Cook County
Department of Public Health
Cook County Health and Hospitals System

BENCHMARK STUDY REPORT
Final 2011

Strategic Planning
August 2010-April 2011
EXECUTIVE SUMMARY
As part of its strategic planning effort, Cook County Department of Public Health (CCDPH) sought to gain a greater understanding of the challenges and opportunities facing other local health departments around the country as a frame of reference for strategic decision-making.

Five health departments were chosen for comparison based on their relative similarity to CCDPH:
- Cambridge Public Health Department (CPHD), Massachusetts
- Denver Public Health (DPH), Colorado
- Harris County Public Health and Environmental Services (HCPHES), Texas
- Hennepin County Human Services and Public Health Department (HCHSPH), Minnesota
- Public Health of Seattle & King County (PHSKC), Washington

This report serves to highlight the innovations, opportunities, and challenges that five local health departments are currently facing in the areas of governance, operational/programmatic strategies, and funding. In reading this report, it is important to understand that no two health departments are the same in function and structure, so there is not a “right” or “wrong” way for a health department to be governed, organized, or funded. Data for this report was collected through informational interviews and publicly-available online information.

Governance and Jurisdictional Organization – Key Findings
- Every local public health department has a distinctive governance structure with particular benefits and challenges.
- The most recent change to a governance structure among the study group was in 2004, when Hennepin Human Services and Public Health merged into one large department focused on regional service delivery.
- Cambridge and Denver, the two health departments that sit within an integrated health system, moved into that structure in 1996 and 1997 respectively.
- None of the LHDs interviewed expect major governance changes within the next five years.
- All of the benchmark agencies are in decentralized states. The LHDs’ relationship with the state department of health is generally centered on disease reporting, grant funding and reporting, and certification requirements. The state department of health does not provide direct governance.
- Three of the five benchmark agencies operate with a local board of health.
- By viewing each of the benchmark departments as a governance case study, CCDPH can glean potential strategies or best practices for relevant governance issues.

Funding - Key Findings
- In this continuing climate of budget austerity, all five departments are concerned with maintaining their current funding levels.
- Local and state public health funding is perceived as the highest risk for reduction due to decreased revenue available for the city, county, or state general funds.
- In addition, some states are re-allocating categorical dollars that traditionally went to public health programs, such as tobacco control and tuberculosis, in order to balance the state budget. Public health departments are now struggling to maintain these important programs without the traditional funding that fueled them for many years.
Three of the five benchmark entities stated they receive funding based on a local property tax levy. None of the three anticipate growth in resources from their levy, nor the possibility of new levies being assessed on taxpayers until the economy improves.

Of all public health department services provided, clinical services are currently the most difficult to fund and are expected to be the most difficult to fund in the near future due to potential decreases in Medicaid reimbursement rates and decreased local and state funding levels.

Collection of environmental health fees has also been reduced in the past few years with the slowdown in new construction. The health departments anticipate this funding will increase as the economy rebounds.

Only one of the health departments uses an outside fiscal agent.

All five health departments state they receive at least some of their federal funding as a pass-through from their state health department, and the state health department takes an administrative fee. The exact fees were either not known or not disclosed.

When asked the question “How does your health department evaluate and report the return on investment (ROI) of funding provided to your agency?” two answered that they provide grant reports and annual reports. One stated they do not provide any such reports, and one stated they don’t use the term ROI.

Four out of the five respondents discussed politics as a critical component in the determination of local health department funding. This information was unsolicited as there was no question asking the respondent to discuss the impact of politics on their health department. Respondents felt that the political environment presented both opportunities and challenges.

Funding - Innovations and Strategies

**Strategy #1 – Diversify the Funding Sources**

One way to maintain and/or grow a public health department in the near future is to diversify the department’s funding sources to offset or supplement the typical/traditional funding streams that are being cut.

- Be more entrepreneurial or aggressive about expanding into cutting-edge areas of public health work to capture new sources of funding. (Examples: obesity prevention programs, built environment policy work)
- Seek private foundation grants
- Apply for federal research grants and/or clinical trial grants
- Apply for FQHC status for public health clinics in order to receive increased Medicaid reimbursement rates
- Increase fee-based services and/or implement a more robust practice to bill and collect fees for current services offered

**Strategy #2 – Internal Restructuring**

Three of five health departments are restructuring to bring about greater efficiency and cost-savings. Cambridge is re-aligning its department to ensure that staff functions and staff capacity match the needs of the community. Denver is restructuring its multiple clinical services divisions for STD, HIV, and TB into one department as they anticipate that funding from the CDC will be provided in this more integrated, less categorical, fashion. Finally, since 2004, Hennepin County has been in the process of restructuring its services to be delivered in a regional, comprehensive manner.
• **Strategy #3 – External Strategic Alliances/Partnerships/Collaborations**

Finally, all five of the health departments are collaborating or entering into strategic alliances/partnerships with other entities in order to share resources and bring about greater efficiency. All five benchmark entities expressed that the majority of the programs they carry out involve working with a partner, whether it be community-based, governmental, business, or faith-based. This is a general theme that has surfaced in other recent benchmark studies, such as in the Milne and Associates National Best Practices background paper for the King County Public Health Operational Master Plan.\(^1\) Looking forward to the next five years, the benchmark entities anticipate that some of their partnerships will be “outside of the box” and take the form of cross-sector public/private collaborations. The respondents believe that these new strategic alliances will be particularly helpful in implementing prevention programs.

The benchmark agencies referenced numerous partnerships and collaborations they use to carry out their work. For example:
- PHSKC partners with a wide variety of community organizations for their Healthcare for the Homeless grant.
- PHSKC is also beginning to partner with various entities to implement culturally competent health services for immigrants and refugees.
- Harris County works with a wide range of stakeholders, including local, state, and federal emergency response planners, school districts and public information officers to carry out its emergency preparedness program, as does Cambridge.
- Harris and Denver also received funding from such institutions as the Robert Wood Johnson Foundation and the CDC’s ACHIEVE program to form coalitions to tackle systemic and policy changes that will reduce the incidence of childhood obesity.

**Funding – Future Opportunities**

- Three of the five health department respondents mentioned **health reform** as a future opportunity for the public health sector. This information was unsolicited as there was not a specific interview question asking about their perception of health reform. The health-reform opportunities most mentioned by respondents included new funding streams directed at prevention programs as well as the future ability to bill for more clinical services when more patients are covered by health insurance.
- Four of the five benchmark entities also mentioned **voluntary accreditation** through the Public Health Accreditation Board (PHAB) as an opportunity for public health. Even though the monetary value of accreditation has not yet been determined, these health departments believe that at some point in the future, funders will require accreditation. Therefore, many departments are being proactive about preparing for accreditation. In addition to the monetary opportunity that accreditation may provide, the health departments also see that accreditation can provide an opportunity to thoroughly assess their organization and become more efficient and effective in the process.

**Organizational Structure – Key Findings**

- All five health departments are expecting flat growth or a decrease in clinical services within the next five years.

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The five health departments are expecting potential growth in policy advocacy and prevention programs. Much of the policy work is expected to relate to obesity prevention in some way – such as advocating for changes in the built environment, advocating for menu labeling, etc. Three of the five health departments specifically mentioned obesity prevention programs as a trend in the coming years, particularly with the influx of foundation (Robert Wood Johnson) and federal (Communities Putting Prevention to Work) funding. Two health departments mentioned the importance of continued federal support for their emergency preparedness programs. Three of the health departments have a unionized workforce - Cambridge, King County, and Hennepin County. The three health departments acknowledge that it can be challenging to manage union contracts, but also pointed out that the unions are one of the biggest budget allies. The three health departments also stated that they recently have had generally positive interactions with the unions. All five health departments interviewed stated that partnerships and collaborations are a key organizational strategy used to accomplish department goals and that nearly everything the department does requires working with a partner. The communities served by all five benchmark entities are undergoing some degree of demographic change, and all departments are proactive about addressing cultural competency, health disparities, and health equity issues. Three of the health departments have strategic plans or a similar document to guide their decision-making.
INTRODUCTION AND METHODOLOGY

Local health departments (LHDs) are noted for their diversity in function and structure. There is wide variance among local health departments in terms of the size of the populations they serve, their governance and funding structures, the mandates they operate under, and the services they provide. Only recently has the field begun to develop and implement common definitions and standards for LHDs, but even these are only designed to promote common functions and excellence; they will not create uniformity in terms of specific services and programs offered, which are a function of local and state public health systems and funding streams.

The National Association of County and City Health Officials (NACCHO), in its ‘Operational Definition of a Functional Local Health Department’ states that “each community has a unique ‘public health system’ comprising individuals and public and private entities that are engaged in activities that affect the public’s health.” Furthermore, according to NACCHO, “over the past 15 years, several large-scale efforts have significantly influenced local public health practice by defining public health (Public Health in America, also known as the ‘10 essential services’), measuring the performance of public health systems (National Public Health Performance Standards Program), setting public health goals (Healthy People 2010), and identifying components of public health systems (The Future of Public Health and The Future of the Public’s Health in the 21st Century, both from the Institute of Medicine). All of these activities have evolved in the absence of a commonly-held notion of what constitutes a functional local public health agency.”

Despite the difficulty in making functional comparisons, Cook County Department of Public Health (CCDPH) seeks to gain a greater understanding of the challenges and opportunities facing five similar local health departments through a benchmark study. In order to choose the five comparison departments, PwC provided an initial list of ten health departments that are similar to CCDPH. From the initial list of ten, the Strategic Planning Steering Committee chose five to be interviewed. One health department declined to participate in the benchmark study necessitating a substitution, and the final list of benchmark entities is as follows:

- Cambridge Public Health Department (CPHD), Massachusetts
- Denver Public Health (DPH), Colorado
- Harris County Public Health and Environmental Services (HCPHES), Texas
- Hennepin County Human Services and Public Health Department (HCHSPH), Minnesota
- Public Health of Seattle & King County (PHSKC), Washington

After the five health departments were chosen, an ad-hoc Benchmark Advisory Group was formed to oversee and review the study. Initial information was gathered online for each of the health departments, using variables identified by the advisory group. Based on this initial information, an interview guide was developed and consultants held phone interviews with a designated key informant from each of the five health departments. Interview questions focused on the governance structure, funding mechanisms, and operational/programmatic strategies of each local health department. The interviews were completed in November 2010. This report serves to capture the innovations, opportunities, and challenges that five local health departments face in the areas of governance, operational/programmatic strategies, and funding.

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2 Milne and Associates. “King County Operational Master Plan: Role Definition Background Report”. Page 188. April 12, 2006.
3 NACCHO. “Operational Definition of a Functional Local Health Department”. November 2005.
4 Ibid.
5 “Benchmark Scorecard_10 Potential Entities to Compare”. Consultant deliverable. Refer to appendix.
**GENERAL OVERVIEW OF THE FIVE BENCHMARK ENTITIES**

<table>
<thead>
<tr>
<th>Public Health Department</th>
<th>Budget</th>
<th>Jurisdiction Size</th>
<th>Per Capita Expenditure</th>
<th># of Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCDPH</td>
<td>$55.8M (^6) (Nov 30, 2009)</td>
<td>2.4M (excluding Chicago)</td>
<td>$23.25</td>
<td>340</td>
</tr>
<tr>
<td>Cambridge Public Health Dept. (CPHD)</td>
<td>$8.8M (FY10)</td>
<td>105,000</td>
<td>$83.81</td>
<td>60</td>
</tr>
<tr>
<td>Denver Public Health Dept. (DPH)</td>
<td>$21M (according to respondent)</td>
<td>610,000</td>
<td>$34.43</td>
<td>113</td>
</tr>
<tr>
<td>Harris County Public Health and Environmental Services Dept. (HCPHES)</td>
<td>$77M (FY 2009 annual report)</td>
<td>1.9 M (excluding Houston)</td>
<td>$40.53</td>
<td>614</td>
</tr>
<tr>
<td>Hennepin County Human Services and Public Health Dept. (HCHSPH)</td>
<td>$20M (Public Health portion, Human Services comprises $446M out of total $466M proposed 2011 HCHSPH budget)</td>
<td>602,000 (excluding Minneapolis, Bloomington, Edina, &amp; Richfield)</td>
<td>$33.22</td>
<td>2,765</td>
</tr>
<tr>
<td>Public Health of Seattle and King County (PHSKC)</td>
<td>$288M (FY 2009 actual budget)</td>
<td>1.9 M (including Seattle)</td>
<td>$151.58</td>
<td>1,490</td>
</tr>
</tbody>
</table>

The five health departments in the benchmark study are of varying sizes in terms of budget and the size of the population each serves. According to the NACCHO 2008 National Profile of Local Health Departments, nearly two-thirds serve a population of less than 50,000 people. Only five percent serve populations of 500,000 or more\(^7\), including four of the five benchmark health departments and CCDPH. Two of out the five selected benchmark health departments (PHSKC & HCPHES) plus CCDPH are designated as major metropolitan health departments (MMHD) -- serving between 1.2 M to 9M people.

Per capita public health dollars were calculated for the purposes of this benchmark study to allow a more direct comparison of budgets. One finding that is quite apparent is the large range of per capita funding. One factor that accounts for this variance is the structure of the health department and the services each offers. For instance, Hennepin County has combined their human and public health services into one department leading to a very high per capita amount. Public Health of Seattle and King County includes Jail Health and Emergency Medical Services, which also skews their per capita amount to the high end.

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\(^6\) $55,779,773 total funding received as of Nov 30, 2009 as listed in the document titled “Public Health Strategic Planning Work Stream, October 2010” prepared by CCDPH for PwC. The CCDPH FY09 annual report lists the operating budget at $46M.

\(^7\) NACCHO. “2008 National Profile of Local Health Departments”. Available at www.naccho.org
In comparing the state average per capita public health dollars spent to the local health department per capita public health dollar expenditure, it is obvious that the local health department per capita expenditures do not line up with the state per capita public health expenditures. Much of this discrepancy can again be attributed to the scope of services each local health department offers. Some of the discrepancy can also be accounted to the difference in methodology from how the United Health Foundation calculated the state per capita versus how this consultant calculated the local health department per capita expenditures. Nevertheless, this chart clearly shows that while the State of Illinois falls in the middle of the benchmark entities in terms of state public health dollar expenditures, CCDPH falls to the bottom of the chart in terms of LHD per capita expenditures.

CCDPH’s budget was also compared to those of nine other local health departments that are members of the Northern Illinois Public Health Consortium (NIPHC).

<table>
<thead>
<tr>
<th>Public Health Department</th>
<th>Budget</th>
<th>Jurisdiction Size (2009 US Census estimates)</th>
<th>Per Capita Expenditure (average $44.85)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCDPH</td>
<td>$55.8M</td>
<td>2.4M (excluding Chicago)</td>
<td>$23.25 (#7)</td>
</tr>
<tr>
<td>Chicago</td>
<td>$182M</td>
<td>2.8M (excluding Chicago)</td>
<td>$65.00 (#2)</td>
</tr>
<tr>
<td>DuPage</td>
<td>$47.5M</td>
<td>933K</td>
<td>$50.91 (#4)</td>
</tr>
<tr>
<td>Grundy</td>
<td>$1.0M</td>
<td>48K</td>
<td>$20.83 (#8)</td>
</tr>
<tr>
<td>Kane</td>
<td>$9.4M</td>
<td>512K</td>
<td>$18.36 (#10)</td>
</tr>
<tr>
<td>Kendall</td>
<td>$5.3M</td>
<td>105K</td>
<td>$50.48 (#5)</td>
</tr>
<tr>
<td>Lake</td>
<td>$74M</td>
<td>713K</td>
<td>$103.79 (#1)</td>
</tr>
<tr>
<td>McHenry</td>
<td>$6.6M</td>
<td>321K</td>
<td>$20.56 (#9)</td>
</tr>
<tr>
<td>Will</td>
<td>$29.7M</td>
<td>685K</td>
<td>$43.36 (#6)</td>
</tr>
<tr>
<td>Winnebago</td>
<td>$15.6M</td>
<td>300K</td>
<td>$52.00 (#3)</td>
</tr>
</tbody>
</table>

As evidenced in the chart above, CCDPH ranks seven of out ten in per capita public health expenditures. The state average per capita expenditure is $61.57, but this group of ten averages out to $44.85. No matter which average is used, CCDPH clearly has a relatively low per capita rate. Additionally, the Chicago Department of Public Health, which is closest to CCDPH in terms of population size, has a budget three times larger than CCDPH’s budget.

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8 http://www.americashealthrankings.org/
9 Ibid.
**Funding Source Comparisons and Percentages**

Local health departments of all sizes rely almost exclusively on public funding and service reimbursement to support operations.\(^{10}\) Budget sources include local tax support, state funding, federal funding, service reimbursement (Medicaid, Medicare, fee-for-service), and other sources (private grants, etc.).

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The above chart compares percentages for various sources of funding for the benchmark entities and CCDPH. Local funding from the city, county, or both, is a very important part of each health department’s budget, comprising anywhere from 30-66% of the overall budget. The one exception to this is King County, which derives less than 20% of its funding from local sources. This phenomenon was noted by PHSKC itself during the formulation of its 2007 Master Operational Plan, and has contributed to the diversification of that department’s funding sources, as evidenced by the multi-segmented PHSKC funding pie chart above.

Additionally, it is noticeable that nearly all the local health departments in this study derive 80% - 100% of their funding from three combined sources – local, state, and federal. Denver Public Health falls into this category, but it is important to note that they separate their federal research dollars (16% of their overall budget) from the other federal monies they receive. King County, at nearly 80%, has the lowest amount of funding from combined local, state, and federal sources, and Medicaid reimbursement is nearly 20% of their combined local/state/federal dollars. PHSKC, having the most diverse funding base, receives the most income from fees and other sources compared to the other benchmark entities.

There are some caveats to note when comparing the budget percentages. First of all, and most importantly, each public health department has a slightly different way to categorize their budget dollars. For CCDPH, local funding is that which comes from the county general fund, state funding comes from the state general fund, and federal dollars are primarily grants that are passed through IDPH. Denver breaks out its federal research funding into a separate column. It is unknown if the other departments don’t receive enough federal research funding to warrant a separate line item. Additionally, two departments (Denver and Cambridge) note their state and federal dollars in a combined manner. We do not know if King, Harris, and Hennepin account for their pass-through funds in the state or federal category. Finally, the “Other” column represents something slightly different for
each health department. For some of the health departments that do not have a separate fees column (CCDPH, Denver, Cambridge), the “other” column includes fees.

When CCDPH funding sources are compared to those of its neighbor health departments, it becomes clear that most of the other LHDs use reimbursements and fees to offset their local, state, and federal revenue streams (property taxes, grants, general corporate funding).

**CCDPH Funding Allocations by Service Unit/Staff**

As seen in the pie chart below, approximately 50% of CCDPH’s total staff (about 160 out of 340+) work in the Integrated Health Support Service unit. This unit includes many public health nurses, and accounts for much of the agency’s direct personal and population health care services. The next largest CCDPH unit is Communicable Disease with 11% of the staff. The remainder of CCDPH’s service units each account for 8% or less of the overall staff.

When the staff is divided based on services offered, sixty-one percent of CCDPH staff are dedicated to personal and population health, 27% of CCDPH staff are dedicated to population health functions or services, and 12% of CCDPH staff are dedicated to administrative or operational functions.
This division of staff by functional service area is important when examining how CCDPH allocates its funding across service units. The below bar graph shows how CCDPH staff positions are funded. The green indicates the percentage of staff positions funded by grant money, while the blue and red indicate the percentage of staff positions funded by local funding (corporate funding from the Cook County General Fund).
The bar graph shows that only 30% of all CCDPH staff positions are funded by grant money. According to CCDPH staff, the percentage of grant funded positions is lower than in past years, meaning that CCDPH has become increasingly reliant on local funding (specifically the Cook County General Fund). This is a concern because local funding levels have become volatile in recent years. With a high reliance on local funding, a reduction in Cook County General Funds translates to a possible need for a staff lay-off.

The service units with the highest percentage of grant-funded positions are Communicable disease (CD) at 65%, Environmental Health (EHS) at 50%, and Prevention Services (PSU) at 37%. Integrated Health Support Services only has about one-third grant funded positions, which translate to about 50 out of 160 positions in this unit. IHSS will be very susceptible to lay-offs should the local funding levels be reduced. Finally, nearly all administrative and operational functions/staff positions are funded by corporate (Cook County General Fund) money. Human Resources is the exception to this. Again, administrative positions are in many cases essential, but they are at-risk of lay-off if CCDPH continues its’ heavy reliance on local funding.
### Public Health Services Offered

<table>
<thead>
<tr>
<th>SERVICE DIVISIONS</th>
<th>CCDPH</th>
<th>Cambridge</th>
<th>Denver</th>
<th>Harris</th>
<th>Hennepin</th>
<th>King</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Integrated Health Support Services (Clinical)</td>
<td>PH Nursing (CD prevention and control, health ed)</td>
<td>Epidemiology &amp; Surveillance</td>
<td>Disease Control and Clinical Prevention</td>
<td>Due to integration &amp; regionalization of services, it is hard to tease out the division. Hennepin has one public health clinic that houses the clinical function for traditional PH areas like STDs, HIV, TB, immunizations, and refugee care.</td>
<td>Community Health Services (including clinics, WIC, SBHCs, oral health, pharmacy, homeless health, etc)</td>
</tr>
<tr>
<td></td>
<td>Environmental Health</td>
<td>School Health</td>
<td>Health Promotion</td>
<td>(includes 13 WIC sites, 6 health clinics, immunizations, epidemiologic surveillance, HIV/STD prevention, TB, school-based)</td>
<td>Mosquito Control</td>
<td>Regional Cross-Cutting &amp; Admin (including Preparedness, Policy, Assessment, IT, HR, Finance, Partnerships, Communications)</td>
</tr>
<tr>
<td></td>
<td>Policy Development &amp; Communications</td>
<td>Community Health</td>
<td>HIV Prevention and Training</td>
<td>Health Ed &amp; Promotion</td>
<td>Environmental Public Health</td>
<td>Jail Health</td>
</tr>
<tr>
<td></td>
<td>Communicable Disease Prevention and Control</td>
<td>Environmental Health</td>
<td>Immunization &amp; Travel Clinic</td>
<td>Veterinary Public Health</td>
<td>Operations and Finance</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td></td>
<td>Prevention Services</td>
<td>Emergency Preparedness</td>
<td>Infectious Disease/AIDS Services</td>
<td>Public Health</td>
<td>Public Health Preparedness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preparedness</td>
<td>Preparedness</td>
<td>Public Information (risk communication/social marketing)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>STD Tx &amp; Control</td>
<td>Public Information</td>
<td>Policy and Planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TB Control and Clinic</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Vital Records</td>
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</tbody>
</table>

Local health departments offer similar services, but there is no requirement for all health departments to organize themselves in the same way. As such, there is some variance in the organizational structure of the five benchmark entities due to differences in their state and local mandates, leadership decisions, governance structure, available funding and needs of the community. For instance, Harris County has a veterinary public health division, and PHSKC oversees jail health and emergency medical services for the county, but the other benchmark entities do not provide those services. And while environmental health is nearly ubiquitous with public health, Denver Public Health does not offer environmental services.

All of the public health departments offer clinical services, mostly relating to the prevention and control of communicable diseases such as HIV/AIDS, TB, and STDs using methods such as screening and immunizations. The benchmark health departments offer very little primary care/medical home services, with the exception of PHSKC which has a Federally Qualified Health Center.
Demographic Comparisons

Racial/Ethnic Percentages

(Note: The data for the charts in this section on demographics came from the 2009 US Census estimations for county populations, with the exception of Cambridge, which came from 2000 US Census information. With the exception of Cambridge, the data in all these graphs reflects county-wide demographic information. As Harris, Cook, and Hennepin County do not serve the entire population of their county, the percentages of their specific jurisdiction may be different from that presented.)

The main finding of the racial/ethnic comparison is that Denver and Harris are similar to Cook County in that their White non-Hispanic populations fall below 60%. Cook County has the highest percentage of Black residents, while Harris has the highest percentage of Hispanic residents.

Immigrant Populations by Percent

Hennepin and King have the lowest percentages of foreign-born residents. Harris County, given its large Hispanic population, has nearly the highest percentage of foreign-born residents and the highest percentage of those that speak a language other than English at home. Cambridge has the highest percentage of foreign-born residents. This phenomenon is most likely attributable to the many universities within and near the city that attract an international student body and faculty.)
Cook, Denver, Hennepin, and King Counties look very similar in terms of their young and elderly populations. Harris County’s population is slightly more skewed to the young side, while Cambridge has fewer young and old residents and more residents between the ages of 18-64 (again, probably attributable to the university environment.)

The dollar amounts listed next to each county name represent the median income based on 2008 census numbers. Cook is fairly similar to Denver in terms of the percentage of the population below poverty level and insured. Hennepin and King Counties, both with higher median incomes, have lower percentages of residents in poverty and uninsured. Harris County has a very high rate of uninsured residents, disproportionate to the percentage of its residents below poverty. This could be attributed to its higher percentage of Hispanic residents, who, in national studies, are disproportionately uninsured. Cambridge is a very interesting case because so few of its residents are uninsured despite poverty levels comparable to the other benchmark entities. This is also most certainly largely attributable to the Commonwealth of Massachusetts’ health reform law.
Governance and Jurisdictional Organization
Local health departments operate under highly complex governance structures. They must be responsive to state statutory and regulatory requirements, as well as local ordinances from counties, cities, municipalities, and local boards of health. Additionally, each local health department has a unique leadership structure, and deals with multiple entities to secure its annual budget.

Within this complex framework, there are five basic types of local health department jurisdictional structures:\n\begin{enumerate}
\item County based (60% of all local health departments)
\item Combined city-county (11%)
\item Town/Township based (11%)
\item Multi-county or Regional/District (9%)
\item City based (7%)
\end{enumerate}

Given the variance in governance structures, this report first provides a basic summary of the governance structure and jurisdictional organization each of the benchmark entities, and then the key findings and points of comparison are provided at the end of this section.

Cook County Department of Public Health
CCDPH is a county-based jurisdiction. However, Chicago and the suburban municipalities of Evanston, Skokie, Oak Park, and Stickney Township have their own certified local health departments and are not served by CCDPH. CCDPH provides public health services for the other 125 municipalities and 30 townships that comprise suburban Cook County. In addition CCDPH is not a stand-alone health department, but is embedded within the county health service delivery system – Cook County Health and Hospital Systems.

Hennepin County Human Services and Public Health Department (HCHSPH)
HCHSPH is also a county-based jurisdiction. The Director of HCHSPH reports directly to the county administrator, who in turn, reports directly to the board of seven county commissioners.

In contrast to CCDPH, HCHSPH is separate from the county health system. Hennepin Healthcare System, Inc., which operates the Hennepin County Medical Center (HCMC), is a public subsidiary corporation owned by Hennepin County. The Healthcare System is overseen by a 13-member board, however the Hennepin county board retains oversight of its safety-net mission and authority over its operating budget and capital plans. Furthermore, the county owns the hospital assets and provides millions of dollars in funding from property tax revenues.

Similar to CCDPH, HCHSPH is not the public health entity for all of Hennepin County. Minneapolis has its own public health department, as do the combined municipalities of Bloomington/Edina/Richfield. However, while the Chicago Department of Public Health eclipses CCDPH in terms of size and budget, the Minneapolis Department of Health and Family Support (MDHFS) has slowly been shrinking in terms of direct service staff and now HCHSPH has become the major direct service public health entity in the county. According to the Hennepin respondent, MDHFS staff serve in a policy and planning capacity and

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\footnote{NACCHO. “2008 National Profile of Local Health Departments”. www.naccho.org.}
\footnote{http://www.hcmc.org/medcenter/about.htm}
excel at getting federal grants such as Healthy Start and Steps, and they sometimes contract with HCHSPH to provide service delivery within the city boundaries.\textsuperscript{13}

Also in contrast to CCDPH, Hennepin County combined six separate departments providing human/social services and public health services into one department. Hennepin County determined that public health services should not operate in a silo, and that it would be best for county residents to receive services in regional hubs that offered a continuum of care – a “one-stop shop.” Thus, the Human Service and Public Health departments of Hennepin County merged in 2004.\textsuperscript{14} HCHSPH has spent the past six years making its vision of regional comprehensive service delivery a reality, and the first regional service center will open in the summer of 2011. The HCHSPH respondent described the merger as beneficial for public health in two ways. First, human services/social services receive more funding than public health, so public health actually boosted its resources by combining with the human services agency. Secondly, the combination of the two agencies has allowed for employees to broaden their perspectives about service delivery. Social service providers have been introduced to the public health perspective, and vice versa.\textsuperscript{15}

\textbf{Harris County Department of Public Health and Environmental Services (HCPHES)}

HCPHES is a county-based jurisdiction. Like Hennepin, HCPHES reports directly to the County Commissioners Court. Also like Hennepin, but dissimilar to CCDPH, HCPHES is an independent public health department, separate from the Harris County Hospital District. The Harris County Hospital District reports to a local governing board of managers, whose members are appointed by the county commissioners. Unlike health departments with a local board of health, HCPHES does not have the benefit of a board of health to advocate for public health issues. As such, HCPHES general fund dollars compete with other governmental departments such as law enforcement, public infrastructure, the toll road authority, etc. Furthermore, funding depends greatly on the Commissioner’s Court understanding of public health and political will, which is often does not optimally support the mission of public health.\textsuperscript{16} More about this will be described in the funding section.

Similar to CCDPH and Hennepin, Harris County is not the only public health department in the county. The Houston Department of Health and Human Services (HDHHS) provides disease surveillance, preventive health care, treatment for selected diseases, a wide range of environmental services, and enforcement of certain city and state laws for the residents of Houston.\textsuperscript{17} In comparison to Harris County, which employs 614 FTEs on a budget of $77M, HDHHS has an annual budget of about $48M with approximately 600 FTEs.\textsuperscript{18} The two departments collaborate on an as-needed basis, usually when the task at hand makes collaboration sensible. For instance, on behalf of an ad-hoc steering committee with members from both HCPHES and HDHHS, HCPHES recently submitted a grant to a local foundation to implement a comprehensive childhood obesity planning grant that spans both the HCPHES and HDHHS jurisdictions. Additionally, HCPHES provides some services with the boundaries of Houston, such as refugee health screenings and mosquito control operations. HCPHES and HDHHS have discussed merging into one department over the years, but the idea has never really gained traction.\textsuperscript{19}

\textsuperscript{13} Monson, Todd. Personal interview. November 18, 2010.
\textsuperscript{14} Hennepin County HSPHD. “Regional Services Planning and Client Service Delivery Model”. August, 2009.
\textsuperscript{15} Monson, Todd. Personal interview. November 18, 2010.
\textsuperscript{17} www.houstontx.gov/health
\textsuperscript{18} http://www.houstontx.gov/budget/11budadopt/V_HHS.pdf
**Public Health of Seattle and King County (PHSKC)**

PHSKC has a combined city-county jurisdictional structure. In contrast to Hennepin, Harris, and CCDPH, Seattle’s public health department is folded into the county department, making PHSKC the single public health entity for the county. PHSKC reports directly to the county council, which approves the PHSKC annual budget. PHSKC also has a local board of health comprised of members from the county government, the city of Seattle, as well as three representatives from suburban King County municipalities. The board of health sets policy for PHSKC, and can advocate for a particular budget, but they have no authority to set or approve the budget.

The King County and Seattle Public Health Departments started to merge about 20 years ago, and, according to the respondent, it took approximately ten years for the two entities to completely merge, with the human resource and budget systems the last components to be integrated.  

As shown earlier in this report, PHSKC receives the lowest amount of local funding compared to the other benchmark agencies. The majority of the local funding they receive comes from the county general fund. Seattle is the only municipality within King County that provides enhancement funding to PHSKC. Seattle is not mandated to provide any funding for PHSKC services, but they choose to do so in order to enhance services to Seattle residents. Essentially, the leadership of the City of Seattle determines how much, if any, funding Seattle provides to PHSKC in any given year. Recently, Seattle voted in a new mayor who is interested in public health, and this may renew and increase involvement between the City and PHSKC.

Despite the complex governing structure, PHSKC considers its relationship with the county to be a “blessing” because of the deep support and resources it receives from the county. The King County informant stressed that maintaining positive relationships and partnerships within a county structure is a constant process, but the trade-off is the deep support the county provides in difficult times.

**Denver Public Health Department (DPH)**

Denver also has a city-county jurisdictional governance as the boundary of the City of Denver is also the boundary of Denver County. As such, the Denver city counselors are also the Denver county commissioners. One benefit of Denver’s same-border city-county structure is that it eliminates any sort of competition or tension that may be felt in other health departments with non-matching borders (such as Hennepin/Minneapolis, Harris/Houston, or Cook County/Chicago).

Just as CCDPH’s is part of the larger CCHHS, DPH is also a part of its larger county health system - Denver Health. There are ten different components of Denver Health -

- Denver Health Medical Center,
- Rocky Mountain Regional Trauma Center,
- 911 Emergency Response (including Rocky Mountain Center for Medical Response to Terrorism, Mass Casualties and Epidemics),
- Community Health Services (eight family clinics, 12 school-based health centers),
- Rocky Mountain Poison and Drug Center,
- Denver CARES (detox center),
- Correctional Care,
- Denver Health Medical Plan,

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Denver Health Physicians, and
Denver Public Health.  

Approximately ¼ of all children in Denver and ¼ of all adult residents of Denver receive health services through one or more components of Denver Health.

Denver Health in its current form was incepted in 1997, and Denver Public Health was part of this system from the beginning. Denver Public Health manages ¼ of the tuberculosis patients in Denver and ½ the AIDS patients, and receives 18,000 STD clinical visits each year. Since 2005, Denver Health has used Lean principles to transform the way it does business. The Lean system was pioneered at Toyota post World War II, and, at its essence, promotes cost cutting with consistently high-quality work. Since its Lean conversion, Denver Health has saved $54 million.

Denver Public Health does not provide environmental health services as those are provided by the Denver Department of Environmental Health. DPH works closely with the Dept of Environmental Health, especially in times of infectious disease outbreaks, but the Dept of Environmental Health has remained a separate entity that sits outside of the Denver Health system. In instances of outbreaks, the Dept of Environmental Health provides public education, while DPH provides the investigative and surveillance services. In fact, DPH employs six physicians who specialize in infectious diseases, and the surrounding counties actually contract with DPH to provide their infectious disease services.

Denver Health’s Community Health Services (CHS), through its clinics and school-based health centers, provides the majority of Maternal and Child Health and WIC services, along with most of the immunization services. However, DPH works collaboratively with CHS to deliver population-based MCH services, as well as other communicable disease services. DPH also operates a fee-based travel immunization clinic.

Clearly, DPH operates many of its programs collaboratively with other arms of Denver Health and with other city departments. In his interview, the Denver Public Health representative indicated that communication and integration between all ten spokes of Denver Health is the key to its success. Communication has not always been perfect between the various Denver Health components, but the respondent stated that as communication improves and increases, the benefits of being part of this larger health system are immense and far outweigh any potential downsides. The Denver Public Health representative also stressed that, in order not to “get lost” in a large integrated health system, the public health department needs to take responsibility of highlighting its vital role within the system. Denver Public Health has created its niche within Denver Health as the center for communicable disease reporting, surveillance, investigation, and control, with an additional focus on grant-funded infectious disease research.

Cambridge Public Health Department (CPHD)
Cambridge has a city (or municipality-based) jurisdiction, and is also the smallest jurisdiction of all the benchmark entities. It was included in the study because, like CCDPH, it is part of a larger health

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21 http://denverhealth.org/AboutUs/FactsandFigures.aspx
24 Ibid.
Cambridge Health Alliance (CHA) is currently transforming its healthcare system into an Accountable Care Organization (ACO) while simultaneously creating patient-centered medical homes to improve its clinical delivery system. At the core of this transformation is CHA's ability to capitalize on, leverage, and integrate its healthcare delivery system, academic programs, public health functions, and managed health plan to improve the health of the individuals and populations it serves. This effort will leverage CHA's strengths as a leader in primary care, and will allow it to embrace and succeed under a new financial model that utilizes global payment methods.26

Though Cambridge Public Health Department is operated by Cambridge Health Alliance, it retains its municipal role as the public health department for the residents of the City of Cambridge. A formal agreement exists between the City of Cambridge and CHA whereby the City of Cambridge appropriates a predetermined amount of money to CHA each year to support public health services. This appropriation is passed through CHA to Cambridge Public Health. CPHD essentially used the city appropriation as general operating support which it leverages to take advantage of other grant opportunities.

CPHD's city funding is earmarked to serve only the residents of Cambridge, therefore many of their services are offered only within the city boundaries. The cities of Somerville and Everett both have a CHA hospital within their boundaries, and they also have their own health departments to serve their residents. So while Cambridge Health Alliance serves patients on a regional basis, CPHD mostly serves Cambridge residents.

Since the majority of CPHD services are offered only within the Cambridge city boundaries, CPHD must secure outside grants in order to serve the population outside of the city boundaries. An example of this would be CPHD’s division of emergency preparedness, which is the department’s broadest reaching program. CPHD serves as the lead entity to coordinate emergency preparedness activities on behalf of 27 cities and towns that comprise Massachusetts Emergency Preparedness Region 4b. (The state is divided into six regions for emergency preparedness, with Boston being its own region.) CPHD receives state funding in order to provide this service on a regional basis.

**State Public Health Department Oversight**
There are three ways in which states are organized with respect to local public health: centralized, where the LHD is a unit of state government, de-centralized, where LHDs are units of local government overseen by local authorities (e.g., local board of health, county or city elected officials) and

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26 http://www.challiance.org/aboutus/transformation/index.shtml
combination, where some LHDs in the state are independent, and others are run by the state health authority. All of the selected benchmark entities are in de-centralized states, meaning that public health department workers are employees of the county or city, not the state. However, the sites’ relationships with the state department of public health vary.

Illinois is a de-centralized state. However, the Illinois Department of Public Health (IDPH) requires that local health departments be certified by the state in order to receive certain state funds. To be certified, an LHD must employ a qualified executive officer and be in substantial compliance with eight public health practice standards, including completion of an internal organizational capacity assessment or strategic plan and a community health needs assessment, and development of a community health plan (IPLAN). Certification makes a local health department eligible for a Local Health Protection Grant. This grant, with award amounts determined according to a need-based formula, provides financial support for local health protection programs. Certified local health departments are also eligible to apply for IDPH categorical grants to address specific health needs. Every five years, CCDPH completes WePLAN, a community health assessment and action plan, as part of re-certification.

Washington State is similar to Illinois in that their 35 local health departments (including PHSKC) are independent from the state in terms of governance but are closely associated through contracts, organizational affiliations, and through numerous joint planning initiatives, including a collaboratively developed state and local health department performance measurement and performance improvement process, developed in response to a state statute on public health improvement. Harris County also has a similar relationship to the Texas Department of Public Health. They are independent from the state department in terms of governance, but maintain the typical grant and reporting relationships.

Cambridge Public Health Department has fewer formal ties with the Massachusetts Department of Public Health. The Commonwealth of Massachusetts has 351 separate boards of health that govern the public health departments. Currently, each local health department in the Commonwealth is required to report communicable diseases to the Massachusetts Department of Public Health, but there is no mandated assessment process like IPLAN or performance improvement process as in Washington. As it explores the recently developed voluntary public health accreditation process, Massachusetts is considering requiring community health improvement plans (CHIPS) from each of the 351 local health departments. Additionally, there is no direct line of funding that Cambridge receives from the state, as CCDPH does from IDPH.

Several state health departments have developed a State Health Improvement Plan (SHIP) meant to guide the efforts of the public health system within that state. Minnesota recently created their Statewide Health Improvement Program, and the state legislators approved a $47M allocation to the SHIP Implementation fund to provide obesity prevention and tobacco reduction programs. Hennepin received $4.2M from the SHIP fund. Given the poor economic situation, the Hennepin respondent expressed concern about the MN legislature continuing to allocate money to this fund. This SHIP implementation fund is innovative, and is something that Illinois could use as an example as it launches

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27 NACCHO. “2008 National Profile of Local Health Departments”. Available at www.naccho.org
28 http://www.idph.state.il.us/about/lhqd&a.htm
the new SHIP Implementation Coordination Council. In 2008, the Colorado legislature approved a bill mandating that all local health departments work with the state health department to create a SHIP that guarantees that every person in Colorado has access to health care.\textsuperscript{32}

**Local Boards of Health**

Most LHDs, regardless of governance type, report to a local board of health (80\% of all LHDs, while only 9\% are governed by a city or county council.)\textsuperscript{33} However, the frequency of local boards of health decreases with increasing jurisdictional size - only 38\% of LHDs who serve a population of more than 1M have a board of health.\textsuperscript{34} Local boards of health serve many functions: adopting public health regulations, setting and imposing fees, approving the LHD budget, hiring or firing the top agency administrator, and requesting a public health levy. Adopting public health regulations (73\%) and setting and imposing fees (68\%) were the two most common functions.\textsuperscript{35}

Of the interviewed health departments, Cambridge, Denver, and King County have a local board of health that serves some governance functions. Harris County and Hennepin County do not have local boards of health. The Harris County Public Health and Environmental Services Departments is governed directly by the county commissioners, and the Hennepin County Human Services and Public Health department is governed directly by the Hennepin County Board of Commissioners.

CCHHS (of which CDPD is part of) previously operated like Harris County and Hennepin County in that it was directly governed by the county board of commissioners. Due to the strong efforts of health advocates in Cook County, an independent board of health for CCHHS was started. Now the independent board of directors oversees the operations of the Cook County Health and Hospital System, including hiring and budget setting. The board of directors reports to the Cook County Board of Commissioners. The independent board presents a budget to the commissioners, who ultimately fund the budget out of the County General Fund. The independent board is relatively new, but its existence has helped to mitigate some of the issues experienced by the health system.

The City of Cambridge has a Board of Trustees whose members are appointed by the City Manager. A sub-set of the Board of Trustees is the Cambridge Public Health sub-committee, which is the local board of health. PHSKC has a local board of health comprised of members from the county government, the city of Seattle, as well as three representatives from suburban King County municipalities. The board of health sets policy for PHSKC, and can advocate for a particular budget, but the county council must approve the budget. The Denver City Council has a Health, Safety, Education, and Services committee, which oversees public health as an area of responsibility. In addition, Denver Health has a nine-member Health and Hospital Authority Board of Directors appointed by the Mayor of Denver. Board members serve five-year terms and direct Denver Health's activities, which includes financial management; education and quality assurance; personnel and compensation; and the Denver Health Medical Plan, Inc.

\textsuperscript{32} Urbina, Dr. Chris. Personal interview. November 16, 2010.
\textsuperscript{33} NACCHO. “2008 National Profile of Local Health Departments”. Available at www.naccho.org
\textsuperscript{34} Ibid.
\textsuperscript{35} Milne and Associates. “King County Operational Master Plan”. 2006.
GOVERNANCE - KEY FINDINGS

- Each of the local public health departments in the study has a different governance structure with distinctive benefits and challenges.
- Among the study group, the most recent change to a governance structure was in 2004, when Hennepin Human Services and Public Health merged into one large department focused on regional service delivery.
- Denver and Cambridge, the two health departments that sit within an integrated health system, moved into that structure in 1997 and 1996 respectively.
- None of the LHDs interviewed expect major governance changes within the next five years.
- All of the benchmark agencies are in decentralized states. The LHD relationship with the state department of health is generally centered on disease reporting, grant funding and reporting, and certification requirements. The state department of health does not provide direct governance.
- Three of the five benchmark agencies operate with a local board of health.

As no two public health departments are identical in their governance structure, each benchmark entity provides an interesting point of comparison or contrast for CCDPH to review and consider. The chart below shows a summary of the similarities, differences, and points of special note for each department.

<table>
<thead>
<tr>
<th>Health Dept.</th>
<th>County/City/ Combined</th>
<th>Part of integrated health system?</th>
<th>Have local Board of Health?</th>
<th>Other major LHD within county border?</th>
<th>Of special note for CCDPH to investigate further:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCDPH</td>
<td>County</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, Chicago</td>
<td>CCHHS transformation, relationship to CDPH</td>
</tr>
<tr>
<td>Cambridge</td>
<td>City</td>
<td>Yes</td>
<td>Yes</td>
<td>Not applicable</td>
<td>Integration of CDPH within CHA. CHA transformation into an ACO.</td>
</tr>
<tr>
<td>Denver</td>
<td>County/City</td>
<td>Yes</td>
<td>Yes</td>
<td>No, Denver County only encompasses Denver City</td>
<td>Integration of Denver PH with Denver Health. DH LEAN transformation.</td>
</tr>
<tr>
<td>Harris County</td>
<td>County</td>
<td>No</td>
<td>No</td>
<td>Yes, Houston</td>
<td>Most similar to CCDPH in population size &amp; relationship to Houston’s PH dept.</td>
</tr>
<tr>
<td>Hennepin County</td>
<td>County</td>
<td>No</td>
<td>Yes</td>
<td>Yes, Minneapolis, Bloomington</td>
<td>Outcome of the HCHSPH regional service delivery pilot</td>
</tr>
<tr>
<td>King County</td>
<td>County/City</td>
<td>No</td>
<td>Yes</td>
<td>No, Seattle’s health dept merged with King County</td>
<td>Seattle and King County public health dept merger</td>
</tr>
</tbody>
</table>
Consultant/Respondent Recommendations for CCDPH:

- Given that the Cook County Health and Hospital Systems is also planning to deliver services in a regional delivery format (albeit not combined with social services), it would be worthwhile to monitor the outcome of the Hennepin County regional service delivery pilot.

- Harris County funding at the discretion of the commissioner’s court, and sometimes, there are significant barriers to furthering the interests of the public’s health due to some misunderstandings of the public health mission or ideological differences among members of the court. This point is important to consider should CCDPH decide to de-couple itself from CCHHS. Right now, CCHHS, and as such, CCDPH, has the independent board of health to advocate on their behalf with the Cook County Commissioners, and CCDPH should consider how the loss of this advocate could impact their department should they no longer want to be a part of the larger health and hospital system.

- Harris County and Houston have discussed merging into one public health department over the years, but the idea has never really gained traction. If CCDPH explores a potential merger with CDPH, it may prove useful to learn more about the reasons for the non-merger in Harris County.

- The merger process between Seattle and King County could potentially be another example for CCDPH to learn about during the exploration of a potential merger with CDPH.

- PHSKC respondent recommends that in the absence of a merger, CCDPH should attempt to partner and collaborate with CDPH as much as possible to leverage expertise and funding, instead of competing with each other.

- PHSKC respondent also advised against de-coupling the health department from an entity that provides deep resources, which is food for thought as CCDPH considers a scenario of decoupling from CCHHS in its potential recommendations for governance structure.

- The Denver Public Health Department representative stressed that a public health department needs to highlight its important role if they sit within a larger health system.

- Denver Public Health’s experience within the larger Denver Health System, and Cambridge Public Health’s experience within Cambridge Health Alliance can provide instruction as CCDPH explores increased integration or independence from CCHHS.
FUNDING — KEY FINDINGS
Public health funding is not predictable, and most, if not all, public health departments in the country are facing challenges with regard to funding. The recent economic recession and accompanying real estate implosion has strained city and state revenue streams, which in turn has led to reduced local and state funding for public health. In early 2010, NACCHO completed a series of surveys measuring the impact of the economic recession on local health departments. The surveys found that LHDs across the country face deepening revenue cuts, undermining their ability to protect the public. Between January 2008 and December 2009, LHDs lost roughly 15% of their entire workforce, and an additional 25,000 LHD employees were subjected to reduced hours or mandatory furloughs. In 2009, more than half of LHDs had to make cuts to important programs due to budget shortfalls. However, most local health departments are experiencing an increased need for their services as more people become unemployed and thus lose their health insurance. In these times of across-the-board budget cuts and public health staff layoffs and furloughs, health departments are faced with a difficult question – “How do we provide more services with less money and staff?”

- In this continuing climate of budget austerity, all five departments are concerned with maintaining their current funding levels.
- Local and state public health funding is perceived as the highest risk for reduction due to decreased revenue available for the city, county, or state general funds.
- In addition, some states are re-allocating categorical dollars that traditionally went to public health programs, such as tobacco control and tuberculosis, in order to balance the state budget. Public health departments are now struggling to maintain these important programs without the traditional funding that fueled them for many years.
- Three of the five benchmark entities stated they receive funding based on a local property tax levy. None of the three anticipate growth in resources from their levy, nor the possibility of new levies being assessed on taxpayers until the economy improves.
- Of all public health department services provided, clinical services are currently the most difficult to fund and are expected to be the most difficult to fund in the near future due to potential decreases in Medicaid reimbursement rates and decreased local and state funding levels.
- Collection of environmental health fees has also been reduced in the past few years due to the slowdown in new construction. The health departments anticipate this funding will increase as the economy rebounds.
- Only one of the health departments uses an outside fiscal agent.
- All five health departments stated they receive at least some of their federal funding as a pass-through from their state health department, and the state health department takes an administrative fee. The exact fees were either not known or not disclosed.
- When asked the question “How does your health department evaluate and report the return on investment (ROI) of funding provided to your agency?” two answered that they provide grant reports and annual reports. One stated they do not provide any such reports, and one stated they don’t use the term ROI.

Four out of the five respondents discussed politics as a critical component in the determination of local health department funding. This information was unsolicited as there was no question asking the respondent to discuss the impact of politics on their health department. Respondents felt that the political environment presented both opportunities and challenges.

**Funding Innovations**

The interviewed health departments had several strategies on how to maintain funding over the next few years:

**Strategy #1 - Diversify the Funding Sources**

One way to maintain and/or grow a public health department in the near future is to diversify the department’s funding sources to offset or supplement the typical/traditional funding streams that are being cut. This means that as the local and state funding percentages shrink, health departments will expand into new funding areas and look to increase their federal and service reimbursement funding categories.

**New Funding**

One way to diversify the funding portfolio is by being more entrepreneurial or aggressive about expanding into cutting-edge areas of public health work to capture new sources of funding.

For example, in the next few years, Denver Public Health anticipates that it will focus more on policy advocacy to influence built environment systems change.38 This targeted shift to built environment policy change will help to address many issues, among them obesity and violence. Denver Public Health plans to partner closely with the larger public health system, including transportation, parks and recreation, and food stores, to bring these changes about. Cambridge Public Health anticipates that its environmental division, currently its smallest, will grow the most over the next five years due to an increased focus on planning and policy intervention in the environment.39 CPHD recently led a successful campaign to ban smoking in private workplaces to protect workers from environmental tobacco smoke, and banned the use of trans-fats in restaurants to protect residents from their harmful coronary effects, and launched its’ “Healthy Living Cambridge” initiative. CPHD has also devoted significant sections on its website to “Lifestyle & Wellness” and “Policy & Practice”. And Hennepin County also recently received a grant to work with area restaurants on decreasing their carbon footprint.40

Public/private partnerships are the primary sources of funding for these new cutting-edge public health ventures. For example, Denver Public Health receives funding from the Robert Wood Johnson Foundation to implement environmental advocacy and obesity prevention programs, and Harris County receives funding from the CDC ACHIEVE program to implement obesity prevention programs.41

**Federal**

One way to diversify the federal funding portfolio is to apply for federal research grants and/or clinical trial grants. For example, Denver Public Health uses their clinical trials funding to offset

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clinical service expenses. This particular method requires that a health department have robust clinical department and research staff.

Another way to increase funding for clinical services is to apply for a 330 grant (FQHC status) for a public health clinic in order to receive increased Medicaid reimbursement rates. PHSKC has an FQHC, and Medicaid reimbursements constitute 19% of their overall budget.

Applying for federal grants for special projects is third way to diversify funding. For example, Cambridge Public Health Department received a 3-year $750,000 grant from the federal Office of Minority Health to participate in a national demonstration project to reduce health disparities among men of color.42

Service Reimbursement
Many health departments anticipate increasing fee-based services and/or implementing a more robust practice to bill and collect fees for services rendered. For example, Denver Public Health anticipates expanding its Travel Immunization Clinic, which serves all Denver residents on a fee-based, cash-only basis.43 Health reform is also viewed as an opportunity to be better reimbursed for clinical services (more below).

Caveats to Funding Diversity
Competition is one drawback to increasing the reliance on grant funding, both public and private. Local health departments must compete against each other as well as other non-profit health and human service agencies in order to secure a finite number of dollars from public and private grants. Cambridge Health Department, in particular, mentioned competition as a major drawback to an increased focus on grant funding. Additional reporting requirements and the possibility of non-renewed funding were noted as other drawbacks. From a consultant perspective, it will be tempting for health departments to chase after whatever new funding streams arise over the next few years of lean budgets, but health departments first need to be clear about their overall vision and create a viable plan for sustainability before expanding in multiple new directions.

Strategy #2 – Internal Restructuring
Three of the five health departments are restructuring to bring about greater efficiency and cost-savings. For instance, Cambridge is re-aligning its department to ensure that staff functions and staff capacity match the needs of the community. Denver is restructuring its multiple clinical services divisions for STD, HIV, and TB into one department as they anticipate that funding from the CDC will be provided in this more integrated, less categorical, fashion. Finally, since 2004, Hennepin County has been in the process of restructuring its services to be delivered in a regional, comprehensive manner.

Strategy #3 – External Strategic Alliances/Partnerships/Collaborations
Finally, all five of the health departments are collaborating or entering into strategic alliances/partnerships/collaborations with other entities in order to share resources and bring about greater efficiency. All five benchmark entities expressed that the majority of the programs they carry out involve working with a partner, whether it be community-based, governmental, business, or faith-based. This is a general theme that has surfaced in other recent benchmark studies, such as in the Milne and Associates National Best Practices background paper for the King County Public Health Operational

Looking forward to the next five years, the benchmark entities anticipate that some of their partnerships will be “outside of the box” and take the form of cross-sector public/private collaborations. The respondents believe that these new strategic alliances will be particularly helpful in implementing prevention programs.

LHDs as a whole are shifting to less direct service delivery and more service delivery through networks and collaborations, an overall trend coined “government by network”.\textsuperscript{44} The focus of local public health departments is broadening to include the entire “system”, including community-based organizations, health care delivery systems, businesses, transportation, the media, academia, etc. As public health departments work in concert with more outside agencies, they become the key facilitators and form the core of the ever-expanding public health system, and are better able to leverage limited resources to address public health issues.

The benchmark agencies referenced all sorts of partnerships and collaborations they use to carry out their work. For example:

- PHSKC is not part of an integrated county-wide health system, but they do partner with the county-owned Harborview Medical Center.
- For their Healthcare for the Homeless grant, PHSKC partners with a wide variety of community organizations.
- PHSKC is also beginning to partner with various entities to implement culturally competent health services for immigrants and refugees.
- Harris County works with a wide range of stakeholders, including local, state, and federal emergency response planners, school districts and public information officers to carry out its emergency preparedness program, as does Cambridge.
- Harris and Denver also received funding from such institutions as the Robert Wood Johnson Foundation and the CDC’s ACHIEVE program to form coalitions to tackle systemic and policy changes that will reduce the incidence of childhood obesity.

The Impact of Politics on Funding

Four out of the five respondents discussed politics as a critical component in the determination of local health department funding. This information was unsolicited as there was no question asking the respondent to discuss the impact of politics on their health department. Respondents suggested that the political environment and politics offered both challenges and opportunities.

For example, Harris County Public Health and Environmental Services Department is overseen directly by the county commissioner’s court, without the help of a local board of health to advocate for their agenda and budget. Recently, a strong supporter on the commissioner’s court lost re-election, and the new commissioner’s position on public health is not known. HCPHES works to build relationships with the commissioners and educate them about the importance of public health so that when it comes time to decide the annual budget, the commissioners will be aware of the need to fund public health adequately.\textsuperscript{45}

Denver and King County also spoke to the importance of building relationships with local elected officials to educate them about public health. They suggested that in times of budget austerity in

\textsuperscript{44} King County Public Health Operational Master Plan. “Milne and Associates Role Definition Background Report.” April 12, 2006. Page 192-193.

particular, constituents want to “see” where their tax dollars are going. And when politicians need to be re-elected, they tend to put money in projects that are visible. As the work of public health is often invisible (though necessary), politicians often shift money away from public health in order to fund higher visibility projects that will increase the odds of re-election. Public health must be constantly vigilant about marketing itself and promoting the importance of its programs with both the general public and the local politicians.

Additionally, politicians are wary of increasing taxes and levies during economic recessions. Of the three entities who stated they received funding based on a local property tax levy, none of them anticipate an increase to this current tax levy in the near future, and none of them foresee the possibility of any new public health levies being assessed on tax payers until the economy improves.

Conversely, politics can work to the advantage of public health. For example, the recent focus from the White House on obesity has triggered multiple new funding streams within the federal government and has also stimulated new private dollars with a focus on obesity prevention programs. This has given public health an enormous opportunity to go after new funding sources and streams. It remains to be seen if these funding streams will be sustainable.

The King County representative also discussed the relatively positive atmosphere for public health policy in the United States. In her experience, elected officials enjoy working with the local health department on policy initiatives, and that can be used as a method to both start and build strong relationships with elected officials.

Future Funding Opportunity – Health Reform

Three of the five health department respondents spoke positively of health reform as an opportunity for the public health sector. The two other informants did not comment on health reform at all. There was not a specific interview question asking about the informants’ perception of health reform, so all comments on this topic were unsolicited. None of the respondents elaborated much on the topic of health reform. This could have been a function of interview time constraints or a lack of knowledge about the specific impact of health reform.

The health-reform opportunity most mentioned by respondents are the new funding streams directed at prevention programs. King County, which provides more clinical primary care services than the average local health department, is looking forward to the full implementation of health reform when more patients are covered by Medicaid and private insurance, and the health department will have an increased ability to bill for clinical services provided.

The role and impact on health departments vis-à-vis health care reform will differ depending on the organization of local governmental public health and the extent to which the local health department delivers clinical services. However, all LHDs need to look closely at health care reform and consider how to strategically position themselves, particularly with respect to the delivery of community-based prevention and health promotion services that will be necessary, and potentially funded, as part of the new incentives and disincentives that health reform will establish for providers of clinical/acute care.

Future Funding Opportunity – Accreditation

Four of the five benchmark entities also mentioned voluntary accreditation through the Public Health Accreditation Board (PHAB) as an extraordinary opportunity for public health. This information was unsolicited as there was not a specific interview question asking about their perception of accreditation.
Hennepin County was one of the 30 sites chosen for beta-testing, and the respondent from this department was very positive about the accreditation process.\textsuperscript{46} This study’s finding of high interest in accreditation dovetails with a 2008 NACCHO finding that 72\% of LHDs serving 500,000 or more intend to seek accreditation (compared to only 47\% of LHDs serving less than 50,000).\textsuperscript{47}

Even though the monetary value of accreditation has not yet been determined, these health departments believe that at some point in the future, funders will require accreditation. Therefore, many departments are being proactive about preparing for accreditation. In addition to the possible monetary opportunity that accreditation provides, the health departments also see that accreditation can provide an opportunity to thoroughly assess their organization and become more efficient and effective in the process.

The consultant did not probe the respondents to discuss their progress with accreditation preparation. However, the three pre-requisites to applying for accreditation are:

1. Community/State Health Assessment
2. Community/State Health Improvement Plan (updated at least every five years)
3. Agency Strategic Plan – This document should set forth the department’s mission, vision, guiding principles and values, and strategic priorities, as well as describe measurable and time-framed goals and objectives. It should also include steps to implement portions of the community health improvement plan as well as other strategic issues for the department.

Harris County and King County have strategic plans for their health department. Cambridge discussed the fact that Massachusetts is considering implementing Community Health Improvement Plans (CHIPs) to prepare for accreditation. Hennepin completed the beta test of accreditation. It appears that at least four of the five benchmark entities have at least one of the components in place already (or at least have plans to move forward with the components).

\textsuperscript{47} NACCHO. 2008 National Profile of Local Health Departments. www.naccho.org
ORGANIZATIONAL/PROGRAMMATIC STRATEGIES - KEY FINDINGS

- All five health departments are expecting flat growth or a decrease in clinical services within the next five years.
- The five health departments are expecting potential growth in policy advocacy and prevention programs.
- Much of the policy work is expected to relate to obesity prevention in some way – such as advocating for changes in the built environment, advocating for menu labeling, etc.
- Three of the five health departments specifically mentioned obesity prevention programs as a trend in the coming years, particularly with the influx of foundation (Robert Wood Johnson) and federal (Communities Putting Prevention to Work) funding.
- Two health departments mentioned the importance of continued federal support for their emergency preparedness programs.
- Three of the health departments have a unionized workforce - Cambridge, King County, and Hennepin County. (Harris County and Denver do not have union employees.) The three health departments acknowledge that it can be challenging to manage union contracts, but also pointed out that the unions are one of the biggest budget allies. The three health departments also stated that they recently have had generally positive interactions with the unions.
- All five health departments interviewed stated that partnerships and collaborations are a key organizational strategy used to accomplish department goals and that nearly everything the department does requires working with a partner.
- The communities served by all five benchmark entities are undergoing some degree of demographic change, and all are proactive about addressing cultural competency, health disparities, and health equity.
- Three of the health departments have strategic plans or a similar document to guide their decision-making.

Staffing Trends

Given the gloomy economic situation, many of the health departments studied are currently experiencing a decrease in staff numbers and expect this trend to continue over the next five years. Harris County has already laid off some staff members, and it has a hiring freeze in place. King County has laid off nearly 300 employees over the past few years. If budget cuts continue over the next few years, the benchmark entities expect that additional staff will have to be laid off in both clinical and non-clinical areas.

Hennepin anticipates that any staff growth in either clinical or non-clinical areas will result from the acquisition of specific grants and program funding. Cambridge is an example of a department where shifts in staffing have been the direct result of the loss or gain of specific grants. For instance, they experienced a reduction in FTE due to the loss of an emergency preparedness grant, but increased FTE in the community health division due to a federal demonstration grant.

Due to the economic crisis and high unemployment rate, Hennepin noted that it has recently been better able to attract nurses to work in the public sector despite the lower pay scale. Recognizing the aging workforce, the Cambridge informant expressed concerned about nurse turnover in the next five years due to retirement. As 50% of the 60-person department is comprised of public health nurses, this impending staff shift could prove to be a difficult challenge.
Three of the benchmark health departments have a unionized workforce - Cambridge, King County, and Hennepin County. These health departments acknowledge that it can be challenging to manage union contracts, but also pointed out that the unions are one of the biggest budget allies. The informants also stated that they recently have had generally positive interactions with the unions. Hennepin County was pleased that there was no pushback when union employees were asked to work non-traditional hours during the H1N1 crisis. And King County’s unions agreed to not have a cost of living allowance (COLA) when the economic crisis hit. King County offered that it is best to be direct and engage the union to help find a suitable solution when a major problem arises.

**Partnerships & Collaborations**

All of the health departments interviewed stated that partnerships and collaborations are a key organizational strategy used to accomplish department goals. This finding dovetails closely with the funding section theme of strategic alliances being used to stretch thin funding dollars. Many of the benchmark entities state that nearly everything they do requires working with a partner – whether community-based/non-profit, faith-based, for-profit, or governmental. In fact, PHSKC has the nickname “Partnerships R Us,” alluding to its numerous collaborations.

In the next five years, the benchmark entities anticipate increasing the depth and breadth of their partnerships in order to increase and amplify the reach of the health department. This emphasis on partnerships is not just a result of funding constraints; the benchmark entities understand it as an inherent function of public health. Essential public health service #4 states that public health will “mobilize community partnerships to identify and solve health problems.” NACCHO further states in its’ 2005 Operational Definition of a Functional Local Health Department that “regardless of the particular local public health system, the LHD has a consistent responsibility to intentionally coordinate all public health activities and lead efforts to meet the standards.”

**Demographic Shifts**

Based on the charts included earlier in this report, all of the benchmark entities have diverse populations in terms of race, ethnicity, age, and socioeconomic status. All of the communities served by benchmark entities are currently experiencing some degree of demographic change, but all of informants expressed confidence that they can meet the changing needs presented by these shifts. Denver stated that they are not expecting much new population growth, but Harris County is on the other end of the spectrum. It has experienced a tremendous growth in their Hispanic population in the past couple of decades, and they are expecting that trend to continue. They are concerned about how to contend with the increasing demand for public health services on a decreasing budget, and are applying a health equity framework to determine services going forward.

Cambridge acknowledges the need to increase their outreach to their vulnerable populations, and Hennepin is focused on addressing existing health disparities within their county.

King County has a very diverse population (one school can have children who speak over 60 languages), and they expect that trend to continue for the next five years. The respondent indicated that providing culturally competent services for such a diverse population can be quite challenging, but diversity can also be an opportunity for innovation. King County is running a pilot research program in the two most diverse communities to determine the best methods of reaching newly arrived immigrants and refugees.

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— such as the use of interpreters and text messaging. King County is also partnering with non-traditional public health partners (such as housing, transportation, economic development) to plan the next steps in how to get healthcare into these underserved immigrant communities.

Because Denver has the reputation of being an active, healthy community, one unique challenge Denver Public Health faces with respect to their demographics is convincing funders that there are vulnerable populations and health disparities that need to be addressed through public health programs.

**Strategic Goals of the Benchmark Entities**
Three of the five benchmark entities had some sort of strategic plan that is available online. Interestingly, the two public health departments embedded within a larger health system (Cambridge and Denver) are the two entities that do not have a publicly available strategic plan for their department.

Harris County’s most recent strategic plan went from 2005-2010. They had six strategic issues within that plan:
1. Responding to Current and Emerging Health Threats
2. Evaluating Service Effectiveness and Service Delivery
3. Fostering Effective Communication, Staff Development, and Leadership
4. Increasing Stakeholder Awareness
5. Enhancing Departmental Resources
6. Maximizing Effective Partnerships

Harris County feels that their 2005-2010 strategic plan is still relevant and is considering a 2-year extension to this plan before engaging in another planning process.

In 2007, King County underwent a process to draft its Public Health Operational Master Plan (PHOMP). This master plan narrowed and simplified the complicated public health functions to three core goals (3 P’S): health protection, provision, and promotion. The PHOMP also includes two additional goal areas relating to human resources and funding/financial infrastructure. The PHOMP serves as more of a directional document as opposed to a workplan with a strict timeline, and the King County informant found it helpful to have the PHOMP act as a guide to formulate strategies when new opportunities and challenges arose. Technically, the PHOMP expires in July 2011. The county will not require the document to be redone, and PHSKC anticipates that the current PHOMP will remain relevant for some time given its more directional essence. Currently, PHSKC uses the PHOMP to orient new employees, to communicate with elected officials, to communicate within the department, and to supplement grant applications. The PHSKC informant contributes the PHOMPs success to two factors:
- 1) they had an outside consultant as a third-party participant who could validate what the health department was doing and move them forward in the process and
- 2) they had a multidisciplinary planning team comprised of PHSKC employees, Board of Health members, and King County executives. This broad scope allowed PHSKC to educate their county officials about the important role of public health and the continued need for stable funding.

Hennepin County Human Services and Public Health Department has a document of ten strategic “directions” from 2006 to 2010:
1) Provide high-quality customer service
2) Create a continuum of services and supports to end homelessness
3) Develop self-reliant youth and young adults through an integrated, coordinated children’s agenda
4) Implement integrated care approaches for service delivery
5) Use eligibility for public assistance programs as a means to improve lives
6) Ensure accountability to achieve results
7) Expand primary prevention
8) Improve customer access to needed services
9) Expand community-based involvement and service delivery across Hennepin County
10) Increase the county’s ability to respond to public health emergencies

Central to many of the ten directions is the HCHSPH movement to implement a regional integrated service delivery model. The Hennepin informant was not asked about the next strategic plan for his department.

Organizational Innovations

Besides the trends and innovations described throughout this paper, there are a few that do not fall neatly into any other category:

- Hennepin has a county-wide initiative for all high school students to graduate. Recent research shows the major connection between healthy brain development from ages 0-3 and success later in life. Trauma inflicted upon a fetus or infant can have a major impact on brain development and thus future life success. As part of their participation in the county-wide graduation initiative, HCHSPH is asking “What does it take for all 3-year-olds in our county to have a healthy brain?” This innovative primary prevention initiative will use the frameworks of both human/social service and public health in its implementation. HCHSPH is hoping to receive funding for this program as it dovetails with the overall county graduation goal.

- Cambridge has purposefully and strategically increased the internal capacity of its epidemiology unit to manage and analyze data in-house. This is opposite of many local health departments around the country, which are understaffed in this area.

- Cambridge is also being purposeful about using social marketing techniques to get public health messages out into the community, and they have received positive feedback from residents.

- Denver plans an initiative to improve the quality of clinical services and client satisfaction over the next five years.
APPENDIX

Benchmark Study Ad-Hoc Advisory Team
- Dr. Stephen Martin, Chief Operating Officer, CCDPH
- Dr. Christina Welter, Deputy Director, Prevention Services Unit, CCDPH
- Mairita Smiltars, McAlpine Consulting for Growth, LLC
- Courtney Showell, PwC
- Sonia Alvarez-Robinson, PwC

Respondents from the Five Benchmark Departments
- Cambridge Public Health Department, Massachusetts
  - Claude-Alix Jacob, November 23, 2010
- Denver Public Health (DPH), Colorado
  - Dr. Chris Urbina, November 16, 2010
- Harris County Public Health and Environmental Services (HCPHES), Texas
  - Rocaille Roberts, November 19, 2010
- Hennepin County Human Services and Public Health Department (HCHSPH), Minnesota
  - Todd Monson, November 18, 2010
- Public Health of Seattle & King County (PHSKC), Washington
  - Dorothy Teeter, November 16, 2010

Separate documents that informed this report
- Benchmark Scorecard - 10 Potential Entities to Compare
- Benchmark Matrix
- Interview Transcripts (Cambridge, Denver, Harris, Hennepin, King)
Benchmark Assessment Questionnaire

1. TRENDS
   a. What, in your perception, are the major recent successes/innovations of your health department (operational and/or programmatic)?
      i. What factors contributed to the success?
   b. What, in your perception, are the biggest challenges/threats facing your health department in the next five years?
      i. How is your health department addressing this?
   c. What are the major opportunities facing your health department in the next five years?
      i. How is your department planning to take advantage of the opportunities?

2. GOVERNING STRUCTURE
   a. Briefly describe the governing structure of your health department.
   b. How long have you had this particular governing structure?
      i. Please note any recent changes/mergers
   c. Describe what you perceive as the benefit(s) of your governing structure.
   d. Describe any challenges you face with your governing structure.
   e. Do you foresee your health department making any major changes in governing structure within the next 5 years?
      i. If yes, can you explain a little bit about those potential changes?
   f. Please describe how your State Health Department is governed and structured. How does that impact your agency?

3. FUNDING
   a. Please list your funding percentages
      i. Federal funding
      ii. State funding
      iii. Non-governmental grants
      iv. Corporate funding
      v. Earned income
      vi. Other (please describe)
   b. What do you perceive as the biggest budgetary challenge facing your health department in the next 5 years?
   c. Does any of your funding come from a tax levy?
      i. If yes, what year did the levy begin?
      ii. Do you anticipate the levy increasing in the next 5 years or will it remain flat?
      iii. Are there any mechanisms attached to the levy that prevent the district from raising it without state legislature or referenda approval?
      iv. Are there any referenda in the near future that would add services to those you are currently mandated to provide?
   d. When your health department receives federal funding, is it granted directly to you, or is it passed through your state?
      i. If the funds are passed through the state, does the state take an administrative fee?
      ii. If yes, what is the percentage of the fee?
e. Does your department use outside fiscal agents?
   i. If yes, in what capacity?

f. How does your health department evaluate and report the return on investment of
   funding provided to your agency?

4. OPERATIONAL/ORGANIZATIONAL STRATEGIES
   a. Please briefly describe the organizational structure of your health department.
      i. Number of units and workflow
      ii. Clinical service offerings
      iii. Non-clinical service offerings
   b. How have you developed your clinical and non-clinical program strategies? How have
      you put those plans into action (operationalized them)?
   c. Do you foresee your health department making any major changes to clinical and/or
      non-clinical service provision within the next five years?
      i. If yes, can you explain a little bit about those potential changes?
   d. Can you please describe staffing trends (e.g. increases or decreases in staff levels, type
      of work, etc.) over the past 3 years?
      i. Do you expect any significant changes in staffing over the next 5 years? If so,
         how?
   e. Are any of your health department staff union employees?
      i. If yes, how do the unions impact your department?
   f. Is your health department jurisdiction experiencing any major demographic changes?
      i. If yes, what are they?
      ii. If yes, can you describe what strategies you are using/thinking of using to assure
          provision of clinical/non-clinical services for the changing population?
   g. Do you use partnerships/collaborations with community coalitions to provide your
      clinical and/or non-clinical services?
      i. If yes, please explain a little bit about your partnerships.