State Governmental Public Health System Baseline Report

2012 Final Report

Acknowledgements

Governmental Public Health System Baseline Report
Modernization Staff, Iowa Department of Public Health

The Public Health Evaluation Committee was formed in 2009 to achieve what very few states have attempted in the past, evaluating the governmental public health system within a state. Many states have initiatives in place to evaluate the efficiency or the effectiveness of programs and services; however, few have assessed system-wide performance.

Committee members, both past and present, accepted the challenge of designing an evaluation methodology head on. During the Committee's first year, members developed their understanding of the governmental public health system. This knowledge assisted them in identifying areas for study. Over the course of the past year and a half, members diligently attended meetings to develop and distribute the baseline survey. Thank you to those individuals who participated in this monumental task. Your collective expertise and commitment to improving public health have been, and will continue to be, assets to Iowa's public health system.

A special thank you also goes to Dr. Tanya Uden-Holman from the University of Iowa, College of Public Health for her assistance with the analysis and interpretation of the data, as well as her dedicated assistance in writing and helping to finalize this report.

Last, but certainly not least, thank you to the Iowa Department of Public Health staff who completed the survey. Without your participation, this report would not be possible.

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Message from the Public Health Evaluation Committee Chair and Vice-Chair

On behalf of the Public Health Evaluation Committee, we are pleased to present the results of the 2011-2012 Governmental Public Health Baseline survey.

Since 2004, public health partners across Iowa have participated in efforts to improve the public health system. These improvement efforts began by asking the question, "What should every Iowan expect from local and state public health?" A collaborative effort between local and state public health professionals and public health partners lead to the development of the Iowa Public Health Standards.

The next step in improving Iowa's governmental public health system was to determine a baseline of the system's current organizational capacity (administration, workforce, planning, evaluation and quality improvement, information technology, and communication) and service delivery (with a specific emphasis on injury prevention, environmental health, disease investigation and control, chronic disease prevention, and public health preparedness). To collect the information needed to describe Iowa's governmental public health system, a baseline survey was developed and distributed to public health partners.

Results of the survey will be used to identify gaps and areas for improvement in the governmental public health system, as well as educate key partners and stakeholders about Iowa's governmental public health system. It is anticipated that there will be follow up surveys to identify changes over time.

We welcome your feedback and your continued interest in and use of these data. If you have questions about the content of the report please contact Joy Harris at joy.harris@idph.iowa.gov.

Sincerely,

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Chapter 1: Introduction

Public Health Modernization Act

The Public Health Modernization Act (Iowa Code chapter 135A) was signed by the governor in 2009. The law focuses on continued development of the governmental public health system (based on standards) and the development of a voluntary accreditation system. The Public Health Modernization Act formalized work that had been ongoing in Iowa since 2004 to address inconsistencies in public health practice across the state. To carry the work forward, two oversight bodies were specified in the Public Health Modernization Act, the Public Health Advisory Council and the Public Health Evaluation Committee.

This baseline report is a direct result of one of the requirements of the Public Health Evaluation Committee as described in the Public Health Modernization Act. In Iowa Code section 135A.5, the evaluation committee is charged with collecting and reporting baseline information for organizational capacity and public health service delivery based on the Iowa Public Health Standards. Having a baseline in place makes it possible to carry out some of the additional duties of the evaluation committee such as evaluating the governmental public health system, the effectiveness of the voluntary accreditation process, and the appropriateness of the Iowa Public Health Standards. Baseline information will also assist the evaluation committee in evaluating process and outcome improvements in the governmental public health system that are attributable to the implementation of public health standards and participation in voluntary accreditation.

Baseline Survey Development

The purpose of the baseline surveys was to gather the necessary information for describing Iowa's governmental public health system for state public health and local public health. The following information provides an overview of the methodology and processes used to develop the state baseline survey:

> *Study Population:* To obtain baseline information, the evaluation committee chose to administer a state public health survey to division directors and bureau chiefs at the Iowa Department of Public Health (IDPH).
>
> *Questionnaire Design:* Members of the evaluation committee were tasked with developing the baseline assessment methodology and survey instruments. Members participated in a webinar in February 2011, to begin discussing the process.

Members were then asked to brainstorm possible evaluation questions and submit them in writing in preparation for a scheduled April meeting. During April 2011, the evaluation committee met for two days to discuss the baseline methodology, discuss potential baseline questions, and draft an initial survey for local public health agencies. In October 2011, committee members began developing questions related to state health department activities. Meetings held during December 2011, and January 2012, were devoted to completing the state health department survey questions.

Baseline Survey Responses

State Health Department Baseline Survey

On March 19, 2012, division directors and bureau chiefs at the Iowa Department of Public Health were invited to complete the state health department baseline survey. Six division directors and 24 bureau chiefs were asked to complete the survey. Additional survey participants were bureau coordinators, or individuals who directly report to a division director (the state baseline survey instrument for bureau chiefs can be found in Appendix A, the survey instrument used with division directors is in Appendix B). Prospective respondents were given two weeks to answer the questions via Survey Monkey. Reminders were sent by IDPH staff one week prior to the close of the survey. Additional follow-up calls were completed to ensure an adequate response rate.

The survey was completed by all requested participants (bureau chiefs, division directors, and bureau coordinators/individuals who directly report to a division director) for a 100% overall response rate.

Data Analysis

Survey responses for the state baseline survey were compiled in Survey Monkey and then exported to Excel. Data analysis was completed by Dr. Tanya Uden-Holman, Associate Dean for Education and Student Affairs from the University Of Iowa College of Public Health.

Report Format

The following report details the results of the state baseline survey. A subsequent report containing the results from the local baseline survey will be released as a separate, companion document.

The state baseline report is divided into chapters; each chapter focuses on a specific topic area. For example, questions about state usage of permanent staff, temporary staff, their

job classifications, and training received can be found in the Public Health Workforce chapter. Each chapter contains a background section that provides information on the importance of the topic area. This is followed by an evaluation questions section. The Public Health Evaluation Committee set out to answer some questions of interest regarding the governmental public health system; the questions appear with a "Q:" before them in the text.

These results are based mostly on overall summary data.

Chapter 2: Overview of the Governmental Public Health System in Iowa

Background

It is important to understand the relationship between state and local public health agencies in the United States; these relationships vary from state to state. There are four main types of relationships between state and local public health agencies: centralized systems, decentralized systems, mixed systems, and shared systems. In *centralized* systems, the local health department is operated by the state health agency or board of health and functions under the state health agency's authority. In *decentralized* systems, local governments have home rule or direct authority over local health agencies. Variations of these two general types include *mixed* systems in which state and local health services are provided by a combination of the state health agency, local government, boards of health, or health departments in other jurisdictions. In *shared* systems, the local health department operates under the shared authority of the state health agency, the local government, and local boards of health.[1]

The public health system in Iowa is decentralized where local governments have home-rule or direct authority over local health priorities. The state health department's role in the system is to partner with local public health, policymakers, health care providers, businesses, and others to promote and protect the health of Iowans.

The following information provides a general overview of the roles and responsibilities of the state board of health and state health department.

State Board of Health and State Health Department

Iowa has had a state public health agency since 1880 when the Eighteenth General Assembly formed the Iowa State Board of Health to provide for the collecting of vital statistics and to assign certain duties to local boards of health. Since then, its duties have

[1] M. Fraser. "State and Local Health Department Structures Implications for Systems Change", NACCHO. Downloaded from http://www.turningpointprogram.org/Pages/transformations/transformations_1298/body_implications.htm on April 9, 2012.

greatly expanded. Today, IDPH serves as the state's leader in administering and funding public health, overseeing more than 85 programs, and employing more than 425 people.[2]

The Iowa Department of Public Health partners with local public health, policy makers, health care providers, businesses, and many others to fulfill its mission of promoting and protecting the health of Iowans. IDPH's primary role is to support Iowa's 98 county boards of health, 2 city boards of health, and 1 district board of health in this mission. To do this, IDPH provides technical support, consultation, and funding to a variety of partners. In addition, IDPH also provides direct services such as licensing health professionals; regulating emergency medical services and substance abuse treatment providers; regulating radioactive materials; and collecting birth, death, and marriage records.

Chapter 136 of the Iowa Code states that the Iowa State Board of Health is IDPH's policy-making body. Iowa State Board of Health members and the department's director are appointed by Iowa's governor. The board provides a forum for the development of public health policy in the state of Iowa. The Iowa State Board of Health has the power and duty to adopt, promulgate, amend, and repeal administrative rules and regulations consistent with law for the protection of the public health and prevention of substance abuse, and for the guidance of the department. The IDPH director works closely with the Iowa State Board of Health to develop state health policy.

State Board of Health Members

Name	City	Term Exp.
Justine Morton, Chairperson	West Des Moines	2013
Maggie Tinsman	Bettendorf	2013
Michael Wolnerman, RPh, CCIM	Des Moines	2013
Ron Abrons, MD	Coralville	2013
Tonya Gray, MD	Mason City	2014
Kenneth Wayne, MD	Ottumwa	2014
Karen Woltman	Swisher	2014
Jay Hansen	Mason City	2015
Ted George, DO	Rockwell City	2015
Diane Thomas	Manchester	2015
Cheryl-Straub-Morarend	Coralville	2015

The Iowa Department of Public Health is organized into six divisions and the Director's Office. Each division is comprised of bureaus and programs designed to improve the quality of life for all Iowans. The following provides a brief explanation of the Director's Office and each of IDPH's six divisions:

[2] 2011 Iowa Department of Public Health Annual Report and Budget Summary

- **Department of Public Health - Director's Office**
  The director is the spokesperson and advocate for public health in Iowa and acts as a liaison to local boards of health, local public health agencies, health care providers, and consumers. The director also represents the department in a variety of national organizations and works with policy makers at the local, state, national and international levels. The Director's Office is comprised of the following boards and offices:
    - Iowa Dental Board
    - Iowa Board of Medicine
    - Iowa Board of Nursing
    - Iowa Board of Pharmacy
    - Office of the State Medical Examiner
    - Iowa State Board of Health

- The **Division of Acute Disease Prevention and Emergency Response** provides support, technical assistance, education, and consultation about infectious disease prevention and control, injury prevention and control, and public health and healthcare emergency preparedness and response. The division is made up of the following centers and bureaus:
    - Center for Acute Disease Epidemiology
    - Center for Disaster Operations and Response
    - Bureau of Communication and Planning
    - Bureau of Emergency Medical Services (EMS)
    - Bureau of Immunization and TB

- The **Division of Administration and Professional Licensure** provides services for birth, marriage and death certificates; monitors and reports progress on health objectives and identifies emerging health issues; coordinates 19 licensure boards regulating the activities of more than 30 health professions; takes respondibility for fiscal management of department revenues and contract administration, as well as software, network and computer support. The division is made up of the following bureaus:
    - Bureau of Finance
    - Bureau of Health Statistics
    - Bureau of Information Management
    - Bureau of Professional Licensure

- The **Division of Behavioral Health** promotes the prevention of substance abuse and problem gambling, secondary conditions among people with disabilities, and violent behavior; and regulates substance abuse and gambling treatment programs. The division is made up of the following offices and bureaus:
    - Office of Disability, Injury and Violence Prevention
    - Office of Problem Gambling Treatment and Prevention
    - Bureau of HIV, STD, and Hepatitis
    - Bureau of Substance Abuse

- The **Division of Environmental Health** provides technical assistance to local boards of health, local environmental health professionals, public health nurses, and local communities in areas relating to environmental health. The division is made up of the following board and bureaus:
    - Bureau of Environmental Health Services
    - Iowa Plumbing and Mechanical Systems Board
    - Bureau of Lead Poisoning Prevention
    - Bureau of Radiological Health

- The **Division of Health Promotion and Chronic Disease Prevention** promotes and supports healthy behaviors and communities; the prevention and management of chronic diseases; and the development of public health infrastructure and access to health care/services at the local and state levels. The division is made of the following centers, offices, and bureaus:
    - Center for Congenital and Inherited Disorders
    - Bureau of Chronic Disease Prevention and Management
    - Bureau of Family Health
    - Bureau of Local Public Health Services
    - Office of Minority and Multicultural Health
    - Bureau of Nutrition and Health Promotion
    - Bureau of Oral and Health Delivery Systems

- The **Division of Tobacco Use Prevention and Control** promotes partnerships among state government, local communities, and Iowans to reduce tobacco use. The division uses the following strategies to reduce tobacco use and the toll of tobacco-caused disease and death by preventing youth from starting, helping adults to quit, and preventing exposure to secondhand smoke:
    - Community Partnerships
    - Enforcement
    - Evaluation and Research
    - Quitline Iowa and Other Cessation Services[3]

[3] Iowa Department of Public Health Website – IDPH's Organization (http://www.idph.state.ia.us/WhatWeDo)

Chapter 3: Public Health Financing

Background

Public health funding is a critical component of Iowa's public health system. The Iowa Department of Public Health is funded by multiple sources. Not all funding received by the department stays at the department, it is passed through to local public health agencies and other public health partners.

Evaluation Questions

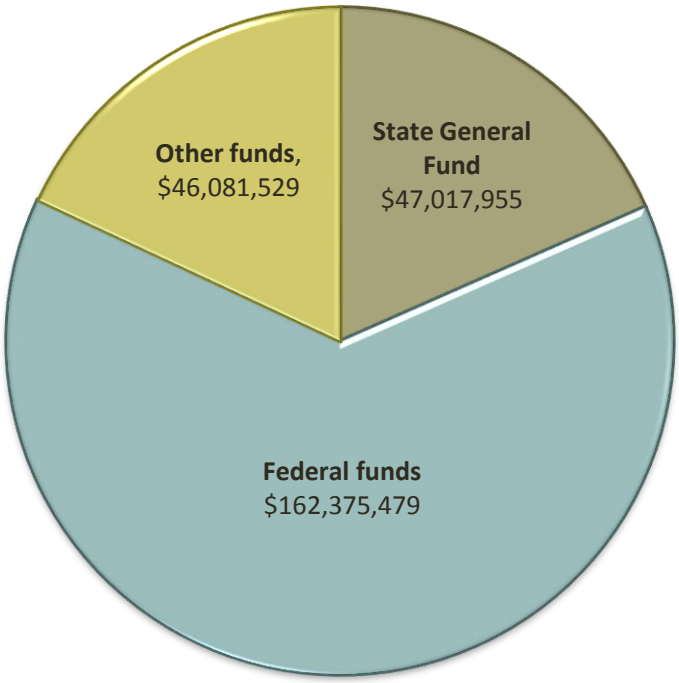
Q: *What are the main funding sources of the state health department?*

Funding for the Iowa Department of Public Health is classified into three main sources.

Source	Definition
State General Fund	State-appointed funds provided for state mandated programs.
Federal funds	Funds appointed by the Federal government or received through a competitive selection process (Federally funded grants).
Other funds	Collected fees, grants received from private organizations, Rebuild Iowa Infrastructure (RIFF) funds, Technology Reinvestment funds, and Underground Storage Tank funds.

During State Fiscal Year (SFY) 2012, the estimated expenditures for IDPH total $255,474,963. Figure 3.1 outlines the breakdown of expenditures by funding source. Figure 3.2 outlines SFY 2010, 2011, and 2012 expenditure information for the department as a whole.

Figure 3.1: Iowa Department of Public Health Annual Budget Compiled by State Fiscal Year*



* Final expenditure values not available by the release date of this report

Figure 3.2: Iowa Department of Public Health Annual Budget Compiled by State Fiscal Year*

Source	SFY2010 Actual	SFY2011 Actual	SFY2012 Estimate**
State General Fund	$50,660,855	$52,242,414	$47,017,955
Health Care Trust Fund	$6,817,581	$0	$0
Federal funds	$128,115,457	$121,918,659	$162,375,479
Other funds	$37,013,066	$31,046,057	$46,081,529
Total funds	$222,606,959	$205,207,129	$255,474,963

* Total funds may not equal sum of individual funding sources due to rounding
**Final expenditure values not available by the release date of this report

Q: *If IDPH relies on grant funding, how are grant writing activities completed at the department?*

In reviewing grant writing activities in IDPH bureaus, 11 of 24 (45.8%) who responded indicated that grant writing is completed entirely by their staff. Another 8 (33%) responded that grant writing is completed by staff in collaboration with other entities. Five bureaus indicated they do not participate in grant writing activities.

The average number of staff members participating in grant development and writing processes was 6, while the range was 1 to 20 staff members. Figure 3.3 provides a breakout of responses by quantity of staff members participating in grant writing activities:

Figure 3.3: Number of staff members who participate in the grant development and writing process (n=19)

	Responses (%)
1-5 staff members participate	8 (42%)
6-15 staff members participate	10 (53%)
≥16 staff members participate (greater than or equal to)	1 (5%)

Q: *How many staff members have received formal grant writing training?*

When asked about formal grant writing training, 78.9% (15/19) of bureaus indicated their staff members have received training. Of these respondents, the average number of staff members receiving training was 4.7 while the range was 0 to 15 staff members. Figure 3.4 provides a breakout of responses by quantity of staff members receiving formal grant writing training:

Figure 3.4: Number of staff members who have received formal grant writing training (n=15)

	Responses (%)
< 1 staff member	1 (6.7%)
1-5 staff members	9 (60.0%)
≥6 staff members	5 (33.3%)

Chapter 4: Public Health Administration

Background

This section addresses elements of the operational procedures and management systems necessary at the state public health department. The requirements of the department are determined by Iowa Administrative Code, the Executive Branch of state government, and internally through the development of departmental policies and procedures.

Evaluation Questions

Q: *What feedback is obtained from stakeholders on new and existing rules?*

The majority of respondents (17/24; 70.8%) indicated their bureau proactively obtains stakeholder input prior to formal rule making for new rules. One respondent indicated the bureau does not write administrative rules. A slightly smaller percentage (15/23; 65.2%) indicated they seek regular input from stakeholders on existing rules.

Q: *Have existing administrative rules been reviewed within the past five years?*

Nineteen of 23 respondents (82.6%) indicated they had reviewed their bureau's administrative rules within the last five years.

Q: *Do IDPH bureaus maintain written procedures?*

The majority of respondents (15/24; 62.5%) indicated their bureau maintains written procedures that describe service delivery. Figure 4.1 provides information on the percentage of programs in their bureau with written procedures in place for *operations* and the percentage with written procedures for *direct services.*

Figure 4.1: Percent of IDPH bureaus with written procedures in place for operations and direct services (n=15).

	Written procedures for operations	Written procedures for direct service
Less than 25%	3	1
25 – 49%	1	3
50 – 74%	6	1
75 – 99%	4	5
100%	1	1
Bureau doesn't provide direct services	n/a	4

Q: *Are written procedures accessible to staff and how often are written procedures reviewed?*

All 15 respondents indicated written procedures are accessible to staff. The majority (10/15; 66.7%) of bureaus have a review of written procedures at least annually, one has a written review of procedures bi-annually, and four have a written review of procedures at least every three years.

Chapter 5: Assessment and Planning

Background

"It is essential to take time at the outset to clarify their purpose and provide a focus for what they want to achieve by developing mission and vision statements. The vision statement is future-focused. It is a statement to inspire the group about its destination, its outcome, its end-product, its finish line. A mission statement is present-focused. It sets priorities and clearly describes how the group will reach a destination or achieve the vision. Both statements should be brief enough to remember, captured quickly, and understood by everyone in the community; they should provide in one or two short sentences why the group exists and where it's headed."[4]

> *"Healthy Iowans living in healthy communities." – IDPH Vision Statement*
> *"Promoting and protecting the health of Iowans." – IDPH Mission Statement*

The Iowa Department of Public Health (IDPH) partners with local public health, policy makers, health care providers, businesses, and many others to fulfill its mission of promoting and protecting the health of Iowans.

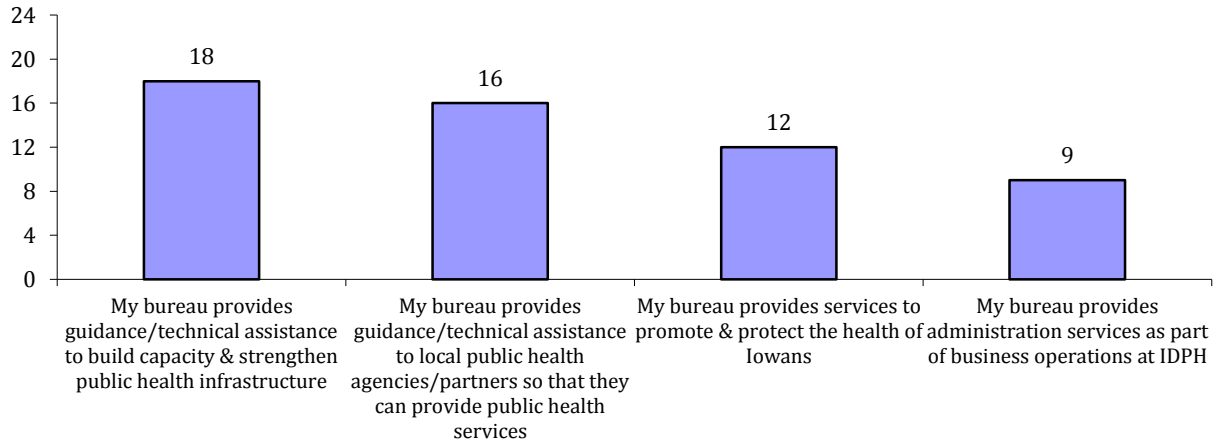
Evaluation Questions

Q: *What roles does the department play in the governmental public health system?*

Figure 5.1 illustrates how the 24 bureau chiefs saw their bureaus' role in the governmental public health system.

[4] http://www.idph.state.ia.us/chnahip/common/pdf/developing_statements.pdf

Figure 5.1: Bureau chief perception on the bureau's role in the governmental public health system.



*Respondents could select more than one response.

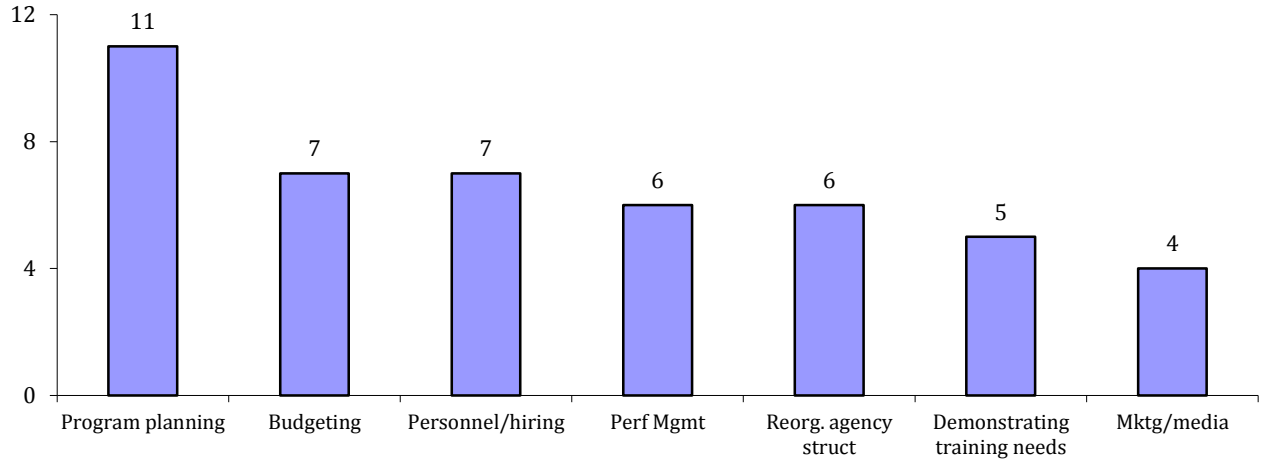
Q: *Do department employees understand how they fit into the IDPH mission and vision?*

All but one of the respondents (23/24; 95.8%) indicated that they know how their bureau fits into the IDPH mission and vision. The respondents were also afforded an opportunity to provide an open-ended response to the question and explain why their bureau fits into the IDPH mission and vision. The responses reflected the breadth of activities that are performed across the department. For example, some bureaus provide services that are focused on internal customers. In other words, they provide services and infrastructure needed by IDPH employees. Many bureau chiefs focused their responses on how they assist partners to carry out public health activities. Other bureaus work with a range of external stakeholders on prevention and wellness-related services; technical assistance is also an important activity of many bureaus. Data collection is another critical function and provides information on health issues that need to be addressed as well as if programs are making a difference in the health of Iowans. Finally, there are bureaus, who due to the regulatory nature of their activities, focus on activities to promote and protect the health of Iowans.

Q: *Do IDPH bureaus maintain and use a strategic plan?*

Slightly less than half (11/24; 45.8%) of bureau chiefs indicated that their bureau has a strategic plan. Of those 11 bureaus that have a strategic plan, one bureau updates their strategic plan more than once a year; four bureaus update their plan annually, three bureaus update their plan every two years; and three bureaus update their plan every four years or more. Figure 5.2 indicates how the 11 bureaus use their strategic plan.

Figure 5.2: Bureau utilization of strategic plan.*



*Respondents could select more than one response.

Q: *Do bureaus have a written continuity of business plan? (A plan to address roles and responsibilities in the event of a non-emergency response related absence.)*

Two-thirds of respondents (16/24) indicated their bureau has a written continuity of business plan, in other words, a plan to address roles and responsibilities in the event of a non-emergency response-related absence.

Q: *How is technical assistance provided to public health partners (e.g., local public health departments, health care organizations, non-profit agencies, etc.)?*

Nineteen of 24 respondents (79%) provide technical assistance to public health partners. Technical assistance is provided to public health partners in a variety of formats which are outlined in Figure 5.3.

Figure 5.3: Methods used by IDPH bureaus to provide technical assistance to program partners.*

*Respondents could select more than one response.

Q: *What percentage of staff's time is spent providing technical assistance to public health partners?*

Nine of the 19 respondents indicated that 25 – 49% of their staffs' time is spent providing technical assistance; 3 respondents indicated 50 – 74% of staffs' time is spent on technical assistance; 6 indicated 75 – 99% of their staffs' time is spent providing technical assistance. Only 1 respondent indicated that less than 25% of staffs' time is spent providing technical assistance.

Q: *What types of technical assistance is provided (to each of the following entities)?*

Figure 5.4 shows the type of technical assistance being provided to each of the providers listed in the table. Technical assistance was most commonly provided to local public health agencies, not-for-profit agencies, other state agencies, and hospitals. The most frequent types of technical assistance involved data collection/data management and policy development. The sample sizes (n) shown in Figure 5.4 for each provider represents the number of bureaus providing technical assistance to that provider. The type of technical assistance is based on the provider type sample size. Example: Of the 9 bureaus that provide technical assistance to emergency responders, 4 (44.4%) do so by providing technical assistance through policy development.

Figure 5.4: Type of technical assistance provided by IDPH bureaus by provider type.*

	Type of Technical Assistance						
Provider Type	Policy Development	Program Management	Service Provision	Data Collection and/or Management	Public Health Law and Rules	Workforce Issues	Other
Emergency responders (n=9)	4	0	2	4	4	2	2
Federal government (n=14)	5	7	5	12	4	3	3
For-profit agencies (n=11)	6	4	5	6	3	3	4
Hospitals (n=17)	12	7	6	9	7	4	3
Laboratories (n=9)	3	3	3	7	5	1	2
Licenses (n=9)	3	2	5	4	6	3	1
Local public health agencies (n=18)	16	13	10	13	12	9	5
Not-for-profit agencies (n=15)	12	10	11	10	8	4	3
Other states (n=16)	10	7	7	11	5	6	4

Provider Type	Type of Technical Assistance						
	Policy Development	Program Management	Service Provision	Data Collection and/or Management	Public Health Law and Rules	Workforce Issues	Other
Other state agencies (n=15)	7	7	7	9	8	2	5
Schools (n=11)	5	5	3	4	4	0	4

*Respondents could select more than one response.

Q: *How does the department assess technical assistance needs and are improvements made based on the assessment?*

Almost 90% of respondents (17/19; 89.5%) indicated their bureau assesses technical assistance needs and 73.6% (14/19) of respondents request feedback on how technical assistance is provided. Of those requesting feedback, all respondents indicated they are using the feedback to improve how technical assistance is provided to public health partners.

Fifteen of 19 respondents (79%) request feedback on what (e.g., information, guidance/instructions, tools/templates) is provided through technical assistance and all of those requesting this feedback use it to improve technical assistance provision. Figure 5.5 outlines how IDPH bureaus conduct technical need assessments with public health providers.

Figure 5.5: IDPH bureau response rate of mechanisms used to assess technical assistance needs of public health providers (n=17).*

	Responses (Percent)
Survey	8 (47.1%)
Site visit	6 (35.3%)
Reports (monthly, bi-annual, annual, etc.)	6 (35.3%)
Requests	4 (23.5%)
Email or phone calls	4 (23.5%)
Other (informal exchange of information, annual work plans, evaluations, stakeholder feedback, etc.)	15 (88.2%)

*Respondents could select more than one response.

Chapter 6: Public Health Workforce

Background

According to a policy brief written in December 2008 by the Association of Schools of Public Health:

"Dramatic public health advances in the 20th century have helped to increase the average lifespan of U.S. residents by more than 30 years and to improve quality of life around the world. Vaccinations, control of infectious diseases, safer workplaces, motor vehicle safety, an improved food supply, strategies to protect the health of mothers and babies, and the recognition of tobacco as a health hazard are among the great public health achievements of the past century, according to the Centers for Disease Control and Prevention.

The public health workforce has made all of this possible through practice, service, and research. These multidisciplinary professionals:

- *Include clinicians and health program administrators, educators, planners, and policy analysts, occupational and environmental health specialists, and economists, epidemiologists, and biostatisticians.*
- *Work in diverse public and private settings, including public health agencies at every level of government, community-based service organizations, academic and research institutions, hospitals, health plans and medical groups, and private companies.*
- *Serve many functions, including health surveillance and protection, wellness promotion, planning and regulating, and organizing, delivering, and evaluating health services."*[5]

Because public health professionals will continue to play an essential role in the public health system, it is important to continue to assess the capacity and training needs of the public health workforce in Iowa. To assist with human resource needs, IDPH works closely with the Department of Administrative Services (DAS).

DAS provides services to IDPH that include but are not limited to verifying qualifications of applicants, job classification, and compensation, affirmative action, workforce planning,

[5] December, 2008. Confronting the Public Health Workforce Crisis: Association of Schools of Public Health Policy Brief.

performance evaluation, labor relations, benefits, safety, workers' compensation, wellness, and training and development.[6] The following questions were designed to learn more about the makeup of the current workforce, training and development.

Evaluation Questions

Q: *How many full time equivalencies (FTE) are in the department (including permanent full-time, permanent part-time, contractual and temporary staff)?*

Due to the methodology of the baseline survey, it was determined that the department's response to the 2012 Association of State and Territorial Health Officials (ASTHO) Profile survey should be presented here.

Figure 6.1: Number of FTEs

	Number
Total Reported FTEs	410
Number of staff members	470
Number of part-time workers	10
Number of hourly (temporary or as needed) workers	50

Q: *What roles do permanent FTEs play at the department?*

The information presented in Figure 6.2 was also gathered for the ASTHO Profile Survey. The data broadly places individuals into roles, as opposed to identifying them by their degree, education, or experience.

[6] http://das.hre.iowa.gov/

Figure 6.2: Total number of FTEs by job role.

	Number of FTE's
Administrative/clerical	81
Public health nurse	10
Environmental health worker	16
Public health manager	24
Epidemiologist/Statistician	14
Health educator	53
Nutritionist	7
Public information specialist	1
Preparedness and response staff	12
Oral health professional	2
Primary care office director	1
Other: Planners	43
Other: Pharmacists	7
Other: IT Specialists	38
Other: Others not listed	101

The department reported having no FTE's in the following roles: nurse practitioner, physician assistant, laboratory worker, social worker, public health informatics specialist, and public health physician.

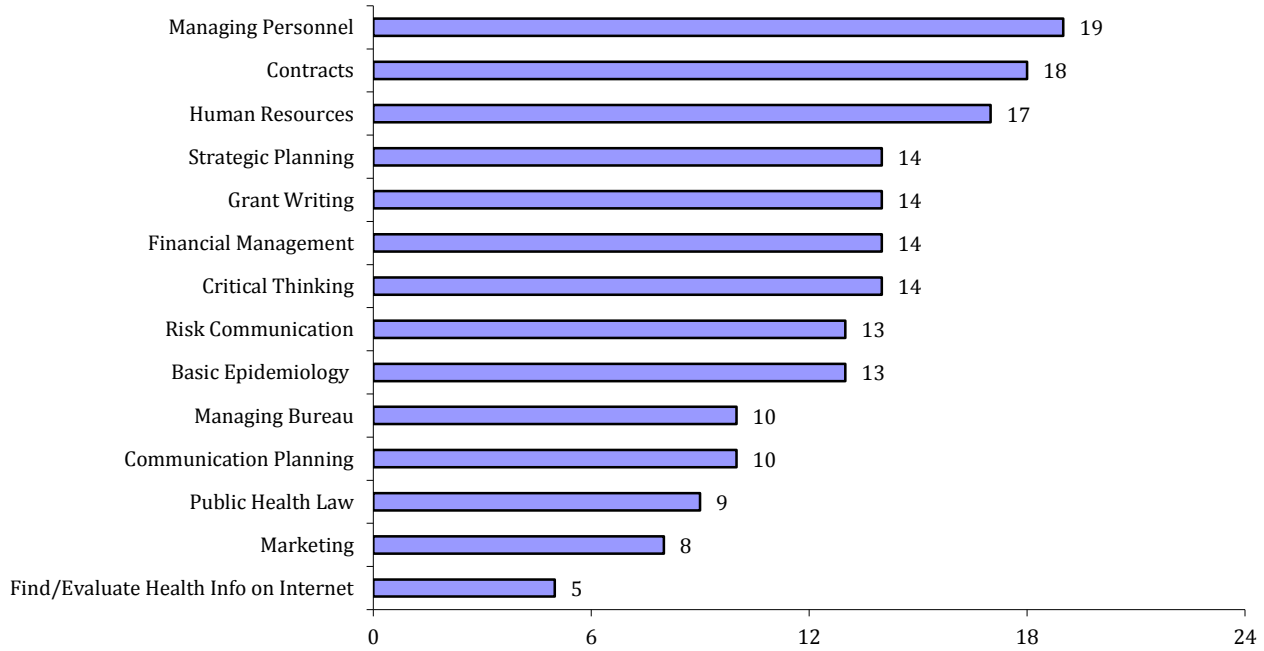
Q: *Do IDPH bureaus utilize workforce development plans and how often are workforce training needs assessed?*

Only 25.0% of bureau chiefs (6/24) indicated they use workforce development plans. When asked how often their bureau assesses workforce training needs, 14 of 24 (58.3%) respondents indicated every 1 – 2 years; 2 (8.3%) indicated every 3 – 4 years; while 8 (33.3%) indicated their bureau has never assessed workforce training needs.

Q: *What workforce development training do bureau chiefs receive?*

Ongoing personnel training is an integral part of continuous workforce development. This question sought to determine the specific training that each of the bureau chiefs has received. Figure 6.3 outlines the responses from each of the bureau chiefs.

Figure 6.3: Individual training received by each bureau chief (n=24).*



*Respondents could select more than one response.

Chapter 7: Communication

Background

"*The population that a health department serves should have accurate and reliable information about how to protect and promote individual and family health. They should have information about healthy behaviors such as good nutrition, hand washing, and seat belt use. The population should have access to accurate and timely information in the case of particular health risks like H1N1, a food-borne disease outbreak, or an anthrax attack. Such information should be communicated in a language and format that people can understand. Public health departments also have a responsibility to educate the public about the value, roles, and responsibilities of the health department and the meaning and importance of public health.*"[7]

Communication is extremely important in every aspect of our lives. It is especially important for public health when it is necessary to be able to receive and disseminate information effectively. The following set of questions further examines how state public health evaluates and accommodates different population needs and how information is disseminated to the public.

Evaluation Questions

Q: *How does the department assure that it is accommodating different populations?*

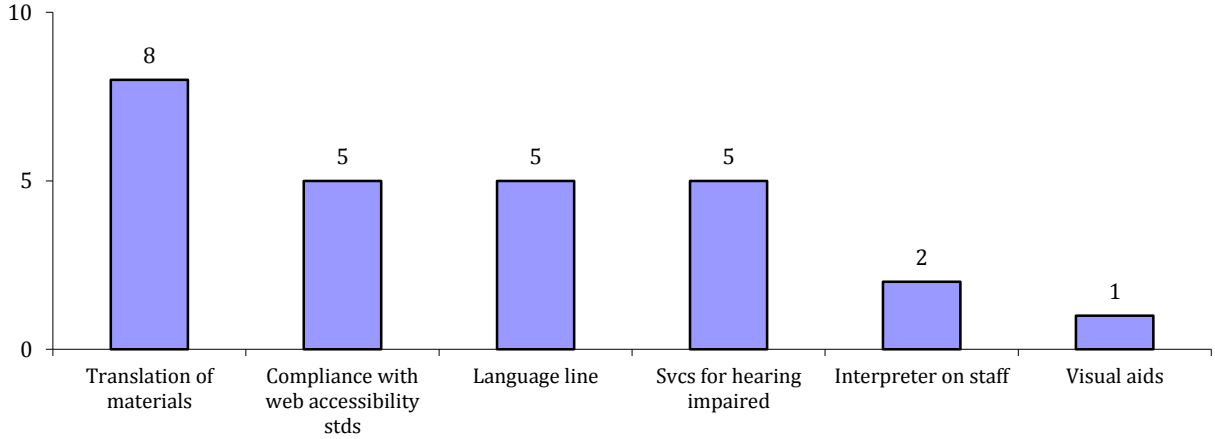
Thirteen of 24 respondents (54.2%) indicated that their bureau assesses whether it is accommodating different populations with appropriate communication formats (e.g., information/documents are available in other languages, direct services are provided where multiple clients gather, bilingual staff are available, extended hours are available before or after normal business hours, when needed).

[7] May 2011. Public Health Accreditation Board: Standards and Measures, Version 1.0. Domain Three: Inform and Educate about Public Health Issues and Functions.

Q: *How does IDPH communicate with people who have functional needs?*

In the past 12 months, less than half of bureaus (10/24; 41.7%) indicated they have implemented strategies to communicate with people who have functional needs (i.e., visually impaired, hearing impaired, mobility impaired, or non-English-speaking persons). Figure 7.1 illustrates the strategies these 10 bureaus have implemented to communicate with people who have functional needs.

Figure 7.1: Communicate with people with functional needs by IDPH bureaus by strategy type.*



*Respondents could select more than one response.

Q: *Does the department employ staff who speaks another language as part of their job description? (The position has a bilingual hiring selective requirement.)*

Of the 24 respondents, one bureau chief (4.2%) indicated employing staff that has a bilingual hiring selective. This bureau employs two such staff members each with the requirement to be able translate and interpret Spanish.

Q: *Does the department use language line to communicate with the public? If yes, how often?*

Reviewing language line services, 45.5% of respondents (5/11) indicated their bureaus use such services. Of the five respondents using language line, two use the service bi-monthly, while one respondent for each indicated daily, weekly, and monthly usage.

Q: *How does the department educate people about public health services available to them?*

Figure 7.2 provides information on the top three ways bureaus educate people about the public health services available to them.

Figure 7.2: IDPH bureau response rate of top ways bureaus educate people about the public health services available to them.*

	Responses (%) (n=24)
Website	18 (75.0%)
Email distribution list	14 (58.3%)
Brochures	9 (37.5%)
Coalition meetings	9 (37.5%)
Meeting with health care providers	9 (37.5%)
Agency-generated newsletters	8 (33.3%)
Press releases	5 (20.8%)
Announcements at public meetings	5 (20.8%)
Direct mail	4 (16.7%)
Health fairs	3 (12.5%)
Posters/flyers	3 (12.5%)
Purchase media	2 (8.3%)
Information booth at community events	2 (8.3%)

*Respondents could select more than one response.

Q: *How does the department make sure the website is maintained? Does the department obtain customer or stakeholder feedback on the content and usability the department's website?*

Assessing how often bureaus review and update content on the IDPH website, half of respondents (12/24) indicated they review and update content annually; one indicated daily; three indicated weekly; five indicated monthly; and three indicated quarterly. Additionally, only 25% (6/24) indicated they had obtained customer or stakeholder feedback on the content and usability of their bureau's webpage.

Chapter 8: Evaluation and Quality Improvement (QI)

Background

Ongoing evaluation and systematic critical review of the effectiveness, accessibility, and quality of public health services are key functions of public health.

Evaluation results can be used to:

- Inform the public and key stakeholders about the successes and lessons learned from public health programs;
- Assure stakeholders that public health programs are effectively addressing the needs of the community so that resources are not wasted;
- Recognize and support programs that successfully affect the health of populations; and
- Identify the strengths and weaknesses of public health programs so appropriate steps can be taken to improve programs or to discontinue programs that are found to be ineffective.

Results can also be used to identify potential quality improvement initiatives. Quality improvement (QI) is defined as "a continuous and ongoing effort to achieve measureable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health."[8] The following set of questions takes a further look into evaluation and quality improvement activities at the state health agency.

Evaluation Questions

Q: *There are a lot of data collection systems at the department, how are thy managed?*

The majority of bureaus (18/24; 75.0%) manage a data collection system to either monitor health indicators or report service provision. A slightly lower percentage (12/18; 66.7%) of bureaus assess the effectiveness of their data collection systems.

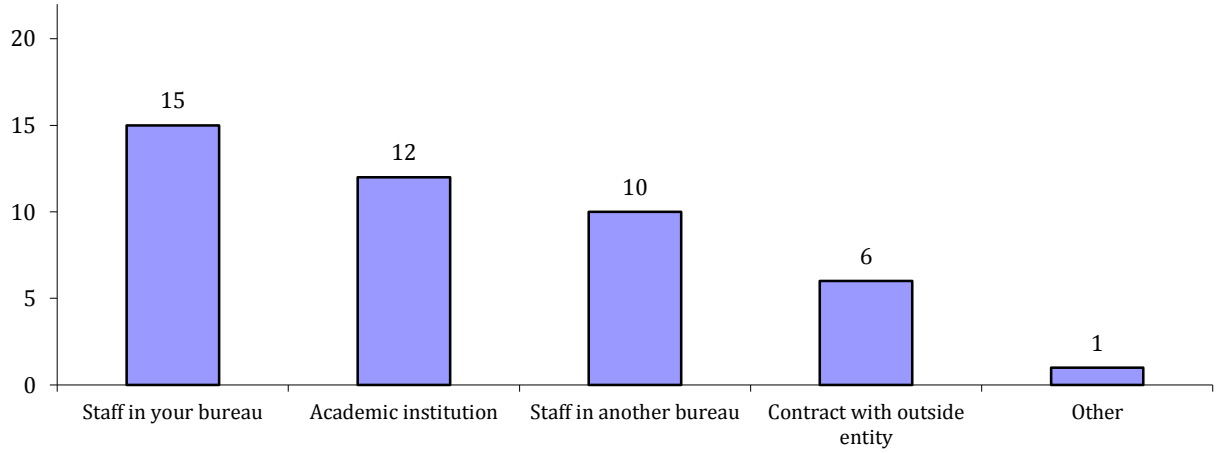
[8] June 2009. Definition of Quality Improvement in Public Health. Accreditation Coalition of the Public Health Foundation.

Half of bureaus (9/18) evaluate response times for issues identified with state-managed data collection systems. The majority of bureaus (14/18; 77.8%) obtain user feedback or stakeholder input to improve data collection systems.

Q: *Do all bureaus have access to someone who can analyze and interpret data?*

The vast majority (22/24; 91.7%) of bureaus have someone in their bureau who can analyze and interpret data. Figure 8.1 shows the mechanisms through which bureaus access data analysis and data interpretation services.

Figure 8.1: Mechanisms used by IDPH bureaus to access data analysis and data interpretation (n=22).*



*Respondents could select more than one response.

Q: *How are public health programs and services evaluated?*

Slightly more than half of respondents (13/24; 54.2%) indicated their bureau had developed goals and objectives for all of the public health programs and services it provides. Performance measures were most likely to have been identified for grant-funded programs and services (17/24; 70.8%).

Non-grant funded programs/services were far less likely to have performance measures (7/24; 29.2%) as were administrative functions (6/24; 25%). The majority of respondents (14/24; 58.3%) indicated they routinely evaluate programs and services, while 25.0% (6/24) of respondents indicated they evaluate programs and services when it is required by the funder. Only four (16.7%) respondents indicated they rarely or never evaluate programs and services.

Q: *Does the department assess the need for disseminating reports including internal and external utilization of reports that are produced?*

Less than half of respondents (10/24; 41.7%) indicated their bureau assesses internal and external utilization of the reports it produces. Only seven of 24 respondents (29.2%) assess the need for disseminating reports. Figure 8.2 provides information on how often bureaus assess report utilization and dissemination.

Figure 8.2: Frequency that IDPH bureaus assess report utilization and dissemination.

	Assess report utilization (n = 10)	Assess report dissemination (n = 7)
Monthly	3	0
Quarterly	2	3
Annually	3	3
Other	2	1

Q: *What quality improvement activities are happening at the department?*

Figure 8.3 provides information on bureau quality improvement activities. Although 95.8% (23/24) of bureaus indicate some quality improvement activities, no bureau has implemented a formal quality improvement program bureau-wide.

Figure 8.3: Current IDPH bureau quality improvement activities.

	Responses(%) (n=24)
Formal quality improvement activities are being implemented in specific programmatic or functional areas of the bureau, but not on an bureau-wide basis.	13 (54.2%)
My bureau's quality improvement activities are informal or ad hoc in nature.	10 (41.7%)
We have implemented a formal quality improvement program bureau-wide.	0 (0.0%)
My bureau is not currently involved in quality improvement activities.	1 (4.2%)

Q: *What kinds of tools are being used in the department's quality improvement efforts in the past year?*

Figure 8.4 provides data on elements that have been included in bureaus' quality improvement efforts. The elements used most frequently were setting measurable objectives, obtaining baseline data, and mapping a process.

Figure 8.4: Activities used in Quality Improvement efforts by IDPH bureaus in the past year (n=24).*

ACTIVITY	FREQUENCY (N=24)
Setting measurable objectives	18
Obtaining baseline data	17
Mapping a process	16
Identifying root cause	11
Analyzing test results	8
Formally adopting a tested intervention	4
None of the above	2

*Respondents could select more than one response.

Q: *How does the department support or encourage staff involvement in quality improvement efforts?*

Illustrated in Figure 8.5, half of respondents (12/24) provide training to staff in quality improvement methods, while one-third (8/24) includes quality improvement in job descriptions for some employees. However, one-quarter of respondents (6/24) indicated that they had not utilized any of the listed avenues to support or encourage staff involvement in quality improvement activities.

Figure 8.5: IDPH bureau activities to promote staff involvement in quality improvement (QI) activities (n=24).*

ACTIVITY	FREQUENCY (N=24)
Provide QI training to staff	12
QI in job descriptions	8
QI included in performance goals	5
QI committee coordinates QI efforts	4
Provide funding to QI	3
Recognize outstanding QI work	1
None of the above	6
Other	4

*Respondents could select more than one response.

Q: *Is customer feedback data used for process and/or program improvement?*

The majority of respondents (16/24; 66.7%) indicated they use customer feedback for process and/or program improvement. However, one-third (8/24) indicated they do not collect customer feedback data.

Chapter 9: Public Health Services

Background

Where you live, learn, work, and play make a big difference in how healthy you are.

A range of factors like education, employment, income, family and social support, community safety, and the physical environment, impact our health.

In many communities, healthy choices are easy choices for their residents. In these communities, there are plenty of gyms, safe places to jog, and community recreation centers with gleaming swimming pools and sports fields. The children play and exercise in well maintained parks and playgrounds. But in many other American communities, there are obstacles to healthy living:

- *Parks and playgrounds are not well-kept or unsafe.*
- *There are few places to get out and exercise — some communities don't even have sidewalks for walking.*
- *School meals are low in nutritional value, school vending machines sell junk food, and students don't get regular physical education classes. Access to fruit and vegetables is limited because there are no supermarkets.*
- *Dilapidated housing, crumbling schools, abandoned factories, and freeway noise and fumes cause illness and injury.*

The poor overall conditions cause higher levels of obesity and chronic disease, including diabetes, heart disease, and cancer, leading to higher health care costs.

One major factor in the health of a community is whether or not they have a strong public health system. Public health departments can help improve the health of communities, since they are responsible for finding ways to address the systemic reasons why some communities are healthier than others — and for developing policies and programs to remove obstacles that get in the way of making healthy choices possible.[9]

[9] http://www.healthyamericans.org/assets/files/Investing%20in%20America's%20Health.pdf

Evaluation Questions

Q: *What types of written agreements are currently used by the department, and are they compiled on a master document (that includes: name of contractor, purpose of contract, dates of contract, amount of contract, and counties served)?*

A review of the types of written agreements used by the 23 bureaus that responded showed that 22 (95.7%) use contracts, 19 (82.6%) use service agreements, 17 (73.9%) use memorandums of understanding, 10 (43.5%) use memorandums of agreement, 14 (60.9%) use intergovernmental agreements, and seven (30.4%) use 28E agreements (respondents could select more than one response).

Slightly more than half of respondents (13/23) indicated their bureau maintains a master document of contractors that includes the following information: the name of the contractor, the purpose of the contract, the dates of contract, the amount of the contract, and the counties served by the contract. Of those 13 that maintain a master list, only six indicate the document is available to the public. Of the 10 that do not have a master contractor document, only three plan to create one in the next 12 months.

Q: *Which other state agencies does IDPH partner with to provide public health services?*

Three-quarters (18/24) of bureaus partner with other state agencies to provide public health services to Iowans. Figure 9.1 provides information on the state agencies with which IDPH bureaus partner. Partnerships are most likely to occur with the Department of Human Services, state universities, and the Department of Education. Two bureaus listed other partners which included the Iowa Finance Authority and the Attorney General's Office.

Figure 9.1: State agencies with which bureaus partner to provide public health services.

	Responses (%) n=18
Department of Human Services	12 (66.7%)
State Universities	12 (66.7%)
Department of Education	11 (61.1%)
State Hygienic Laboratory	8 (44.4%)
Department of Aging	7 (38.9%)
Department of Corrections	6 (33.3%)
Department of Human Rights	6 (33.3%)
Department of Inspections & Appeals	6 (33.3%)
Department of Transportation	5 (27.8%)
Department of Administrative Services	4 (22.2%)
Department of Economic Development	4 (22.2%)
Department of Natural Resources	4 (22.2%)
Department of Public Safety	4 (22.2%)
Iowa Occupational Safety & Health	4 (22.2%)
Department of Agriculture and Land Stewardship	3 (16.7%)
Department of Homeland Security and Emergency Management	3 (16.7%)
Department of Management	3 (16.7%)
Iowa National Guard	2 (11.1%)
Civil Rights Commission	1 (5.6%)
Department for the Blind	1 (5.6%)
Department of Commerce	1 (5.6%)
Department of Cultural Affairs	1 (5.6%)
Department of Labor	1 (5.6%)
Department of Revenue	1 (5.6%)

*Respondents could select more than one response.

Q: *Which other local agencies/organizations does the department partner with to provide public health services to Iowans?*

Of the 23 respondents, 18 (78.3%) bureaus also indicated their bureau partners with local agencies/ organizations to provide public health services to Iowans. Figure 9.2 illustrates the partner organizations and the type of activity involved.

Figure 9.2: State agencies with which bureaus partner to provide public health services.*

	Exchanged information	Served together on committees, work groups, or advisory bodies	Worked together on specific activities or projects	Provided financial resources through contracts with IDPH	No relationship	N/A (this organization does not exist in our jurisdiction)
Area education agencies (n=17)	9	6	6	2	7	0
Business (n=17)	11	8	7	2	6	1
Community-based organizations (n=16)	12	12	10	6	3	0
Community development agencies (n=15)	5	5	3	0	8	0
Community health centers (n=16)	12	7	8	5	4	0
Conservation organizations (n=16)	1	0	0	0	14	1
Cooperative extensions (n=17)	7	5	4	1	10	0
County attorneys (n=15)	6	1	1	1	9	0
Economic development agencies	2	3	2	0	13	0

	Exchanged information	Served together on committees, work groups, or advisory bodies	Worked together on specific activities or projects	Provided financial resources through contracts with IDPH	No relationship	N/A (this organization does not exist in our jurisdiction)
(n=17)						
Emergency responders (n=15)	7	2	5	2	7	0
Environmental organizations (n=15)	7	3	3	1	9	0
Faith communities (n=16)	7	6	6	3	7	0
Health insurers (n=16)	9	8	7	0	4	0
Hospitals (n=18)	14	9	12	4	2	0
Housing agencies (n=15)	8	3	4	0	6	1
Land use agencies (n=14)	1	0	0	0	12	1
Local public health agencies (n=17)	14	13	16	13	0	0
Media (n=15)	12	1	7	1	1	0
Physician practices/medical groups (n=18)	15	12	10	3	3	0
Other health care providers (n=17)	15	15	10	2	2	0
Other voluntary or nonprofit organizations (n=16)	12	11	10	5	3	0
Parks and recreation	4	1	0	0	10	0

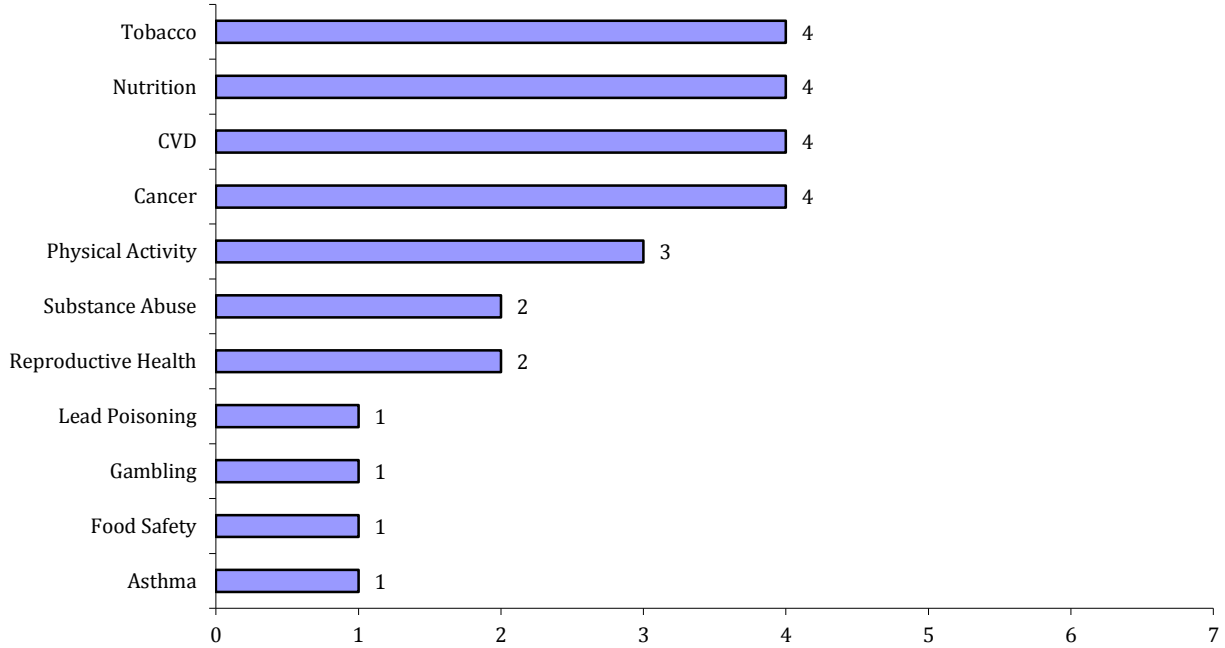
	Exchanged information	Served together on committees, work groups, or advisory bodies	Worked together on specific activities or projects	Provided financial resources through contracts with IDPH	No relationship	N/A (this organization does not exist in our jurisdiction)
(n=14)						
Regional cancer societies (n=14)	3	4	2	1	10	0
Schools (n=16)	12	8	10	2	2	0
Transportation (n=14)	6	3	3	1	8	0
Tribal government agencies / other tribal community (n=15)	10	4	5	2	5	0
Universities (n=17)	14	13	15	11	1	0
Universities: Extension offices (n=14)	8	4	5	4	6	0
Utility companies/agencies (n=13)	1	1	0	0	11	0

*Respondents could select more than one response.

Q: *For which prevention program areas are evidence-based interventions used?*

Slightly more than half (10/18) of respondents indicated their bureau provides chronic disease prevention or wellness programs/services. Figure 9.3 presents data on areas where evidence-based interventions are used to provide prevention programming, and Figure 9.4 provides the focus area of the intervention.

Figure 9.3: Areas where evidence-based interventions are used to provide prevention programming (n = 7).



*Respondents could select more than one response.

Figure 9.4: Bureau focus areas by evidence-based interventions (n=7).

Intervention	Focus Area
Tobacco	Quitline Iowa Community Partnerships Youth Executive Council
Physical Activity	Small Media Provider Targeted Tool-Kit Safe Routes to School Pick a Better Snack
Nutrition	Small Media Provider Targeted Tool-Kit NEMS-V WIC Pick a Better Snack
Cancer	"Body & Soul"
Other	Chronic Disease Self-Management Programming support/materials/training funds Oral Health Disease Prevention MCH-Medical home Adolescent development – TOP Wise Guys HCCI – Child Care Nurse Consultant Better Choices/Better Health – Chronic Disease Prevention

Q: *What services do IDPH divisions provide?*

Figure 9.5 provides information on the services that are either directly performed by division staff or for which there is a written agreement in place with another agency/entity to provide the activity/service. Data were provided by IDPH division directors.

Figure 9.5: Services provided by IDPH division directly or through written agreement with another provider.

	Responses
Immunizations—Vaccine order mgmt/inventory distribution	
Adult (n = 6)	1
Childhood (n = 6)	1
Immunizations—Administration of Vaccine to Population	
Adult (n = 6)	2
Childhood (n = 6)	2
Screening for Diseases/Conditions	
Asthma (n=6)	0
Blood lead (n = 6)	2
Cancer (n = 6)	1
Cardiovascular disease (n = 6)	1
Diabetes (n = 6)	1
High blood pressure (n = 6)	1
HIV/AIDS (n = 6)	1
Newborn screening (n = 6)	1
Obesity (n = 6)	1
STDs (n = 6)	1
Tuberculosis (n = 5)	1
Other public health screening (n=6)	2

	Responses
Registry Maintenance	
Congenital & inherited disorders (n=6)	1
Cancer (n = 6)	1
Immunization (n = 6)	1
Diabetes (n = 6)	0
Infectious disease (n = 6)	1
Injury e.g., farm injury, trauma (n = 6)	2
Newborn screening—early hearing detection/intervention (n= 6)	1
Disease Treatment Services	
Asthma (n = 6)	0
Blood lead (n = 6)	1
Cancer (n = 6)	0
Coronary heart disease (n = 6)	0
Diabetes (n = 6)	0
High blood pressure (n = 6)	0
HIV/AIDS (n = 6)	1
Infectious disease (n = 6)	1
STDs (n = 6)	1
Tuberculosis (n = 5)	1
Other public health treatment (n = 6)	1
Maternal and Child Health Services	
Child nutrition (daycare providers) (n = 6)	1
Children with special health care needs (n = 6)	1
Comprehensive school health clinical services (n = 6)	0
Early intervention services for children (n = 6)	1
Early and periodic screening, diagnosis & treatment (n = 6)	1
Family planning (n = 6)	1
MCH home visits (n = 6)	1

	Responses
Non-WIC nutrition assessment & counseling (n = 6)	1
Outreach and enrollment for medical insurance (n = 6)	1
Prenatal care (n = 6)	1
Comprehensive primary care clinics for children (n = 6)	1
School health services (non-clinical) (n = 6)	1
Well child services (n = 6)	1
WIC (n = 6)	1
Other Health Services Provided to Individuals	
Domestic violence victims services (n = 6)	1
Hearing (n = 6)	0
Oral health (n = 6)	1
Problem gambling treatment (n = 6)	1
Substance abuse education/prevention services (n = 6)	1
Substance abuse treatment services (n = 6)	1
Vision (n = 6)	1
Data Collection, Epidemiology/Surveillance Activities	
Adolescent behavior (n = 6)	3
Behavioral risk factors (n = 6)	2
Cancer incidence (n = 6)	1
Chronic diseases (n = 6)	2
Communicable/infectious diseases (n = 6)	3
Environmental health (n = 6)	1
Foodborne illness (n = 6)	2
Injury (n = 6)	2
Morbidity (n = 6)	0
Perinatal events or risk factors (n = 6)	1
Reportable diseases (n = 6)	2
Syndromic surveillance (n = 6)	0

	Responses
Vital statistics (n = 6)	1
Population-based Primary Prevention Services	
Abstinence only education (n = 6)	1
Asthma (n = 6)	0
Breast and cervical cancer (n = 6)	1
Diabetes (n = 6)	1
HIV/AIDS (n = 6)	1
Hypertension (n = 6)	1
Immunization (n = 6)	2
Injury (n = 6)	3
Mental illness (n = 6)	0
Nutrition (n = 6)	1
Physical activity (n = 6)	1
Problem gambling (n = 6)	1
Sex education (n = 6)	2
Sexually transmitted disease counseling (n = 6)	1
Skin cancer (n = 6)	1
Substance abuse (n = 6)	2
Suicide (n = 6)	1
Tobacco (n = 6)	3
Unplanned pregnancy (n = 6)	1
Violence (n = 6)	2
Regulation, Inspection, and/or Licensing Activities	
Acupuncture (n = 6)	0
Assisted living (n = 6)	0
Beaches (n = 6)	0
Biomedical waste (n = 6)	0
Body piercing (n = 6)	0

	Responses
Campgrounds & RVs (n = 6)	0
Childcare facilities (n = 6)	0
Cosmetology businesses (n = 6)	1
Emergency medical services (n = 6)	1
Food processing (n = 6)	0
Food service establishments (n = 6)	0
Hospice (n = 6)	0
Hospitals (n = 6)	0
Hotels/motels (n = 6)	0
Housing (healthy homes) (n = 6)	1
Jails/prisons (n = 6)	0
Lead inspection (n = 6)	1
Long-term care facilities (n = 6)	0
Migrant housing (n = 6)	1
Milk processing (n = 6)	0
Mobile homes (n = 6)	0
Private drinking water (n = 6)	0
Public drinking water (n = 6)	0
Septic tank systems (n = 6)	0
Smoke-free ordinances (n = 6)	1
Solid waste haulers (n = 6)	0
Swimming pools (public) (n = 6)	1
Tanning salons (n = 6)	1
Tobacco retailers (n = 6)	2
Trauma system (n = 6)	1
Professional Licensure	
Athletic training (n = 6)	1
Barbering (n = 6)	1

	Responses
Behavioral science (n = 6)	1
Chiropractic (n = 6)	1
Cosmetology arts & sciences (n = 6)	1
Dentists (n = 6)	0
Dietetics (n = 6)	1
Hearing aid dispensers (n = 6)	1
Massage therapy (n = 6)	1
Mortuary science (n = 6)	1
Nursing home administrators (n = 6)	1
Nurses (any level) (n = 6)	0
Optometry (n = 6)	1
Pharmacists (n = 6)	0
Physical and occupational therapy (n = 6)	1
Physicians (n = 6)	0
Physician assistants (n = 6)	1
Podiatry (n = 6)	1
Psychology (n = 6)	1
Respiratory care (n = 6)	1
Sign language interpreters and translators (n = 6)	1
Social work (n = 6)	1
Speech pathology & audiology (n = 6)	1
Other Environmental Health Activities	
Air pollution (n = 6)	0
Animal control (n = 6)	0
Collection of used pharmaceuticals (n = 6)	0
Environmental epidemiology (n = 6)	1
Food safety education (n = 6)	2
Groundwater protection (n = 6)	1

	Responses
Hazardous waste disposal (n = 6)	0
Hazmat response (n = 6)	0
Indoor air quality (n = 6)	1
Land use planning (n = 6)	0
Mosquito control (n = 6)	0
Noise pollution (n = 6)	0
Outdoor air quality regulations (n = 6)	0
Poison control (n = 6)	1
Private water supply safety (n = 6)	1
Public water supply safety (n = 6)	0
Radiation control (n = 6)	1
Radon control (n = 6)	1
Surface water protection (n = 6)	0
Toxicology (n = 6)	1
Vector control (n = 6)	1
Other Public Health Activities	
Certificate of need (n = 6)	1
Communication and public education (n = 6)	5
Eldercare services (n = 6)	1
Emergency preparedness (n = 6)	3
Institutional review board (n = 6)	0
Medical examiner (n = 6)	0
Needle exchange (n = 6)	0
Non-clinical services in correction facilities (n = 6)	1
State health planning and development (n = 6)	4
Substance abuse treatment facilities (n = 6)	1
Trauma system coordination (n = 6)	1
Veterinarian public health activities (n = 6)	1

	Responses
Access to Health Care Services	
Disability and health (n = 6)	2
Emergency medical services (n = 6)	0
Faith-based health programs (n = 6)	2
Health disparities and/or minority health initiatives (n = 6)	2
Outreach and enrollment for medical insurance (n = 6)	1
Rural health (n = 6)	1
State children's health insurance program (SCHIP) (n = 6)	1
State provided health insurance (not supported by federal funds) (n = 6)	1
Tribal health (n = 6)	1

Chapter 10: Iowa Public Health Standards

Background

The Iowa Public Health Standards describe the basic public health services and infrastructure that all Iowans should expect from local and state public health. The standards answer the essential question of the Public Health Modernization initiative, "What should every Iowan expect from local and state public health?" The standards represent the collaborative effort of over 150 local and state public health professionals and public health partners. Their combined expertise, scientific knowledge, and practical experience provide the foundation for defining the responsibilities of governmental local and state public health. The Iowa Public Health Standards were first published in December 2007. The most recent version became effective January 1, 2013.

Evaluation Questions

Q: *What activities has the department undertaken related to the implementation of the Iowa Public Health Standards?*

Only seven of 23 respondents (30.4%) indicated their bureau had initiated activities related to the Iowa Public Health Standards. One additional bureau indicated activities have been planned but not implemented. Activities bureaus had started included: collecting and submitting evidence as part of a departmental assessment (4), communication/updates with staff (2), and an assessment of which standards related to their bureau's functions/activities (1). One other respondent noted beginning to implement changes as a result of recommendations from the assessment.

Only six of 23 respondents (26.1%) indicated their bureau has a process in place to orient staff to the Iowa Public Health Standards and that their bureau provided technical assistance to local health departments to help them meet the Iowa Public Health Standards.

Chapter 11: Conclusion

This baseline report shows that Iowa Department of Public Health is working to serve the population of Iowa in many diverse ways. The acquisition of the data is an important first step in a comprehensive study of the state governmental public health system. Some of the findings lend themselves to further study, while others serve as important benchmarks to be revisited on a regular basis for evaluating changes in the system.

The Public Health Evaluation Committee will work to identify areas of further study and a plan to follow up on the information provided in this report.

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