State Public Health Agency Classification: Understanding the Relationship Between State and Local Public Health

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The conclusions and opinions expressed in this report are the authors' alone. No endorsement by RWJF, CDC, or other parties is intended or should be inferred.

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Background

States have organized their governmental public health systems in different ways. Exploring the relationships between state and local public health has important implications for delivery of public health services and for determining which delivery strategies and models may best apply in different settings. There have been several attempts in the past to classify the organizational structure of state health agencies (SHAs), with the intent of understanding their relationship with local health departments (LHDs) and the coordination and provision of services within the state. Defining the relationship between state and local public health agencies is important for understanding the roles, responsibilities, and authorities across levels of government for services provided within the community. Having a uniform and objective classification of SHAs can help elucidate the ways in which public health structure influences health departments' operations, financing, and performance and may also be key to understanding how accreditation standards will apply in different states.

Public health systems and services research often refers to several organizational patterns that represent the functional and administrative relationships between state and local public health agencies: centralized, decentralized, shared, and mixed (see Figure 1 for more information on these categories). These four categories are frequently used as explanatory variables in research, and past studies have explored if there are differences based on SHA classifications in the following areas:

- Availability and perceived effectiveness of public health activities.[1]
- Public health system performance.[2]
- The participation of managed care plans in local public health activities.[3]
- Public health financing.[4]

Unfortunately, there are major inconsistencies among past efforts to categorize SHAs. Despite their frequent use in public health systems and services research, the four categories—centralized, decentralized, shared, and mixed—are defined differently in different studies, which has led to variations in the way that states are classified. Further, categorization efforts are often dependent on

1 Mays GP, Halverson PK, Baker EL, Stevens R & Vann JJ. "Availability and perceived effectiveness of public health activities in the nation's most populous communities." 2004. *American Journal of Public Health*, 94:1019-1026.
2 Mays GP, McHugh MC, Shim K, Perry N, Lenaway D, Halverson PK & Moonesinghe R. "Institutional and economic determinants of public health system performance." 2006. *American Journal of Public Health*, 96:523-531.
3 Mays GP, Halverson PK & Stevens R. "The contributions of managed care plans to public health practice: Evidence from the nation's largest local health departments." 2001. *Public Health Reports*, Supplement, 116.
4 Mays GP, McHugh MC, Shim K, Lenaway D, Halverson PK, Moonesinghe R & Honore P. "Getting what you pay for: Public health spending and the performance of essential public health services." 2004. *Journal of Public Health Management Practice*, 10(5):435-443.

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the self-report of health department personnel, so that the response relies on the judgment of the individual completing the survey. Additionally, past surveys typically just ask one question: "Is your state centralized, decentralized, shared, or mixed?"[5] Not only does this methodology mean that an individual state's response may vary from survey to survey depending on who completes it, but there is little transparency behind the classifications. In other words, it is not always clear what respondents mean when they classify their states in a particular way. As a result, a review of past efforts to categorize SHAs revealed very little consistency in the way states were classified. Only eight states had the same classification in all seven of the past reports that were reviewed as part of this study. (Please see Appendix A for a list of how states have been categorized in the past.)

Organizational structure may also have implications for how accreditation standards apply in different states. In both the public vetting of the Public Health Accreditation Board (PHAB) proposed standards and measures for national, voluntary accreditation[6] and the evaluation of the PHAB beta test,[7] participants raised questions about how particular measures would play out in their states given the organizational structure. For example, beta-test participants were uncertain about whether local health departments in centralized states could submit documents that were created by the state or if they would need to tailor them to their communities. Questions were also raised about how state health agencies in centralized states should respond to measures that focus on the relationship with local health departments—if indeed those local health departments are staffed by state employees. PHAB convened a Centralized States Think Tank to address some of these issues and to clarify the application process in centralized states. It may also be helpful to provide training to site visitors to help them understand how the governance structure of the health department they are reviewing may provide important context in assessing that health department's conformity with the PHAB measures.

To address some of the challenges associated with inconsistent SHA classification, in 2009 the Association of State and Territorial Health Officials (ASTHO), with funding from the Robert Wood Johnson Foundation (RWJF), contracted with NORC at the University of Chicago to develop an objective method for categorization. NORC developed a questionnaire for senior SHA personnel to complete that describes the functional characteristics of the SHA and LHDs within their state. The research team used the results from this survey to objectively classify states. In 2011 ASTHO and the National Association of County and City Health Officials (NACCHO), with funding from the Centers for Disease Control and

[5] Fraser M & Downing K, comps. *NACCHO Survey Examines State/Local Health Department Relationships.* Washington, DC: NACCHO. 1998, Research Brief, No. 2.
[6] NORC, *Vetting the Public Health Accreditation Board Standards and Measures*. Alexandria, VA: Public Health Accreditation Board. 2009.
[7] NORC and PHAB *Brief Report: Evaluation of the Public Health Accreditation Board Beta Test.* Alexandria, VA: Public Health Accreditation Board. 2011.

Prevention (CDC), contracted with NORC to gather additional information about several of the states and develop maps depicting the governance structures.

Methodology

This section provides details about how feedback from state health officials and from other experts in the field contributed to the development of the data collection instrument. It also describes the key questions in the survey and the methodology for classifying states based on their survey responses.

Developing and Piloting the Survey

In designing the state survey, NORC researchers conducted a review of the literature, held conversations with experts in the field, and gathered input from ASTHO and NACCHO.

An extensive literature review was conducted to understand the methodology of past categorization efforts, uncovering seven past categorization efforts by various researchers and organizations. From the review of these efforts, an initial set of criteria were developed to be used in categorizing health departments into the four main existing categories—centralized, decentralized, shared, and mixed. From the initial set of criteria, a draft survey about the provision of public health services was developed.

A group of expert advisors was convened via teleconference in February 2009 to discuss the validity and adequacy of the categorization scheme conceived by the research team. The expert advisors provided valuable feedback on the first survey draft, which led to a revised set of questions. A pilot testing phase occurred in the month of May, during which the revised survey draft was sent to four ASTHO members to test the survey questions. During the pilot test, the small group of ASTHO members completed the survey and provided feedback on the following:

- Clarity of questions and definitions.
- Need for additional definitions.
- Importance of factors considered in categorization.
- If SHA respondents had all of the information necessary to complete the survey.
- Additional suggestions for improving the survey.

This feedback permitted the research team to develop a final survey to be fielded to ASTHO members.

Refining the Survey Questions

After refining the questions following the pilot test, a final, web-based version of the survey was developed. The final survey questions are presented in Appendix B. Below, the key elements of the survey are briefly described.

One important part of this survey was defining local health units within the state. A local health unit was defined as "an administrative or service unit of local or state government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than the state." In this way, local health units can be units of either state or local government.

It was considered important to acknowledge that within one state there might be different types of local health units. Thus the survey opened with a table where respondents were asked to fill in both the number of local health units and the percent of the state population served by health units that fit into two different categories—local health units led by state employees and local health units led by local employees.

If respondents indicated that there is at least one local health unit within their state that is led by state employees, they were directed to a series of questions about those state-led health units. These questions asked about:

- The extent to which local governmental entities have authority to make budgetary decisions about those local health units.
- The ability of local health units to establish taxes for public health.
- The ability of local health units to establish fees for public health services.
- The ability of local health units to issue public health orders.
- The entities that appoint and approve local chief executives.

Respondents who indicated the existence of local health units led by local employees were directed to a parallel set of questions that asked about the characteristics of those local health units. If a state had both local health units led by state employees and local health units led by local employees, they were asked to respond to both sets of questions.

Collecting Data

When the survey was finalized, the ASTHO survey team sent emails to the deputy state health officials in all 50 states, inviting them to take the online survey. The survey was in the field from June 10 to mid-July 2009, and ASTHO sent several reminders to individuals who had not yet completed the survey. All 50 states completed the questionnaire.

Responses provided by 16 states were ambiguous and required followup. The research team sent emails to the individuals who had completed the survey to request additional information. Each email had one or two specific questions and invited responses either via e-mail or telephone. The two most common issues that required followup were:

1. States indicated that a portion of the state population was not covered by a local health unit. The research team wrote to respondents to determine if local public health services were provided in those areas and if so, by whom.

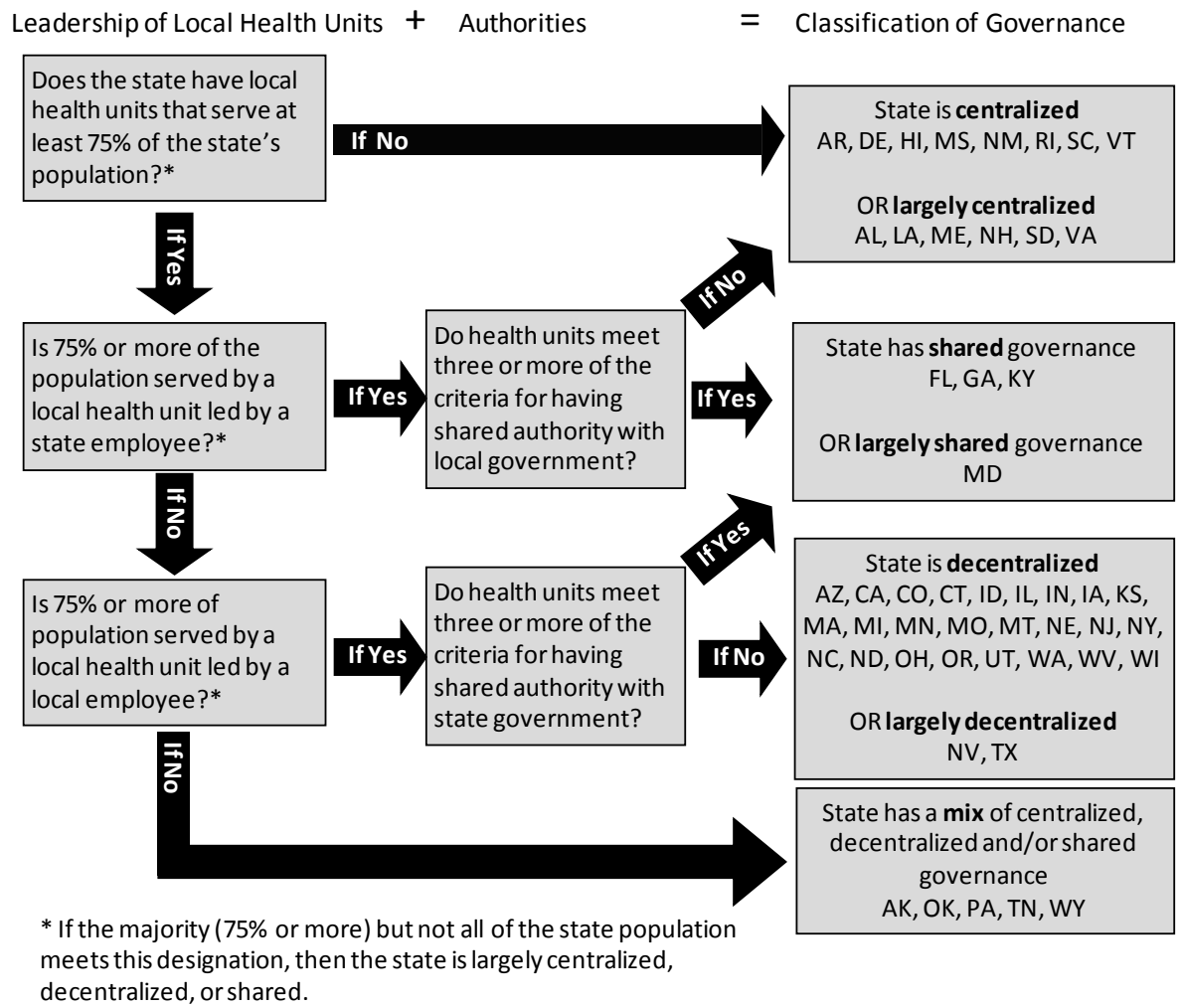
2. Respondents stated that none of the options in the survey adequately described the roles played by state and local entities in making budgetary decisions. The research team asked for details about how those budgetary decisions were made.

Because of the need to ask these clarifying questions, NORC recommends several revisions to the questionnaire, should the survey be fielded again in the future. These recommendations are described in the *Lessons Learned* section on page 14.

Categorizing the States

The research team developed a decision tree to categorize the states (see Figure 1). The decision tree is framed similarly to the survey that was sent to deputy state health officials in that both the leadership of local health units and the authorities of state/local government are considered in the classification of each state's public health agency governance structure.

Figure 1. Decision tree for determining state public health agency (SHA) categorization.



There are several principles that guided the development of the decision tree:

1. If a state reported having no local public health units (i.e., all public health services are administered through the central office), then the state is considered centralized. This is depicted by the topmost arrow on the decision tree. Accordingly, Hawaii and Rhode Island were classified as centralized states.
2. The primary criterion for determining if local health units are centralized or decentralized is whether those units are led by state or local employees. Health units led by state employees are presumed to be centralized and those led by local employees are presumed to be decentralized. However, in acknowledgment of the fact that local and state entities may have shared authority around certain public health budget and governance decisions, the decision tree includes

criteria to determine if local health units within a state should be considered shared, rather than centralized or decentralized. To make that classification decision, state-led health units are considered to have shared authority with local government if they meet three or more of the criteria listed in the left column of the table below (see Figure 2). Similarly, local-led health units are considered to have shared authority with state government if they meet three or more of the criteria in the right column below.

Figure 2. Criteria for determining shared local and state authority for public health units.

Criteria for state-led health units having shared authority with local government	Criteria for local-led health units having shared authority with state government
Local governmental entities have authority to make budgetary decisions	State governmental entities have authority to make budgetary decisions
Local government can establish taxes for public health or establish fees for services AND this revenue goes to local government	Local government cannot establish taxes for public health nor establish fees for services OR this revenue goes to state government
50% or less of local heath unit budget is provided by state public health agency	More than 50% of local heath unit budget is provided by state public health agency
Local governmental entities can issue public health orders	Local governmental entities cannot issue public health orders
Local chief executives are appointed by local officials	Local chief executives are appointed by state officials
Local chief executives are approved by local officials	Local chief executives are approved by state officials

3. If all of the local health units in a state have the same type of organizational structure, the state is classified as centralized, decentralized, or shared. If a large majority of the state's population (75% or more[8]) is served by local health units that have a similar organizational structure, it was deemed important to acknowledge that there is one predominant model in the state. For that reason, those states are considered to be largely centralized, largely decentralized, or largely shared. If there is no one predominant model (i.e., if fewer than 75% of the state's population is served by local health units with the same type of governance structure), the state is considered to be mixed. Six states are classified as mixed for this reason, as is shown in the bottom right of the decision tree (Figure 1).

Using this decision tree, NORC objectively categorized SHAs based on survey responses. States are grouped into four general categories—centralized/largely centralized, decentralized/largely decentralized, shared/largely shared, and mixed. This taxonomy offers more nuance than is found in most past surveys. Based on the logic in the decision tree, these categories are defined as follows:

[8] This threshold was determined in consultation with ASTHO and NACCHO.

- **Centralized/Largely Centralized.** Seventy-five percent or more of the state's population is served by local health units that are led by employees of the state, and the state retains authority over many decisions relating to the budget, public health orders, and the selection of local health officials.
- **Decentralized/Largely Decentralized.** Seventy-five percent or more of the state's population is served by local health units that are led by employees of local governments, and the local governments retain authority over many decisions relating to the budget, public health orders, and the selection of local health officials.
- **Shared/Largely Shared.** Seventy-five percent or more of the state's population is served by local health units that meet one of these criteria: where local health units are led by state employees, local government has authority over many decisions relating to the budget, public health orders, and the selection of local health officials; OR, where local health units are led by local employees, the state has many of those authorities.
- **Mixed.** Within the state there is a combination of centralized, shared, and/or decentralized arrangements. No one arrangement predominates in the state.

Gathering Additional Information about the States

In 2011, ASTHO and NACCHO contracted with NORC to develop a map of the 50 states depicting which states are centralized, decentralized, and shared, as well as maps illustrating which jurisdictions within states fall into these various categories. To generate maps for states in which all jurisdictions did not fall into a single category, it was necessary to know sub-state jurisdictional boundaries by category. In some instances, this information was available on health department websites, while in other cases deputy state health officials were contacted for additional information.

During this stage of the process, NORC, ASTHO, and NACCHO also reviewed data from the 2010 ASTHO and NACCHO profiles and identified any instances in which those profiles provided information that contradicted the results of the initial 2009 survey. For example, there were some instances in which the NACCHO profile identified a larger number of independent health departments than had been reported in 2009. NORC followed up with deputy state health officials in those instances to ensure that this report contains the most up-to-date information about the state.

Findings

State Categorization

After receiving information from all 50 states, the research team classified SHAs based on the methodology presented above. The map below (Figure 3) illustrates how each state has been categorized.

Based on this classification system, 14 states are considered to be centralized/largely centralized, 27 are decentralized/largely decentralized, four states have shared/largely shared governance, and the remaining five states are mixed. The classification is largely consistent with past categorization efforts; with the exception of the nine states that were classified as largely centralized, largely decentralized, or largely shared—designations that have not been used before—for only three states did this system give a state a classification that it had not previously received in at least two studies.

We also provide more detailed profiles about each state in Appendix C. Each state map within Appendix C illustrates, where appropriate, how the jurisdictions within that state have been categorized.

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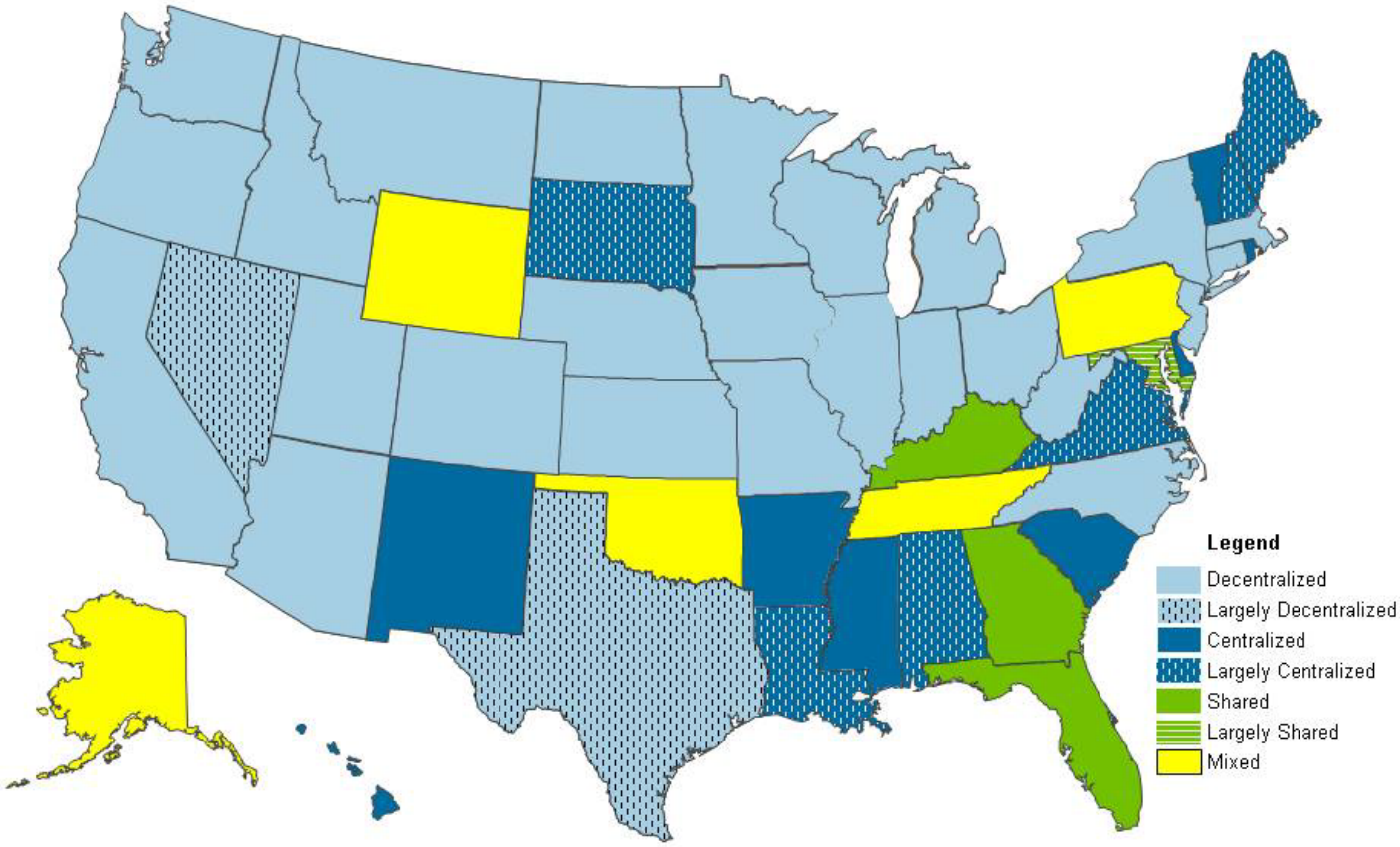
Figure 3. The 50 states and their classification.



Complexities in Categorizing States

This effort highlighted some of the challenges inherent in trying to develop a clear taxonomy to describe all 50 states when the relationships between state and local governmental public health are often complex. Several of the nuanced findings are described below. (Appendix C provides more detail about the states.)

Even in states that are considered centralized, it is not uncommon for local governmental entities to exhibit some authority; likewise, in some decentralized states, state government has some powers regarding the local health unit. (See Figure 4.) In some instances, whole functions may be performed by another level of government. For example, although New York is classified as a decentralized state, the state provides environmental public health services in about one-third of the counties.

Figure 4. Examples of authorities held at a different level of government in centralized and decentralized states.

Among the 14 states classified as centralized/largely centralized …	
Number of States	**Authority**
1	Local entities have the authority to make budgetary decisions
5	Local entities can provide nonbinding input in the budgetary process
3	Local entities can generate taxes or fees and that revenue either goes to local government or can be allocated for some local public health services
5	Local entities can issue public health orders
1	Local entities can appoint local chief executives
Among the 27 states classified as decentralized/largely decentralized …	
Number of States	**Authority**
2	State entities can provide nonbinding input in the budgetary process
8	State entities can approve local chief executives

These nuances are particularly striking when it comes to funding and the authority to make budgetary decisions. Even in decentralized states where local governmental entities have budgetary authority, states often contribute some resources. These funds are often tied to guidelines on how the money can be spent. In these circumstances, states are still classified as decentralized, but it should be noted that local health units may still feel the impact of state decisions. The importance of contributing funds also plays out in states where local health units are led by state employees. The responses to the survey questions and the conversations related to follow-up questions suggested that in cases where local

governmental entities contribute revenue to the local health unit, local governmental entities assumed control over portions of the budget.

Another complicating issue is the fact that states may have multiple, coexisting layers of governmental public health. In addition to a state level and a local level, some states also have regional public health offices. Based on the definition of a local health unit provided as part of this survey, regional arms of a SHA could be considered local health units. Indeed, this was done deliberately so that states would have the opportunity to describe the budgetary processes in these state-employee-led health units if they are the only health units operating in a particular area. However, it would have been more useful if the survey explicitly stated that in cases where there are both regional arms of SHAs and local health units that cover smaller jurisdictions, the respondent should focus on those smaller jurisdictions when answering the questions. This would provide a clearer picture of on-the-ground provision of local public health services.

Next Steps

The survey and categorization scheme were designed to offer a more transparent and objective method for SHA classification. As such, it may be valuable to use this standard set of questions in future surveys that are seeking to clarify the relationship between state and local governmental public health. Periodic administration of a similar survey on a regular (5- or 10-year) basis to determine if states have changed their organizational structure is recommended. These questions may also be a useful guide for other efforts that would benefit from a clearer understanding of how local and state entities interact. For example, in preparation for assessing states for accreditation, it may be valuable to ask applicant public health agencies a series of questions that are based on the ones used in this study. This may provide valuable contextual information for site visitors.

If these questions are used again in the future, some refinements are recommended. In the *Lessons Learned* box below, several areas for improvement are identified. Appendix D presents suggested revisions to the data collection tool based on those lessons. These revised questions should be pilot tested to ensure usability.

Lessons Learned and Advice for Future Iterations of This Survey

Respondents should be given additional opportunities to provide free-text narrative. Although the survey was deliberately designed to try to capture discrete data points, additional clarification would have proven valuable in several instances. In particular, if states respond that none of the descriptions of budgetary authority apply, they should be given the opportunity to explain how budgetary decisions are made.

An additional question should be added to ask who, if anyone, provides local governmental public health services in areas that are not served by a local health unit.

The opening table should be clarified to indicate that if a particular portion of the population is served both by a locally led health unit serving a smaller jurisdiction (e.g., a county or city) and by a state-led health unit serving a broader jurisdiction (e.g., a regional branch of a SHA), the respondent should focus on the unit that has a smaller jurisdiction.

One of the response options about budgetary authority in local health units that are led by local employees may need to be revised. The response "Aside from requirements to report on the use of state-provided funds, local governmental entities retain decision making capacity about the budget for local health units, with no state input" may need to be broadened to account for the fact that states, as funders of public health activities, may impose guidelines on the use of funds that go beyond simply reporting how they were used.

If a paper-based version of the survey is administered, it should more clearly articulate the skip patterns. In the online version, respondents are directed to answer either the questions about health units led by state employees, the questions about health units led by local employees, or both, based on their responses to the opening table. Similar instructions are needed to direct paper-based respondents to the appropriate responses.

Although this process asks more specific questions about the interactions between state and local public health than previous studies, it still relies on the judgment and knowledge of one respondent. Given the complexity of the issues addressed in this survey, different respondents may interpret the same questions differently. To validate the answers in the survey, it may, therefore, be useful to have respondents first complete the survey and then hold telephone conversations to review their responses and ask clarifying questions to better understand the reasoning behind each response.

In addition to offering a methodology that can be applied in the future, the classifications provided in this report may serve as valuable inputs for future research. For example, it would be interesting to conduct a study that looks at past research that used state classification as an explanatory variable (e.g., the studies on financing and public health performance described above) to see how the results would change if states were categorized in the way recommended in this report. Another area of additional research that flows from this project would be to examine responses to similar questions that are asked of local health departments. Matching local perspectives on the organizational structure in their state to

state perspectives would provide an even richer picture of intergovernmental public health relationships.

This project has developed a replicable process for objectively classifying states based on the distribution of public health authorities between state and local governmental entities. The state classifications put forth through this effort can serve as a strong foundation for future efforts in public health systems and services research.

Appendices

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Appendix A: Comparison of Classifications of States

	DeFriese et al. (1981)[9]	Mullan & Smith (1988)[10]	CDC (1991)[11]	NACCHO (1998)[12]	Gostin & Hodge (2002)[13]	PHF (2002)[14]	ASTHO (2007)[15]	NORC (2011)
Alabama	Mixed	Shared	Shared	Mixed	Hybrid	Mixed	Mixed	Largely Centralized
Alaska	Shared	Mixed	Mixed	Mixed	Hybrid	Mixed	Mixed	Mixed- Decentralized & Centralized
Arizona	Mixed	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Decentralized	Shared	Decentralized
Arkansas	Centralized	Centralized	Centralized	Centralized	Centralized- Top Down	Centralized	Centralized	Centralized
California	Decentralized	Mixed	Mixed	Mixed	Hybrid		Decentralized	Decentralized
Colorado	Shared	Decentralized	Decentralized	Shared	Decentralized-Bottom Up	Shared	Mixed	Decentralized
Connecticut	Centralized	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Decentralized	Shared	Decentralized
Delaware	*Reported no LPHAs		Centralized	Centralized		Centralized	*Reported no LPHAs	Centralized
Florida	Centralized	Centralized	Centralized	Centralized	Centralized- Top Down	Shared	Centralized	Shared- State Led
Georgia	Shared	Shared	Shared	Decentralized	Hybrid	Decentralized	Shared	Shared- State Led
Hawaii	Centralized		Centralized	Other		Centralized	*Reported no LPHAs	Centralized
Idaho	Decentralized	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Shared	Shared	Decentralized
Illinois	Decentralized	Mixed	Mixed	Decentralized	Hybrid	Decentralized	Decentralized	Decentralized
Indiana	Shared	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Decentralized	Decentralized	Decentralized
Iowa	Decentralized	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Decentralized	Decentralized	Decentralized
Kansas	Decentralized	Mixed	Mixed	Decentralized	Hybrid	Decentralized	Decentralized	Decentralized
Kentucky	Shared	Shared	Shared	Shared	Hybrid	Decentralized	Shared	Shared- Local Led
Louisiana	Centralized	Centralized	Centralized	Centralized	Centralized- Top Down	Centralized	Centralized	Largely Centralized

	DeFriese et al. (1981)[9]	Mullan & Smith (1988)[10]	CDC (1991)[11]	NACCHO (1998)[12]	Gostin & Hodge (2002)[13]	PHF (2002)[14]	ASTHO (2007)[15]	NORC (2011)
Maine	Decentralized	Decentralized	Mixed	Decentralized	Decentralized-Bottom Up		Centralized	Largely Centralized
Maryland	Centralized	Shared	Shared	Mixed	Hybrid	Shared	Mixed	Largely Shared- State Led
Massachusetts	Decentralized	Mixed	Mixed	Decentralized	Hybrid	Mixed	Decentralized	Decentralized
Michigan	Shared	Mixed	Mixed	Decentralized	Hybrid	Decentralized	Decentralized	Decentralized
Minnesota	Centralized	Shared	Shared	Decentralized	Hybrid	Decentralized	Decentralized	Decentralized
Mississippi	Centralized	Centralized	Centralized	Centralized	Centralized- Top Down	Centralized	Centralized	Centralized
Missouri	Mixed	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Decentralized	Decentralized	Decentralized
Montana	Centralized	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Decentralized	Decentralized	Decentralized
Nebraska	Decentralized	Decentralized	Decentralized	Mixed	Decentralized-Bottom Up	Decentralized	Mixed	Decentralized
Nevada	Centralized	Decentralized	Mixed	Centralized	Decentralized-Bottom Up		Shared	Largely Decentralized
New Hampshire	Decentralized	Mixed	Mixed	Mixed	Hybrid	Decentralized	Decentralized	Largely Centralized
New Jersey	Shared	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Decentralized	Decentralized	Decentralized
New Mexico	Centralized	Centralized	Centralized	Centralized	Centralized- Top Down	Centralized	Centralized	Centralized
New York	Shared	Mixed	Mixed	Decentralized	Hybrid	Mixed	Mixed	Decentralized
North Carolina	Decentralized	Shared	Shared	Decentralized	Hybrid	Decentralized	Decentralized	Decentralized
North Dakota	Centralized	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Decentralized	Decentralized	Decentralized
Ohio	Decentralized	Shared	Shared	Decentralized	Hybrid	Shared	Decentralized	Decentralized
Oklahoma	Shared	Mixed	Mixed	Centralized	Hybrid	Mixed	Mixed	Mixed- Centralized & Decentralized
Oregon	Decentralized	Decentralized	Decentralized	Decentralized	Decentralized-Bottom Up	Mixed	Decentralized	Decentralized
Pennsylvania	Mixed	Mixed	Mixed	Decentralized	Hybrid	Mixed	Mixed	Mixed- Centralized & Decentralized

	DeFriese et al. (1981)[9]	Mullan & Smith (1988)[10]	CDC (1991)[11]	NACCHO (1998)[12]	Gostin & Hodge (2002)[13]	PHF (2002)[14]	ASTHO (2007)[15]	NORC (2011)
Rhode Island	*Reported no LPHAs		*Reported no LPHAs	Other		Centralized	*Reported no LPHAs	Centralized
South Carolina	Centralized	Centralized	Centralized	Centralized	Centralized- Top Down	Centralized	Centralized	Centralized
South Dakota	Decentralized	Mixed	Mixed	Mixed	Hybrid	Centralized	Centralized	Largely Centralized
Tennessee	Centralized	Mixed	Mixed	Mixed	Hybrid	Mixed	Decentralized	Mixed- Centralized & Decentralized
Texas	Decentralized	Mixed	Mixed	Mixed	Hybrid	Mixed	Mixed	Largely Decentralized
Utah	Decentralized	Decentralized	Decentralized	Decentralized	Decentralized- Bottom Up	Decentralized	Decentralized	Decentralized
Vermont	*Reported no LPHAs		Centralized	Centralized		Centralized	Centralized	Centralized
Virginia	Centralized	Centralized	Centralized	Centralized	Centralized- Top Down	Mixed	Mixed	Largely Centralized
Washington	Decentralized	Decentralized	Decentralized	Decentralized	Decentralized- Bottom Up	Decentralized	Decentralized	Decentralized
West Virginia	Shared	Shared	Shared	Decentralized	Hybrid	Decentralized	Decentralized	Decentralized
Wisconsin	Mixed	Decentralized	Decentralized	Decentralized	Decentralized- Bottom Up	Decentralized	Shared	Decentralized
Wyoming	Mixed	Mixed	Mixed	Decentralized	Hybrid	Mixed	*Reported no LPHAs	Mixed- Shared (State Led) & Decentralized

References for Table

[9] DeFriese GH, Hetherington JS, Brooks EF, Miller CA, Jain SC, Kavaler F & Stein JS. "The program implications of administrative relationships between local health departments and state and local government." 1981. *American Journal of Public Health, 71*(10):1109-1115.

[10] Mullan F & Smith J. *Characteristics of state and local health* agencies, mimeographed paper. Baltimore, MD: Johns Hopkins University School of Hygiene and Public Health, 1998, cited in Pickett, GE and Hanlon, JJ. *Public health: administration and practice* (9th ed.). St. Louis: Times Mirror/Mosby College. 1990.

[11] Centers for Disease Control (CDC) and Public Health Practice Program Office (PHPPO). *Profile of state and territorial public health system, 1991.* U.S. Department of Health and Human Services. 1991. Available at: http://wonder.cdc.gov/wonder/sci_data/misc/type_txt/stprof91.asp.

[12] Fraser M & Downing K, comps. *NACCHO Survey Examines State/Local Health Department Relationships.* Washington, DC: NACCHO. 1998. Research Brief, 2.

[13] Gostin LO & Hodge JG. *State public health law assessment report*. 2002. Turning Point: Collaborating for a New Century in Public Health. Available at: http://www.turningpointprogram.org/Pages/pdfs/statute_mod/phsm_state_ph_law_assessment_report.pdf.

[14] Public Health Foundation. Survey on performance management practice in states: results of a baseline assessment of state health agencies. Seattle, WA: Turning Point National Program Office at the University of Washington. 2002.

[15] Association of State and Territorial Health Officials. ASTHO Baseline Survey. 2007.

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Appendix B: Survey Instrument

SHA Survey

Contact Information
Name

Job Title

E-mail Address

Phone Number

In what state is your public health agency located?

Introductory Table

The following definitions will be helpful in completing the introductory table:

Local health unit – A local health unit is an administrative or service unit of local or state government concerned with health, and carrying some responsibility for the health of a jurisdiction smaller than the state. (*This includes local public health departments, regional public health departments, and regional and local units of state public health agencies.* ***Please do not consider tribal health agencies when responding.*** *We understand that tribal health agencies make an important contribution to protecting the public health in many states; however, because tribal nations have sovereignty, their relationship with state public health agencies may differ from the relationship between states and local health units.)*

State Employee – An individual is a state employee if that individual's salary is paid directly by the state government.

Local Employee – An individual is a local employee if that individual's salary is paid by a city, county, or other sub-state jurisdiction.

Led by – An organization is led by the employee at the organization with the most seniority.

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Please provide your best estimates to complete the following table. You will be asked about two different types of local health units—those led by a state employee and those led by a local employee. For each type of health unit, please indicate in the first column the number of such units in your state. In the second column, please indicate the percentage of the TOTAL state population that lives in an area served by that type of health unit.

	Number of this type of local health unit	**% of TOTAL state population served by this type of local health unit***
Local health unit led by a STATE employee		
Local health unit led by a LOCAL employee		

What percent of the state's population lives in areas that are not served by a local health unit?	
	% of TOTAL state population served by this type of local health unit*
State population not served by a local health unit	

Please note: The three percentages in the columns marked with an * in the above questions should add up to 100 percent.

Areas Served by Health Units Led by a State Employee

When you respond to questions in this section, please think ONLY about areas served by health units led by a STATE employee.

How would you describe local involvement with budgetary decisions related to local health units that are led by a state employee? (Please select ONLY ONE response.)

- o Local governmental entities (e.g., local health departments, local elected officials, or Boards of Health) have the authority to make budgetary decisions about allocating resources for programs within the local health unit.
- o All authority to make budget decisions is held at the state level with no local input.
- o All authority for budget decisions is held at the state level, but local governmental entities play a nonbinding advisory role related to setting the budget for local health units.
- o Varies by health unit among health units that are led by a state employee. (Please provide additional details in the space provided.)
- o None of the above applies to local health units that are led by a state employee.

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Do any local governmental entities (e.g., local health departments, local elected officials, or Boards of Health) have the ability to do any of the following? (Select all that apply.)

- o Establish taxes for public health
- o Establish fees for services without getting approval from a governmental entity led by a state employee
- o Issue public health orders (e.g., close a food-service establishment)
- o None of the above

Where does the revenue generated from those taxes or fees go? (Select ONLY ONE response.)

- o To local government
- o To state government
- o Some revenue goes to state government and some to local government

Which of these statements most accurately reflects how the top executive in the local health unit is appointed and approved? (Select ONLY ONE response.)

- o Local chief executives are appointed and approved by the state public health agency (SPHA) or other state entities.
- o Local chief executives are appointed by the SPHA or other state entities but are approved by local officials.
- o Local chief executives are appointed by local officials but are approved by the SPHA or other state entities.
- o Local chief executives are appointed and approved by local officials.
- o It varies.

On average, what proportion of local health unit budgets is provided by the state public health agency (including federal flow-through)? Your best estimate is fine. (Select ONLY ONE response.)

- o 0 - 25%
- o 26 - 50%
- o 51 - 75%
- o 76 - 100%
- o Don’t know

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Areas Served by Health Units Led by a Local Employee

When you respond to questions in this section, please think ONLY about areas served by health units led by a LOCAL employee.

How would you describe state involvement with budgetary decisions related to local health units that are led by a local employee? (Select ONLY ONE response.)

- o State authority is required to allocate resources for programs within the local health unit.
- o Aside from requirements to report on the use of state-provided funds, local governmental entities (e.g., local health departments, local elected officials, or Boards of Health) retain decision making capacity about the budget for local health units, with no state input.
- o All authority for budget decisions is held at the local level, but there is a nonbinding advisory role at the state level.
- o Varies by health unit among health units that are led by a local employee. (Please provide additional details in the space provided.)
- o None of the above applies to local health units that are led by a local employee.

Do any local governmental entities (e.g., local health departments, local elected officials, or Boards of Health) have the ability to do any of the following? (Select all that apply.)

- o Establish taxes for public health
- o Establish fees for services without getting approval from a governmental entity led by a state employee
- o Issue public health orders (e.g., close a food services establishment)
- o None of the above

Where does the revenue generated from those taxes or fees go? (Select ONLY ONE response.)

- o To local government
- o To state government
- o Some revenue goes to state government and some to local government

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Which of these statements most accurately reflects how the top executive in the local health unit is appointed and approved? (Select ONLY ONE response.)

- o Local chief executives are appointed and approved by the state public health agency (SPHA) or other state entities.
- o Local chief executives are appointed by the SPHA or other state entities but are approved by local officials.
- o Local chief executives are appointed by local officials but are approved by the SPHA or other state entities.
- o Local chief executives are appointed and approved by local officials.
- o It varies.

On average, what proportion of local health unit budgets is provided by the state public health agency (including federal flow-through)? Your best estimate is fine. (Select ONLY ONE response.)

- o 0 - 25%
- o 26 - 50%
- o 51 - 75%
- o 76 - 100%
- o Don't know

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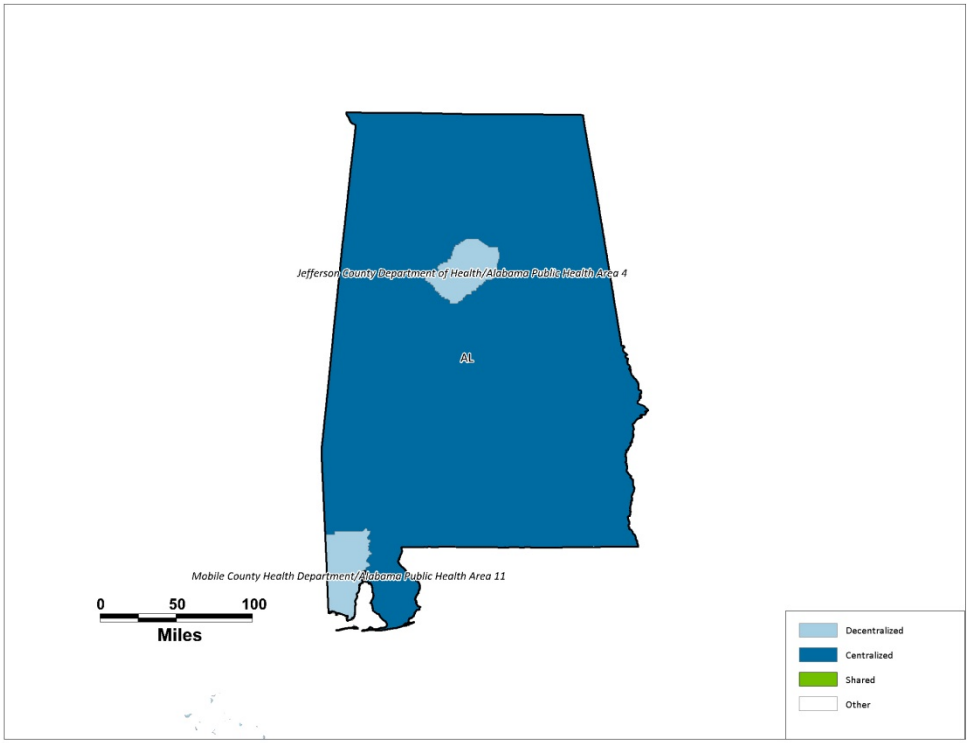
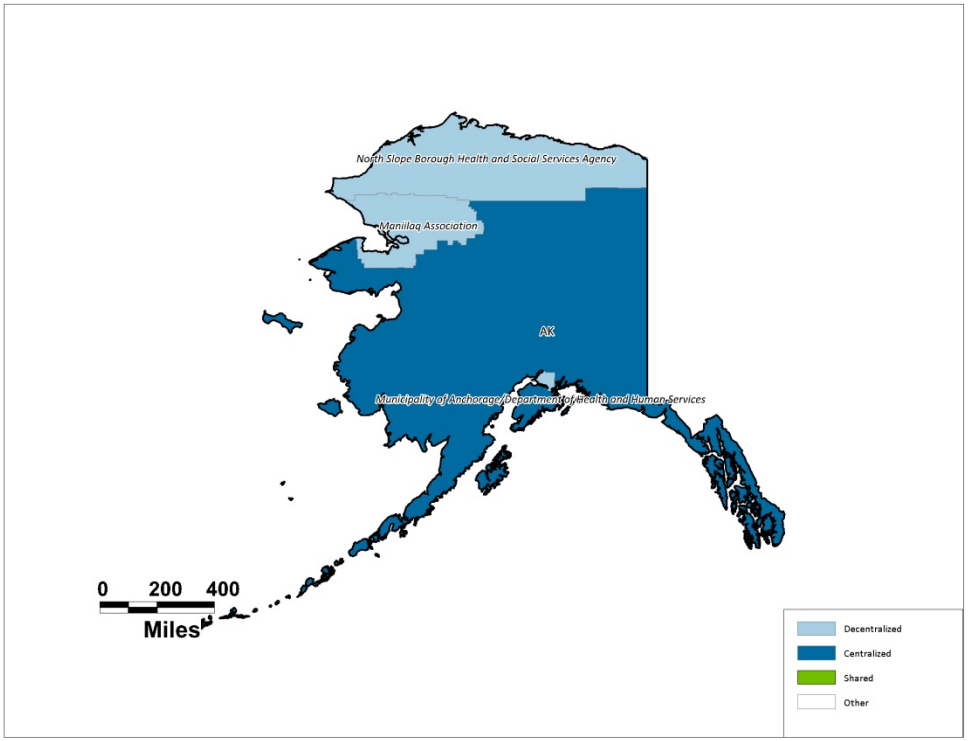
Appendix C: Detailed Descriptions of Each State

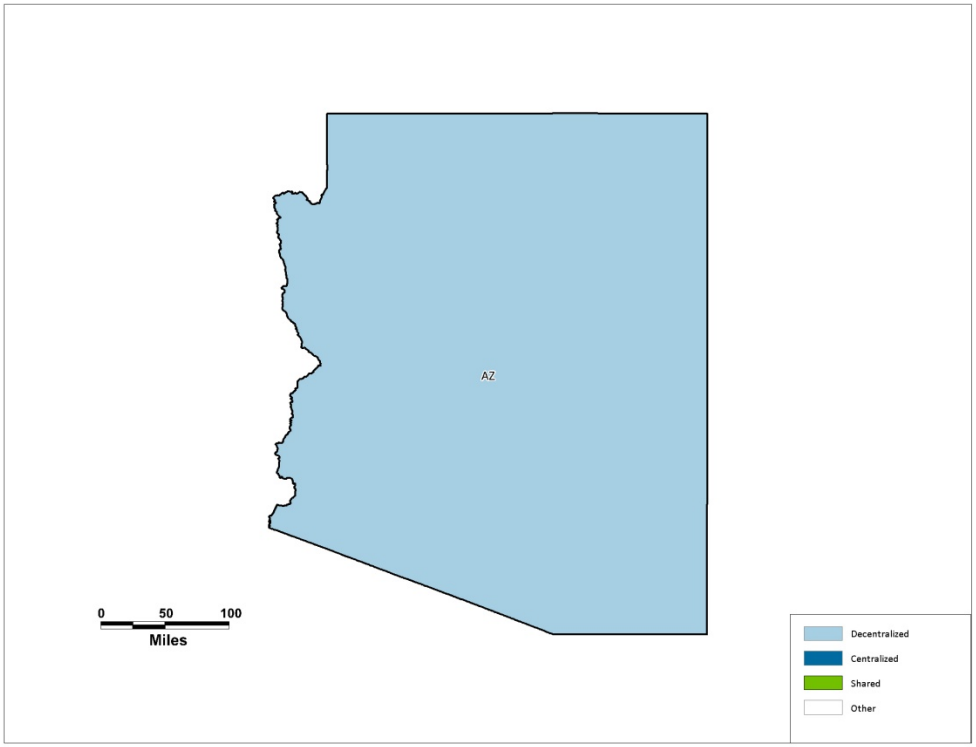
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

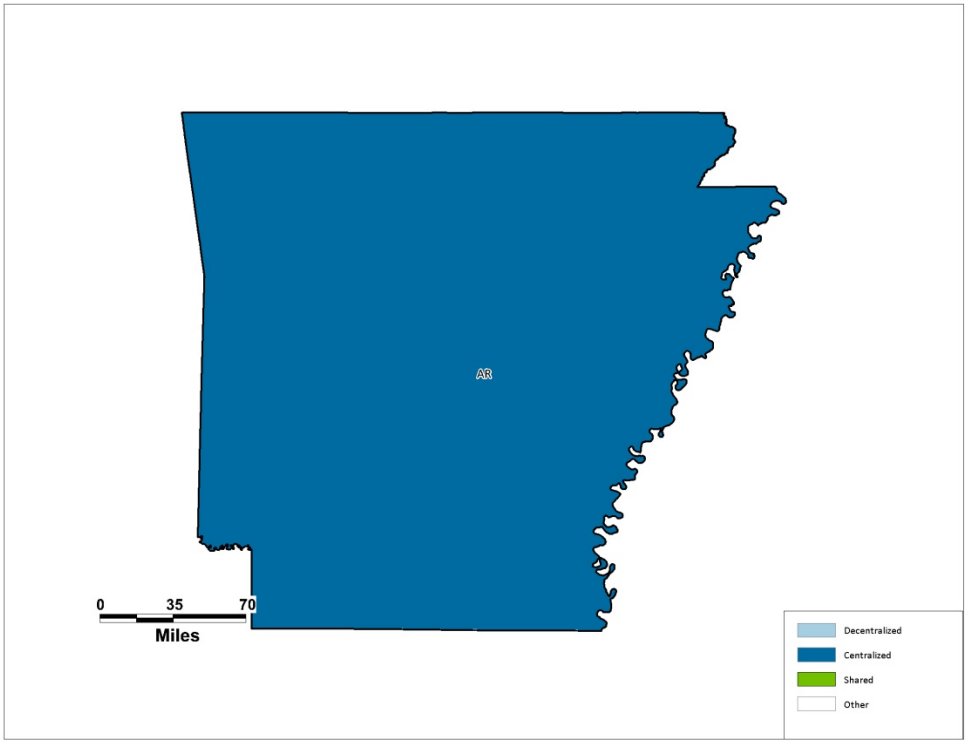
Alabama
Largely Centralized
 
 	
	<u>Centralized</u>:
	65 local health units led by state employee, serving 77% of total state population. For these areas:
	• Budgetary authority rests with state government, but local government plays a nonbinding advisory role
	• Local governmental entities may:
	  • Issue public health orders
	• Top executive is appointed and approved by the state
	• 0-25% of local health unit budget is provided by the state
	
	<u>Decentralized:</u>
	2 local health units led by local employee, serving 23% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed by local officials but approved by the state
	• 0-25% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

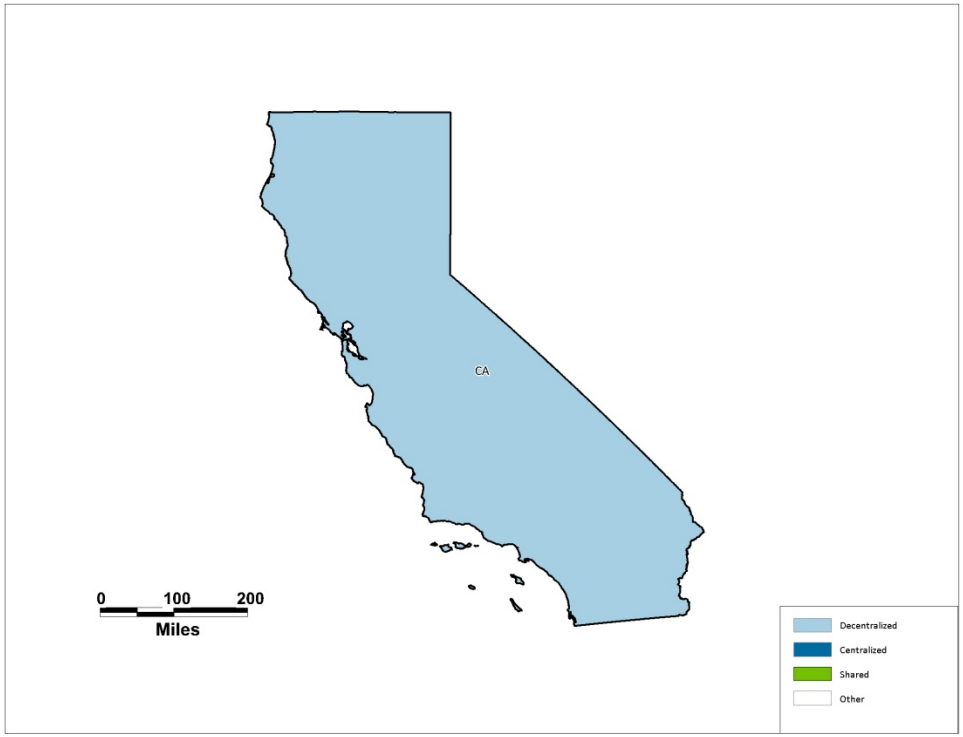
Alaska
Mixed – Decentralized & Centralized
 
 	
	<u>Decentralized</u>:
	3 local health units led by local employee, serving 43% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 51-75% of local health unit budget is provided by the state
	
	<u>Centralized</u>:
	23 local health units led by state employee, serving 57% of total state population. For these areas:
	• Budgetary authority rests with state government with no local input
	• Top executive is appointed and approved by the state
	• 76-100% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

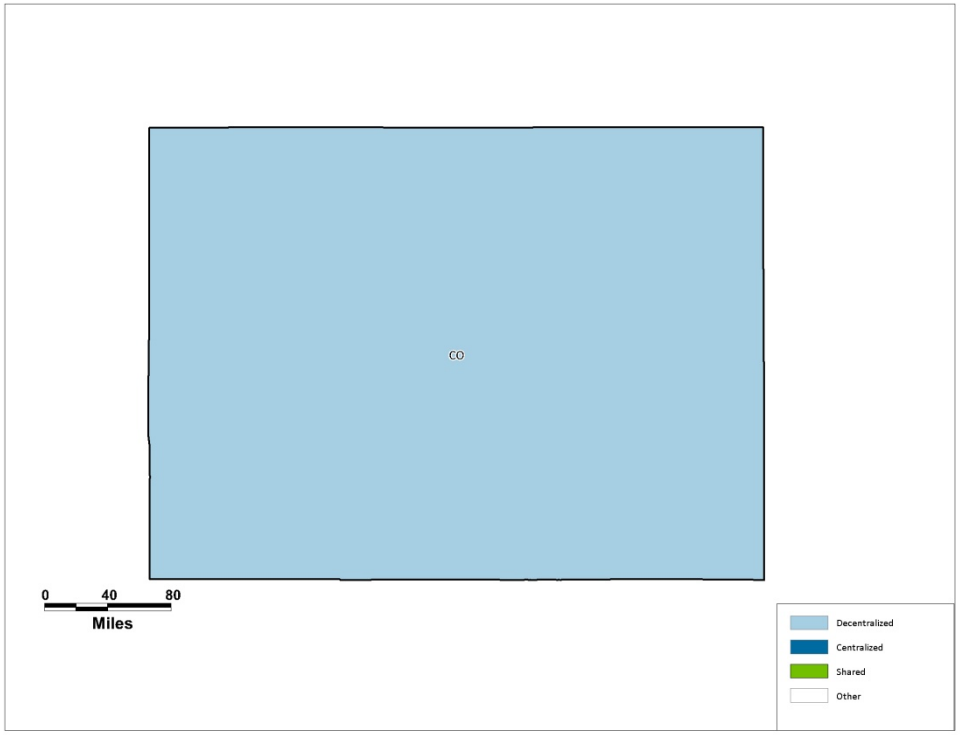
Arizona
Decentralized
 
 	
	<u>Decentralized</u>:
	15 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0-25% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies
Arkansas ***Centralized***  	**<u>Centralized</u>:** 94 local health units led by state employee, serving 100% of total state population. For these areas: • Budgetary authority rests with state government, but local government plays a nonbinding advisory role • Top executive is appointed and approved by the state • 76-100% of local health unit budget is provided by the state

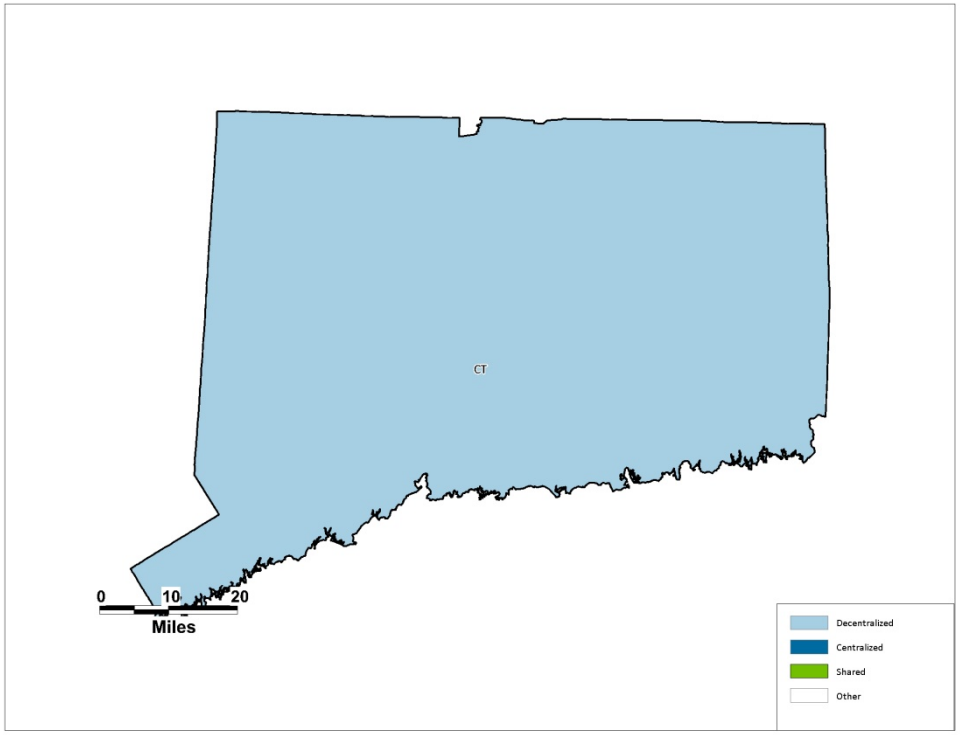
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

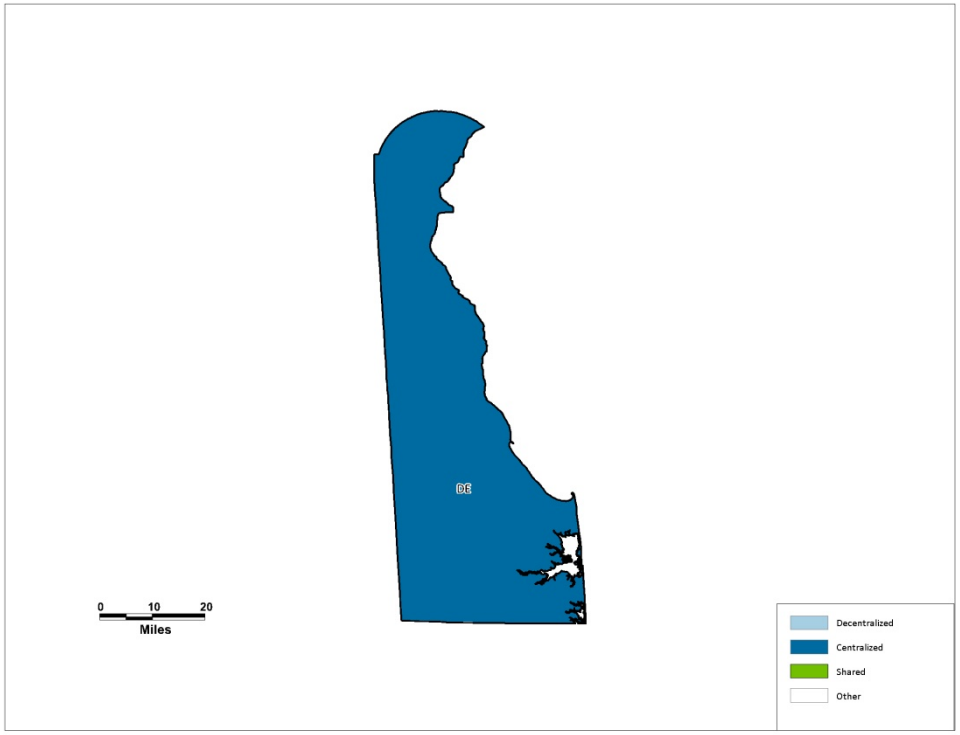
California
Decentralized
 
 	
	<u>Decentralized</u>:
	61 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 51-75% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

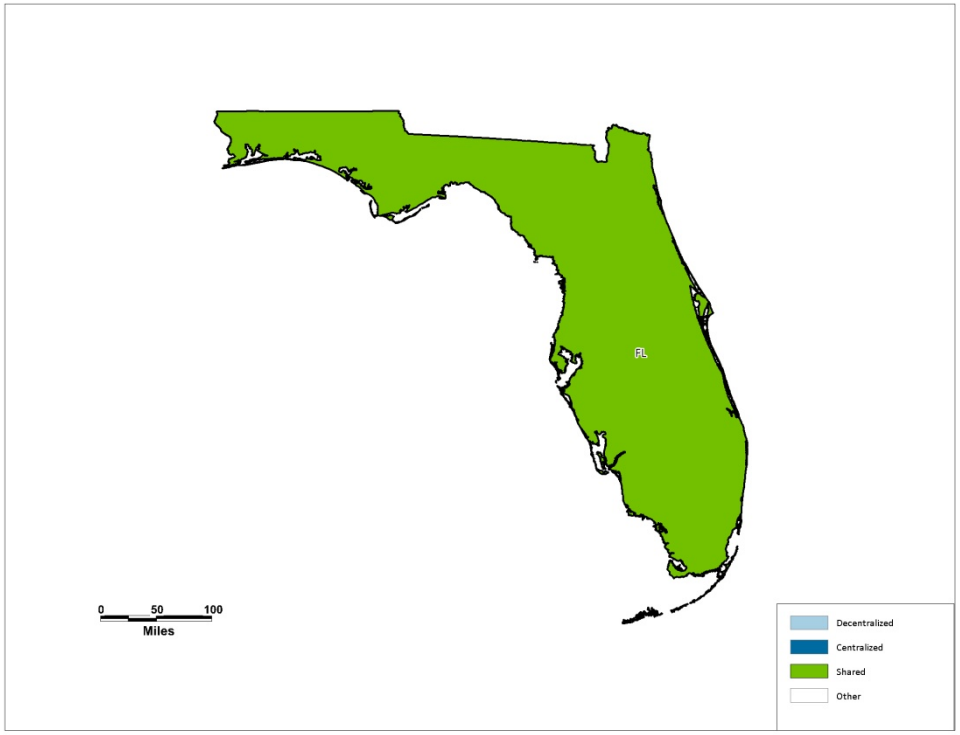
Colorado
Decentralized
 
 	
	<u>Decentralized</u>:
	54 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 76-100% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

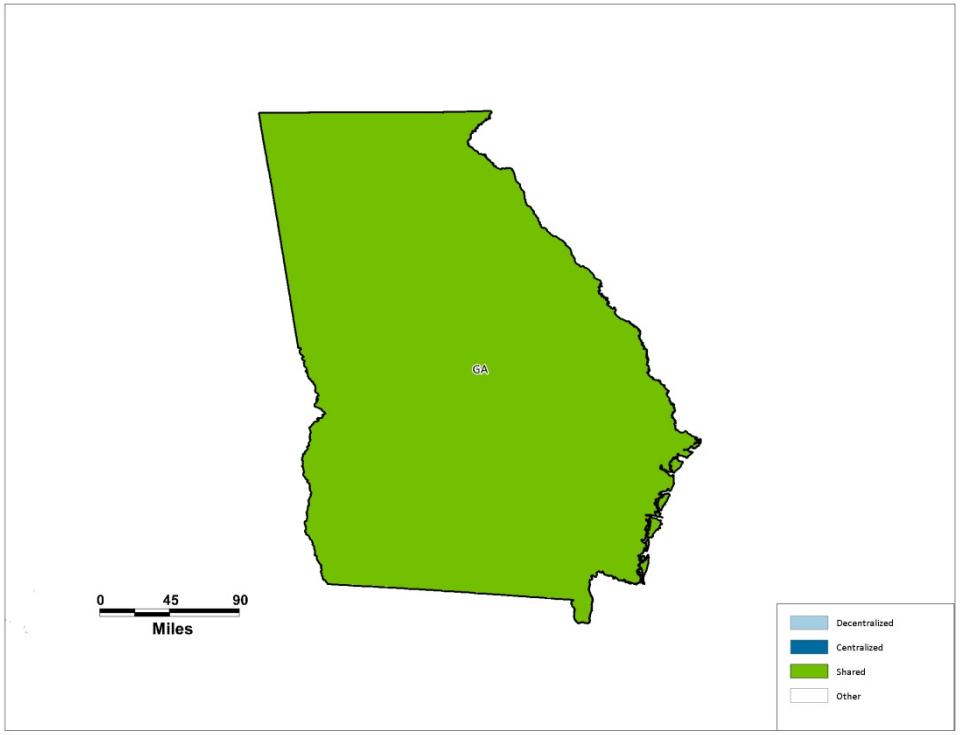
Connecticut
Decentralized
 
 	
	<u>Decentralized</u>:
	80 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Top executive is appointed by local officials but approved by the state
	• 51-75% of local health unit budget is provided by the state

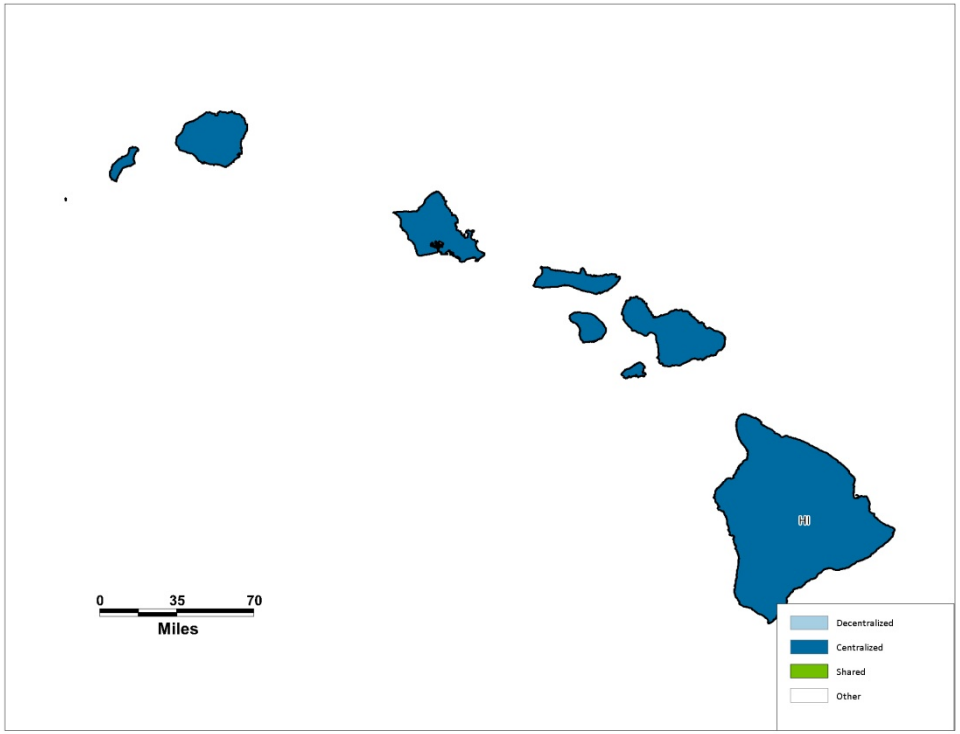
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies
Delaware ***Centralized***  	**<u>Centralized</u>:** No local health units are reported for the state. However, there are two satellite clinics of the state health department.

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

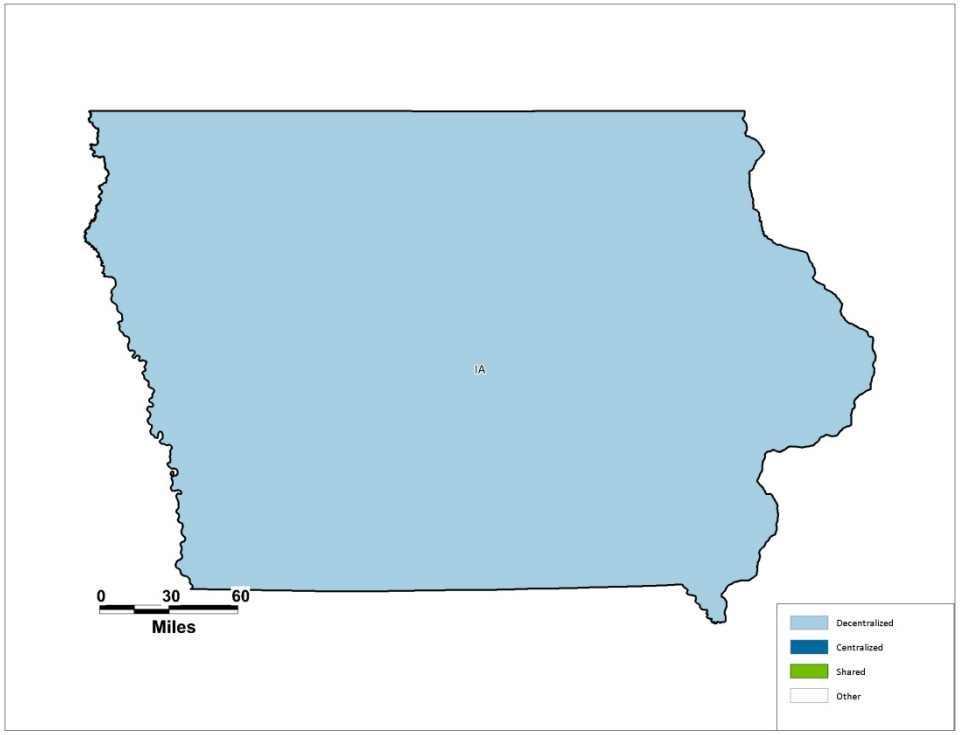
Florida
Shared (State Led)
 
 	
	<u>Shared (State Led)</u>:
	67 local health units led by state employee, serving 100% of total state population. For these areas:
	• Both the state Department of Health and the Board of County Commissioners contribute funding; Board of County Commissioners can designate how the funds it contributes will be used
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to state government
	• Top executive is appointed by the state but approved by local officials
	• 26-50% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

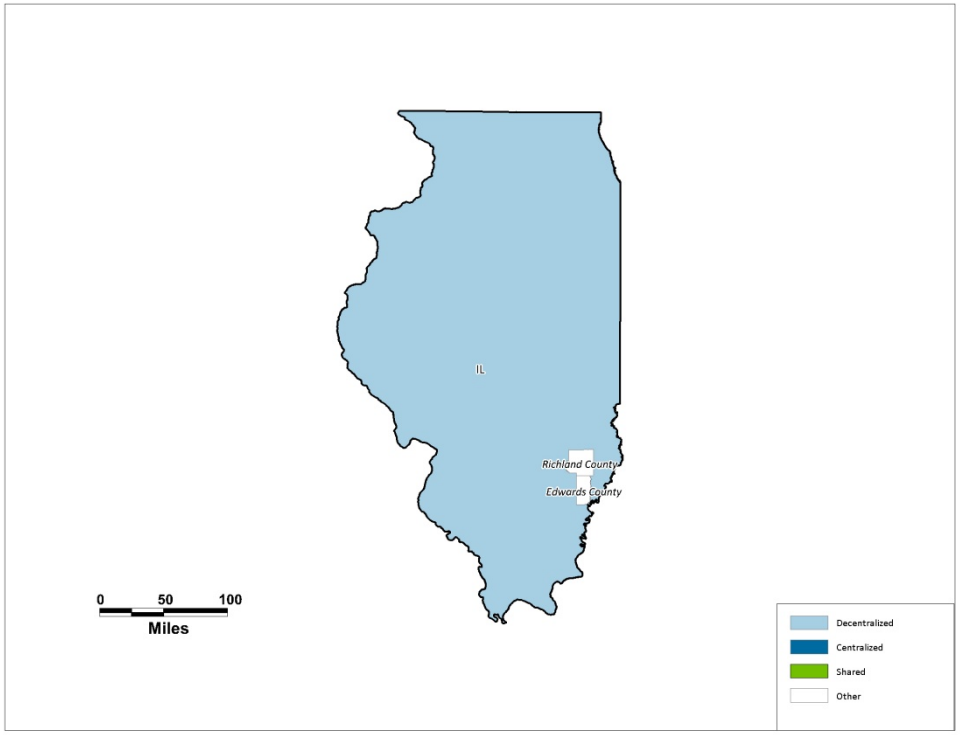
Georgia
Shared (State Led)
 
 	
	<u>Shared (State Led)</u>:
	18 local health units led by state employee, serving 100% of total state population. For these areas:
	• Local governmental entities have authority to make budgetary decisions
	• Local governmental entities may:
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from fees goes to local government
	• Top executive is appointed and approved by the state
	• 26-50% of local health unit budget is provided by the state
	
	Georgia has 18 regional offices. There are also 159 local health units that are run by local boards of health.

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies
Hawaii ***Centralized***  	**<u>Centralized</u>:** Local public health services are organized at the state level by one state health agency with district health offices providing local health services.

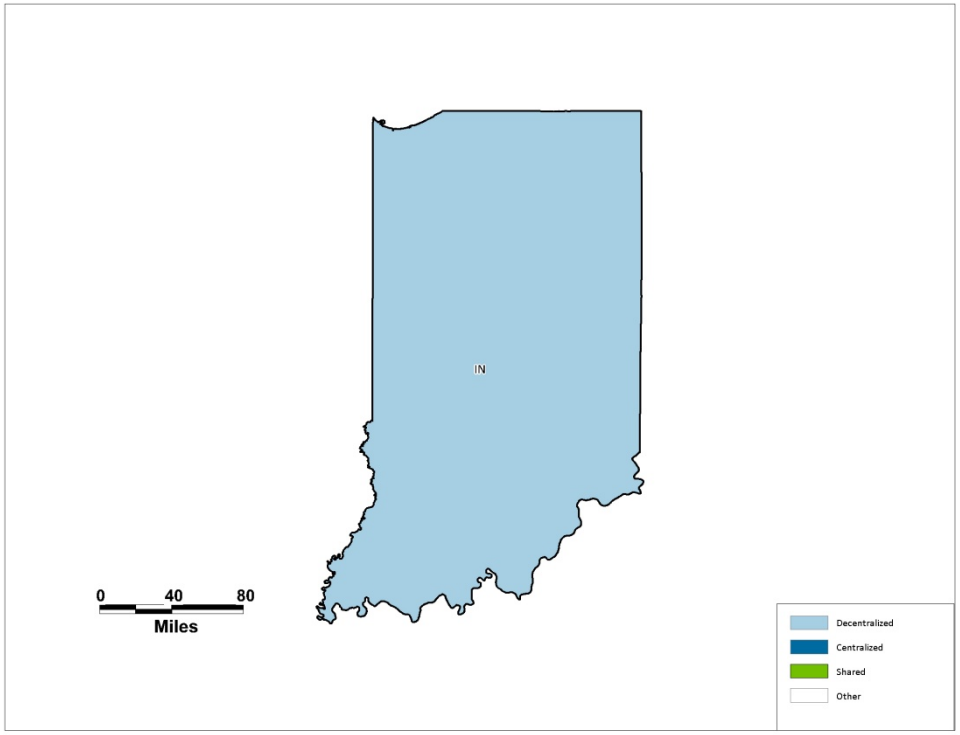
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Idaho
Decentralized
 
 	
	<u>Decentralized</u>:
	7 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority varies among health units
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 51-75% of local health unit budget is provided by the state

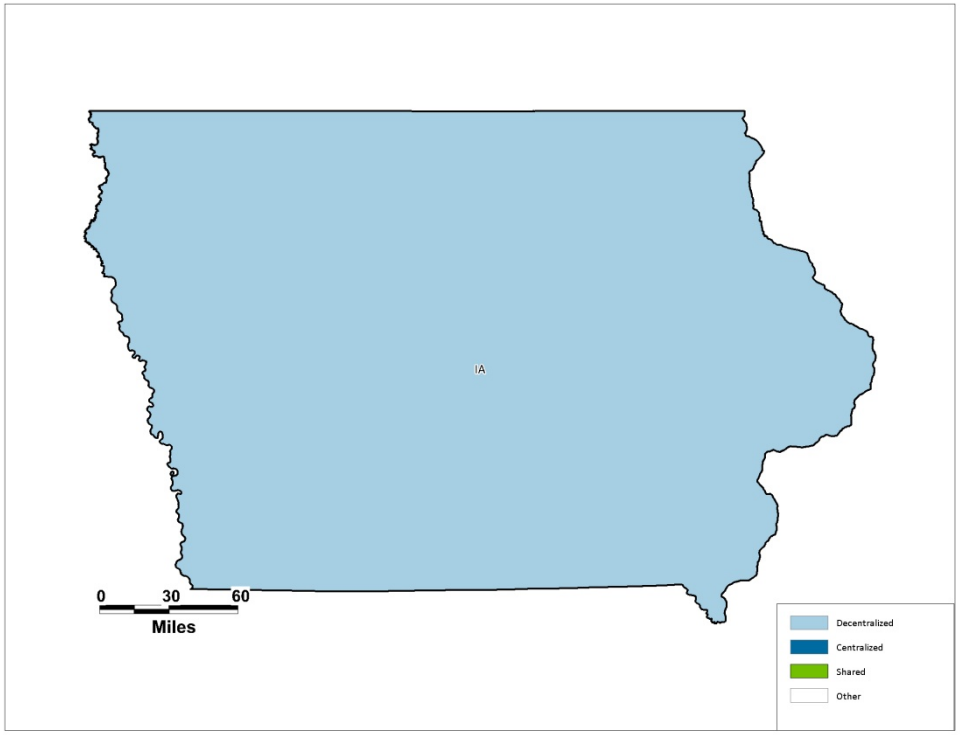
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Illinois
Decentralized
 
 	
Note: Areas labeled as "other" represent communities in which state public health agency respondents indicated no local public health units. In many of these areas, at least a limited set of services may be provided by the state health department, neighboring local health departments, or other entities.
	<u>Decentralized</u>:
	96 local health units led by local employee, serving 99.5% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input*
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed by local officials but approved by the state
	• 51-75% of local health unit budget is provided by the state
	
	0.5% of the population is not served by local health units. There is no organized governmental public health unit in these areas, which have a combined population of about 23,000 individuals. Some services (although not comprehensive) are provided by neighboring health departments; the funds for these services are designated by the state, specifically to cover this population. The only mandated state function is support at the local level in case of foodborne illness.
	
	*State has influence over local budgets in their determination of the level of funding that reaches local public health.

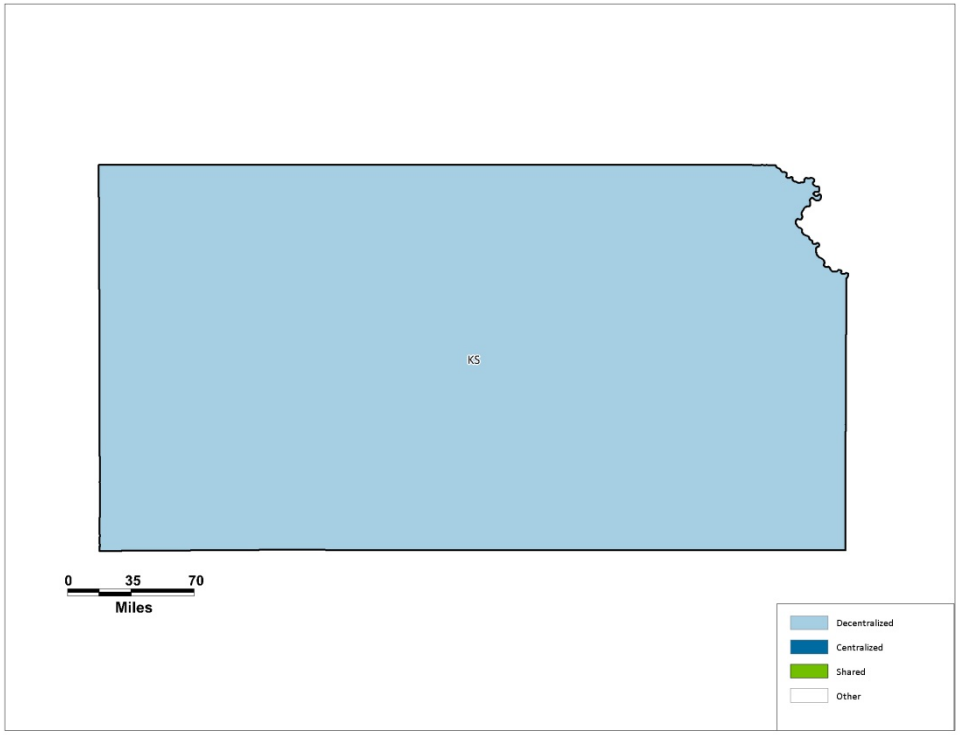
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Indiana
Decentralized
 
 	
	<u>Decentralized</u>:
	93 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0-25% of local health unit budget is provided by the state

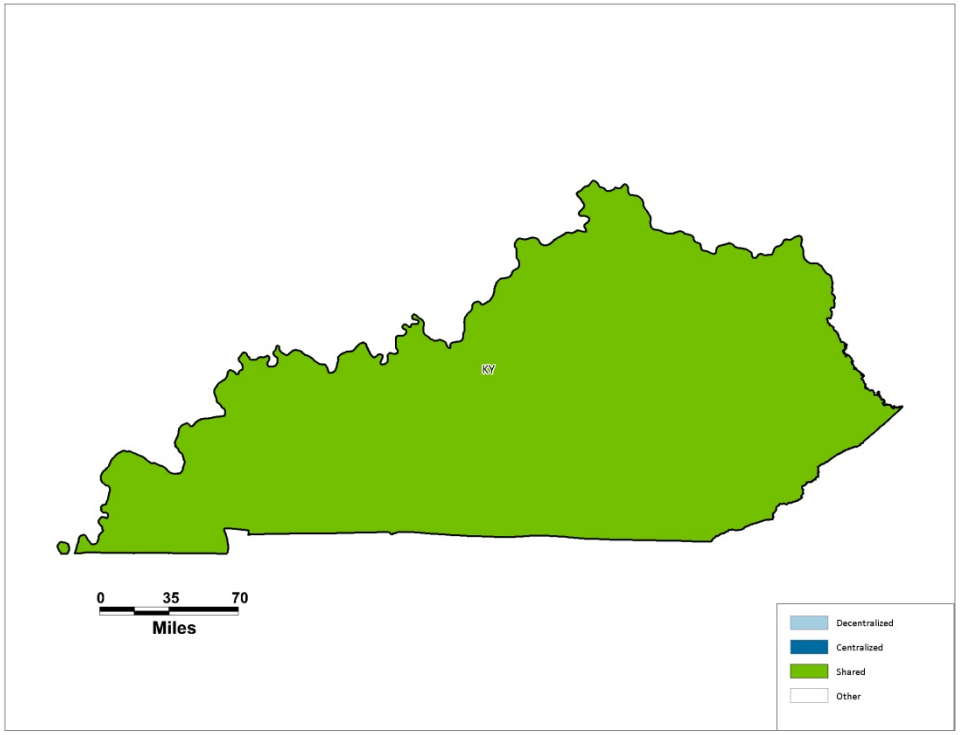
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Iowa
Decentralized
 
 	
	<u>Decentralized</u>:
	101 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government, but state government plays a nonbinding advisory role
	• Local governmental entities may:
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 51-75% of local health unit budget is provided by the state

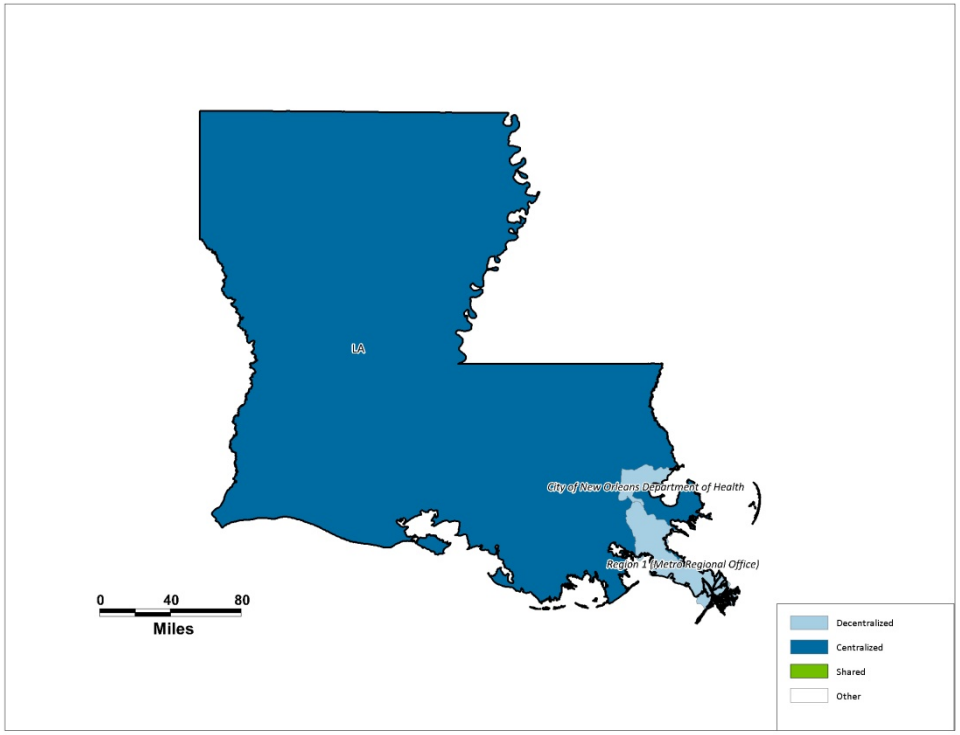
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

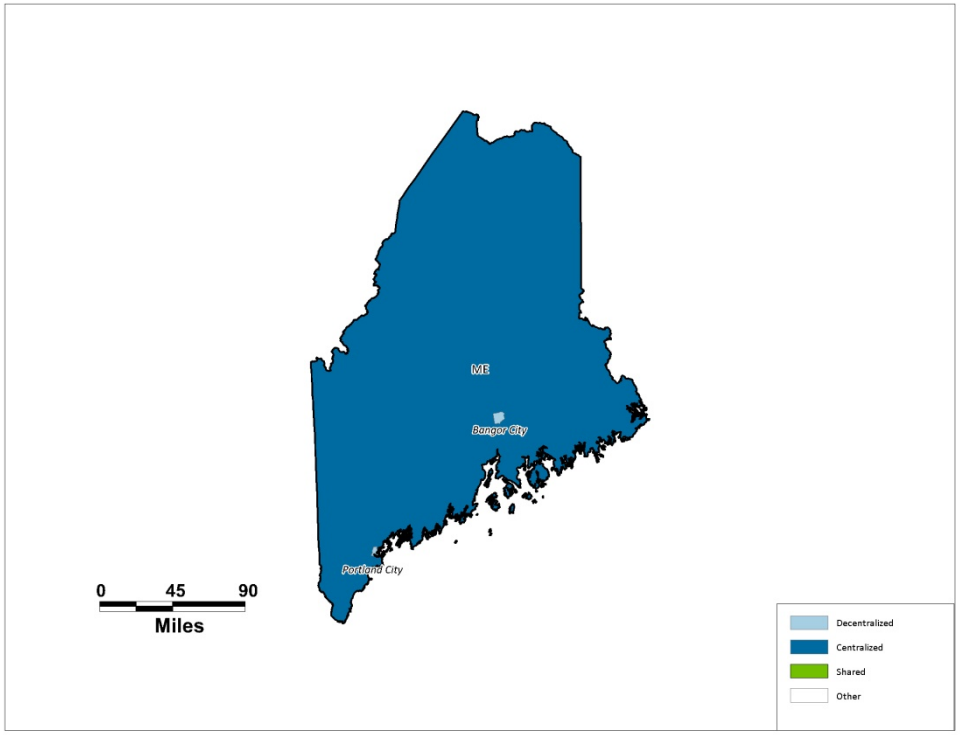
Kansas
Decentralized
 
 	
	<u>Decentralized</u>:
	100 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0-25% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

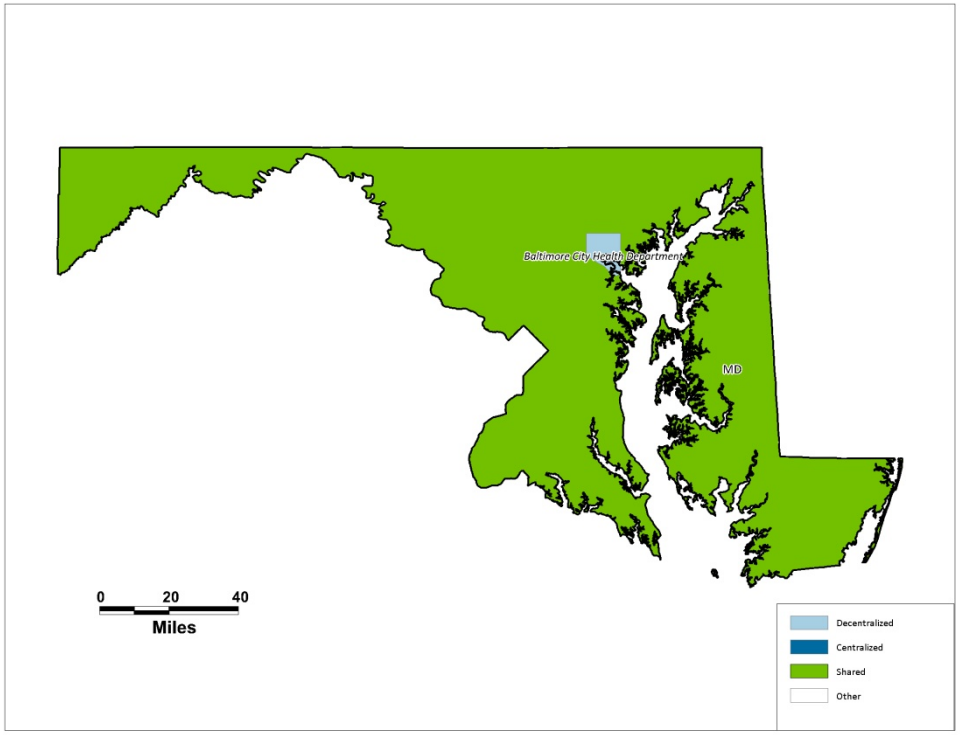
Kentucky
Shared (Local Led)
 
 	
	<u>Shared (Local Led)</u>:
	57 local health units led by local employee, serving 100% of total state population. For these areas:
	• State authority is required to allocate resources
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to both state and local government
	• Top executive is appointed by local officials but approved by the state
	• 51-75% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

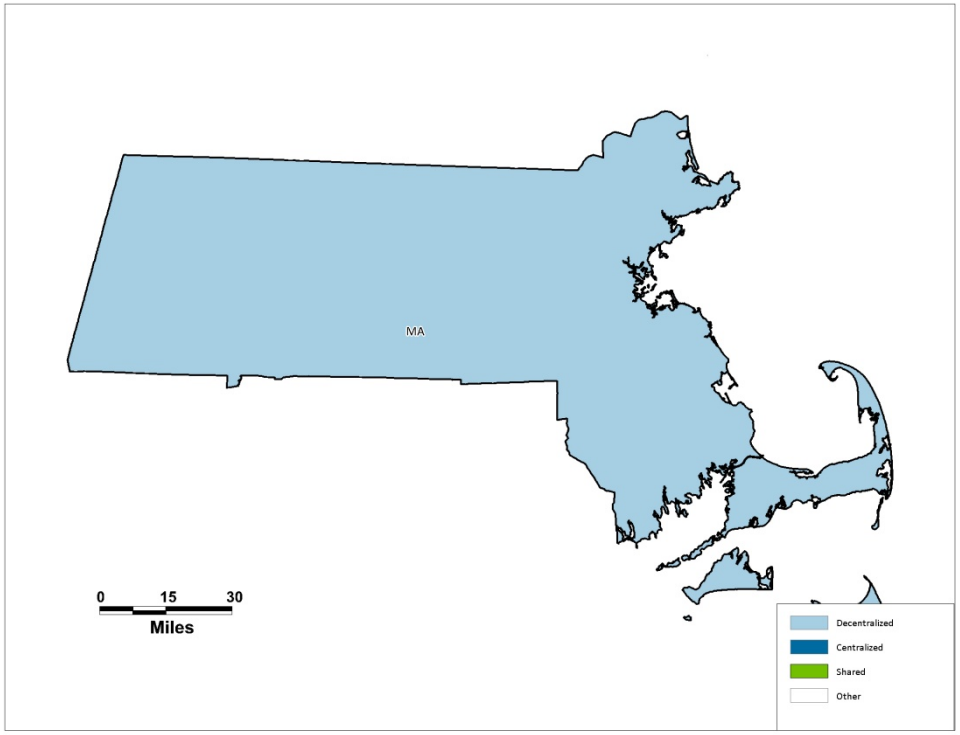
Louisiana
Largely Centralized
 
 	
	<u>Centralized</u>:
	9 local health units led by state employee, serving 92% of total state population. For these areas:
	• Budgetary authority rests with state government with no local input
	• Local governmental entities may:
	  • Establish taxes for public health
	• Revenue from taxes goes to local government
	• Top executive is appointed and approved by the state
	• 76-100% of local health unit budget is provided by the state
	
	<u>Decentralized</u>:
	2 local health units led by local employee, serving 8% of total state population. For these areas:
	• Budgetary authority rests with local government, but state government plays a nonbinding advisory role
	• Local governmental entities may:
	  • Establish taxes for public health
	• Revenue from taxes goes to local government
	• Top executive is appointed and approved by local officials
	• 51-75% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies
Maine ***Largely Centralized***  	**<u>Centralized</u>:** 8 local health units led by state employee, serving 90% of total state population. For these areas: • Budgetary authority rests with state government, but local government plays a nonbinding advisory role • Top executive is appointed and approved by the state • 76-100% of local health unit budget is provided by the state **<u>Decentralized</u>:** 2 local health unit led by local employee, serving 10% of total state population. For this area: • Budgetary authority rests with local government with no state input • Top executive is appointed and approved by local officials • 26-50% of local health budget is provided by the state.

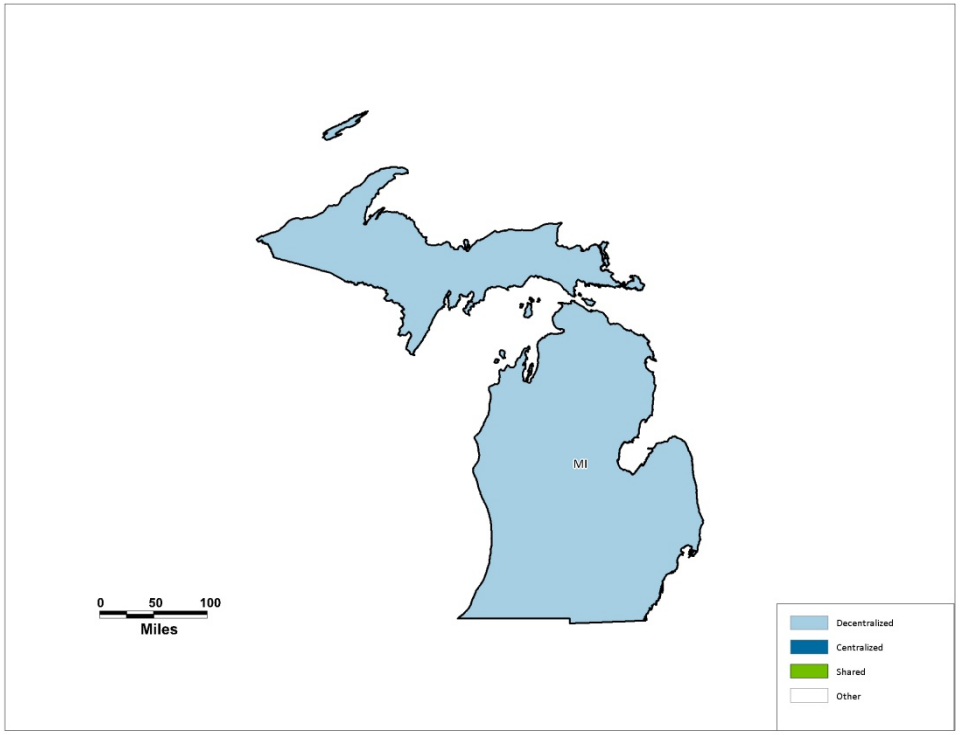
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Maryland
Largely Shared (State Led)
 
 	
	<u>Shared (State Led)</u>:
	23 local health units led by state employee, serving 92% of total state population. For these areas:
	• Local governmental entities have authority to make budgetary decisions
	• Local governmental entities may*:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed by local officials but approved by the state
	• 51-75% of local health unit budget is provided by the state
	
	<u>Decentralized</u>:
	1 local health unit led by local employee, serving 8% of total state population. For this area:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 76-100% of local health unit budget is provided by the state
	
	*For those few services that are completely locally funded

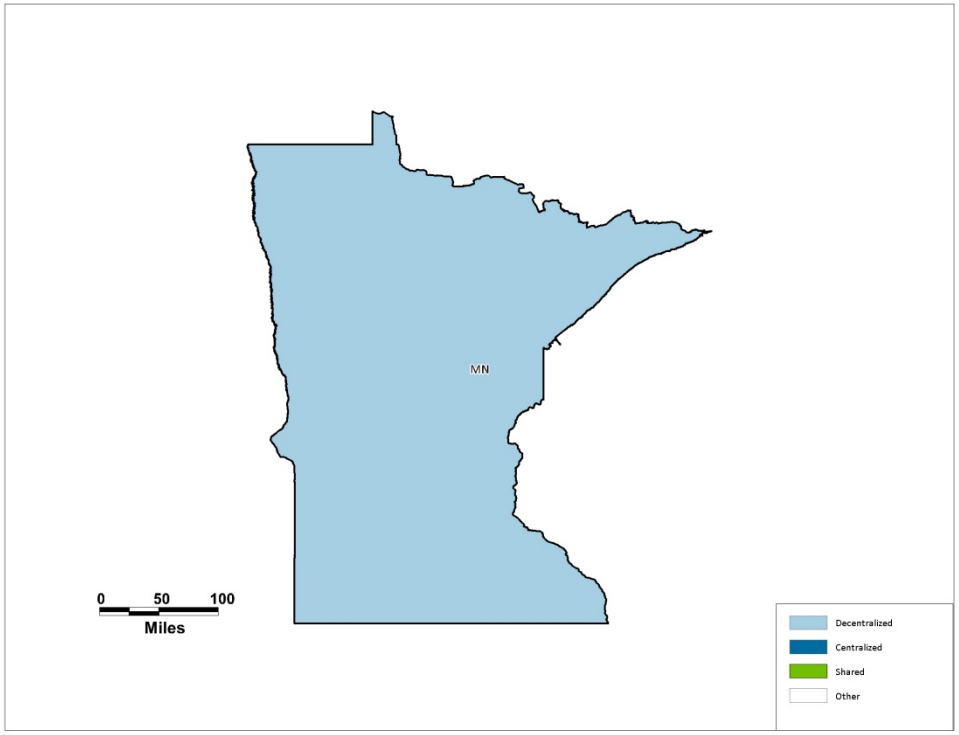
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

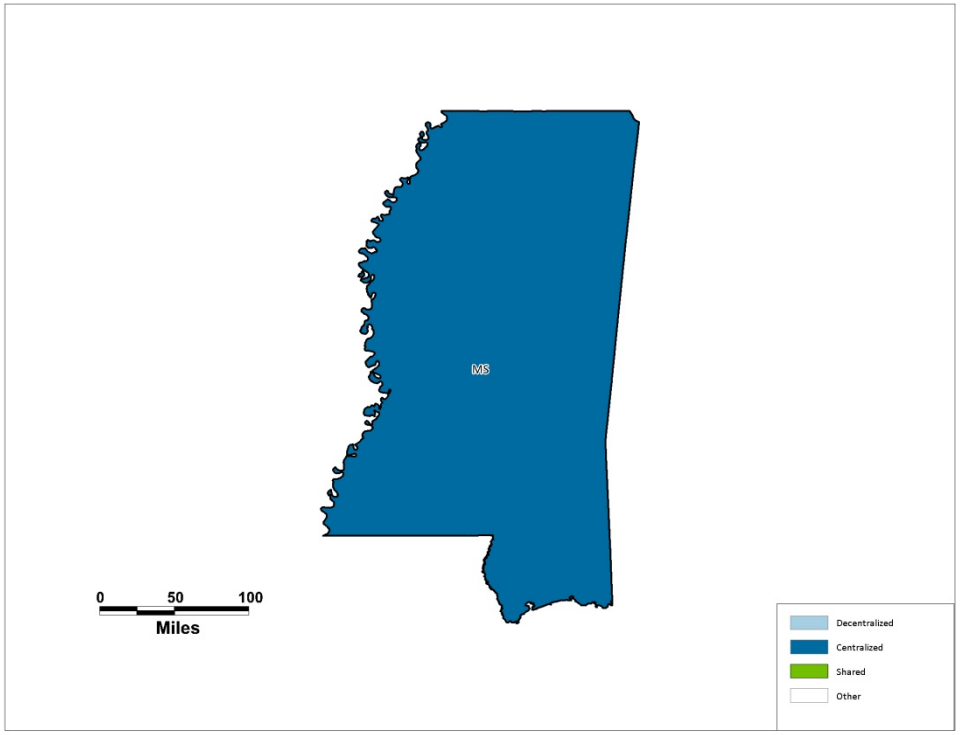
Massachusetts
Decentralized
 
 	
	<u>Decentralized</u>:
	351 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0-25% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

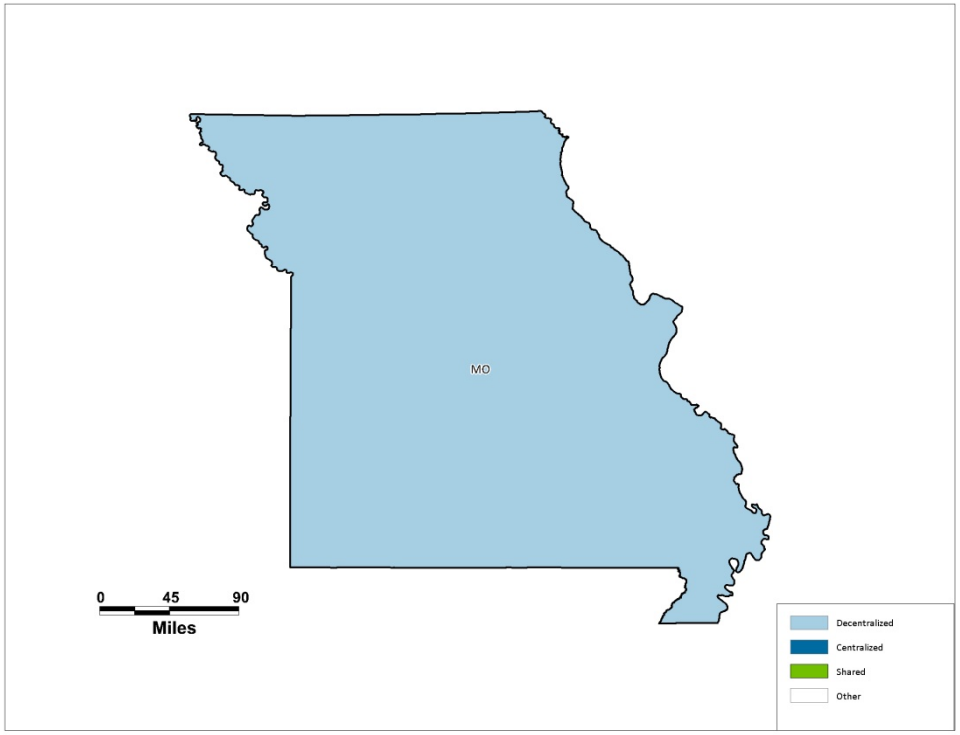
Michigan
Decentralized
 
 	
	<u>Decentralized</u> :
	45 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed by local officials but approved by the state
	• 26-50% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

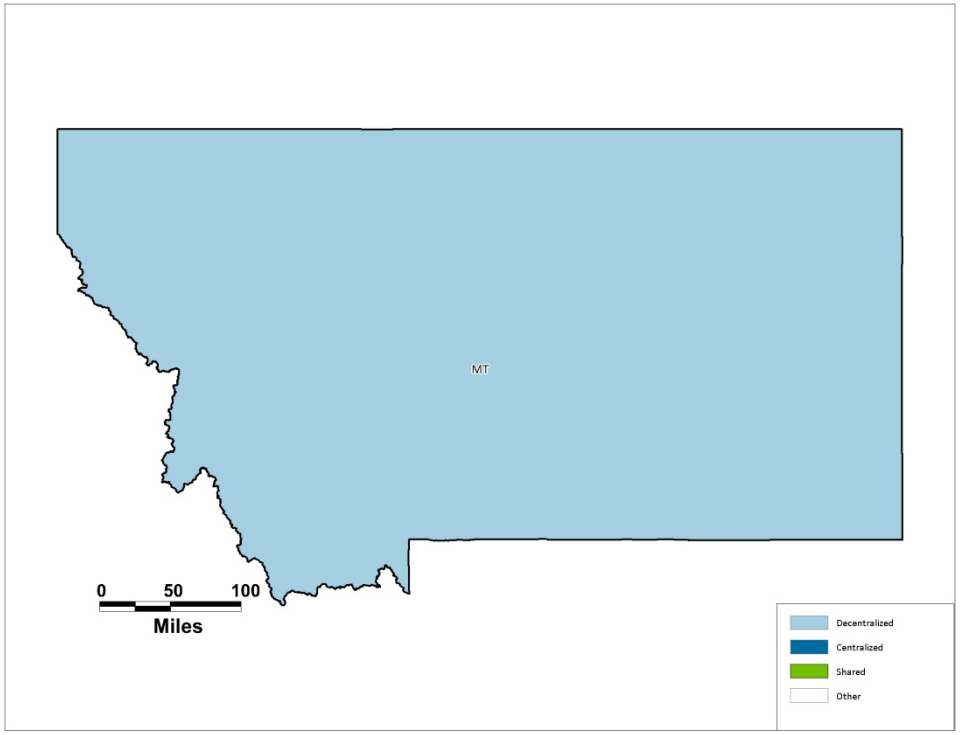
Minnesota
Decentralized
 
 	
s
	<u>Decentralized</u>:
	51 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 26-50% of local health unit budget is provided by the state
	
	The number of local health units fluctuates frequently, as local health units close or combine when they do not cover a certain population threshold. In addition to these local health units, there are 8 district offices in the state.

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies
Mississippi ***Centralized***  	**<u>Centralized</u>:** 81 local health units led by state employee, serving 100% of total state population. For these areas: • Budgetary authority rests with state government, but local government plays a nonbinding advisory role • Local governmental entities may: • Issue public health orders • Top executive is appointed by local officials but approved by the state • 76-100% of local health unit budget is provided by the state

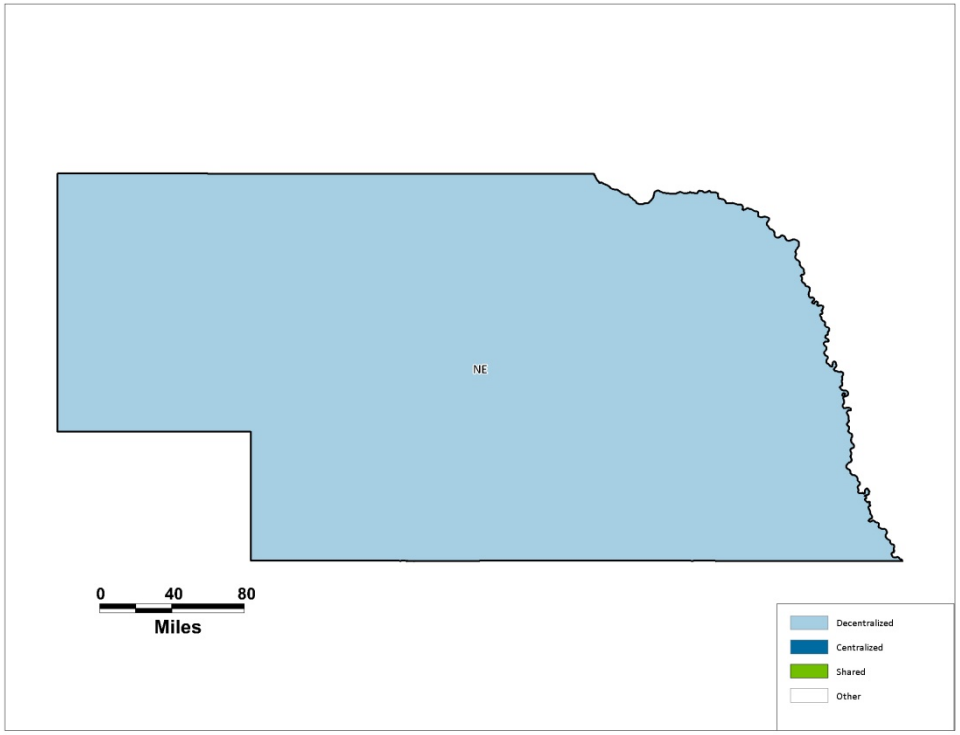
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Missouri
Decentralized
 
 	
	<u>Decentralized</u>:
	115 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0-25% of local health unit budget is provided by the state

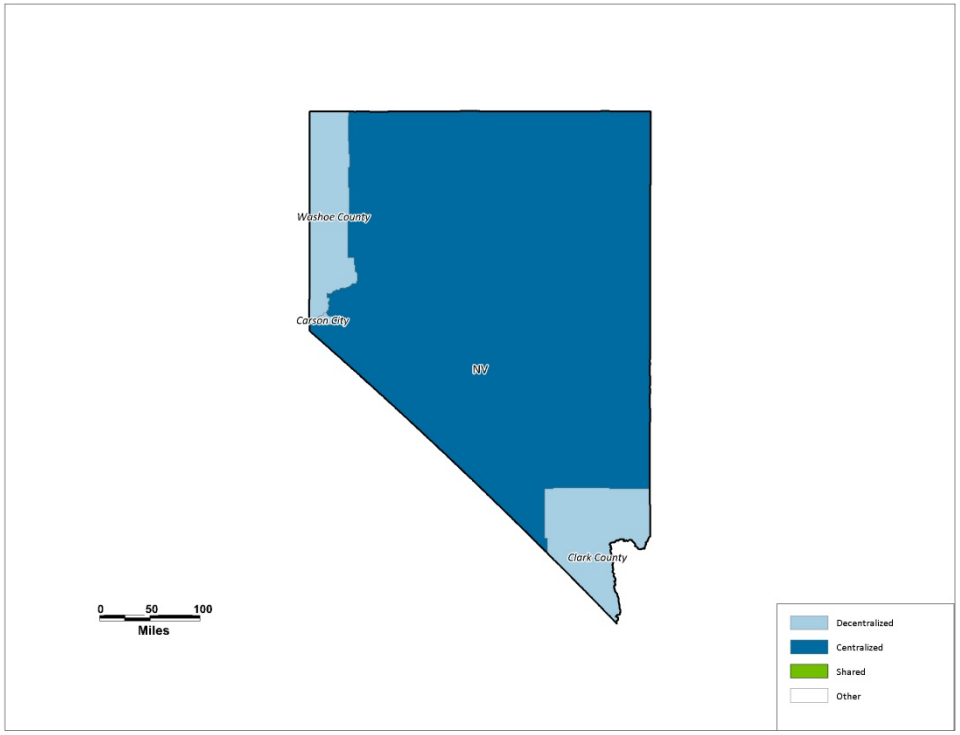
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Montana
Decentralized
 
 	
	<u>Decentralized</u>:
	50 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed by local officials but approved by the state
	• 51-75% of local health unit budget is provided by the state

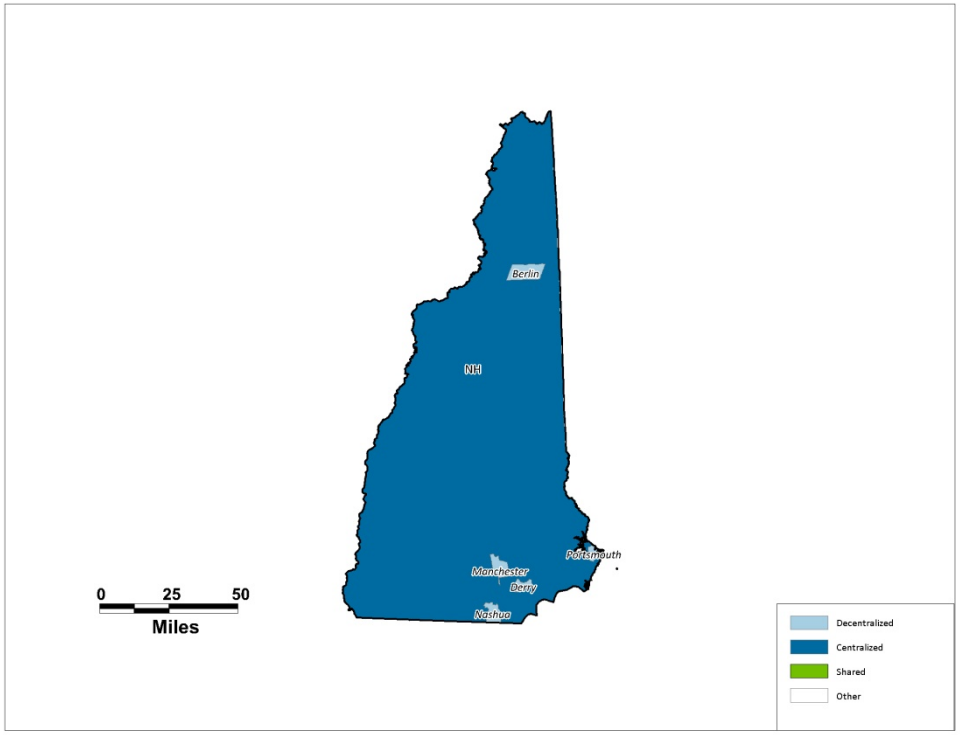
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Nebraska
Decentralized
 
 	
	<u>Decentralized</u>:
	21 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed by local officials but approved by the state
	• 51-75% of local health unit budget is provided by the state

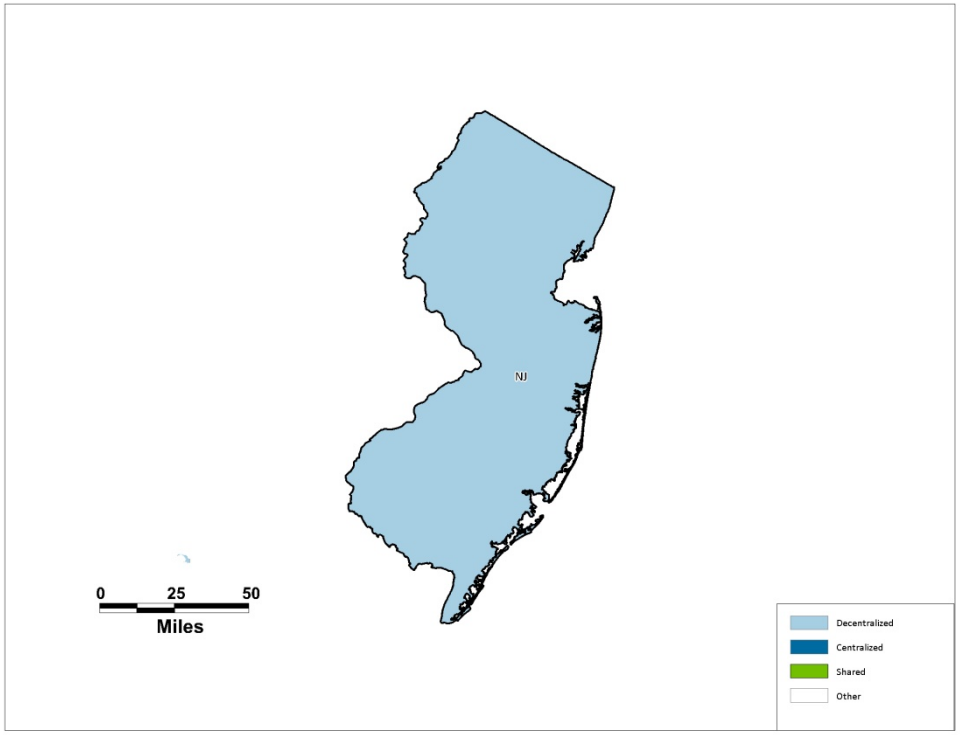
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

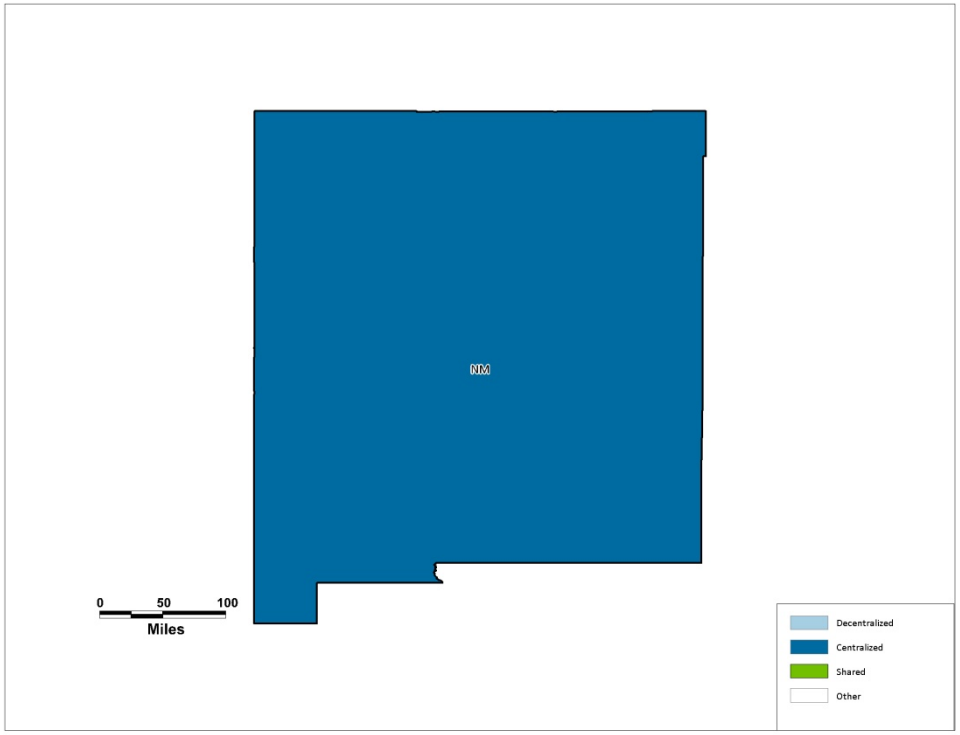
Nevada
Largely Decentralized
 
 	
	<u>Decentralized</u>:
	3 local health units led by local employee, serving 84% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input.
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 51-75% of local health unit budget is provided by the state
	
	<u>Centralized</u>:
	1 local health unit led by state employee, serving 16% of total state population. For these areas:
	• Budgetary authority rests with state government with some local input
	• Local governmental entities may*:
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from fees goes to state government**
	• Top executive is appointed and approved by the state
	• 76-100% of local health unit budget is provided by the state
	
	*If the state serves as their health authority, local health units typically do not establish separate local fees. The state provides guidance for health issues ordered by the locally appointed health officer.
	** Revenue is generated through the taxing authority and comes to the state through an agreement or billing arrangement.

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

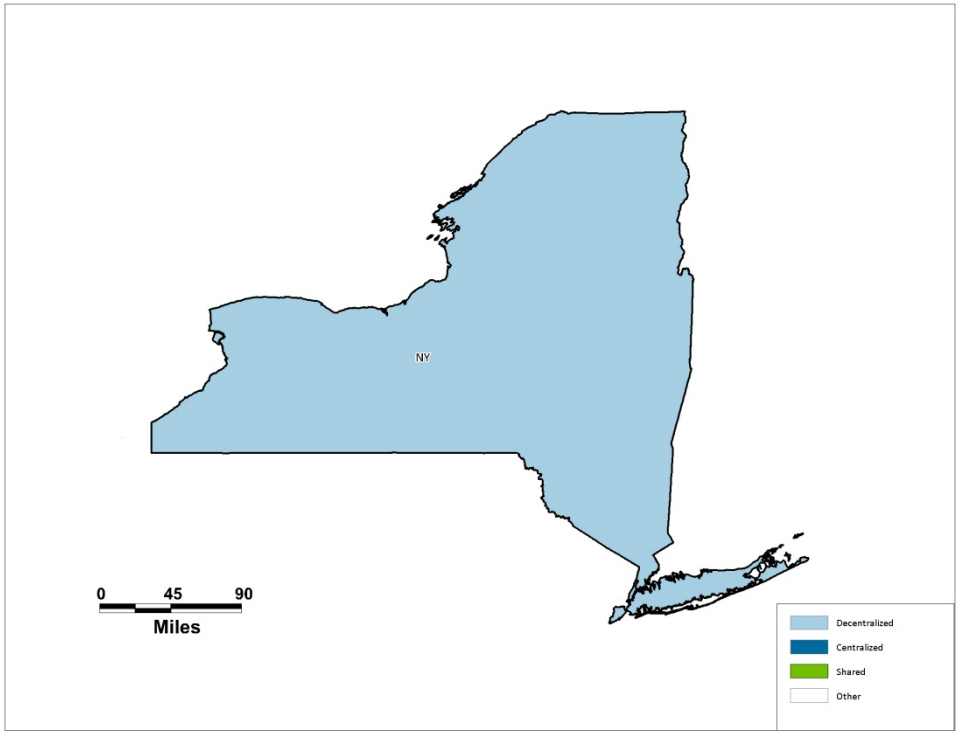
New Hampshire
Largely Centralized
 
 	
	<u>Centralized</u>:
	80% of the population is not served by local health units. For this population, the state is responsible for contracting or directly providing public health services.
	
	<u>Decentralized</u>:
	5 local health units led by local employee, serving 20% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 26-50% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

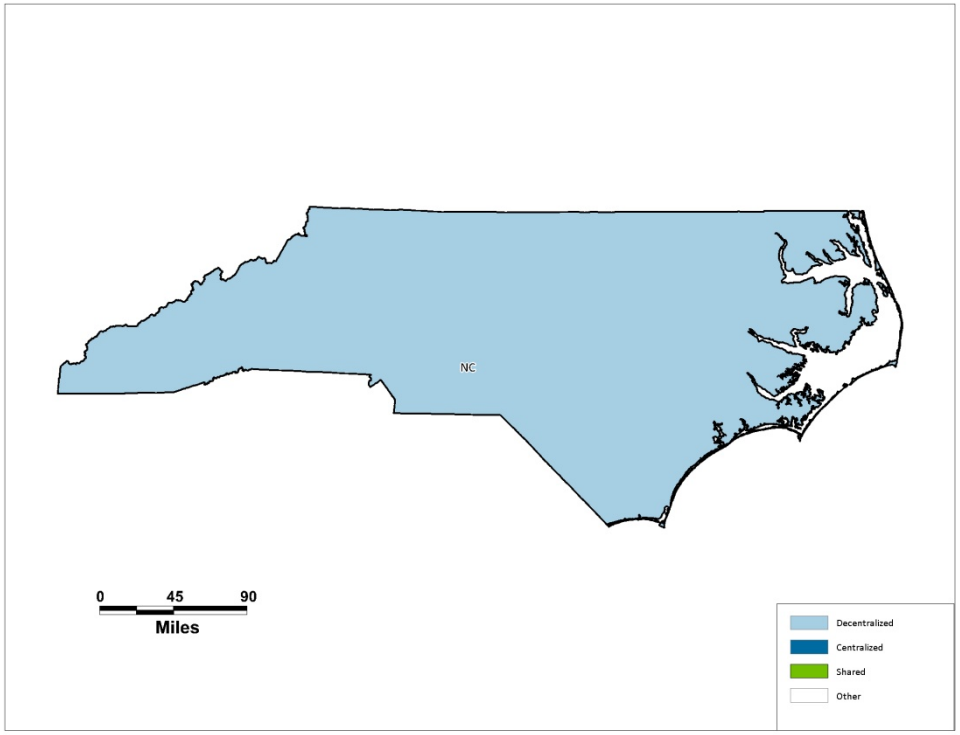
New Jersey
Decentralized
 
 	
	<u>Decentralized</u>:
	100 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0-25% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies
New Mexico ***Centralized***  	**<u>Centralized</u>:** 4 regional health units led by state employee, serving 100% of total state population. For these areas: • Budgetary authority rests with state government, but local government plays a nonbinding advisory role • Top executive is appointed and approved by the state • 76-100% of local health unit budget is provided by the state In addition, there are 55 county health offices led by state employees, and the city of Albuquerque has an Environmental Health Department.

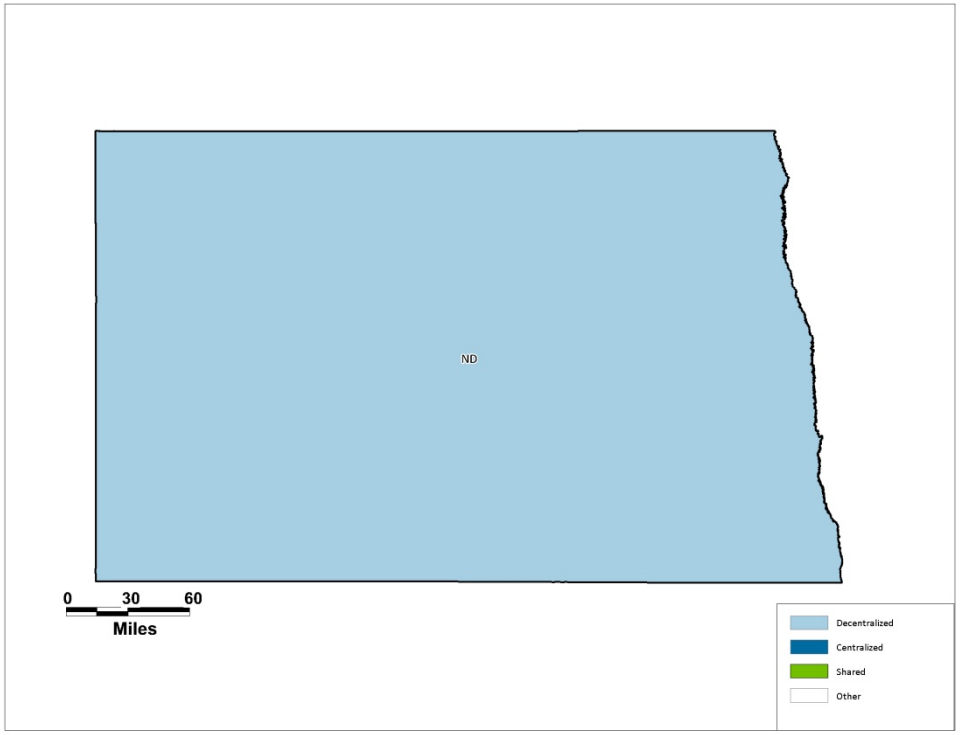
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

New York
Decentralized
 
 	
	<u>Decentralized</u>:
	58 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government, but state government plays a nonbinding advisory role
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed by local officials but approved by the state
	• 26-50% of local health unit budget is provided by the state

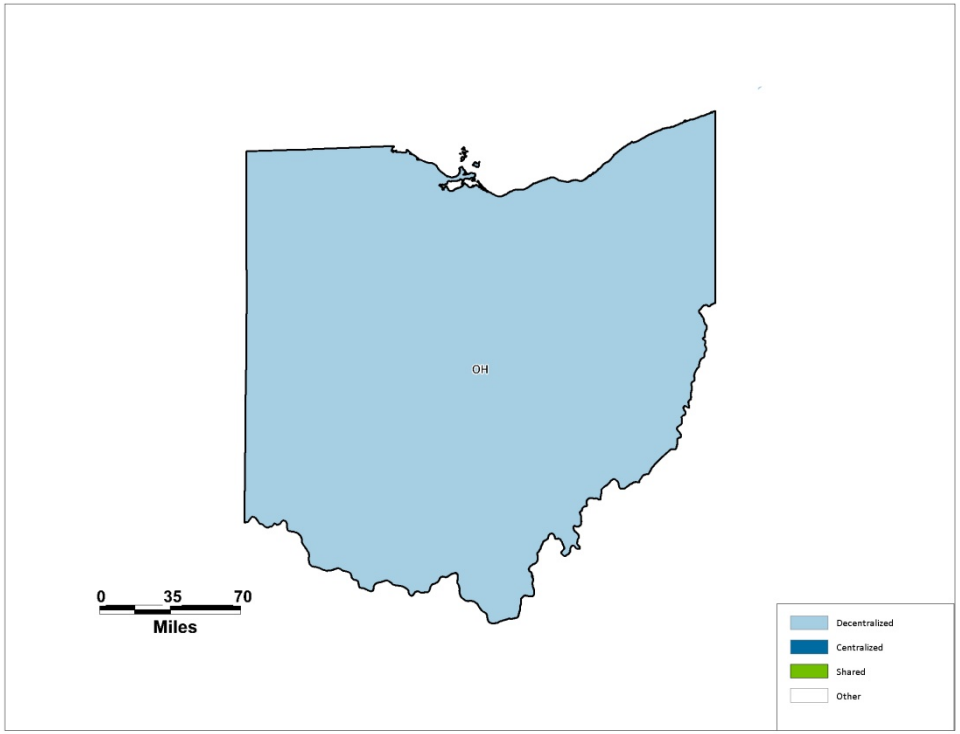
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

North Carolina
Decentralized
 
 	
	<u>Decentralized</u>:
	85 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0-25% of local health unit budget is provided by the state

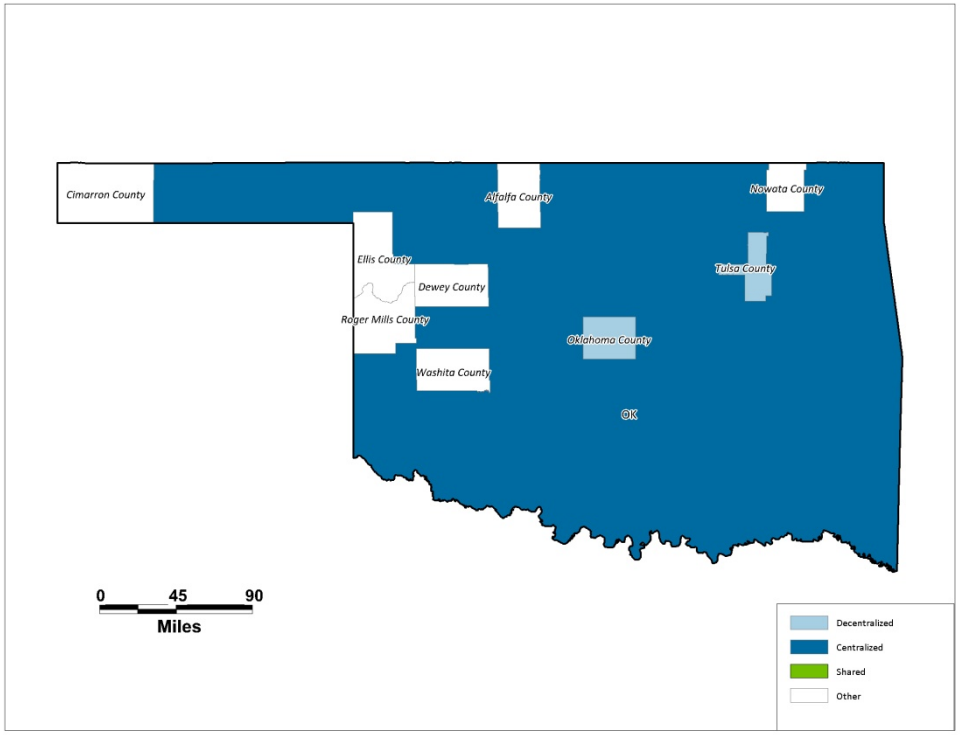
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

North Dakota
Decentralized
 
 	
	<u>Decentralized</u>:
	28 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 26-50% of local health unit budget is provided by the state

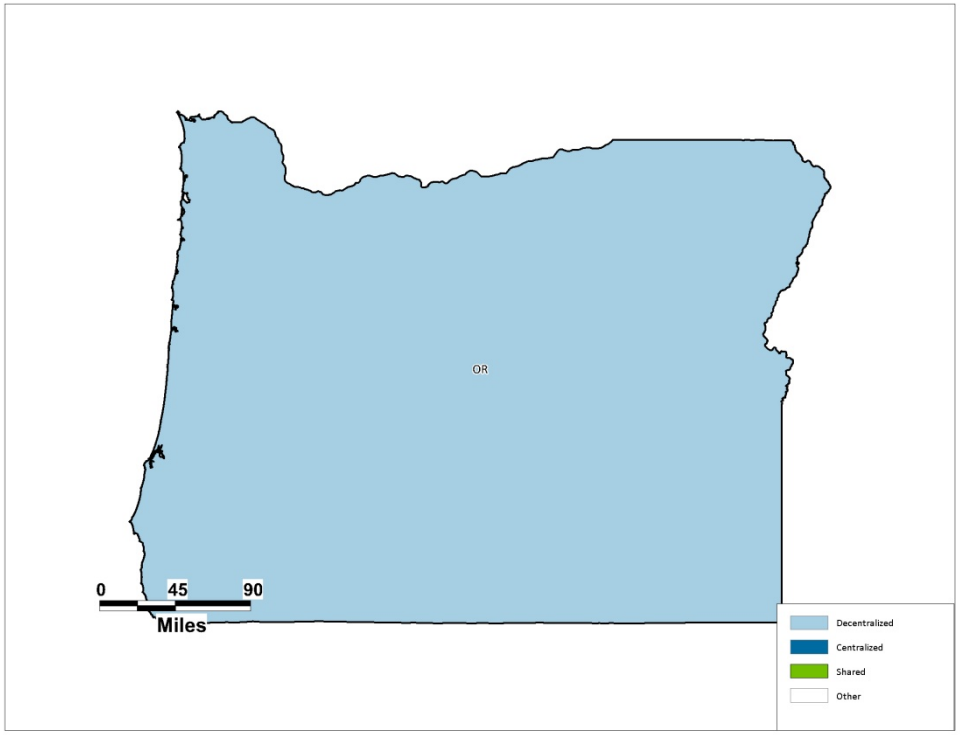
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Ohio
Decentralized
 
 	
	<u>Decentralized</u>:
	125 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Issue public health orders
	• Revenue from taxes goes to both state and local government
	• Top executive is appointed by local officials but approved by the state
	• 0-25% of local health unit budget is provided by the state

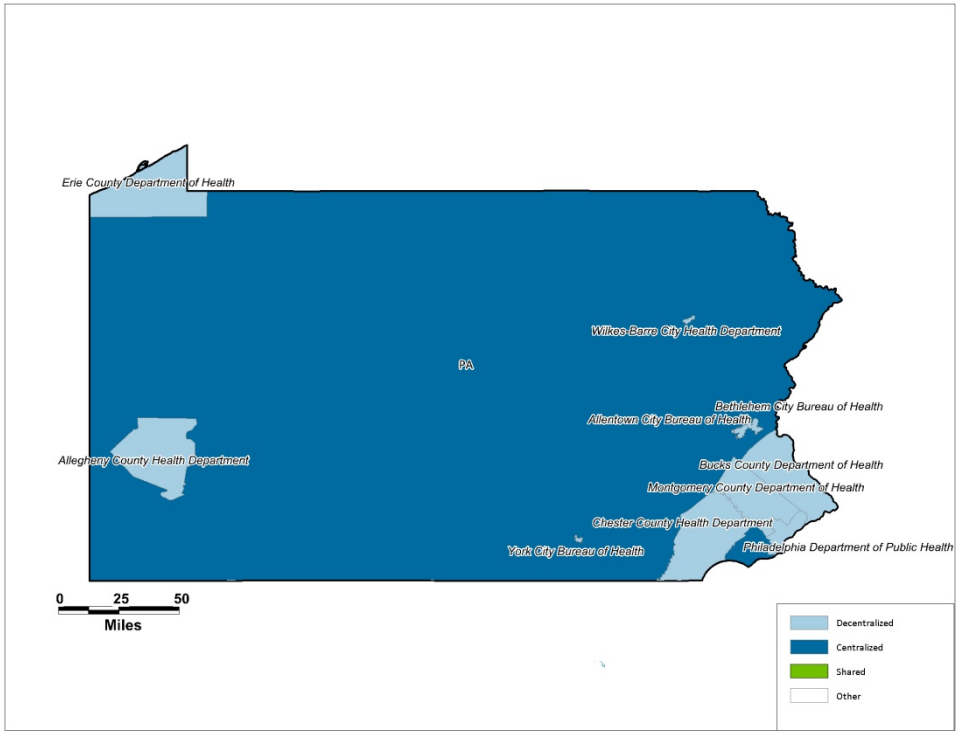
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

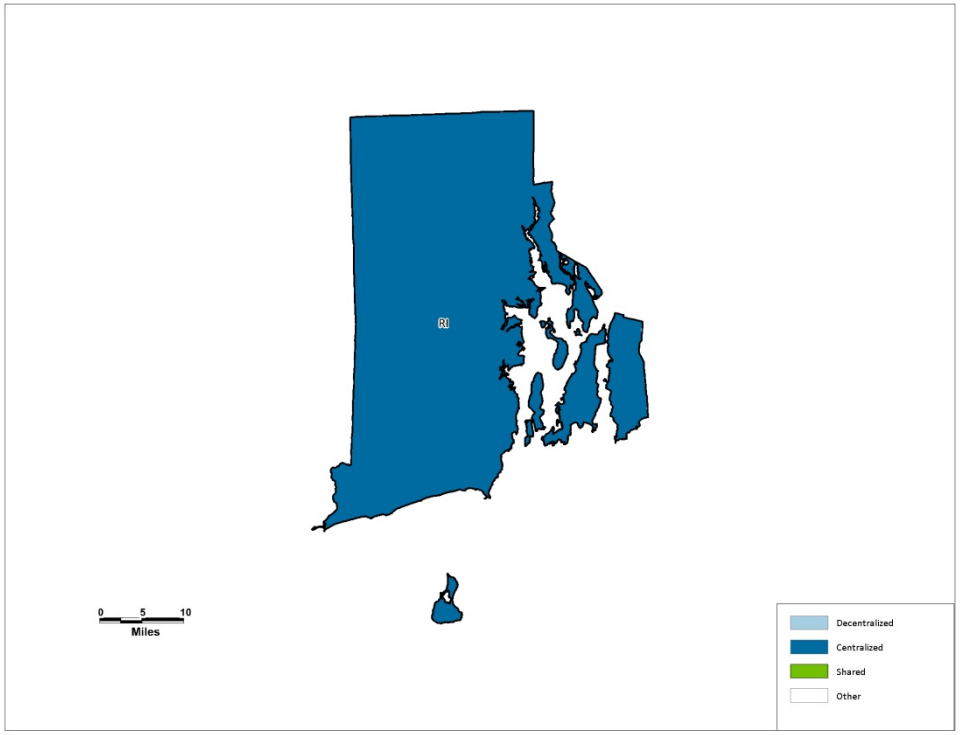
Oklahoma
Mixed – Centralized & Decentralized
 
 	
Note: Areas labeled as "other" represent communities in which state public health agency respondents indicated no local public health units. In many of these areas, at least a limited set of services may be provided by the state health department, neighboring local health departments, or other entities.
	<u>Centralized</u>:
	68 local health units led by state employee, serving 63.2% of total state population. For these areas:
	• Budgetary authority rests with state government, but local government plays a nonbinding advisory role*
	• Local governmental entities may:
	  • Establish taxes for public health
	• Revenue from taxes goes to local government
	• Top executive is appointed and approved by the state
	• 51-75% of local health unit budget is provided by the state
	
	<u>Decentralized</u>:
	2 local health units led by local employee, serving 35.6% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 51-75% of local health unit budget is provided by the state
	
	1.2% of the state population is not served by local health units. This population may seek governmental public health services in adjoining counties provided by county health departments and/or by state central office.
	
	*The budgetary process is controlled by the state, but the county may have limited oversight for funds that are generated through millage or taxes.

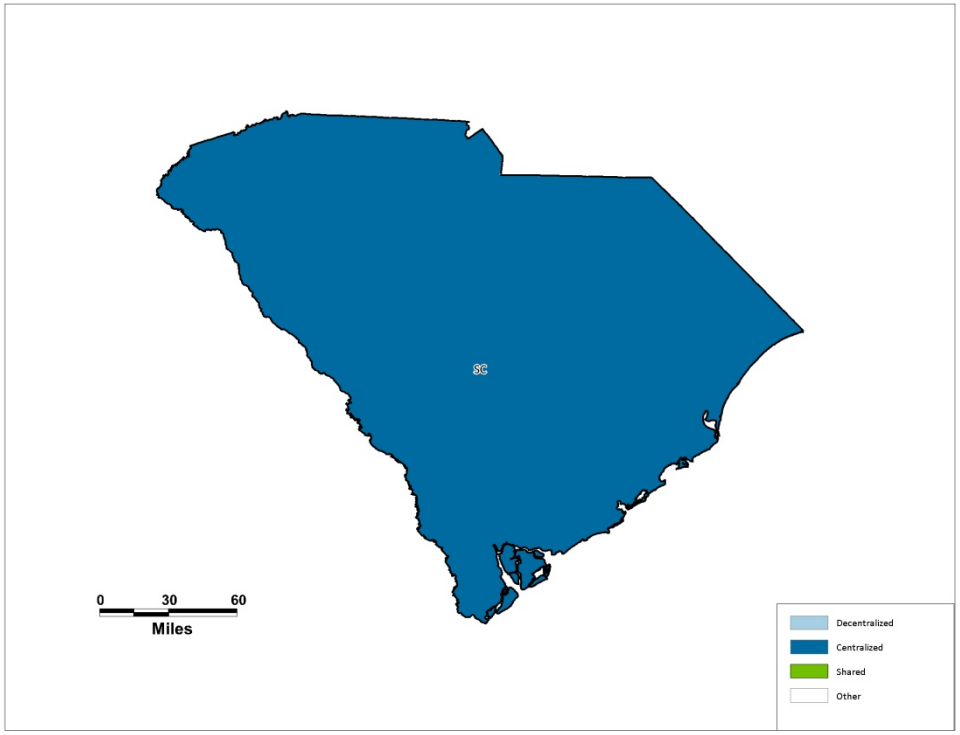
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Oregon
Decentralized
 
 	
	<u>Decentralized</u>:
	34 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to both state and local government
	• Top executive is appointed and approved by local officials
	• 26-50% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Pennsylvania
Mixed – Centralized & Decentralized
 
 	
	<u>Centralized</u>:
	6 local health units led by state employee, serving 60% of total state population. For these areas:
	• Budgetary authority rests with state government, but local government plays a nonbinding advisory role
	• Local governmental entities may:
	  • Issue public health orders
	• Top executive is appointed and approved by the state
	• 51-75% of local health unit budget is provided by the state
	
	<u>Decentralized</u>:
	10 local health units led by local employee, serving 40% of total state population. For these areas:
	• Budgetary authority rests with local government, but state government plays a nonbinding advisory role
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by the state
	• 51-75% of local health unit budget is provided by the state

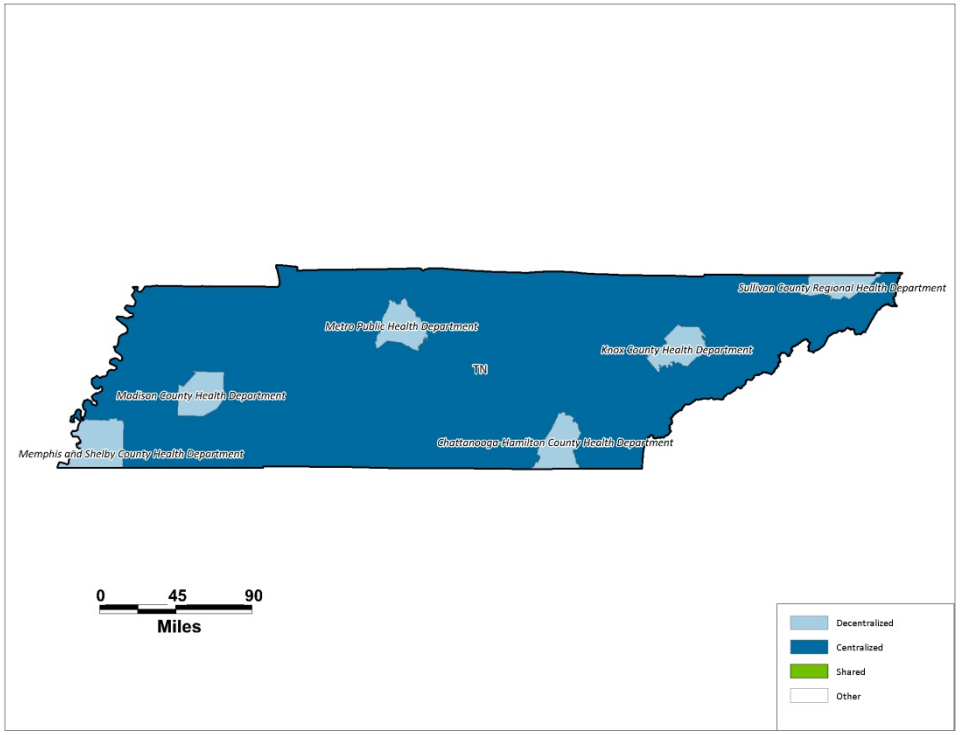
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies
Rhode Island ***Centralized***  	**<u>Centralized</u>:** No local health units are reported for the state.

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies
South Carolina ***Centralized***  	**<u>Centralized</u>:** 8 local health units led by state employee, serving 100% of total state population. For these areas: • Local governmental entities have authority to make budgetary decisions • Local governmental entities may: • Issue public health orders • Top executive is appointed and approved by the state • 76-100% of local health unit budget is provided by the state

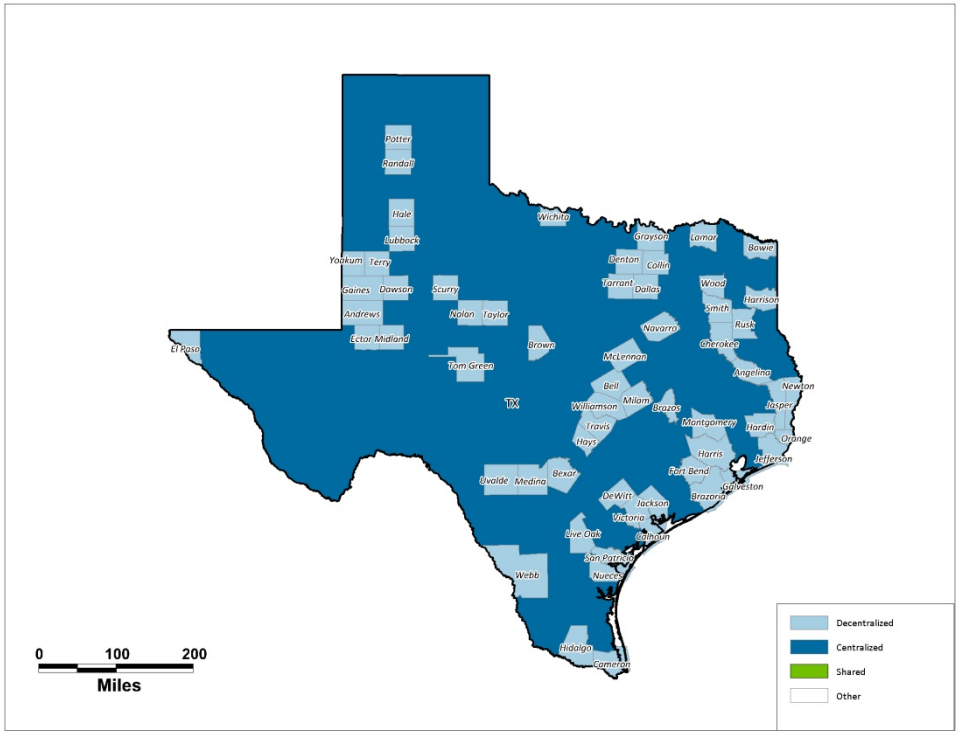
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

South Dakota
Largely Centralized
 	
Note: Areas labeled as "other" represent communities in which state public health agency respondents indicated no local public health units. In many of these areas, at least a limited set of services may be provided by the state health department, neighboring local health departments, or other entities.
	<u>Centralized</u>:
	67 local health units led by state employee, serving approximately 81% of total state population. For these areas:
	• Budgetary authority rests with state government with no local input
	• Local governmental entities may:
	  • Issue public health orders
	
	<u>Decentralized</u>:
	1 local health unit led by local employee, serving approximately 17% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0-25% of local health unit budget is provided by the state
	
	2% of the total state population is not served by local health units. This population represents counties predominantly consisting of Tribal populations, which may receive public health services through IHS.
	
	In addition to the 67 state-led local health units, there are 7 state-run regional units that do not provide direct services.

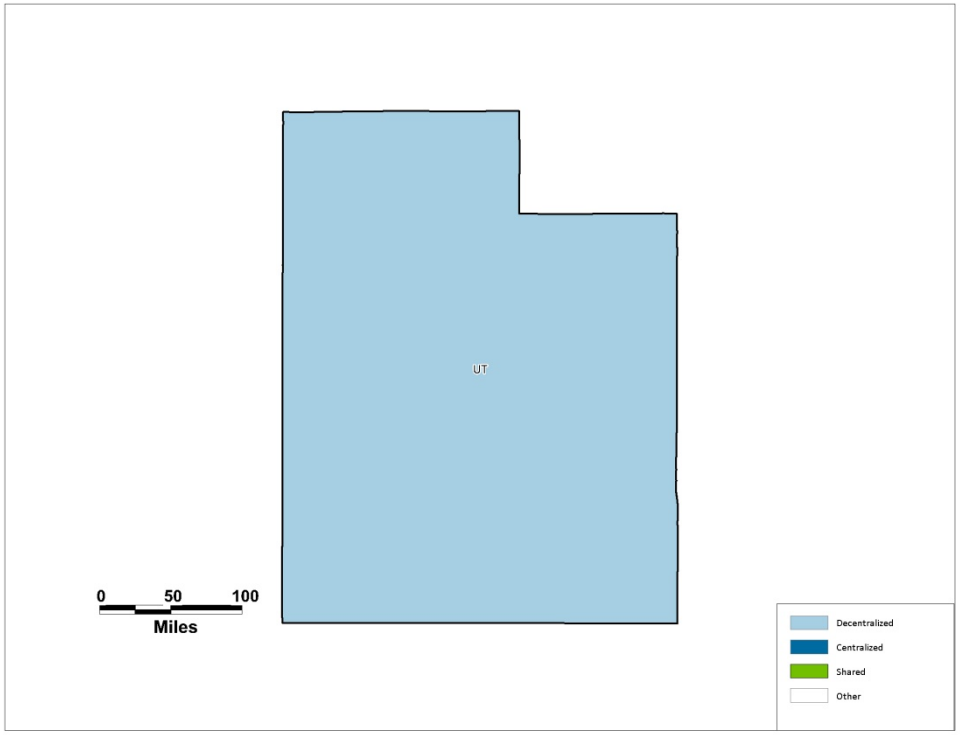
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Tennessee
Mixed – Centralized & Decentralized
 
 	
	<u>Centralized</u>:
	89 local health units led by state employee, serving 71.7% of total state population. For these areas:
	• Budgetary authority varies among health units—some local governments contribute resources to local health units and participate in budgetary decision making regarding those funds
	• Top executive is appointed and approved by the state
	• 76-100% of local health unit budget is provided by the state
	
	<u>Decentralized</u>:
	6 local health units led by local employee, serving 28.3% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials

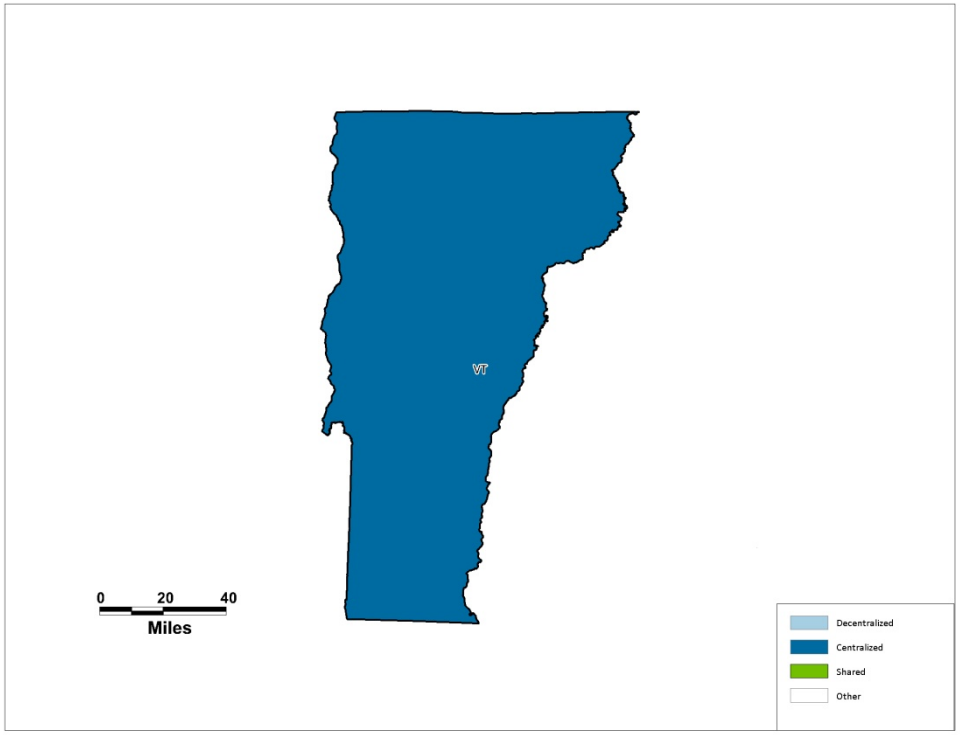
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Texas
Largely Decentralized
 
 	
	<u>Decentralized</u>:
	60 local health units led by local employee, serving 79% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from fees goes to local government
	• Top executive is appointed and approved by local officials
	• 26-50% of local health unit budget is provided by the state
	
	<u>Centralized</u>:
	8 local health units led by state employee, serving 21% of total state population. For these areas:
	• Budgetary authority rests with state government with no local input
	• Local governmental entities may:
	  • Issue public health orders
	• Top executive is appointed and approved by the state
	• 76-100% of local health unit budget is provided by the state

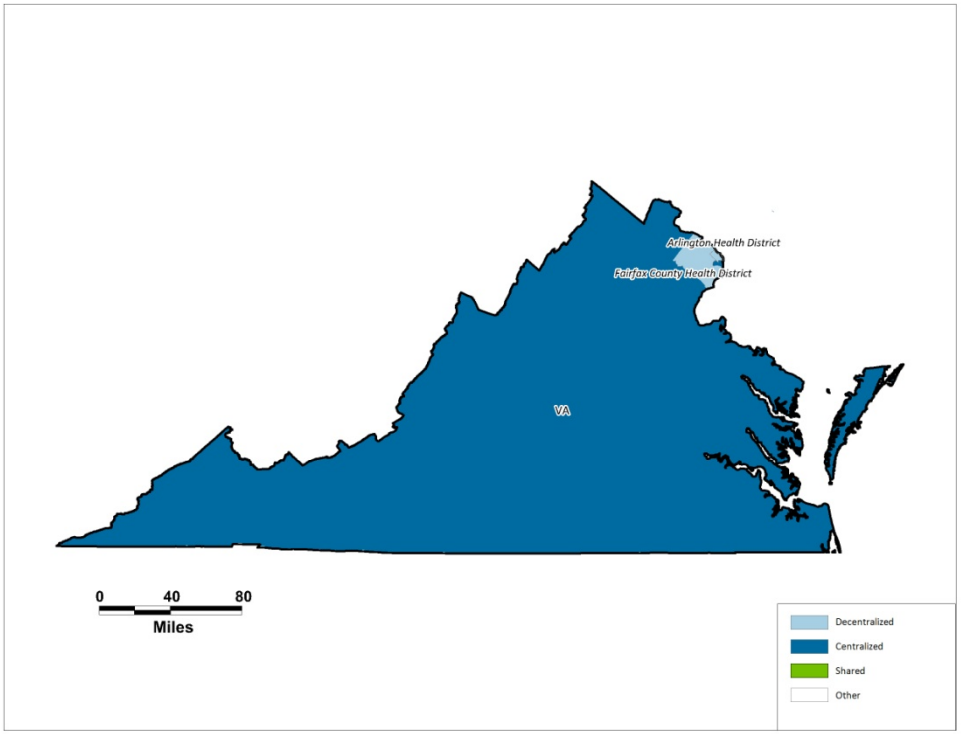
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Utah
Decentralized
 
 	
	<u>Decentralized</u>:
	12 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed by local officials but approved by the state
	• 26-50% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Vermont
Centralized
 
 	
	<u>Centralized</u>:
	12 local health units led by state employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with state government
	• Local governmental entities may:
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from fees goes to local government
	• Top executive is appointed and approved by the state
	• 76-100% of local health unit budget is provided by the state

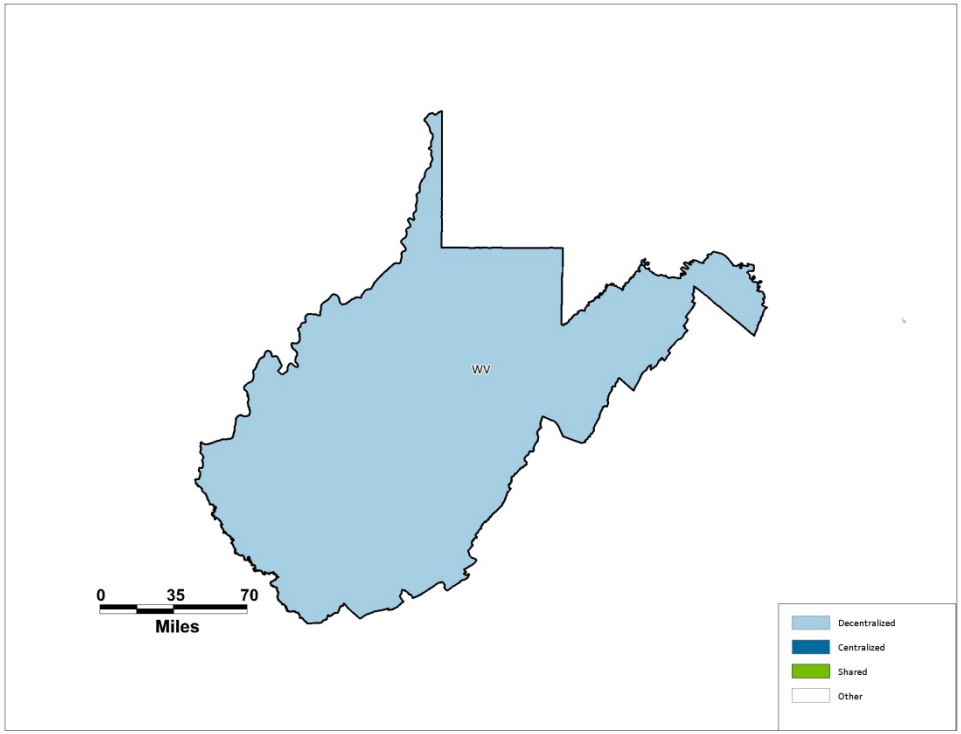
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Virginia
Largely Centralized
 
 	
	<u>Centralized</u>:
	33 local health units led by state employee, serving 84.3% of total state population. For these areas:
	• Localities can allocate additional funds from their general revenue or raise fees on a set list of public health services and then allocate additional funds to services that are local priorities
	• Local governmental entities may:
	  • Establish fees for services without state approval*
	  • Issue public health orders
	• Top executive is appointed and approved by the state
	• 51-75% of local health unit budget is provided by the state
	
	<u>Decentralized</u>:
	2 local health units led by local employee, serving 15.7% of total state population. For these areas:
	• Budgetary authority rests with local government, but state government plays a nonbinding advisory role
	• Local governmental entities may:
	  • Establish fees for services without state approval*
	  • Issue public health orders
	• Top executive is appointed by local officials but approved by the state
	• 26-50% of local health unit budget is provided by the state
	
	* Local fees can be established only within the framework expressly designated by state law.

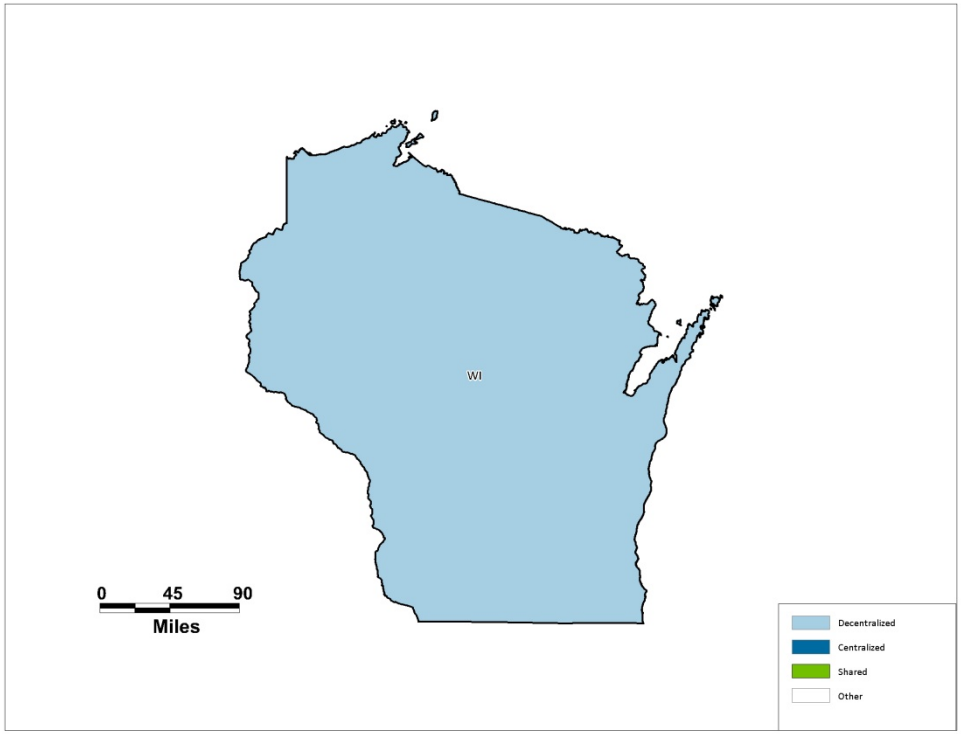
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Washington
Decentralized
 	
	<u>Decentralized</u>:
	35 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0-25% of local health unit budget is provided by the state

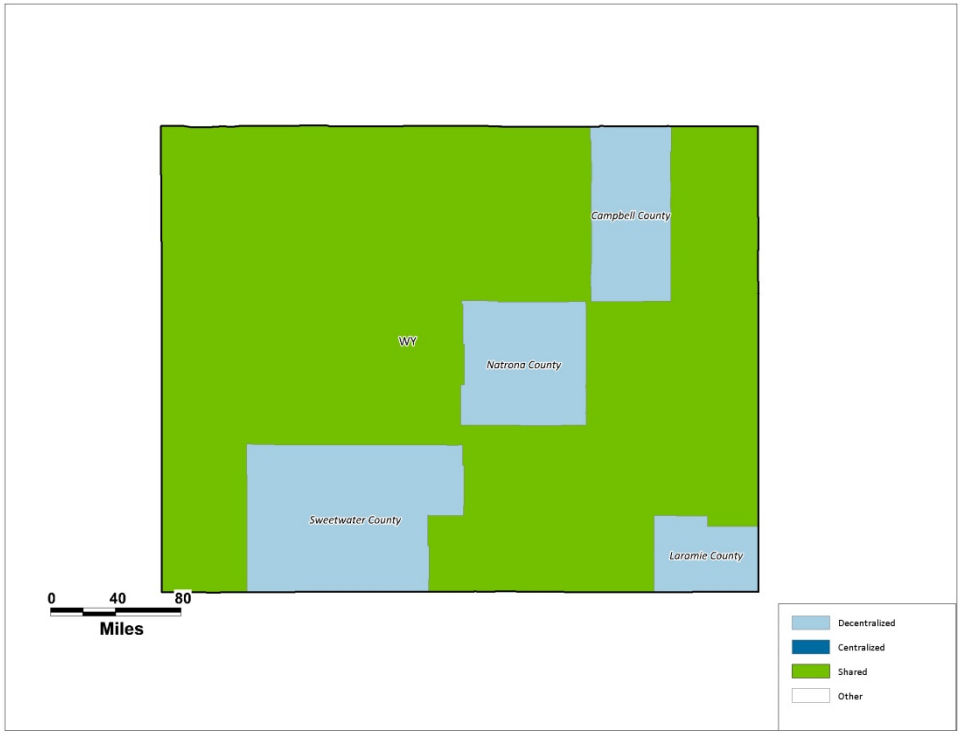
State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

West Virginia
Decentralized
 
 	
	<u>Decentralized</u>:
	49 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Issue public health orders
	• Revenue from taxes goes to local government
	• Top executive is appointed and approved by local officials
	• 51-75% of local health unit budget is provided by the state

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Wisconsin
Decentralized
 
 	
	<u>Decentralized</u>:
	92 local health units led by local employee, serving 100% of total state population. For these areas:
	• Budgetary authority rests with local government with no state input
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 26-50% of local health unit budget is provided by the state
	
	In addition to the 92 local health units covering the entire population, there are 5 regional offices staffed by state health employees.

State Name and *Categorization*	Details About the Relationship Between State and Local Public Health Agencies

Wyoming
Mixed – Shared (State Led) & Decentralized
 
 	
	<u>Shared (State Led)</u>:
	19 local health units led by state employee, serving 55% of total state population. For these areas:
	• Budgetary decisions are jointly made between state and county officials, per a state-county contract
	  • Local budgets are a mix of state and local funds (and mix of state and local employees)
	• Local governmental entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed by the state but approved by local officials.
	• 26-50% of local health unit budget is provided by the state
	
	<u>Decentralized</u>:
	4 local health units led by local employee, serving 45% of total state population. For these areas:
	• Budgetary authority varies among health units.
	  • 1 local health unit is 100% county funded; 2 local health units share budget responsibilities between state and county employees
	• Local government entities may:
	  • Establish taxes for public health
	  • Establish fees for services without state approval
	  • Issue public health orders
	• Revenue from taxes/fees goes to local government
	• Top executive is appointed and approved by local officials
	• 0 - 25% of local health unit budget is provided by the state

Appendix D: Suggested Modifications to Survey Questions

Below, we present the survey instrument used in this study, with several recommended revisions. Language we recommend adding is underlined and language we recommend deleting is ~~crossed out~~.

Introductory Table

The following definitions will be helpful in completing the introductory table:

Local health unit – A local health unit is an administrative or service unit of local or state government concerned with health, and carrying some responsibility for the health of a jurisdiction smaller than the state. (*This includes local public health departments, regional public health departments, and regional and local units of state public health agencies.* ***Please do not consider tribal health agencies when responding.*** *We understand that tribal health agencies make an important contribution to protecting the public health in many states; however, because tribal nations have sovereignty, their relationship with state public health agencies may differ from the relationship between states and local health units.)*

State Employee – An individual is a state employee if that individual's salary is paid directly by the state government.

Local Employee – An individual is a local employee if that individual's salary is paid by a city, county, or other sub-state jurisdiction.

Led by – An organization is led by the employee at the organization with the most seniority.

Are there any regional or district offices of the state public health agency in your state?

- o No
- o Yes

If there are regional or district offices of the state public health agency, do they serve populations that are also served by other local health units?

- o No, there are no regional or district offices.
- o No, the regional or district offices only serve populations that are also served by local health units that cover a smaller jurisdiction (e.g., city or county).
- o Yes

Please provide your best estimates to complete the following table. You will be asked about two different types of local health units—those led by a state employee and those led by a local employee. For each type of health unit, please indicate in the first column the number of such units in your state. In the second column, please indicate the percentage of the TOTAL state population that lives in an area served by that type of health unit. If you answered "yes" to both of the questions above, please consider those regional or district health offices as local health units. If you answered "no" to one or both of the questions above, please disregard those regional or district offices as you complete the questions below.

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	Number of this type of local health unit	% of TOTAL state population served by this type of local health unit*
Local health unit led by a STATE employee		
Local health unit led by a LOCAL employee		

What percent of the state's population lives in areas that are not served by a local health unit?	
	% of TOTAL state population not served by a ~~this type of~~ local health unit*
State population not served by a local health unit	

Please note: The three percentages in the columns marked with an * in the above questions should add up to 100 percent.

If you indicated that at least some of the residents of your state live in areas not served by a local health unit, please answer the following question:

Are local governmental public health services provided in those areas? (Select all that apply.)

- o Yes, services are provided on military bases.
- o Yes, services are provided by the Indian Health Service.
- o Yes, services are provided by another entity. (Please describe who provides those services in the space provided.)
- o None of the above—there are no local governmental public health services.

Areas Served by Health Units Led by a State Employee

When you respond to questions in this section, please think ONLY about areas served by health units led by a STATE employee. If there are no health units led by a state employee in your state, please skip this section.

How would you describe local involvement with budgetary decisions related to local health units that are led by a state employee? (Please select ONLY ONE response.)

- o Local governmental entities (e.g., local health departments, local elected officials, or Boards of Health) have the authority to make budgetary decisions about allocating resources for programs within the local health unit.
- o All authority to make budget decisions is held at the state level with no local input.
- o All authority for budget decisions is held at the state level, but local governmental entities play a nonbinding advisory role related to setting the budget for local health units.
- o Varies by health unit among health units that are led by a state employee. (Please provide additional details in the space provided.)
- o None of the above applies to local health units that are led by a state employee. (Please provide additional details in the space provided.)

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Do any local governmental entities (e.g., local health departments, local elected officials, or Boards of Health) have the ability to do any of the following? (Select all that apply.)

- o Establish taxes for public health
- o Establish fees for services without getting approval from a governmental entity led by a state employee
- o Issue public health orders (e.g., close a food-service establishment)
- o None of the above

Where does the revenue generated from those taxes or fees go? (Select ONLY ONE response.)

- o To local government
- o To state government
- o Some revenue goes to state government and some to local government

Which of these statements most accurately reflects how the top executive in the local health unit is appointed and approved? (Select ONLY ONE response.)

- o Local chief executives are appointed and approved by the state public health agency (SPHA) or other state entities.
- o Local chief executives are appointed by the SPHA or other state entities but are approved by local officials.
- o Local chief executives are appointed by local officials but are approved by the SPHA or other state entities.
- o Local chief executives are appointed and approved by local officials.
- o It varies.

On average, what proportion of local health unit budgets is provided by the state public health agency (including federal flow-through)? Your best estimate is fine. (Select ONLY ONE response.)

- o 0-25%
- o 26-50%
- o 51-75%
- o 76-100%
- o Don’t know

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Areas Served by Health Units Led by a Local Employee

When you respond to questions in this section, please think ONLY about areas served by health units led by a LOCAL employee. If there are no health units led by a local employee in your state, please skip this section.

How would you describe state involvement with budgetary decisions related to local health units that are led by a local employee? (Select ONLY ONE response.)

- o State authority is required to allocate resources for programs within the local health unit.
- o Aside from requirements ~~to report on~~ associated with the use of state-provided funds, local governmental entities (e.g., local health departments, local elected officials, or Boards of Health) retain decision making capacity about the budget for local health units, with no state input.
- o All authority for budget decisions is held at the local level, but there is a nonbinding advisory role at the state level.
- o Varies by health unit among health units that are led by a local employee. (Please provide additional details in the space provided.)
- o None of the above applies to local health units that are led by a local employee. (Please provide additional details in the space provided.)

Do any local governmental entities (e.g., local health departments, local elected officials, or Boards of Health) have the ability to do any of the following? (Select all that apply.)

- o Establish taxes for public health
- o Establish fees for services without getting approval from a governmental entity led by a state employee
- o Issue public health orders (e.g., close a food-service establishment)
- o None of the above

Where does the revenue generated from those taxes or fees go? (Select ONLY ONE response.)

- o To local government
- o To state government
- o Some revenue goes to state government and some to local government

Which of these statements most accurately reflects how the top executive in the local health unit is appointed and approved? (Select ONLY ONE response.)

- o Local chief executives are appointed and approved by the state public health agency (SPHA) or other state entities.
- o Local chief executives are appointed by the SPHA or other state entities but are approved by local officials.
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- o Local chief executives are appointed and approved by local officials.
- o It varies.

On average, what proportion of local health unit budgets is provided by the state public health agency (including federal flow-through)? Your best estimate is fine. (Select ONLY ONE response.)

- o 0-25%
- o 26-50%
- o 51-75%
- o 76-100%
- o Don't know

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