

Little is known about the extent to which community health service (CHS) administrators and local health directors<sup>1</sup> have key authorities related to budgeting and access to elected officials. Information on authority and organizational positioning is needed to help articulate roles of public health leadership. Issues related to authority and positioning are crucial considerations during succession planning, and when discussing changes to local public health governance and organization.

Minnesota's State Community Health Services Advisory Committee (SCHSAC) has begun to more fully articulate the expected authorities of a CHS administrator, in order to focus attention on this issue, motivate discussion and change where needed, and help assure that these authorities endure periodic changes to local public health governance and organizational structures.<sup>2</sup>

In May 2010, the Minnesota Public Health Research to Action Network<sup>3</sup> designed and conducted a survey of CHS administrators and local health directors to address three key questions:

1. To what extent do CHS administrators and local health directors report having key authorities?
2. To what extent are CHS administrators and local health directors positioned to exercise their authorities?
3. Is there a relationship between organizational structure and authority of local health directors?

This brief will examine the authorities of CHS administrators in relation to their community health boards (CHBs), and the authorities of local health directors in relation to their county boards or city councils. It is important to distinguish between these roles and boards for two reasons. First, the CHB is often a distinct entity from the county board or city council

## At a Glance

Most Minnesota local health directors and CHS administrators reported that they have six key authorities related to budgeting and interaction with elected officials.

The percentage of local health directors who reported having all six authorities was higher among local health directors in stand-alone departments (82%), than among local health directors in combined organizations (50%).

Of the six authorities, directors and administrators were most likely to report lacking authority to initiate communication with elected officials.

Twelve (12) directors (16%) and 4 administrators (8%) report that they have four or fewer of the six authorities. Local health directors in combined structures were more likely to report that they have 4 or fewer authorities (26%), than directors in stand-alone structures (11%).

Those who report having a given authority may not be positioned to exercise it.

Many believe these authorities are essential. In 2010, the State Community Health Services Advisory Committee (SCHSAC) began to more fully articulate expected and enduring authorities of a CHS administrator.

Health directors, CHS administrators and local elected officials are encouraged to use this brief to advance local discussion on these authorities, and champion change as needed.



(e.g., a multi county situation where members of respective county boards come together as a CHB, or a single county setting in which the CHB includes elected members and non-elected members). Second, multi county CHBS, and even some single county or city CHBs, have multiple people serving as CHS administrator and local health director.

## Level of authority

The majority of local health directors and administrators reported having all six authorities included in the survey (see Figure 1 and refer to Table 1 for a description of authorities). Yet several reported having four or fewer authorities (16% of local health directors and 8% of CHS administrators).

In follow up interviews, some local health directors and administrators who reported having only one or two authorities were asked to characterize the implications of this relatively low level of authority. Comments described the role of local health director as providing influence and input, but not the lead when making decisions (e.g., budgeting, priorities or new initiatives).

Additional comments pointedly linked an apparent lack of interest in public health issues among local elected officials to a lack of authority to initiate communication or present to the county board. Others emphasized a lack of clarity around authority. For example, some noted that they *act* as if they have certain authorities, although their authorities have not been clearly articulated or documented.

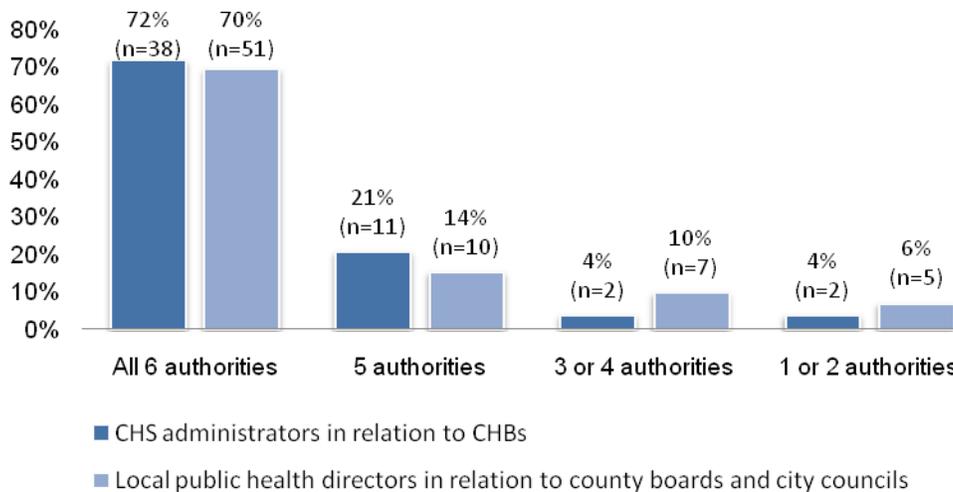
Findings presented here suggest that some local health directors and administrators need more authority—or need more explicit authority—to most effectively protect and enhance the health of their communities

### Table 1. Questions to Assess Authority.

The Research to Action Network coordinated with the SCHSAC Blueprint Workgroup to develop six yes or no survey questions to assess authority:

1. Do you usually take the lead role in developing the initial budget priorities for the health department?
2. Do you have flexibility to modify the health department budget during the budget year (e.g., shift dollars within and between programs)?
3. Do you have day to day responsibility to oversee the health department budget (e.g., monitor spending and revenues to ensure that public health programs stay within their allocated spending limits and that the health department is collecting anticipated revenues)?
4. Do you (or someone accountable to you) usually initiate public health agenda items for county board meetings?
5. Do you (or someone accountable to you) usually take the lead role presenting public health agenda items at county board meetings?
6. Do you have authority to initiate communication with members of the county board between meetings?

**Figure 1. Extent of authority reported by Minnesota CHS administrators and local health directors, 2010.**



*73 of 75 local health departments (96%)  
 53 of 53 CHBs (100%)*

Figure 2 presents the number and percentage of local health directors and CHS administrators who report lacking each of the six authorities. Among the key findings:

- The clear majority of administrators and directors reported having each of the six authorities.
- An important minority of administrators and directors lack each of the six authorities.
- Local health directors consistently reported lower levels of authority (in relation to county boards and city councils) than CHS administrators (in relation to CHBs).

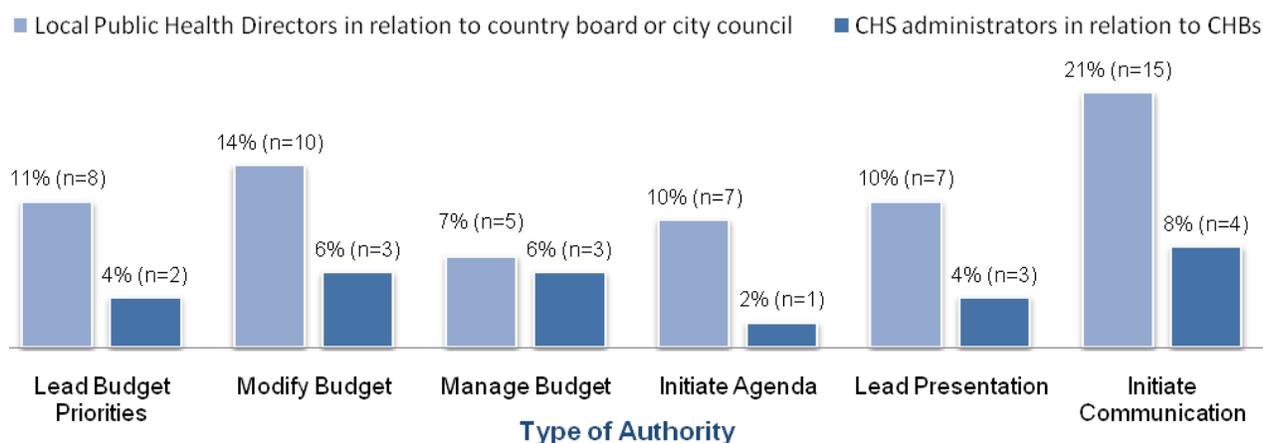
The authority most commonly lacking for both local health directors and CHS administrators, was the authority to initiate communication with their locally elected officials. In follow up interviews, some expressed surprise and interest that their peers reported having this authority. They had mistakenly assumed that most other directors and administrators lacked this authority as well.

Many respondents who lack authority to modify the public health budget, explained that they do have discretion to modify the public health department budget up to a certain amount. Some CHS administrators who reported that they lack a specific authority, indicated that a local health director does have that authority (e.g., in some

multi-county CHBs, the CHB budget is initiated by the individual local health directors rather than the CHS administrator).

Health directors who reported that they do not usually initiate public health agenda items or take a lead role in presenting public health agenda items to the county board, were asked to indicate who *does* take these actions. Responses included *health and human services director* and *CHS administrator* (eg, in a multi county CHB).

**Figure 2. Number and percentage of CHS administrators and local health directors who report lacking six authorities, 2010.**



73 of 75 local health departments (96%)  
 53 of 53 CHBs (100%)

## Organizational positioning

The survey included some questions intended to explore how local health directors and CHS administrators are positioned to exercise their authorities. The following case studies illustrate instances in which respondents describe their authority in specific situations.

### **Case study #1: Developing a budget and budget priorities for the local health department.**

Local health directors were asked to select all individuals and/or committees (not accountable to them) that must approve the local public health budget before it is submitted to the county board or city council for final approval. Response options included a city or county administrator or coordinator, an accountant or accounting department, an advisory or executive committee, the CHS administrator, the director of a health and human services agency, or none of the above.



One third of directors (n=25, 33%) indicated that a city or a county administrator or coordinator must approve a proposed public health budget, followed by an accountant or accounting/finance department (n=14, 19%), an advisory or executive committee (n=13, 17%), or a health and human services director (n=12, 16%).

Since respondents were directed to check *all* individuals or committees that need to approve a preliminary budget prior to board consideration, it is possible to calculate the number of pre-approvals needed within each local health department. Just over one-third of public health directors reported seeking one approval prior to submitting a preliminary budget to the county board or city council. Seven directors (n=9) reported seeking approval from three individuals or committees. A sizeable number responded that they don't seek approval

**Table 2. Number of individuals or committees that must approve a preliminary public health budget prior to submitting to county board or city council for approval, Minnesota, 2010.**

Number of pre-approvals needed	Number (%) of local health departments	
1	27	(36%)
2	14	(14%)
3	7	(9%)
None of those listed *	16	(21%)

\* City or county administrator or coordinator, an accountant or accounting department, advisory body, another public health official, HHS director: 64 of 75 LHDs (85%).

from any of the options listed in the question. Follow up communication confirmed that several directors submit budgets directly the county board. Others clarified that they submit a preliminary budget to a mayor or the director of a combined agency (other than an HHS director). One director of a multi-county CHB explained that she develops a budget that goes directly to the CHB, and then to each county auditor for inclusion into the county budget. In some cases the budget is developed by a committee.

The budget approval process clearly plays out in many different ways, although there may be a tendency to assume all CHS administrators follow a similar process (e.g., *As any CHS administrator, generally I submit our preliminary budget directly to the CHB for approval*). Altogether directors reported more than 20 different approval combinations. The varied processes in place are worth noting, though it's not possible to determine "best practices" from this descriptive study. In some cases, having more layers of approval may "dilute" the original intent of the public health director. On the other hand, a more inclusive approval process that engages multiple individuals and committees may lead to a stronger budget.



## **Case study #2: Initiating communication with members of the community health board.**

Most CHS administrators report having authority to initiate communication with members of the CHB between meetings (e.g., email correspondence, telephone calls, face-to-face meetings; n=47, 89%). The eight CHS administrators with no authority to initiate communication represent six single county/city CHBs in four different regions of the state.

Approximately two-thirds of CHS administrators (63%) report having a mechanism in place for regular communication on public health issues with members of the CHB between meetings (i.e., standing meeting, schedule for sending email updates). The remaining administrators either do not have a mechanism in place (n=14, 26%), or do not have authority to initiate communication (and were not asked this question, n=6, 11%).

Some open-ended responses explained the communication procedures in more detail (e.g., steps typically followed to seek permission and/or guidance prior to talking to elected officials), or underscored the value of having “direct access.” A few respondents also clarified that they interact regularly with some (but not all) members of the board (e.g., a SCHSAC representative).

Frequency of CHB meetings ranges from monthly (n=19, 36%) to twice per year (n=10, 19%). CHBs that meet relatively frequently, or that convene an executive committee, may have less need for interaction between meetings.

Although more frequent communication isn’t necessarily better, it seems likely that open channels of communication—and an existing mechanism for communication with the board chair or board members—is desirable.

## **Relationship between level of authority and organizational structure**

In 2010, approximately one-third of local health departments (n=23, 31%) were part of a broader organization (e.g., health and human services, community services). In 2010, approximately 28% of county boards and city councils had discussed an organizational change that would impact public health services (though fewer than half of them had decided or begun to implement a change). Issues related to authority merit thorough consideration.<sup>4</sup>

In this study, local health directors in combined structures (e.g., organizations that combine public health and social services) were more likely to report that they have 4 or fewer authorities (26%), than directors in stand-alone structures (11%). In both types of structures, *most* local health directors reported having all six authorities, but the percentage was higher among local health directors in stand-alone departments (82%), than among local health directors in combined organizations (50%). (See Table 3).



**Table 3. Comparison of the number and percent of local health directors who report each level of authority, in stand-alone and combined structures.\***

<b>Public health structure</b>	<b>6 of 6 authorities</b>	<b>5 of 6 authorities</b>	<b>3 to 4, of 6 authorities</b>	<b>1 to 2, of 6 authorities</b>	<b>Total</b>
Public health is a stand-alone department	31 (82%)	3 (8%)	3 (8%)	1 (3%)	38 (100%)
Public health is part of a combined structure	15 (50%)	7 (23%)	4 (13%)	4 (13%)	30 (100%)

$\chi^2(3, N = 68) = 8.28, p = 0.041$   
 68 of 75 LHDs (91%)

\* This table excludes hospital-based public health departments

## Moving forward

Findings from this survey suggest action is needed to achieve recommendations included in the 2010 *Updating Minnesota’s Blueprint for Public Health*. In that report, SCHSAC called for direct communication between CHBs and local public health leadership (i.e., the CHS administrator and/or local public health director) in the jurisdiction. SCHSAC also called for CHS administrators to have

- sufficient and regular access to the CHB and county boards (or city councils) to provide regular updates and give needed input on matters pertaining to public health; and
- authority to oversee the development and execution of the budget for funds or resources going through the CHB.

These authorities are in step with new national standards for local health departments, and many believe the authorities cited here are crucial for effective and efficient leadership.

Public health directors, CHS administrators and local elected officials are encouraged to:

1. use the findings of this issue brief and the recent SCHSAC *Blueprint* report to advance local discussion on these authorities, and bring about change where needed; and
2. participate in future practice-based research to understand the connections between authority, performance, and outcomes.



Minnesota Public Health  
**RESEARCH TO ACTION NETWORK**  
*Conducting Research. Making Change. Improving Health.*

## About the Research to Action Network

For more information on this issue brief or the Minnesota Public Health Research to Action Network, contact Kim Gearin at [kim.gearin@state.mn.us](mailto:kim.gearin@state.mn.us) or (651) 201-3884.

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### Endnotes

<sup>1</sup> For this survey, local health directors were identified using contact information for *public health nursing director* in the CHB contact database within PPMRS (Planning and Performance Measurement System). In some cases, consultation with district public health nurse consultants helped to identify a single local health director for each entity that reported to PPMRS in 2010. In practice, local health directors who completed this survey have many different titles within Minnesota's local public health system (e.g., *Director, Public Health Director, Public Health Nurse Director or Supervisor, Community Health Manager, or Agency Coordinator*). Many local health directors are also CHS administrators and/or are the director of a combined agency.

<sup>2</sup> State Community Health Services Advisory Committee. (December, 2010). *Updating Minnesota's blueprint for public health*. St. Paul: MDH. Available at: <http://www.health.state.mn.us>.

<sup>3</sup> This study was conducted by the Minnesota Public Health Research to Action Network, comprised of the Minnesota Local Public Health Association (LPHA), State Community Health Services Advisory Committee (SCHSAC), University of Minnesota School of Public Health (SPH) and Minnesota Department of Health (MDH). For more information, contact Kim Gearin at [kim.gearin@state.mn.us](mailto:kim.gearin@state.mn.us).

<sup>4</sup> State Community Health Services Advisory Committee. (December, 2010). *A discussion guide for exploring public health governance and structure change*. St. Paul: MDH. Available at: <http://www.health.state.mn.us>.