2023 Local Public Health Structures

Iowa's Local Governmental Public Health System: Local Public Health Structures

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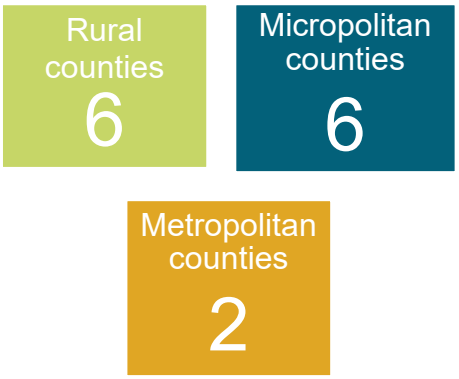
STRUCTURE A

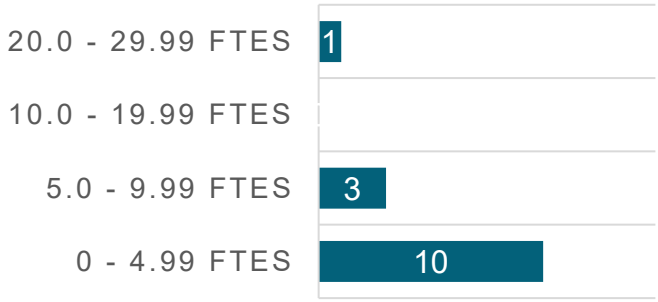
Structure A includes counties whose Boards of Health directly employ public health staff. The recognized public health agencies in these counties provides population-based activities and services only. Home health is not provided by public health staff, nor is it offered through a contract with another agency. There are 14 counties in this structure.

POPULATION

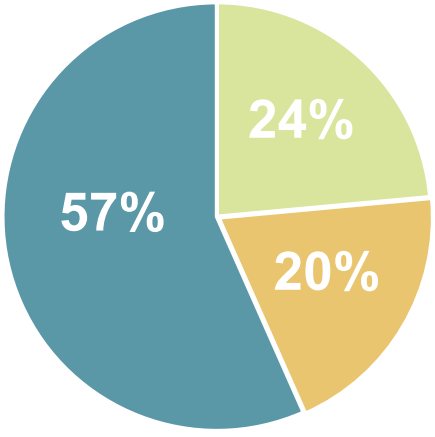


WORKFORCE

Full-time Equivalent (FTE)



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 fewer than 5.0 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 three micropolitan agencies reported having just 2.0 FTEs. The agency with the most FTEs in this structure had 22.0 FTEs. As a whole, there were 75.6 FTEs (across all 14 agencies) at the end of the state fiscal year (SFY23).



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 39.7 FTEs (57%), 16.5 FTEs (24%) were leadership roles, and operational functions accounted for 13.9 FTEs (20%).

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*
Disease Follow-up, Surveillance, and Control	14 (100%)
Emergency Preparedness and Response	14 (100%)
Immunization and Tuberculosis	13 (93%)
Public Information, Health Education and Community Engagement	13 (93%)

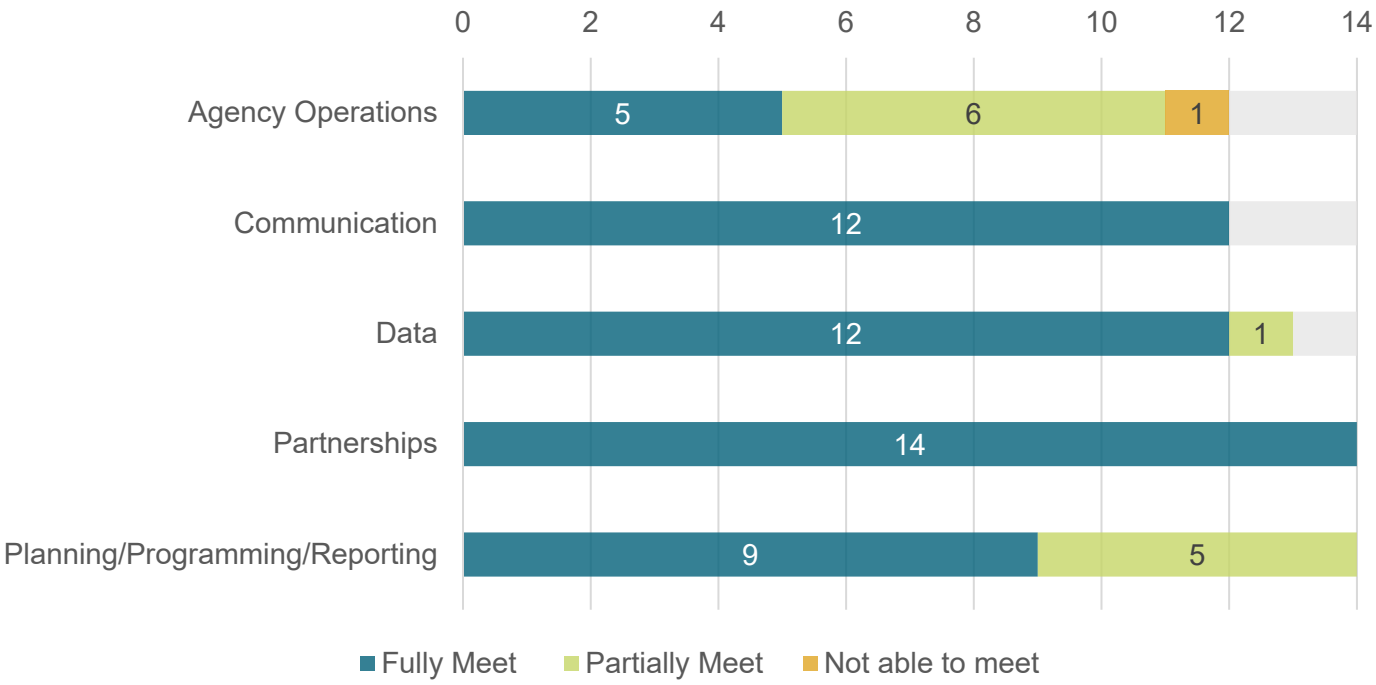
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure A. As noted in the structure description, agencies in this structure do not provide home health services. No two counties are alike, even when looking at their specific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

Service Category	Number of Agencies*	Service Category	Number of Agencies*
Nutrition and Physical Activity	10 (72%)	Family Health	6 (43%)
Chronic Disease and Disability Prevention and Management	9 (64%)	Injury Prevention	6 (43%)
Environmental Health	8 (57%)	Tobacco Use Prevention and Control	5 (36%)
Substance Use Disorder Prevention	8 (57%)	Behavioral Health	3 (21%)
Screening and Assessment	7 (50%)	HIV, STI, and Hepatitis	3 (21%)

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 orange boxes on page 31 of this report). 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. Partnerships is the strongest category in Structure A, followed by Communication and Data. 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.



REVENUE AND EXPENSES

STRUCTURE A RURAL AGENCIES

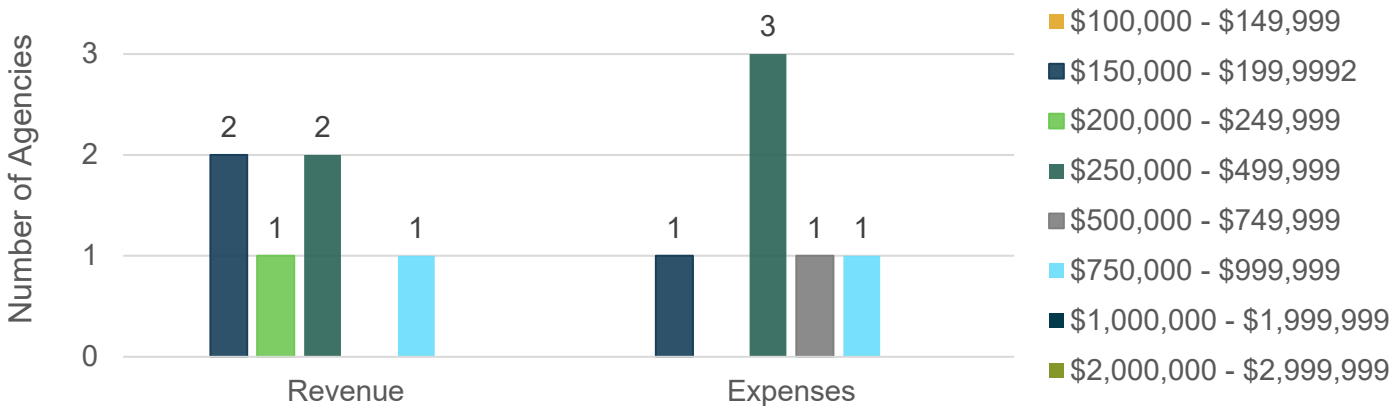
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the five rural counties in Structure A. Population is not a determining factor for revenue or expenses for this group of agencies. Five counties had less than $499,999 in revenue; with one agency in the $750,000 - $999,999 category. Expenses for two counties exceeded $500,000. 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 A 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; Injury Prevention; Nutrition and Physical Activity; Public Information, Health Education and Community Engagement; Screening & Assessment; and Substance Use Disorder Prevention

Less than half of the rural agencies in Structure A provide:

Behavioral Health; HIV, STI, and Hepatitis; and Tobacco Use Prevention and Control



STRUCTURE A MICROPOLITAN AGENCIES:

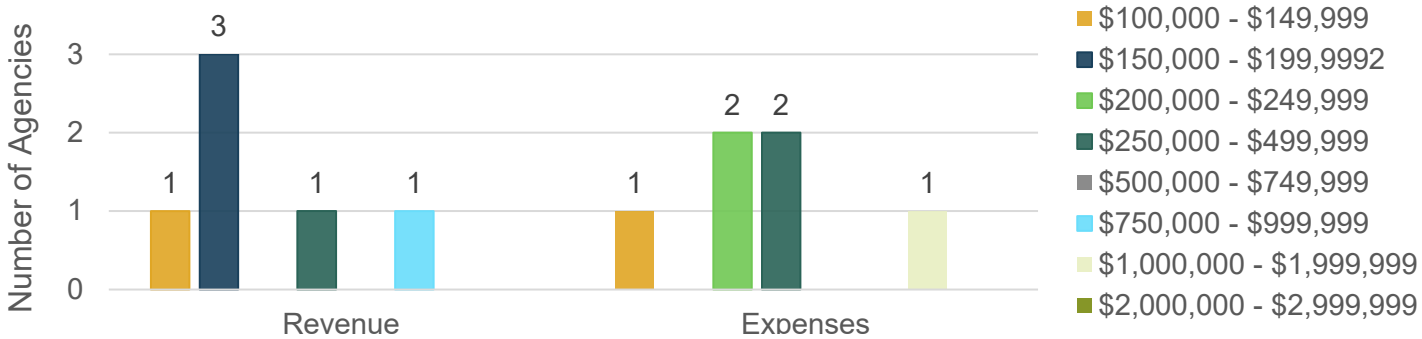
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the six micropolitan counties in Structure A. Population is not a determining factor for revenue or expenses for this group of agencies. Five of the six agencies reported less than $500,000 for both revenue and expenses; with one agency reporting a little over $1,000,000 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.

Half or more of the micropolitan agencies in Structure A provide:

Chronic Disease and Disability Prevention and Management; Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Immunization and Tuberculosis; and Nutrition and Physical Activity; Public Information, Health Education and Community Engagement; and Substance Use Disorder Prevention

Less than half of the micropolitan agencies in Structure A provide:

Behavioral Health; Environmental Health; Family Health; HIV, STI, and Hepatitis; Injury Prevention; Screening and Assessment; and Tobacco Use Prevention and Control



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; Nutrition and Physical Activity; and Public Information, Health Education and Community Engagement

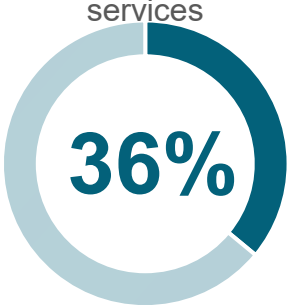
Also provided by a metropolitan county in Structure A:

Chronic Disease and Disability Prevention and Management; Family Health; HIV, STI, and Hepatitis; Screening and Assessment; Screening and Assessment; Substance Use Disorder Prevention; and Tobacco Use

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 public health activities and services

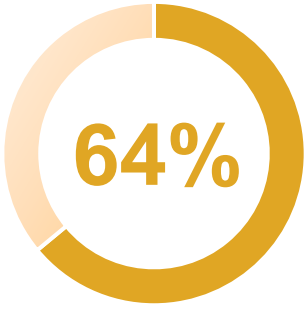


Five administrators reported they share the delivery of public health activities and services with another agency; while nine reported they do not share the delivery of public health activities and services with another agency.

Currently shares staff

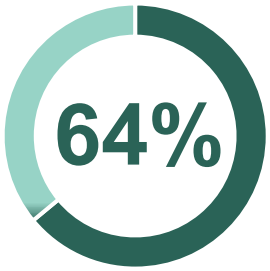
Two administrators reported they share staff with another agency; while 12 reported they do not share staff with another agency.

Would consider sharing the delivery of activities and services



Nine administrators responded that they would consider sharing the delivery of public health activities and services with another agency; while five responded that they would not consider sharing.

Would consider sharing staff



Nine administrators responded that they would consider sharing staff with another agency; while five responded that they would not consider sharing staff.

STRUCTURE B

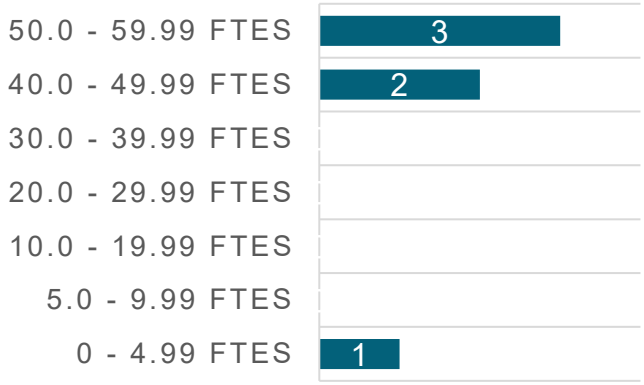
Structure B includes counties whose Boards of Health directly employ public health staff. The recognized public health agencies in these counties provide population-based activities and services only. Home health is provided through a contract with another agency. There are six counties in this structure.

POPULATION

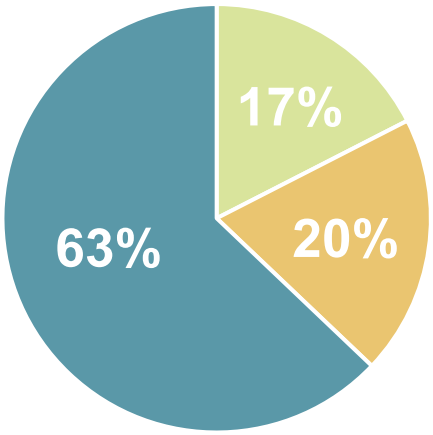
Metropolitan counties
6

WORKFORCE

Full-time Equivalent (FTE)



Workforce varies from county to county. Structure B administrators were asked to provide the total number of full-time equivalents (FTEs) for their agency. Staff FTEs were similar for five of the six agencies in this structure. The agency with the most FTEs in this structure had 54.5 FTEs; the agency with the least FTEs had 3.0 FTEs. As a whole, there were 254.2 FTEs (across all six agencies) at the end of the state fiscal year (SFY23). 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 129.6 FTEs (63%), 40.5 FTEs (20%) were operational functions, and leadership roles accounted for 36.0 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. All of the agencies in Structure B provide at least two-thirds of population health activities and services.

Service Category	Number of Agencies*
Public Information, Health Education and Community Engagement	6 (100%)
Disease Follow-up, Surveillance, and Control	5 (83%)
Emergency Preparedness and Response	5 (83%)
Immunization and Tuberculosis	5 (83%)

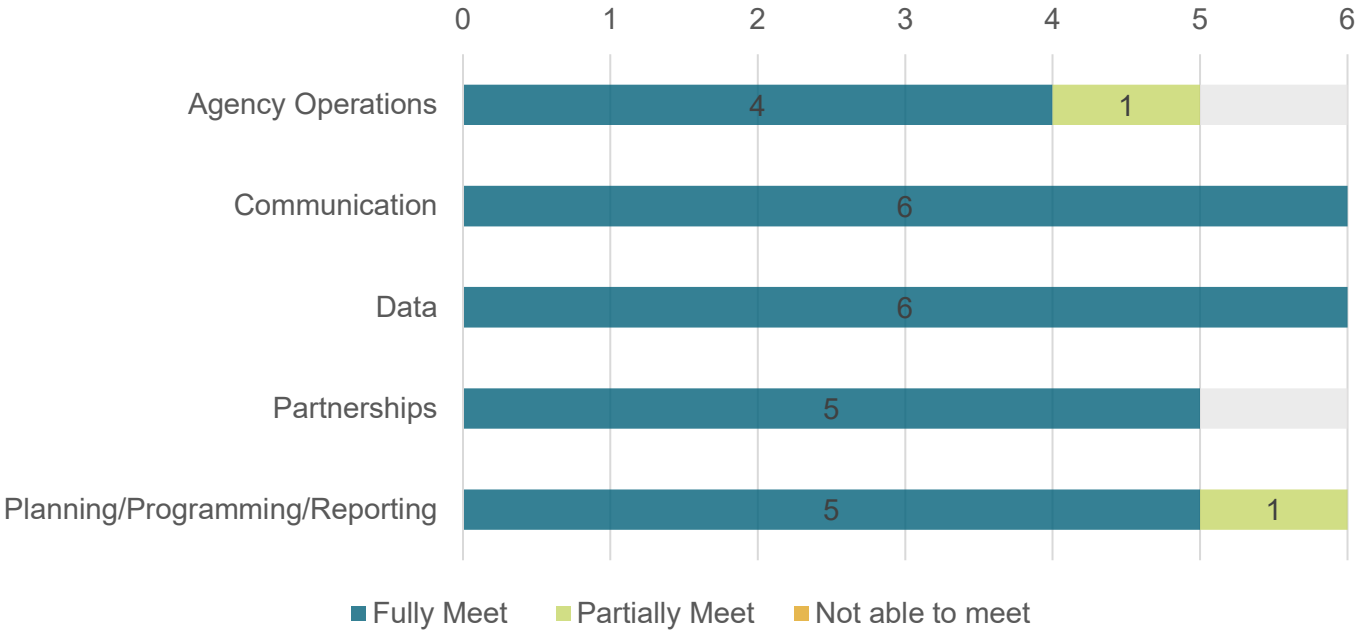
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure B. As noted in the structure description, the agencies in this structure do not provide home health services. No two counties are alike, even when looking at their specific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

Service Category	Number of Agencies*	Service Category	Number of Agencies*
Environmental Health	6 (100%)	Nutrition and Physical Activity	3 (50%)
HIV, STI, and Hepatitis	5 (83%)	Injury Prevention	1 (17%)
Screening and Assessment	4 (67%)	Substance Use Disorder Prevention	2 (33%)
Chronic Disease and Disability Prevention and Management	3 (50%)	Tobacco Use Prevention and Control	2 (33%)
Family Health	3 (50%)	Behavioral Health	0 (0%)

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 orange boxes on page 31 of this report). 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

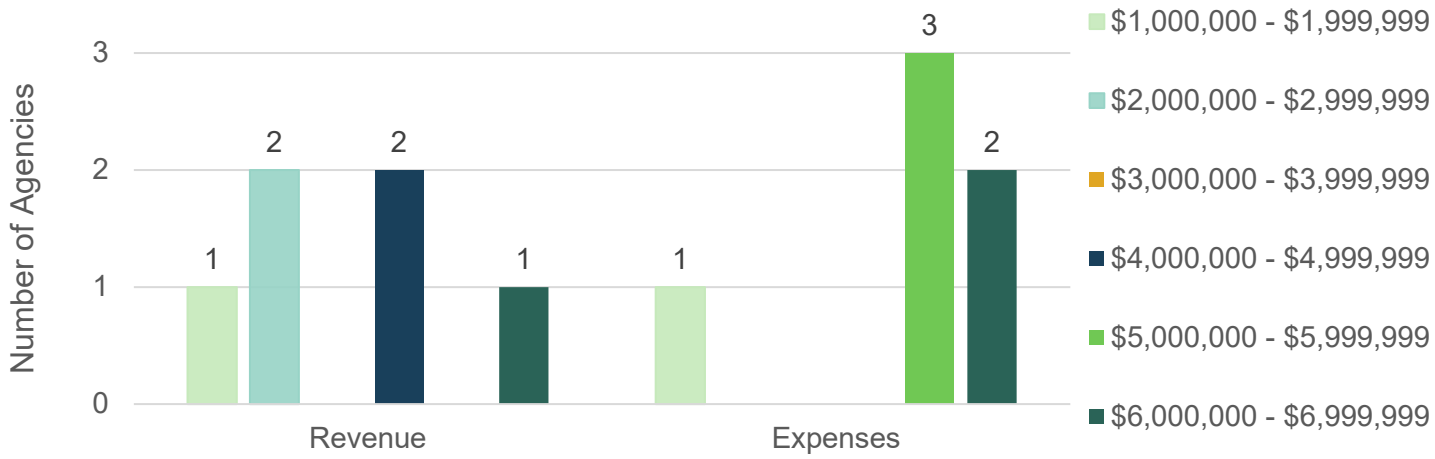
meet the capabilities in the Agency Operations and Planning/Programming/Reporting categories. The overall goal would be for each agency to appear in blue in each of the five categories.



REVENUE AND EXPENSES

STRUCTURE B AGENCIES:

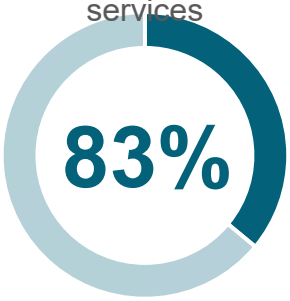
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the five metropolitan counties in Structure B. Revenue for three of the six agencies was greater than $4,000,000; with one agency reporting revenue of less than $2,000,000. Expenses for five of the six agencies exceeded $5,000,000. Population is not a determining factor for revenue or expenses for this group of agencies. The agencies that reported the highest revenue and expenses for SFY23 were 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 six agencies provided direct service clinics and one agency provided correctional health nursing. Serving as the primary contractor for a grant can also contribute to budget variability. Three of the six 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 A.

Currently shares the delivery of public health activities and services

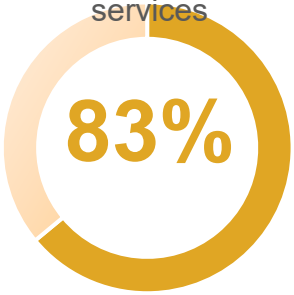


Five administrators reported they share the delivery of public health activities and services with another agency; while one reported they do not share the delivery of public health activities and services with another agency.

Currently shares staff

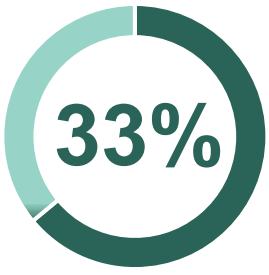
One administrator reported they share staff with another agency; while five reported they do not share staff with another agency.

Would consider sharing the delivery of activities and services



Five administrators responded that they would consider sharing the delivery of public health activities and services with another agency; while one responded that they would not consider sharing.

Would consider sharing aastaff



Two administrators responded that they would consider sharing staff with another agency; while four responded that they would not consider sharing staff.

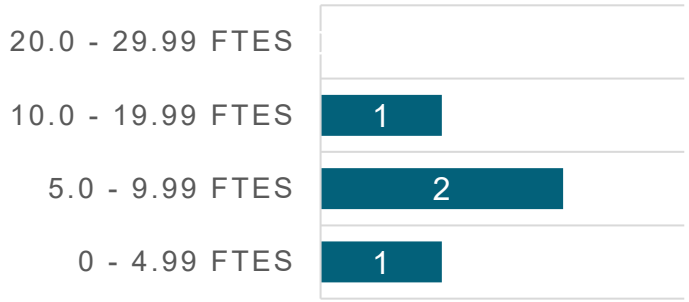
STRUCTURE C

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.

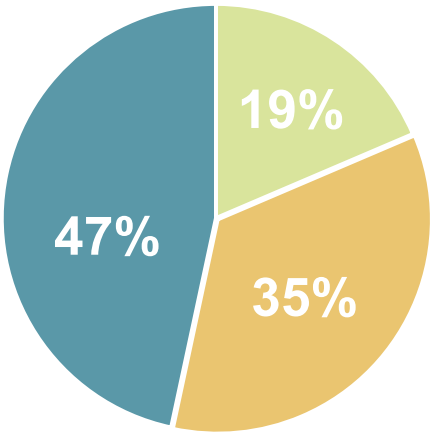
POPULATION

Rural counties
4

WORKFORCE
Full-time Equivalent (FTE)



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 10.0 or fewer FTEs. Population served was not a factor in determining the number of FTEs for an agency. One agency, that serves the most populous county in this structure, reported having 12.3 FTEs. The agency serving the next most populous county reported 3.0 FTEs, the least amount for this structure. As a whole, there were 25.8 FTEs (across the four agencies) at the end of the state fiscal year (SFY23).



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 11.8 FTEs (47%), 8.8 FTEs (35%) were operational functions, and leadership roles accounted for 4.7 FTEs (19%).

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 C provide basic population health activities and services.

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

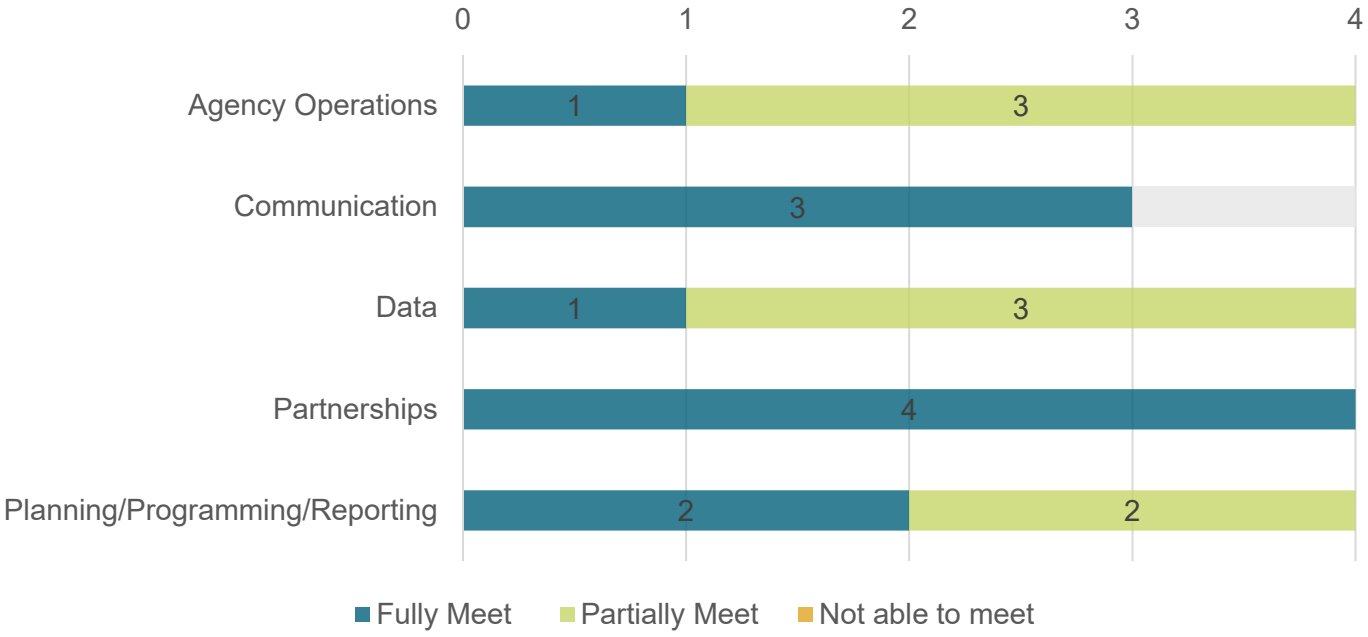
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure C. As noted in the structure description, agencies in this structure provide some home health services. Two of the four agencies reported spending 50% of more of their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

Service Category	Number of Agencies*	Service Category	Number of Agencies*
Chronic Disease and Disability Prevention and Management	4 (100%)	HIV, STI, and Hepatitis	1 (25%)
Screening and Assessment	4 (100%)	Substance Use Disorder Prevention	1 (25%)
Family Health	3 (75%)	Behavioral Health	0 (0%)
Injury Prevention	2 (50%)	Environmental Health	0 (0%)
Nutrition and Physical Activity	2 (50%)	Tobacco Use Prevention and Control	0 (0%)

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 orange boxes on page 31 of this report). 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

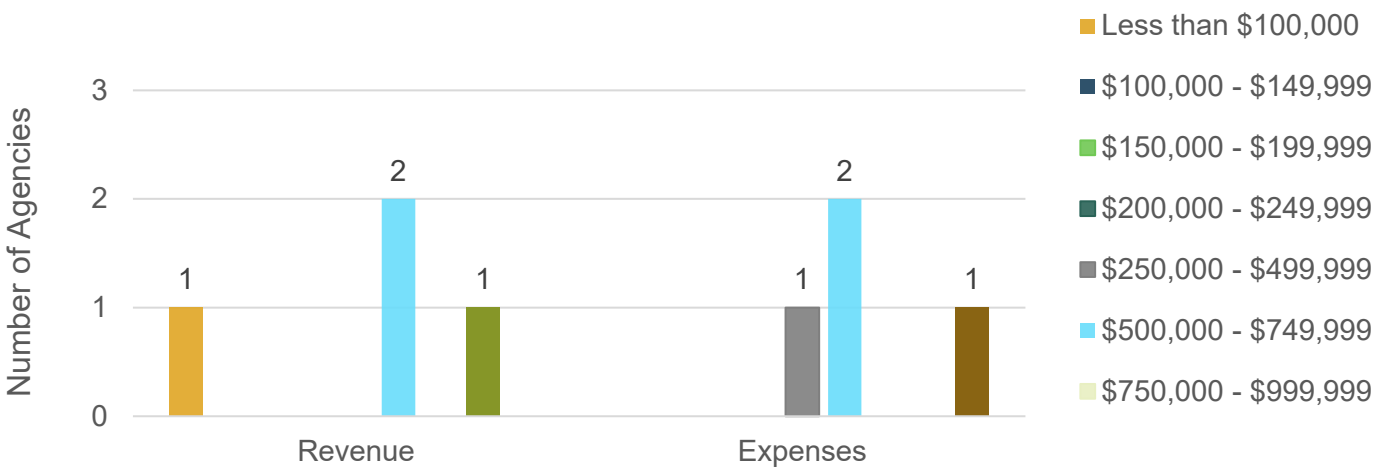
Structure A, followed by Data and Partnerships. Administrators reported being less able to meet the capabilities in the Agency Operations and Planning/Programming/Reporting categories. The overall goal would be for each agency to appear in blue in each of the five categories.



REVENUE AND EXPENSES

Structure C Agencies:

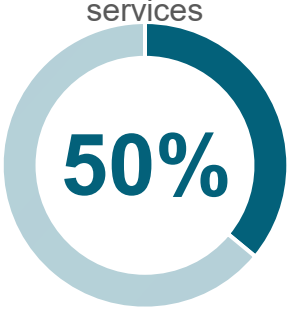
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the four rural counties in Structure C. Population is not a determining factor for revenue or expenses for this group of agencies. Each of the four agencies fell within a different category for both 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 public health activities and services



Two administrators reported they share the delivery of public health activities and services with another agency and two reported they do not share the delivery of public health activities and services with another agency.

Currently shares staff

One administrator reported they share staff with another agency; three reported they do not share staff with another agency.

Would consider sharing the delivery of activities and services

All four administrators responded that they would consider sharing the delivery of public health activities and services with another agency.

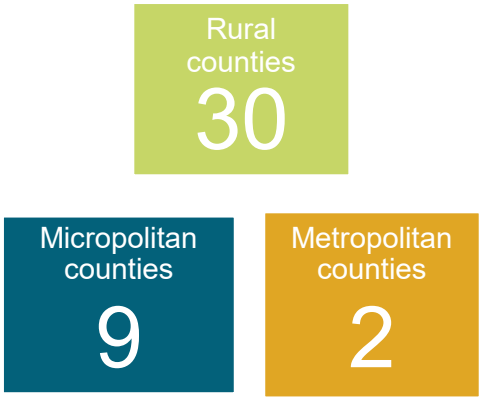
Would consider sharing staff

Three administrators responded that they would consider sharing staff with another agency; one responded that they would not consider sharing staff.

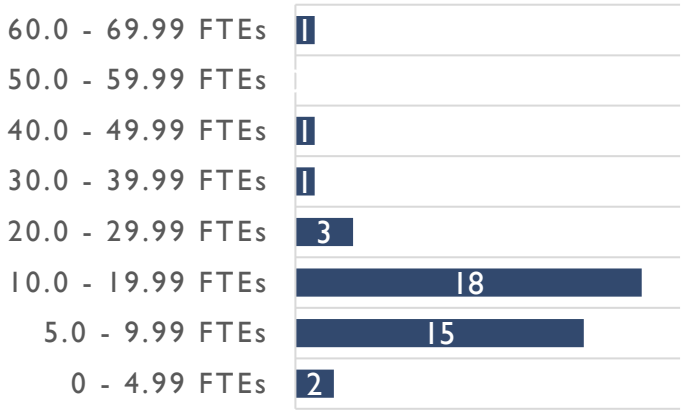
STRUCTURE D

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.

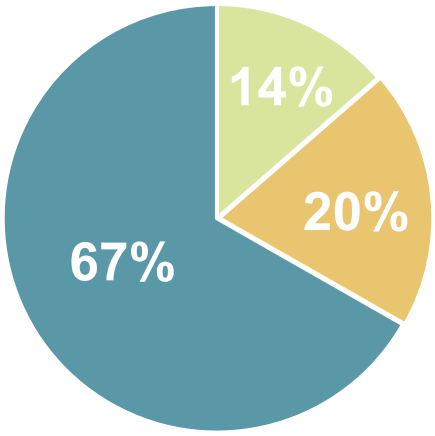
POPULATION



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. One rural agency reported having 3.7 FTEs and one micropolitan agency reported having 8.0 FTEs. The agency with the most FTEs in this structure had 64.1 FTEs. As a whole, there were 586.5 FTEs (across all 41 agencies) at the end of the state fiscal year (SFY23).



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 375.4 FTEs (67%), 110.5 FTEs (20%) were operational functions, and leadership roles accounted for 76.5 FTEs (14%).

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. Almost all of the agencies in Structure D provide basic population health activities and services.

Service Category	Number of Agencies*
Disease Follow-up, Surveillance, and Control	41 (100%)
Emergency Preparedness and Response	41 (100%)
Immunization and Tuberculosis	40 (98%)
Public Information, Health Education and Community Engagement	39 (95%)

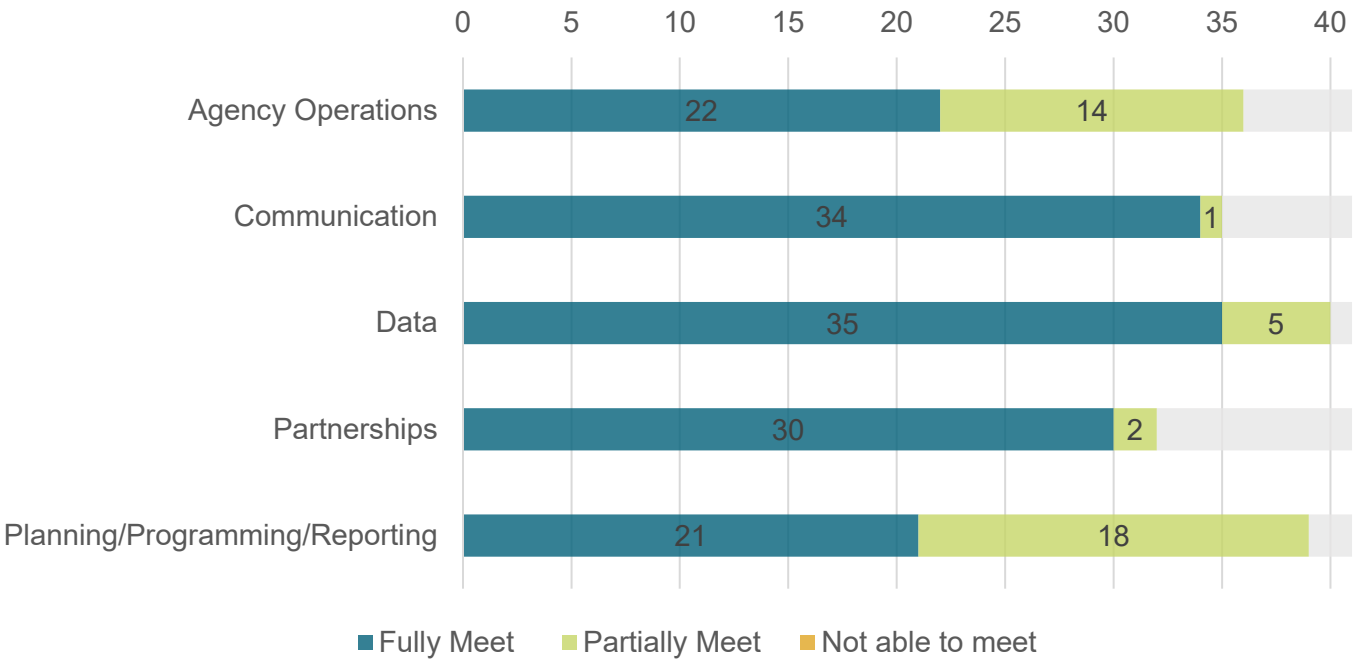
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure D. As noted in the structure description, agencies in this structure also provide home health services; 22 agencies reported spending 50% or more of their time providing 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*
Environmental Health	28 (68%)	Injury Prevention	14 (34%)
Chronic Disease and Disability Prevention and Management	25 (61%)	Tobacco Use Prevention and Control	14 (34%)
Screening and Assessment	24 (59%)	Substance Use Disorder Prevention	11 (27%)
Family Health	17 (41%)	HIV, STI, and Hepatitis	10 (24%)
Nutrition and Physical Activity	16 (39%)	Behavioral Health	6 (14%)

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 orange boxes on page 31 of this report). 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.



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. Nineteen of the 30 rural agencies reported less than $750,000 in revenue and 14 agencies reported more than $1,000,000 in expenses. Population is not a determining factor for revenue or expenses for this group of agencies. One agency reported between $250,000 - $499,999 in revenue and $500,000 - $749,999 in expenses; one agency reported $2,000,000 - $3,000,000 in 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 rural agencies in Structure D provide:

Chronic Disease and Disability Prevention and Management; Disease Follow-up, Surveillance, and Control; Emergency Preparedness and Response; Environmental Health; Immunization and Tuberculosis; Public Information, Health Education and Community Engagement and Screening and Assessment

Less than half of the rural agencies in Structure D provide:

Behavioral Health; Family Health; 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:

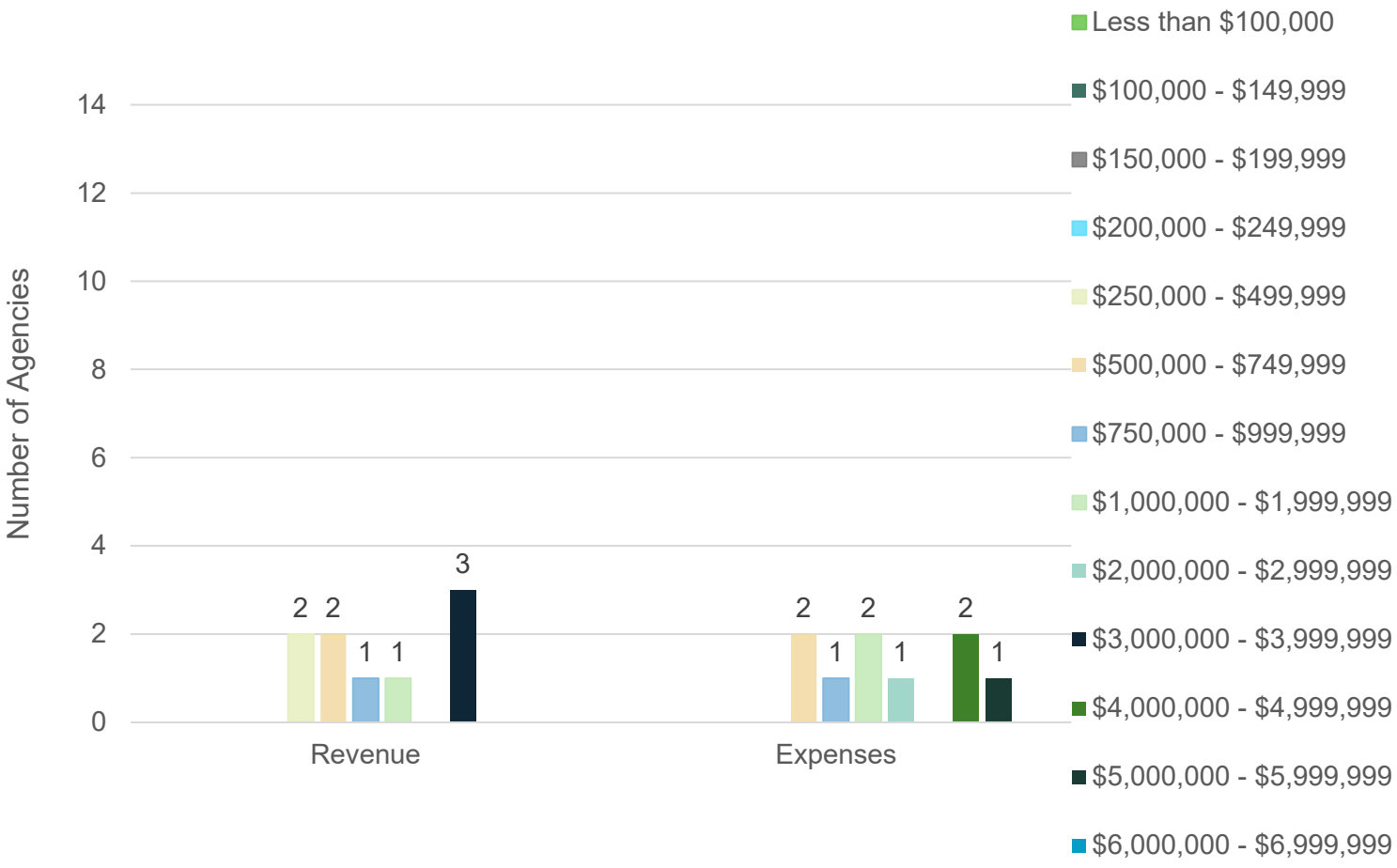
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the nine micropolitan counties in Structure D. Population is not a determining factor for revenue or expenses for this group of counties. Three of the nine agencies reported revenue and expenses of more than $3,000,000; while two agencies reported revenue in the $250,000 - $499,999 category and expenses 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.

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



STRUCTURE D METROPOLITAN AGENCIES:

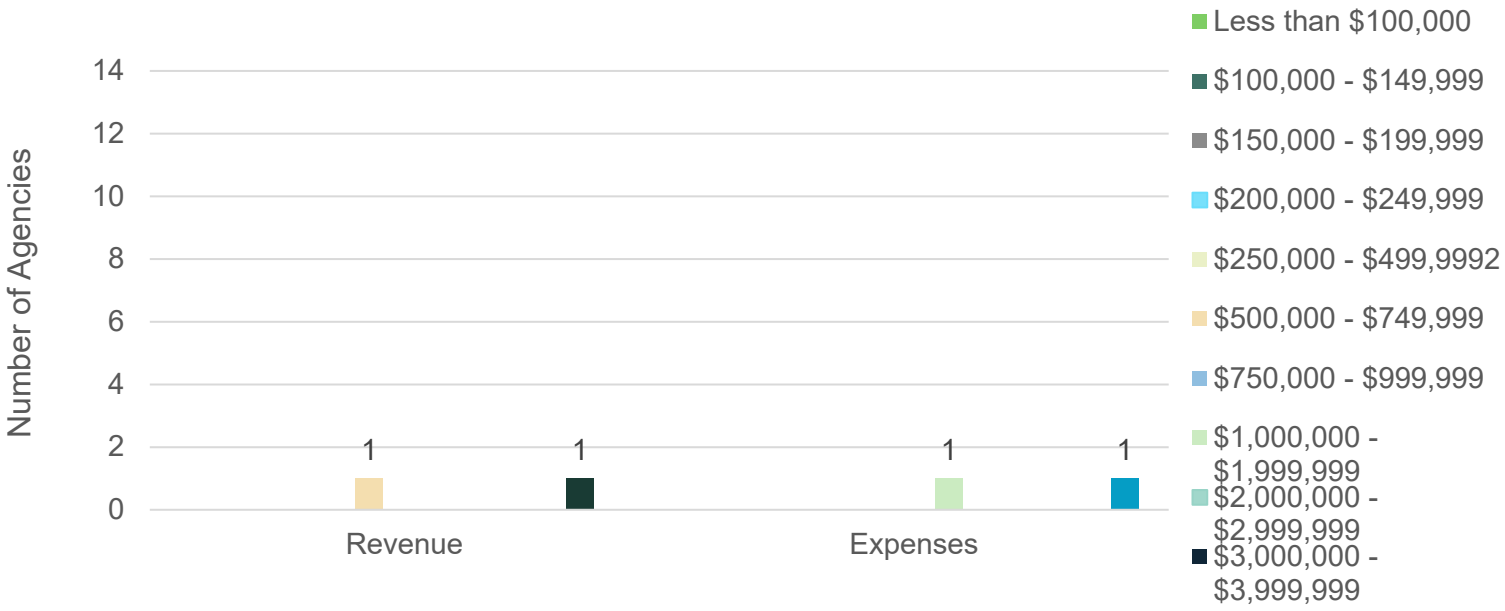
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the two metropolitan counties in Structure D. Population is not a determining factor for revenue or expenses for this group of agencies. One agency reported revenue and expenses in the $1,000,000 - $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:

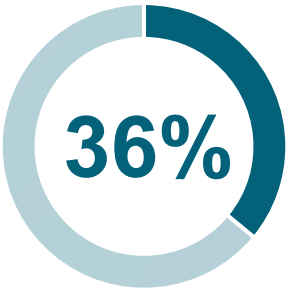
Behavioral Health; HIV, STD, and Hepatitis; Nutrition and Physical Activity; and Tobacco Use Prevention and Control



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 A.

Currently shares the delivery of public health activities and services

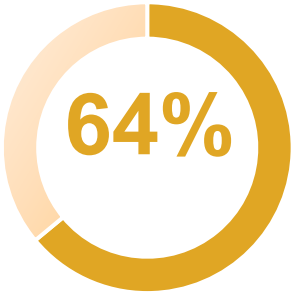


Five administrators reported they share the delivery of public health activities and services with another agency; while nine reported they do not share the delivery of public health activities and services with another agency.

Currently shares staff

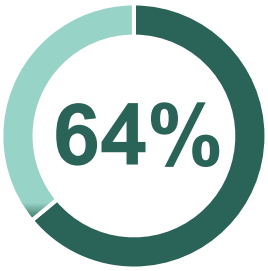
Two administrators reported they share staff with another agency; while 12 reported they do not share staff with another agency.

Would consider sharing the delivery of activities and services



Nine administrators responded that they would consider sharing the delivery of public health activities and services with another agency; while five responded that they would not consider sharing.

Would consider sharing staff

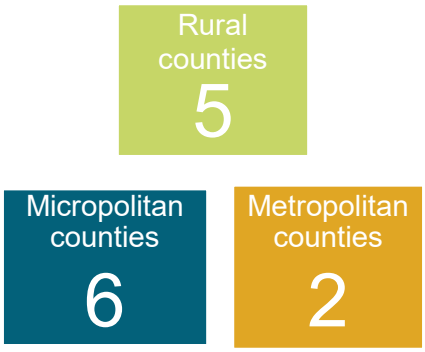


Nine administrators responded that they would consider sharing staff with another agency; while five responded that they would not consider sharing staff.

STRUCTURE E

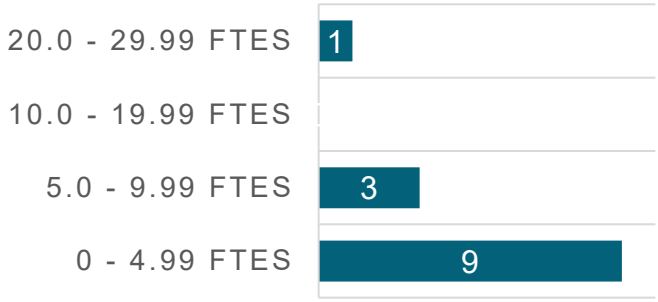
Structure E includes counties whose Boards of Health contract with an outside agency for services. The recognized public health agencies in these counties provide population-based activities and services only. Home health is not provided by the county. There are four counties in this structure.

POPULATION

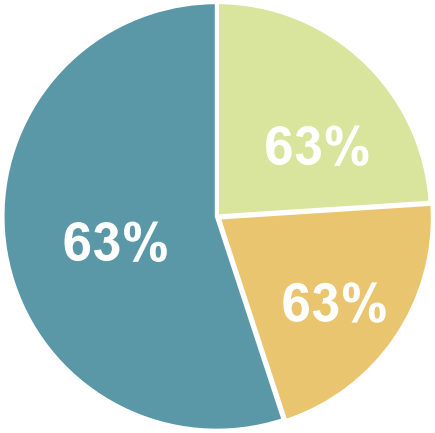


WORKFORCE

Full-time Equivalent (FTE)



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 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 E 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%)

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.

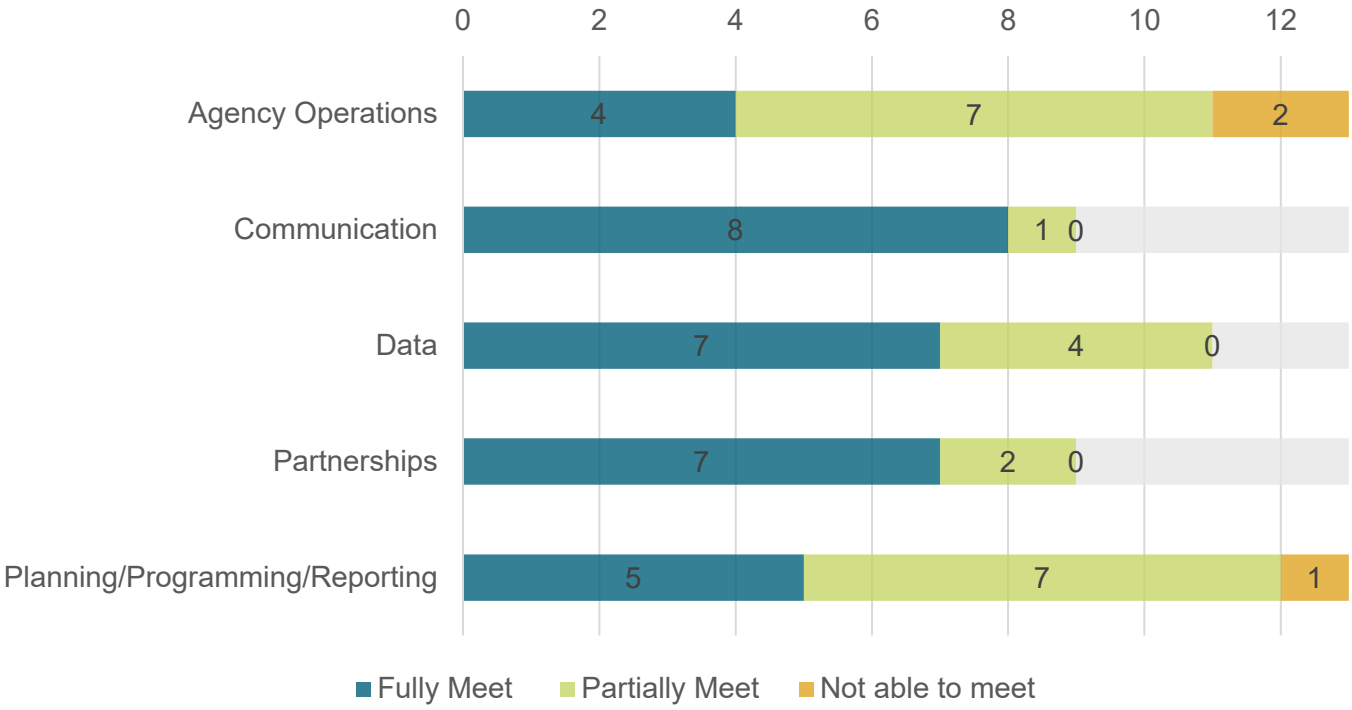
Service Category	Number of Agencies*	Service Category	Number of Agencies*
Environmental Health	5 (45%)	Injury Prevention	2 (18%)
Family Health	4 (36%)	Behavioral Health	1 (9%)
Nutrition and Physical Activity	4 (36%)	HIV, STI, and Hepatitis	1 (9%)
Screening and Assessment	3 (27%)	Substance Use Disorder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

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 orange boxes on page 31 of this report). 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 is the strongest category in Structure E, 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.



REVENUE AND EXPENSES

STRUCTURE E RURAL AGENCIES:

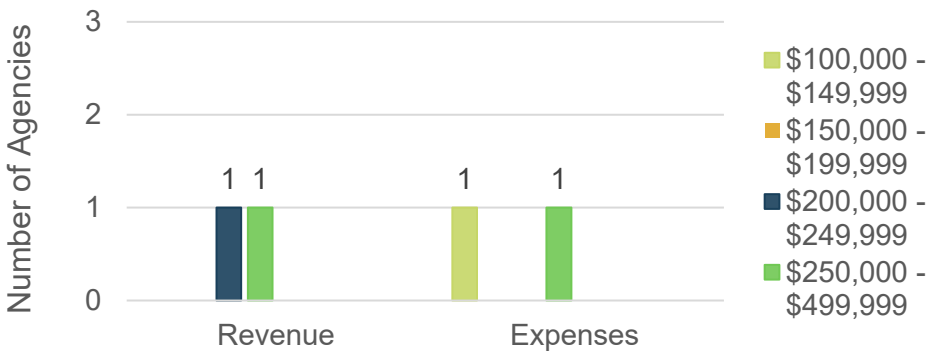
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the two rural counties in Structure E. One agency fell within the $250,000 - $499,999 category for both revenue and expenses; the other agency in the $200,000 - $249,999 category for revenue and the $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:

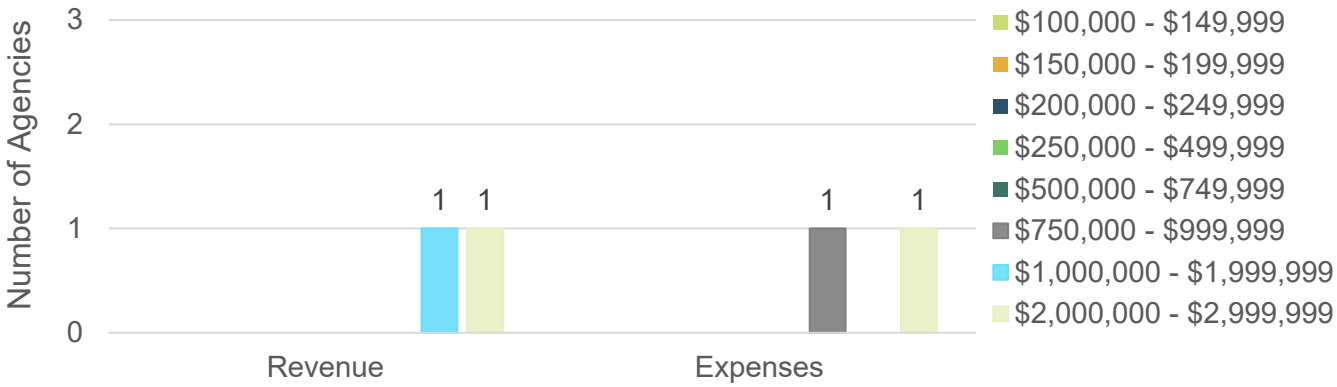
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the two micropolitan counties in Structure E. Population is not a determining factor for revenue or expenses for this group of agencies. One agency reported two and a half times the revenue (and expenses) 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:

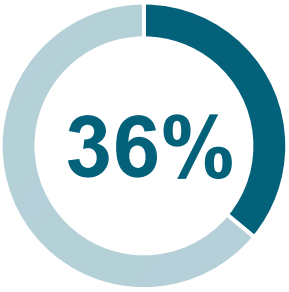
Chronic Disease and Disability Prevention and Management; Environmental Health; Immunization and Tuberculosis; Nutrition and Physical Activity; Public Information, Health Education, and Community Engagement; and Tobacco Use Prevention and Control



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 public health activities and services

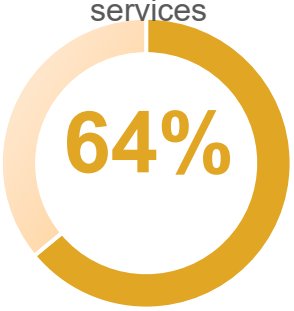


Five administrators reported they share the delivery of public health activities and services with another agency; while nine reported they do not share the delivery of public health activities and services with another agency.

Currently shares staff

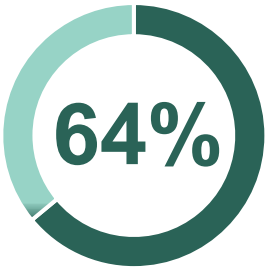
Two administrators reported they share staff with another agency; while 12 reported they do not share staff with another agency.

Would consider sharing the delivery of activities and services



Nine administrators responded that they would consider sharing the delivery of public health activities and services with another agency; while five responded that they would not consider sharing.

Would consider sharing staff

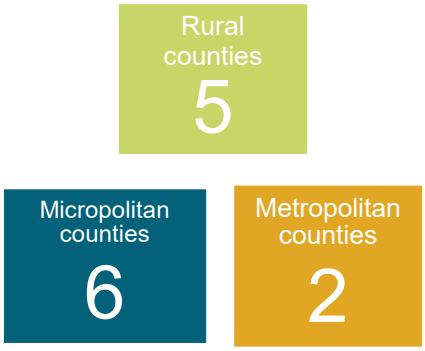


Nine administrators responded that they would consider sharing staff with another agency; while five responded that they would not consider sharing staff.

STRUCTURE F

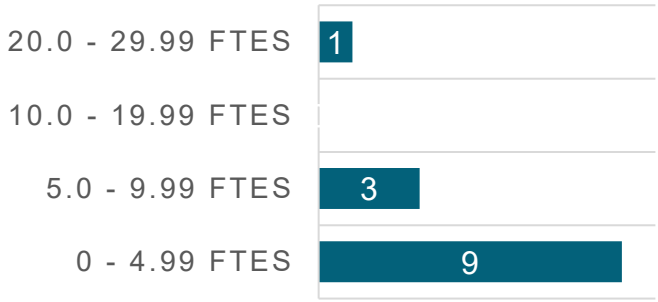
Structure F includes counties whose Boards of Health contract with an outside agency for services. The recognized public health agencies in these counties provides population-based activities and services only. Home health is provided by the county through an additional contracted agency. There are eight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

POPULATION

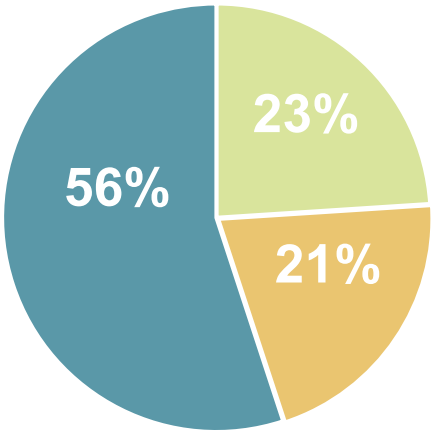


WORKFORCE

Full-time Equivalent (FTE)



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 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 F, 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 F 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%)

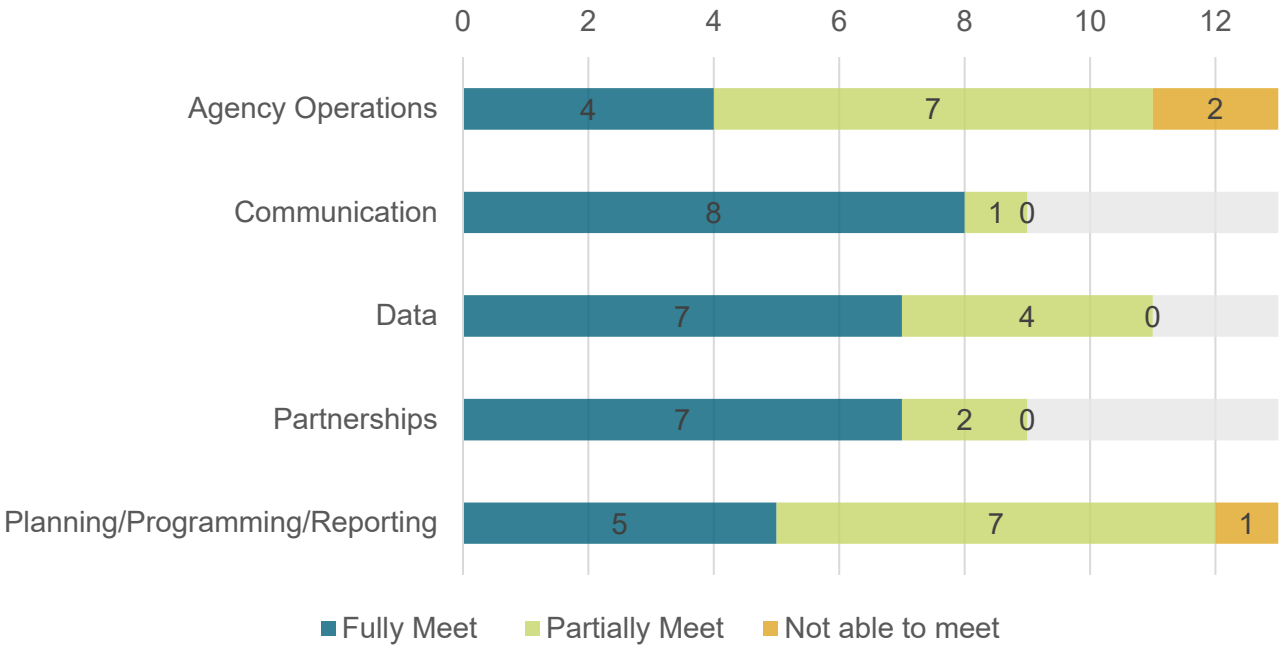
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure F. As noted in the structure description, agencies in this structure do not provide home health services. No two counties are alike, even when looking at their specific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

Service Category	Number of Agencies*	Service Category	Number of Agencies*
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 orange boxes on page 31 of this report). 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. 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.



REVENUE AND EXPENSES

STRUCTURE F RURAL AGENCIES:

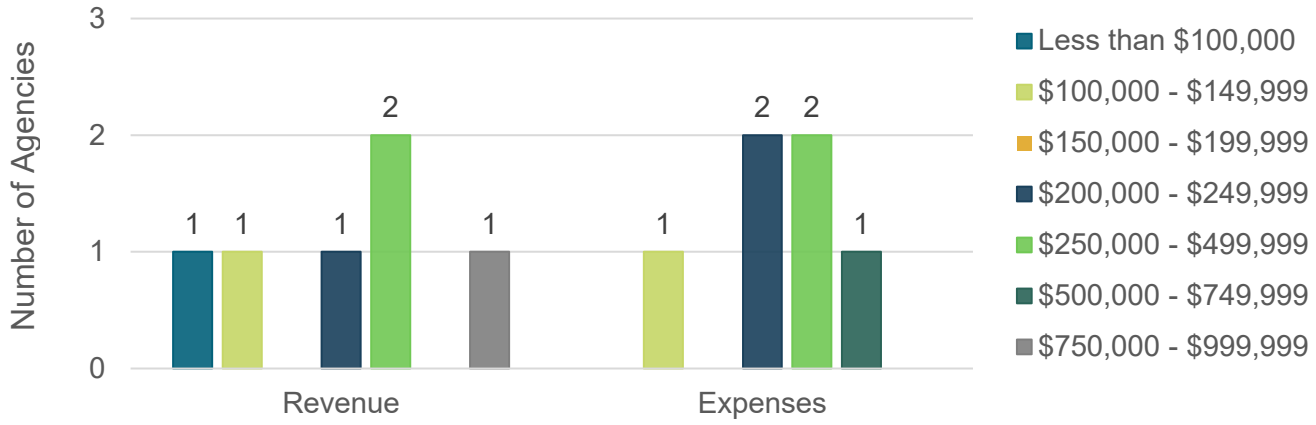
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the six rural counties in Structure F. Population is not a determining factor for revenue or expenses for this group of agencies. One rural agency reported less than $100,000 in revenue and less than $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:

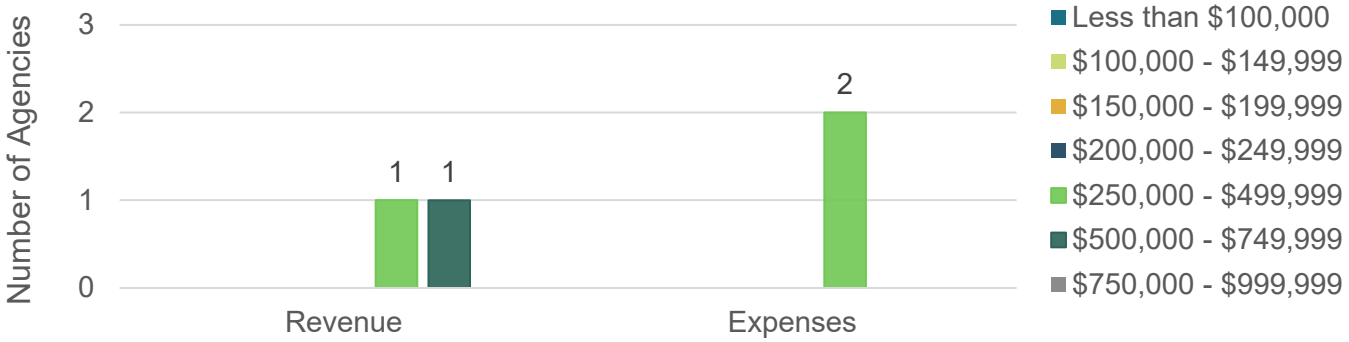
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the micropolitan and metropolitan counties in Structure F. Population is not a determining factor for revenue or expenses for this group of agencies. Both agencies fell within the $250,000 - $499,999 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.

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:

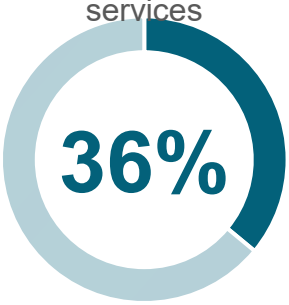
Chronic Disease and Disability Prevention and Management; Environmental Health; Nutrition and Physical Activity; and Screening and Assessment



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 public health activities and services

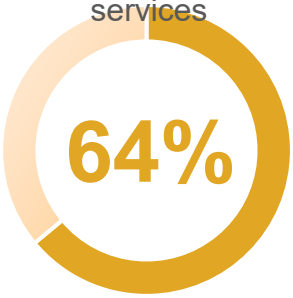


Five administrators reported they share the delivery of public health activities and services with another agency; while nine reported they do not share the delivery of public health activities and services with another agency.

Currently shares staff

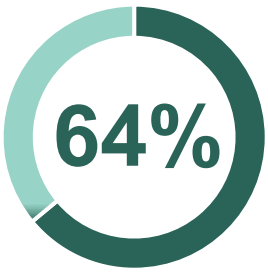
Two administrators reported they share staff with another agency; while 12 reported they do not share staff with another agency.

Would consider sharing the delivery of activities and services



Nine administrators responded that they would consider sharing the delivery of public health activities and services with another agency; while five responded that they would not consider sharing.

Would consider sharing staff

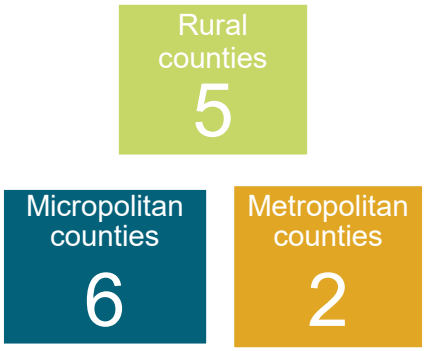


Nine administrators responded that they would consider sharing staff with another agency; while five responded that they would not consider sharing staff.

STRUCTURE H

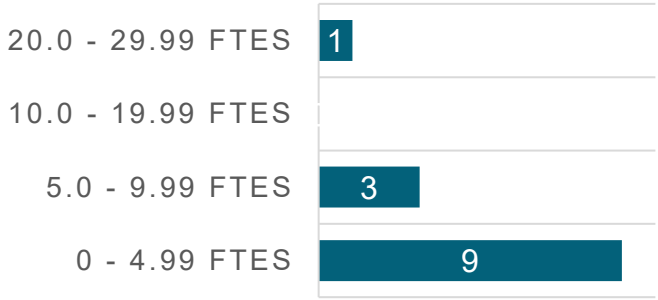
Structure H includes counties whose Boards of Health contract with an outside agency for services. The recognized public health agencies in these counties provide population-based activities and services and home health services. There are 17 counties in this structure.

POPULATION

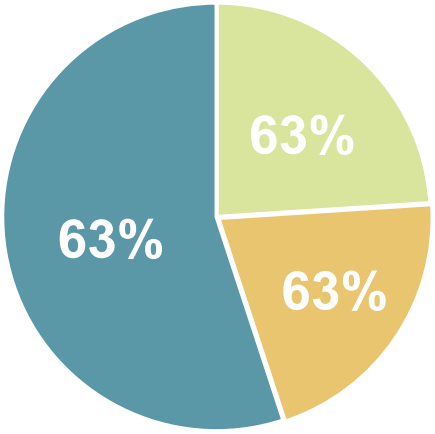


WORKFORCE

Full-time Equivalent (FTE)



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 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 H 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%)

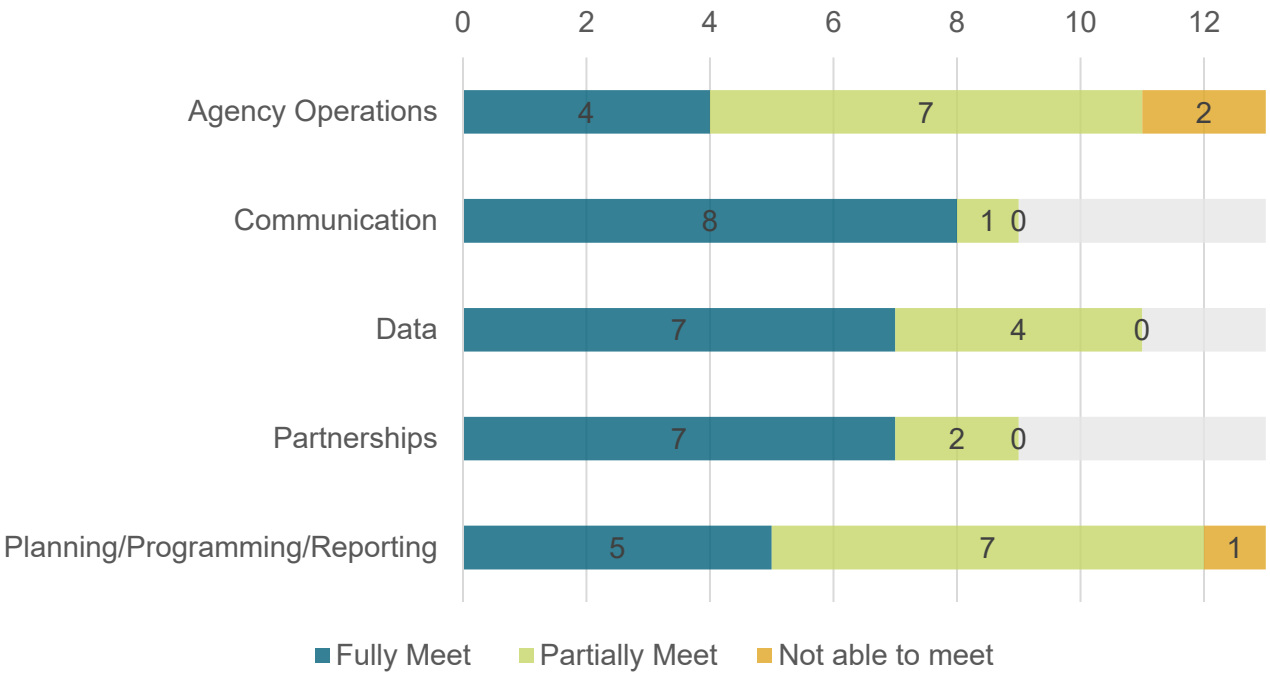
The table below shows the types of specialized activities and services provided by recognized local public health agencies in Structure H. As noted in the structure description, agencies in this structure do not provide home health services. No two counties are alike, even when looking at their specific 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 orange boxes on page 31 of this report). 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.



REVENUE AND EXPENSES

STRUCTURE H RURAL AGENCIES:

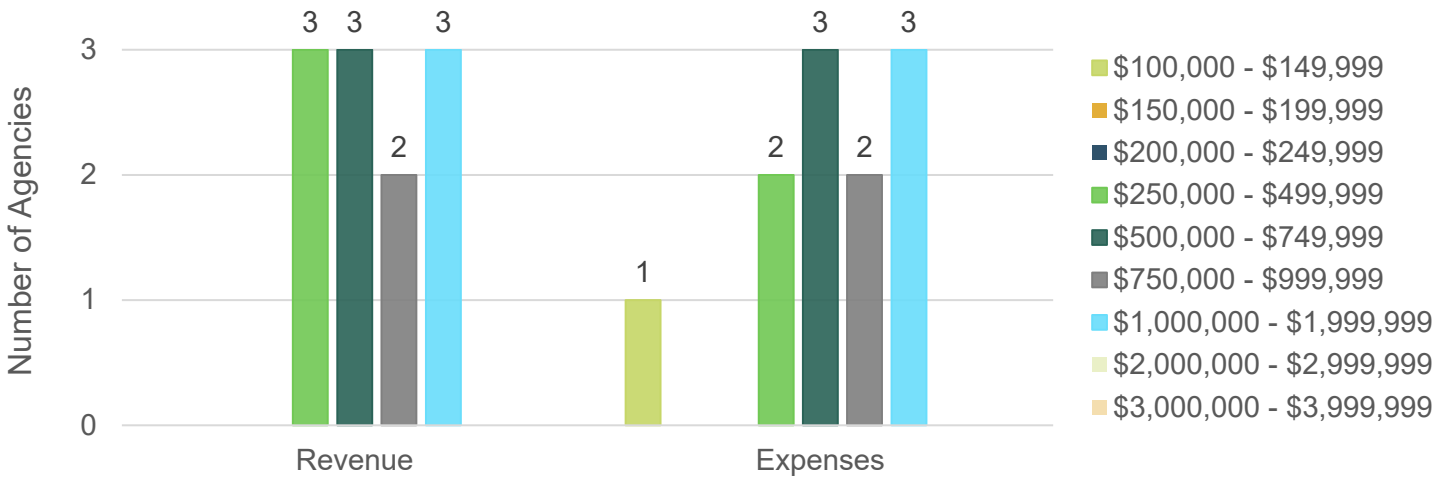
The charts below show the expenses and revenue ranges for the recognized local public health agencies in 11 of the 12 rural counties in Structure H*. Population is not a determining factor for revenue or expenses for this group of agencies. One agency reported less than $150,000 in expenses and between $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



STRUCTURE H MICROPOLITAN AND METROPOLITAN AGENCIES:

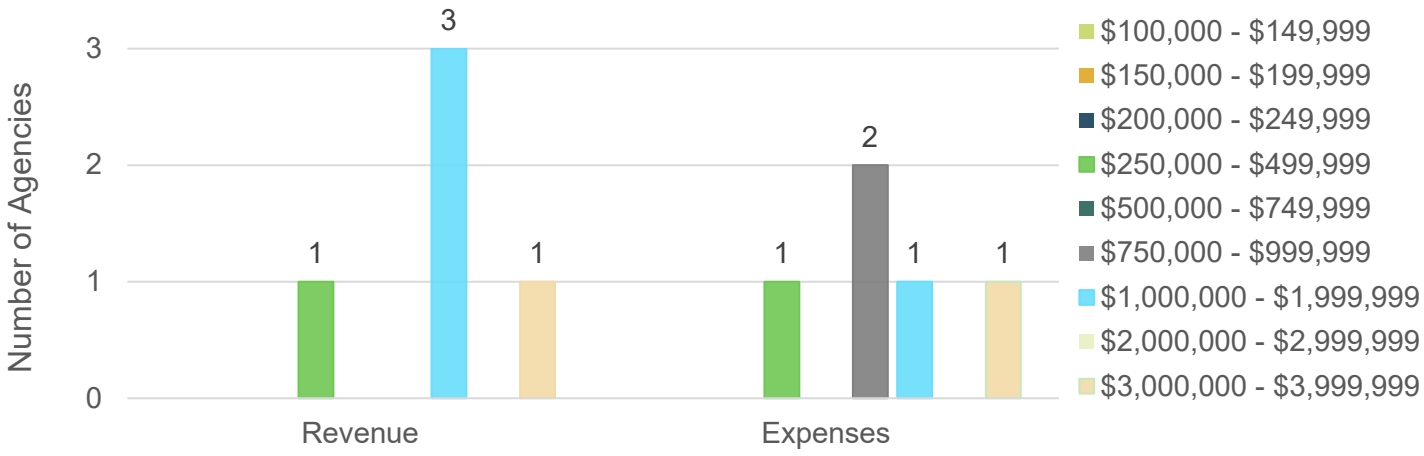
The charts below show the expenses and revenue ranges for the recognized local public health agencies in the micropolitan and metropolitan counties in Structure H. Population is not a determining factor for revenue or expenses for this group of agencies. One micropolitan agency reported both expenses 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

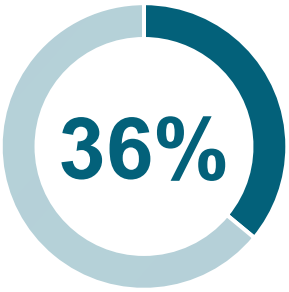


Serving as the primary contractor for a grant can also contribute to budget variability. Agencies that serve as the contractor for a multiple county area (such as the agency represented on the far-right below) administer higher dollar contracts to help assure the provision of specialized public health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

Currently shares the delivery of public health activities and services

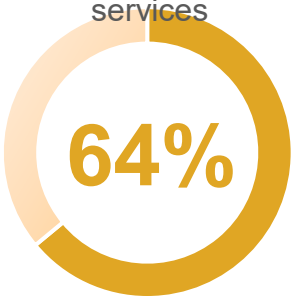


Five administrators reported they share the delivery of public health activities and services with another agency; while nine reported they do not share the delivery of public health activities and services with another agency.

Currently shares staff

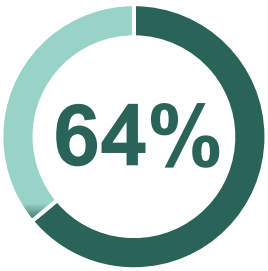
Two administrators reported they share staff with another agency; while 12 reported they do not share staff with another agency.

Would consider sharing the delivery of activities and services



Nine administrators responded that they would consider sharing the delivery of public health activities and services with another agency; while five responded that they would not consider sharing.

Would consider sharing staff



Nine administrators responded that they would consider sharing staff with another agency; while five responded that they would not consider sharing staff.