2022

IOWA'S LOCAL GOVERNMENTAL PUBLIC HEALTH SYSTEM

A Report on the Results of the
Local Public Health Systems Survey

Public Health
IOWA HHS

ACKNOWLEDGEMENTS

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MESSAGE FROM IOWA HHS

Dear Public Health Partners,

On behalf of the Iowa Department of Health and Human Services (HHS), we are pleased to share the data of the 2022 Local Public Health Systems Survey. We want to thank all who participated and provided responses. This data will help shape our approach for public health initiatives, and systems development work at the Iowa Department of Health and Human Services.

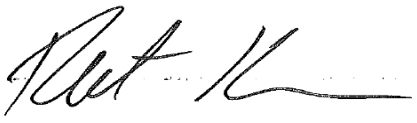
The 2022 report, along with this unique moment in time, solidify that this is the right time for us to redefine what our public health system looks like in Iowa. In short – we have identified exciting opportunities to harness the expertise and passion of our public health workforce, to better leverage existing financial resources, and to continue to engage and support our community partners and local stakeholders while acknowledging the evolution of our state's resources and population.

This year, we will examine public health practice statewide. That effort will include a focus on the role variability plays in how we deliver and plan public health activities and services. Through this exercise, we will identify and lift up best practices, hone in on improvement opportunities and establish additional resources, all with renewed focus on improved outcomes for everyone who calls Iowa home.

Understanding the roles of community and statewide partners, as well as how partners work together to protect and improve the health of Iowans, is crucial. We are eager to dig into that work – and invite you to the table as we do so.

We welcome your feedback and your continued interest in, and use of, these data. Please contact Erin Barkema at erin.barkema@idph.iowa.gov if you have questions about the content of the report.

In partnership,



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EXECUTIVE SUMMARY

Iowa is a decentralized, home rule state. Its governmental public health system is complex and consists of two components:

> 1) State-level entities (the Iowa Department of Health and Human Services (HHS) and its governing body, and the State Hygienic Laboratory (housed within the University of Iowa); and
> 2) The local governmental public health system (96 recognized local public health agencies and their governing bodies (local boards of health, agency boards of directors, or agency boards of trustees), 34 local boards of health (serving in an advisory capacity), and assistance provided by 99 county boards of supervisors).

Local control allows for great variability from county to county and agency to agency. Examining public health practice across all 99 counties is key to understanding the role variability plays in implementing public health activities and services, determining similarities and differences within public health structures, and identifying opportunities to enhance and advance Iowa's public health system. This report illustrates Iowa's local governmental public health system as of June 30, 2022.

In the summer of 2022, HHS staff developed the 2022 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 August 2022. Survey responses were collected using the survey tool Cognito. Additional information was clarified through correspondence with specific local public health administrators. There was a100% response rate for the 2022 survey.

Data were also collected from HHS programs, through email or by 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.

The full report provides an overview of Iowa's local public health system and results of the qualitative and quantitative data collected through the third annual Local Public Health Systems Survey. For the purposes of this report all data, unless otherwise noted, are for state fiscal year 22 (SFY22: July 1, 2021 – June 30, 2022). Report findings illustrate the complexity of the system, including the variability of activities and services, staffing, funding, and infrastructure capacity from agency to agency. No two counties are alike. 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.

EXECUTIVE SUMMARY

The following are limitations of this report:

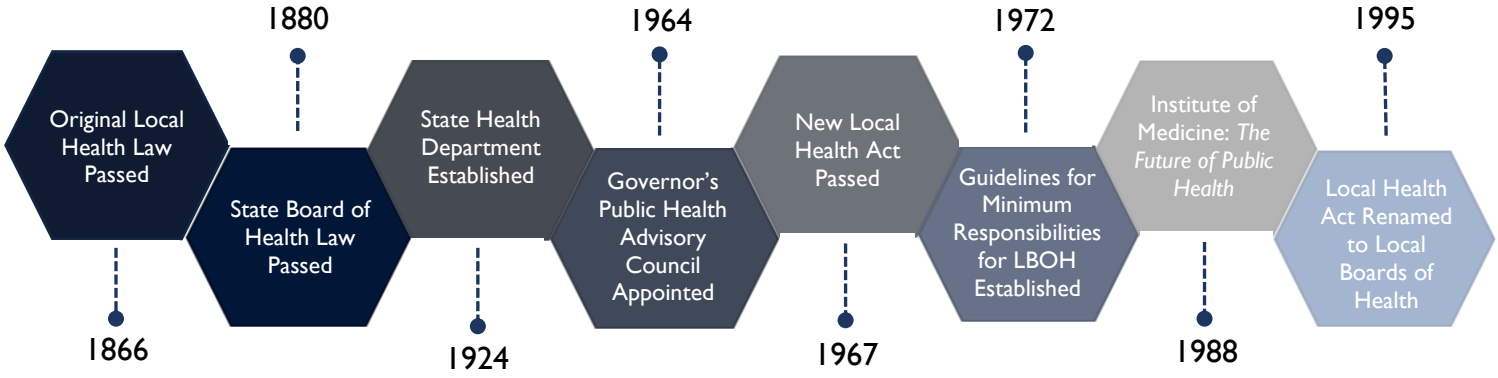
1. The survey required the input of local public health administrators. Local boards of health or other public health staff were not surveyed.
2. Approximately one-third of Iowa's local environmental health departments are included in the data. This is because the majority of environmental health departments 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 charts of accounts and funding 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 SFY22. 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 so local public health administrators may have answered the questions differently. A companion document was provided to clarify select questions.

Comparisons of statewide data collected by Iowa HHS – Division of Public Health (DPH) over the past three state fiscal years (SFY20, SFY21, and SFY22) 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 Appendix B, can be used to compare both similarities and differences within each structure and across structures.

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.

PUBLIC HEALTH IN IOWA



Public health in Iowa dates back to 1866 with the passing of the Original Local Health Law. This law designated the mayor and members of the town council or the township trustees in rural areas as the local board of health. The law gave board members the authority to establish regulations for public health and safety, to control nuisances, and to regulate sources of filth and causes of sickness in communities. In 1880, Iowa's State Board of Health Law was passed. This law required the creation of a state board of health. It also required each town, city, or township board to appoint a physician as a health officer for the community. In 1924, the state health department was established, its primary responsibilities included controlling infectious diseases and compiling birth and death records. The Governor's Public Health Advisory Council was appointed in 1964 and made recommendations to strengthen public health in Iowa.

Adopted in 1967, Chapter 137 of the Code of Iowa marked the beginning of a new era of public health. This law, known as the New Local Health Act, required each county to establish a local board of health with one member being a physician licensed by the State of Iowa. The county board of supervisors then appointed additional members to the local board. The law also provided cities with populations greater than 25,000 with the option to establish a city board of health. At this time, the New Local Health Act gave boards powers but did not establish requirements. It wasn't until 1972 when guidelines for minimum local board of health responsibilities were defined by special committees.

As Iowa's population has grown and changed, so have public health's duties. State and local public health has evolved from primarily compiling and reporting statistics or providing direct care services to an overarching mission of protecting and improving the public's health. This evolution stemmed from a report published in 1988 by the Institute of Medicine. Titled "*The Future of Public Health*", the report provided a long list of enduring and emerging public health issues and raised questions about the capacity of the public health service system to address these concerns. It called for comprehensive action to bring about necessary changes including a clear delineation of the mission of the public health service system and improvement in technical, political, managerial and programmatic skills of public health practitioners. The report stated, "no citizen from any community, no matter how small or remote, should be without identifiable and realistic access to the benefits of public health protection, which is possible only through a local component of the public health delivery system" (Institute of Medicine, 1988, p. 9). This fundamental concept holds true today.

In 1995, the New Local Health Act was renamed to Local Boards of Health.

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 STATE BOARD OF HEALTH AND THE IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES: The State Board of Health, the policy-making body for public health matters at the Iowa Department of Health and Human Services, has the powers and duties to adopt, promulgate, amend and repeal rules and regulations, and advises or makes recommendations to the Governor, General Assembly, or Department Director on public health, hygiene, and sanitation.

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, enforcement, or change, and support and implement local public health efforts. The remainder of this report will focus on the local governmental public health system.

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:

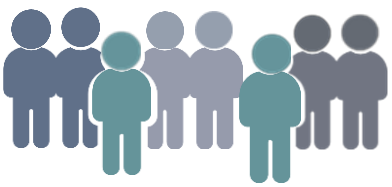
A local board of health shall

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.



546

people served on their local board of health in SFY22

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 seven boards of health that had seven members in SFY22.

All members of the local board of health are volunteers and are appointed by the county board of supervisors. Fifty-eight new members were appointed to a local board of health during SFY22, a 22% decrease in board of health turnover from SFY21. 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.

IOWA'S PUBLIC HEALTH SYSTEM

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 546 members in SFY22, local public health administrators reported that 96 members (approximately 18%) are retired. This is a 28% decrease in retired members from SFY21.

Member Background	Number of BOH Members
Professional - medical	258
Elected officials	56
Professional	40
Managers/administration	33
Education	32
Animal Science/Veterinarian	27
Self-employed	19
Farmer	14
Finance	14
Service	12
Other	12
Clerical	11
Legal	7
Sales	6
Religious	3
Labor	2

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. Thirty percent of chairs had served on their board of health for less than five years, while 20% had served on a board of health for 20 years or more.

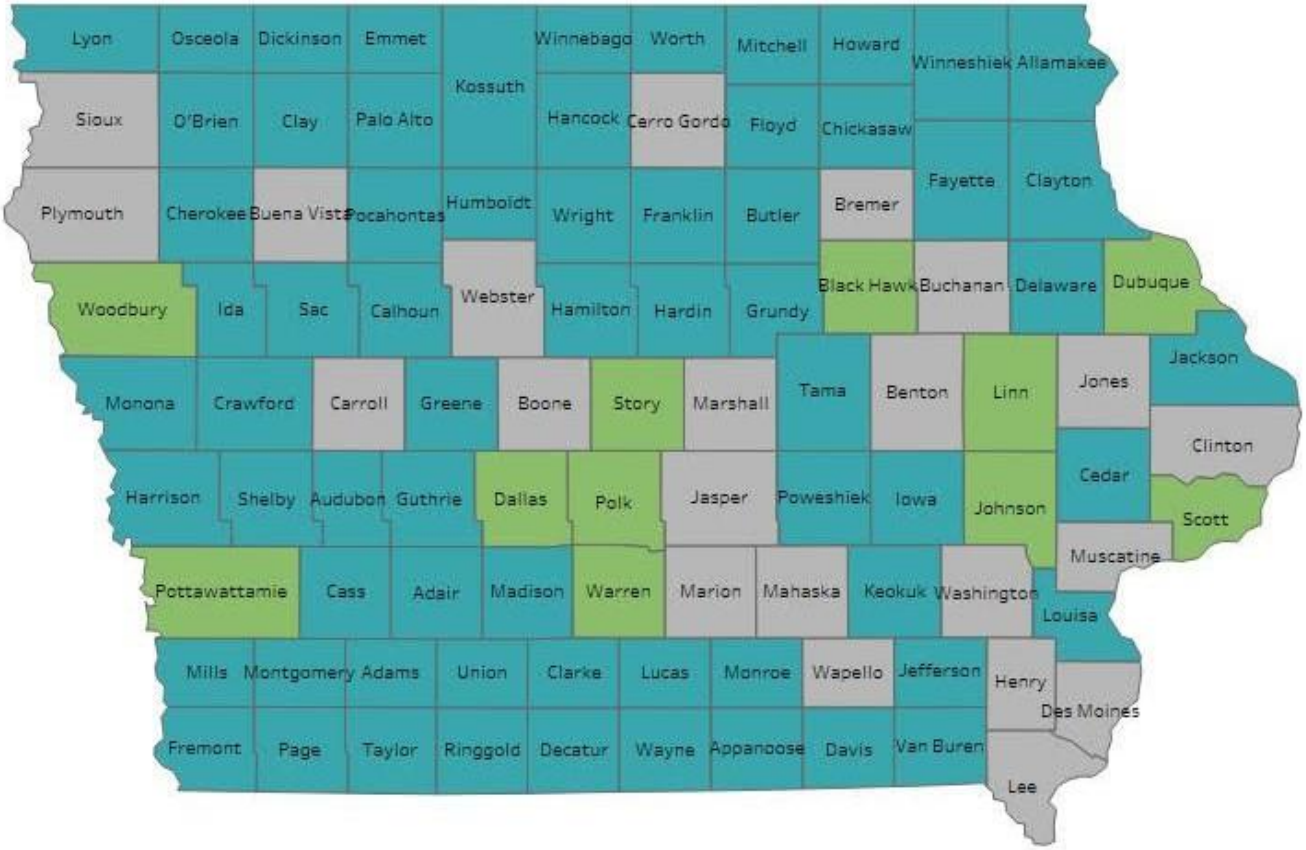
For all other board of health members, the average number of years served was 6.5. Fourteen percent of members had served just one year, while one member has served on their local board of health for 48 years. The breakdown of years of service for board of health members who did not serve as the chair during SFY22 is as follows:

IOWA'S PUBLIC HEALTH SYSTEM

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. Those factors include population, whether the local Board of Health employs staff or contracts with another entity for services, and individual county needs.

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. The population breakdowns used for the purposes of this report are: rural (fewer than 20,000 people), micropolitan (20,000 – 49,999 people), and metropolitan (more than 50,000 people). There are 66 rural counties, 22 micropolitan counties, and 11 metropolitan counties in Iowa. The map below illustrates the population category for each county.



Population
(Rural = blue, Micropolitan = gray, Metropolitan = green)

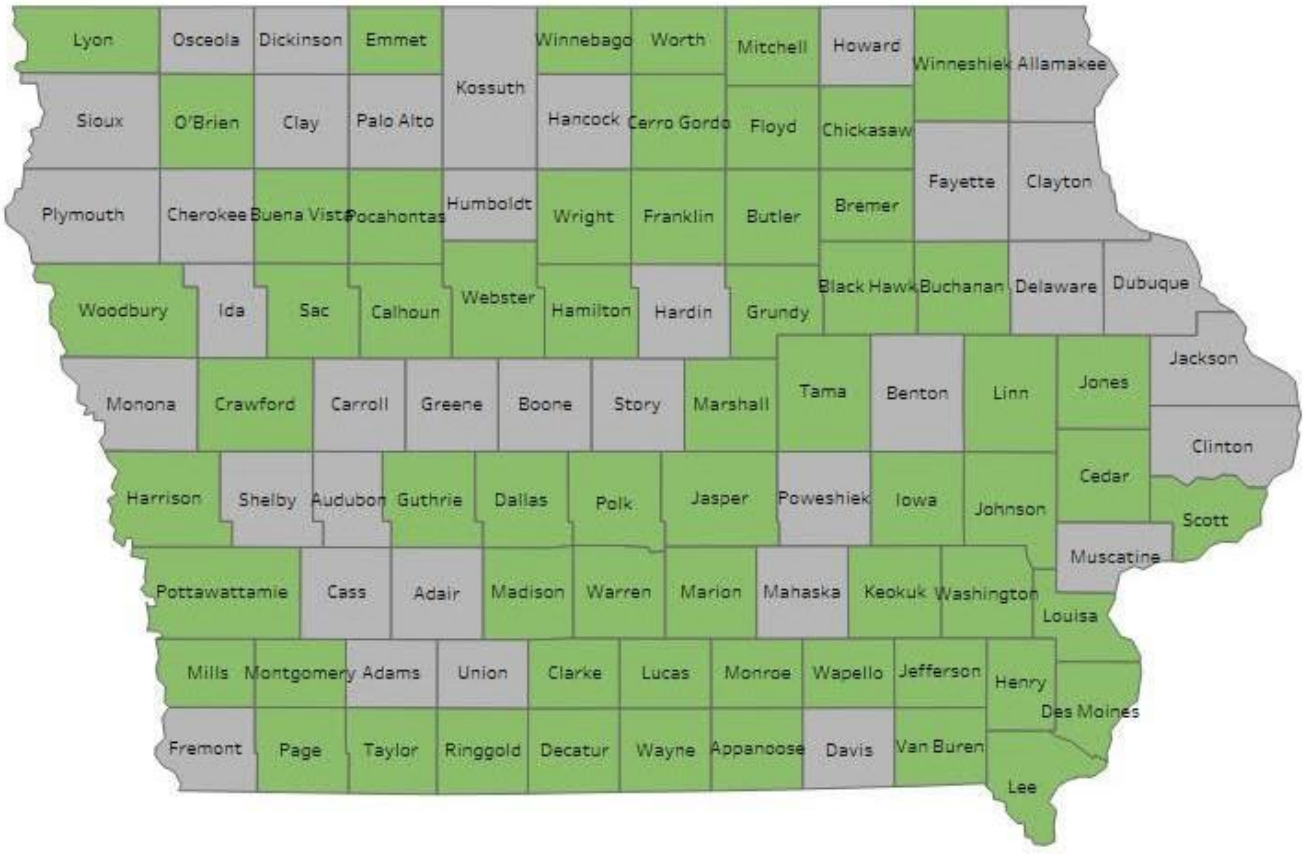
IOWA'S PUBLIC HEALTH SYSTEM

PUBLIC HEALTH SERVICE PROVISION: Local boards of health are tasked with safeguarding and improving the health of the people in their county. This goal is achieved by assuring the core public health functions are met and essential public health services are delivered throughout the county. Each board of health recognizes a single agency as the local public health agency for the county.

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 SFY22, there were 62 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.

The map below illustrates the public health service provision type for each county.

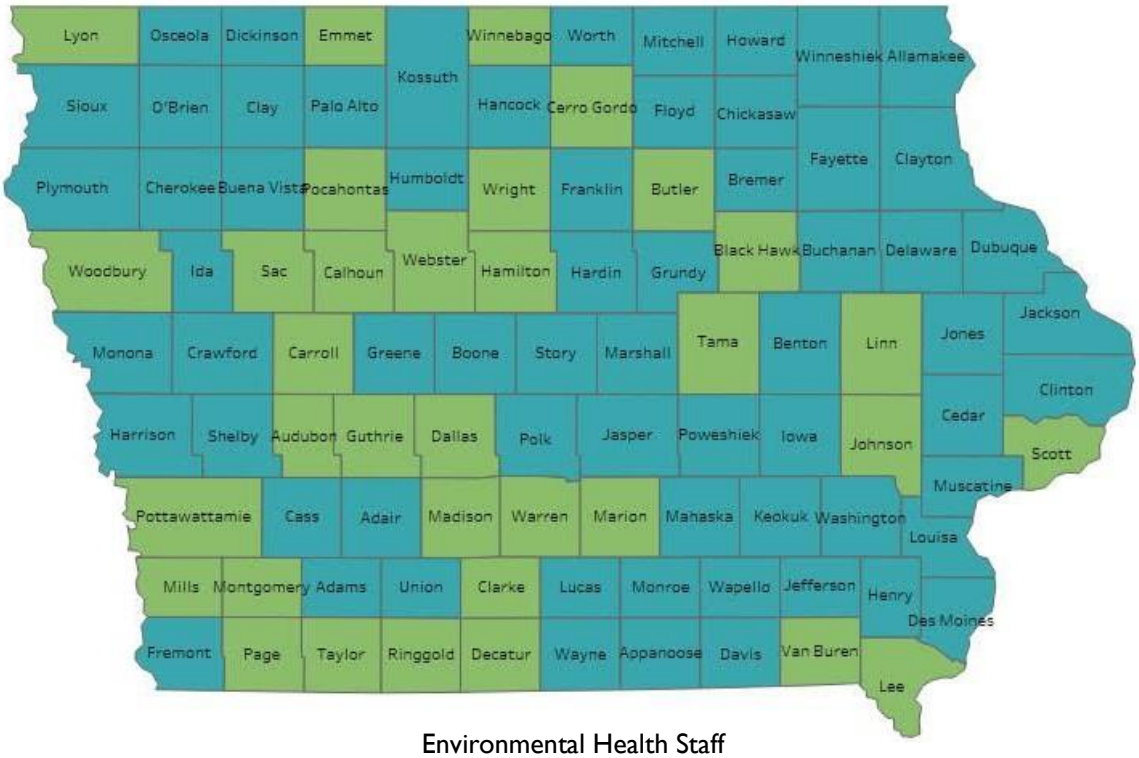


Public Health Service Provision
(Employs Staff = green, Contracts for Services = gray)

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 (e.g., regulate the construction and installation of private wells, collect water samples from new and existing wells, and provide financial assistance to help residents pay for the cost of well abandonment, well rehabilitation and well water sampling);
- providing private sewage disposal (septic) system services (e.g., regulate the design, construction and installation of all private sewage disposal systems installed, sample systems with open discharges (regulation of Iowa DNR), and review proposed subdivision plans and provides direction concerning sewage systems and water supply);
- conducting safety inspections (e.g., inspect tattoo parlors, food establishments, registered aquatic facilities, homes, hotels and motels, private sewage disposal systems, or tanning facilities);
- addressing complaints (e.g., receive and addresses environmental health related complaints); or
- providing education (e.g., provide 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. In SFY22, there were 34 counties in which environmental health staff were directly employed by the recognized local public health agency. The map below illustrates the environmental health staff type for each county. In SFY21 and SFY20, 31 and 29 counties respectively employed environmental health staff through the recognized local public health agency.



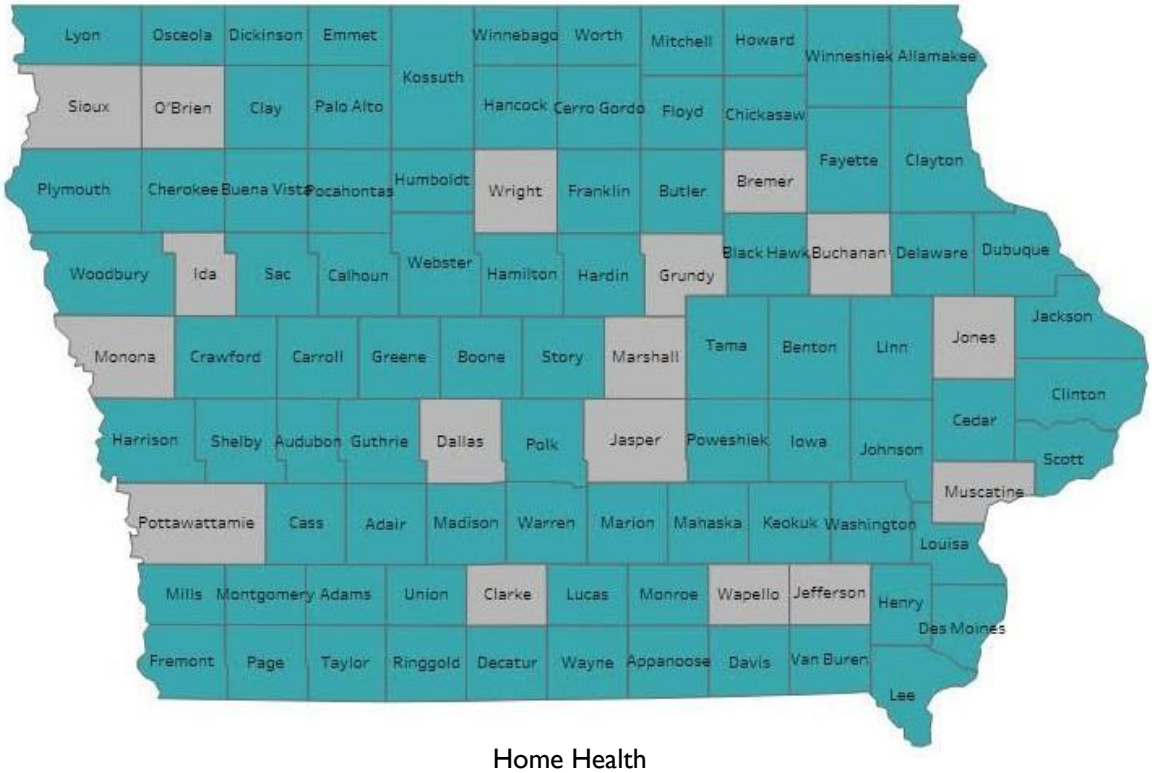
Environmental Health Staff
(EH staff employed by the Recognized Local Public Health Agency = green, EH staff not employed by the Recognized Local Public Health Agency = blue)

IOWA'S PUBLIC HEALTH SYSTEM

INDIVIDUAL COUNTY NEEDS - HOME HEALTH: Iowa Code Chapter 137 gives boards of health the authority to provide population-based activities and services and personal health services (i.e. home health) as may be deemed necessary for the promotion and protection of the health of the public 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 SFY22, 82 counties provided home health services either directly or through a contract with an outside agency. The map below shows the counties whose boards of health provided home health services.

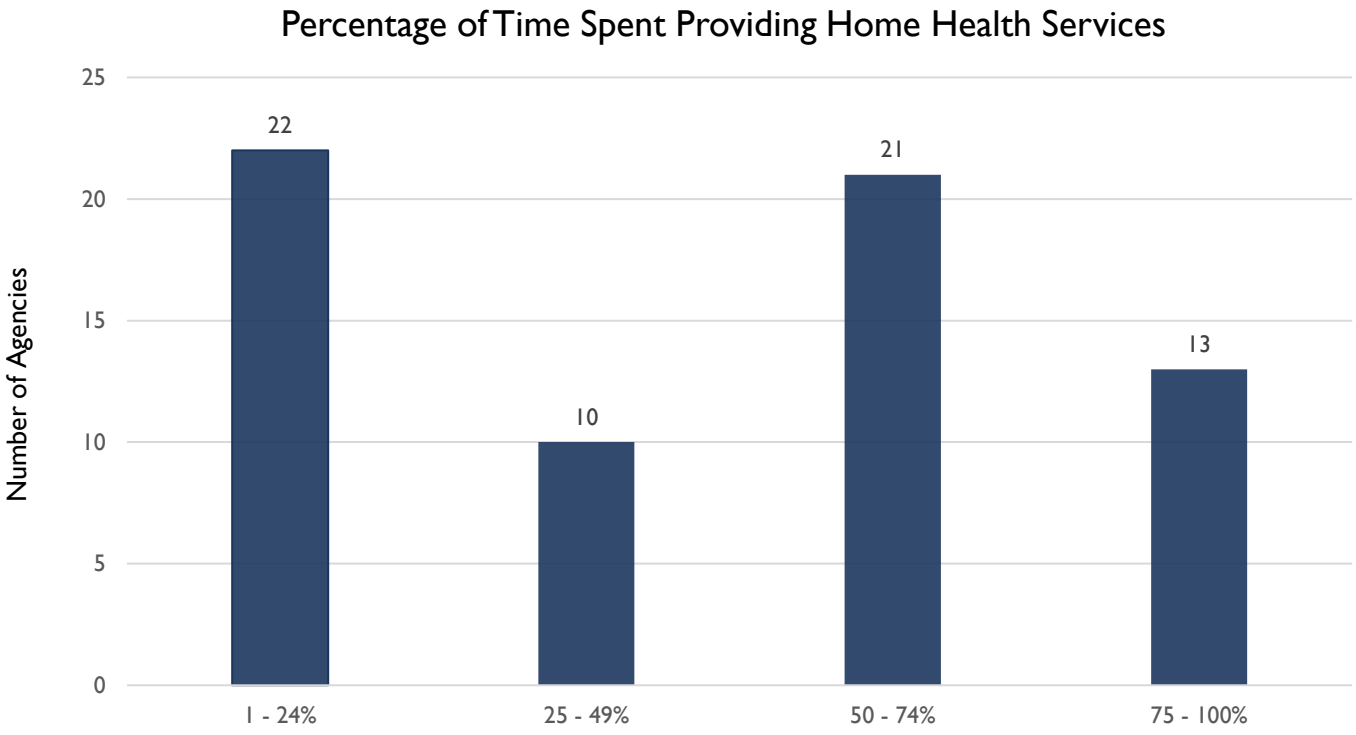


Home Health
(Board of Health provides home health= blue, Board of Health does not provide home health = gray)

Of the 82 counties that provided home health in SFY22, home health was provided by 66 recognized local public health agencies. Two counties contracted with the board of health of a contiguous county for services; one county contracted for services with the recognized local public health agency of a contiguous county. The remaining 13 counties contracted with an outside agency for home health 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. Certified status requires agencies to follow rules and regulations for each insurance provider. Those 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). Certified agencies receive revenue through claims to insurance providers in addition to county tax dollars. 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. Of the 66 recognized local public health agencies that provided home health in SFY22, 42 provided certified services.

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 chart below illustrates the percentage of work focused on home health services for the past fiscal year. Of the 66 recognized local public health agencies that provided home health services, 34 (52%) spent half or more of their time providing home health services.



IOWA'S PUBLIC HEALTH SYSTEM

LOCAL PUBLIC HEALTH STRUCTURES

The saying, "If you've seen one public health department in Iowa, you've seen one public health department" is often used when describing Iowa's complex local governmental public health system. However, 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 including where they are similar and where they are different. 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.

To note: In SFY22, two boards of health (Adams County and Audubon County) contracted for services with another board of health of a contiguous county. The Clayton County Board of Health directly contracted with the recognized local public health agency of a contiguous county for services. Responses for those three counties were incorporated into the respective responses of the lead recognized local public health agency's responses.

The eight structure documents can be found in Appendix B. Where relevant, data were broken down, analyzed, and reported by rural, micropolitan, and metropolitan counties.

LOCAL PUBLIC HEALTH AGENCIES

As a decentralized, home rule state with 99 county boards of health and 99 recognized local public health agencies, variability from county to county is expected. To gain a better understanding of the similarities and differences throughout the local governmental public health system, 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. To note, counties where a board of health contracts with the board of health of a contiguous county or contracts with the recognized local public health agency of a contiguous county are represented within the response of the contracted, recognized local public health agency. Consequently, the total number of respondents for a majority of the questions in the sections below equals 96 agencies.

INFRASTRUCTURE

LOCAL PUBLIC HEALTH INFRASTRUCTURE

"Local public health infrastructure includes the systems, competencies, frameworks, relationships, and resources that enable public health agencies to perform their core functions and essential services. Infrastructure categories encompass human, organizational, informational, legal, policy, and fiscal resources" (National Association of County and City Health Officials). The following infrastructure categories were included in the 2022 Local Public Health Systems Survey:

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

Results from each of the three categories are described in detail below.

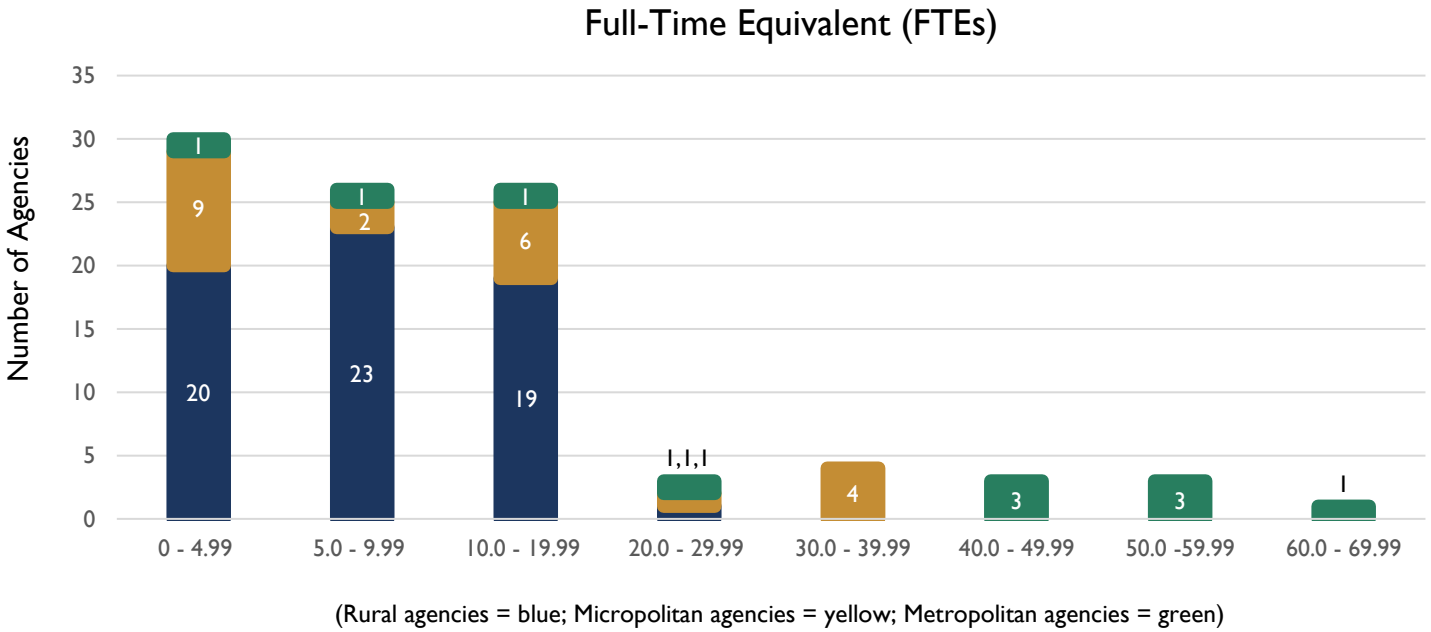
WORKFORCE: The heart of Iowa's public health system is the public health workforce. The breadth and depth of the workforce plays a key role in maintaining a strong system. Administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency; this included permanent full-time, permanent part-time, and temporary staff. As a whole, there were 1,216 FTEs (for 1,439 employees across all 96 agencies) at the end of SFY22. This was a 4.7% decrease in FTEs from SFY21; the number of FTEs reported in SFY22 were similar to the number of FTEs reported in SFY20 (1,211 FTEs). The minimum number reported by an administrator for an agency was 1.0 FTE; the maximum number reported was 64.1 FTEs. The minimum number of FTEs for SFY22 was the same as the minimum number of FTEs reported in SFY21. The maximum number of FTEs reported by an agency decreased by 35% between SFY21 and SFY22.

Population size was not a factor in determining the number of FTEs for an agency. The chart below provides information about FTEs as they relate to county population. The average number of FTEs has decreased from SFY20 to SFY22 for both rural and micropolitan counties; however, the average number of FTEs for metropolitan counties has increased during the same time period. Although the average number of FTEs looks to be proportionate to the population size, there are significant ranges for each population category.

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

INFRASTRUCTURE

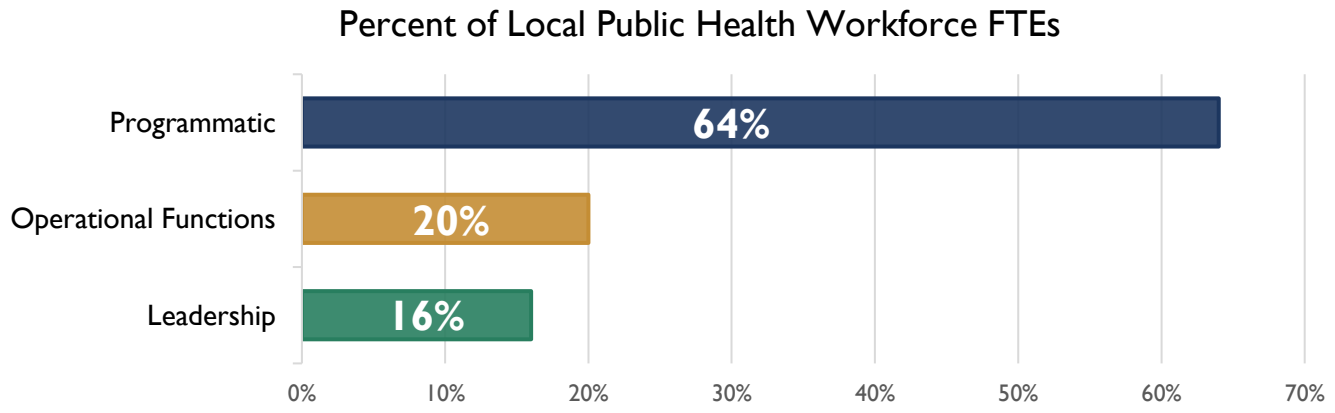
The chart below shows the breakdown of the number FTEs statewide. As demonstrated in both the table above and the chart below, there is great variability in the number of FTEs in agencies across the state. A majority of the recognized public health agencies employed less than 20.0 FTEs. One rural agency, five micropolitan agencies, and eight metropolitan agencies had 20.0 FTEs or more. There are also counties in which capacity is minimal to serve their population. Five administrators from rural, as well as micropolitan agencies, reported fewer than two FTEs. Half of the 22 micropolitan agencies reported 10.0 FTEs or less and one metropolitan administrator reported employing less than 5.0 FTEs.



(Rural agencies = blue; Micropolitan agencies = yellow; Metropolitan agencies = green)

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), and Programmatic (staff in a variety of areas providing activities and services to Iowans).

Statewide, programmatic roles made up 712.2 FTEs (64%), operational functions accounted for 225.7 FTEs (20%), and 173.7 FTEs (16%) were leadership roles.



INFRASTRUCTURE

WORKFORCE – AGENCY ADMINISTRATION: The position of local public health administrator is an important and vital role in protecting and improving the health of Iowans. Local public health administrators are responsible for the day-to-day operations of public health agencies, working 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 SFY22, there were 95 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 and one administrator oversaw services for Dubuque and Clayton counties. In addition to the 95 administrators, there were 78.65 FTEs dedicated to leadership roles within recognized local public health agencies.

Administrator turnover over the past fiscal year increased. There were 22 new local public health administrators in SFY22; compared to 12 new administrators in SFY21 and 16 in SFY20. Significant time goes into orienting new administrators both by state staff and local staff. The role of public health administrator is complex; administrators learn a great deal during the first few years.

56% of local public health administrators have been in their position ***less than five years.***

WORKFORCE – LOCAL PUBLIC HEALTH STAFF: Public health staff "protect and improve community well-being by preventing disease, illness and injury and impacting social, economic and environmental factors fundamental to excellent health" (National Association of County and City Health Officials). Each and every day, local public health staff work to deliver the 10 Essential Public Health Services:

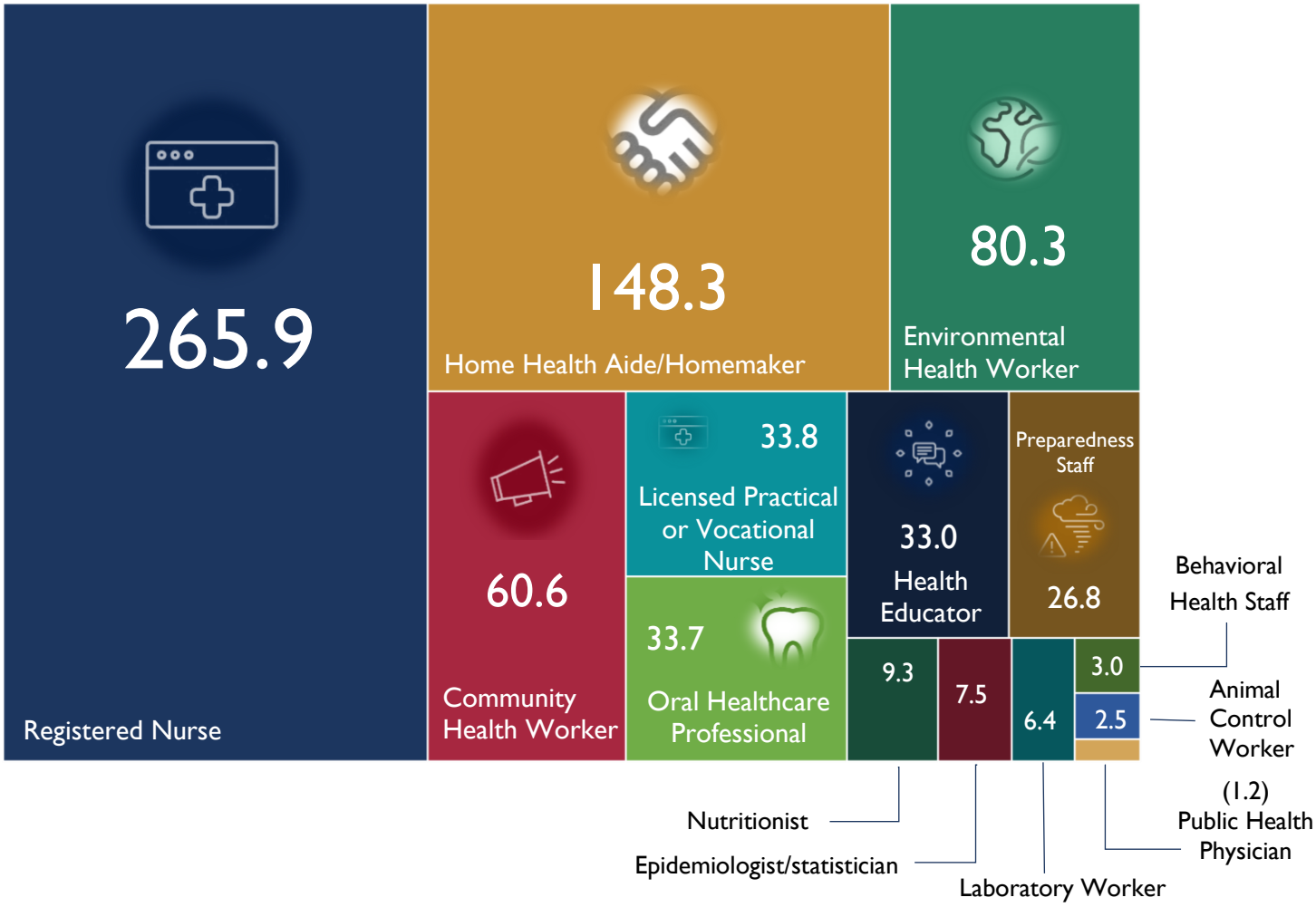
- assess and monitor population health status, factors that influence health, and community needs and assets,
- investigate, diagnose, and address health problems and hazards affecting the population,
- communicate effectively to inform and educate people about health, factors that influence it, and 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.

INFRASTRUCTURE

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

Environmental health workers represented 11% of programmatic staff. This number only includes environmental health workers employed by recognized local public health agencies.

Full-time Equivalents (FTEs) – Programmatic Staff



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 – 148.5 FTEs (66%)
- Business and financial operations staff – 67.0 FTEs (30%)
- Public information professional – 7.3 FTEs (3%)
- Information systems specialist – 3.0 FTEs (1%)

INFRASTRUCTURE

Local public health staff turnover remained similar between SFY22 (256 people) and SFY21 (251 people). Seventeen administrators reporting no loss of staff for SFY22 compared to 21 administrators in SFY21. Administrators were also asked to identify the positions that were most difficult to fill. The top two position categories were Registered Nurse (37 responses) and Nursing Aide/Home Health Aide/Homemaker (31 responses). The next highest categories were agency leadership including the Administrator (13 responses), and Health Educator (10 responses).

WORKFORCE – CONTRACTED STAFF AND INTERNS: In addition to full and part-time staff, public health agencies may utilize contracted staff or interns to complete the work necessary to meet the needs of their communities. In SFY22, 34% of administrators responded that they contracted for personnel and 32% used interns to help collect and analyze data or develop and implement public health activities. Temporary staff (contracted staff or interns) continue to be used each year to increase capacity at the local level.

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. Twenty-one percent 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), while 18% said they have developed high potential employees. Fourteen percent of administrators 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 SFY22. Workforce related barriers were reported by 51% of local public health administrators. They included:

- lack of staff,
- staff spread too thin among many services,
- recruitment and retention including not being able to compete with salaries, benefits, and flexible work schedules,
- competing priorities, staff pulled to assist with other duties, and staff time and bandwidth,
- lack of training opportunities,
- having qualified people and having the right person in the right position at the right time,
- burnout and fatigue, and
- the time needed to train new staff as well as completing their tasks when positions are open.

Emerging workforce related issues were noted by 16% of administrators. Those issues included:

- increased demand for work-life balance,
- workforce trauma and burnout leading to staff turnover and staff shortages in health care, public health and long-term care, and
- increasing number of local public health administrators nearing retirement age and lack of experienced public health leaders creates significant concern for succession planning.

INFRASTRUCTURE

REVENUE AND EXPENSES: "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). Budgeting is a complex business practice as both revenue and expenses can come from a variety of sources. Budgets from one public health agency are difficult to compare to another public health agency.

REVENUE: A number of 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
- 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 services provided within the county, the way in which the county is structured, the amount of investment in public health by the county board of supervisors, and other factors. Counties that provide a wide variety of population health activities and services have revenues larger than those counties that provide minimal population health due to grants and other resources they seek out to meet community needs. Counties that provide certified home health services typically demonstrate higher revenue as they provide home care to more clients than those counties that are decertified; certified agencies are 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 population health activities and services.

Amount invested in public health by Iowa's boards of supervisors in SFY22

$41,538,792

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. In SFY22, Iowa's boards of supervisors invested $41,538,792 in the local governmental public health system; a decrease of $224,779 from SFY21.

INFRASTRUCTURE

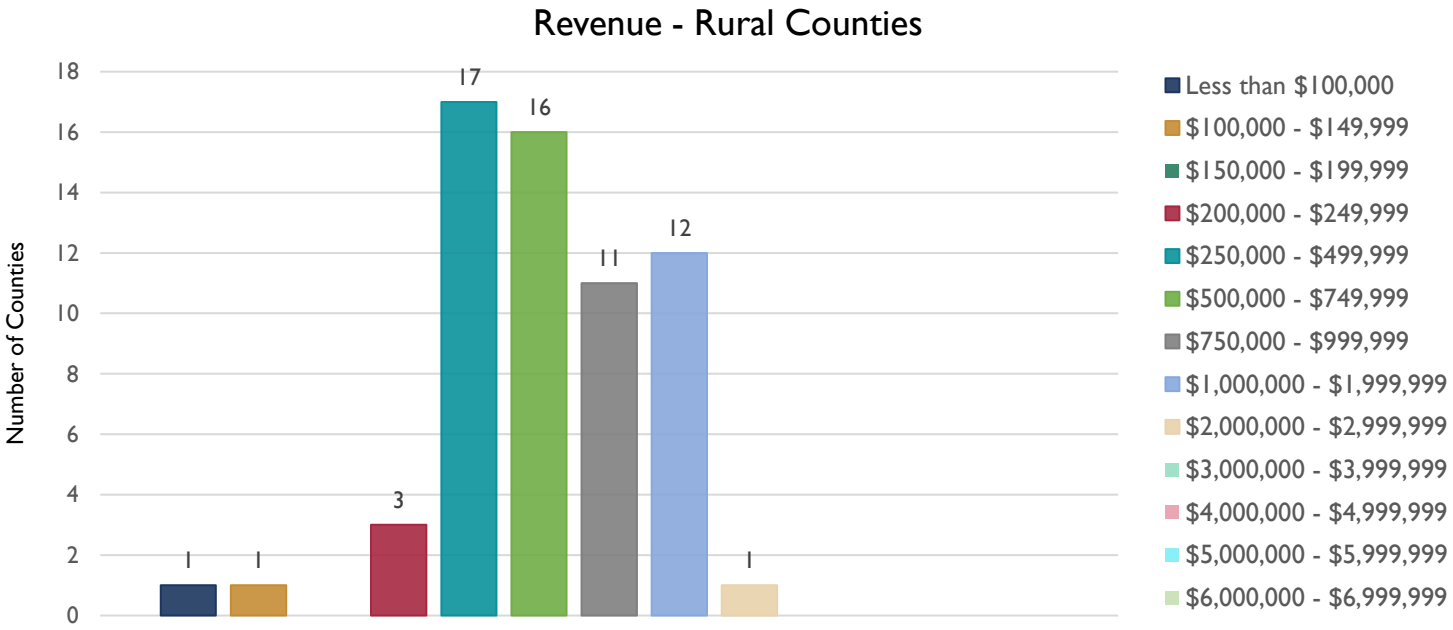
The chart below shows the amount of county tax dollars allocated to support local public health efforts in SFY22. Half of Iowa's counties received less than $200,000 in SFY22. Three counties reported receiving no support from their county board of supervisors.

BOS Allocation	Number of Counties	BOS Allocation	Number of Counties
Less than $100,000	17	$750,000 - $999,999	2
$100,000 - $149,999	22	$1,000,000 - $1,999,999	1
$150,000 - $199,999	12	$2,000,000 - $2,999,999	5
$200,000 - $249,999	9	$3,000,000 - $3,999,999	1
$250,000 - $499,999	24	$4,000,000 - $4,999,999	1
$500,000 - $749,999	4		

Administrators were asked to provide their agency's total revenue, including the amount of county tax dollars allocated by their board of supervisors, for SFY22. One county did not report revenue for this past fiscal year. Revenue for 95 of 96 counties totaled $123,651,332. (Note: The revenue for the three counties that contract for services with a contiguous county or agency appears in lead county's budget).

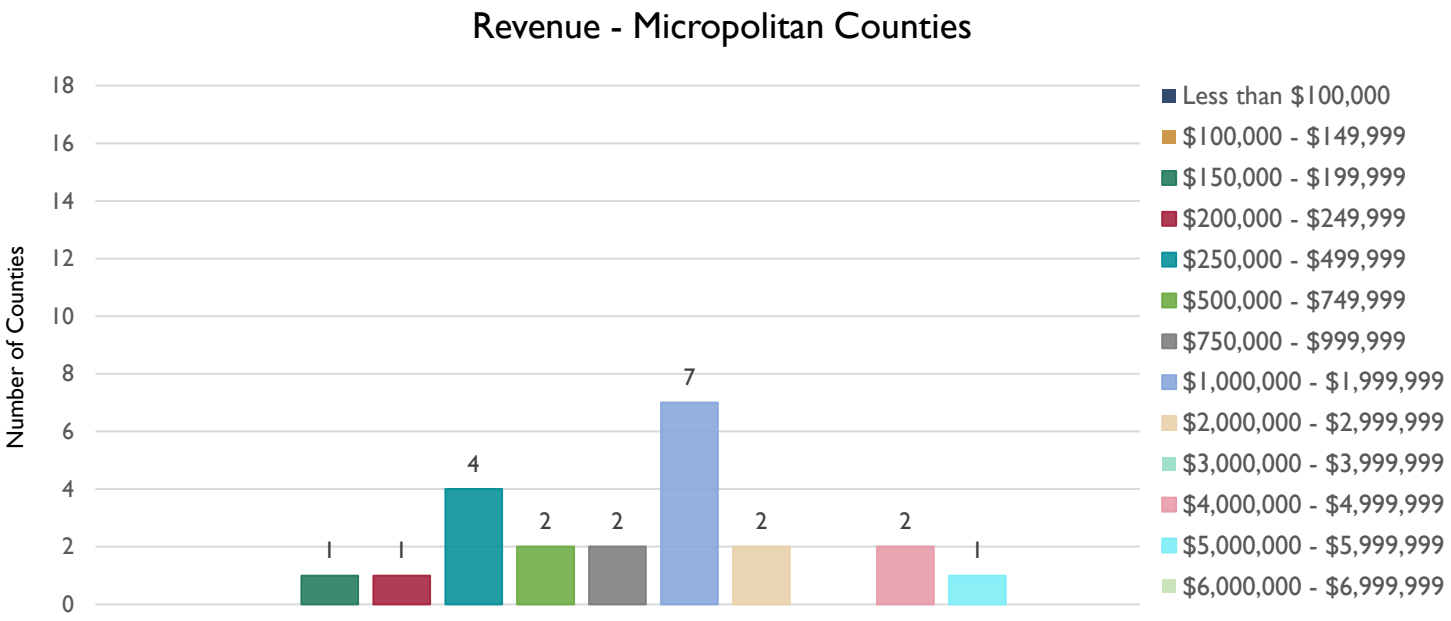
The charts below illustrate total revenue broken down by rural, micropolitan, and metropolitan counties.

Rural Counties: This chart shows the revenue ranges for 62 of 63 rural counties in Iowa. Population is not a determining factor for revenue for rural counties. Seventeen of the 62 counties fall within the $250,000 - $499,999 category for revenue; with one county in the less than $100,000 category and one in the $2,000,000 - $2,999,999 category.

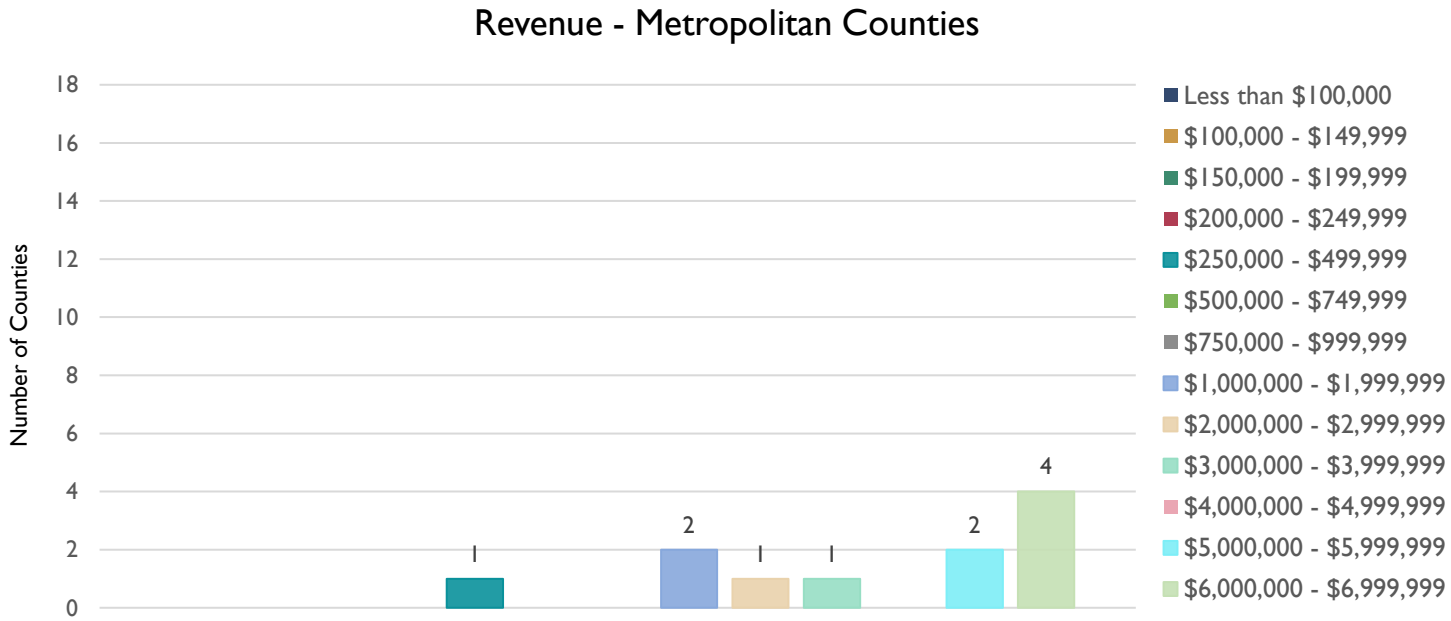


INFRASTRUCTURE

Micropolitan Counties: This chart shows the revenue ranges for the 22 micropolitan counties in Iowa. Population is not a determining factor for revenue for micropolitan counties. Seven of the 22 counties fell within the $1,000,000 - $1,999,999 category for revenue; with one county in the $150,000 - $199,999 category and one in the $5,000,000 - $5,999,999 category.



Metropolitan Counties: This chart shows the revenue ranges for the 11 metropolitan counties in Iowa. Similar to rural and micropolitan counties, population is not a determining factor for revenue for metropolitan counties. Four of the 11 counties fell within the $6,000,000 - $6,999,999 category for revenue; with one county in the $250,000 - $499,999 category. The agency that reported the most revenue in SFY22 was not the most populous county in the state.



INFRASTRUCTURE

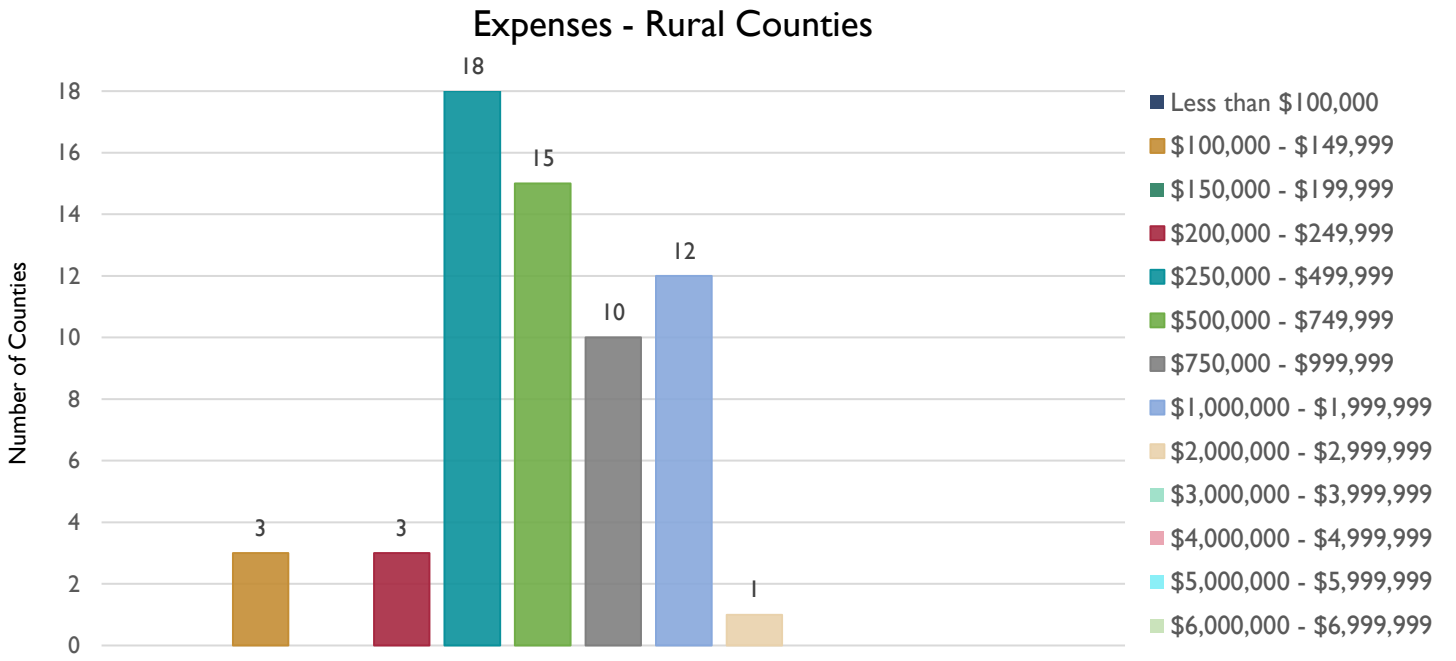
EXPENSES: Although a majority of expenses for a local public health agency come from salaries and fringe, there are a number of other necessary expenses over the course of a fiscal year. They can include, but are not limited to:

- 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 SFY22. One county did not report expenses for this past fiscal year. Expenses for 95 of 96 counties totaled $120,310,785. (Note: The expenses for the three counties that contract for services with a contiguous county or agency appears in lead county's budget).

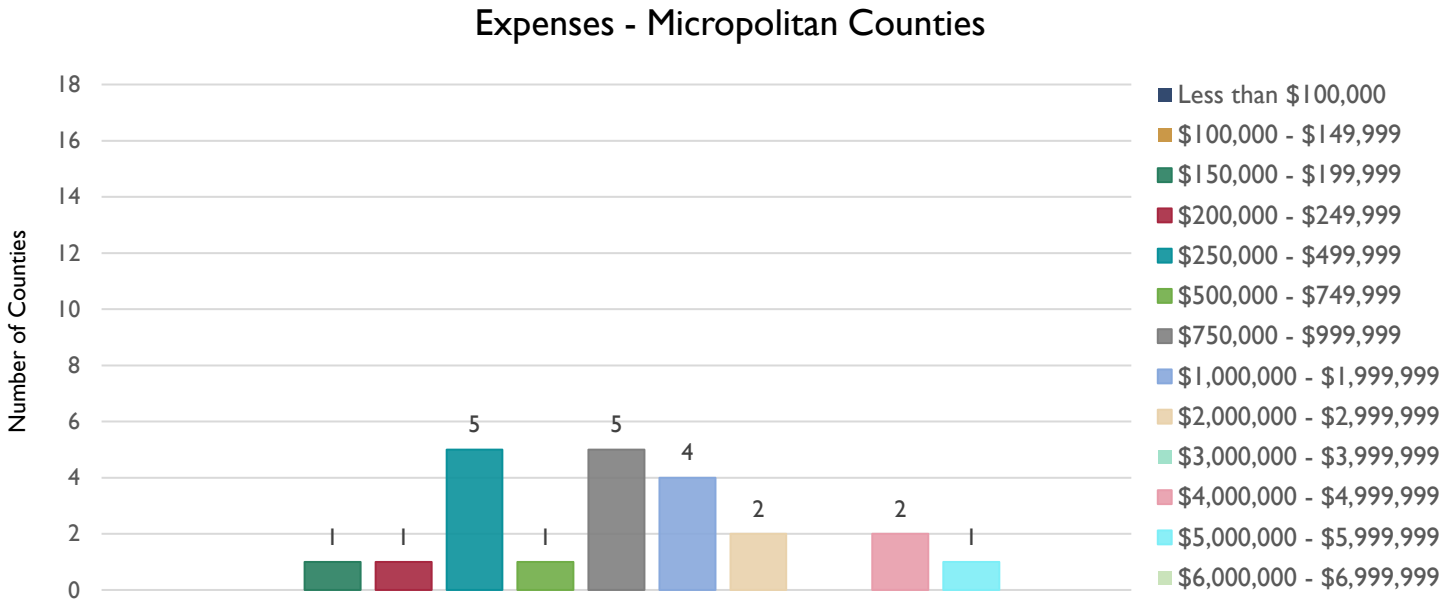
The charts below illustrate total expenses broken down by rural, micropolitan, and metropolitan counties.

Rural Counties: This chart shows the expense ranges for 62 of 63 rural counties in Iowa. Population is not a determining factor for expenses for rural counties. Eighteen of the 62 counties reported expenses in the $250,000 - $499,999 category; with three counties in the $100,000 - $149,999 category and one in the $2,000,000 - $2,999,999 category.

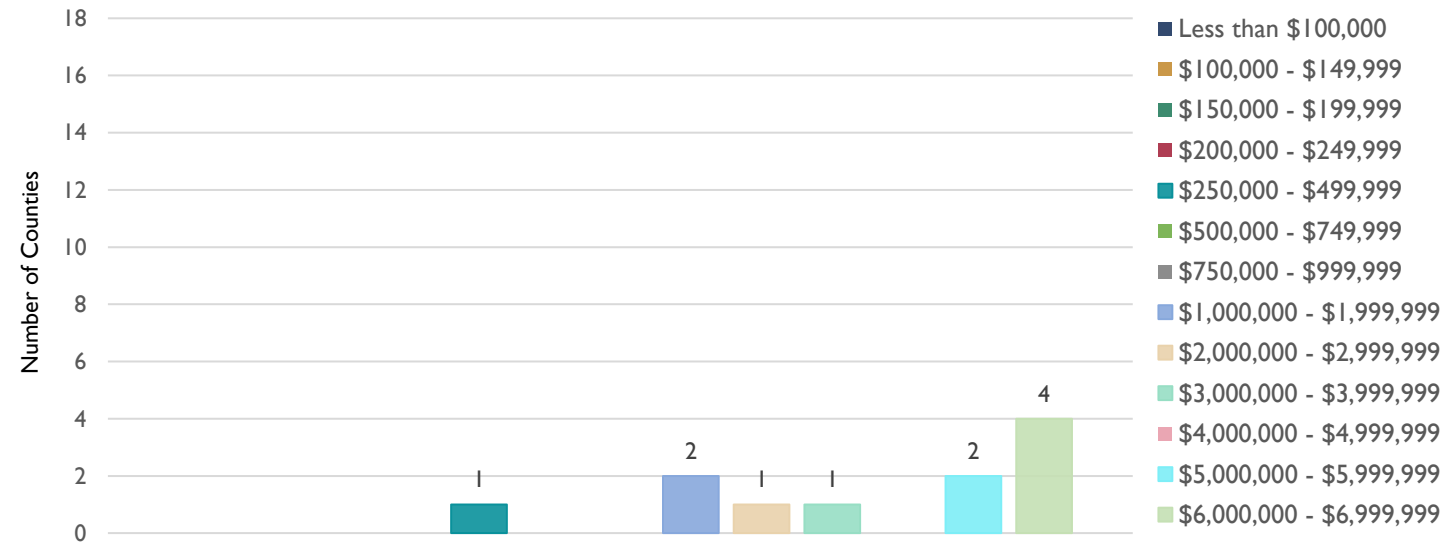


INFRASTRUCTURE

Micropolitan Counties: This chart shows the expense ranges for the 22 micropolitan counties in Iowa. Population is not a determining factor for expenses for micropolitan counties. Five of the 22 counties reported expenses in the $250,000 - $499,999 category and five in the $750,000 - $999,999 category. One administrator reported between $150,000 - $199,999 in expenses and one reported between $5,000,000 - $5,999,999.



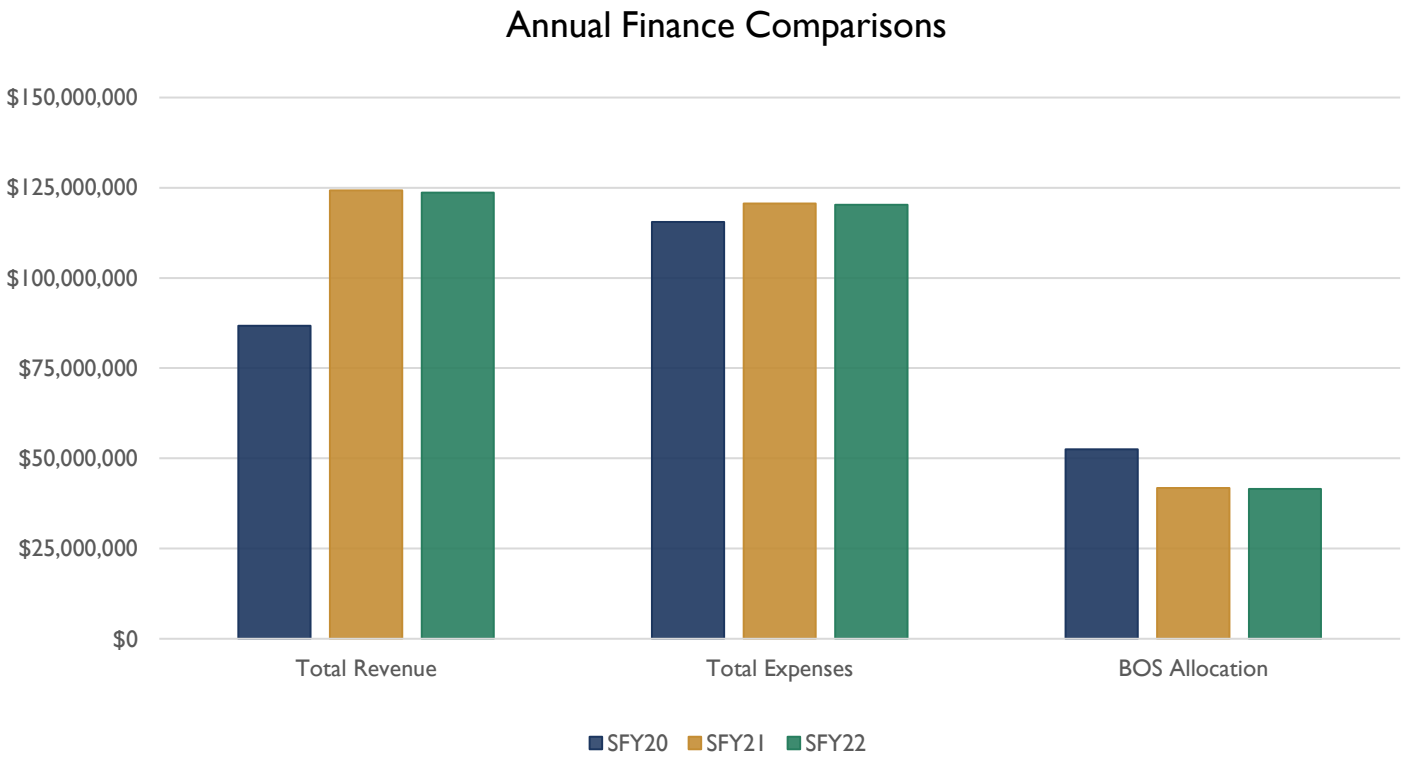
Metropolitan Counties: This chart shows the expense ranges for the 11 metropolitan counties in Iowa. As noted for rural and micropolitan counties, population is not a determining factor for expenses for metropolitan counties. Similar to the revenue chart for the 11 metropolitan counties, four of the 11 counties fell within the $6,000,000 - $6,999,999 category for expenses and one county in the $250,000 - $499,999 category. The agency that reported the highest expenses in SFY22 was not the most populous county in the state.



INFRASTRUCTURE

Expenses vary based on the level of services provided within the county (and the staff needed to meet the needs of the community), the way in which the county is structured, 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. In addition, 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 three fiscal years. The comparisons show an increase in revenue from SFY20 to SFY21 and a slight increase in expenses for that same time period. 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. Since January 2020, public health agencies were called to safeguard the public's health in a way very few people have witnessed. This increased ask of public health was supported by COVID relief funds in SFY21 and SFY22. Reciprocally, board of supervisor allocations decreased over the same time period.



INFRASTRUCTURE

REVENUE AND EXPENSES - BARRIERS AND EMERGING ISSUES: Administrators were asked to report the challenges and emerging issues their agency encountered in SFY22. Finance related barriers were reported by 60% of local public health administrators. They included:

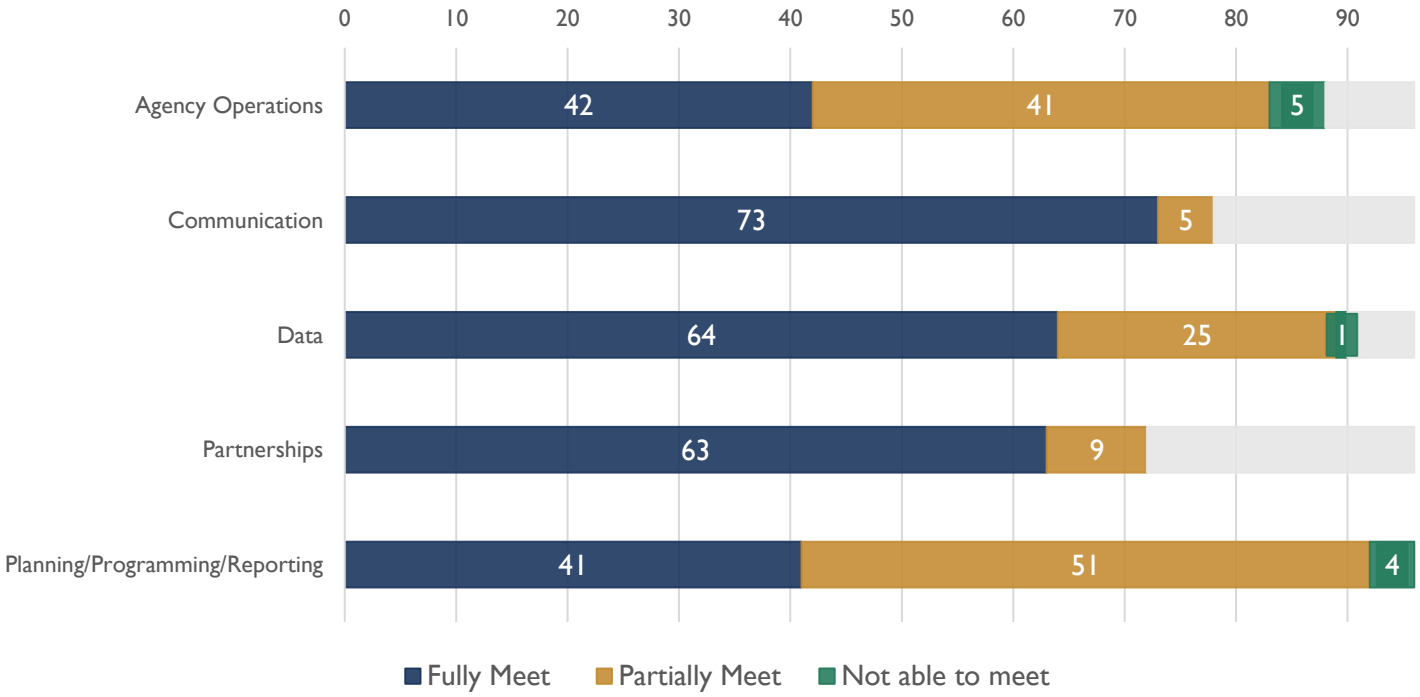
- lack of funding (from the state and local levels) to operate programs,
- lack of funding to meet the gaps and needs for population health and infrastructure building,
- state and local funding is not aligned with service delivery expectations - the request of all programs and grants to "do more with less",
- increased requirements and administrative burden for grants with decreased funding,
- changes in the way funding is allowed to be spent,
- lack of sustainable and flexible funding, and
- the inability for local public health to bill Medicaid and provide screening services in schools.

Emerging finance related issues were noted by 9% of administrators. Those issues included:

- funding for local public health,
- flexible infrastructure funding,
- political pressure to reduce public health funding,
- alterations in infrastructure changes related to funding,
- struggles when transitioning to new payment systems for home care, and
- public health system changes are making it more difficult to serve individuals in need.

INFRASTRUCTURE

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 gray boxes below). The chart below shows local public health agencies' ability to meet each infrastructure category. If an administrator responded that they could fully meet at least half or more of the capabilities in the category, they appear in the blue portion (first section) of the column; could partially meet at least half or more of the capabilities in the category, they appear in yellow (second section); or is not able to meet half or more of the capabilities in the category, they appear in green (third section), if applicable. Communication is the strongest category followed by Data and Partnerships. 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.



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

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

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

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

INFRASTRUCTURE

A number of key capabilities relate to an agency's ability to assess the health of their communities, develop a plan to meet identified needs, and implement strategies to improve health. At the local level this formal process, called Community Health Assessment and Community Health Improvement Planning (CHA CHIP), takes place at least every five years. Agency staff either facilitate the process or participate in a process conducted by one of their community partners. When asked about the assessment process for their county, a majority of administrators (66%) responded that their county government based public health agency takes the lead. For those counties that indicated the process is led by their local hospital, 64% responded that the CHA CHIP is completed by the public health department in the hospital. Six administrators also reported their CHA CHIP process is conducted in conjunction with multiple partners (e.g. health systems, human service organizations, or other recognized local public health agencies).

For the past several years, Iowa has emphasized the importance of healthy equity. 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). These efforts are also 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.

	Not True	Somewhat True	Very True	I Don't Know
My agency has the funding to address social determinants of health.	28%	59%	11%	2%
My agency has staff members trained to address social determinants of health.	19%	59%	20%	2%
My agency has engaged with local governmental agencies or other external organizations to support policies and programs to achieve health equity.	9%	60%	28%	2%
My agency considers health equity issues in program planning and implementation.	0%	48%	51%	1%

High performing local public health agencies allocate resources to build public health capacity and meet the foundational capabilities. Agencies can be assessed and recognized nationally for their commitment to quality through an accreditation process. The national health department accreditation program, administered by the Public Health Accreditation Board (PHAB), was launched in September 2011. Six recognized local public health agencies have completed the accreditation process and are recognized by PHAB as an accredited health department. Those six agencies are:

- Black Hawk County Health Department
- Cerro Gordo (CG) Public Health
- Johnson County Public Health
- Linn County Public Health
- Scott County Health Department
- Siouxland District Health Department

INFRASTRUCTURE

FOUNDATIONAL CAPABILITIES – BARRIERS AND EMERGING ISSUES: When asked about emerging issues and barriers, many administrators gave responses that reflected the five foundational capabilities categories. Responses that have not already been mentioned in other sections of this report included:

Agency Operations

- Lack of public health infrastructure and disjointed linking with the state department; inability to plan at the local level because of lack of involvement with comprehensive planning
- Lack of space and storage
- Supply chain interruptions
- Time; multiple competing priorities and often things get pushed back

Data

- Difficulty collecting meaningful data that supports efforts and shows improved outcomes
- Lack of data surveillance activities
- Manipulation of data by special interest groups and politicians that changes the story public health is attempting to tell
- Need for modernized data infrastructure and joint surveillance system

Planning/Programming/Reporting

- Ability to drive change in our county - obesity, poverty, drug abuse, etc...
- Lack of buy in by community members and groups; lack of community readiness for change
- Lack of interest and participation in programs especially among the populations that could most benefit; consumer apathy
- Public not understanding the role of local public health

Communication

- Availability of interpreters
- Barriers in communication outside of social media
- Communication late from higher ups
- Community fatigue with health messaging
- Conflicting information or miscommunication
- Lack of education or outreach materials in languages other than English

Partnerships

- Communication channels (or lack of) between like agencies to form partnerships
- Community partners are overworked, understaffed, and can't continue to help on projects
- Disconnect between evidence-based issues and goals of partner organizations
- No local partnerships to give quality services
- Reactive services vs proactive, preventative planning
- Service providers with strong perceptions contradictory to local data

SERVICE DELIVERY

SERVICE DELIVERY

In Iowa, local public health is governed and operated through local control. 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 residents in the county. 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; where as 69% of recognized local public health agencies provide home health services. Funding and staff capacity also play a role in the number and types of activities and services provided within a county.

There are a variety of population-based activities and services. Administrators were asked to provide a detailed list of areas of programming that their agency provides. Ninety-two of 96 administrators responded to the question. The responses provided were then sorted into one of 14 population-based areas.

Two-thirds of administrators responded that they provide 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 (93%)

EMERGENCY PREPAREDNESS AND RESPONSE (88%)

IMMUNIZATION AND TUBERCULOSIS (93%)

PUBLIC INFORMATION, HEALTH EDUCATION, AND COMMUNITY ENGAGEMENT (70%)

Administrators also provided responses about specialized activities and services to meet community needs. Those activities and services, and the percentage of administrators that provided a response for each area, were:

- Family Health (57%)
- Environmental Health (38%)
- Screening & Assessment (29%)
- Chronic Disease and Disability Prevention and Management (28%)
- Injury Prevention (20%)
- Tobacco Use Prevention and Control (17%)
- Nutrition and Physical Activity (16%)
- HIV, STI, and Hepatitis (10%)
- Behavioral Health (8%)
- Substance Use Disorder Prevention (5%)

Although service delivery in the top four areas listed above was consistent for most counties, there were differences across population categories. Twenty-eight percent of rural counties provided injury prevention services; in comparison to no micropolitan counties and 9% of metropolitan counties. For micropolitan counties, 40% provided chronic disease and disability prevention and management services: whereas only 21% of rural counties and 45% of metropolitan counties provided these services.

SERVICE DELIVERY

The percentage of counties that provided family health services was similar for both rural and metropolitan counties (52% and 55% respectively); however, 70% of micropolitan counties provided family health services. The percentage of metropolitan counties that provided specialized activities and services was higher than both rural and micropolitan counties in eight of the 10 service categories: behavioral health; chronic disease and disability prevention and management; environmental health; HIV, STI, and Hepatitis; nutrition and physical activity; screening & assessment; substance use disorder prevention; 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 was 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.

Public Health Program	Percent of population served by local public health agencies SFY20	Percent of population served by local public health agencies SFY21	Percent of population served by local public health agencies SFY22
Cancer Screening & Detection and WISEWOMAN	Not collected	89% of recipients received screening and lifestyle intervention services	97% of recipients received screening and lifestyle intervention services
Child Health	42% of all child health clients	52% of all child health clients	58% of all child health clients
Influenza (flu) vaccine**	5% of all influenza vaccine given	4% of all influenza vaccine given	4% of all influenza vaccine given
Maternal Health	24% of all maternal health clients	28% of all maternal health clients	34% of all maternal health clients
Oral Health (I-Smile)	57% of all kids served by I-Smile	63% of all kids served by I-Smile	61% of all kids served by I-Smile
Oral Health (I-Smile Silver)	100% of all individuals served by I-Smile Silver	100% of all individuals served by I-Smile Silver	100% of all individuals served by I-Smile Silver
Supplemental Nutrition Program for Women, Infants, and Children (WIC)	15% of all WIC participants	14% of all WIC participants	16% of all WIC participants

SERVICE DELIVERY – BARRIERS AND EMERGING ISSUES: The top five emerging issues and barriers categories related to service delivery were: communicable diseases (COVID-19, Monkey Pox, Tuberculosis); mental health; chronic disease; disparities, health equity, and accessibility; and substance abuse.

CROSS-JURISDICTIONAL SHARING

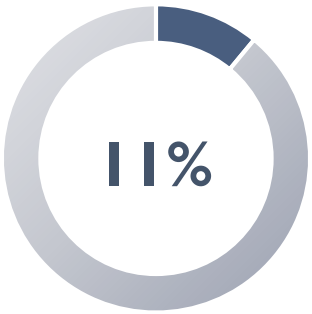
CROSS-JURISDICTIONAL SHARING

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; examples might include regional preparedness plans or community health improvement plans.
>
> 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.

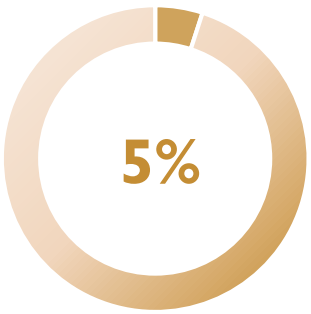
Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency currently shares the delivery of services or staff with another agency, and two questions to gauge the extent of which their agency would consider sharing the delivery of services or staff with another agency. The statewide data for SFY22 showed the following.

Currently shares the delivery of services



Sixty-three agencies reported they minimally or do not currently share the delivery of services; while 22 reported they somewhat share the delivery of services. Eleven agencies (11%) reported they significantly or completely share the delivery of services.

Currently shares staff with another agency

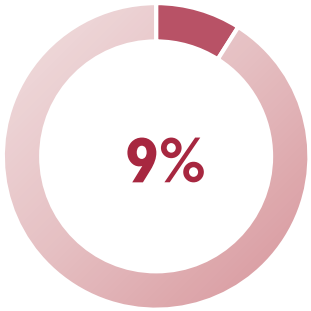


Eighty-one agencies reported they minimally or do not share staff with another agency; while 10 reported they somewhat share staff. Five agencies (5%) reported they significantly or completely share staff with another agency.

Would consider sharing the delivery of services

Thirty-six agencies reported they would somewhat consider sharing the delivery of services with another agency. Fifteen agencies (16%) reported they would significantly or completely consider sharing; while 45 agencies would minimally consider or would not at all consider sharing the delivery of services.

Would consider sharing staff with another agency



Thirty-one agencies reported they would somewhat consider sharing staff with another agency. Nine agencies (9%) reported they would significantly or completely consider sharing staff; while 55 agencies would minimally consider or would not at all consider sharing the delivery of services.

CONCLUSION

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

When reviewing the responses provided by administrators the saying, "when you've seen one recognized local public health agency in Iowa, you've seen one agency" holds true.

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, service delivery, workforce, funding and the level of board of supervisor investment in public health, or even 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 opportunities for state, local, and other partners to work together to enhance and advance Iowa's public health system.

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Appendix A: 2022 Local Public Health Systems Survey Questions and Data Tables

SURVEY QUESTIONS AND DATA TABLES

In August 2022, 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 2022 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 = 95)
Black or African American	1
White	94

Question 4: Please identify your age.

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

Question 5: Please identify your gender.

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

,

Question 6: Who leads the community health assessment (CHA) for your county?

Leads Community Health Assessment	Number of Counties (n = 96)
Another county's public health agency	2
Hospital	25
The county government based public health agency	63
Other	6

WORKFORCE

Question 7: What was the total number of FTEs in your agency/department at the conclusion of FY 22 (July 1, 2021 - June 30, 2022)? (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

FTE Range	Number of Agencies (n = 96)
0 – 4.99	30
5.0 – 9.99	26
10.0 – 19.99	26
20.0 – 29.99	3
30.0 – 39.99	4
40.0 – 49.99	3
50.0 – 59.99	3
60.0 – 69.99	1

Question 8: What number of the 0.00 FTE's (as reported in question 7) are allocated to each of the job categories below?

Job Category	Total FTEs, Number of Agencies Reporting		
	SFY20	SFY21	SFY22
Agency administrator	101.7 (96)	Not asked	95.0 (96)
Agency leadership	Not asked	154.4 (97)	Not asked
Agency leadership, not including agency administrator	Not asked	Not asked	78.7 (35)
Animal control worker	Not asked	5.5 (5)	2.5 (1)
Behavioral health staff	10.6 (9)	8.3 (5)	3.0 (3)
Business and financial operations staff	Not asked	68.2 (50)	67.0 (49)

Question 8 continued.

Job Category	Total FTEs, Number of Agencies Reporting		
	SFY20	SFY21	SFY22
Care administrator/coordinator	43.9 (34)	Not asked	Not asked
Chronic disease care coordinator	10.2 (8)	Not asked	Not asked
Clerical	156.6 (88)	Not asked	Not asked
Community health worker	Not asked	54.1 (23)	60.6 (23)
Dental hygienist	26.9 (14)	Not asked	Not asked
Environmental health administrator	26.1 (27)	Not asked	Not asked
Environmental health specialist (non-managers)	64.1 (29)	Not asked	Not asked
Environmental health worker	Not asked	86.4 (34)	80.3 (31)
Epidemiologist/ statistician	Not asked	9.2 (11)	7.5 (7)
Financial specialist	41.9 (38)	Not asked	Not asked
Health educator	29.2 (25)	29.7 (28)	33.0 (26)
Home health aide (providing direct care)	175.8 (63)	Not asked	Not asked
Home health nurse (providing direct care)	135.9 (53)	Not asked	Not asked
Information systems specialist	Not asked	6.5 (6)	3.0 (4)
Laboratory worker	Not asked	8.1 (6)	6.4 (4)
Licensed practical or vocational nurse	Not asked	31.3 (24)	33.8 (29)
Non-STD infectious disease investigator who enters data into IDSS	42.9 (37)	Not asked	Not asked
Nursing aide/home health aide/homemaker	Not asked	166.9 (67)	148.3 (55)
Nutritionist	14.1 (7)	10.3 (5)	9.3 (4)
Office and administrative support staff	Not asked	152.1 (79)	148.5 (81)
Oral healthcare professional	Not asked	25.8 (15)	33.8 (15)
Physician/Nurse Practitioner/Physician Assistant	5.0 (7)	Not asked	Not asked
Preparedness staff	30.1 (48)	40.6 (39)	26.8 (29)
Public health nurse	166.1 (83)	Not asked	Not asked
Public health physician	Not asked	2.5 (4)	1.2 (3)
Public information professional	Not asked	10.4 (15)	7.3 (8)
Registered nurse	Not asked	322.5 (93)	265.9 (85)
Social worker	26.9 (14)	Not asked	Not asked
Other	143.0 (42)	151.0 (37)	Not asked

SURVEY QUESTIONS AND DATA TABLES

Question 9: What is the total number of employees in your agency/department at the conclusion of FY22 (July 1, 2021 - June 30, 2022)?

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

Question 10: What is the total number of employees in your agency/department, that only implement public health interventions (i.e., population health)?

Fiscal Year	Number of Employees Public Health Interventions (n = 96)
SFY22	380

Question 11: What is the total number of employees in your agency/department, that only provide personal health services (i.e., population health)?

Fiscal Year	Number of Employees Personal Health Services (n = 96)
SFY22	350

Question 12: What is the total number of employees, in your agency/department, that provide personal health services (i.e., non-population health) AND implement public health interventions (i.e., population health)?

Fiscal Year	Number of Employees Public Health Interventions and Personal Health Services (n = 96)
SFY22	678

Question 13: Please identify which jobs you have had difficulties filling in your agency/department in the last year (select all that apply).

Job Category	Number of Agencies		
	SFY20	SFY21	SFY22
Agency leadership (includes the administrator	Not asked	7	13
Animal control worker	Not asked	1	0
Behavioral health staff	2	2	2
Business and financial operations staff	Not asked	1	1
Care administrator/coordinator	1	Not asked	Not asked
Community health worker	Not asked	6	7

Question 13 continued.

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

Question 14: How many staff departed your department/agency in FY22 (July 1, 2021 - June 30, 2022)? (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

SURVEY QUESTIONS AND DATA TABLES

Question 15: How many open positions do you have now (as of June 30, 2022)?

Fiscal Year	Total Number of Open Positions, Number of Agencies Reporting
SFY20	Not asked
SFY21	79 (45)
SFY22	80 (43)

Question 16: My agency has implemented succession planning including:

Succession Planning Activities	Number of Agencies (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

Question 17: Did you use interns to help collect and analyze data, and/or develop and implement public health activities?

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

Question 18: Did you contract for personnel in FY 22 (July 1, 202 - June 30, 2022)?

Contracted for Personnel	Number of Agencies (n = 96)
No	63
Yes	33

Question 19: How many years has each member been serving on the local board of health?

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

Question 19 continued.

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

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

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

Question 20: Please indicate the number of board of health members who have an occupational background in the following areas. Each board of health member should only be counted once.

Background	Number of Board of Health Members		
	SFY20	SFY21	SFY22
Animal science/veterinarian	23	24	27
Clerical	6	9	11
Craftsperson	0	2	0
Education	27	34	32

Question 20 continued.

Background	Number of Board of Health Members		
	SFY20	SFY21	SFY22
Elected officials	Not asked	53	56
Farmer	26	14	14
Finance	Not asked	9	14
Labor	3	4	2
Legal	Not asked	8	7
Managers/administration	45	23	33
Professional	39	18	40
Professional - medical	259	254	258
Religious	2	5	3
Sales	9	8	6
Self-employed	17	30	19
Service	5	15	12
Other	42	18	12

Question 21: Of the number of board of health members reported in question 19 how many are retired?

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

SERVICES

Question 22: What percentage of your agency's/department's work is providing home health care?

Home Care Provision	Number of Agencies		
	SFY20 (n = 96)	SFY21 (n = 96)	SFY22 (n = 96)
0%	Category not asked	28	30
1-24%	Category not asked	24	22
25-49%	9	12	10
50-74%	20	17	21
75-100%	16	15	13

Question 23: What areas of programming does your agency/department provide?

Administrators were able to write a list of programs, services and activities that their agency provides in a blank field. Responses were analyzed and a summary of the most frequent answers appear in the final report under Service Delivery.

SURVEY QUESTIONS AND DATA TABLES

Question 24: Please indicate which answer best reflects the agency/department's current practice.

Share Services	Number of Agencies		
	SFY20: To what extent do you share the delivery of public health services with another agency? (n = 97)	SFY21: To what extent do you share the delivery of public health services with another agency? (n = 98)	SFY22: To what extent do you share the delivery of public health services with another agency? (n = 96)
Completely	1	1	1
Minimally	20	19	22
Not at all	34	37	41
Significantly	9	12	10
Somewhat	33	29	22

Share Staff	Number of Agencies		
	SFY20: To what extent do you share staff with another agency? (n = 97)	SFY21: To what extent do you share staff with another agency? (n = 98)	SFY22: To what extent do you share staff with another agency? (n = 96)
Completely	1	0	1
Minimally	9	12	13
Not at all	75	73	68
Significantly	2	7	4
Somewhat	10	6	10

Question 25. Please indicate which answer best reflects what you may be willing to consider sharing in the future.

Consider Sharing Services	Number of Agencies		
	SFY20: To what extent would you consider sharing the delivery of public health services with another agency? (n = 97)	SFY21: To what extent would you consider sharing the delivery of public health services with another agency? (n = 98)	SFY22: To what extent would you consider sharing the delivery of public health services with another agency? (n = 96)
Completely	8	4	2
Minimally	18	24	31
Not at all	17	17	14
Significantly	11	14	13
Somewhat	43	39	36

Question 25 continued.

Consider Sharing Staff	Number of Agencies		
	SFY20: To what extent would you consider sharing staff with another agency? (n = 97)	SFY21: To what extent would you consider sharing staff with another agency? (n = 98)	SFY22: To what extent would you consider sharing staff with another agency? (n = 95)
Completely	16	3	2
Minimally	22	33	35
Not at all	30	23	20
Significantly	8	15	7
Somewhat	29	24	31

Question 26: Do you have staff available during business hours to collect and transport patient samples associated with outbreaks and high priority issues?

Staff Available	Number of Agencies		
	SFY20 (n= 96)	SFY21 (n= 98)	SFY22 (n = 96)
No	18	15	14
Yes	78	83	82

Question 27: Do you have staff available after hours to collect and transport patient samples associated with outbreaks and high priority areas?

Staff Available	Number of Agencies		
	SFY20 (n= 96)	SFY21 (n= 98)	SFY22 (n = 96)
No	31	22	25
Yes	65	76	71

EMERGING ISSUES

Question 28: What are the emerging public health issues your county has experienced in fiscal year 22 (July 1, 2021 - June 30, 2022)?

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 29: What barriers do you experience in providing services to your county?

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

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

Question 30: Funding to Address Social Determinants	Number of Agencies		
	SFY20: My health department has the funding to address social determinants of health.	SFY21: My health department has the funding to address social determinants of health. (n = 96)	SFY22: My health department has the funding to address social determinants of health. (n = 95)
I don't know	Not asked	5	2
Not true	Not asked	26	27
Somewhat true	Not asked	54	56
Very True	Not asked	11	10

Question 31: Staff Trained	Number of Agencies		
	SFY20: My health department has staff members trained to address social determinants of health.	SFY21: My health department has staff members trained to address social determinants of health. (n = 96)	SFY22: My health department has staff members trained to address social determinants of health. (n = 96)
I don't know	Not asked	1	2
Not true	Not asked	17	18
Somewhat true	Not asked	58	57
Very True	Not asked	20	19

Question 32: Engaged with Partners	Number of Agencies		
	SFY20: My health department/agency has engaged with local governmental agencies or other external organizations to support policies and programs to achieve health equity. (n = 97)	SFY21: My health department/agency has engaged with local governmental agencies or other external organizations to support policies and programs to achieve health equity. (n = 96)	SFY22: My health department/agency has engaged with local governmental agencies or other external organizations to support policies and programs to achieve health equity. (n = 96)
I don't know	4	1	2
Not true	12	7	9
Somewhat true	47	60	58
Very True	34	28	27

Question 33: Considered in Planning and Implementation	Number of Agencies		
	SFY20: My health department/agency considers health equity issues in program planning and implementation. (n = 97)	SFY21: My health department/agency considers health equity issues in program planning and implementation. (n = 97)	SFY22: My health department/agency considers health equity issues in program planning and implementation. (n = 96)
I don't know	3	2	1
Not true	5	2	0
Somewhat true	39	45	46
Very True	50	48	49

BUDGET

Question 34: What was your agency's/ department's total revenue without county tax allocation for FY22 (July 1, 2021 - June 30, 2022)? Please round to the nearest dollar.

Fiscal Year	Total Revenue Without County Tax Allocation (Statewide)
SFY20	$34,238,777
SFY21	$82,501,564
SFY22	$82,501,832

SURVEY QUESTIONS AND DATA TABLES

Question 36: How much money did the agency/department receive from the county board of supervisors to support agency/department services in FY 22 (July 1, 2021 - June 30, 2022)? Please round to the nearest dollar.

Fiscal Year	Total Funds Received from County Boards of Supervisors (Statewide)
SFY20	$52,505,982
SFY21	$41,763,571
SFY22	$41,538,792

Funds Received from County Boards of Supervisors	Number of Agencies (n = 98)
Less than $100,000	17
$100,000 - $149,999	22
$150,000 - $199,999	12
$200,000 - $249,999	9
$250,000 - $499,999	24
$500,000 - $749,999	4
$750,000 - $999,999	2
$1,000,000 - $1,999,999	1
$2,000,000 - $2,999,999	5
$3,000,000 - $3,999,999	1
$4,000,000 - $4,999,999	1

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

Total Revenue	Number of Agencies (n = 95)		
	Rural	Micropolitan	Metropolitan
Less than $100,000	1	0	0
$100,000 - $149,999	1	0	0
$150,000 - $199,999	0	1	0
$200,000 - $249,999	3	1	0
$250,000 - $499,999	17	4	1
$500,000 - $749,999	16	2	0
$750,000 - $999,999	11	2	0
$1,000,000 - $1,999,999	12	7	2
$2,000,000 - $2,999,999	1	2	1
$3,000,000 - $3,999,999	0	0	1
$4,000,000 - $4,999,999	0	2	0
$5,000,000 - $5,999,999	0	1	2
$6,000,000 - $6,999,999	0	0	4

SURVEY QUESTIONS AND DATA TABLES

Question 35: What were your agency's/ department's total expenditures for FY 22 (July 1, 2021 - June 30, 2022)?

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

Total Expenses	Number of Agencies (n = 95)		
	Rural	Micropolitan	Metropolitan
Less than $100,000	0	0	0
$100,000 - $149,999	3	0	0
$150,000 - $199,999	0	1	0
$200,000 - $249,999	3	1	0
$250,000 - $499,999	18	5	1
$500,000 - $749,999	15	1	0
$750,000 - $999,999	10	5	0
$1,000,000 - $1,999,999	12	4	2
$2,000,000 - $2,999,999	1	2	1
$3,000,000 - $3,999,999	0	0	1
$4,000,000 - $4,999,999	0	2	0
$5,000,000 - $5,999,999	0	1	2
$6,000,000 - $6,999,999	0	0	4

Question 37: 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)
No	84	82	83
Yes	14	17	13

SURVEY QUESTIONS AND DATA TABLES

FOUNDATIONAL PUBLIC HEALTH SERVICES

Question 38: Please self-score your agency's/department's ability to demonstrate each of these Foundational Public Health Services.

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)**
Fully meet	70	68	69
Not able to meet	3	2	2
Partially meet	23	27	25
Did not answer	3	2	0

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 = 95)**
Fully meet	61	64	59
Not able to meet	4	6	3
Partially meet	31	27	33
Did not answer	3	2	1

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)**
Fully meet	25	37	38
Not able to meet	14	11	8
Partially meet	57	49	50
Did not answer	3	2	0

Question 38 continued.

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 = 95)**
Fully meet	31	40	43
Not able to meet	12	11	8
Partially meet	53	45	44
Did not answer	3	3	1

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)**
Fully meet	71	77	81
Not able to meet	0	0	0
Partially meet	25	20	15
Did not answer	3	2	0

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)**
Fully meet	51	62	54
Not able to meet	6	3	3
Partially meet	38	31	39
Did not answer	4	3	0

Question 38 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)**
Fully meet	21	31	30
Not able to meet	6	5	7
Partially meet	67	60	59
Did not answer	5	3	0

Communication Procedures • Have a communication plan/procedure that details: o How information will be disseminated to different audiences o How messaging will be coordinated with community partners o A contact list of media and key stakeholders o 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)**
Fully meet	55	53	60
Not able to meet	2	0	0
Partially meet	38	43	34
Did not answer	4	3	2

Question 38 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)**
Fully meet	33	46	43
Not able to meet	4	2	2
Partially meet	59	48	51
Did not answer	3	3	0

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)**
Fully meet	53	51	47
Not able to meet	3	2	3
Partially meet	39	42	45
Did not answer	4	4	1

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)**
Fully meet	45	44	42
Not able to meet	5	4	10
Partially meet	45	47	43
Did not answer	4	4	1

Question 38 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)**
Fully meet	42	39	36
Not able to meet	8	8	11
Partially meet	46	49	49
Did not answer	3	3	0

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)**
Fully meet	26	30	30
Not able to meet	15	16	15
Partially meet	54	50	51
Did not answer	2	3	0

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)**
Fully meet	61	64	55
Not able to meet	4	1	2
Partially meet	30	31	39
Did not answer	2	3	0

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

Question 38 continued.

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.	**Number of Agencies**		
	SFY20 (n = 97)	**SFY21 (n = 97)**	**SFY22 (n = 96)**
Fully meet	68	70	67
Not able to meet	2	1	2
Partially meet	26	25	25
Did not answer	1	3	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)**
Fully meet	51	61	59
Not able to meet	4	0	1
Partially meet	39	34	36
Did not answer	3	4	0

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)**
Fully meet	36	46	44
Not able to meet	10	3	4
Partially meet	50	46	46
Did not answer	1	4	2

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)**
Fully meet	21	29	26
Not able to meet	22	22	18
Partially meet	54	46	52
Did not answer	0	2	0

Question 38 continued.

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)**
Fully meet	30	31	35
Not able to meet	8	10	12
Partially meet	59	55	49
Did not answer	0	3	0

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)**
Fully meet	36	33	32
Not able to meet	12	12	10
Partially meet	48	51	54
Did not answer	1	3	0

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)**
Fully meet	35	44	39
Not able to meet	11	10	10
Partially meet	51	43	47
Did not answer	0	2	0

Question 38 continued.

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)**
Fully meet	38	40	43
Not able to meet	12	10	9
Partially meet	46	45	44
Did not answer	1	4	0

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)**
Fully meet	89	91	91
Not able to meet	0	1	0
Partially meet	7	3	4
Did not answer	1	4	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)**
Fully meet	86	88	85
Not able to meet	0	0	0
Partially meet	11	6	10
Did not answer	0	5	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)**
Fully meet	84	90	89
Not able to meet	0	0	0
Partially meet	11	6	7
Did not answer	2	3	0

Question 38 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)**
Fully meet	87	91	90
Not able to meet	0	0	0
Partially meet	10	6	6
Did not answer	0	2	0

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)**
Fully meet	92	95	92
Not able to meet	0	0	0
Partially meet	4	2	4
Did not answer	1	2	0

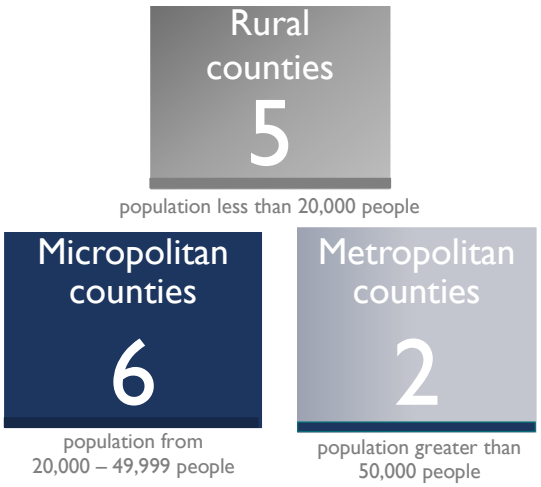
Communicate with the Governing Entity About Health Department Performance Assessment and Improvement • Communicate with the LBOH on plans and processes for improving health agency/department performance • Communicate with the LBOH on performance improvement efforts	**Number of Agencies**		
	SFY20 (n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

Appendix B: Local Public Health Structures

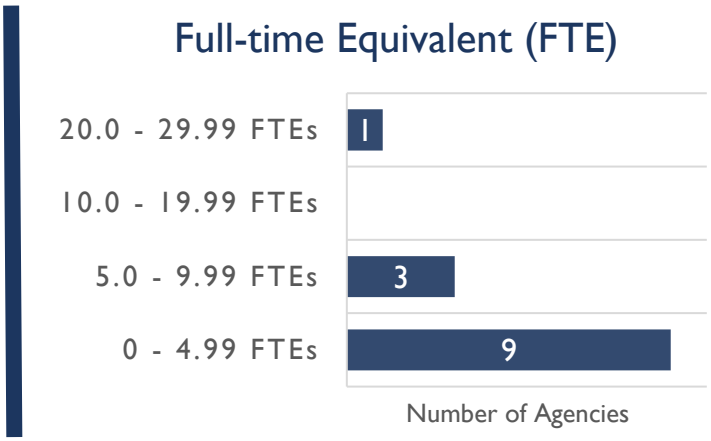
STRUCTURE A

Structure A includes counties whose Boards of Health directly employ public health staff. The recognized public health agencies in these counties provides population-based activities and services only. Home health is not provided by public health staff nor is it offered through a contract with another agency. There are 13 counties in this structure.

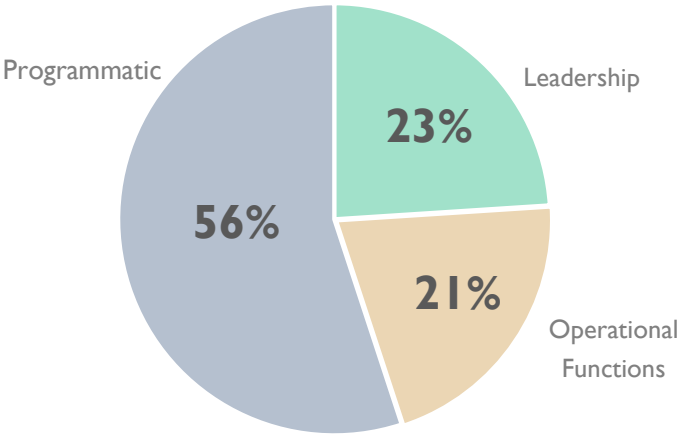
POPULATION:



WORKFORCE:



Workforce varies from county to county. Structure A administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency. The majority of administrators reported having 5.0 or fewer FTEs. Population served was not a factor in determining the number of FTEs for an agency. One rural agency reported having 8.0 FTEs and one micropolitan agency reported having just 1.0 FTE. The agency with the most FTEs in this structure had 22.5 FTEs. As a whole, there were 70.9 FTEs (across all 13 agencies) at the end of the state fiscal year (SFY22).



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), and Programmatic (staff in a variety of areas providing activities and services to county residents).

For Structure A, programmatic roles made up 36.2 FTEs (56%), 15.0 FTEs (23%) were leadership roles, and operational functions accounted for 13.3 FTEs (21%).

SERVICES PROVIDED:

In Iowa, local public health is governed and operated through local control. To meet the unique needs of residents in each county, the activities and services provided by the recognized local public health agency are determined by the county Board of Health. This leads to great variability of service provision from county to county. Funding and staff capacity also play a role in the number and types of activities and services provided within a county. Two-thirds or more of the agencies in Structure A provide basic population health activities and services.

Service Category	Number of Agencies*
Immunization and Tuberculosis	11 (100%)
Disease Follow-up, Surveillance, and Control	10 (91%)
Public Information, Health Education and Community Engagement	9 (82%)
Emergency Preparedness and Response	9 (82%)

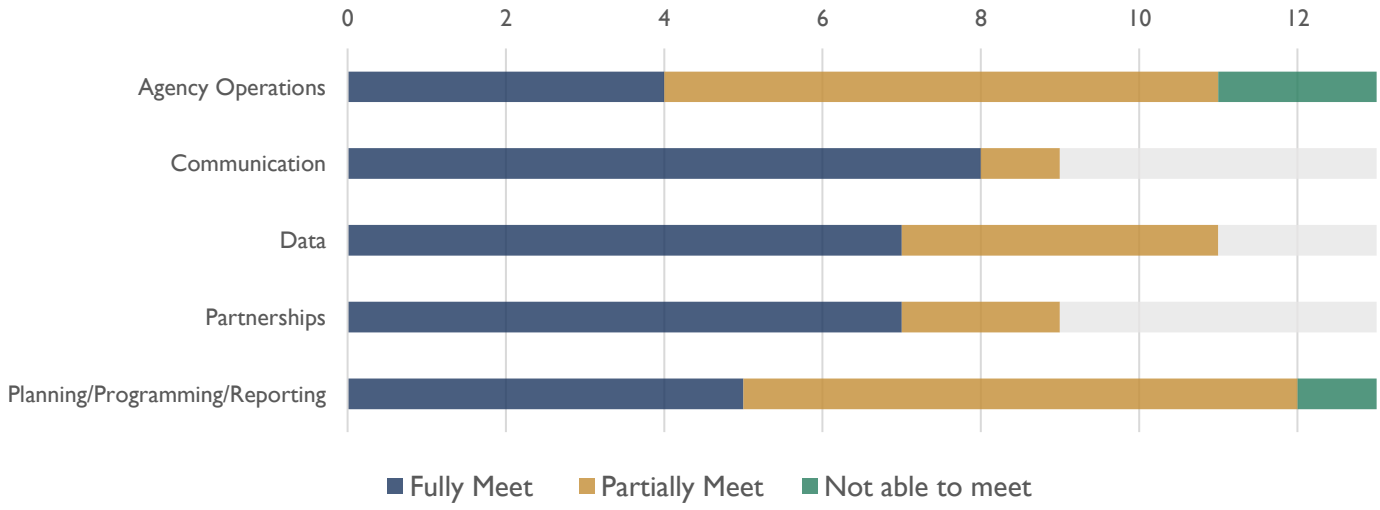
* Eleven of thirteen administrators responded to the services question

The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure A. As noted in the structure description, agencies in this structure do not provide home health services. No two counties are alike, even when looking at their specific structure type.

Service Category	Number of Agencies*	Service Category	Number of Agencies*
Environmental Health	5 (45%)	Injury Prevention	2 (18%)
Family Health	4 (36%)	Behavioral Health	1 (9%)
Nutrition and Physical Activity	4 (36%)	HIV, STI, and Hepatitis	1 (9%)
Screening and Assessment	3 (27%)	Substance Use Disorder Prevention	1 (9%)
Chronic Disease and Disability Prevention and Management	2 (18%)	Tobacco Use Prevention and Control	1 (9%)

FOUNDATIONAL CAPABILITIES

The Foundational Public Health Services (FPHS), 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 in each structure, the capabilities have been grouped into five categories (see the gray boxes below). The chart below illustrates Structure A agencies' ability to meet each infrastructure category. If an administrator responded that they could fully meet at least half or more of the capabilities in the category, they appear in the blue portion (first section) of the column; could partially meet at least half or more of the capabilities in the category, they appear in yellow (second section); or is not able to meet half or more of the capabilities in the category, they appear in green (third section), if applicable. Communication is the strongest category in Structure A, followed by Data and Partnerships. Administrators reported being less able to meet the capabilities in the Agency Operations and Planning/Programming/Reporting categories. The overall goal would be for each agency to appear in blue in each of the five categories.



Agency Operations
- Workforce development
- Strategic plan
- Emergency operations plan
- Financial management system
- Performance management system
- Quality improvement (QI) program
- QI activities

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

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

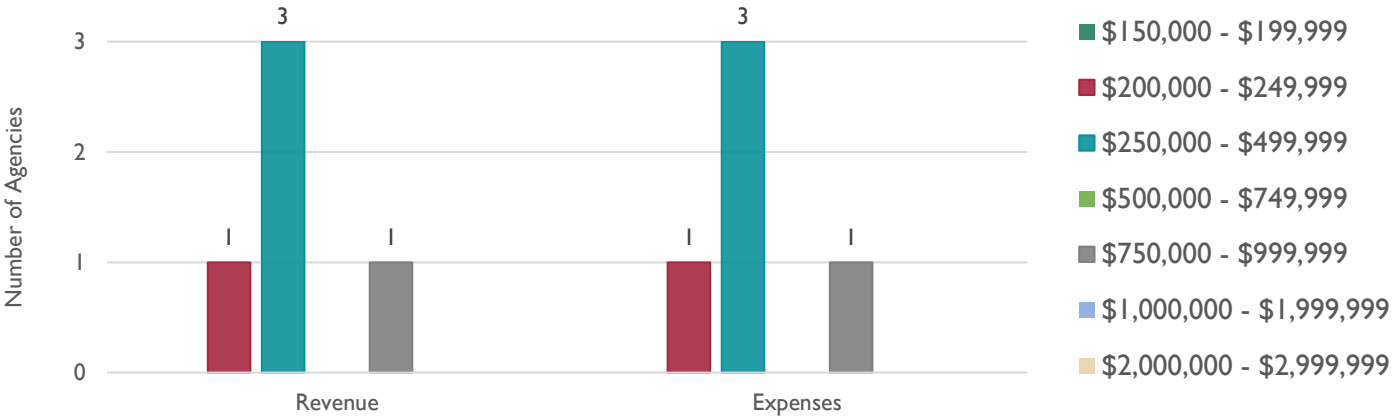
Partnerships
- Collaborative work through partnerships
- Health improvement plan implemented in partnership with others
- Access to legal counsel
- Implement strategies to increase access to care services

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

REVENUE AND EXPENSES

Structure A Rural Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the five rural counties in Structure A. Population is not a determining factor for revenue or expenses for this group of agencies. Three of the five agencies fall within the $250,000 - $499,999 category for both revenue and expenses; with one agency in the $200,000 - $249,999 category and one in the $750,000 - $999,999 category. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

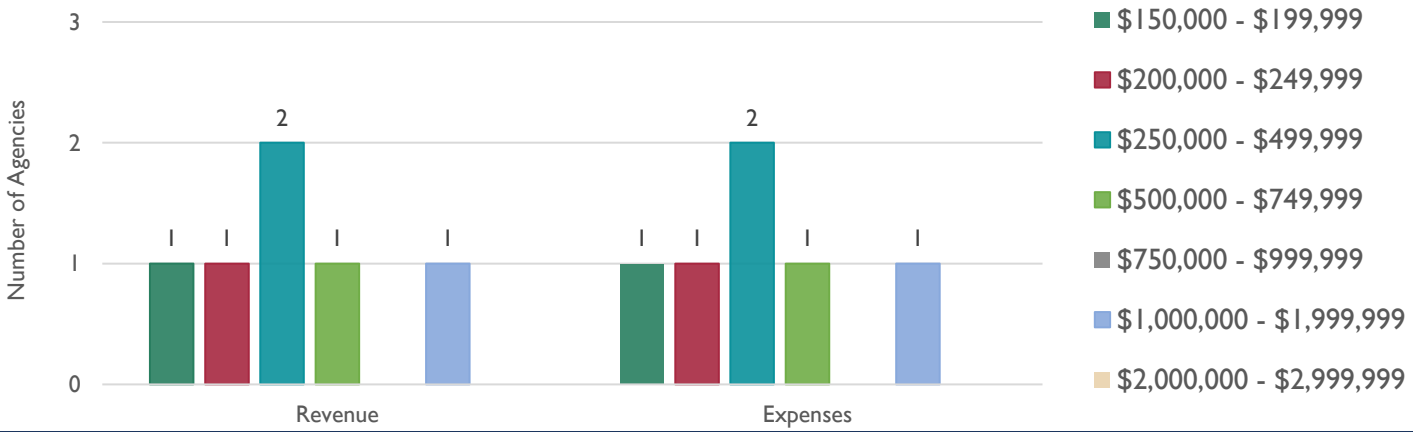
Half or more of the rural agencies in Structure A provide:	Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Environmental Health; Immunization and Tuberculosis; and Public Information, Health Education and Community Engagement
Less than half of the rural agencies in Structure A provide:	Behavioral Health; Chronic Disease and Disability Prevention and Management; Family Health; HIV, STI, and Hepatitis; Injury Prevention; Nutrition and Physical Activity; and Tobacco Use Prevention and Control



Structure A Micropolitan Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the six micropolitan counties in Structure A. Population is not a determining factor for revenue or expenses for this group of agencies. Four of the six agencies reported less than $500,000 for both revenue and expenses; with one agency reporting a little over $1,000,000 for both revenue and expenses. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

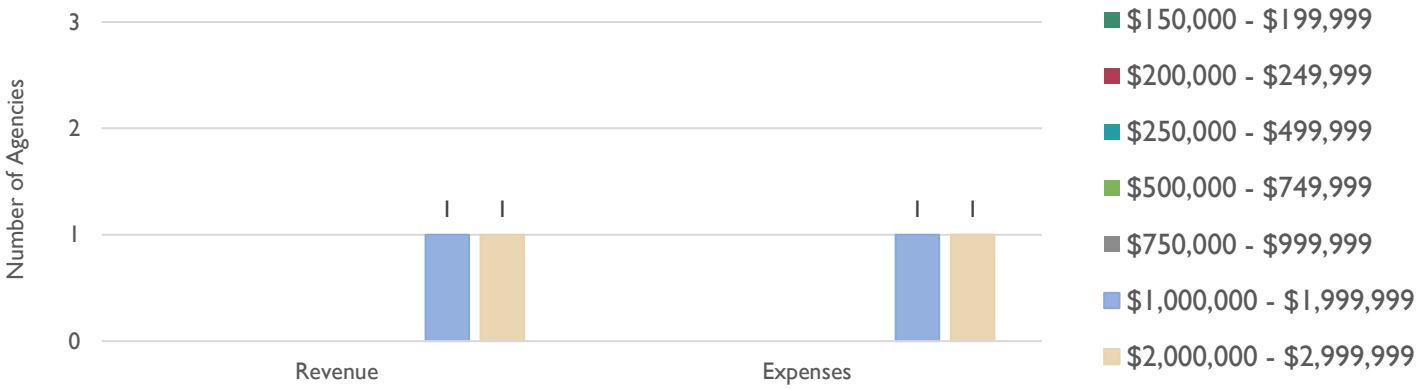
Half or more of the micropolitan agencies in Structure A provide:	Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Family Health; Immunization and Tuberculosis; and Public Information, Health Education and Community Engagement
Less than half of the micropolitan agencies in Structure A provide:	Chronic Disease and Disability Prevention and Management; Environmental Health; Nutrition and Physical Activity; and Screening and Assessment

Serving as the primary contractor for a grant can also contribute to budget variability. Agencies that serve as the contractor for a multiple county area (such as the agency represented in the far-right column below) administer higher dollar contracts to help assure the provision of public health activities and services within a defined service area.



Structure A Metropolitan Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the two metropolitan counties in Structure A. Population is not a determining factor for revenue or expenses for this group of agencies. Local control allows for greater variability in the services provided to meet the needs of county residents. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets. Providing additional services upon the request of the county Board of Health or Board of Supervisors can also contribute to budget variability (such as the agency represented in the far-right column below).

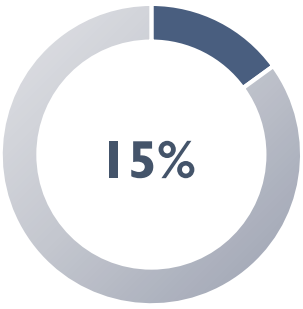
Both metropolitan counties in Structure A provide:	Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Environmental Health; Immunization and Tuberculosis; and Public Information, Health Education and Community Engagement
Also provided by a metropolitan county in Structure A:	Injury Prevention; Screening and Assessment; and Substance Use Disorder Prevention



CROSS-JURISDICTIONAL SHARING

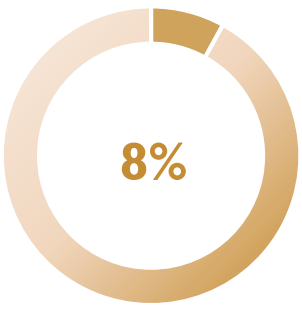
One option to assure public activities and services are provided at a high level is to share the delivery of services or staff between counties. Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency *currently* shares the delivery 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 data showed the following for the agencies in Structure A.

Currently shares the delivery of services



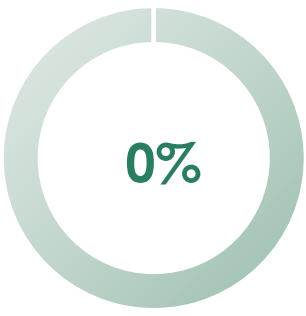
Eight agencies reported they minimally or do not currently share the delivery of services; while three reported they somewhat share the delivery of services. Two agencies (15%) reported they significantly or completely share the delivery of services.

Currently shares staff with another agency



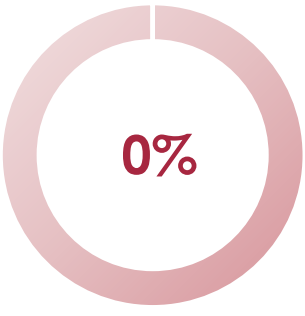
Twelve agencies reported they minimally or do not share staff with another agency. One agency (8%) reported they significantly or completely share staff with another agency.

Would consider sharing the delivery of services



Six agencies reported they would somewhat consider sharing the delivery of services. No agencies (0%) reported that they would significantly or completely consider sharing; while seven agencies would minimally consider or would not at all consider sharing the delivery of services.

Would consider sharing staff with another agency



Six agencies reported they would somewhat consider sharing the delivery of services. No agencies (0%) reported that they would significantly or completely consider sharing; while seven agencies would minimally consider or would not at all consider sharing staff with another agency.

Public Health
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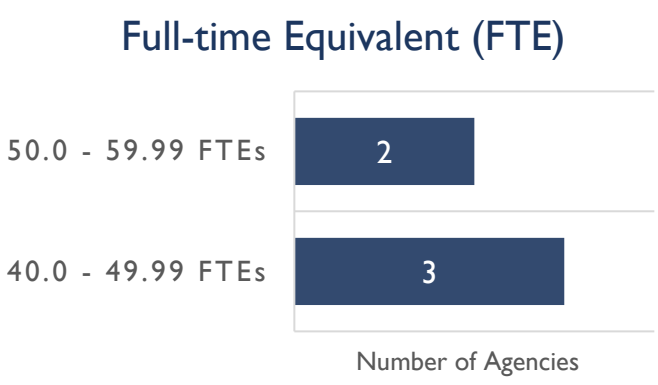
STRUCTURE B

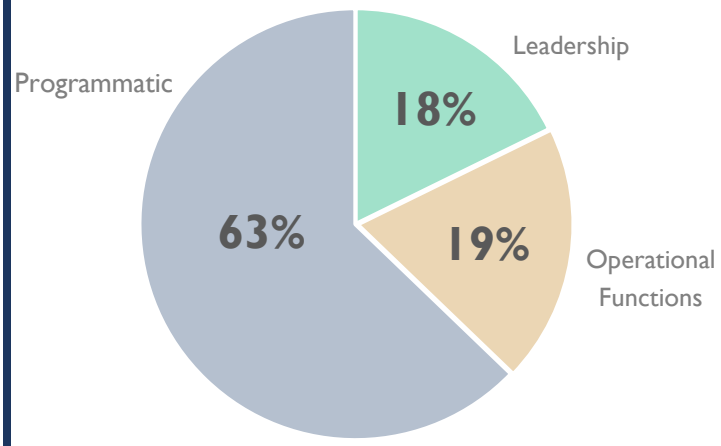
Structure B includes counties whose Boards of Health directly employ public health staff. The recognized public health agencies in these counties provide population-based activities and services only. Home health is provided through a contract with another agency. There are five counties in this structure.

POPULATION:

WORKFORCE:



Structure B administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency. Staff FTEs were similar from agency to agency in this structure. The agency with the most FTEs in this structure had 53.5 FTEs; the agency with the least FTEs had 45.0 FTEs. As a whole, there were 248.5 FTEs (across all five agencies) at the end of the state fiscal year (SFY22). This total included 45.6 FTEs from additional temporary staff needed to meet the population health needs in the county.



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), and Programmatic (staff in a variety of areas providing activities and services to county residents).

For Structure B, programmatic roles made up 127.5 FTEs (63%), 39.5 FTEs (19%) were operational functions, and leadership roles accounted for 36.0 FTEs (18%).

SERVICES PROVIDED:

In Iowa, local public health is governed and operated through local control. To meet the unique needs of residents in each county, the activities and services provided by the recognized local public health agency are determined by the county Board of Health. This leads to great variability of service provision from county to county. Funding and staff capacity also play a role in the number and types of activities and services provided within a county. All of the agencies in Structure B provide basic population health activities and services and environmental health activities.

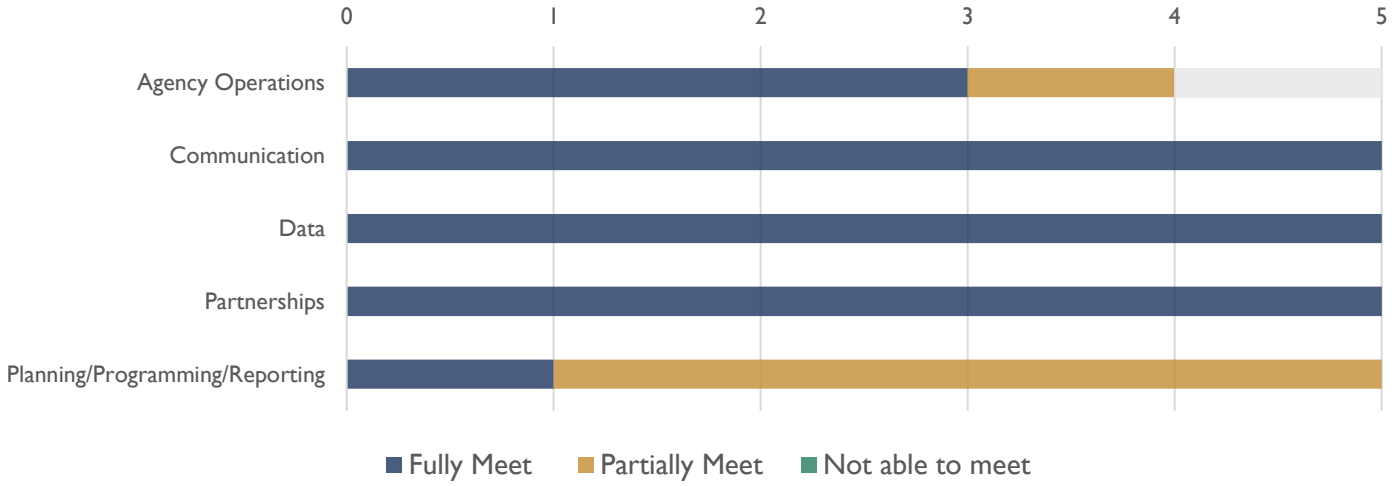
Service Category	Number of Agencies
Disease Follow-up, Surveillance, and Control	5 (100%)
Emergency Preparedness and Response	5 (100%)
Environmental Health	5 (100%)
Immunization and Tuberculosis	5 (100%)
Public Information, Health Education and Community Engagement	5 (100%)

The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure B. As noted in the structure description, the agencies in this structure do not provide home health services. No two counties are alike, even when looking at their specific structure type.

Service Category	Number of Agencies	Service Category	Number of Agencies
HIV, STI, and Hepatitis	4 (80%)	Nutrition and Physical Activity	2 (40%)
Family Health	3 (60%)	Tobacco Use Prevention and Control	2 (40%)
Screening and Assessment	3 (60%)	Behavioral Health	1 (20%)
Chronic Disease and Disability Prevention and Management	2 (40%)	Structure B agencies did not report providing injury prevention or substance use disorder prevention activities.	

FOUNDATIONAL CAPABILITIES

The Foundational Public Health Services (FPHS), 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 in each structure, the capabilities have been grouped into five categories (see the gray boxes below). The chart below illustrates Structure B agencies' ability to meet each infrastructure category. If an administrator responded that they could fully meet at least half or more of the capabilities in the category, they appear in the blue portion (first section) of the column; could partially meet at least half or more of the capabilities in the category, they appear in yellow (second section); or is not able to meet half or more of the capabilities in the category, they appear in green (third section), if applicable. Communication, Data, and Partnerships were the strongest categories in Structure B. Administrators reported being less able to meet the capabilities in the Agency Operations and Planning/Programming/Reporting categories. The overall goal would be for each agency to appear in blue in each of the five categories.



Agency Operations
- Workforce development
- Strategic plan
- Emergency operations plan
- Financial management system
- Performance management system
- Quality improvement (QI) program
- QI activities

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

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

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

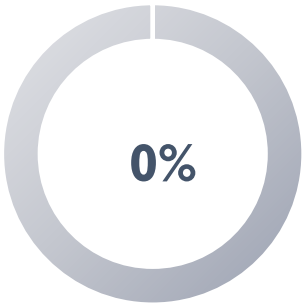
REVENUE AND EXPENSES

Structure B Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the five metropolitan counties in Structure B. Two of the five agencies fell within the $5,000,000 - $5,999,999 category for both revenue and expenses; with the other three agencies in the $6,00,000 - $6,999,999 category. Population is not a determining factor for revenue or expenses for this group of agencies. The agency that reported the highest revenue and expenses for SFY22 was not the most populous county in Structure B. Local control allows for greater variability in the services provided to meet the needs of county residents. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets. For example, four of the five agencies reported providing direct service clinics and one agency reported providing correctional health nursing. Serving as the primary contractor for a grant can also contribute to budget variability. Three of the five agencies serve as the contractor for a multiple county area and administer higher dollar contracts to help assure the provision of specialized public health activities and services within a defined service area.

CROSS-JURISDICTIONAL SHARING

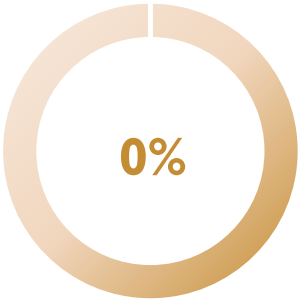
One option to assure public activities and services are provided at a high level is to share the delivery of services or staff between counties. Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency *currently* shares the delivery 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 data showed the following for the agencies in Structure B.

Currently shares the delivery of services



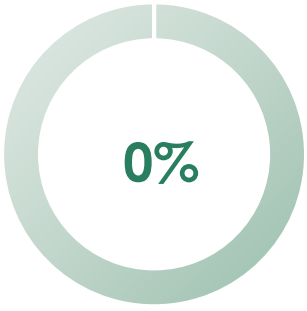
Four agencies reported they minimally or do not currently share the delivery of services; while one reported they somewhat share the delivery of services. No agencies (0%) reported that they significantly or completely share the delivery of services.

Currently shares staff with another agency



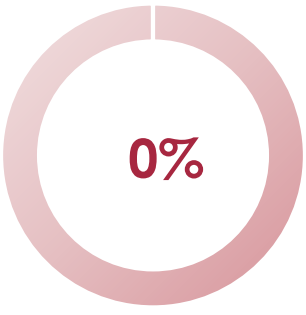
All five agencies reported they minimally or do not share staff with another agency. No agencies (0%) reported that they significantly or completely share staff with another agency.

Would consider sharing the delivery of services



One agency reported they would somewhat consider sharing the delivery of services. No agencies (0%) reported that they would significantly or completely consider sharing; while four agencies would minimally consider or would not at all consider sharing the delivery of services.

Would consider sharing staff with another agency



All five agencies reported they would minimally consider or would not at all consider sharing staff. No agencies (0%) reported that they would significantly or completely consider sharing staff with another agency.

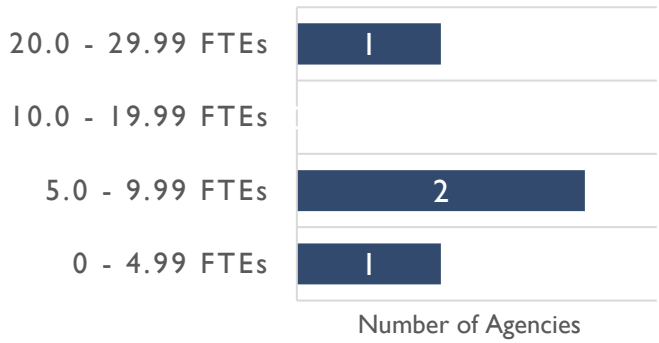
Public Health
IOWA HHS

STRUCTURE C

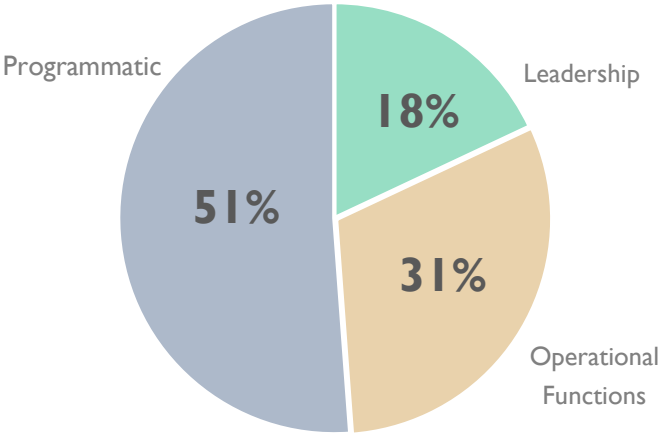
Structure C includes counties whose Boards of Health directly employ public health staff. The recognized public health agencies in these counties provide population-based activities and services and some home health services. Additional home health services are provided through a contract with another agency. There are four counties in this structure.

POPULATION:

WORKFORCE:



Workforce varies from county to county. Structure C administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency. The majority of administrators reported having fewer than 10.0 FTEs. Population served was not a factor in determining the number of FTEs for an agency. One agency in Structure C reported having 23.4 FTEs; while another agency reported having 3.0 FTEs. As a whole, there were 39.9 FTEs (across all four agencies) at the end of the state fiscal year (SFY22).



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), and Programmatic (staff in a variety of areas providing activities and services to county residents).

For Structure C, programmatic roles made up 20.0 FTEs (51%), 12.1 FTEs (31%) were operational functions, and leadership roles accounted for 7.1 FTEs (18%).

SERVICES PROVIDED:

In Iowa, local public health is governed and operated through local control. To meet the unique needs of residents in each county, the activities and services provided by the recognized local public health agency are determined by the county Board of Health. This leads to great variability of service provision from county to county. Funding and staff capacity also play a role in the number and types of activities and services provided within a county. Two-thirds or more of the agencies in Structure C provide basic population health activities and services and family health activities.

Service Category	Number of Agencies
Disease Follow-up, Surveillance, and Control	4 (100%)
Immunization and Tuberculosis	4 (100%)
Emergency Preparedness and Response	3 (75%)
Family Health	3 (75%)
Public Information, Health Education and Community Engagement	3 (75%)

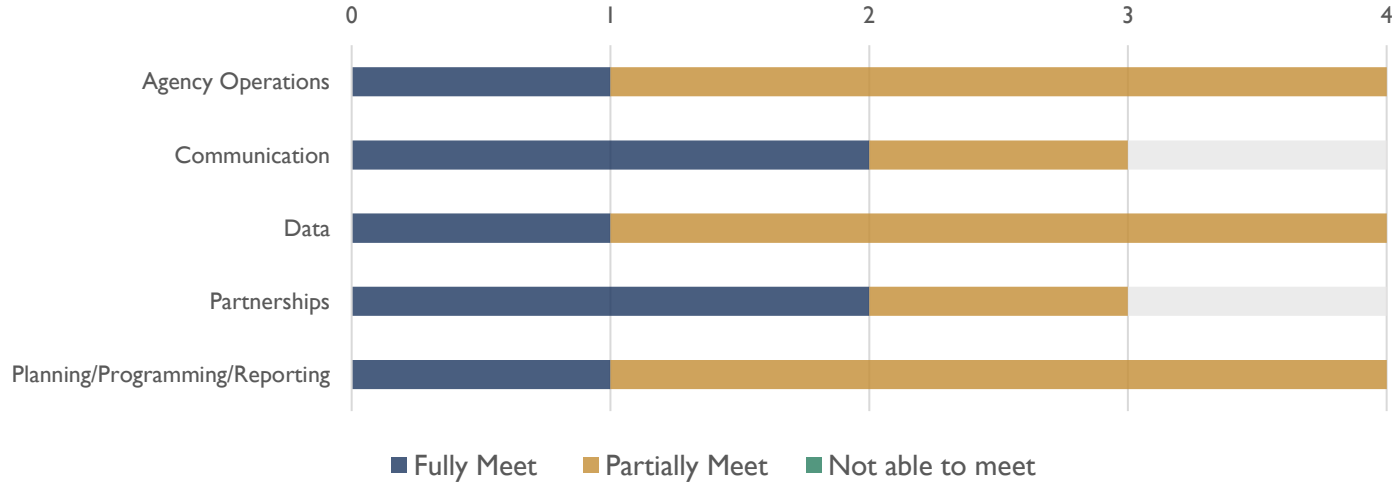
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure C. As noted in the structure description, agencies in this structure provide some home health services. Two of the four agencies reported spending 50% of more of their time providing home health services. No two counties are alike, even when looking at their specific structure type.

Service Category	Number of Agencies
Chronic Disease and Disability Prevention and Management	2 (50%)
Screening and Assessment	2 (50%)
Injury Prevention	1 (25%)

Structure C agencies did not report providing behavioral health; environmental health; HIV, STI, and Hepatitis; nutrition and physical activity; substance use disorder prevention; or tobacco use prevention and control activities.

FOUNDATIONAL CAPABILITIES

The Foundational Public Health Services (FPHS), 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 in each structure, the capabilities have been grouped into five categories (see the gray boxes below). The chart below illustrates Structure C agencies' ability to meet each infrastructure category. If an administrator responded that they could fully meet at least half or more of the capabilities in the category, they appear in the blue portion (first section) of the column; could partially meet at least half or more of the capabilities in the category, they appear in yellow (second section); or is not able to meet half or more of the capabilities in the category, they appear in green (third section), if applicable. Communication and Partnerships are the two strongest categories in Structure C. Administrators reported being less able to meet the capabilities in the Agency Operations, Data, and Planning/Programming/Reporting categories. The overall goal would be for each agency to appear in blue in each of the five categories.



Agency Operations

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

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

Data

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

Partnerships

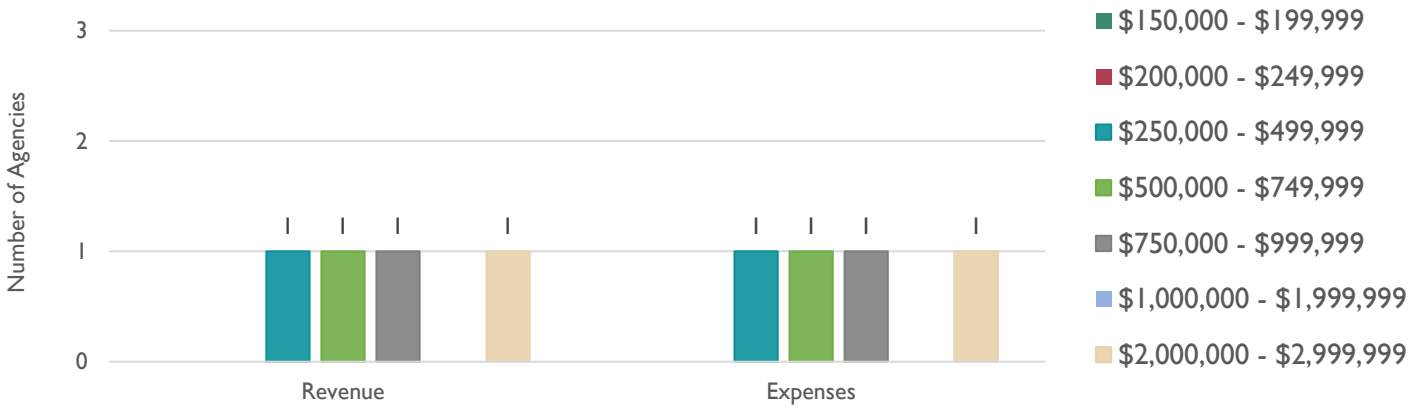
- Collaborative work through partnerships
- Health improvement plan implemented in partnership with others
- Access to legal counsel
- Implement strategies to increase access to care services

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

REVENUE AND EXPENSES

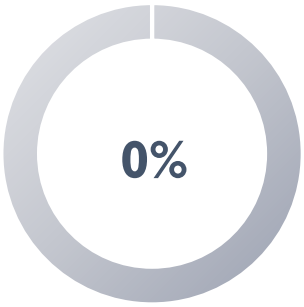
Structure C Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the four rural counties in Structure C. Population is not a determining factor for revenue or expenses for this group of agencies. Each of the four agencies fell within a different category for both revenue and expenses; with one agency in the $250,000 - $499,999 category and one in the $2,000,000 - $2,999,999 category. The least populous county in Structure C reported the second highest revenue and expenses; while the second most populous county reported the least high revenue and expenses. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets. Serving as the primary contractor for a grant can also contribute to budget variability. Agencies that serve as the contractor for a multiple county area (such as the county represented in the far-right column below) administer higher dollar contracts to help assure the provision of public health activities and services within a defined service area.



CROSS-JURISDICTIONAL SHARING

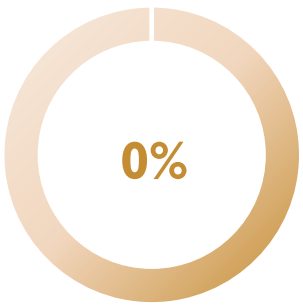
One option to assure public activities and services are provided at a high level is to share the delivery of services or staff between counties. Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency *currently* shares the delivery 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 data showed the following for the agencies in Structure C.

Currently shares the delivery of services



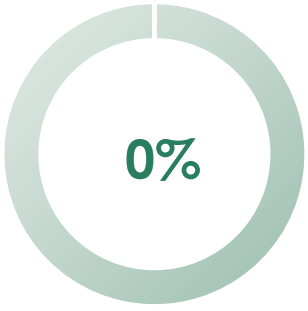
Four agencies reported they minimally or do not currently share the delivery of services. No agencies (0%) reported that they significantly or completely share the delivery of services.

Currently shares staff with another agency



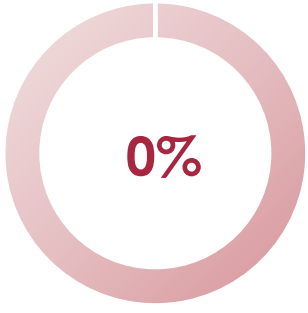
Three agencies reported they minimally or do not share staff with another agency; while one reported they somewhat share staff. No agencies (0%) reported that they significantly or completely share staff with another agency.

Would consider sharing the delivery of services



One agency reported they would somewhat consider sharing the delivery of services. No agencies (0%) reported that they would significantly or completely consider sharing; while three agencies would minimally consider or would not at all consider sharing the delivery of services.

Would consider sharing staff with another agency

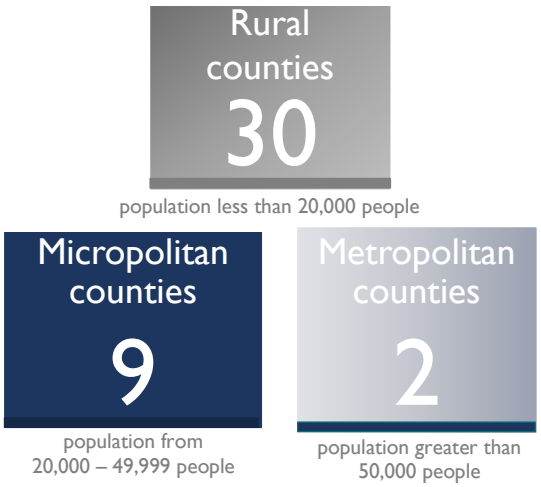


One agency reported they would somewhat consider sharing staff with another agency. Two agencies reported they would minimally consider or would not at all consider sharing staff. No agencies (0%) reported that they would significantly or completely consider sharing staff with another agency. One agency did not respond.

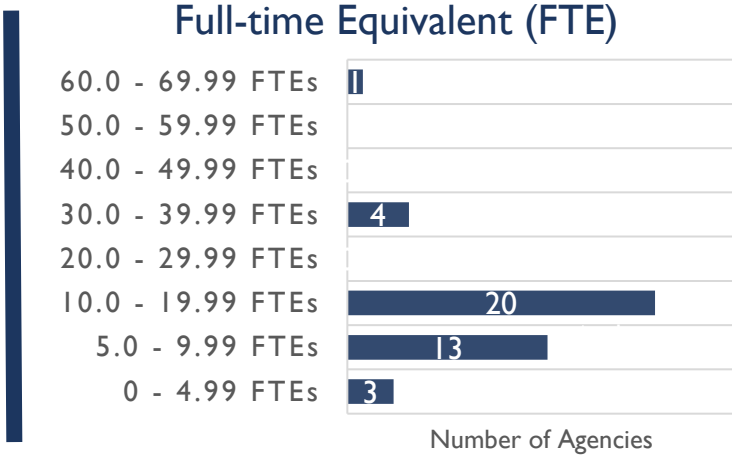
STRUCTURE D

Structure D includes counties whose Boards of Health directly employ public health staff. The recognized public health agencies in these counties provide population-based activities and services and home health services. There are 41 counties in this structure.

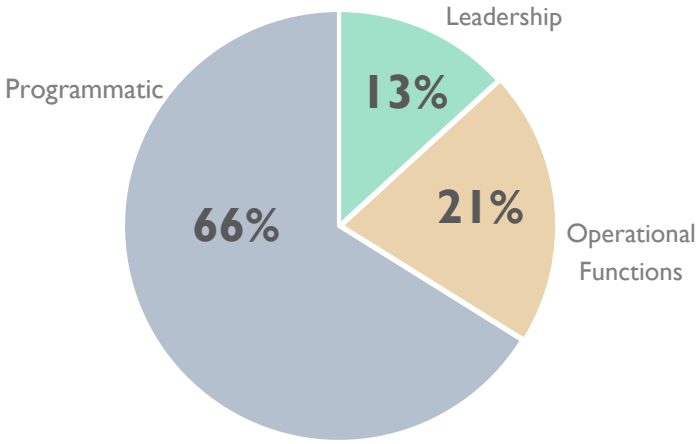
POPULATION:



WORKFORCE:



Workforce varies from county to county. Structure D administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency. The majority of administrators reported having 20.0 or fewer FTEs. Population served was not a factor in determining the number of FTEs for an agency. For the nine micropolitan agencies, five reported less than 16.0 FTEs each; the other four reported 35.0 or more FTEs each. The agency with the most FTEs in this structure had 64.1 FTEs. As a whole, there were 587.6 FTEs (across all 41 agencies) at the end of the state fiscal year (SFY22).



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), and Programmatic (staff in a variety of areas providing activities and services to county residents).

For Structure D, programmatic roles made up 376.5 FTEs (66%), 117.6 FTEs (21%) were operational functions, and leadership roles accounted for 75.2 FTEs (13%).

SERVICES PROVIDED:

In Iowa, local public health is governed and operated through local control. To meet the unique needs of residents in each county, the activities and services provided by the recognized local public health agency are determined by the county Board of Health. This leads to great variability of service provision from county to county. Funding and staff capacity also play a role in the number and types of activities and services provided within a county. Two-thirds or more of the agencies in Structure D provide basic population health activities and services.

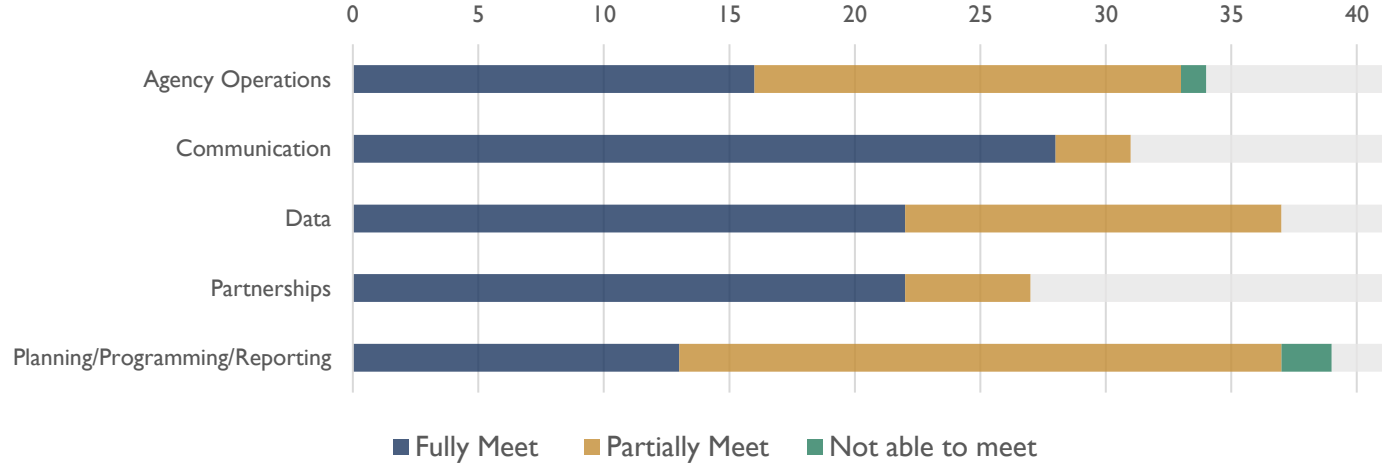
Service Category	Number of Agencies
Disease Follow-up, Surveillance, and Control	39 (95%)
Emergency Preparedness and Response	38 (93%)
Immunization and Tuberculosis	38 (93%)
Public Information, Health Education and Community Engagement	28 (68%)

The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure D. As noted in the structure description, agencies in this structure also provide home health services; 20 agencies reported spending 50% or more of their time providing home health services. No two counties are alike, even when looking at their specific structure type.

Service Category	Number of Agencies	Service Category	Number of Agencies
Family Health	25 (61%)	Injury Prevention	9 (22%)
Environmental Health	23 (56%)	Nutrition and Physical Activity	7 (17%)
Chronic Disease and Disability Prevention and Management	13 (32%)	Behavioral Health	5 (12%)
Screening and Assessment	13 (32%)	HIV, STI, and Hepatitis	3 (7%)
Tobacco Use Prevention and Control	10 (24%)	Substance Use Disorder Prevention	3 (7%)

FOUNDATIONAL CAPABILITIES

The Foundational Public Health Services (FPHS), 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 in each structure, the capabilities have been grouped into five categories (see the gray boxes below). The chart below illustrates Structure D agencies' ability to meet each infrastructure category. If an administrator responded that they could fully meet at least half or more of the capabilities in the category, they appear in the blue portion (first section) of the column; could partially meet at least half or more of the capabilities in the category, they appear in yellow (second section); or is not able to meet half or more of the capabilities in the category, they appear in green (third section), if applicable. Communication is the strongest category in Structure D, followed by Data and Partnerships. Administrators reported being less able to meet the capabilities in the Agency Operations and Planning/Programming/Reporting categories. The overall goal would be for each agency to appear in blue in each of the five categories.



Agency Operations
- Workforce development
- Strategic plan
- Emergency operations plan
- Financial management system
- Performance management system
- Quality improvement (QI) program
- QI activities

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

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

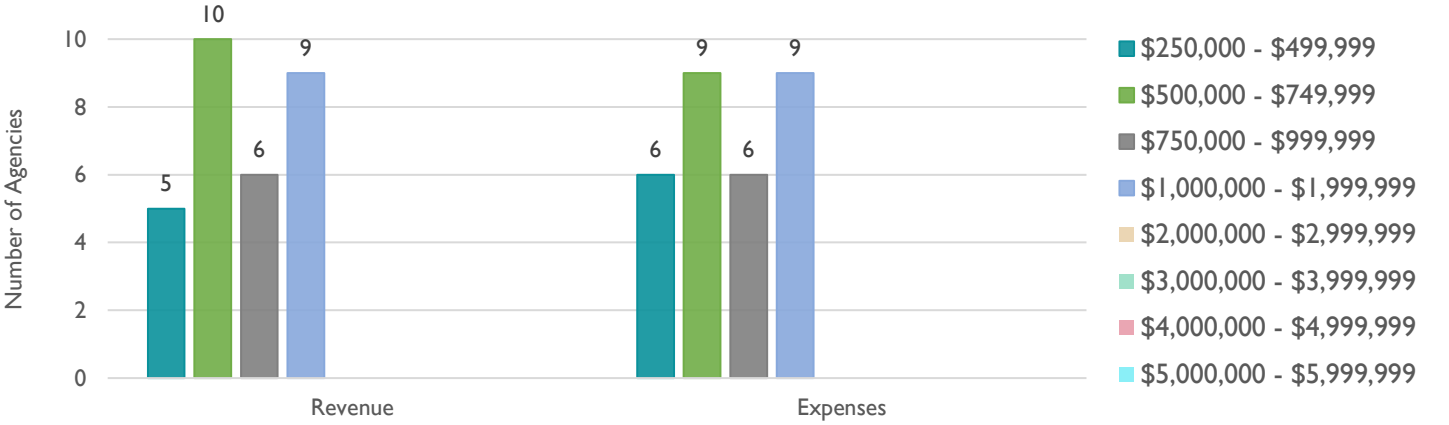
Partnerships
- Collaborative work through partnerships
- Health improvement plan implemented in partnership with others
- Access to legal counsel
- Implement strategies to increase access to care services

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

REVENUE AND EXPENSES

Structure D Rural Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the 30 rural counties in Structure D. Population is not a determining factor for revenue or expenses for this group of agencies. Half of the agencies reported under $750,000 for both revenue and expenses; with no more than six agencies in the $250,000 - $499,999 category and nine agencies in the $1,000,000 - $1,999,999 category. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

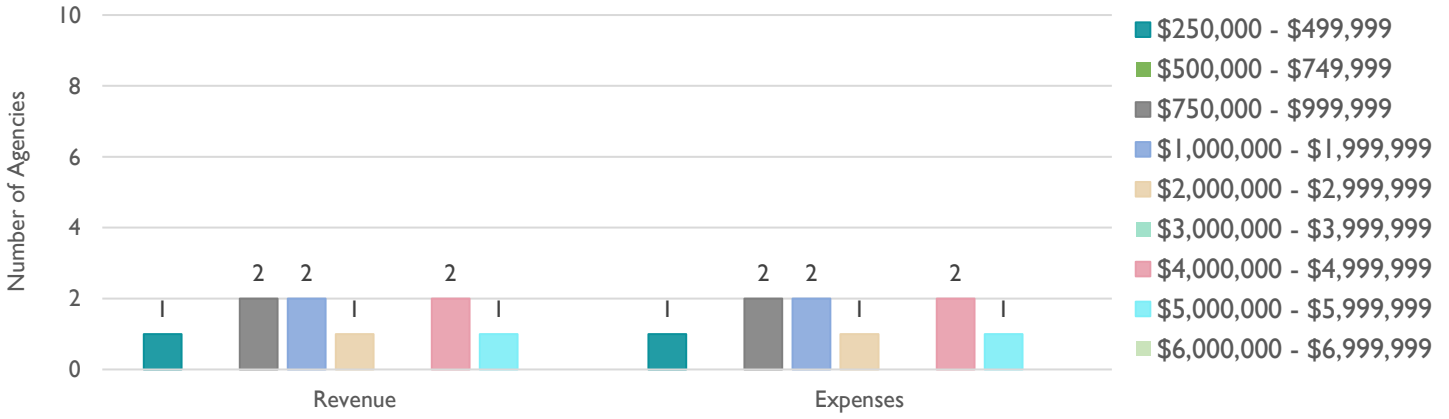
Half or more of the rural agencies in Structure D provide:	Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Environmental Health; Family Health; Immunization and Tuberculosis; and Public Information, Health Education and Community Engagement
Less than half of the rural agencies in Structure D provide:	Behavioral Health; Chronic Disease and Disability Prevention and Management; HIV, STI, and Hepatitis; Injury Prevention; Nutrition and Physical Activity; Screening and Assessment; Substance Use Disorder Prevention, and Tobacco Use Prevention and Control



Structure D Micropolitan Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the nine micropolitan counties in Structure D. Population is not a determining factor for revenue or expenses for this group of counties. Six of the nine agencies reported revenue and expenses of more than $1,000,000; while one agency reported both revenue and expenses in the $250,000 - $499,999 category. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

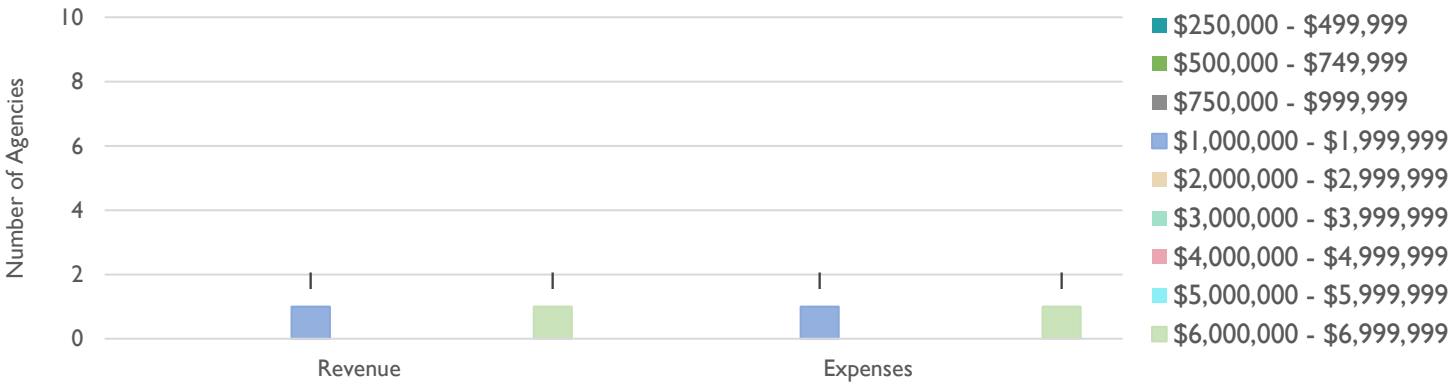
Half or more of the micropolitan agencies in Structure D provide:	Chronic Disease and Disability Prevention and Management; Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Environmental Health; Family Health; Immunization and Tuberculosis; and Public Information, Health Education and Community Engagement
Less than half of the micropolitan agencies in Structure D provide:	Behavioral Health; HIV, STI, and Hepatitis; Nutrition and Physical Activity; Screening and Assessment; Substance Use Disorder Prevention; and Tobacco Use Prevention and Control

Serving as the primary contractor for a grant can also contribute to budget variability. Agencies that serve as the contractor for a multiple county area (such as the agencies represented in the columns over $4,000,000 below) administer higher dollar contracts to help assure the provision of specialized public health activities and services, to Iowans, within a defined service area.



Structure D Metropolitan Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the two metropolitan counties in Structure D. Population is not a determining factor for revenue or expenses for this group of agencies. One agency reported revenue and expenses in the $1,000,000 - $1,999,999 category; the other in the $6,000,000 - $6,999,999 category. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets. Local control allows for greater variability in the services provided to meet the needs of county residents.

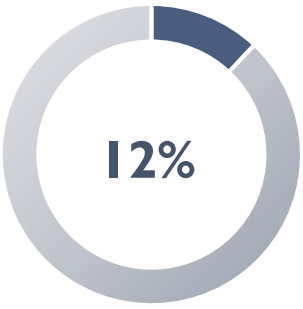
Both metropolitan agencies in Structure D provide:	Chronic Disease and Disability Prevention and Management; Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Environmental Health; Family Health; Immunization and Tuberculosis; and Public Information, Health Education and Community Engagement
Also provided by a metropolitan agency in Structure D:	Behavioral Health; HIV, STD, and Hepatitis; Nutrition and Physical Activity; and Tobacco Use Prevention and Control



CROSS-JURISDICTIONAL SHARING

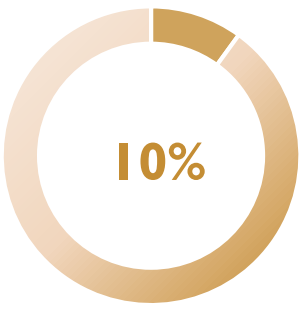
One option to assure public activities and services are provided at a high level is to share the delivery of services or staff between counties. Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency *currently* shares the delivery 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 data showed the following for the agencies in Structure D.

Currently shares the delivery of services



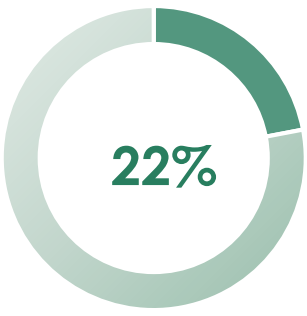
Twenty-six agencies reported they minimally or do not currently share the delivery of services; while 10 reported they somewhat share the delivery of services. Five agencies (12%) reported that they significantly or completely share the delivery of services.

Currently shares staff with another agency



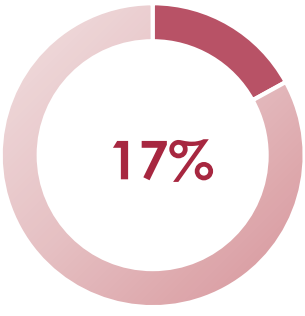
Thirty-two agencies reported they minimally or do not share staff with another agency; while five reported they somewhat share staff. Four agencies (10%) reported that they significantly or completely share staff with another agency.

Would consider sharing the delivery of services



Seventeen agencies reported they would somewhat consider sharing the delivery of services. Nine agencies (22%) reported that they would significantly or completely consider sharing; while fifteen agencies would minimally consider or would not at all consider sharing the delivery of services.

Would consider sharing staff with another agency



Sixteen agencies reported they would somewhat consider sharing staff with another agency. Eighteen agencies reported they would minimally consider or would not at all consider sharing staff. Seven agencies (17%) reported that they would significantly or completely consider sharing staff with another agency.

Public Health
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STRUCTURE E

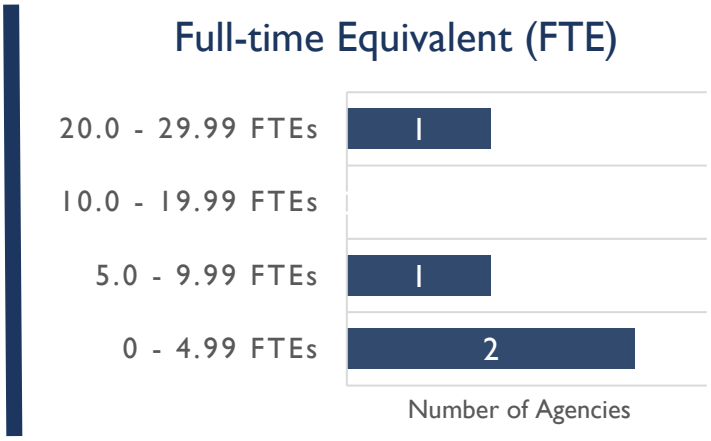
Structure E includes counties whose Boards of Health contract with an outside agency for services. The recognized public health agencies in these counties provide population-based activities and services only. Home health is not provided by the county. There are four counties in this structure.

POPULATION:

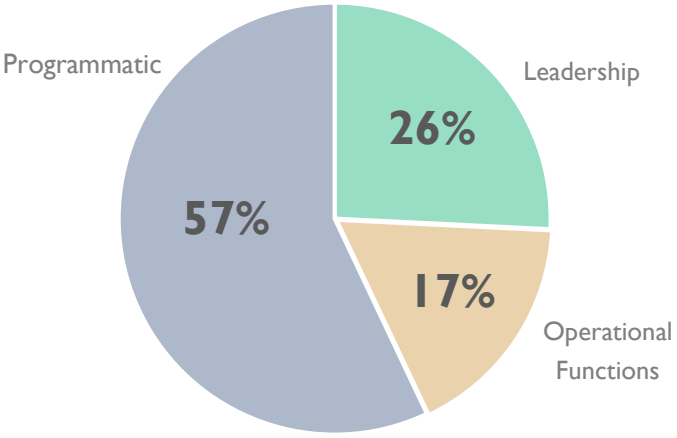
Rural counties
2
population less than 20,000 people

Micropolitan counties
2
population from 20,000 – 49,999 people

WORKFORCE:



Workforce varies from county to county. Structure E administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency. The majority of administrators reported fewer than 7.0 FTEs. Population served was not a factor in determining the number of FTEs for an agency. For micropolitan agencies, one agency reported having 7.0 FTEs and the other agency reported having 27.0 FTEs (the most in this structure). As a whole, there were 39.6 FTEs (across all four agencies) at the end of the state fiscal year (SFY22).



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), and Programmatic (staff in a variety of areas providing activities and services to county residents).

For Structure E, programmatic roles made up 17.3 FTEs (57%), 7.8 FTEs (26%) were leadership roles, and operational functions accounted for 5.2 FTEs (17%).

SERVICES PROVIDED:

In Iowa, local public health is governed and operated through local control. To meet the unique needs of residents in each county, the activities and services provided by the recognized local public health agency are determined by the county Board of Health. This leads to great variability of service provision from county to county. Funding and staff capacity also play a role in the number and types of activities and services provided within a county. Two-thirds or more of the agencies in Structure E provide basic population health activities and services.

Service Category	Number of Agencies
Emergency Preparedness and Response	4 (100%)
Disease Follow-up, Surveillance, and Control	3 (75%)
Immunization and Tuberculosis	3 (75%)
Public Information, Health Education and Community Engagement	3 (75%)

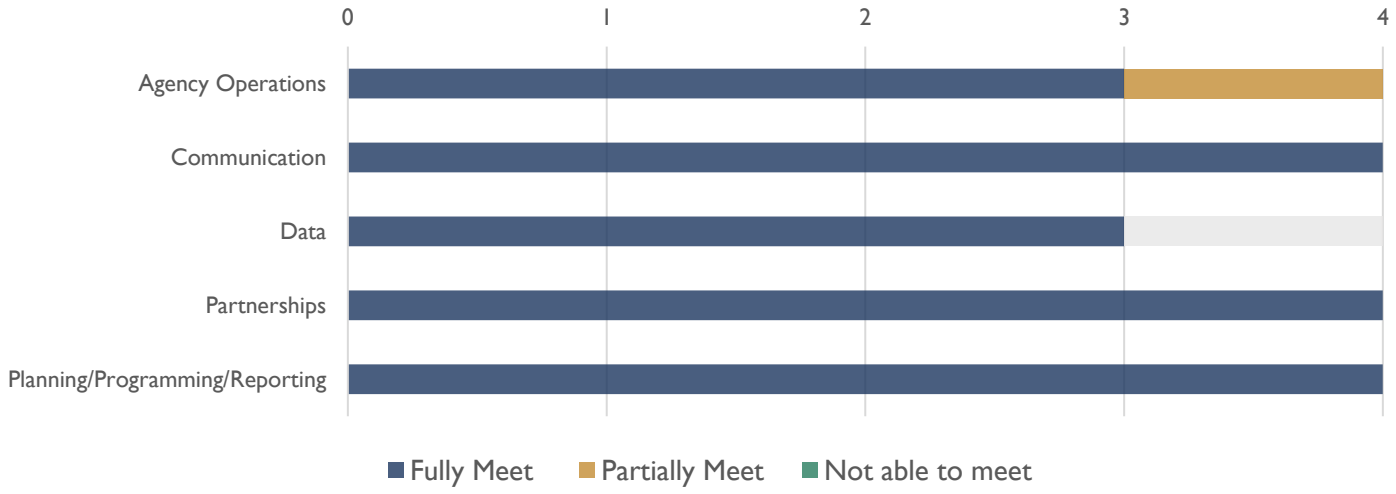
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure E. As noted in the structure description, agencies in this structure do not provide home health services. No two counties are alike, even when looking at their specific structure type.

Service Category	Number of Agencies
Family Health	2 (50%)
Chronic Disease and Disability Prevention and Management	1 (25%)
Environmental Health	1 (25%)
Nutrition and Physical Activity	1 (25%)
Tobacco Use Prevention and Control	1 (25%)

Structure E agencies did not report providing behavioral health; HIV, STI, and Hepatitis; injury prevention; screening and assessment; and substance use disorder prevention activities.

FOUNDATIONAL CAPABILITIES

The Foundational Public Health Services (FPHS), 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 in each structure, the capabilities have been grouped into five categories (see the gray boxes below). The chart below illustrates Structure E agencies' ability to meet each infrastructure category. If an administrator responded that they could fully meet at least half or more of the capabilities in the category, they appear in the blue portion (first section) of the column; could partially meet at least half or more of the capabilities in the category, they appear in yellow (second section); or is not able to meet half or more of the capabilities in the category, they appear in green (third section), if applicable. Communication, Partnerships, and Planning/Programming/Reporting are the strongest categories in Structure E. Administrators reported being less able to meet the capabilities in the Agency Operations and Data categories. The overall goal would be for each agency to appear in blue in each of the five categories.



Agency Operations

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

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

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

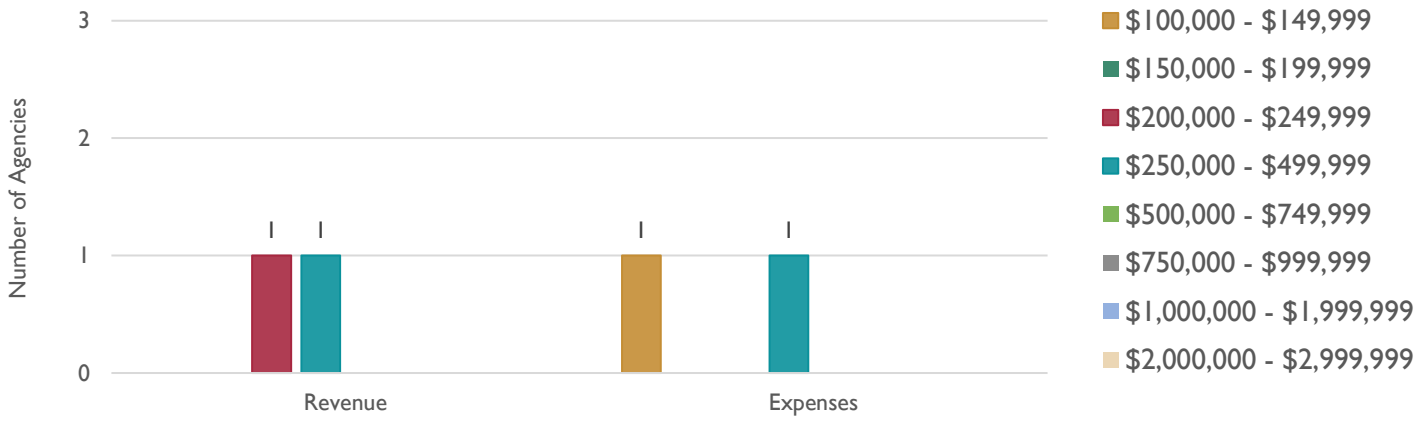
Planning/Programming/Reporting

- 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

REVENUE AND EXPENSES

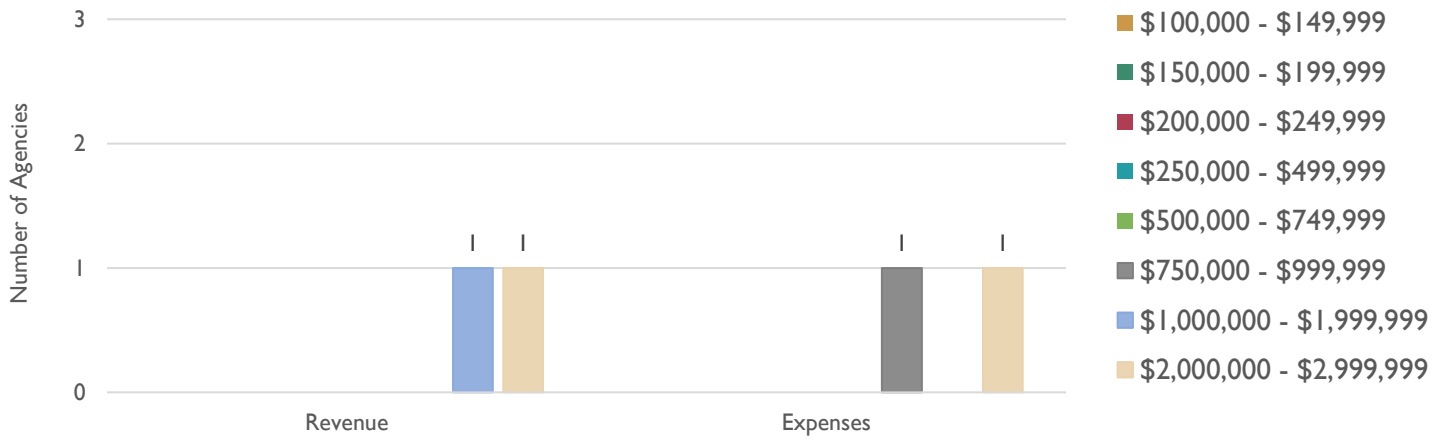
Structure E Rural Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the two rural counties in Structure E. One agency fell within the $250,000 - $499,999 category for both revenue and expenses; the other agency in the $200,000 - $249,999 category for revenue and the $100,000 - $149,999 category for expenses. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

Both of the rural agencies in Structure E provide:	Emergency Preparedness and Response; Immunization and Tuberculosis; and Public Information, Health Education and Community Engagement
Also provided by a rural agency in Structure E:	Disease Follow-up, Surveillance, and Control



Structure E Micropolitan Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the two micropolitan counties in Structure E. Population is not a determining factor for revenue or expenses for this group of agencies. One agency reported two and a half times the revenue (and expenses) of the other agency. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

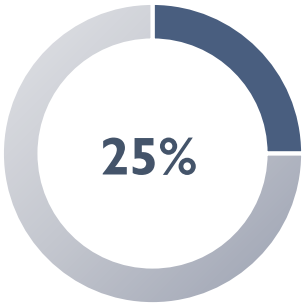
Both micropolitan agencies in Structure E provide:	Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; and Family Health
Also provided by a micropolitan agency in Structure E:	Chronic Disease and Disability Prevention and Management; Environmental Health; Immunization and Tuberculosis; Nutrition and Physical Activity; Public Information, Health Education, and Community Engagement; and Tobacco Use Prevention and Control



CROSS-JURISDICTIONAL SHARING

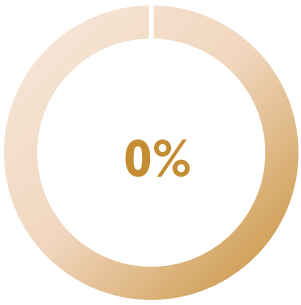
One option to assure public activities and services are provided at a high level is to share the delivery of services or staff between counties. Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency *currently* shares the delivery 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 data showed the following for the agencies in Structure E.

Currently shares the delivery of services



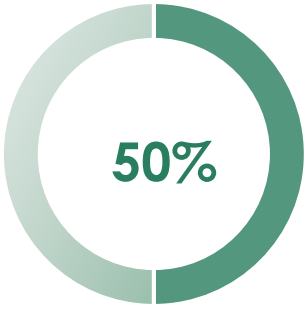
One agency reported they minimally or do not currently share the delivery of services; while two reported they somewhat share the delivery of services. One agency (25%) reported that they significantly or completely share the delivery of services.

Currently shares staff with another agency



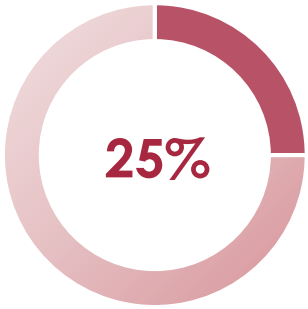
One agency reported they minimally or do not share staff with another agency; while three reported they somewhat share staff. No agencies (0%) reported that they significantly or completely share staff with another agency.

Would consider sharing the delivery of services



Two agencies reported they would somewhat consider sharing the delivery of services. Two agencies (50%) reported they would significantly or completely consider sharing.

Would consider sharing staff with another agency



Three agencies reported they would somewhat consider sharing staff. One agency (25%) reported they would significantly or completely consider sharing staff with another agency.

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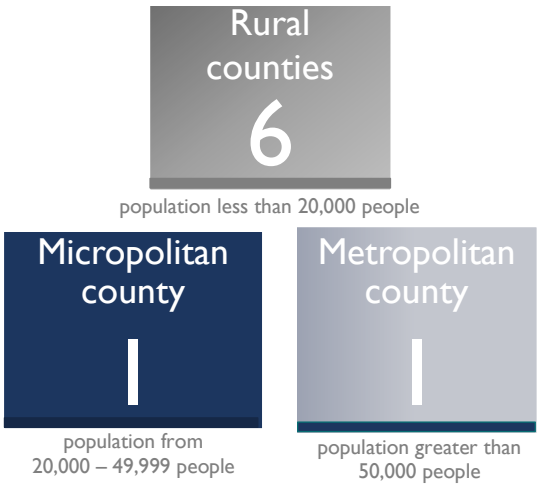
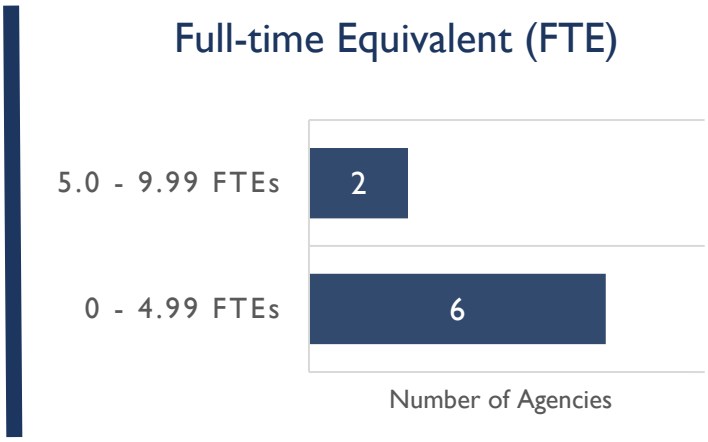
STRUCTURE F

Structure F includes counties whose Boards of Health contract with an outside agency for services. The recognized public health agencies in these counties provides population-based activities and services only. Home health is provided by the county through an additional contracted agency. There are eight counties in this structure.

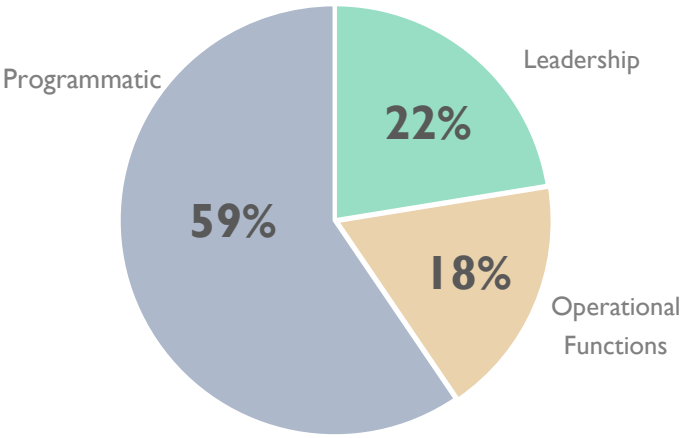
POPULATION:



WORKFORCE:



Workforce varies from county to county. Structure F administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency. The majority of administrators reported having fewer than 5.0 FTEs. Population served was not a factor in determining the number of FTEs for an agency as rural, micropolitan, and metropolitan counties all reported between 2.0 FTEs and 6.5 FTEs. As a whole, there were 28.2 FTEs (across all eight agencies) at the end of the state fiscal year (SFY22).



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), and Programmatic (staff in a variety of areas providing activities and services to county residents).

For Structure F, programmatic roles made up 14.8 FTEs (59%), 5.6 FTEs (22%) were leadership roles, and operational functions accounted for 4.5 FTEs (18%).

SERVICES PROVIDED:

In Iowa, local public health is governed and operated through local control. To meet the unique needs of residents in each county, the activities and services provided by the recognized local public health agency are determined by the county Board of Health. This leads to great variability of service provision from county to county. Funding and staff capacity also play a role in the number and types of activities and services provided within a county. Two-thirds or more of the agencies in Structure F provide basic population health activities and services.

Service Category	Number of Agencies
Disease Follow-up, Surveillance, and Control	8 (100%)
Emergency Preparedness and Response	8 (100%)
Immunization and Tuberculosis	7 (88%)
Public Information, Health Education & Community Engagement	7 (88%)

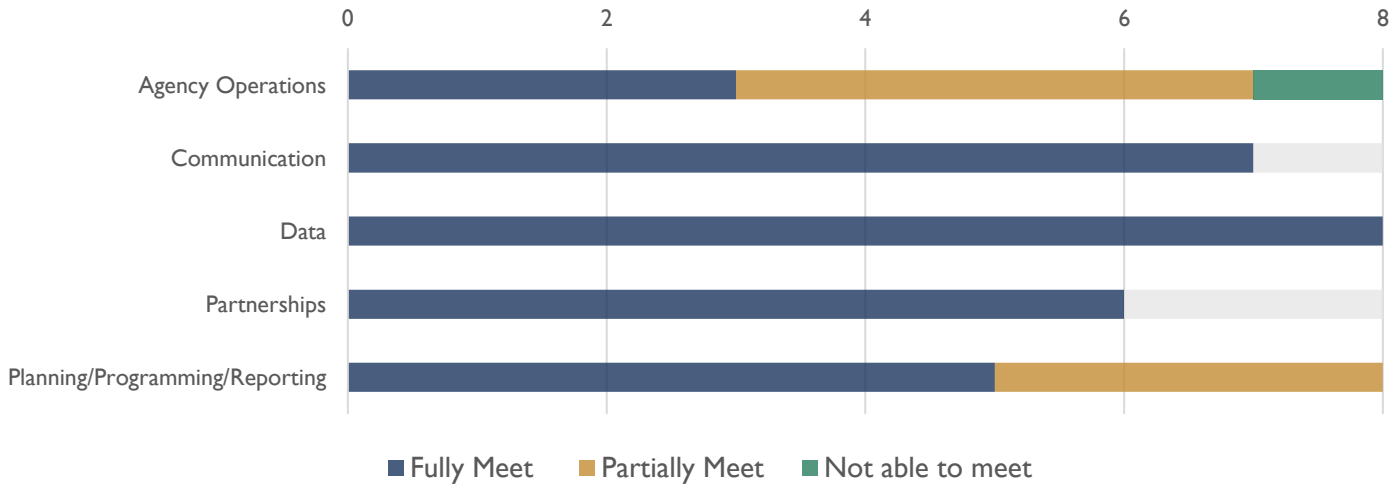
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure F. As noted in the structure description, agencies in this structure do not provide home health services. No two counties are alike, even when looking at their specific structure type.

Service Category	Number of Agencies	Service Category	Number of Agencies
Family Health	4 (50%)	Injury Prevention	2 (25%)
Screening and Assessment	3 (38%)	Environmental Health	1 (13%)
Chronic Disease and Disability Prevention and Management	2 (25%)	Nutrition and Physical Activity	1 (13%)

Structure F agencies did not report providing behavioral health; HIV, STI, and Hepatitis; substance use disorder prevention; or tobacco use prevention and control activities.

FOUNDATIONAL CAPABILITIES

The Foundational Public Health Services (FPHS), 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 in each structure, the capabilities have been grouped into five categories (see the gray boxes below). The chart below illustrates Structure F agencies' ability to meet each infrastructure category. If an administrator responded that they could fully meet at least half or more of the capabilities in the category, they appear in the blue portion (first section) of the column; could partially meet at least half or more of the capabilities in the category, they appear in yellow (second section); or is not able to meet half or more of the capabilities in the category, they appear in green (third section), if applicable. Data is the strongest category in Structure F, followed by Communication and Partnerships. Administrators reported being less able to meet the capabilities in the Agency Operations and Planning/Programming/Reporting categories. The overall goal would be for each agency to appear in blue in each of the five categories.



Agency Operations
- Workforce development
- Strategic plan
- Emergency operations plan
- Financial management system
- Performance management system
- Quality improvement (QI) program
- QI activities

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

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

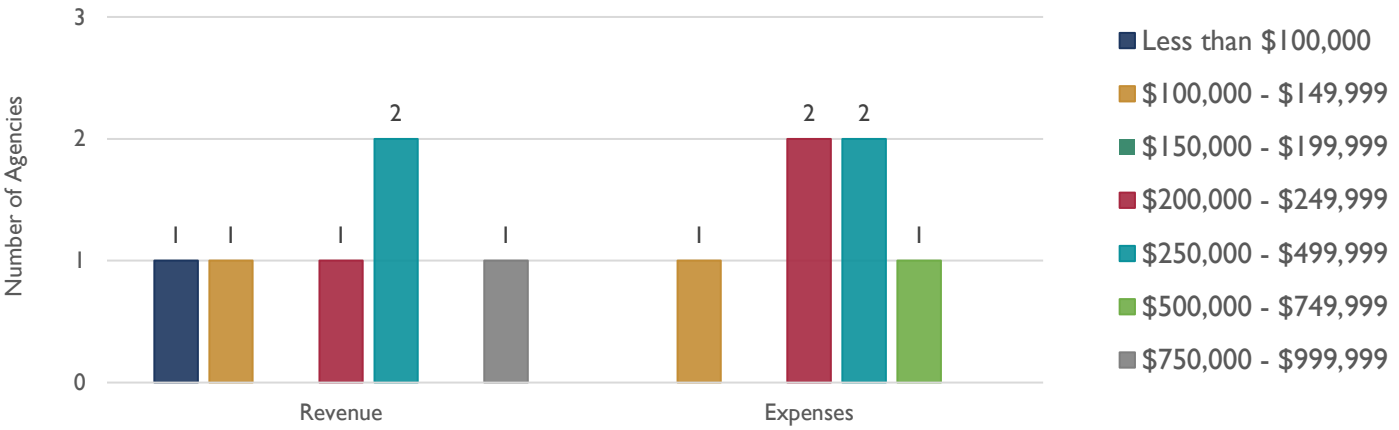
Partnerships
- Collaborative work through partnerships
- Health improvement plan implemented in partnership with others
- Access to legal counsel
- Implement strategies to increase access to care services

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

REVENUE AND EXPENSES

Structure F Rural Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the six rural counties in Structure F. Population is not a determining factor for revenue or expenses for this group of agencies. One rural agency reported less than $100,000 in revenue and less than $350,000 in expenses; while another agency reported revenue in the $750,000 - $999,999 category and expenses less than $750,000. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

Half or more of the rural agencies in Structure F provide:	Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Family Health; Immunization and Tuberculosis; and Public Information, Health Education and Community Engagement
Less than half of the rural agencies in Structure F provide:	Chronic Disease and Disability Prevention and Management; Environmental Health; Injury Prevention; Nutrition and Physical Activity; and Screening and Assessment



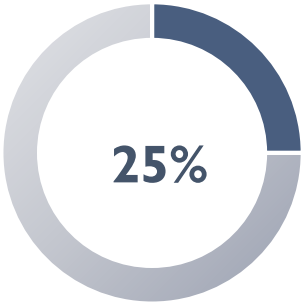
Structure F Micropolitan and Metropolitan Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the micropolitan and metropolitan counties in Structure F. Population is not a determining factor for revenue or expenses for this group of agencies. Both agencies fell within the $250,000 - $499,999 category for expenses; however, the metropolitan agency reported revenue in the $250,000 - $499,999 category and the micropolitan agency reported revenue in the $500,000 - $749,999 category. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

Both of the micropolitan and metropolitan agencies in Structure F provide:	Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Immunization and Tuberculosis; and Public Information, Health Education and Community Engagement
Also provided by a micropolitan or metropolitan agency in Structure F:	Family Health and Screening and Assessment

CROSS-JURISDICTIONAL SHARING

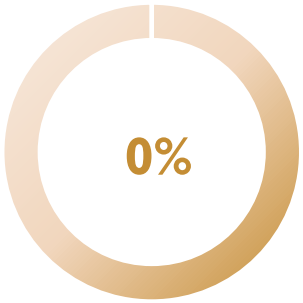
One option to assure public activities and services are provided at a high level is to share the delivery of services or staff between counties. Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency *currently* shares the delivery 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 data showed the following for the agencies in Structure F.

Currently shares the delivery of services



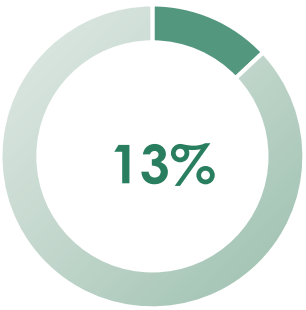
Four agencies reported they minimally or do not currently share the delivery of services; while two reported they somewhat share the delivery of services. Two agencies (25%) reported they significantly or completely share the delivery of services.

Currently shares staff with another agency



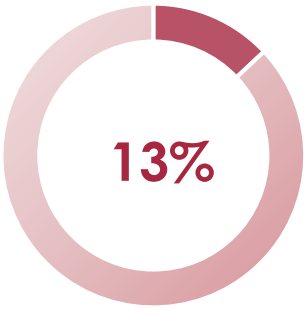
Seven agencies reported they minimally or do not share staff with another agency; while one reported they somewhat share staff. No agencies (0%) reported that they significantly or completely share staff with another agency.

Would consider sharing the delivery of services



Three agencies reported they would somewhat consider sharing the delivery of services. One agency (13%) reported that they would significantly or completely consider sharing; while four agencies would minimally consider or would not at all consider sharing the delivery of services.

Would consider sharing staff with another agency



Three agencies reported they would somewhat consider sharing staff with another agency. One agency (13%) reported that they would significantly or completely consider sharing; while four agencies would minimally consider or would not at all consider sharing staff with another agency.

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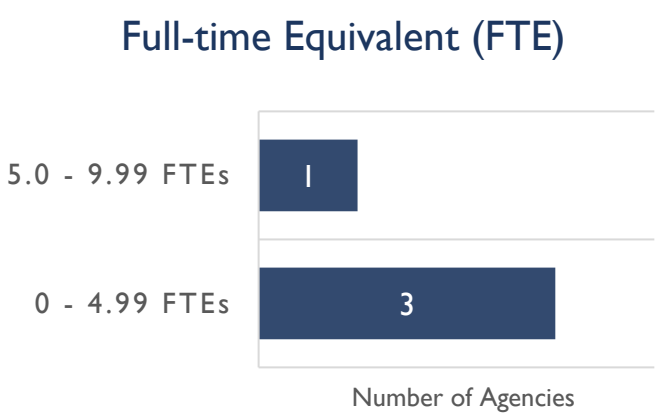
STRUCTURE G

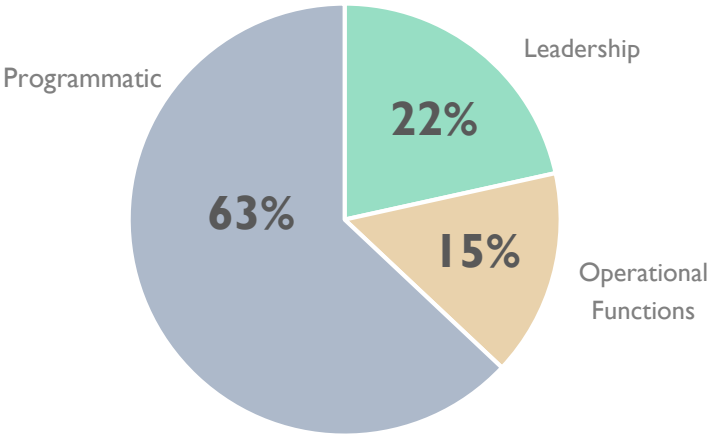
Structure G includes counties whose Boards of Health contract with an outside agency for services. The recognized public health agencies in these counties provide population-based activities and services and some home health services. Additional home health services are provided through a contract with another agency.
There are four counties in this structure.

POPULATION:

WORKFORCE:



Workforce varies from county to county. Structure G administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency. The majority of administrators reported having fewer than 5.0 FTEs; administrators reported having 2.0 FTEs (the minimum for this structure) to 5.4 FTEs (the maximum for this structure). As a whole, there were 15.3 FTEs (across all four agencies) at the end of the state fiscal year (SFY22).



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), and Programmatic (staff in a variety of areas providing activities and services to county residents).

For Structure G, programmatic roles made up 11.4 FTEs (63%), 3.9 FTEs (22%) were leadership roles, and operational functions accounted for 2.8 FTEs (15%).

SERVICES PROVIDED:

In Iowa, local public health is governed and operated through local control. To meet the unique needs of residents in each county, the activities and services provided by the recognized local public health agency are determined by the county Board of Health. This leads to great variability of service provision from county to county. Funding and staff capacity also play a role in the number and types of activities and services provided within a county. Two-thirds or more of the agencies in Structure G provide basic population health activities and services and family health activities.

Service Category	Number of Agencies
Disease Follow-up, Surveillance, and Control	4 (100%)
Family Health	4 (100%)
Immunization and Tuberculosis	4 (100%)
Emergency Preparedness and Response	3 (75%)
Public Information, Health Education and Community Engagement	3 (75%)

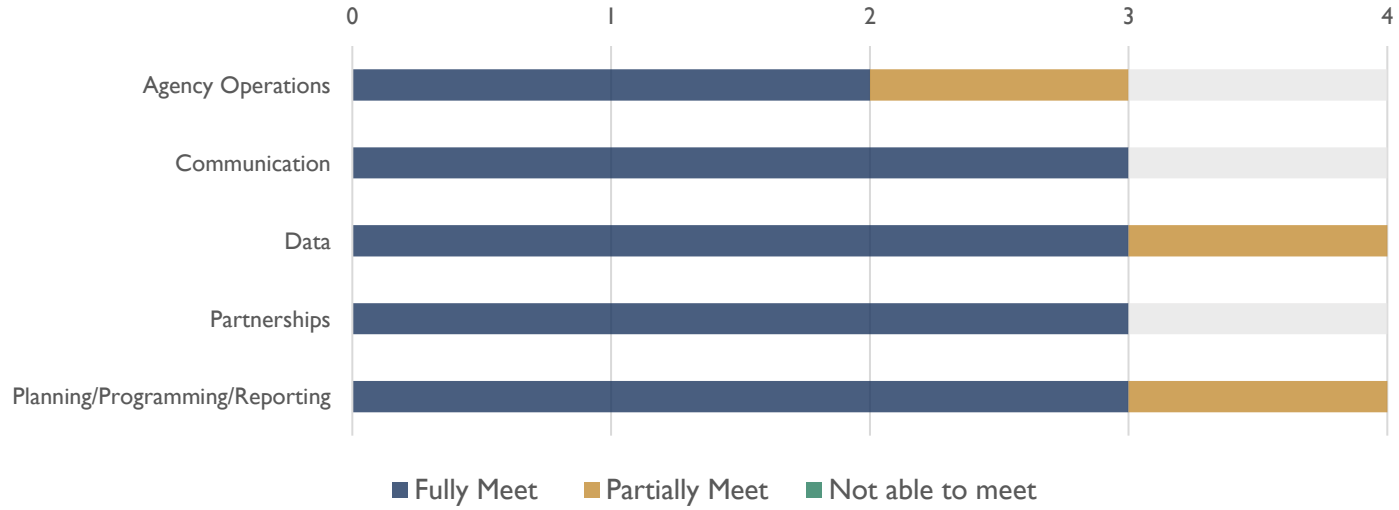
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure G. As noted in the structure description, agencies in this structure provide some home health services; all four agencies reported spending less than 25% of their time providing home health services. No two counties are alike, even when looking at their specific structure type.

Service Category	Number of Agencies	Service Category	Number of Agencies
Chronic Disease and Disability Prevention and Management	1 (25%)	Screening and Assessment	1 (25%)
Injury Prevention	1 (25%)	Tobacco Use Prevention and Control	1 (25%)

Structure G agencies did not report providing behavioral health; environmental health; HIV, STI, and Hepatitis; nutrition and physical activity; or substance use disorder prevention activities.

FOUNDATIONAL CAPABILITIES

The Foundational Public Health Services (FPHS), 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 in each structure, the capabilities have been grouped into five categories (see the gray boxes below). The chart below illustrates Structure G agencies' ability to meet each infrastructure category. If an administrator responded that they could fully meet at least half or more of the capabilities in the category, they appear in the blue portion (first section) of the column; could partially meet at least half or more of the capabilities in the category, they appear in yellow (second section); or is not able to meet half or more of the capabilities in the category, they appear in green (third section), if applicable. Communication, Data, Partnerships, and Planning/Programming/Reporting were the strongest categories in Structure G. Administrators reported being less able to meet the capabilities in the Agency Operations category. The overall goal would be for each agency to appear in blue in each of the five categories.



Agency Operations
- Workforce development
- Strategic plan
- Emergency operations plan
- Financial management system
- Performance management system
- Quality improvement (QI) program
- QI activities

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

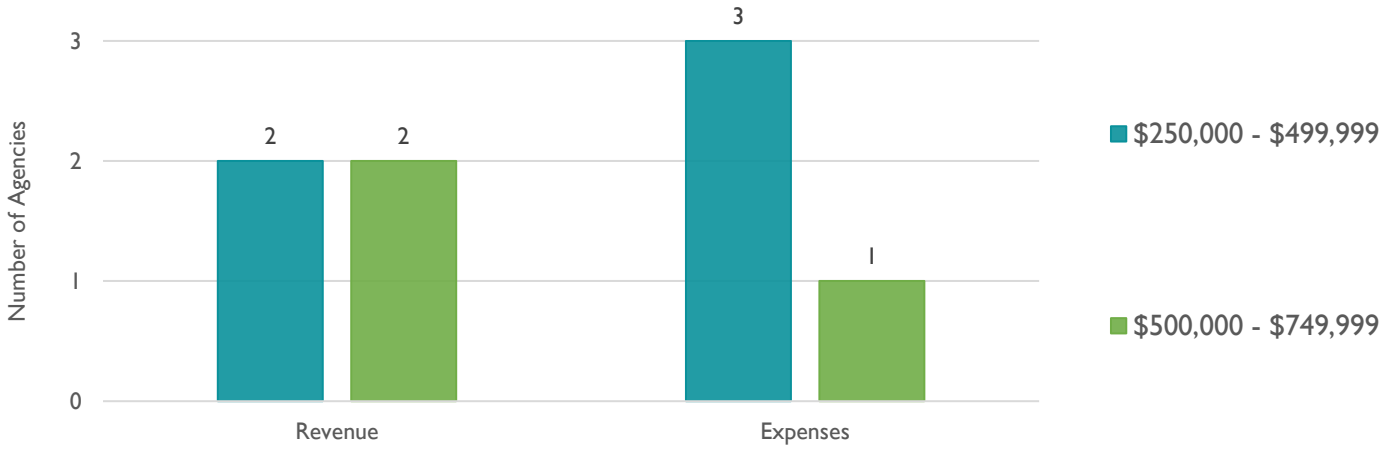
Data
- Community Health Assessment
- 24/7 surveillance system
- Data analysis and conclusions
- Fact sheets of data to support improvment planning
- Confidentiality policies

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

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

REVENUE AND EXPENSES

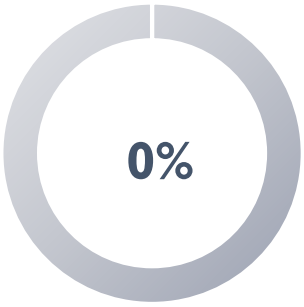
Structure G Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the four rural counties in Structure G. Population is not a determining factor for revenue or expenses for this group of agencies. The county with the lowest population reported the second highest revenue. Although the population was almost double between the least populous county and the second least populous county in this structure, the least populous county reported approximately $90,000 more in expenses. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.



CROSS-JURISDICTIONAL SHARING

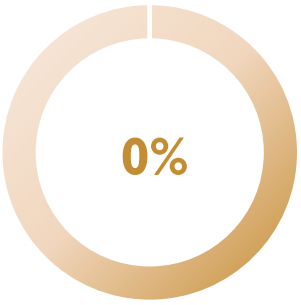
One option to assure public activities and services are provided at a high level is to share the delivery of services or staff between counties. Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency *currently* shares the delivery 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 data showed the following for the agencies in Structure G.

Currently shares the delivery of services



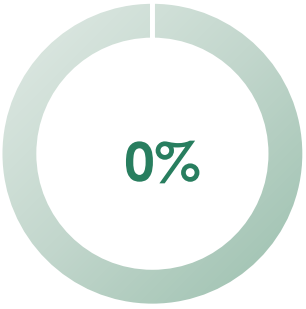
All four agencies reported they minimally or do not currently share the delivery of services. No agencies (0%) reported that they significantly or completely share the delivery of services.

Currently shares staff with another agency



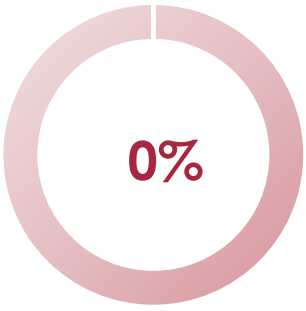
All four agencies reported they minimally or do not share staff with another agency. No agencies (0%) reported that they significantly or completely share staff with another agency.

Would consider sharing the delivery of services



Two agencies reported they would somewhat consider sharing the delivery of services. No agencies (0%) reported that they would significantly or completely consider sharing; while two agencies would minimally consider or would not at all consider sharing the delivery of services.

Would consider sharing staff with another agency



All four agencies reported they would minimally consider or would not at all consider sharing staff. No agencies (0%) reported that they would significantly or completely consider sharing staff with another agency.

Public Health
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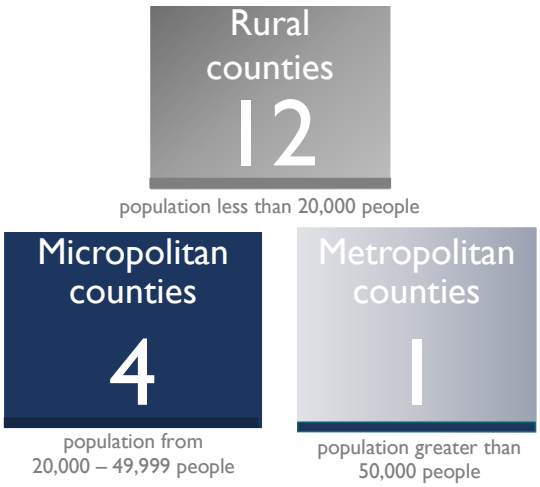
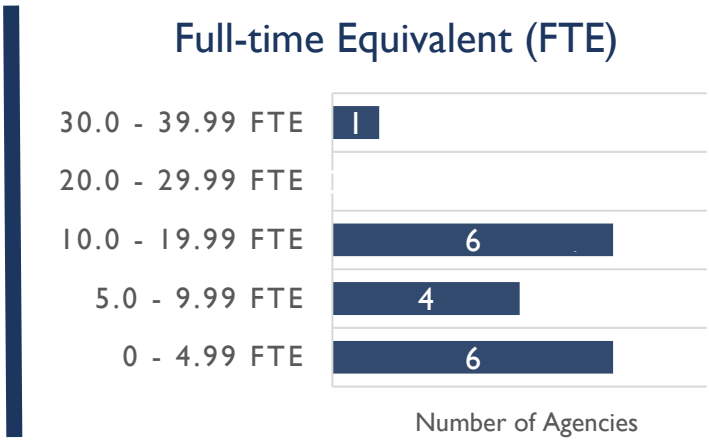
STRUCTURE H

Structure H includes counties whose Boards of Health contract with an outside agency for services. The recognized public health agencies in these counties provide population-based activities and services and home health services. There are 17 counties in this structure.

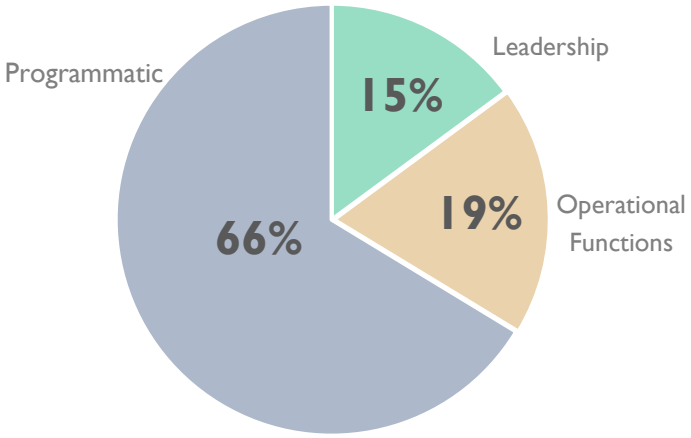
POPULATION:



WORKFORCE:



Workforce varies from county to county. Structure H administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency. The majority of administrators reported having 14.0 or fewer FTEs. Population served was not a factor in determining the number of FTEs for an agency. One micropolitan agency reported having just 1.5 FTEs and one rural agency reported having 18.5 FTEs. The agency with the most FTEs in this structure had 33.4 FTEs. As a whole, there were 168.9 FTEs (across all 17 agencies) at the end of the state fiscal year (SFY22).



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), and Programmatic (staff in a variety of areas providing activities and services to county residents).

For Structure H, programmatic roles made up 98.3 FTEs (66%), 27.8 FTEs (19%) were operational functions, and leadership roles accounted for 22.1 FTEs (15%).

SERVICES PROVIDED:

In Iowa, local public health is governed and operated through local control. To meet the unique needs of residents in each county, the activities and services provided by the recognized local public health agency are determined by the county Board of Health. This leads to great variability of service provision from county to county. Funding and staff capacity also play a role in the number and types of activities and services provided within a county. A majority of agencies in Structure H provide basic population health activities and services.

Service Category	Number of Agencies
Immunization and Tuberculosis	14 (82%)
Disease Follow-up, Surveillance, and Control	13 (76%)
Emergency Preparedness and Response	11 (65%)

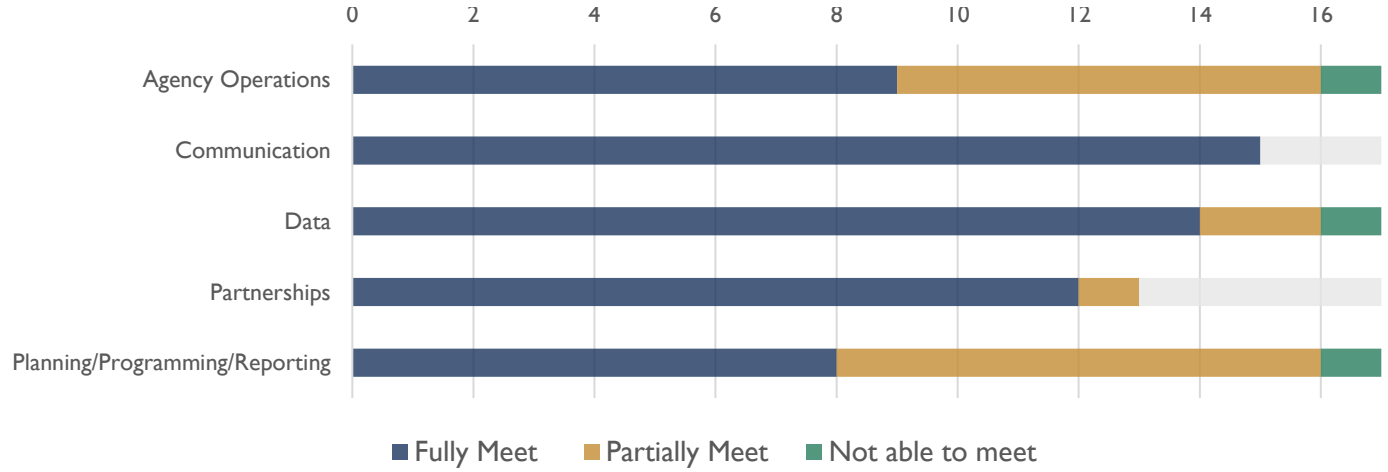
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure H. As noted in the structure description, agencies in this structure also provide home health services; 12 of the 17 agencies reported spending 50% or more of their time providing home health services. No two counties are alike, even when looking at their specific structure type.

Service Category	Number of Agencies	Service Category	Number of Agencies
Family Health	7 (41%)	Screening and Assessment	2 (12%)
Public Information, Health Education and Community Engagement	7 (41%)	HIV, STI, and Hepatitis	1 (6%)
Chronic Disease and Disability Prevention and Management	3 (18%)	Substance Use Disorder Prevention	1 (6%)
Injury Prevention	3 (18%)	Tobacco Use Prevention and Control	1 (6%)

Structure H agencies did not report providing behavioral health; environmental health; or nutrition and physical activity.

FOUNDATIONAL CAPABILITIES

The Foundational Public Health Services (FPHS), 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 in each structure, the capabilities have been grouped into five categories (see the gray boxes below). The chart below illustrates Structure H agencies' ability to meet each infrastructure category. If an administrator responded that they could fully meet at least half or more of the capabilities in the category, they appear in the blue portion (first section) of the column; could partially meet at least half or more of the capabilities in the category, they appear in yellow (second section); or is not able to meet half or more of the capabilities in the category, they appear in green (third section), if applicable. Communication is the strongest category in Structure H, followed by Data and Partnerships. Administrators reported being less able to meet the capabilities in the Agency Operations and Planning/Programming/Reporting categories. The overall goal would be for each agency to appear in blue in each of the five categories.



Agency Operations
- Workforce development
- Strategic plan
- Emergency operations plan
- Financial management system
- Performance management system
- Quality improvement (QI) program
- QI activities

Communication
- Communication procedures
- Information available to the public
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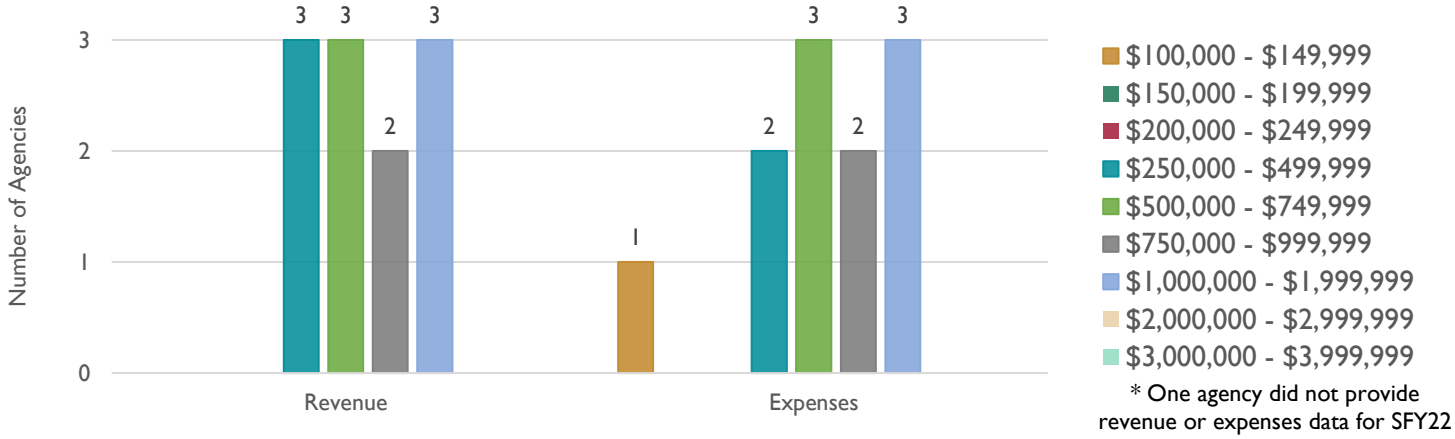
- Implement strategies to increase access to care services

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

REVENUE AND EXPENSES

Structure H Rural Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in 11 of the 12 rural counties in Structure H*. Population is not a determining factor for revenue or expenses for this group of agencies. One agency reported less than $150,000 in expenses and between $250,000 - $499,999 in revenue; three other agencies reported both revenue and expenses in the $1,000,000 - $1,999,999 category. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

Half or more of the rural agencies in Structure H provide:	Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; and Immunization and Tuberculosis
Less than half of the rural agencies in Structure H provide:	Chronic Disease and Disability Prevention and Management; Family Health; Injury Prevention; Public Information, Health Education, and Community Engagement; Screening and Assessment; and Substance Use Disorder Prevention

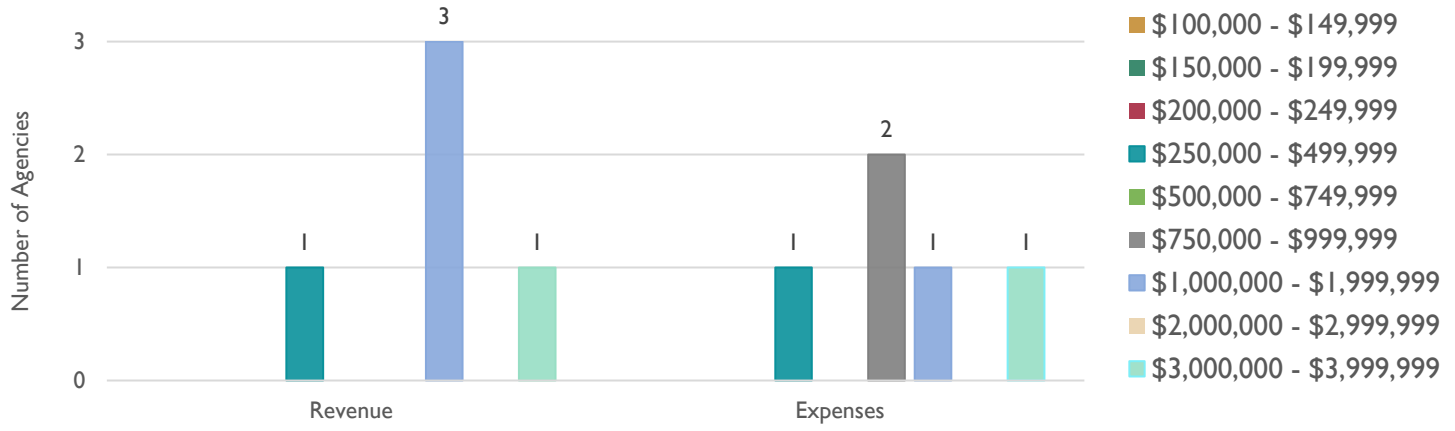


* One agency did not provide revenue or expenses data for SFY22

Structure H Micropolitan and Metropolitan Agencies: The charts below show the expenses and revenue ranges for the recognized local public health agencies in the micropolitan and metropolitan counties in Structure H. Population is not a determining factor for revenue or expenses for this group of agencies. One micropolitan agency reported both expenses and revenue in the $250,000 - $499,999 category; while the three other micropolitan agencies reported revenue in the $1,000,000 - $1,999,999 category and expenses between $914,000 and $1,280,000. The level of Board of Supervisor investment in public health and level of activities and services provided (including the number of staff needed to provide those services) are factors that contribute to the variability of agency budgets.

Half or more of the micropolitan and metropolitan agencies in Structure H provide:	Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; and Immunization and Tuberculosis
Less than half of the micropolitan or metropolitan agencies in Structure H provide:	Chronic Disease and Disability Prevention and Management; Family Health; HIV, STI, and Hepatitis; Public Information, Health Education and Community Engagement; and Tobacco Use Prevention and Control

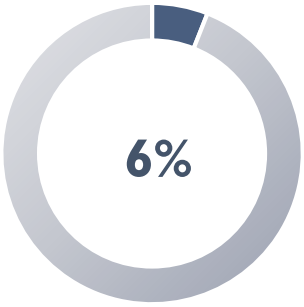
Serving as the primary contractor for a grant can also contribute to budget variability. Agencies that serve as the contractor for a multiple county area (such as the agency represented on the far-right below) administer higher dollar contracts to help assure the provision of specialized public health activities and services within a defined service area.



CROSS-JURISDICTIONAL SHARING

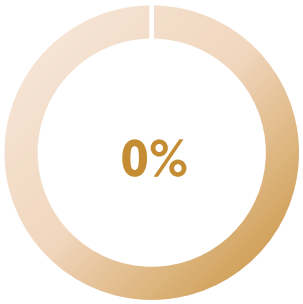
One option to assure public activities and services are provided at a high level is to share the delivery of services or staff between counties. Each administrator was asked to answer four questions about sharing; two questions to gauge the extent of which their agency *currently* shares the delivery 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 data showed the following for the agencies in Structure H.

Currently shares the delivery of services



Twelve agencies reported they minimally or do not currently share the delivery of services; while four reported they somewhat share the delivery of services. One agency (6%) reported that they significantly or completely share the delivery of services.

Currently shares staff with another agency

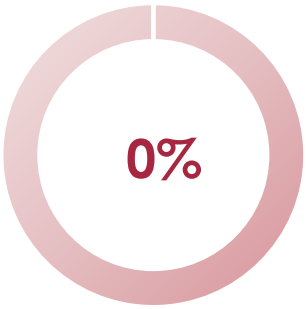


All seventeen agencies reported they minimally or do not share staff with another agency. No agencies (0%) reported they significantly or completely share staff with another agency.

Would consider sharing the delivery of services

Four agencies reported they would somewhat consider sharing the delivery of services. Three agencies (18%) reported they would significantly or completely consider sharing; while 10 agencies would minimally consider or would not at all consider sharing the delivery of services.

Would consider sharing staff with another agency



Two agencies reported they would somewhat consider sharing staff with another agency. No agencies (0%) reported that they would significantly or completely consider sharing; while 15 agencies would minimally consider or would not at all consider sharing staff with another agency.