Budget Analysis for CCPD:

Preliminary Findings

March 2022

Health & Medicine
POLICY RESEARCH GROUP

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About Health & Medicine Policy Research Group

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Executive Summary

The amount of public funding allocated to public health in the U.S. has decreased significantly over the past two decades—excluding temporary increases for the COVID-19 pandemic response. This trend in public health funding affects both local and state health departments nationwide, including local health departments in Illinois. Between June 2020 and December 2021, Health & Medicine staff reviewed local health department capacity data from the National Association for County and City Health Officials (NACCHO) 2019 National Profile of Local Health Departments (LHDs) report for nine health departments and interviewed representatives from five local health departments to compare the Cook County Department of Public Health (CCDPH) to some of their peers' overall funding, staffing, and functions, and provide recommendations.

This analysis purposely focused on 2019 data in order to ascertain funding before the onset of the COVID-19 pandemic. The pandemic led to large, temporary influxes of funding for health departments, and this study sought to focus on and compare pre-pandemic funding, capacity, and function of local health departments.

The following are summary statements from this analysis:

- In 2019, the Cook County Department of Public Health's revenue and expenditure were significantly lower per-capita than the other local health departments in our sample.
- Of the staff interviewed at local health departments, none––except for Harris County––claimed to have received an increase in funding in the decade prior to 2020 across all three categories of federal, state, and local funding prior to 2020.
- Several health departments have identified the following as programmatic priority areas: HIV and sexually transmitted diseases (STD), violence prevention, behavioral health, maternal and child health, and vaccination services.
- Across the health departments in this study, there was a limited number of full-time equivalent (FTE) positions focused on policy; however, several health departments expressed interest in making policy change a priority focus.
- Several health departments staff members have indicated that there is an overarching focus on health equity throughout program areas and across their health departments.

The following are our recommendations based on the research reflected in the following report:

1. The Cook County Department of Public Health (CCDPH) should use this comparison of its budget to other departments and qualitative data, as well as its most recent community health assessment, community health improvement plan, and strategic plan to develop a list of specific unfunded or under-resourced aspects of its work, the amount of capacity needed to better fulfill its mission, including new services and programs, and a cost estimate of what it would take to fill these gaps.

2. CCDPH leadership and Cook County Health (CCH) leadership should work together to make coordinated asks for one or multiple major budget increases through collaboration with the Cook County President's Office, and with Cook County Commissioners regarding degree of increase to meet current and emergent public health needs, based on the analysis spelled out in the first recommendation.

3. To begin making staff changes, CCDPH capacity would improve by funding, developing, and integrating both a designated Policy Division within the department and an Office of Health Equity modeled on work at the Los Angeles Department of Public Health, and taking lessons from other health equity offices within health departments.

4. Cook County Health should shift some positions that are currently within CCH that do work for CCDPH to being located directly within the health department. Concurrently or alternatively, the CCH and CCDPH could create staffing minimums for the department that meet its needs.

5. In line with the increased interest in enhancing behavioral health services across major health departments in the U.S, CCDPH should seek new funding and/or allocate existing funds to develop a behavioral health unit to expand their coordination, planning, and delivery of population health and clinical behavioral health services.

Introduction

In 2020, Health & Medicine Policy Research Group was contracted by the Cook County Department of Public Health (CCDPH) to compare its funding and workforce functions to other similarly situated health departments.

This paper focuses on funding at CCDPH, particularly as it compares to other local health departments across the country. CCDPH is a state-certified public health agency serving a population of over 2.5 million residents in 125 municipalities in suburban Cook County, located in Northeastern Illinois.[1] The department specializes in chronic and communicable disease, community health planning and epidemiology, emergency preparedness and response, environmental health, lead poisoning, policy development, public information, and public health nursing.[1]

The purpose of this study is to identify gaps in services, focus, and funding for CCDPH relative to other health departments and provide recommendations related to CCDPH's budget in alignment with the WePlan 2020 report. This report aims to assist CCDPH in comparing its own budget to that of other similarly situated health departments, obtaining sustainable funding needed to carry out the three core functions of public health: assessment, policy development, and assurance as well as the ten essential services––all with a health equity focus. For more information, please contact the research team at Health & Medicine Policy Research Group:

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Context

The amount of public funding allocated to public health in the U.S. has decreased significantly within the past two decades––excluding temporary increases for the COVID-19 pandemic response. A recent study found that "in 2008 mean and median per capita population weighted state government spending for public health was $80.40 and $62.37, respectively" however, "by 2018 those figures had decreased to $75.83 and $54.28," respectively.[2] In fact, throughout this period there was no increase in states' average per capita spending on public health across the country.[2]

Furthermore, from 2010 to 2020, "spending for state public health departments has dropped by 16% per capita and spending for local health departments has fallen by 18%."[3] This has also impacted the number of public health workers within the public sector, with a reduction of over 38,000 state and local public health jobs since the 2008 recession.[3] At the federal level, in 2018, public health spending in the U.S. made up as little as 3% of all healthcare spending in the country.[4] At the state level, in FY19, states received on average $23.53 per capita through CDC grants, with New Jersey at the low-end of the spectrum, receiving a mere $18.44 per capita.[4]

Given the COVID-19 pandemic, over the last couple of years, the federal government has temporarily increased funding for public health emergency response. That includes "more than $13 billion to state and local health departments, for activities including contact tracing, infection control and technology upgrades" and under the American Rescue Plan, "nearly $150 million to community-based health care providers to aid their response to COVID-19."[3,5] Several states have also made a commitment to increase allocations for state public health budgets.[3] However, due to the nature of this increase in public health funding being temporary––with programs often having to fit relatively short-term, narrow grant requirements––this increase in annual allocations fails to create a sustainable shift toward funding increases for local and state public health.

This summarizes the context of public health funding over the last two decades that affects both local and state health departments writ large as well as CCDPH specifically.

Data Methods

Quantitative Data Collection and Participants

In June 2021, Health & Medicine staff retrieved local health department capacity data for nine health departments from the National Association for County and City Health Officials (NACCHO) 2019 National Profile of Local Health Departments (LHDs) report. This NACCHO report addresses funding, staffing, governance, and activities of LHDs across the United States. The research team at Health & Medicine chose 2019 data to seek to evaluate local public health funding prior to the influx of federal funding (cited above) in response to the COVID-19 pandemic.

For this study, the local health departments of interest for which we received releases of the NACCHO data from the departments' leadership included: Cook County Department of Public Health (CCDPH), Chicago Department of Public Health, Hennepin County Public Health Department, Minneapolis Health Department, Wayne County Health Department, Detroit Health Department, Baltimore City Health Department, Los Angeles County Department of Public Health, and Denver Department of Public Health & Environment. These were chosen through exploration between CCDPH leadership and the research team, using similarities with CCDPH such as serving a large jurisdiction, as the basis for invites. Several other departments either chose not to participate or did not reply to outreach. The areas of interest for this analysis included population size served, staffing capacity, and department budgets with a particular focus on per capita revenue allocation and expenditure. The data collected from the NACCHO survey of local health departments included four focus areas: Funding, Revenue Sources, Total FTEs by Position, and Total FTEs by Occupation. Included below are the indicators by which these focus areas were assessed.

Figure 1.1: Health Department Funding

Funding
Revenue
Expenditure

Figure 1.2: Revenue Sources

Revenue Sources
Local
State Direct
Federal Pass Through
Medicaid and Medicare
Private Health Insurance
Patient Personal Fees
Non-clinical fees and fines
Private Foundations
Other

Figure 1.3: Health Department FTEs by Position

Total FTEs by Position
Full-Time
Part-Time
Contractual
Seasonal

Figure 1.4: Health Department FTEs by Occupation

FTEs by Occupation
Agency leadership
Animal control worker
Behavioral health staff
Business and financial operations staff
Community health worker
Environmental health worker
Epidemiologist/Statistician
Health educator
Information systems specialist
Laboratory worker
Licensed practical or vocational nurse
Nursing aide and home health aide
Nutritionist
Office and administrative support staff
Oral health care professional
Preparedness staff
Public health physician
Public information professional
Registered nurse

Qualitative Data Collection and Participants

From June 2021 to September 2021 the research team at Health & Medicine conducted key informant interviews with representatives of the local health departments of interest. Of the nine health departments that were contacted, six agreed to an interview. A semi-structured interview guide was created to gather information on funding capacity, general concerns of the local health departments, policy and health equity prioritizations, and programmatic interests. All interviews were conducted by Joy Getzenberg or Mariam Siddiqui and a content-based analysis was conducted to assess overarching themes and trends.

Data Analysis

All local health department representatives were asked the following questions:

- What funding trends did your health department observe in the last few years prior to the pandemic (through 2019)?
- What are some funding concerns your health department is facing?
- How many staff are working on health policy, equity, and social determinants of health?
- Are there public health functions that your health department does not have funds or staff to work on? If so, what are they?
- In the last 5-10 years, are there functions your health department has taken on that seemed beneficial or particularly appropriate?

Participants were asked budget-specific questions based on the data received from NACCHO. For the analysis stage of this research, the research team relied on content analysis of notes from interviews with key informants.

Limitations

The NACCHO 2019 Profile of Local Health Departments study had pre-existing categories for health department budgets that may not have reflected the individual budget breakdown of these health departments. This is also true of the worker position data: survey respondents input their information based on the categories given by NACCHO, even though they may not have matched the positions within each of their respective health departments. Therefore, representatives of health departments had to use personal judgement to recategorize their budgets and workers into the proscribed categories. This surely led to some variance in how the data was input. Also, while gathering data from the 2019 NACCHO Profile of Local Health Departments report, several data points were missing or incomplete across the nine local health departments. These data points were filled retrospectively by representatives of the local health departments that were interviewed or addressed verbally during the interviews. There could be some recall bias introduced from this follow-up data collection.

Furthermore, not every department that was asked for permission to have their data collected by NACCHO shared with the research team agreed to the request, introducing non-response bias. Additionally, the research team worked in consultation with CCDPH leadership to identify which health departments to review, which introduced sampling bias. For two of the nine health departments, too many data points were missing and so these departments were therefore omitted from the comparison study. Additionally, two of the nine public health departments the research team received NACCHO data from either declined or did not respond to interview requests, introducing another non-response bias.

Interviews were conducted with individual representatives of health departments, rather than a sample of staff, which could lead to the possibility of a selection bias influencing the qualitative data collected. Interviewees were also asked to recall information prior to 2019, which could result in recall bias.

FINDINGS

RESULTS FROM QUANTITATIVE REVIEW

Figure 2: Health Department Revenue and Expenditure

	Cook County		Chicago		Hennepin County		LA County		Denver County		Harris County	
	Total ($)	$ per Capita	Total ($)	$ per Capita	Total ($)	$ per Capita	Total ($)	$ per Capita	Total ($)	$ per Capita	Total ($)	$ per Capita
Revenue	22,158,647	8.87	126,613,710	46.89	63,888,597	75.55	699,628,000	74.18	88,066,749	124.82	88,900,000	38.65
Expenditure	23,804,751	9.52	171,346,000	63.46	63,888,597	75.55	921,352,000	97.69	79,849,061	113.17	87,000,000	37.83

Figure 2 compares the revenue and expenditure of each health department in 2019. Also provided is a comparison of total dollar amount and per capita allocation. The Cook County Department of Public Health's expenditure exceeds their revenue as the department has had to draw on an account that holds carry-over funds to meet the needs of their programs/services.

In 2019, the Cook County Department of Public Health received $8.87 per capita in revenue. This value is based on the department's total revenue in 2019, including public support, fees and grants, but not including the money drawn from their existing funds reserve, divided by the population served. In comparison, on a per capita basis, Chicago received $46.89, Hennepin County received $75.55, LA County received $74.18, Denver County received $124.82, and Harris County received $38.65.

In terms of expenditure, in FY2019, the Cook County Department of Public Health spent $9.52 per capita. In comparison, on a per capita basis, Chicago spent $63.46, Hennepin County spent $75.55, Los Angeles County spent $97.69, Denver County spent $113.17, and Harris County spent $37.83.

Note: Health department functions vary across municipalities. As an example of some services at a local health department that are not available through all other health departments, the Hennepin County Health Department interviewee shared that the department provides emergency mental health response and health care for the homeless, as well as refugee health services. As another example of varied functions, the Chicago Department of Public Health interviewee emphasized their budget allocation for their Family Connects program, which is a universal home visiting program for families with newborns. Some other departments may also have these functions; the key point is that the relative emphasis, amount, and availability varies across departments, and no two are exactly the same with regard to what services they provide and how well they are funded. Further, because these major functions vary, programmatic funding allocation and staffing is also difficult to compare. Similarly, counties such as LA County provide clinical services, while CCDPH does not. These discrepancies in functions may limit the ability to provide a true comparison of values.

Figure 3: Revenue Sources

	Cook County	Chicago	Hennepin County
Population	**2.5 million**	**2.7 million**	**845,676**

	Total ($)	$ per Capita	% of Total Revenue	Total ($)	$ per Capita	% of Total Revenue	Total ($)	$ per Capita	% of Total Revenue
Local	13,036,000	5.21	58.8%	36,000,000	13.33	28.4%	26,363,186	31.17	41.3%
State direct	5,444,783	2.18	24.6%	8,000,000	2.96	6.3%	7,391,233	8.74	11.6%
Federal pass through	2,040,440	0.82	9.2%	10,000,000	3.70	7.9%	12,684,729	15.00	19.9%
Federal direct	390,963	0.16	1.8%	107,000,000	39.63	84.5%	9,274,200	10.97	14.5%
Medicaid and Medicare	0	0	0%	376,000	0.14	0.3%	4,499,222	5.32	7.0%
Private health insurance	0	0	0%	0	0	0.0%	1,248,936	1.48	2.0%
Patient personal fees	0	0	0%	0	0	0.0%	129,487	0.15	0.2%
Non-clinical fees and fines	1,214,768	0.49	5.5%	4,000,000	1.48	3.2%	1,781,121	2.11	2.8%
Private foundations	31,693	0.01	0.1%	6,000,000	2.22	4.7%	0	0	0%
Other	0	0	0%						

Figure 3: Revenue Sources, cont.

	LA County			Denver County			Harris County		
Population	**9.431 million**			**705,576**			**2.3 million**		
	Total ($)	**$ per Capita**	**% of Total Revenue**	**Total ($)**	**$ per Capita**	**% of Total Revenue**	**Total ($)**	**$ per Capita**	**% of Total Revenue**
Local	1,902,000	0.20	0.3%	47,667,444	67.56	54.1%	26,000,000	11.3	29.3%
State direct	243,046,000	25.77	34.7%	3,935,593	5.58	4.5%	5,600,000	2.43	6.3%
Federal pass through	72,640,000	7.70	10.4%	16,586,009	$23.51	18.8%	14,000,000	6.09	15.8%
Federal direct	127,435,000	13.51	18.2%	-	-	-	32,000,000	13.9	36%
Medicaid and Medicare	131,093,000	13.90	18.7%	0	0	0%	1,200,000	0.52	1.4%
Private health insurance	25,000	$0	0.0%	0	0	0%	100,000	0.04	0.1%
Patient personal fees	354,000	0.04	0.1%	0	0	0%	0	0	0.0%
Non-clinical fees and fines	101,480,000	10.76	14.5%	$2,265,239	$3.21	2.6%	8,000,000	3.5	9%
Private foundations			0.0%	$905,803	$1.28	1.0%	2,000,000	0.87	2.3%
Other	3,232,000	0.34	0.5%	$14,897,337	$21.11	16.9%			

Figure 3 compares the types of revenue sources at each health department in 2019. These revenue categories were determined by NACCHO in their 2019 National Profile of Local Health Departments report. Also provided is a comparison of total revenue amount and per capita revenue allocation. The chart also indicates the percentage of revenue type compared to the overall revenue amount.

**Note: The research team at Health & Medicine discovered several discrepancies in revenue dollar amounts for CCDPH and LACDPH which were retrospectively addressed through personal communication with representatives from these health departments.*

In 2019, the Cook County Department of Public Health's revenue was far behind the amount of local, state direct, federal direct and pass through, and non-clinical fees and fines revenue received by other health departments.

In terms of **local** funding, CCDPH received $5.21 per capita. In comparison, on a per capita basis, Chicago received $13.33, Hennepin County received $31.17, Denver County received $67.56, and Harris County received $11.30.

In terms of **state direct** funding, CCDPH received $2.18 per capita. In comparison, on a per capita basis, Chicago received $2.96, Hennepin County received $8.74, LA County received $25.77, Denver County received $5.58, and Harris County received 2.43.

In terms of **federal pass-through** funding, CCDPH received $0.82 per capita. In comparison, on a per capita basis, Chicago received $3.70, Hennepin County received $15.00, LA County received $7.70, Denver County received $23.51, and Harris County received $6.09.

In terms of **federal direct** funding, CCDPH received $0.16 per capita. In comparison, on a per capita basis, Chicago received $39.63, Hennepin County received $10.97, LA County received $13.51, and Harris County received $13.9 per capita.

In terms of **non-clinical fees and fines**, CCDPH received $0.49 per capita. In comparison, on a per capita basis, Chicago received $1.48, Hennepin County received $2.11, LA County received $10.76, Denver County received $3.21, and Harris County received $3.5 per capita.

In terms of funding from **private foundations**, CCDPH received $0.01 per capita. In comparison, on a per capita basis, Chicago received $2.22, Denver County received $1.28, and Harris County received $0.87 per capita.

The Cook County Department of Public Health also received no revenue ($0.00) from Medicaid/Medicare, private health insurance, and patient personal fees due to that funding being allocated to the Cook County Health and Hospital System (now called Cook County Health (CCH), and CCDPH not providing Medicaid- or Medicare-reimbursable services. All of the other health departments in this sample received some revenue in one or more of these categories.

Figure 4: Revenue Sources (Without Direct Patient Care Services)

	Cook County	Chicago	Hennepin County
Population	**2.5 million**	**2.7 million**	**845,676**

	Total ($)	$ per Capita	% of Total Revenue	Total ($)	$ per Capita	% of Total Revenue	Total ($)	$ per Capita	% of Total Revenue
Local	13,036,000	5.21	58.8%	36,000,000	13.33	28.4%	26,363,186	31.17	41.3%
State direct	5,444,783	2.18	24.6%	8,000,000	2.96	6.3%	7,391,233	8.74	11.6%
Federal pass through	2,040,440	0.82	9.2%	10,000,000	3.70	7.9%	12,684,729	15.00	19.9%
Federal direct	390,963	0.16	1.8%	107,000,000	39.63	84.5%	9,274,200	10.97	14.5%
Non-clinical fees and fines	1,214,768	0.49	5.5%	4,000,000	1.48	3.2%	1,781,121	2.11	2.8%
Private foundations	31,693	0.01	0.1%	6,000,000	2.22	4.7%	0	0	0%
Other	0	0	0%						

	LA County	Denver County	Harris County
Population	**9.431 million**	**705,576**	**2.3 million**

	Total ($)	$ per Capita	% of Total Revenue	Total ($)	$ per Capita	% of Total Revenue	Total ($)	$ per Capita	% of Total Revenue
Local	1,902,000	0.20	0.3%	47,667,444	67.56	54.1%	26,000,000	11.3	29.3%
State direct	243,046,000	25.77	34.7%	3,935,593	5.58	4.5%	5,600,000	2.43	6.3%
Federal pass through	72,640,000	7.70	10.4%	16,586,009	$23.51	18.8%	14,000,000	6.09	15.8%
Federal direct	127,435,000	13.51	18.2%	-	-	-	32,000,000	13.9	36%
Non-clinical fees and fines	101,480,000	10.76	14.5%	$2,265,239	$3.21	2.6%	8,000,000	3.5	9%
Private foundations			0.0%	$905,803	$1.28	1.0%	2,000,000	0.87	2.3%
Other	3,232,000	0.34	0.5%	$14,897,337	$21.11	16.9%			

Figure 4 shows a comparison of the types of revenue sources, seeking to exclude at least most funding for direct patient care services, at each health department in 2019. To seek to exclude direct patient services, the Medicaid, Medicare, and Insurance categories were excluded from this comparison chart. By eliminating the categories for revenue dollar amounts from direct patient care, this chart provides a more comparable portrayal of revenue dollars.

As noted before, the data from NACCHO included breakdowns of worker positions in terms of number of full-time equivalencies (FTEs) by type (full-time, part-time, contractual, or seasonal), as well as by position type.

Figure 5: Total FTEs by Position

	Cook County	Chicago	Hennepin County	LA County	Denver County	Harris County
Population	**2.5 million**	**2.7 million**	**845,676**	**9.431 million**	**705,576**	**2.3 million**

	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
Full-time	226	9.04	497	18.41	335	39.61	4096	43.43	220	31.18	481	20.9
Part-time	5.5	0.22	0	0	42	4.97	64	0.68	103	14.6	1.5	0.07
Contractual	0	0	4	0.15	0	0	110	1.17	15	2.13	82	3.6
Seasonal	0	0	0	0	108	12.77	0	0	0	0	1	0.04

Figure 5 shows the total number of full-time, part-time, contractual, and seasonal employees across the five municipal health departments. Also provided is a comparison of the number of employees available based on the size of the population served for each municipality, represented by number of FTEs per 100,000 people. It is important to keep in mind differences in scale and functions across the health departments as context.

Comparisons of CCDPH to other individual health departments (based on the data above) are displayed in a series of charts below.

Figure 5.1: Total FTEs in Cook County and Los Angeles County

	Cook County	Los Angeles County
Population	2.5 million	9.431 million

	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
Full-time	226	9.04	4096	43.43
Part-time	5.5	0.22	64	0.68
Contractual	0	0	110	1.17
Seasonal	0	0	0	0

Los Angeles County serves a population of 9.431 million and had 4096 employees in 2019, resulting in **4.8** times the number of FTEs available per capita compared to Cook County. This is due in part to the Los Angeles County Department of Public Health operating the Children's Medical Services (CMS) program. If CCDPH were to match Los Angeles County's rate of FTEs per capita, they would have to increase the number of staff to 1,085.

Note: Los Angeles County's health department budget has 18.8% of revenue that seems to be clinical, derived from Medicaid and Medicare, private health insurance, and patient personal fees. Although some of these dollars may support public health services, we think the majority could be considered clinical in nature. For example of overlap, vaccination campaigns are a public health measure carried out at the individual clinical level. That said, not all vaccines are given in a clinical setting.

By comparison, CCDPH's budget has 0% of its revenue from these three categories, while the larger CCH enterprise (of which CCDPH is a part) has a large amount of revenue for these services. This does not completely account for the difference in funding between these two health departments, but it is an important context.

Figure 5.2: Total FTEs in Cook County and Hennepin County

	Cook County	Hennepin County
Population	2.5 million	845,676

	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
Full-time	226	9.04	335	39.61
Part-time	5.5	0.22	42	4.97
Contractual	0	0	0	0
Seasonal	0	0	108	12.77

Figure 5.3: Total FTEs in Cook County and Denver County

	Cook County	Denver County
Population	2.5 million	705,576

	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
Full-time	226	9.04	220	31.18
Part-time	5.5	0.22	103	14.6
Contractual	0	0	15	2.13
Seasonal	0	0	0	0

In 2019, Hennepin County and Denver County local health departments also exceeded CCDPH's rate of FTEs available per capita. More notably, Hennepin County had **4.4** times the number of FTEs per capita, and Denver County had **3.5** times. If CCDPH were to match Hennepin County's rate of FTEs per capita, they would have to increase the number of staff to 990 and if the department were to match Denver County's rate of FTEs per capita, the department would have to increase the number of staff to 780.

Note: The number of FTE for Denver County may include Denver Health and Hospital FTEs; however, the Denver Department of Public Health does not have the capability to differentiate the two. For the past 20 years, the Denver Department of Public Health has an operating agreement with Denver Health and Hospitals system in which Denver DPH provides funding for the hospital system to provide several public health services and care for the medically indigent. More information can be found in the Data Analysis section (pg. 38). This seems in some ways to be the inverse of the relationship that CCDPH has to CCH. As a reminder, CCDPH is within the CCH bureaucracy. The budget for CCDPH is part of the CCH budget, and the director of CCDPH reports to the CEO of CCH. So, while Denver's LHD is providing clinical services, the CCH system includes a LHD, which provides public health services for its jurisdiction.

Figure 5.4: Total FTEs in Cook County and Chicago

	Cook County		Chicago	
Population	2.5 million		2.7 million	
	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
Full-time	226	9.04	497	18.41
Part-time	5.5	0.22	0	0
Contractual	0	0	4	0.15
Seasonal	0	0	0	0

The Cook County Department of Public Health serves a population of 2.5 million residents and has a total of 226 full-time employees. In comparison, with 497 FTEs, the Chicago Department of Public Health (CDPH) has **2.04** times the number of FTEs available per capita. If CCDPH were to match CDPH's rate of FTEs per capita, they would have to increase the number of staff to 460.3. Notably, CDPH's number of FTEs per capita is low compared to the number of FTEs per capita of the other departments in this sample, except for Harris County. While comparing these raw numbers of employees is important, the numbers also have to be examined in the

context of the service array offered by each health department and the degree of contracting. For example, CDPH contracts out several services, using a significant portion of its budget on contracting rather than FTEs.

Figure 5.5: Total FTEs in Cook County and Harris County

	Cook County		Harris County	
Population	2.5 million		2.3 million	
	Total FTEs	**FTEs per 100,000 population**	**Total FTEs**	**FTEs per 100,000 population**
Full-time	226	9.04	481	20.9
Part-time	5.5	0.22	1.5	0.07
Contractual	0	0	82	3.6
Seasonal	0	0	1	0.04

Harris County Public Health (HCPH) serves a population of 2.3 million and had a total of 481 full-time employees in 2019, resulting in **2.3** times the amount FTEs available per capita compared to Cook County. If CCDPH were to match Harris County's rate of FTEs per capita, they would have to increase the number of staff to 523.

Figure 6: Total FTEs by Occupation

	Cook County		Chicago		Hennepin County		LA County		Denver County		Harris County	
	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
Agency leadership	14	0.56	10	0.37	17	2.01	22	0.23	9	1.28	11	0.48
Animal control worker	0	0.00	0	0.00	0	0.00	15	0.16	18	2.55	21	0.91
Behavioral health staff	0	0.00	48	1.78	95	11.23	608	6.45	7	0.99	1	0.04
Business and financial operations staff	6.5	0.26	31	1.15	10	1.18	568	6.02	5	0.71	14	0.61
Community health worker	13	0.52	0	0.00	33	3.90	107	1.13	22	3.12	18	0.78
Environmental health worker	29	1.16	18	0.67	25	2.96	564	5.98	85	12.05	40	1.74
Epidemiologist/Statistician	29	1.16	29	1.07	11	1.30	84	0.89	2	0.28	20	0.87
Health educator	14	0.56	0	0.00	28	3.31	55	0.58	0	0.00	11	0.48
Information systems specialist	0	0.00	7	0.26	0	0.00	194	2.06	1	0.14	6	0.26
Laboratory worker	1	0.04	1	0.04	2	0.24	107	1.13	0	0.00	1	0.04
Licensed practical or vocational nurse	6	0.24	0	0.00	5	0.59	749	7.94	0	0.00	9	0.39
Nursing aide and home health aide	0	0.00	0	0.00	0	0.00	6	0.06	0	0.00	0	0.00
Nutritionist	22.5	0.90	19	0.70	40	4.73	5	0.05	0	0.00	16	0.70
Office and administrative support staff	30	1.20	59	2.19	35	4.14	788	8.36	10	1.42	17	0.74
Oral health care professional	0	0.00	4	0.15	0	0.00	5	0.05	0	0.00	10	0.43
Preparedness staff	9	0.36	38	1.41	3	0.35	16	0.17	4	0.57	7	0.30
Public health physician	2.5	0.10	8	0.30	1	0.12	69	0.73	4	0.57	4	0.17
Public information professional	1	0.04	4	0.15	3	0.35	4	0.04	3	0.43	11	0.48
Registered nurse	54	2.16	48	1.78	6	0.71	58	0.00	0	0.00	15	0.65

Figure 6 shows the total number of full-time staff by occupation across the five municipal health departments. These occupational categories are the ones that NACCHO uses for its survey of local health departments. Each FTE total is then compared to the total population served by the respective health departments. Figure 6 shows a comparison of the number of employees available per capita (per 100,000) across the five health departments.

The Cook County Department of Public Health **has fewer FTEs than do the** other sampled municipal health departments in the following staffing categories:

Figure 6.1: FTEs in Behavioral Health

Cook County		Chicago		Hennepin County		Los Angeles County	
Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
0	0	48	1.78	95	11.23	608	6.45

*In 2019, CCDPH had 0 FTEs per 100,000 population working on **behavioral health**. In comparison, Chicago had 1.78 FTE per 100,000 working on behavioral health, Hennepin County had 11.23, and Los Angeles County had 6.45 (each per 100,000 population).*

Figure 6.2: FTEs in Business and Financial Operations

Cook County		Chicago		Hennepin County		Los Angeles County	
Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
6.5	0.26	31	1.15	10	1.18	568	6.02

*In 2019, CCDPH had 0.26 FTEs per 100,000 population working on **business and financial operations**. In comparison, Chicago had 1.15 FTEs per 100,000 population working on business and financial operations Hennepin had 1.18, and Los Angeles County had 6.02 (each per 100,000 population).*

Note: For context, CCDPH has business and financial operations staff assigned to provide services to the department, who are employed at CCH and Cook County government. There are likely efficiency and efficacy costs to not having sufficient business and financial operations staff within CCDPH itself, in terms of a variety of functions, including writing and reporting on grants, which could grow the department's capacity. Furthermore, having functions like grant writing located within a different part of the system may result in missed opportunities for fundraising because the health department is dwarfed by the needs of the larger system.

Figure 6.3: FTEs in Community Health

Cook County		Hennepin County		Los Angeles County		Denver County	
Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population)	Total FTEs	FTEs per 100,000 population)	Total FTEs	FTEs per 100,000 population
13	0.52	33	3.9	107	1.13	22	3.12

*In 2019, CCDPH had 0.52 FTEs per 100,000 population working as **community health workers**. In comparison, Hennepin County had 3.9 FTEs per 100,000 working as community health workers, Los Angeles County had 1.13, and Denver County had 3.12 (each per 100,000 population).*

Figure 6.4: FTEs in Information Systems

Cook County		Chicago		Los Angeles County		Harris County	
Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population)	Total FTEs	FTEs per 100,000 population)	Total FTEs	FTEs per 100,000 population
0	0.00	7	0.26	194	2.06	6	0.26

*In 2019, CCDPH had 0 FTEs per 100,000 population working as **information systems specialists**. In comparison, Chicago had 0.26 FTEs per 100,000 working as information systems specialists, Los Angeles County had 2.06, and Harris County had 0.26 (each per 100,000 population). As pointed out above, this may be because information systems specialists are located within the larger health system.*

In 2019, the Cook County Department of Public Health **exceeded** most other municipal health departments in this sample in the following staffing categories:

Figure 6.5: FTEs in Epidemiology/ Statistics

Cook County		Hennepin County		Los Angeles County		Denver County		Harris County	
Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
29	1.16	11	1.3	84	0.89	2	0.28	20	0.87

*CCDPH had 1.12 FTEs per 100,000 population working as **epidemiologists/statisticians** in 2019. In comparison, Hennepin County had 1.3 (just slightly more per capita), Los Angeles County had 0.89, Denver had 0.28, and Harris County had 0.87, each per 100,000 population.*

Figure 6.6: FTEs in Agency Leadership

Cook County		Chicago		Los Angeles County		Harris County	
Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
14	0.56	10	0.37	22	0.23	11	0.48

*CCDPH had 0.56 FTEs per 100,000 population working in **agency leadership positions** in 2019. In comparison, Chicago had 0.37, Los Angeles County had 0.23, and Harris County had 0.48, each per 100,000 population.*

Figure 6.7: FTEs in Health Education

Cook County		Chicago		Denver County		Harris County	
Total FTEs	FTEs per 100,000 population	Total FTEs	Total FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
14	0.56	0	0.00	0	0.00	11	0.48

*CCDPH had 0.56 FTEs per 100,000 population working as **health educators** in 2019. In comparison, Chicago and Denver County had 0.00, and Harris County had 0.48, each per 100,000 population.*

Figure 6.8: FTEs in Licensed Practical or Vocational Nursing

Cook County		Chicago		Denver County		Harris County	
Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
6	0.24	0	0.00	0	0.00	9	0.39

*CCDPH had 0.24 FTEs per 100,000 population working as **licensed practical or vocational nurses** in 2019. In comparison, Chicago and Denver County had 0.00, and Harris County had 0.39, each per 100,000 population.*

Figure 6.9: FTEs in Nutrition

Cook County		Chicago		Los Angeles County		Denver County		Harris County	
Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
22.5	0.90	19	0.70	5	0.05	0	0.00	16	0.70

*CCDPH had 0.90 FTEs per 100,000 population working as **nutritionists** in 2019. In comparison, Chicago had 0.70, Los Angeles County had 0.05, Denver County had 0.00, and Harris County had 0.70, each per 100,000 population.*

Figure 6.10: FTEs in Nursing

Cook County		Hennepin County		Los Angeles County		Denver County		Harris County	
Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population	Total FTEs	FTEs per 100,000 population
54	2.16	6	0.71	58	0.00	0	0.00	15	0.65

*CCDPH had 2.16 FTEs per 100,000 population working as **nurses** in 2019. In comparison, Hennepin County had 0.71, Los Angeles County and Denver County had 0.00, and Harris County had 0.65, each per 100,000 population.*

Results from Qualitative Interviews

This section examines major themes that arose from the interviews with representatives of local health departments. The following key themes emerged from our analysis:

Theme 1: Most health departments reported not receiving an increase in federal, state, or local funding in the decade prior to 2020.

Of the health departments interviewed, no department except for Harris County claimed to have received an increase in funding in the decade prior to 2020 in all three categories of federal, state, and local funding prior to 2020. Funding in Hennepin County, Chicago, and Minneapolis has been flat overall. While Hennepin County did not have any significant operational changes due to funding concerns, Minneapolis's funding has shifted as the local funding sources have increased while state funding has continuously decreased. Los Angeles County and Cook County also experienced overall decreases in funding. In Los Angeles County, the Department of Health had to go into "belt-tightening mode" and froze positions that were not grant funded due to the decrease in funding from the state. In Cook County, several positions were removed without discussion with CCDPH leadership, and some positions were transferred from the Department of Public Health to CCH.

Theme 2: Health departments have adapted their operational capacity to better address population-based needs.

Several interviewees addressed the poor state of the infrastructure at their health departments as a major concern. In order to address programmatic and funding constraints, the health departments adapted their operational capacity to better serve their populations. In Minneapolis and Denver, the health department focused on being nimble and more responsive to emerging public health issues rather than being a provider of direct services. In Chicago, the health department increasingly moved away from direct service functions to what they consider to be a population-based focus on changing policies, systems, and environments. In Hennepin County, the health department reorganized their maternal and child health services in order to better connect the services they offer.

Theme 3: Several health departments have identified HIV and sexually transmitted diseases (STD), violence prevention, maternal and child health, and vaccination services to be programmatic priority areas.

Most of the health departments interviewed offered HIV/STD, maternal and child health, and vaccination services, and considered these program areas to be essential for their populations. Violence prevention, homelessness, and mental health programs were also significant interest areas across all health departments that were interviewed. Several health departments addressed their interest in breaking down programmatic silos, either those found within the health department or in other governmental agencies to enhance effectiveness of programmatic efforts.

Theme 4: Policy change is a priority focus across health departments.

Across the health departments interviewed, there was a limited number of official policy positions; however, several health departments expressed interest in making both health equity and policy change priority foci. Los Angeles County and Hennepin County had a unique approach to addressing policy in their health departments. Los Angeles County's Office of Planning piloted a new program to deepen their policy work across the public health department. It brought together 15-20 public health programs that had a policy focus and encouraged collaboration to strengthen their policy work.

Theme 5: There is significant attention paid to health equity across departments.

While many departments have staff with health equity in their titles and both initiatives and offices focused on strengthening their focus on health equity, some departments consider all their staff to be working on health equity. The Chicago Department of Public Health is structured so that everyone has a role in health equity and noted they have 5-20 people who are working exclusively on health equity in their day-to-day work. Hennepin County and Los Angeles County health departments also noted that they believe all their employees are working on health equity in some capacity. The Hennepin County health department also has a cross-departmental work group on health equity.

Qualitative Data Analysis

The following pages provide profiles of the health departments that agreed to have leadership interviewed.

Cook County

The Cook County Department of Public Health has experienced a gradual decrease in funding over the few years prior to the COVID-19 pandemic.

Key Takeaways

1. CCDPH does not have dedicated funding for all the public health work for which they are responsible
2. Staffing positions have been removed without discussion with CCDPH leadership
3. CCDPH does not have designated staff positions for health policy
4. Important staff positions have moved to the clinical operations side of Cook County Health

Funding

In the years prior to the pandemic, funding at CCDPH had been relatively low when compared with other health departments in this study sample, and that amount had slowly decreased over the years. The department experienced the removal of positions which occurred without discussion with leadership. These positions were also not filled after removal. A few of these positions disappeared completely, including those in policy, public communications, and clerical support. Several positions that had been within CCDPH were moved to the clinical operations of CCH, including family planning and immunization staff. While most employees kept their jobs, they were unable to help with key public health functions within CCDPH, such as H1N1 response. This separate reporting structure contributes to a lack of integration of key public health functions within CCDPH (i.e., the health department itself).

There are three core functions for public health: assessment, policy development, and assurance, and ten essential services fit into those three categories. To carry out all three core functions and the ten essential services, with a health equity focus, CCDPH needs to have staffing sufficient to fulfill these duties, with appropriate education, training, and experience. Having some important public health functions fulfilled outside of the health department is insufficient and means that the health department is unable to fully respond to public health needs and fulfill its responsibilities.

Concerns

Within county bureaus, CCDPH falls under the organizational umbrella of Cook County Health, an enterprise that is predominantly oriented to providing healthcare (i.e., medical care), not the broader work and lens of public health. As a small piece of the overall health system, CCDPH is often unable to hire more public health staff because the larger system is given priority when allocating financial resources. A general shortage of funding for the overall system means that scarce resources are more likely to be allocated to clinical operations rather than public health. This has had a clear negative impact on capacity and impact of the public health department. Not having dedicated funding to support FTEs focus on work CCDPH is responsible for, such as community health planning, has forced the department to depend heavily on grant funding; however, grant funding not only varies in amount by year, but it is often categorical, which limits its use and ability to address gaps in services, emerging issues, and cross-cutting issues, such as root causes of health inequities that relate to many disease categories.

Policy/Health Equity Efforts

CCDPH has no designated staff positions for health policy. They are currently (during the COVID-19 pandemic) creating a position for health equity, using a $25 million CDC grant for post-COVID-19 public health staffing and infrastructure. However, this is funded through temporary emergency response dollars. To expand their health equity efforts, the department is planning the development of an office focused on health equity with the function of coordinating the health equity work conducted internally as well as engaging externally with communities. As a departmental strategy, CCDPH is also interested in viewing community-based organizations as an extension of the health department and a critical part of the health system.

CHICAGO

Key Takeaways

1. CDPH receives most of their federal funding from the Department of Health and Human Services, and local dollars make up 20-25% of the budget
2. No service area is adequately funded
3. CDPH has a policy unit of 4 FTEs that work exclusively on health policy; the positions are primarily city funded
4. CDPH is increasingly moving away from direct service functions to changing policies, systems, and environments to support public health

Funding

CDPH receives most of their federal funding from the Department of Health and Human Services, and a smaller amount through the Department of Housing and Urban Development. In 2019, local dollars made up 20-25% of the budget, which is a smaller proportion of local funding than some other city health departments such as Minneapolis (example shared by interviewee).

Concerns

The CDPH interviewee reported that no service area in the department is adequately funded. A few key areas the department struggles to adequately support include: chronic disease response, food inspection, health code inspection, and environmental zoning and permitting.

Programs

CDPH has a strong interest in improving their substance abuse, violence prevention, child adolescent and infant health, and vector control programs. They are also interested in improving their school-based health services. CDPH is actively trying to move toward a systems approach to work in mental health. In 2019, CDPH launched the Family Connects program which is a universal home visiting program for families with newborns. CDPH was the largest jurisdiction in the country to take it on, according to the interviewee. Also, between 2015-2019 CDPH changed its strategy in HIV services and prevention to focus on supporting the state's Getting to Zero HIV infections plan.

Policy/Health Equity Efforts

CDPH has a policy unit of 4 FTEs that work exclusively on health policy work. These positions are primarily city funded. They also recently created a Chief Racial Equity Officer position (an executive-level position) in 2018 or 2019 (interviewee was unsure of exact year) which is wholly funded through local dollars, as well as a Director of Health Equity and Strategic Partnerships position, which was created a few years prior. They also

have a senior-level position that oversees the implementation of Healthy Chicago 2025, the department's community health improvement plan, which focuses on closing the racial life expectancy gap. CDPH is structured so that everyone has a role in health equity and noted they have around 5-20 people who are working exclusively on health equity in their day-to-day work.

Hennepin County

Key Takeaways

1. Emergency response funding has decreased every year in recent years
2. The department lacks a sustainability plan for infrastructure
3. As a part of their public health clinic, Hennepin County provides refugee health and emergency public health response services
4. This agency has a cross-departmental work group on health equity

Funding

The Hennepin County Public Health department has had no increase in state local health department grants and their emergency preparedness funding has decreased in recent years. The county is also trying to reduce the property tax burden related to the health department. Despite these funding setbacks, the health department has not cut any functions or services they provide.

Concerns

A significant concern expressed by the interviewee from the Hennepin County health department is the lack of a sustainability plan for their infrastructure. The health department is also interested in increasing their relationship-building efforts within the local community. The health department staff are also concerned about their inability to secure funding for the department's violence prevention programs.

Programs

The Hennepin County Public Health department has a public health clinic which provides a variety of services including refugee health and HIV/STD services. The health department also provides emergency mental health response and health care for the homeless. Hennepin County has also uniquely reorganized their maternal and child health services as well as their immunization services to shift away from providing clinical response and focus on a more population-based approach while working with the epidemiology division.

The Hennepin County Public Health department is pursuing a few noteworthy strategic initiatives. One of these is creating a unit that includes health promotion, racial equity, and community engagement officers. They are also working on a new project to obtain certification of their mental health services. The County has also achieved success in this area and has considered several domains for health equity work (including education and housing) using a tool based on the *health in all policies* approach. The health department has also started working on a healthy aging designation for the county and has brought the staff focused on reducing inequities into the health department.

Policy/Health Equity Efforts

While the Hennepin County Public Health department does not have a designated Health Equity Officer, the interviewee said they believe all their employees are working on health equity. The department has a cross-departmental work group on health equity, with a focus on racial inequities, formed after the murder of George Floyd in 2020. The board also passed a resolution saying that racism is a public health issue. The Board of Health also requires a *disparities reduction* statement for any budget request.

In terms of policy work, the Hennepin County Public Health department believes all their employees are involved with policy work. They have one manager for policy and grants management and have a handful of staff working on policy full time. These positions are mostly funded by local tax dollars, with a small portion of funding coming from the state.

Los Angeles County

Key Takeaways

1. Prior to the pandemic, the department went into "belt-tightening" mode and froze several positions that were not grant-funded due to decreased funding from the state
2. Los Angeles County has a large HIV/AIDs program
3. The department has a Center for Health Equity which includes six permanent FTEs working exclusively on health equity
4. The department has a program that brings together different public health programs across the department to strengthen their policy capacity

Funding

Prior to the pandemic, the Los Angeles County Department of Public Health went into "belt-tightening" mode and froze several positions that were not grant-funded due to decreased funding from the state. However, this did not affect a significant proportion of the overall positions due to the overall high number of staff. Since the beginning of the pandemic, local revenue dedicated to the department has increased.

Programs

The Los Angeles County Public Health Department runs public health clinics to provide vaccinations and provide best practice interventions on STDs but has a separate county department that provides ambulatory care (public hospitals and public clinics). The board has also made domestic violence a new priority and developed a Domestic Violence Council staffed by the Los Angeles Public Health Department and comprised mostly of community members. Los Angeles County also has a distinctively large HIV/ AIDS program which has an estimated 600 FTEs.

Policy/Health Equity Efforts

Three years ago, Los Angeles County set up a Center for Health Equity which is housed and staffed by the Department of Public Health, even though it is a partnership with the Department of Health Services and Department of Mental Health. While the department has staff working on health equity throughout, they have six permanent FTEs working exclusively on health equity. They offer a variety of services but are heavily focused on community-level interventions. For example, one violence prevention program is working with hospitals to send in gang intervention workers from community-based organizations to counsel the victims or perpetrators who come to receive treatment.

The department's Office of Planning also piloted a new program to deepen the department's policy work in part by bringing together 15-20 public health programs that were interested in strengthening their policy capacity. At the leadership level, the Director of Policy mainly coordinates state and federal advocacy efforts. The department is engaged in policy at both the city and county levels; while policymaking is more controlled and less open to their input at the county level, there is more flexibility at the city level. The county is involved in city decisions as it relates to a variety of issues including tobacco programs and unincorporated land use matters.

Key Takeaways

1. Due to limited funding, programs continued at a reduced service level compared to prior years
2. The department has a strong focus on behavioral and mental health
3. The department has one dedicated health equity staff member

Funding

The Denver Department of Public Health and Environment did not receive adequate funding for their programs and services in 2019. A majority of their funding comes from the general fund, tax initiatives, and a smaller portion from the city's operating budget. The department also has a multimillion-dollar contract with Denver Health and Hospitals to support their provision of several local public health services.

In 2018-2019, the Healthy Food for Denver tax initiative significantly increased revenue by an estimated ten million dollars that went into the budget for the health department. In 2019, their Solutions Center initiative also received revenue to remodel and build a 45-bed facility for individuals experiencing mental health problems which also went into the budget for the health department.

Concerns

For the past 20 years, the Denver Department of Public Health and Environment had a working multimillion-dollar contract agreement with Denver Health and Hospitals. As such, the public health department continuously provided funding to the hospital system to provide care for the those in need of services as well as their clinics. However, just this year they moved a significant number of local public health services from the Denver Health and Hospitals system back to the Department of Public Health.

While the health department did not lose funding in the years prior to 2018, they also did not receive any increased funding in the years prior to 2018. Therefore, programs continued but at a reduced service level to stay within budget constraints. There were some services and functions they chose to change because, according to the interviewee, there is not a great ROI in terms of investment and impact, and because their resources were stretched. For example, due to increased workload and limited staffing resources pre-COVID, there were reductions in the frequency of some inspections including body art (i.e., tattoo parlors) site inspections, facility inspections, swimming pool inspections, and temporary retail food inspections. The time to complete plan reviews also increased considerably because of the increased workload. In addition to the reduction in the frequency of some inspections, the health department experienced delays in moving some programs forward.

In terms of grants, the health department has seen a trend with funding from philanthropy and even government entities that had geo-location components as well as topical focus areas of interest to the department. That focus has largely gone away in the last 5-7 years in favor of a focus on solely funding for specific areas of work.

Programs

The department has a strong focus on behavioral and mental health, which used to be a part of Denver Health and Human Services, but is now being carried out by the health department. This transition brought in an influx of funding for the health department, and is now a priority area. The department is particularly interested in learning what the landscape of services looks like in the community to better understand gaps in services (i.e. a preventive approach), rather than providing a reactive response to overdoses.

Policy/Health Equity Efforts

While the department has no staff designated as focused on policy, every division director works on policy for their focus area. They also have one dedicated health equity staff member.

Harris County

Key Takeaways

1. The department is overly reliant on grant funding
2. The department has become a public health data hub
3. There is an increased interest in improving care coordination and creating a sustainable integrated health care system
4. The department aims to have public health prevention services become reimbursable

Funding

The interviewee at Harris County Public Health (HCPH) department stated that there has been a slight increase in public health funding overall in the years prior to 2019. Prior to the COVID-19 pandemic, a majority of funding came from local taxes. A large initiative from the state side involved including local health departments when planning through a delivery system reform incentive payment program (DSRIP) and Medicaid 1115 waiver funding, which helped local health departments become more fully engaged with Medicaid and become part of the conversation regarding value-based care and the safety net.

The health department hopes to have public health prevention services, (e.g., chronic disease, health education, etc.) become reimbursable. There had been discussions about local health departments billing for Medicaid and setting up an alternate funding pool through the 1115 waiver and outside of DSRIP funds. However, while that initiative may have been beneficial, the health department currently lacks the necessary infrastructure and planning needed to access those funds.

In terms of specific grants, the health department has noticed that family planning grant contracts were beginning to require patients be documented rather than undocumented––restricting the type of populations they could serve. Also, during the Trump administration, the health department's refugee services grant was lower than it had been in previous years due to the changes to the refugee admissions ceiling at the federal level.

Overall, the health department has not cut any functions or services they provide; however, they have noted their resources have been stretched.

Concerns

A significant concern for Harris County is that a majority of their funding comes from grants. While this allows for increased funding, it also allows the county government to assume that the health department does not need local funding for some services because grants cover them. A particular concern is that these grants are restricted and germane only to what a given grant contract stipulates, which leaves little room for carrying out other necessary functions. It also gives the false impression that the health department has a large amount of discretionary funds. This can be misleading, especially for elected officials who might assume their locality has a better-funded public health system than it does.

The interviewee gave their opinion that the county does not contribute enough of their general fund to the health department's local funding. For example, Harris County Public Health currently has $150 million in grants, $45 million in general funding, and $18 million in special revenue funding. As a percentage of the County's general fund, the health department is allocated about 1.4%. In comparison, the Houston Health

Department receives more than 2% of the city's total general funding. This lack of adequate funding allocation contributes to the county health department's increased reliance on grant funding.

Recently, during the COVID-19 pandemic, the health department has been making ARPA and County dollar requests for care coordination and data development. Given that developers and quality data analysts are expensive to hire, these areas were only able to expand during the pandemic with increased grant funding, raising a sustainability challenge. The health department is also aiming to grow their support offices so that they are more robust; however, finding staff who are experienced in healthcare administration has been difficult.

Programs

The Harris County health department noted that, prior to the pandemic, they were interested in doing more in the realm of access to economic opportunity and housing. The health department is now focusing on violence prevention and care coordination. They are also working on plans to improve billing and reimbursement policies.

The health department has also notably become a public health hub for data. If someone brings a public health question, the department has a team that will work on exploring the issue and figuring out how to answer the question using their data. The health department is also increasing their focus on behavioral and mental health, including improving the provision of integrated health care and ensuring that behavioral health is embedded into physical health services.

Policy/ Health Equity Efforts

The Harris County Public Health department has around ten FTEs working on health equity and policy. These staff work throughout all divisions of the health department, with some focused on health equity, some on preparedness and resilience, and some on governmental affairs. These positions are all funded through local general funding. The health department was inclined to use the CDC equity grant to fund these positions; however, they chose not to due to the lack of sustainability of the grant.

Recommendations

The following our recommendations based on the analysis of the quantitative and qualitative research reflected above.

Recommendation 1: Use this analysis and other resources to determine what funding increases and new programs and services are needed to successfully fulfill CCDPH's mission.

The Cook County Department of Public Health (CCDPH) should use this comparison of its budget to other departments and qualitative data, as well as its most recent community health assessment, community health improvement plan, and strategic plan to develop a list of specific unfunded or under-resourced aspects of its work, the amount of capacity needed to better fulfill its mission, including new services and programs, and a cost estimate of what it would take to fill these gaps.

Recommendation 2: Attain a major increase in the local budget allocation to CCDPH phased in over the upcoming 4-5 fiscal years and sustained thereafter.

The Cook County Department of Public Health would be better positioned to support the health of the communities they serve if it were to receive a significant increase in sustained local funding that is flexible to respond to needs. In 2019, In terms of local funding, CCDPH received $5.21 per capita. In comparison, on a per capita basis, Chicago received $13.33, Hennepin County received $31.17, Denver County received $67.56, and Harris County received $11.30.

CCDPH leadership and Cook County Health leadership should together make coordinated asks for a major budget increase through communications with the Cook County President's Office, and with Cook County Commissioners. In addition to a general funds flexible request, the department would benefit from making specific "asks" in particular areas that they see as key needs for investment (e.g., workforce categories that the department has few / zero FTEs) commensurate with priority areas and needs. Additionally, the department should request funding focused on developing several staff positions to work on health equity in all policies (more information is in recommendation 2). The department should make these requests through a phased approach over the next four to five fiscal years, so as to make the possibility of increased revenue allocation both attainable and economically feasible.

The department would also benefit from having more grants development staff within CCDPH who are dedicated to seeking additional federal and private foundation grants to supplement local tax dollar allocations.

Recommendation 3: Develop a robust Health Policy division.

The Cook County Department of Public Health lacks dedicated FTEs working directly on health policy. CCDPH could model a designated policy division based on the work done in the Los Angeles County Department of Public Health whose Office of Planning piloted a new program to deepen the department's policy work in part by bringing together 15-20 public health programs that were interested in strengthening their policy capacity. At the leadership level, the Director of Policy mainly coordinates state and federal advocacy efforts. This would also encourage the allocation of dedicated policy staff.

Recommendation 4: Develop and sustain funding for a Health Equity Office within the Cook County Department of Public Health.

The Cook County Department of Public Health could model a Health Equity Office based on the Los Angeles County Department of Public Health's Center for Health Equity. This program area includes six permanent FTEs working exclusively on health equity. They offer a variety of services but are heavily focused on community-level interventions. CCDPH has to develop an office focused on addressing health equity, but will need to acquire sustained funding to institutionalize the program when the Health Equity grant ends.

Recommendation 5: Develop staffing division between CCDPH and CCH, and establish staffing minimums.

Since several FTE positions have been moved to CCH, including policy and development staff, CCDPH's capacity would benefit from creating a policy to have some of the positions currently at CCH that do work for CCDPH to be re-directed to work directly within CCDPH, and/or creating staffing minimums for the department. This would require a set number of staff per program area/division to be filled at all times, so as to prevent positions from being removed and sent to CCH without being replaced at CCDPH.

Recommendation 6: Expand the delivery of behavioral health services.

Aligned with the increased interest in enhancing behavioral health services across major health departments in the U.S, CCDPH should seek new funding and/or allocate some existing funds to develop a behavioral health unit to expand their delivery of behavioral health services. For example, to meet the growing demand for behavioral health services in Denver County, the public health department has shifted their behavioral health programs from their Health and Human Services department to the public health department. This transition brought in an influx of funding for the health department, and is now a priority area. Similarly, Harris County is also increasing their focus on behavioral and mental health. The Harris County Public Health department is currently working toward improving the provision of integrated health care and making sure that behavioral health is embedded into physical health services.

Areas for Future Research

The following questions were identified as potential future research questions that may be useful to further advance understanding of CCDPH's funding, staffing, and programming and services compared to other health departments. Each of these questions or analysis could be a starting point of a research project that could lead to developing other related questions to seek to answer. The research and analysis included in these can be used to develop further recommendations for improving CCDPH's budget situation, staffing, programming, and services.

- How do non-local funding sources compare across local health departments?
- Which local health departments use centralized administrative services outside of their department?
- How much of each local health department is dedicated to provision of direct patient care?
- Conduct a systematic analysis of functions provided at other health departments that are not provided at CCDPH.
- Conduct an analysis of CDC grants to large jurisdictions to see how CCDPH's exclusion from being considered one of the direct CDC funding recipients affects CCDPH's budget as compared to CDPH's budget.
    - Include a comparison to other large jurisdictions, both those with a single local health department that covers both the major city and suburbs, and those with two or more health departments covering the major city separately from suburbs.

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