). Health equity is reflected in many of the foundational capabilities. Administrators were asked how they felt about four statements (two regarding the social determinants of health and two about implementation of health equity efforts). Their responses to the four statements are below:

Table 4: Administrators reported improved capacity to implement health equity efforts in SFY23

	Not True	Somewhat True	Very True	I Don't Know
My agency has the funding to address social determinants of health.	33%	55%	12%	0%
My agency has staff members trained to address social determinants of health.	7%	64%	29%	0%
My agency has engaged with local governmental agencies or other external organizations to support policies and programs to achieve health equity.	5%	52%	42%	1%
My agency considers health equity issues in program planning and implementation.	0%	35%	65%	0%

Progress was made between SFY22 and SFY23 in implementing health equity efforts. This was especially notable in three of the four areas:

- In SFY22, 19% of administrators responded not true about whether their staff had received training to address the social determinants of health; in SFY23 only 7% responded not true.
- Engagement with local partners and organizations to support policies and programs to achieve health equity also improved. Forty-two percent of administrators responded very true in SFY23, compared to 28% in SFY22.
- Finally, when asked whether their agency considers health equity issues in program planning and implementation, 48% of administrators responded somewhat true and 51% responded very true in SFY22. Two-thirds of administrators (65%) responded very true to that same question in SFY23.
- The fourth area, funding to address social determinants of health, continues to be an issue for local public health administrators.

Foundational Capabilities – Barriers and Emerging Issues:

When asked about emerging issues and barriers, many administrators gave responses that reflected the five foundational capabilities categories. Response categories that have not already been mentioned in other sections of this report included:

Agency Operations

- Lack of stakeholders' understanding of public health rules and regulations
- Lack of support from elected officials
- Syndromic surveillance capabilities
- Loss of local infrastructure to be able to respond to public health emergencies
- Billing issues with Medicaid, Managed Care Organizations (MCOs), and private insurance
- Increase in unfunded mandates
- Increased advocacy needs for public health services

Communication

- Lack of health literacy
- Coordinated communication from state to local public health
- Lack of education about services available
- Lack of messaging for low literacy and Spanish speaking populations
- Language and cultural barriers with indigenous dialects
- Lack of interpreters
- The need for culturally and linguistically adapted care coordination and navigation for the social determinants of health
- Conflicting information or miscommunication
- Educating the community and stakeholders about the importance of public health

Data

- Health inequities
- Data and technology resources at the county and state level

Partnerships

- Working with partners that are experiencing workforce issues
- Fostering strong community partner re-engagement for CHA CHIP processes
- Ethnic and minority partnership building
- Turnover at partner organizations
- Decreased community partner/stakeholder interaction

Planning/Programming/Reporting

- Lack of translated outreach/promotional materials for state grants and programs
- Grant reporting on different schedules
- Ability to stand up prevention programming while dealing with emerging issues
- Limited ability to grow programs
- Lack of public awareness/attitudes about social determinants of health
- Lack of public buy-in
- Consumer apathy
- Lack of participation in educational programs
- Lack of health education
- Community and outreach strategies not always well received
- Continued care coordination for those who don't use technology
- Lack of resources to help people with paperwork and navigating systems

Service Delivery

The activities and services provided by the recognized local public health agency are determined by each county board of health to meet the unique needs of their county residents. Funding and staff capacity also play a role in the number and types of activities and services provided. This leads to great variability of service provision from county to county. Population-based activities and services are provided by every recognized local public health agency in the state; whereas 63% of recognized local public health agencies provide home health services.

There are a variety of population-based activities and services. Administrators were asked to provide information about their agency's programming by selecting from a list of 14 population health-based areas. Responses were provided by all 97 administrators.

92% of administrators responded that they provided all four of the following areas (the percentage of administrators that provided a response for each area is also listed):

Disease Follow-Up, Surveillance, And Control (99%)

Emergency Preparedness And Response (98%)

Immunization And Tuberculosis (97%)

Public Information, Health Education, And Community Engagement (95%)

In addition to core population health areas, administrators were also able to select from specialized activities and services they delivery to meet community needs. Those activities and services, and the percentage of administrators that provided a response for each area, were:

- Chronic Disease and Disability Prevention and Management (63%)
- Screening & Assessment (60%)
- Environmental Health (46%)
- Family Health (43%)
- Nutrition and Physical Activity (43%)
- Injury Prevention (36%)
- Tobacco Use Prevention and Control (29%)
- Substance Use Disorder Prevention (28%)
- HIV, STI, and Hepatitis (23%)
- Behavioral Health (12%)

Although service delivery in the top four areas listed above was consistent for most counties, there were differences across population categories. Sixty-nine percent of rural counties and 59% of micropolitan counties provided chronic disease and disability prevention and management services; in comparison to 36% of metropolitan counties. Injury prevention activities were provided by 44% of rural counties, whereas only 22% of micropolitan counties and 18% of metropolitan counties provided these activities.

The percentage of counties that provided family health services was similar for both rural and micropolitan counties (42% and 41% respectively); however, 55% of metropolitan counties provided family health services. The percentage of metropolitan counties that provided specialized services was higher than both rural and micropolitan counties in four of the 10 service categories; environmental health; HIV, STI, and Hepatitis; nutrition and physical activity; and tobacco use prevention and control.

Not all public health services are provided by agencies in the local governmental public health system. Funds received by HHS for the provision of public health services at the local level is contracted out to local boards of health, directly to recognized local public health

agencies, or to agencies not in the governmental public health system. To illustrate the role recognized local public health agencies play in service delivery for the public health system, additional data were collected from HHS program staff. The data provided are not all inclusive of the programming that takes place at the local level.

Public health programs vary in the number of people who participate in them or the number of people local staff are able to reach through specific community-based activities. The table below outlines the percent of the population served by a recognized local public health agency for the past three fiscal years.

Table 5: Population served by a recognized local public health agency over the past three fiscal years

Public Health Program (Population Definition)	Percent of population served by local public health agencies SFY21	Percent of population served by local public health agencies SFY22	Percent of population served by local public health agencies SFY23
Cancer Screening & Detection and WISEWOMAN (recipients receiving screening and lifestyle intervention services)	89%	97%	97%
Child Health (child health clients)	52%	58%	58%
Influenza (flu) vaccine (influenza vaccine given)	4%	4%	4%
Maternal Health (maternal health clients)	28%	34%	34%
Oral Health (I-Smile) (all kids served by I-Smile)	63%	61%	54%
Oral Health (individuals served by I-Smile Silver)	100%	100%	100%
Supplemental Nutrition Program for Women, Infants, and Children (WIC) (WIC participants)	14%	16%	9%

SERVICE DELIVERY – BARRIERS AND EMERGING ISSUES: The top five emerging issues and barriers categories related to service delivery were: accessibility to dental care and health care, communicable diseases (COVID-19, RSV, Tuberculosis); services for the elderly, immunizations, and care coordination.

Cross-Jurisdictional Sharing

The Centers for Disease Control and Prevention defines cross-jurisdictional sharing as:

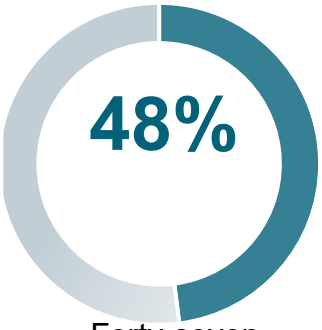
- The deliberate exercise of public authority to enable collaboration across jurisdictional boundaries to deliver essential public health services" (Center for Sharing Public Health Services, 2013). Cross-jurisdictional sharing can range from supporting informal arrangements to more formal changes in structure. In public health, cross-jurisdictional sharing often occurs between health departments or agencies serving two or more jurisdictions. Collaboration allows communities to solve issues or problems that cannot be easily solved by a single organization or jurisdiction.

- Examples of cross-jurisdictional sharing include: sharing staff between two or more health departments; sharing defined services; or collaborative assessment and planning processes that include two or more health departments and leads to shared priorities.

- Cross-jurisdictional sharing (CJS) is a growing strategy used by state, tribal, local, and territorial agencies and organizations to address opportunities and challenges such as tight budgets, increased burden of disease, and regional planning needs.

Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency currently shares the delivery of services or staff with another agency, and two questions to gauge the extent of which their agency would consider sharing the delivery of services or staff with another agency. The statewide data for SFY23 showed the following.

Currently shares the delivery of public health activities and services

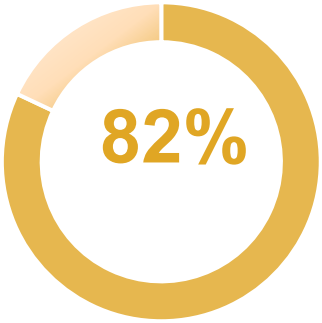


Forty-seven administrators reported they share service delivery with another agency; while 50 reported they do not share service delivery with another agency.

Currently shares staff

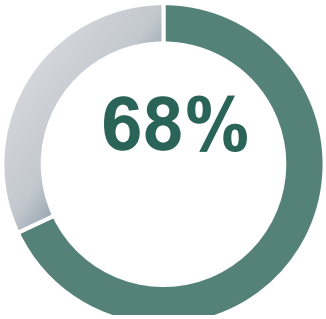
Twenty administrators reported they share staff with another agency; while 77 reported they do not share staff with another agency.

Would consider sharing the delivery of public health activities and services



Eighty administrators reported they would consider sharing service delivery with another agency; while 17 reported they would not consider sharing service delivery with another agency.

Would consider sharing staff



Sixty-six administrators reported they would consider sharing staff with another agency; while 31 reported they would not consider sharing staff with another agency.

Conclusion

This report demonstrates the complexity of Iowa's local governmental public health system.

Local control allows for great variability from county to county and agency to agency. No two counties are alike. Whether you are looking at structure, workforce, revenue and expenses, funding and board of supervisor investment, service delivery, or the ability to meet the foundational capabilities, there is no predictable correlation between the population of a county and the different variables studied through the Local Public Health Systems Survey or between variables themselves.

In a decentralized system, the need to understand the roles partners play, as well as how the components of the system work together to protect and improve the health of Iowans, is crucial. This report not only provides context to help develop that understanding, but brings to light strengths and opportunities for state, local, and other partners to work together to enhance and advance Iowa's public health system.

References

Centers for Disease Control and Prevention. (n.d.). *Cross-jurisdictional sharing of public health services.* https://www.cdc.gov/publichealthgateway/cjs/index.html

Centers for Disease Control and Prevention. (1994). *Original essential public health services framework.* https://www.cdc.gov/publichealthgateway/publichealthservices/originalessentialhealthservices.html

Institute of Medicine. (1988). *The future of public health*. The National Academies Press. https://doi.org/10.17226/1091

Iowa Department of Health and Human Services. (n.d.). *Health equity*. https://hhs.iowa.gov/Health-Equity

Local Boards of Health, Iowa Code § 137 (1967 & rev. 2022). https://www.legis.iowa.gov/docs/code/137.pdf

Local Boards of Health, Iowa Administrative Code 641.77 (1967 & rev. 2017). https://www.legis.iowa.gov/docs/iac/chapter/641.77.pdf

National Association of County and City Health Officials. (n.d.). *Public health finance.* https://www.naccho.org/programs/public-health-infrastructure/public-health-finance

National Association of County and City Health Officials. (n.d.). *Public health infrastructure and systems*. https://www.naccho.org/programs/public-health-infrastructure

National Association of County and City Health Officials. (n.d.). *The role of local health departments* [Fact sheet]. https://www.naccho.org/uploads/downloadable-resources/Fact_Sheet_2.doc

RESOLVE. (n.d.) *Foundational public health capabilities and services*. https://www.resolve.ngo/site-healthleadershipforum/defining-and-constituting-foundational-capabilities-and-areas.htm

Rothwell, W. J. (2010). *Effective succession planning: Ensuring leadership continuity and building talent from within* (4th ed.). AMACOM - American Management Association.

Appendix A: 2023 Local Public Health Systems Survey Questions and Data Tables

Survey Questions and Data Tables

In November 2023, local public health administrators completed the Local Public Health Systems Survey. There was a 100% response rate to the survey. Responses were collected using the survey tool, Cognito, and data were analyzed using Excel. Data were also collected from Iowa Department of Health and Human Services (HHS) programs to provide additional context about service delivery within the local governmental public health system. Programming data, obtained from HHS staff through email or by shared Google documents, are not all inclusive of activities that take place at the local level.

The following are the questions included in the 2023 Local Public Health Systems Survey and the corresponding data tables for each question. Where available, data from previous years are also included. The number of administrators that responded to each question can be found in parenthesis.

Demographics

Question 1: What county are you reporting for?

Administrators selected the county they were reporting for from a drop-down list of all Iowa counties.

Question 2: What is the title of the individual completing this survey?

Administrators typed in their job title. This field was used to assure only one response per county.

Question 3: Please identify your race.

Race	Number of Administrators (n = 94)
Black or African American	0
White	94

Question 4: Please identify your age.

Age Range	Number of Administrators SFY20 (n = 93)	SFY21 (n = 94)	SFY22 (n = 94)	SFY23 (n = 93)
Less than 25	0	0	0	1
25 – 34	14	16	18	17
35 – 44	22	19	21	26
45 – 54	20	26	30	25
55 – 64	34	31	24	23
65+	3	2	1	1

Question 5: Please identify your gender.

Gender	Number of Administrators			
	SFY20 (n = 93)	SFY21 (n = 94)	SFY22 (n = 95)	SFY23 (n = 94)
Female	84	85	87	84
Male	9	8	8	9
Prefer not to answer	0	1	0	1

WORKFORCE

6. What was the total number of FTEs in your agency/department at the conclusion of FY23 (July1,2022 - June 30, 2023)? (Please include permanent full time, permanent part time, and temporary staff.)

Fiscal Year	Total Number of FTEs (Statewide)
SFY20	1,211
SFY21	1,276
SFY22	1,216
SFY23	1,143

FTE Range	Number of Agencies – FY23 (n = 97)
0 – 4.99	30
5.0 – 9.99	29
10.0 – 19.99	25
20.0 – 29.99	5
30.0 – 39.99	1
40.0 – 49.99	3
50.0 – 59.99	3
60.0 – 69.99	1

7. What number of FTE's (as reported in question 6) were allocated to each of the job categories below? (Note: The responses provided for each category listed below should collectively add up to the total FTE number provided in question #6. A warning will appear after each entry until the FTE total equals the number of FTEs provided in question #6.)

Job Category	Total FTEs, Number of Agencies Reporting			
	SFY20	SFY21	SFY22	SFY23
Agency administrator	101.7 (96)	Not asked	95.0 (96)	89.4 (97)
Agency leadership	Not asked	154.4 (97)	Not asked	Not asked
Agency leadership, not including agency administrator	Not asked	Not asked	78.7 (35)	82.94 (40)
Animal control worker	Not asked	5.5 (5)	2.5 (1)	2.0 (1)
Behavioral health staff	10.6 (9)	8.3 (5)	3.0 (3)	3.0 (4)
Business and financial operations staff	Not asked	68.2 (50)	67.0 (49)	60.26 (50)
Care administrator/coordinator	43.9 (34)	Not asked	Not asked	Not asked
Chronic disease care coordinator	10.2 (8)	Not asked	Not asked	Not asked
Clerical	156.6 (88)	Not asked	Not asked	Not asked
Community health worker	Not asked	54.1 (23)	60.6 (23)	40.32 (17)
Dental hygienist	26.9 (14)	Not asked	Not asked	Not asked
Environmental health administrator	26.1 (27)	Not asked	Not asked	Not asked
Environmental health specialist (non-managers)	64.1 (29)	Not asked	Not asked	Not asked
Environmental health worker	Not asked	86.4 (34)	80.3 (31)	79.40 (34)
Epidemiologist/ statistician	Not asked	9.2 (11)	7.5 (7)	12.35 (10)
Financial specialist	41.9 (38)	Not asked	Not asked	Not asked
Health educator	29.2 (25)	29.7 (28)	33.0 (26)	27.07 (23)
Home health aide (providing direct care)	175.8 (63)	Not asked	Not asked	Not asked
Home health nurse (providing direct care)	135.9 (53)	Not asked	Not asked	Not asked
Information systems specialist	Not asked	6.5 (6)	3.0 (4)	3.0 (4)
Laboratory worker	Not asked	8.1 (6)	6.4 (4)	7.35 (4)
Licensed practical or vocational nurse	Not asked	31.3 (24)	33.8 (29)	27.11 (23)
Non-STD infectious disease investigator who enters data into IDSS	42.9 (37)	Not asked	Not asked	Not asked
Nursing aide/home health aide/homemaker	Not asked	166.9 (67)	148.3 (55)	143.97 (57)

Question 7 continued.

Job Category	Total FTEs, Number of Agencies Reporting			
	SFY20	SFY21	SFY22	SFY23
Nutritionist	14.1 (7)	10.3 (5)	9.3 (4)	9.25 (3)
Office and administrative support staff	Not asked	152.1 (79)	148.5 (81)	132.77 (80)
Oral healthcare professional	Not asked	25.8 (15)	33.8 (15)	27.50 (14)
Physician/Nurse Practitioner/Physician Assistant	5.0 (7)	Not asked	Not asked	Not asked
Preparedness staff	30.1 (48)	40.6 (39)	26.8 (29)	26.94 (29)
Public health nurse	166.1 (83)	Not asked	Not asked	Not asked
Public health physician	Not asked	2.5 (4)	1.2 (3)	1.22 (3)
Public information professional	Not asked	10.4 (15)	7.3 (8)	6.80 (9)
Registered nurse	Not asked	322.5 (93)	265.9 (85)	262.27 (89)
Social worker	26.9 (14)	Not asked	Not asked	Not asked
Other	143.0 (42)	151.0 (37)	Not asked	Not asked

8. How many staff departed your department/ agency in FY23 (July 1, 2022 - June 30, 2023)? (Include full time, part-time, PRN, and temporary staff.)

Fiscal Year	Total Number of Staff, Number of Agencies Reporting	Number of Agencies with No Turnover
SFY20	Not asked	Not asked
SFY21	251 (75)	21
SFY22	256 (78)	17
SFY23	210 (97)	27

9. Please identify which jobs you had difficulty filling in FY23 (July 1, 2022 - June 30, 2023). Select all that apply.

Job Category	Number of Agencies			
	SFY20	SFY21	SFY22	SFY23
Agency leadership (includes the administrator	Not asked	7	13	4
Animal control worker	Not asked	1	0	1
Behavioral health staff	2	2	2	0
Business and financial operations staff	Not asked	1	1	4
Care administrator/coordinator	1	Not asked	Not asked	Not asked
Community health worker	Not asked	6	7	4
Chronic disease care coordinator	1	Not asked	Not asked	Not asked
Clerical	5	Not asked	Not asked	Not asked
Dental hygienist	4	Not asked	Not asked	Not asked
Environmental health specialist (non-managers)	1	Not asked	Not asked	Not asked
Environmental health worker	Not asked	1	3	1
Epidemiologist/statistician	Not asked	1	2	0
Financial specialist	1	Not asked	Not asked	Not asked
Health educator	2	4	10	
Home care aide (providing direct care)	27	Not asked	Not asked	Not asked
Home health nurse (providing direct care)	20	Not asked	Not asked	Not asked
Licensed practical or vocational nurse	Not asked	3	5	3
Nursing aide/home health aide/homemaker	Not asked	33	31	23
Nutritionist	4	1	1	3
Office and administrative support staff	Not asked	8	4	5
Oral healthcare professional	Not asked	6	3	2
Preparedness staff	6	3	7	2
Public health administrator	9	Not asked	Not asked	Not asked
Public health nurse	29	Not asked	Not asked	Not asked
Public information professional	Not asked	1	0	0
Registered nurse	Not asked	39	37	33
Other	10	4	5	2

10. What was the total number of employees in your agency/ department at the conclusion of FY23 (July 1, 2022 - June 30, 2023)?

Fiscal Year	Total Number of Employees (Statewide)
SFY20	1,421
SFY21	1,402
SFY22	1,439
SFY23	1,290

11. What is the current, total number of employees in your agency/ department?
(Note: The responses provided for question 12 should collectively add up to the total number of employees provided in this question. A warning will appear after each entry until the number of employees in questions 12 equals the total number of employees reported in this question.)

Fiscal Year	Total Number of Employees (Statewide)
SFY23	1,421

12. Please tell us more about the number of employees in your agency/department that provide population health activities and services and/or non-population health services.
(Note: The responses provided for each question below should collectively add up to the total number of employees provided in question #11).

What is the current, total number of employees in your agency/ department that only provide population health activities and services?

Fiscal Year	Number of Employees Population Health Activities & Services (n = 97)
SFY23	

What is the current, total number of employees in your agency/ department that only provide non-population health services?

Fiscal Year	Number of Employees Non-Population Health Services (n = 97)
SFY23	

What is the current, total number of employees in your agency/ department that provide both non-population health services AND population health activities and services?

Fiscal Year	Number of Employees Population Health Activities & Services and Non-Population Health Services (n = 97)
SFY23	

13. Please indicate the extent to which your agency/department has implemented the following succession planning activities (use the following definitions when answering for each activity - Fully implemented means the activity has been completed by my agency/department; Partially implemented means the activity has been started but has not been completed by my agency/department; Not yet implemented means the activity has not been started by my agency/department; or Not applicable means there are too few employees within my agency/department to plan for the succession of roles and responsibilities):

Succession Planning Activities	Number of Agencies FY22 (n = 95)		
	Fully Implemented	Partially Implemented	Not Yet Implemented
Identifying high potential employees	20	45	30
Developing high potential employees	17	48	30
Having written documentation that describes work of critical importance to the agency	13	46	36
Identifying high potential employees	37	49	6
Developing high potential employees	16	60	19
Having written documentation that describes work of critical importance to the agency	18	60	22

Question 14: Did you use interns to increase agency workforce capacity in FY23?

Used Interns	Number of Agencies			
	SFY20 (n= 95)	SFY21 (n= 98)	SFY22 (n = 96)	SFY23 (n = 97)
No	68	72	65	76
Yes	27	26	31	24

Question 15: Did you contract for staff to help support and/or increase agency workforce capacity in FY23?

Contracted for Personnel	Number of Agencies	
	SFY22 (n= 96)	SFY23 (n= 97)
No	68	77
Yes	27	23

Question 16: How many people currently serve on your county's local board of health?

Fiscal Year	Total Number of Local Board of Health Members (Statewide)
SFY22	546
SFY23	514

Question 17: How many years has each member served on your county's local board of health?

Fiscal Year	Total Number of Years - Board of Health Chairs (Statewide)
SFY20	1,103
SFY21	1,177
SFY22	1,177
SFY23	1,175

Years of Service (Range)	Number of Board of Health Chairs	
	SFY22 (n = 96)	SFY23 (n = 97)
0 – 0.99	1	0
1.0 – 4.99	28	23
5.0 – 9.99	18	24
10.0 – 14.99	16	17
15.0 – 19.99	16	11
20.0 – 29.99	15	18
30.0 – 39.99	3	3
40.0 – 49.99	0	0
50 +	1	1

Question 17 continued.

Fiscal Year	Total Number of Years - All Other Board of Health Members (Not Chair – Statewide)
SFY20	2,444
SFY21	2,544
SFY22	2,621
SFY23	2,762

Years of Service (Range)	Number of All Other Board of Health Members (not Chair) SFY22 (n = 96)	SFY23 (n = 97)
0 – 0.99	58	27
1.0 – 4.99	156	190
5.0 – 9.99	97	108
10.0 – 14.99	54	53
15.0 – 19.99	12	16
20.0 – 29.99	18	19
30.0 – 39.99	6	5
40.0 – 49.99	1	1
50 +	0	1

Question 18: Please indicate the number of board of health members who have an occupational background in the following areas. (Note: Each board of health member should only be counted in one category.)

Background	Number of Board of Health Members SFY20	SFY21	SFY22	SFY23
Animal science/veterinarian	23	24	27	25
Clerical	6	9	11	5
Craftsperson	0	2	0	1
Education	27	34	32	33
Elected officials	Not asked	53	56	55
Farmer	26	14	14	14
Finance	Not asked	9	14	9
Labor	3	4	2	0
Legal	Not asked	8	7	7
Managers/administration	45	23	33	23
Professional	39	18	40	31
Professional - medical	259	254	258	275
Religious	2	5	3	2
Sales	9	8	6	4
Self-employed	17	30	19	11
Service	5	15	12	7
Other	42	18	12	11

Question 19: Of the number of board of health members reported in question #18, how many are retired?

Fiscal Year	Number of Retired Board of Health Members (Statewide)
SFY20	136
SFY21	133
SFY22	96
SFY23	150

SERVICES

These questions will collect information that will be used to describe the services provided by the local governmental public health system.

Question 20: What percentage of your agency's/department's work is spent providing non-population health services, regardless of funding source?

Non-Population Health Service Provision	Number of Agencies SFY23 (n = 97)
0%	17
1-24%	24
25-49%	22
50-74%	22
75-100%	12

Question 21: Please identify your agency/department's areas of programming for FY23? (July 1, 2022 – June 30, 2023). Select all that apply.

Program Areas	Number of Agencies SFY23 (n = 97)
Behavioral health	12
Chronic disease & disability prevention and management	61
Disease follow-up, surveillance, and control	96
Emergency preparedness & response	95
Environmental health	45
Family health	42
HIV, STI, & Hepatitis	22
Immunizations & Tuberculosis	94
Injury prevention	35

Nutrition & physical activity	42
Public information, health education, & community engagement	92
Screening & assessment	58
Substance use disorder prevention	27
Tobacco use prevention & control	28
Other	32

Please indicate which answer best reflects the agency/department's current practice.

Question 22: Does your agency/department currently share the delivery of public health activities and services with another agency?

Shares the Delivery of Public Health Activities and Services	Number of Agencies SFY23 (n= 97)
No – my agency/department does not share services with another agency	50
Yes - my agency/department does share services with another agency	47

Question 23: Does your agency/department currently share staff with another agency?

Shares Staff	Number of Agencies SFY23 (n= 97)
No – my agency/department does not share staff with another agency	77
Yes - my agency/department does share staff with another agency	20

Question 24: Would your agency/department consider sharing the delivery of public health activities and services with another agency in the future?

Would Consider Sharing the Delivery of Public Health Activities and Services	Number of Agencies SFY23 (n= 97)
No – my agency/department would not consider sharing services with another agency	17
Yes - my agency/department would consider sharing services with another agency	80

Question 25: Would your agency/department consider sharing staff with another agency in the future?

Would Consider Sharing Staff	Number of Agencies SFY23 (n= 97)
No – my agency/department would not consider sharing staff with another agency	31
Yes - my agency/department would consider sharing staff with another agency	66

EMERGING ISSUES

These questions will collect information that will be used to describe the emerging public health issues the governmental local public health system is facing.

Question 26: What are the emerging public health issues your county experienced in FY23 (July 1, 2022 - June 30, 2023)?

Administrators were able to write a list of emerging issues in a blank field. Responses were analyzed and a summary of the most frequent answers appear in the appropriate sections of the final report.

Question 27: What barriers to providing activities and services did your agency/department experience in FY23 (July 1, 2022 - June 30, 2023)?

Administrators were able to write a list of barriers in a blank field. Responses were analyzed and a summary of the most frequent answers appear in the appropriate sections of the final report.

HEALTH EQUITY

These questions will collect broad information that will be used to describe how the local governmental public health system is incorporating concepts of health equity into practice.

Please indicate which answer best reflects the agency/department's current practice.

Question 28: My health department has the funding to address social determinants of health.	Number of Agencies			
	SFY20	SFY21 (n = 96)	SFY22 (n = 95)	SFY23 (n = 97)
I don't know	Not asked	5	2	0
Not true	Not asked	26	27	32
Somewhat true	Not asked	54	56	53
Very True	Not asked	11	10	12

Question 29: My health department has staff members trained to address social determinants of health.	Number of Agencies			
	SFY20	SFY21 (n = 96)	SFY22 (n = 95)	SFY23 (n = 97)
I don't know	Not asked	1	2	0
Not true	Not asked	17	18	7
Somewhat true	Not asked	58	57	62
Very True	Not asked	20	19	28

Question 30: My health department/agency has engaged with local governmental agencies or other external organizations to support policies and programs to achieve health equity.	Number of Agencies			
	SFY20	SFY21 (n = 96)	SFY22 (n = 95)	SFY23 (n = 97)
I don't know	4	1	2	1
Not true	12	7	9	5
Somewhat true	47	60	58	50
Very True	34	28	27	41

Question 31: My health department/agency considers health equity issues in program planning and implementation.	Number of Agencies			
	SFY20	SFY21 (n = 96)	SFY22 (n = 95)	SFY23 (n = 97)
I don't know	3	2	1	0
Not true	5	2	0	0
Somewhat true	39	45	46	5034
Very True	50	48	49	63

BUDGET

These questions will collect information that will be used to describe, at a high level, how the local governmental local public health system is funded.

Question 32: What was your agency's/ department's total revenue for FY23 (July 1, 2022 - June 30, 2023)? Please round to the nearest dollar.

Fiscal Year	Total Revenue (Statewide)
SFY20	$86,744,759
SFY21	$124,265,135
SFY22	$123,651,332
SFY23	$91,448,274

Total Revenue	Number of Agencies – FY23 (n = 97)		
	Rural	Micropolitan	Metropolitan
Less than $100,000	3	0	0
$100,000 - $149,999	5	1	0
$150,000 - $199,999	3	4	0
$200,000 - $249,999	5	1	0
$250,000 - $499,999	18	5	2
$500,000 - $749,999	11	2	1
$750,000 - $999,999	9	2	0
$1,000,000 - $1,999,999	8	4	2
$2,000,000 - $2,999,999	1	0	2
$3,000,000 - $3,999,999	1	3	0
$4,000,000 - $4,999,999	0	0	2
$5,000,000 - $5,999,999	0	0	1
$6,000,000 - $6,999,999	0	0	1

Question 33: What was the total amount of funds received by your agency/department to provide population health activities and services in FY23 (July 1, 2022 - June 30, 2023)? Please round to the nearest dollar.

Fiscal Year	Total Received for Population Health (Statewide)
SFY23	$38,071,794

Question 34: What were your agency/department's total expenditures for FY23 (July 1, 2022 - June 30, 2023)?

Fiscal Year	Total Expenses (Statewide)
SFY20	$115,512,881
SFY21	$120,635,151
SFY22	$120,310,785
SFY23	$125,334,992

Question 35: What was the total amount of funds expended by your agency/department to provide population health activities and services in FY23 (July 1, 2022 - June 30, 2023)? Please round to the nearest dollar.

Fiscal Year	Total Expended for Population Health (Statewide)
SFY23	$50,297,743

Question 36: Provide the amount of money your county board of supervisors ACTUALLY CONTRIBUTED to your agency/department, to support agency/department activities and services, in FY23 (July 1, 2022 - June 30, 2023)? Please round to the nearest dollar.

Fiscal Year	Total Contributed for Activities and Services (Statewide)
SFY23	$42,524,774

Question 37: Using the value from question #36, what was the amount of funds expended to provide population health activities and services in FY23 (July 1, 2022 - June 30, 2023)? Please round to the nearest dollar."

Fiscal Year	Total Contributed for Population Health Activities and Services (Statewide)
SFY23	$22,398,122

Question 38. Provide the amount of money your county board of supervisors BUDGETED for your agency/department, to support agency/department activities and services, in FY23 (July 1, 2022 - June 30, 2023)? Please round to the nearest dollar.

Fiscal Year	Total Budgeted for Activities and Services (Statewide)
SFY23	$62,001,368

Question 39: Does your agency/department have a public health fund, that allows the agency/department to accumulate fund balances from year to year and carry forward fund balances from year to year, in your budget?

Public Health Fund	Number of Agencies			
	SFY20 (n= 98)	SFY21 (n= 99)	SFY22 (n = 96)	SFY23 (n = 97)
No	84	82	83	80
Yes	14	17	13	17

Question 40: To what extent can your agency/department meet each of the following Foundational Public Health Services (use the following definitions when answering for each service - Fully meet means my agency/department can demonstrate all of the bulleted aspects of the service; Partially meet means my agency/department can demonstrate some but not all of the bulleted aspects of the service; or Not Able to Meet means my agency/department cannot demonstrate any of the bulleted aspects of the service):

A Community Health Assessment • Data from multiple sources • Demographics of the population served • Factors that contribute to health challenges • A description of community assets and resources to address health issues • Community input in the process	Number of Agencies			
	SFY20 (n = 97)	SFY21 (n = 97)	SFY22 (n = 96)	SFY23 (n = 97)
Fully meet	70	68	69	88
Not able to meet	3	2	2	0
Partially meet	23	27	25	9
Did not answer	3	2	0	1

24/7 Surveillance System • Processes and protocols in place to collect, review and analyze comprehensive surveillance data on multiple health conditions from multiple sources • Processes and protocols to assure confidential data is maintained in a secure manner • A system for the agency/department to receive data 24/7 • The 24/7 system is tested	Number of Agencies			
	SFY20 (n = 97)	SFY21 (n = 97)	SFY22 (n = 96)	SFY23 (n = 97)
Fully meet	61	64	59	67
Not able to meet	4	6	3	0
Partially meet	31	27	33	30
Did not answer	3	2	1	1

Question 40 continued.

Data Analysis and Public Health Conclusions Drawn • Able to analyze qualitative, quantitative, primary and secondary data • Compares data to other agencies, the state, the nation, or other similar data over time. • Shares data analysis • Combines primary and secondary data	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	25	37	38	49
Not able to meet	14	11	8	3
Partially meet	57	49	50	45
Did not answer	3	2	0	1

Community Summaries or Fact Sheets of Data to Support Public Health Improvement Planning Processes • Provide summaries or fact sheets of community health data that condense public health data to public health system partners, community groups, and key stakeholders.	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	31	40	43	50
Not able to meet	12	11	8	3
Partially meet	53	45	44	42
Did not answer	3	3	1	2

Question 40 continued.

Collaborative Work through Established Governmental and Community Partnerships on Investigations of Reportable Diseases, Disease Outbreaks, and Environmental Public Health Issues • Have established partnerships with other governmental agencies/ departments and/or key community stakeholders that play a role in investigations or have direct oversight.	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	71	77	81	88
Not able to meet	0	0	0	0
Partially meet	25	20	15	9
Did not answer	3	2	0	1

Complete After Action Reports • Have a protocol to describe the process used to determine when events rise to the significance for the development and review of an After Action Report • Complete After Action Reports according to the protocol	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	51	62	54	62
Not able to meet	6	3	3	4
Partially meet	38	31	39	30
Did not answer	4	3	0	1

Question 40 continued.

Efforts to Specifically Address Factors that Contribute to Specific Population's Higher Health Risks and Poorer Health Outcomes • Identify and implement strategies to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or health inequity • Analyze factors that contribute to higher health risks and poorer health outcomes of specific populations • Identify community factors that contribute to specific population's higher health risks and poorer health outcomes • Have internal policies and procedures to ensure programs address specific populations at higher risk for poor health outcomes	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	21	31	30	42
Not able to meet	6	5	7	3
Partially meet	67	60	59	52
Did not answer	5	3	0	1

Communication Procedures • Have a communication plan/procedure that details: ○ How information will be disseminated to different audiences ○ How messaging will be coordinated with community partners ○ A contact list of media and key stakeholders • Responsibilities of the public information officer and any other staff interacting with the news media	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	55	53	60	58
Not able to meet	2	0	0	1
Partially meet	38	43	34	38
Did not answer	4	3	2	1

Question 40 continued.

Information Available to the Public • An agency/department website that includes: ○ A 24/7 contact number for reporting emergencies ○ Information about notifiable/reportable conditions ○ Health data ○ Links to public health laws ○ Program information and materials ○ Links to CDC and other public health related agencies ○ Names of agency leadership • Use at least two other mechanisms to make information available to the public (newspaper, radio, Facebook, newsletter, etc.)	Number of Agencies			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	33	46	43	45
Not able to meet	4	2	2	2
Partially meet	59	48	51	50
Did not answer	3	3	0	1

Community Health Improvement Plan • Links to the community health needs assessment • Details priorities for action • Includes strategies to be implemented and who is responsible for carrying those out	Number of Agencies			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	53	51	47	77
Not able to meet	3	2	3	0
Partially meet	39	42	45	19
Did not answer	4	4	1	2

Health Improvement Plan Implemented in Partnership with Others • Have a process to track implementation of the strategies included in the community health improvement plan	Number of Agencies			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	45	44	42	65
Not able to meet	5	4	10	2
Partially meet	45	47	43	30
Did not answer	4	4	1	1

Question 40 continued.

Monitor and Revise as Needed the Community Health Improvement Plan • Do an annual report on progress made in implementing the strategies in the community health improvement plan • Revise the health improvement plan based on the findings of the annual report	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	42	39	36	58
Not able to meet	8	8	11	3
Partially meet	46	49	49	35
Did not answer	3	3	0	2

Implement a Strategic Plan • Have a strategic plan • Develop reports documenting progress toward meeting the goals and objectives in the strategic plan	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	26	30	30	39
Not able to meet	15	16	15	8
Partially meet	54	50	51	50
Did not answer	2	3	0	1

Testing and Revision of the Public Health Emergency Operations Plan • Review and test the plan through the use of exercises and drills • Develop after action report after an exercise or drill • Revise the public health emergency operations plan based on the findings of the after action report	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	61	64	55	71
Not able to meet	4	1	2	0
Partially meet	30	31	39	26
Did not answer	2	3	0	1

Question 40 continued.

Access to Legal Counsel • Have access to legal counsel review and advice	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	80	84	86	92
Not able to meet	1	1	1	2
Partially meet	14	10	9	3
Did not answer	2	4	0	1

Procedures and Protocols for Routine and Emergency Situations Requiring Enforcement and Complaint Follow-up • Formally document actions taken as a result of investigations or follow up of complaints. • Have standards for follow up. • Communicate with regulated entities regarding a complaint or compliance plan. • Communicate with regulated entities regarding a complaint or compliance plan.	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	68	70	67	76
Not able to meet	2	1	2	0
Partially meet	26	25	25	20
Did not answer	1	3	2	2

Implement Strategies to Increase Access to Health Care Services • **Work collaboratively to assist the population in obtaining health care services**	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	51	61	59	77
Not able to meet	4	0	1	1
Partially meet	39	34	36	18
Did not answer	3	4	0	2

Question 40 continued.

Implement Culturally Competent Initiatives to Increase Access to Health Care Services for Those Who May Experience Barriers to Care Due to Cultural, Language, or Literacy Differences • Implement initiatives or collaborate with others to ensure access and barriers are addressed in a culturally competent manner	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	36	46	44	60
Not able to meet	10	3	4	3
Partially meet	50	46	46	34
Did not answer	1	4	2	1

Workforce Development Strategies • Have a workforce development plan • Have workforce development strategies that are implemented • Conduct regular assessments of the workforce	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	21	29	26	30
Not able to meet	22	22	18	13
Partially meet	54	46	52	54
Did not answer	0	2	0	1

Performance Management Policy/System
• Adopt a performance management system that includes:
  ○ Performance standards (goals, targets, outcomes)
  ○ Communication of expectations regarding performance
  ○ Performance measurement (including how data is collected)
  ○ Progress reporting
  ○ Analysis of data
  ○ A process to identify opportunities for quality improvement based on analysis of data
	Number of Agencies			

	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	30	31	35	42
Not able to meet	8	10	12	6
Partially meet	59	55	49	48
Did not answer	0	3	0	2

Question 40 continued.

Implemented Performance Management System • Have a team monitoring performance standards (goals, objectives) • Implement a process for monitoring performance of goals and objectives • Identify areas of need • Identify next steps for goals and objectives	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	36	33	32	43
Not able to meet	12	12	10	7
Partially meet	48	51	54	44
Did not answer	1	3	0	1

Establish a Quality Improvement (QI) Program • Have a written quality improvement plan that includes: ○ Key quality terms ○ A description of the current culture of quality and the desired future state for QI ○ A structure for QI (Who is responsible?) ○ QI Training ○ QI Goals ○ Communication of QI Activities ○ Process to assess the effectiveness of the QI plan	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	35	44	39	42
Not able to meet	11	10	10	11
Partially meet	51	43	47	44
Did not answer	0	2	0	1

Implement QI Activities • Implement the QI Plan • Be able to describe the process and outcomes of QI work	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	38	40	43	44
Not able to meet	12	10	9	11
Partially meet	46	45	44	42
Did not answer	1	4	0	1

Question 40 continued.

Policies Regarding Confidentiality, Including Applicable HIPAA Requirements • Have written confidentiality policies and procedures • Train staff on confidentiality policies	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	89	91	91	94
Not able to meet	0	1	0	0
Partially meet	7	3	4	3
Did not answer	1	4	1	1

Financial and Programmatic Oversight of Grants and Contracts • Complete regular agency-wide/departmentwide financial audit reports • Complete required program reports to funding organizations	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	86	88	85	92
Not able to meet	0	0	0	0
Partially meet	11	6	10	5
Did not answer	0	5	1	1

Financial Management System • Have an approved health budget • Conduct quarterly financial reports	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	84	90	89	92
Not able to meet	0	0	0	0
Partially meet	11	6	7	5
Did not answer	2	3	0	1

Question 40 continued.

Communicate with the Local Board of Health About the Responsibilities of the Department and the Responsibilities of the LBOH • Communicate with the LBOH about the responsibilities of the public health agency/department as set forth in code, administrative rule, and local rules and regulations • Communicate with the LBOH about their responsibilities as set forth in code, administrative rule, and local rules and regulations • Have an orientation process for new LBOH members	Number of Agencies			
	SFY20 (n = 97)	SFY21 (n = 97)	SFY22 (n = 96)	SFY23 (n = 97)
Fully meet	87	91	90	91
Not able to meet	0	0	0	0
Partially meet	10	6	6	6
Did not answer	0	2	0	1

Information Provided to the LBOH About Important Public Health Issues Facing the Community, the Health Department and/or Recent Actions of the Health Department • Communicate with the LBOH about important public health issues and/or recent actions of the health agency/department.	Number of Agencies			
	SFY20 (n = 97)	SFY21 (n = 97)	SFY22 (n = 96)	SFY23 (n = 97)
Fully meet	92	95	92	95
Not able to meet	0	0	0	0
Partially meet	4	2	4	1
Did not answer	1	2	0	2

Question 40 continued.

Communicate with the Governing Entity About Health Department Performance Assessment and Improvement • Communicate with the LBOH on plans and processes for improving health agency/department performance • Communicate with the LBOH on performance improvement efforts	**Number of Agencies**			
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**	**SFY23 (n = 97)**
Fully meet	79	84	83	86
Not able to meet	1	2	0	0
Partially meet	17	11	13	11
Did not answer	0	2	0	1