IOWA COUNTY BOARDS OF HEALTH
MEMBERS' ORIENTATION, TRAINING, FUNCTIONS AND
DEMOGRAPHIC CHARACTERISTICS

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Drake University

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of the Requirements for the Degree
Master of Science in Nursing

by
Martha Franc
August, 1991
IOWA COUNTY BOARDS OF HEALTH
MEMBER'S ORIENTATION, TRAINING, FUNCTIONS,
AND DEMOGRAPHIC CHARACTERISTICS

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MEMBERS' ORIENTATION, TRAINING, FUNCTIONS AND

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An Abstract of a Thesis by
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August, 1991
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The problem. Boards of Health and public health nurses face increased demands for service and shrinking resources. Little is known about Board of Health member characteristics and functions.

Procedure. A questionnaire developed by the researcher was mailed to a randomly selected sample of 100 Iowa County Board of Health members. The questionnaire was designed to elicit information about how board members were oriented and trained, their perceptions of board functions, and selected demographic characteristics.

Findings. A majority of respondents were male, over 50 years old, and had served on the board from one to six years. Only a fourth had received initial orientation. The most highly rated functions were assessing community health needs and the appointment of a qualified administrator. Low ranked functions included exercising political influence, appointment of advisory committee members, and improving agency image.

Conclusions. Board members demonstrated interest in the topic by their high response rate. Boards may need to place more emphasis on linking nursing agencies to elements of their environment.

Recommendations. More research is needed to identify the outcomes of board activities, to assess members' training needs, to identify nurse administrator and board perceptions of each others roles, and to explore the potential use of advisory committees in completing board duties.
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Chapter I

INTRODUCTION

The health care industry of the United States is enduring a period of intense scrutiny. The self examination of providers within the system is spurred by calls for reform from users, purchasers, and regulators of service. On national and state levels, debate centers on how to improve quality, increase access, control costs, and grapple with ethical issues. City and county level governments deal with many of the same problems while also being called upon to provide and fund increasing amounts of health services. In Iowa counties, Boards of Health are appointed to oversee health matters for their residents, which may include environmental and sanitation services, school health, animal control, counseling services, home care and public health nursing services. The literature provides little information about characteristics of Board of Health members and their activities.

Background

Levy and Loomba (1984) consider health care to be conveyed through two primary sources - personal health services and public health services. Personal health services have generally been developed in the private
sector to diagnose and treat illness and concentrate on the individual. These services are often provided by physicians and acute care facilities, with their many ancillary components. Public health in contrast developed under government auspices with family, groups, and communities as its focus. As quoted in Pickett and Hanlon (1990), Winslow's definition of public health is still pertinent and applicable:

Public Health is the Science and Art of (1) preventing disease, (2) prolonging life, and (3) promoting health and efficiency through organized community effort for:
(a) the sanitation of the environment,
(b) the control of communicable infections,
(c) the education of the individual in personal hygiene,
(d) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and
(e) the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health,
so organizing these benefits as to enable every citizen to realize his birthright of health and longevity (p. 4).
Thus the public sector maintains a broad focus on the health needs of the whole community and on working to see that those needs are met. Sometimes the public sector provides the needed services directly, and at other times it helps to organize the overall public, private, and voluntary health care system.

In *The Future of Public Health* (1988) the Institute of Medicine reported a study carried out by a multidisciplinary team over a two year period. The publication noted barriers to effective action in the current public health system. These included, (a) a lack of consensus on the mission and content of public health, (b) inability to identify the essential functions of public health agencies, (c) a complex set of organizational and jurisdictional relationships limiting decisive planning and action, and (d) deficits in the capacity to conduct public health programs. In other words, the role of public health services in an overall troubled health system is not clear and the resources necessary to plan and conduct community health programs are not consistently available.

Conspicuously absent from the Institute of Medicine's 1988 report on public health was any discussion of public health nursing agencies as providers and leaders in the public health movement.
One of the ways in which local governments have provided health services has been through public health nursing agencies. These agencies have traditionally worked to identify community health needs and to develop resources to meet those needs, with involvement of all community sectors in decision-making (Cherry, 1988; Muller and Ventriss, 1985). Today public health nurses continue to plan programs to reduce the risk of disease and promote positive health behaviors in the community. They also provide skilled nursing services for reimbursement to individuals who are sick or recuperating in their homes. In recent years, the acuity and technological needs of home care patients have increased dramatically. The governing boards of public health nursing agencies have become dependent on dollars generated from the care of these sick patients and often neglect the community-based public health programs that do not pay for themselves. Private home care agencies have proliferated with the advent of insurance payment for home care, decreasing referral of private pay patients to public health agencies. Thus public health nursing administrators and their governing bodies face many of the same crises that plague health policy-makers at other levels of government as they struggle to define a coherent system
that is increasingly dependent on scarce resources.

Governing boards foster an organization through a variety of activities. Local Boards of Health govern public health nursing agencies and perform other mandated functions. Little is known about the members of Boards of Health and how they perform board duties. A better understanding of board members' perceptions of their roles and training needs will assist nurse administrators to work more effectively with their boards. This study focused on county Boards of Health in Iowa as decision makers and providers of essential community health services.

Purpose

The purpose of this study was to survey Iowa local Board of Health members about their preparation for board duties, about factors that may be helpful for board membership, about how boards could be more successful, and to determine whether certain demographic characteristics influence how board members rank their various functions.
Chapter II
LITERATURE REVIEW

The review of literature first describes the conceptual orientation of the study, then defines the terms "governing board" and "Board of Health." Expert opinions of board functions and studies relating board characteristics with board functions are also examined.

Conceptual Orientation

General systems theory (von Bertalanaffy, 1968) provided the overall framework for the study. A system is defined as a set of interrelated and interdependent parts or subsystems designed to achieve a set of goals (Levey and Loomba, 1984). A change in one part or subsystem affects the other subsystems within the whole. Systems have boundaries which are defined by purpose. An open system communicates continuously with its surrounding environment (Nadler and Tushman, 1980) at various points or interfaces. The system may function within a suprasystem that affects the interaction between the system and the environment. Input from the environment is acted upon or transformed within the system, producing output to the environment. There is an ongoing process of feedback to the system.
from the generated output. The system may make adjustments based on changes in input, feedback information, or changes within the system. These adjustments keep the parts of the system in a state of balance or equilibrium (Nadler and Tushman, 1980).

An organization was defined for the study as a purposeful arrangement of parts (Levey and Loomba, 1984). The subsystems within the organization work together to produce specific outputs. The organization is made up of people using various forms of technology and the behaviors, interactions, and relationships of those people. Supervision, management, decision-making, planning, communication, and control activities are all subsystems of the organization (Harrison, 1987).

The organization receives input from its environment and the successful organization adjusts to its environment (Levey and Loomba, 1984). At the same time, it attempts to influence the environment to obtain inputs of resources, human and material, that fit well with the organizational goals. The process of influencing the environment is termed politics, while power is the ability to obtain resources or otherwise modify the behavior of others. Thus increased power makes the political process more effective.
Information, resources, and support are all necessary for the accumulation of power (Del Bueno, 1986). Elements of the environment will have varying degrees of power related to the dependence of a system or subsystem on that element for legal validation, policies, services, or information (Hazanfeld, 1983).

The public health nursing agency may be viewed as a system with the Board of Health as a suprasystem which processes inputs such as funds, personnel, and rules and regulations. The Board of Health also communicates with important elements of the environment. It competes for scarce resources within the county with departments providing many other vital services.

Health care was viewed for this study as one huge, complex system with numerous subsystems, such as preventive care, primary, secondary, and tertiary care, restorative care and long-term care. Common goals of the overall system relate to promoting health, preventing disease and disability, treating illness, restoring health, and improving access to health services (Schulz and Johnson, 1983). While various parts of the health care system share some of the same goals, services are often fragmented and uncoordinated. Furthermore, the supply of health care providers and
workers has been excessive in some instances and inadequate in others. Within the system, duplication, inappropriate use of personnel, overuse of technology and lack of cooperation have been observed.

Many segments of society are calling for an integrated health system and overall policies to guide that system (Hiatt, 1987; Maglacas, 1988; Milio, 1981, 1988). Societal conditions precipitating the calls for change include an aging population, a move to consumerism, rising costs and questionable results of care, including less than satisfactory infant mortality and life expectancy rates as compared to other developed countries. The Federal government has responded by attempting to force cost containment on the system and by introducing competition to health care (Brown, 1986; Schramm, 1986). Regulation from third party payors has increased. These efforts have not resulted in significant cost savings, however, and may be narrowing the scope of accessibility.

**Governing Boards**

Almost all entities organized to produce a specific service or other output require an overseer governing board. Houle (1989) defined the board as "an organized group of people with the authority collectively to control and foster an institution that
is usually administered by a qualified executive and staff" (p. 6). This definition addressed both the internally focused activities related to control of various organizational functions and the externally focused behaviors necessary to ensure the capture of scarce resources. The governing body plays an essential role in attaining organizational objectives. Study of governing board functions may provide insight and direction for improving organizational effectiveness. Houle (1989) emphasizes the importance of selection and training in the development of a strong, active board. No studies were available in the literature detailing preparation or function of boards of health, thus the reports of research into boards of hospitals, businesses, and schools were reviewed for this study.

Pickett and Hanlon (1990) explained that while most agencies of the state and local government are directly responsible to chief executive(s), schools and health departments are common exceptions. Boards of Health are put in place partly to protect public health programs from electoral politics. Pickett and Hanlon (1990) further stated that the most important role of the Board of Health, other than development of regulations, is to expand the deliberative capacity of
local government and provide a better sense of the community's health needs and expectations. Thus the Board of Health functions as a governing body for the public health nursing agency (Appendix A, Iowa Administrative Code, Ch. 79 and Appendix B, Federal Register Vol. 54, No. 155, part 484) and also has a rule-making and enforcement capacity in areas of public health (Appendix C, Iowa Code, Ch. 137, Local Boards of Health).

Local Boards of Health are mandated through these documents to plan for public health services in their jurisdictions, assure that health programs are related to identified community health needs, enforce state health laws and rules, and make and enforce reasonable rules and regulations pertaining to the public health. Boards of Health may provide personal and environmental services deemed necessary and may charge reasonable fees for services, licenses and permits issued. Boards receiving state nursing grant funds must hire a qualified administrator and staff, ensure adequate record-keeping, ensure a sound personnel management system, and regularly evaluate the agency. Medicare regulations for the certified home care agency also require a professional advisory group and oversight by the board of all management and fiscal affairs of the
agency.

Defriese et al. (1981) performed a secondary analysis of data from their 1974-75 study of characteristics of local health departments and local health officers in order to project the possible impact of national health policy development on funding and operation of local health department programs. The sample consisted of all local health departments across the country, with a 68% response rate. The data included information about department jurisdiction, organization, finance, functions, and staffing. Agencies were grouped by the pattern of their prescribed relationship with the state health department into four categories: centralized, decentralized, shared, and mixed. In Iowa and other states comprising the decentralized category, local Boards of Health were viewed as an important influence on programs and activities, while local government was viewed as only relatively important. The local government becomes an important part of the agency environment when the board seeks funds and other resources in order to implement programs.

Board Functions

Three primary functions of governing boards of hospitals were listed by Schulz and Johnson (1983) as,
(a) formal and legal responsibility for controlling and maintaining organizational effectiveness, (b) helping gain support for the hospital from its environment, and (c) representing and being accountable to the region and/or subgroups from its environment. Two of the three broad areas listed by these experts address the board's relation to the environment.

A model of functions of hospital directors was developed by Hickey (1972) from a review of related literature. He conducted a survey to determine whether directors agreed with the model and how the directors ranked the functions in order of importance. Of 1,024 directors contacted, 51.4% responded. Of those who responded, 91% agreed that nine of the following functions were board functions:

a) select, appoint, and evaluate CEO
b) establish institutional objectives
c) review/approve plans and programs
d) review/approve policies
e) trusteeship
f) maintain qualified medical staff
g) evaluate institutional performance
h) organize board of directors
i) review/approve institutional decisions
j) general advisory role to management
Only in the case of "maintain qualified medical staff" was there a significant number who did not accept that function as their responsibility. The functions were ranked in the order listed above. Additional functions were listed by 11.7% of the respondents. These fell into the areas of a) public relations, b) finance, and c) long-range planning. Hickey recommended research into the success of boards in carrying out their functions.

Kaluzny and Veney (1972) questioned administrators and board members from 49 acute care hospitals in New York State outside of New York City about board functions. The report of the study did not indicate how this sample was chosen. Responses were received from 49 administrators and 373 directors. The questions asked for a ranking of relative participation of administrator's activities having to do with appointments of staff, long-range planning, development of external affiliations, adoption of programs, and allocation of income. The report of the study does not indicate any significant findings, but does display a consistent difference in response, with administrators perceiving that directors have more influence in organization activities than the directors themselves perceive.
Board Characteristics Related to Functions

Miller and Weiss (1988) conducted a study of human service agencies in the Philadelphia area to analyze the relationship between size of the boards of directors and their organizational participation. Questionnaires were mailed to 319 organizations with a 57% response rate. Executive directors answered the questions about how active the board had been in the previous twelve months in each of eleven activities. These activities were of three types: internal, including planning, budgeting, and oversight activities; external, including fund-raising, agency image, and political influence; and advisory, including legal and financial advice. A significant positive linear relationship was found between board size and board activity in eight of eleven functions; the larger the board the more active in these particular functions. The smaller boards were much less involved in program and budget planning, oversight, and political influence. The authors conclude that while the findings suggest that adding board members might enhance board involvement, the correlational nature of the study precludes drawing conclusions about cause and effect. Since the number of Iowa County Board of
Health members is fixed at five (Iowa Code, Ch. 137, Local Boards of Health), the findings may not be pertinent. Boards however often use nursing agency Advisory Committees, an appointed group of professionals and others, to perform some of the oversight and advisory functions not feasibly handled by such a small board. The authors suggest further study of boards and their linkage to the environment.

Pfeffer (1973) studied the relationship of board functions to certain characteristics of hospitals. Only short-term, general hospitals were sampled. Of the 100 contacted, 57 cooperated by means of completion of a questionnaire by the chief administrator. Pfeffer found a significant relationship between 1) type of hospital ownership and importance of the fund raising function of the board, 2) reliance on government funding and the administrative function of the board, 3) selecting board members for their influence in the community and the type of hospital ownership, and 4) selecting board members for regional representation and political connections and the type of hospital ownership and funding. He found a significant relationship between the need for linkage to the environment and size of the board. Private, nonprofit
organizations tended to choose larger boards more for connections to the environment and for fund raising than did those more dependent on government funding, which chose smaller boards for more internally oriented functions. The relatively small Iowa county Boards of Health might therefore be expected to focus more on internal than external functions.

Provan (1980) examined several board characteristics related to agencies' effectiveness in acquiring funding. He studied data from 46 nonprofit human service agencies formally affiliated with the local United Way agency in a large, industrial city. Characteristics measured included a board prestige scale, a board linkage (to other agencies) scale, board size, and percent of males on the board. This combination of board characteristics was assumed to be a measure of board power. One measure of organizational effectiveness was a three year average of the absolute amount of money an agency received from United Way, from non-United Way sources, and from bequests. This static measure was contrasted with a more dynamic measure of the percentage increase in both United Way and non-United Way funding over a three year period. Strong correlations were found between all measured board characteristics and static measures of
effectiveness, except between board size and bequests. There were no significant correlations between percent of males on the board and any of the static measures. Results indicated that the powerful board had little importance in increasing funding to the organization. The author concluded that powerful boards may be most useful to agencies already receiving considerable funding in maintaining that level in the face of competition from its environment.

Kesner (1988) randomly selected 250 Fortune 500 companies from the year 1983. She used data about board member characteristics obtained from proxy statements filed with the Securities and Exchange Commission. The characteristics studied include occupation, length on the board, gender, and whether the member was from within the organization or an outsider. She correlated these variables with membership on the most important committees and found that committee membership was significantly correlated with being an outsider, coming from a business occupation, and having longer tenure. Gender, however, did not affect committee membership.

When the American School Board Journal randomly surveyed 4,441 board members (Luckett, Underwood, and Fortune, 1987), the 33% who responded indicated
differences in the way women and men perceived their roles and responsibilities on the board. Seventy four percent of women said they felt best qualified in the area of curriculum and instruction while the majority of men (68.7%) felt best qualified in the area of finances. Both sexes stated they were most involved in policy-making. Following policy-making, women listed planning and goal setting, community relations, and curriculum and instruction as the functions in which they were most involved. Men listed budget development, collective bargaining, facilities, and business management as the functions in which they were most involved after policy-making. The gender difference may be related to the fact that 68.5% of the men worked in professional or managerial careers, while only 36.4% of the women surveyed had that type of career and 40.5% were homemakers. Significant differences between the respondents was not discussed.

Governing boards play an important role in the operation of organizations. Boards of Health are governing boards and have additional responsibilities for rule-making and enforcement, which is of particular importance in states such as Iowa with a decentralized public health structure. Careful selection, orientation, and training for these various activities
will contribute to their successful completion (Houle, 1969).

Miller and Weiss (1988), Hickey (1987), Schulz and Johnson (1963), and Kaluzny and Veney (1972) defined board functions. Miller and Weiss (1988), Provan (1980), and Pfeffer (1973) studied the relation of board size to function. Provan (1980), Pfeffer (1973), and Kesner (1988) focused on the linkage of organizations to their environments through various board member characteristics. The effectiveness of links to the environment seems to be measured best by success in obtaining funding and other resources. This function is receiving renewed attention by local public agencies as tax-based funds become more scarce. Kesner (1988) and Luckett et al. (1987) examined member characteristics. Kesner (1988) found that occupation and length on the board were significantly related to committee membership while gender was not. Luckett et al. (1987), however, found correlation between gender and perceived roles on school boards, although the findings may have been influenced by other characteristics.

The literature relating to boards rarely addresses Boards of Health. Information about Board of Health members' orientation and training, functions, and
demographic characteristics are unavailable in the literature. In order to perform the work of assessing and meeting public health needs most effectively, public health nurse administrators and board members need this information.
Chapter III
METHODOLOGY

In order to discover how Board of Health members were oriented, trained, their perceptions of the importance of board functions, and selected demographic characteristics, a random sample of county Board of Health members in Iowa was questioned via a mailed questionnaire developed by the investigator.

Research Questions

Research questions were:

1. How are Iowa Board of Health members oriented and trained?
2. How do members rank their functions vis a vis the nursing agency?
3. What other board memberships have these respondents held?
4. What influence do members have in the community that may be helpful on the board?
5. How do members think they could be more successful in carrying out their board duties?
6. What other board functions do members feel they perform that are not listed on the questionnaire?
**Hypotheses**

1. There will be no difference in the ranking of internal operation and policy between males and females.
2. There will be no difference in the ranking of finance and budgeting between males and females.
3. There will be no difference in the ranking of concerns about program planning and procedure between members from health care occupations and those from business occupations.
4. There will be no difference in the ranking of concerns about fiscal operation and planning between members from health care occupations and those from business occupations.

The Mann - Whitney U test of significant differences in ranking of ordinal data between two independent groups was used to test the hypotheses. The sample was described using percentages, means, and standard deviation.

**Setting and Sample**

A random sample of 100 members was selected from a current list of all county Board of Health members obtained from the Iowa Department of Public Health. The list included 495 members from the 99 county boards of health. Although the state is divided into
districts by the Iowa Department of Public Health (Appendix D), the sample was not stratified according to district.

**Instrument**

A questionnaire was developed by the researcher based on information gathered in the literature review and sources regarding questionnaire design (Sudman and Bradburn, 1986 and Fowler, 1984). The questionnaire (Appendix E) included four questions about orientation and training and several demographic questions about gender, age, occupation, and length of time on the board. One question was designed to elicit perceptions of board members' experience which might have contributed to their selection for the board.

A list of board functions was compiled from the literature review, the rules pertaining to Iowa Boards of Health (Appendices A, B, C) and investigator experience. The respondents were directed to rank the functions in order of importance and to cross off those functions their board does not perform. Respondents were given an open-ended question in which to describe how boards could be more successful.

Content validity of the instrument was obtained by sharing it with four individuals chosen by the investigator for their expertise in community health
practice, including the Chief of the Public Health Nursing Bureau, a nurse consultant for the Bureau, and two experienced nurse administrators (Appendix F). Each was contacted by telephone about two weeks after receipt of the questionnaire and provided expert validation of the instrument.

The reliability of the portion of the instrument ranking functions of Boards of Health was not established.

**Procedure**

A pilot study was first conducted in which a random sample of ten board members were asked to complete the questionnaire. The respondents then answered a separate set of questions regarding the clarity and readability of the wording and instructions and length of time needed to answer the questionnaire (Appendix G). All ten of the pilot sample replied and based on their responses, the questionnaire was determined to be readable and easily understood without revision.

The questionnaire was preceded by a cover letter (Appendix H) explaining the study, assuring confidentiality, and promising a summary report (Baker, 1985). The questionnaire and cover letter were mailed, with a self-addressed stamped envelope, to the sample
in December, 1990. A postcard was mailed to
nonrespondents one week later to remind them of the
importance of their response and request their prompt
reply. A second questionnaire, cover letter (Appendix
I), and self-addressed stamped envelope were mailed two
and one half weeks later to those who still had not
replied.

**Ethical Considerations**

Approval for this study was granted by the Human
Subjects Research Review Committee at Drake University
before the study was instigated (Appendix J).
Confidentiality was maintained by identifying
questionnaires by number with a key available only to
the researcher for the purpose of identifying which
questionnaires had been returned. Informed consent was
implied by the return of the completed questionnaire.
Chapter IV

ANALYSIS AND RESULTS

The results are reported by first describing the sample followed by the findings for each of the research questions and hypotheses.

Description of the Sample

Of the 100 questionnaires that were mailed out, one was undeliverable, three responded that they would be unable to participate, seven did not respond, and 89 questionnaires were answered and returned (Table 1).

Table 1
Survey Response

<table>
<thead>
<tr>
<th>Mailings</th>
<th>#Surveys Sent</th>
<th>#Surveys Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>100</td>
<td>49</td>
</tr>
<tr>
<td>Postcard</td>
<td>51</td>
<td>24</td>
</tr>
<tr>
<td>Follow-up</td>
<td>27</td>
<td>16</td>
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</table>

The high response rate, adjusted to 93%, may reflect the board members' interest in the subject. It may also reflect the success of the questionnaire mailing technique.
The Iowa Department of Public Health has divided the state into districts, each encompassing 10 - 12 counties. Each Iowa Department of Public Health district (Appendix D) was represented by responses, ranging in number from 5 to 13 per district (Table 2).

Table 2

**Distribution of Responses by Geographic Location**

<table>
<thead>
<tr>
<th>District</th>
<th>Number Sent</th>
<th>Number Returned</th>
<th>% Returned in District</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>11</td>
<td>9</td>
<td>82</td>
</tr>
<tr>
<td>2</td>
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<td>11</td>
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<td>91</td>
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<tr>
<td>9</td>
<td>6</td>
<td>5</td>
<td>83</td>
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</tbody>
</table>

\[N = 100\] \[N = 89\]

Although the sample was chosen randomly, district nine may be underrepresented due to the low number of questionnaires sent to that area.
The investigator grouped counties by population (Table 3) and determined that respondents were well-distributed throughout counties of varying population size (Appendix K).

<table>
<thead>
<tr>
<th>Population</th>
<th># counties</th>
<th>%</th>
<th># responses</th>
<th>%</th>
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<tbody>
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<td>18</td>
<td>16</td>
<td>18</td>
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<td>10-15,000</td>
<td>28</td>
<td>28</td>
<td>25</td>
<td>28</td>
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<tr>
<td>15-20,000</td>
<td>22</td>
<td>22</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>20-40,000</td>
<td>18</td>
<td>18</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>&gt;40,000</td>
<td>13</td>
<td>13</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>N= 99</td>
<td></td>
<td></td>
<td>N= 89</td>
<td></td>
</tr>
</tbody>
</table>

All questionnaires contained data used for describing the characteristics of the sample, however, not every question was answered by each respondent. Thus the total number of responses (N) may vary in the tables.

**Demographic Characteristics of the Sample**

Most of the subjects were male (63%) and over 50 years old (55%) (see Table 4). Over a third (38%) of respondents worked in health related occupations. There were 14 physicians and 10 nurses. Of note is the Iowa Code requirement that each Board of Health must include a physician in its membership.
Subjects from business occupations included owners of businesses, bankers, an engineer, lawyer, cosmetologist, blacksmith, and insurance salesman. About a fourth (24%) were grouped into other occupations. Included in this number were 10 county supervisors, 11 farmers, a minister and a social worker. Those not employed outside the home included 5 homemakers and two people retired from unspecified occupations. A majority of respondents (58%) had served on the Board of Health from one to six years. Almost a fourth (22%) have served for ten years or more.

Table 4  
Demographic Characteristics

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td>52</td>
<td>63</td>
</tr>
<tr>
<td>female</td>
<td>31</td>
<td>37</td>
</tr>
</tbody>
</table>

N= 83
Demographic Characteristics (cont.)

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-30</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>31-40</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>41-50</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>51-60</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>61-70</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>71-80</td>
<td>11</td>
<td>13</td>
</tr>
</tbody>
</table>

\[ \text{N= 83} \quad \overline{X}=54 \text{ yr} \quad 100\% \]

SD=13.8

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>health-related</td>
<td>34</td>
<td>41</td>
</tr>
<tr>
<td>business</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>education</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>other</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>unemployed</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>

\[ \text{N= 83} \quad 100\% \]

<table>
<thead>
<tr>
<th>Length on Board (years)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1-3</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>4-6</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td>7-9</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>10 or more</td>
<td>20</td>
<td>22</td>
</tr>
</tbody>
</table>

\[ \text{N= 89} \quad \overline{X}=6.5 \text{ yr} \quad 100\% \]

SD=5.02
The following reports results in response to each research question and hypothesis.

1. How are Iowa Board of Health members oriented and trained?

Of the 84 respondents who answered questions about orientation and training, only about a fourth (27%) reported receiving initial orientation (see Table 5). Only one person had had a formal orientation program. There were 13 to 18 affirmative answers for each of the other methods of orientation listed. Close to half (45%) responded that they had received some additional training during their time as a board member. More than half, however, responded to the question asking for the specific type of ongoing training. Almost all of those responding to that question indicated that they had received all three types of training. Nine individuals commented that members should receive more orientation and training.
Table 5

**Initial and Ongoing Orientation and Training**

<table>
<thead>
<tr>
<th></th>
<th>number</th>
<th>percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. initial orientation</td>
<td>23</td>
<td>27</td>
</tr>
<tr>
<td>2. how oriented?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>by appointing body</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>by nurse administrator</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>formal orientation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>reading on own</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>by other board members</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>3. receive additional training?</td>
<td>38</td>
<td>45</td>
</tr>
<tr>
<td>4. type of additional training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>information at meetings</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>separate inservice</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>reading materials</td>
<td>51</td>
<td>61</td>
</tr>
<tr>
<td>other</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
2. How do members rank their functions vis a vis the nursing agency?

There were 75 usable responses to the request to rank the functions of the Board of Health according to their importance. The results for Table 8 are grouped by whether a function was ranked as one of the three most important (high) or three least important (low). See Appendix L for a more complete listing of ranks of each function.

Table 6

<table>
<thead>
<tr>
<th>Overall Ranking of Functions</th>
<th>N = 75</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
</tr>
<tr>
<td>Assess community health needs</td>
<td>40</td>
</tr>
<tr>
<td>Appoint administrator</td>
<td>39</td>
</tr>
<tr>
<td>Planning and budgeting</td>
<td>30</td>
</tr>
<tr>
<td>Oversee management/finance</td>
<td>30</td>
</tr>
<tr>
<td>Oversee agency programs</td>
<td>29</td>
</tr>
<tr>
<td>Advise agency management</td>
<td>26</td>
</tr>
<tr>
<td>Review/approve policies</td>
<td>26</td>
</tr>
<tr>
<td>Improve agency image</td>
<td>5</td>
</tr>
<tr>
<td>Appoint advisory committee</td>
<td>3</td>
</tr>
<tr>
<td>Exercise political influence</td>
<td>1</td>
</tr>
</tbody>
</table>
Functions ranked highly by a majority include appointment of a qualified administrator (52%) and assessment of community health needs (53%). Notable findings include the sizable majority (71%) who rank exerting political influence as among the least important functions, with an additional 10 respondents crossing the item off as not performed by their board. Other functions given a low ranking by a majority include working to improve the agency image (63%) and appointment of advisory committee (61%).

3. What other board memberships have these respondents held?

Seventy respondents listed boards, commissions, committees, and task forces to which they belong or have belonged in response to the question regarding other board experience. The numbers indicate that Board of Health members are involved and active residents of their communities. These other community memberships were grouped by the author as follows: church 27, school 13, health-related 39, state and local government 33, civic 37, professional 9, and others 23 (see Appendix M for a more complete listing of other community memberships).
4. What influence do members have in the community that may be helpful on the board?

A majority of respondents had some community influence or experience that they considered helpful in their role as a board member (Table 7).

Table 7 (N= 89)

Factors Considered Helpful on the Board

<table>
<thead>
<tr>
<th></th>
<th>number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connections in the community</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>Past experiences</td>
<td>50</td>
<td>56</td>
</tr>
<tr>
<td>Occupation</td>
<td>52</td>
<td>58</td>
</tr>
<tr>
<td>Special skills or knowledge</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

5. How do board members think they could be more successful in carrying out their board duties?

The open-ended question regarding how boards could be more successful resulted in a variety of responses from 47 subjects. Several (N=16) called for better communication with the agency administration, with the county medical and political communities, and with the state departments. In the area of agency oversight, comments suggested the importance of hiring a competent
nurse administrator (N=3), better marketing (N=2),
board members spending time in the agency (N=6), and
better defining the agency objectives and goals (N=3).
Suggestions for improved board functioning included
making sure to stay within the policy-making realm
(N=2), better training and orientation (N=8), not
hesitating to act when necessary (N=1), and finding
highly motivated members with varied backgrounds
(N=5). See Appendix N for a complete listing of these
comments.

6. What other board functions do members feel they
perform that are not listed on the questionnaire?

In the open-ended question regarding other
functions of the board, 21 respondents listed several
other public health functions, such as oversight of
sanitarian and homemaker-health aide programs,
pollution control, waste cleanup, ambulance services,
swimming pool regulations, zoning variances, animal
control, and wells. One person commented that more
school health activities were needed.

Hypothesis Testing

Ranking of functions were used to test hypotheses
using the Mann - Whitney U. The level of significance
was placed at .05. The researcher selected two Board
functions to represent the activities in each
hypothesis. For the first two hypotheses, the results of rank ordering of functions by 47 males and 30 females were used.

1. There will be no difference in the ranking of internal operation and policy between males and females.

The first function whose ranks were tested to represent this activity was A. Advise agency management. Result was $Z = 1.38$, $p > .08$, hypothesis supported. The second function used to test this hypothesis was, E. Review/approve policies. Result was $Z = .32$, $p > .375$, hypothesis supported.

2. There will be no difference in the ranking of finance and budgeting between males and females.

The first board function used to test this hypothesis was B. oversee management/finance. Result was $Z = 2.06$, $p < .05$, hypothesis not supported.

The second function used was, F. Planning and budgeting. Result was $Z = 1.19$, $p > .117$, hypothesis supported.

For hypotheses 3 and 4 the rank ordering of 35 respondents from health occupations and 13 from business occupations were used.

3. There will be no difference in the ranking of concerns about program planning and procedure between
members from health care occupations and those from business occupations.

The first function whose ranks were used to test this hypothesis was, C. Assess community health needs. Result was $Z = .70$, $p > .24$, hypothesis supported. The second function was, I. Oversee agency programs. The result was $Z = 1.18$, $p > .119$, hypothesis supported.

4. There will be no difference in the ranking of concerns about fiscal operation and planning between members from health care occupations and those from business occupations.

The first function used to test this hypothesis was, B. Oversee management/finance. The result was $Z = .13$, $p > .45$, hypothesis supported. The second function used was, F. Planning and budgeting. Result $Z = .96$, $p > .17$, hypothesis supported.

Other Comments

Finally, respondents were given an opportunity to write any other comments about this study or other Board of Health matters. Fourteen subjects wrote additional comments indicating concerns about the increased needs, increased costs, and increased regulation in public health, but also indicating pride in the accomplishments of boards (see Appendix O for a complete listing). Perhaps one comment summarizes some
of the concerns of boards for the future:

With the advent of private home health care services, public health nursing needs to reassess its role - are we spending our tax resources in the most advantageous way? Are we meeting needs not met by the private sector (are we duplicating private sector efforts?) - What of the new public health issues (AIDS, sexually transmitted diseases, etc) are we addressing them? If we had to, what service or program is most dispensable?
Chapter V
DISCUSSION

The purpose of this study was to survey Iowa county Board of Health members to obtain their perceptions of how they were oriented and trained for their role, factors that may be helpful for board membership, how boards could be more successful, and to determine whether certain demographic characteristics influence how members rank their various functions. A random sample of 100 Board of Health members from across the state received the questionnaire, with a response of 83%.

This study produced a number of interesting findings. First, the unusually high response rate may reflect the interest of Board of Health members in their roles. While several board functions were ranked fairly high, selection of the nurse administrator and assessment of community health needs were the only two ranked highly by a majority of respondents. Conversely, three functions were ranked of low importance by a sizable majority: exerting political influence, working to improve agency image, and selection of Advisory Committee members. Only one hypothesis was partially supported by the differences
in ranking of functions. About a fourth (27%) of respondents reported initial orientation received from a variety of sources, while 45% felt they had received additional training since becoming a board member. Although 63% of members are male, there is a wide diversity of occupations and other board memberships represented.

The data provide a base for understanding the makeup of county Boards of Health in Iowa today. The high ranking of appointment of nurse administrator is consistent with the findings in Hickey's (1972) study, in which the selection, appointment, and evaluation of the CEO was the highest rated function. The high ranking of community need assessment will be gratifying to public health nurses, who understand the need to link services to identified needs. This high ranking may reflect the efforts in recent years of the Iowa Department of Public Health to educate boards and nurses in the area.

The low ranking of exercising political influence and improving agency image is consistent with the findings in the studies by Miller and Weiss (1988), Provan (1980), and Pfeffer (1973) which found small boards more involved in internal matters. With today's emphasis on the capture of scarce resources, however,
and the proliferation of competitive agencies, boards may need to rethink the importance of political and image-enhancing activities. Perhaps the third low-ranked function, appointment of advisory committee members, could help the board in these areas through careful selection and training of members for their links to the environment. If the board is truly a suprasystem communicating between the nursing agency and its environment, these activities will have to take a higher priority in the future.

While the hypotheses were not supported except in one area, more research needs to be directed at studying the characteristics of boards to determine how they influence activities and success of boards. Perhaps if functions were explained more fully or more choices were given, subtle differences could be discerned. Particularly, the meaning of various functions may have been interpreted differently by subjects due to not having a clear explanation of the intent. A sample of public health officials, educators, and a larger sample of Board of Health members could be asked to list the functions of boards and then a delphi technique used to achieve consensus on those functions.

The relatively low rate of initial orientation
points to a need for improvement in this area. The complexity of health care issues and growing needs for health services in the public sector will demand careful ongoing inservice and training for the dedicated, diverse individuals serving on boards of health. The liaison person to boards of health who was recently hired by the Iowa Department of Public Health may be able to work with nurse administrators and others to provide this type of meaningful training.

**Limitations**

While the sampling method and response rate make these findings generalizable to Iowa county Boards of Health, the findings could not be applied to boards in other states, although they may have some merit as beginning work in other states with decentralized state public health systems.

**Recommendations**

Recommendations for further research include investigations into the outcomes of board of health activities, that is, how well do boards perform their duties? Part of the data for further research could come from investigating the success of Boards of Health in capturing scarce resources from the environment. Also important to determine is how well Board of Health activities fit with identified
community health needs. Are there gaps or overlaps?

A comparison of Board of Health member, public health nurse, and nurse administrator views of each others' roles and performance is also recommended. The same questionnaire could be administered to each group to rank themselves and each other. Potential misconceptions could be discovered after obtaining this information.

A more detailed assessment of the training needs of board members and effective means of presenting that training is needed as well. Finally, a survey of advisory committee members, including demographic data such as age, tenure on the committee, and gender, training needs, and perception of functions should be conducted. These members have the potential to extend and enhance the function of the Board of Health, yet they have received little, if any, study.

Conclusion

Public health nurses and Boards of Health are faced today with increasing health care needs, fragmented delivery systems, and shrinking resources. There is growing recognition that solutions to complex health care problems will have to be innovative and include all segments of the health care system and our communities. This study has identified Iowa county
Board of Health members' orientation, training, functions, and demographic characteristics. This information provides nurses with a better understanding of their governing boards, their activities, and training needs. Better understanding may encourage nurses and boards to work more effectively to accomplish the difficult tasks ahead.
References


APPENDIX
Appendix A

Chapter 79
Public Health Nursing

641-79.1(135) Program Purpose. The purpose of Public Health Nursing is the prevention of illness and the promotion of health. To accomplish this goal, public health nurses work individually or with other disciplines to assist persons, families, groups and communities in life-style changes for optimal health. The public health nurse also provides home care for disease and disability patients needing assistance.

641-79.2(135) Definitions. For the purpose of these rules, unless otherwise defined:

"Agency" means a government or nonprofit organization designated by the local board to subcontract for state public health nursing appropriation funds.

"Department" means the Iowa department of public health.

"Disease and disability patient" means a person receiving nursing intervention under a specified medical diagnosis(es) and will have a plan of care from a licensed physician.

"Health promotion" means a program of teaching or nursing intervention that will emphasize self, and environmental awareness, and will promote a life-style change that will result in optimal health.

"Local board" means a county, city, or district board of health as defined in Iowa Code section 137.2.

"Public health nurse" means a registered nurse licensed in the state of Iowa or in possession of a valid work permit as issued by the Iowa board of nursing and is one who has knowledge of primary prevention, health promotion and community health nursing concepts.

641-79.3(135) Appropriation. Appropriations to the local board are determined by formula based on county population, percent of those over age 60, and those below the poverty level.

641-79.4(135) Local board responsibility. The local board shall be responsible for a plan to provide public health services for individuals and groups in their jurisdiction.

79.4(1) Needs assessment. The local board shall:

a. Be responsible for a plan to meet the public health needs of the community, identifying and coordinating the plan with related community agencies and organizations.

b. Encourage appropriate utilization of health services.

c. Encourage the development of services where they are
absent or inadequate.
d. Be responsible to assure health programs are in
relation to community health needs.
79.4 (2) Evaluation of agency.
a. The local board shall evaluate or be responsible to
ensure that agencies evaluate the public health nursing
program according to written objectives. This portion
is to be completed within three months of the end of
the fiscal year.
b. In addition, the local board will evaluate the total
public health nursing program assessing the extent to
which the entire program was appropriate, adequate,
effective, and efficient. (1) Appropriateness. The
degree of relevancy of service programs to identified
health care needs of the community.
(2) Adequacy. The degree to which the scope and
services of the program permit the accomplishment of
program objectives; and the degree to which the program
fulfills the health care needs of the community within
the framework of the agency’s resources, capabilities,
and established priorities. (3) Effectiveness. The
degree to which a program’s service accomplishes the
job it sets out to do; the relationship between
objectives and achievement.
(4) Efficiency. The degree to which costs, in terms of
manpower and physical and financial facilities, are
kept to a minimum consistent with quality of work
expected.
79.4(3) Communicable disease control. The local board
shall encourage agencies to provide:
a. Intervention for all referred tuberculosis patients.
b. Assistance with epidemiological investigation of
referred communicable diseases.
c. Immunizations when needed as defined by Iowa Code
section 139.9, subsection 7.
d. Audit of immunization cards for schools within the
jurisdiction.
79.4(4) Risk reduction and health promotion. The local
board shall encourage agencies to:
a. Promote/provide community health education in
conjunction with the needs assessment.
b. Promote participation in preconceptual, prenatal,
intrapartum and postpartum services.
c. Provide nursing assessment, advocacy and health
teaching to individuals and families when there is no
specific medical diagnosis.
d. Provide assistance for individuals and families to
obtain health care services by providing information
about the health care system and available resources.
e. Promote screening programs such as, but not limited
to, hypertension, diabetes, and cholesterol screenings and well elderly clinics.
79.4(5) Public health nursing care to disease and disability patients. The local board shall ensure:
a. The availability of part-time intermittent nursing care in the patient's home directly or by contract through a nonprofit agency certified as a home health agency by the health insurance benefits program (Medicare).
b. That every agency receiving public health nursing appropriations will have completed an annual cost analysis according to the Health Care Financing Administration Cost Report or an alternative cost report approved by the department. A full fee and a sliding fee scale shall be established and used for those persons able to pay all or a part of the cost of service. Income and resources shall be considered in the application of the sliding fee scale. Income generated by resources shall be considered income not resources. Such sliding fee scales shall be used as guidelines with exceptional circumstances defined in agency policy and implemented in a consistent manner with the patient or client.
641-79.5(135) Assignment of responsibilities. The local board may choose to provide some of the previously mentioned components through subcontracts with nonprofit agencies. When this is done, the assignment of the responsibilities of each agency must be clearly documented in the board of health's total plan. When the services are provided by more than one agency, the evaluation shall include the degree to which the combination of the services meets the identified public health needs of the community.
79.5(1) Agency eligibility. In order to receive state public health nursing funds the provider agency must meet the following requirements:
a. The agency shall have the necessary legal authority to operate in conformity with federal, state, local laws and regulations.
b. The governing authority shall employ an agency administrator to whom authority and responsibility for overall agency administration are delegated.
c. The governing authority shall assure a personnel management system to include the following:
   (1) Written job descriptions and qualifications for each job category.
   (2) Established wage scales for each job category.
   (3) Written personnel policies to include:
       recruitment and selection processes, equal employment opportunity and affirmative action, orientation,
benefits, leaves and absences, hours of employment, staff development, evaluation, discipline, termination, grievance procedures and appeals process. Recommendation and example of the above may be obtained from the Guidelines for Boards of Health Personnel Policies as provided by the department. Local boards may choose to adopt the entire Guidelines or choose portions of the Guidelines and supplement with local policies.

79.5(2) Records. The agency shall maintain at a minimum the following records:
   a. Administrative and fiscal. These records shall include agency policies, board minutes and reports, service statistics, accounting records which indicate all accrued revenue and income and expenditures. The agency shall submit to the public health nursing bureau annually a copy of the Health Care Financing Administration Cost Report or an alternate cost report as approved by the public health nursing bureau. The agency shall submit statistical reports identified by annual contract from the department.
   b. Clinical. There shall be a clinical record for each patient or client or family who meets the admission criteria of the agency and is provided public health nursing service in the individual's place of residence or the agency office. The clinical record is considered confidential and the department representatives will respect that confidentiality. The provider agency shall provide for appropriate safety and security of the clinical records. The clinical record shall include:
      (1) Documentation of the nursing process: assessment, planning, intervention, and evaluation.
      (2) Documentation shall be completed by all individuals providing patient or client services.

Authorized representatives of the department shall have access to all administrative, fiscal, personnel, and patient/client records.

79.5(3) Agency responsibilities. The agency shall ensure:
   a. Development of programs in response to community health needs.
   b. Establishment of priorities for each identified program.
   c. Approval of policies and procedures governing the programs, services and professional practices.
   d. Establishment of measurable objectives for each program assigned.

79.5(4) State responsibilities. Technical assistance and consultation will be provided to the agency by the
regional community health consultants of the public health nursing bureau of the Iowa department of public health. Additional technical assistance and consultation will be available from the chief and assistant chief of the public health nursing bureau, other bureaus of the family and community health division and other divisions of the department.

641-79.6(135) Services billable to state grant funds. The state grant funds shall be billed for nursing services at the cost of disease and disability services as determined by the Health Care Financing Administration Cost Report not reimbursed by third-party payers or the portion not paid by the recipient on the sliding fee scale. Third party payers shall be billed first. The state grant funds may also be billed at the cost for health promotion services as determined by the Health Care Financing Administration Cost Report or an alternative cost report approved by the department. Cost information may be submitted to the public health nursing bureau on a quarterly basis to request a revision in the contract. State grant funds may be used for public health nursing health promotion activities described in the Iowa Code and the Iowa Administrative Code. The specific process for expenditure and vouchering of state funds will be defined in the administrative contract. For agencies not using the Health Care Financing Administration Cost Report, no more than 5% of state funds received can be used for administrative expense.

641-79.7(135) Eligibility. Every Iowan shall be eligible for nursing service.

641-79.8(135) Right to appeal. Whenever an agency denies, reduces or terminates nursing service against the wishes of the client or patient, the agency shall notify the individual of the action, the reason for the action, and of their right to appeal.

78.8(1) Agency level. The agency, alone or in coordination with the board of health or other community agencies, shall establish a written local procedure to hear such appeals. The local procedure shall at a minimum include the method of notification of the right of appeal; The method of requesting a local hearing; the designation of the body to hear the appeal; the procedure for conducting the appeal hearing; the time frame limits for each step; and the method of notification of the outcome of the hearing and notification of the appellant of the right to appeal to the state. Notifications of the outcome of the local hearing shall include the facts used to reach a decision and the conclusions drawn from the facts to
support the local agency decision. The written appeals procedure and the record of appeals filed (including the hearing record and disposition of each) shall be available for inspection by authorized Iowa department of public health representatives.

79.8(2) State review request. If a patient or client is dissatisfied with the decision of the local appeal, they may appeal to the state. The appeal shall be made in writing by certified mail, return receipt requested, to the Division Director, Division of Family and Community Health, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319 - 0075, within 15 days following the local agency's appeal determination.

79.8(3) Contested case. Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

79.8(4) Hearing. The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481-Chapter 4, Iowa Administrative Code.

79.8(5) Decision of administrative law judge. When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director of public health is taken as provided in subrule 79.8(6).

79.8(6) Appeal the director of public health. Any appeal to the director of public health for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director of public health by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

79.8(7) Record of hearing. Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director.
The record shall include the following:
a. All pleadings, motions and rules.
b. All evidence received or considered and all other submissions by recording or transcript.
c. All statements of all matters officially noticed.
d. All questions and offers of proof, objections and rulings thereon.
e. All proposed findings and exceptions.
f. The proposed decision and order of the law judge.

Decision of director of public health. The decision and order of the director of public health becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

79.8(9) Exhausting administrative remedies. It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director of public health of the district court as provided in Iowa Code section 17A.19 The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

These rules are intended to implement Iowa Code section 135.11(15).

Ronald D. Eckoff, MD, MPH
Acting Director
Iowa Department of Public Health

9/28/90
Appendix B

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Part 484 - Conditions of Participation: Home Health Agencies

Subpart A - General Provisions
484.1 Basis and scope.
This part implements the requirements of sections 1861(o) and 1891(a) of the Act for HHA services and also sets forth the additional requirements considered necessary to ensure the health and safety of patients.

484.2 Definitions.

As used in this part, unless the context indicates otherwise:

"Bylaws or equivalent" means a set of rules adopted by an HHA for governing the agency's operation.

"Branch office" means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home health agency.

"Clinical note" means a notation of a contact with a patient that is written and dated by a member of the health team, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition.

"HHA" stands for home health agency.


"Parent home health agency" means the agency that develops and maintains administrative controls of subunits and/or branch offices.

"Primary home health agency" means the agency that is responsible for the services furnished to patients and for implementation of the plan of care.

"Progress note" means a written notation, dated and signed by a member of the health team, that summarizes facts about care furnished and the patient's response during a given period of time.

"Proprietary agency" means a private profit making agency licensed by the State.
"Public agency" means an agency operated by a State or local government. "Subdivision" means a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the conditions of participation for HHA's. A subdivision that has subunits or branch offices is considered a parent agency. "Subunit" means a semi-autonomous organization that - (1) Serves patients in a geographic area different from that of the parent agency; and (2) Must independently meet the conditions of participation for HHAs because it is too far from the parent agency to share administration, supervision, and services on a daily basis. "Summary report" means the compilation of the pertinent factors of a patient's clinical notes and progress notes that is submitted to the patient's physician. "Supervision" means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity. Unless otherwise specified in this part, the supervisor must be on the premises to supervise an individual who does not meet the qualifications specified in 484.4.

484.4 Personnel qualifications
Staff required to meet the conditions set forth in this part are staff who meet the qualifications specified in this section.

"Administrator, home health agency" A person who:
(a) is a licensed physician; or
(b) is a registered nurse; or
(c) has training and experience in health service administration and at least 1 year of supervisory or administrative experience in home health care or related programs.

"Audiologist". A person who:
(a) Meets the education and experience requirements for a Certificate of Clinical Competence in audiology granted by the American Speech-Language-Hearing Association; or
(b) Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

"Home health aide". Effective for services after August 14, 1980, a person who has successfully completed a State-established or other training program that meets the requirements of 484.36(b) and a
competency evaluation program or State licensure program that meets the requirements of 484.36(b). An individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program, if, since the individual's most recent completion of this program(s), there has been a continuous period of 24 consecutive months during none of which the individual furnished services described in 409.40 of this chapter for compensation.

"Occupational therapist". A person who:
(a) is a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the AmericanOccupational Therapy Association; or
(b) is eligible for the National Registration Examination of the American Occupational Therapy Association; or
(c) Has 2 years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualifications as an occupational therapist after December 31, 1977.

"Occupational therapy assistant". A person who:
(a) Meets the requirements for certification as an occupational therapy assistant established by the American Occupational Therapy Association; or
(b) Has 2 years of appropriate experience as an occupational therapy assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapy assistant after December 31, 1977.

"Physical therapist". A person who is licensed as a physical therapist by the State in which practicing, and
(a) Has graduated from a physical therapy curriculum approved by:
(1) The American Physical Therapy Association; or
(2) The Committee on Allied Health Education and Accreditation of the American Medical Association, or
(3) The Council on Medical Education of the American Medical Association, or
(b) prior to January 1, 1968,
(1) Was admitted to membership by the American Physical Therapy Association, or
(2) Was admitted to registration by the American Registry of Physical Therapists, or
(3) Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or
(c) Has 2 years of appropriate experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or
(d) Was licensed or registered prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy; or
(e) if trained outside the United States,
(1) Has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.
(2) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

"Physioherapy assistant". A person who is licensed as a physical therapy assistant, if applicable, by the State in which practicing, and
(1) Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or
(2) Has 2 years of appropriate experience as a physical therapy assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapy assistant after December 31, 1977.

"Physician". A doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed.

"Practical (vocational) nurse". A person who is
licensed as a practical nurse by the State in which practicing.

"Public health nurse". A registered nurse who has completed a baccalaureate degree program approved by the National League for Nursing for public health nursing preparation or postregistered nurse study that includes content approved by the National League for Nursing for public health nursing preparation.

"Registered nurse (RN)". A graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing.

"Social work assistant". A person who:
(1) Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least 1 year of social work experience in a health care setting; or
(2) Has 2 years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a social work assistant after December 31, 1977.

"Social worker". A person who has a master's degree from a school of social work accredited by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

"Speech pathologist". A person who:
(1) Meets the education and experience requirements for a Certificate of Clinical Competence in speech pathology or audiology granted by the American Speech-Language-Hearing Association; or
(2) Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

Subpart B - Administration
484.10 Condition of participation: Patient rights.
The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of these rights.
(a) Standard: Notice of rights.
(1) The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.
(2) The HHA must maintain documentation showing that it has complied with the requirements of this section.
(b) Standard: Exercise of rights and respect for
property and person.

(1) The patient has the right to exercise his or her rights as a patient of the HHA.

(2) The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent.

(3) The patient has the right to have his or her property treated with respect.

(4) The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.

(5) The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.

(c) Standard: Right to be informed and to participate in planning care and treatment.

(1) The patient has the right to be informed, in advance, about the care to be furnished, and of any changes in the care to be furnished.

(i) The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.

(ii) The HHA must advise the patient in advance of any changes in the plan of care before the change is made.

(2) The patient has the right to participate in the planning of the care. The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.

(d) Standard: Confidentiality of medical records. The patient has the right to confidentiality of the clinical records maintained by the HHA. The HHA must advise the patient of the agency's policies and procedures regarding disclosure of clinical records.

(e) Standard: Patient liability for payment.

(1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA service may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before care is initiated, the HHA must inform the patient, orally and in writing, of -

(i) The extent to which payment may be expected from
Medicare, Medicaid, or any other Federally funded or
aided program known to the HHA:
(ii) The charges for services that will not be covered
be Medicare: and
(iii) The charges that the individual may have to pay.
(2) The patient has the right to be advised orally and
in writing of any changes in the information provided
in accordance with paragraph (e)(1) of this section
when they occur. The HHA must advise the patient of
these changes orally and in writing as soon as
possible, but no later than 15 working days from the
date that the HHA becomes aware of a change.
(f) Standard: Home health hotline. The patient has the
right to be advised of the availability of the toll-
free HHA hotline in the State. When the agency accepts
the patient for treatment or care, the HHA must advise
the patient in writing of the telephone number of the
home health hotline established by the State, the hours
of its operation, and that the purpose of the hotline
is to receive complaints or questions about local
HHA's.

484.12 Condition of participation: Compliance with
Federal, State, and local laws, disclosure of ownership
information, and accepted professional standards and
practices.
(a) Standard: Compliance with Federal, State, and local
laws and regulations. The HHA and its staff must
operate and furnish services in compliance with all
applicable Federal, State, and local laws and
regulations. If State of applicable local law provides
for the licensure of HHA's, an agency not subject to
licensure is approved by the licensing authority as
meeting the standards established for licensure.
(b) Standard: Disclosure of ownership and management
information. The HHA must comply with the requirements
of Part 420, Subpart C of this chapter. The HHA must
also disclose the following information to the State
survey agency at the time of the HHA’s initial request
for certification, for each survey, and at the time of
any change in ownership or management:
(1) The name and address of all persons with an
ownership or control interest in the HHA as defined in
420.201, 420.202, and 420.200 of this chapter.
(3) The name and address of the corporation,
association, or other company that is responsible for
the management of the HHA, and the name and address of
the chief executive officer and the chairman of the
board of directors of that corporation, association, or
other company responsible for the management of the
HHA.

(c) Standard: Compliance with accepted professional standards and principles. The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.

484.14 Condition of participation: Organization, services, administration.
Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care levels are clearly set forth in writing and are readily identifiable. Administrative and supervisory functions are not delegated to another agency or organization and all services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency. If an agency has subunits, appropriate administrative records are maintained for each subunit.

(a) Standard: Services furnished. Parttime or intermittent skilled nursing services and at least one other therapeutic service (physical, speech, or occupational therapy; medical social services; or home health aide service) are made available on a visiting basis, in a place of residence used as a patient's home. An HHA must provide at least one of the qualifying services directly through agency employees, but may provide the second qualifying service and additional services under arrangements with another agency or organization.

(b) Standard: Governing body. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation the agency. The governing body appoints a qualified administrator, arranges for professional advice as required under 484.16, adopts and periodically reviews written bylaws or an acceptable equivalent, and oversees the management and fiscal affairs of the agency.

(c) Standard: Administrator. The administrator, who may also be the physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff; employs qualified personnel and ensures adequate staff education and evaluations; ensures the accuracy of public information materials and activities; and implements an effective budgeting and accounting
system. A qualified person is authorized in writing.
(d) Standard: Supervising physician or registered nurse. The skilled nursing and other therapeutic services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse). This person, or similarly qualified alternate, is available at all times during operating hours and participates in all activities relevant to the professional services furnished including the development of qualifications and the assignment of personnel.
(e) Standard: Personnel policies. Personnel practices and [patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current.
(f) Standard: Personnel under hourly or per visit contract. If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following:
(1) That patients are accepted for care only by the primary home health agency.
(2) The services to be furnished.
(3) The necessity to conform to all applicable agency policies including personnel qualifications.
(4) The responsibility for participating in developing plans of care.
(5) The manner in which services will be controlled, coordinated, and evaluated by the primary agency.
(6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation, and
(7) The procedures for payment for services rendered under the contract.
(g) Standard: Coordination of patient services. All personnel furnishing services maintain liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. A written summary report for each patient is sent to the attending physician at least every 62 days.
(h) Standard: Services under arrangements. Services furnished under arrangements are subject to a written contract conforming with the requirements specified in paragraph (f) of this section and with the requirements of section 1861(w) of the Act(42 U.S.C. 1395x(w)).
(i) Standard: Institutional planning. The HHA under
the direction of the governing body, prepares an overall plan and budget that includes an annual operating budget and a capital expenditure plan. 

(1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in any connection with the budget, an item by item identification of the components of each type of anticipated income or expense.

(2) Capital expenditure plan.

(i) There is a capital expenditure plan for at least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than $600,000 for items that would, under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time but are components of an overall plan or patient care objective are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees: bonds, notes, and other costs incurred for borrowing funds.

(ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health and Crippled Children's Services) or title XVIII (Medicare) or the Social Security Act, the plan specifies the following:

(A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.
(B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42U.S.C. 1320a-1) and implementing regulations.
(C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency.
(3) Preparation of plan and budget. The overall plan and budget is prepared under the direction of the governing body of the HHA by a committee of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA.
(4) Annual review of plan and budget. The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA.

484.16 Condition of participation: Group of professional personnel.

A group of professional personnel, which includes at least one physical and one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, personnel qualifications, and program evaluation. At least one member of the group is neither an owner or an employee of the agency.
(a) Standard: Advisory and evaluation function. The group of professional personnel meets frequently to advise the agency in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program. The meetings documented by dated minutes.

484.18 Condition of participation: Acceptance of patients, plan of care, medical supervision.

Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of care reviewed by a doctor of medicine, osteopathy, or podiatric medicine.
(a) Standard: Plan of care. The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of
services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel participate in developing the plan of care.

(b) Standard: Periodic review of plan of care. The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 62 days. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.

(c) Standard: Conformance with physician's orders. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication, and promptly report any problems to the physician.

Subpart C - Furnishing of Services

484.30 Condition of participation: Skilled nursing services.

The HHA furnishes skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care.

(a) Standard: Duties of the registered nurse. The registered nurse makes the initial evaluation visit, regularly reevaluates the patient's nursing needs, initiates the plan of care and necessary revisions, provides those services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nursing and related
needs, participates in inservice programs, and supervises and teaches other nursing personnel.

(b) Standard: Duties of the licensed practical nurse. The licensed practical nurse furnished services in accordance with agency policies, prepares clinical and progress notes, assists the physician and registered nurse in performing specialized procedures, prepares equipment and materials for treatments observing aseptic technique as required, and assists the patient in learning appropriate self-care techniques.

484.32 Condition of participation: Therapy services.

Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist and in accordance with the plan of care. The qualified therapist assists the physician in evaluating level of function, helps develop the plan of care (revising as necessary), prepares clinical and progress notes, advises and consults with the family and other agency personnel, and participates in inservice programs.

(a) Standard: Supervision of physical therapist assistant and occupational therapist assistant. Services furnished by a qualified physical therapist assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapist assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist, assists in preparing clinical notes and progress reports, and participates in educating the patient and family, and in inservice programs.

(b) Standard: Supervision of speech therapy services. Speech therapy services are furnished only by or under supervision of a qualified speech pathologist or audiologist.

484.34 Condition of participation: Medical social services.

If the agency furnished medical social services, those services are given by a qualified social worker or by a qualified social worker assistant under the supervision of a qualified social worker and in accordance with the plan of care. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems, participates in the development of the plan of care, prepares clinical and progress notes, works with the family, uses
appropriate community resources, participates in discharge planning and inservice programs, and acts as a consultant to other agency personnel.

484.36 Condition of participation: Home health aide services.

Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. They are closely supervised to ensure their competence in providing care. For home health services furnished (either directly or through arrangements with other organizations) after August 14, 1980, the HHA must use individuals who meet the personnel qualifications specified in 484.4 for "home health aide".

(a) Standard: Home health aide training.

(1) Content and duration of training. The aide training program must address each of the following subject areas through classroom and supervised practical training totalling at least 75 hours, with at least 16 hours devoted to supervised practical training. The individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training.

(i) Communications skills.

(ii) Observation, reporting and documentation of patient status and the care or service furnished.

(iii) Reading and recording temperature, pulse, and respiration.

(iv) Basic infection control procedures.

(v) Basic elements of body functioning and changes in body function that must be reported to an aide supervisor.

(vi) Maintenance of a clean, safe, and healthy environment.

(vii) Recognizing emergencies and knowledge of emergency procedures.

(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy and his or her property.

(ix) Appropriate and safe techniques in personal hygiene and grooming that include -

(A) Bed bath.

(B) Sponge, tub, or shower bath.

(C) Shampoo, sink, tub, or bed.

(D) Nail and skin care.

(E) Oral hygiene.
(F) Toileting and elimination.
(xi) Safe transfer techniques and ambulation.
(xii) Normal range of motion and positioning.
(xiii) Adequate nutrition and fluid intake.
(xiii) Any other task that the HHA may choose to have the home health aide perform.

"Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse.

(2) Conduct of training
(i) Organizations. A home health aide training program may be offered by any organization except an HHA that has been determined to be out of compliance with one or more of the requirements of this part within any of the 24 months before the training program is to begin.
(ii) Qualifications for instructors. The training of home health aides and the supervision of home health aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of home health care, and who has supervised home health aide services for at least 6 months. Other individuals may be used to provide instruction under the supervision of a qualified registered nurse.

(3) Documentation of training. The HHA must maintain sufficient documentation to demonstrate that the requirements of this standard are met.

(b) Standard: Competency evaluation and in-service training
(1) Applicability. An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph. The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.

(2) Content and frequency of evaluations and amount of in-service training.
(i) The competency evaluation must address each of the subjects listed in paragraph (a)(1)(ii) through (xiii) of this section.
(ii) The HHA must complete a performance review of each home health aide no less frequently than every 12 months.
(iii) The home health aide must receive at least 3
hours of in-service training per calendar quarter. The in-service training may be furnished while the aide is furnishing care to patients.

(3) Conduct of evaluation and training

(i) Organizations. A home health aide competency evaluation program and the in-service training may be offered by any organization except as specified in paragraph (a)(2)(i) of this section.

(ii) Evaluators and instructors. The competency evaluation must be performed by a registered nurse, and the in-service training generally must be supervised by a registered nurse who possess a minimum of 2 years of nursing experience at least 1 year of which must be in the provision of home health care and who has supervised home health aide services for at least 6 months.

(iii) Subject areas. The subject areas listed at paragraphs (a)(1)(iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aide’s performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.

(4) Competency determination.

(i) A home health aide is not considered competent in any task for which he or she is evaluated as "unsatisfactory". The aide must not perform that task without direct supervision by a licensed nurse until after he or she receives training in the task for which he or she was evaluated as "unsatisfactory" and passes a subsequent evaluation with "satisfactory".

(ii) A home health aide is not considered to have successfully passed a competency evaluation if the aide has an "unsatisfactory" rating in more than one of the required areas.

(5) Documentation of competency. The HHA must maintain documentation which demonstrates that the requirements of this standard are met.

(6) Effective date. The HHA must implement a competency evaluation program that meets the requirements of this paragraph before February 14, 1980, and must provide the preparation necessary for the individual to successfully complete a program after August 14, 1980.

(c) Standard: Assignment and duties of the home health aide. The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or therapist as appropriate. Duties include the
performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient’s conditions and needs, and completing appropriate records.

(d) Standard: Supervision. The registered nurse makes a supervisory visit to the patient’s residence at least every two weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met. If a patient is receiving only skilled therapy services and home health aide services, a skilled therapist may make the supervisory visit at least every two weeks, in lieu of a registered nurse.

484.38 Condition of participation: Qualifying to furnish outpatient physical therapy or speech pathology services.

An HHA that wishes to furnish outpatient physical therapy or speech pathology services must meet all the pertinent conditions of this part and also meet the additional health and safety requirements set forth in 405.1717 through 405.1719, 405.1721, 405.1723, and 405.1725 of this chapter to implement section 1861(p) of the Act.

484.48 Condition of participation: Clinical records.

A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information: name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.

(a) Standard: Retention of records.
Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinues operations. If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient.

(b) Standard: Protection of records.
Clinical record information is safeguarded against loss
or unauthorized use. Written procedures govern use and removal of records and the conditions for release of information. Patient’s written consent is required for release of information not authorized by law.

44.52 Condition of participation: Evaluation of the agency’s program.
The HHA has written policies requiring an overall evaluation of the agency’s total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency’s program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

(a) Standard: Policy and administrative review. As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.

(b) Standard: Clinical record review. At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed records to determine whether established policies are followed in furnishing services directly or under arrangement. There is a continuing review of clinical records for each 62 day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.
Appendix C

Chapter 137

Local Boards of Health

137.1 Title. This chapter may be cited as the "Local Health Act."

137.2 Definitions. As used in this chapter unless the context otherwise requires:

1. "County board" means a county board of health.
2. "City board" means a city board of health.
3. "District board" means a district board of health formed with approval by the state board of health.
4. "District health department" refers to the personnel and property under the jurisdiction of a district board of health.
5. "Local board of health" means a county, city, or district board of health.
6. "State department" means the state department of health.
7. "State board" means the state board of health.
8. "Commissioner" means the commissioner of public health.

137.3 County board. The county board of health in each county shall consist of five members, at least one of whom shall be licensed in Iowa as a doctor of medicine and surgery or as an osteopathic physician and surgeon, as defined by law.

137.4 Appointment - vacancies. All members of the county board shall be appointed by the county supervisors and shall serve for a period of three years.

Vacancies due to death, resignation, or other cause shall be filled as soon as possible after the vacancy exists by appointment of the board of supervisors for the unexpired term of the original appointment.

137.5 Jurisdiction of county and city boards. The county board shall have jurisdiction over public health matters within the county, except as set forth herein and in section 137.13. The council of any city having a population of twenty-five thousand or more, according to the latest federal census, may appoint a city board of health in the manner specified in section 137.3 and
137.4 or the council may appoint itself to act as the city board of health. The city board shall have jurisdiction within the municipal limits.

137.6 Powers of local boards. Local boards shall have the following powers:

1. Enforce state health laws and the rules and lawful order of the state department.

2. Make and enforce such reasonable rules and regulations not inconsistent with law or with the rules of the state board as may be necessary for the protection and improvement of the public health.
   a. Rules of a county board shall become effective upon approval by the county board of supervisors and publication in a newspaper having general circulation in the county.
   b. Rules of a city board shall become effective upon approval by the city council and publication in a newspaper having general circulation in the city.
   c. Rules of a district board shall become effective upon approval by the district board and publication in a newspaper having general circulation in the district.
   d. However, before approving any rule or regulation the local board of health shall hold a public hearing on the proposed rule. Any citizen may appear and be heard at the public hearing. A notice of the public hearing, stating the time and place and the general nature of the proposed rule or regulation, shall be published at least ten days before the hearing in a newspaper of general circulation in the area served by the board.

The board shall also make a reasonable effort to give notice of the hearing to the communications media within said area.

3. May by agreement with the council of any city or town within its jurisdiction enforce appropriate ordinances of said city or town.

4. Employ such employees as are necessary for the efficient discharge of its duties. Employment practices shall meet the requirements of the Iowa merit system council or any civil service provision adopted under Chapter 400.

5. Provide reports of its operation and activities to the state department as may be required by the commissioner.
137.7 Additional powers of local boards. Local boards shall have the following powers and duties to the extent they do not unreasonably interfere with existing patterns of private professional practice of licensed practitioners of the healing arts. Local boards:

1. May provide such personal and environmental health services as may be deemed necessary for the protection and improvement of the public health.

2. May engage in joint operations and contract with colleges and universities, the state department, other public and private agencies, and individuals for public health activities or projects.

3. May charge reasonable fees for personal health services. No person shall be denied necessary services within the limits of available personnel because of inability to pay the cost of such services.

4. May issue licenses and permits and charge reasonable fees therefor in relation to the collection or disposal of solid waste and the construction or operation of private water supplies or sewage disposal facilities.

137.8 District health department plan. The state department shall, after consultation with existing county and city boards, develop and may amend from time to time as necessary a district health department plan. The plan shall set forth recommended areas for the development of district health departments.

137.9 Rules for standards. The state board shall adopt rules and regulations setting minimum standards and procedures for the formation and approval of district health departments.

137.10 District board of health approval requested. The county and city boards in any areas designated by the district health department plan may at any time submit to the state department a request for approval as a district health department. The request shall include:

1. A plan for appointment of a district board of health, the membership of which shall not exceed eleven members who shall be reasonably representative of all existing health jurisdictions in the area. At least
one and not more than three of the members shall be licensed in Iowa as doctors of medicine and surgery or osteopathic physicians and surgeons, as defined by law. The plan shall specify the terms of office of the members, by whom appointments to the board are to be made, and methods for filling vacancies.

2. Evidence that the proposed district health department is consistent with the state district health department plan and will meet the requirements of rules and regulations of the state board.

137.11 Requests reviewed by state department. The state department shall review requests submitted under section 137.10. The state department, upon finding that all necessary conditions are met, shall approve the formation of a district health department and shall so notify the local boards from whom the request was received.

137.12 Appointment. On receipt of notice of approval as a district health department, a district board shall be appointed as specified in the plan. Board members shall serve without compensation, but shall be reimbursed from the local health fund, established under section 137.17, for necessary expenses in accordance with rules and regulations established by the state board.

137.13 Disbandment of local boards. On appointment of a district board, the county and city boards involved shall be disbanded and their powers and duties specified in section 137.6 and 137.7 transferred to the district board.

137.14 Adding to district. A city or county may be added to an existing district health department by submission and approval of a request, as specified in section 137.10 through 137.13, and upon approval of the request by both the district board and the state board.

137.15 Withdrawal from district. A city or county may withdraw from an existing district health department upon submission of a request for withdrawal and approval of the request by both the district board and the state board.

137.16 Local health fund. The treasurer of each county shall establish a "local health fund."
137.17 Local fund for district. On establishment of a district health department, the district board shall designate the treasurer of a city or county within its jurisdiction to establish a "local health fund" for the district. Upon establishment of the fund, moneys in previously existing local health funds in the district shall be transferred to the fund.

137.18 Deposit of moneys in fund. All moneys received by a county or district for local health purposes from federal appropriations, from local taxation, from licenses, from fees for personal services, or from gifts, grants, bequests, or other sources shall be deposited in the local health fund. Expenditures shall be made from the fund on order of the local board for the purpose of carrying out its duties.

137.19 Emergency request for funds. A local board may, in emergency situations, request additional appropriations, which may, upon approval of the commissioner, be allotted from the funds reserved for that purpose. On termination of the emergency situation, the local board shall report its expenditures of emergency funds to the commissioner and return any unexpended funds.

137.20 Appropriation from general fund of county. The board of supervisors of any county may appropriate from the county general fund for the purpose of providing local health services. A county appropriation shall not exceed the statutory limitation found in chapter 444. Moneys appropriated for this purpose shall be deposited in the local health fund as specified in section 137.18.

137.21 Penalties. Any person who violates any provision of this chapter or the rules of a local board or any lawful order of said board, its officers, or authorized agents shall be guilty of a misdemeanor and shall be punished by a fine not to exceed one hundred dollars or by imprisonment in the county jail for not more than thirty days. Each additional day of neglect of failure to comply with such provision, rule or lawful order after notice of violation by the local board shall constitute a separate offense.

137.22 Individual choice of treatment. Nothing in this chapter shall be construed to impede, limit, or restrict the right of free choice by an individual to
the health care or treatment that he may select.
Appendix D

Iowa Department of Public Health Districts
Appendix E

QUESTIONNAIRE

The following questions relate to general board functions and the interaction of the board with the public health nursing agency. If your board does not provide public health nursing, please note that at the end of the questionnaire and answer all questions that apply to your board.

Please mark with an X to the left of all applicable answers on each question, except where otherwise noted. When completed, please return the questionnaire in the envelope provided.

1. How long have you served on the Board of Health?
   _____ a. under one year
   _____ b. 1 - 3 years
   _____ c. 4 - 6 years
   _____ d. 7 - 9 years
   _____ e. 10 or more years

2. What kind of influence do you have in your community or county that is helpful on the board? (may choose more than one answer)
   _____ a. my connections in the community
   _____ b. my past experience
   _____ c. my occupation
   _____ d. my special skills or knowledge

Explain or add other answers here: ____________________________
3. Did you receive orientation or training when you first became a member?
   ___ a. yes
   ___ b. no
   ___ c. I don’t remember

4. If yes, how did you receive that training? (check as many as apply)
   ___ a. talking with those who appointed me
   ___ b. talking with nurse administrator
   ___ c. formal orientation program
   ___ d. reading on my own
   ___ e. talking with other board members

5. Have you received additional training during the time you’ve been a member?
   ___ a. yes
   ___ b. no
   ___ c. I don’t know

6. If yes, how have you received additional training? (check as many as apply)
   ___ a. information presented at board meetings
   ___ b. separate inservice
   ___ c. reading materials provided to me
   ___ d. other (please explain) __________
7. The Board of Health has many responsibilities including enforcing State health laws, making rules and regulations and issuing licenses and permits. Boards also govern public health nursing agencies. I would like you to rank the following activities that boards perform with nursing agencies. Please mark 1 (one) next to the function you feel is most important and number through 10 (ten) for the function you feel is least important. I am interested in your opinion only, there is no "right" way to rank these activities. If there are activities you feel your board doesn't perform, draw a line through those.

___ a. advise the agency management
___ b. oversee management/financial operation
___ c. assess community health needs
___ d. exercise political influence
___ e. review and approve agency policies
___ f. planning, including budgeting
___ g. appointment of qualified administrator
___ h. work to improve agency image
___ i. oversee agency programs, for example, care of the sick, health promotion, maternal and child health
___ j. appointment of advisory committee

8. Please list any other activities you perform regularly on the board that are not included in the above list.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
9. How do you think boards can be more successful in carrying out their activities?

10. What is your sex?  
_____ a. female  
_____ b. male

What is your age?
_____ a. under 21  
_____ b. 21 - 30  
_____ c. 31 - 40  
_____ d. 41 - 50  
_____ e. 51 - 60  
_____ f. 61 - 70  
_____ g. 71 - 80  
_____ h. over 80

11. Please list here previous boards (public or private) on which you have served:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

12. Please describe your occupation ____________________________

_________________________________________________________________
_________________________________________________________________

13. Please use this space for any additional comments about this study or Board of Health matters.

Thank you again for your participation.
Appendix F

Marti Franc, RN  
(hm) 101 E. Montgomery  
Knoxville, IA 50138  
(515) 842-7140  

(wk) Courthouse  
Knoxville, IA 50138  
(515) 828-2238

I am conducting a study of Boards of Health in Iowa as part of my masters program at Drake University. As you know, these boards have many rights and responsibilities as decision makers and providers of essential health services in our communities. I am gathering information to help us better understand board members, so that we might work more effectively with boards to achieve our mutual goals.

I will send a copy of the enclosed questionnaire to a sample of board members around the state. I am asking you, as an experienced public health professional, to review the questionnaire and give me your opinion about whether it would provide information to answer the following questions:
   a. how are board members selected and trained
   b. how do board members rank the importance of functions or activities assigned to them
   c. what are board members' gender and occupations

I will contact you by telephone about a week after you receive this letter and ask you for your reactions to the questionnaire as a tool to gather the above information. Thank you for your consideration.

Sincerely,
Appendix G

I am preparing to complete a study of Boards of Health in Iowa and am requesting your assistance. You are one of ten Board of Health members that I have chosen for my pilot study (done before the actual study).

Please read the enclosed letter and questionnaire and respond to these questions on the back of this letter:

1. Does the enclosed letter clearly explain the project and what I am asking people to do?
2. Are the questions on the questionnaire readable and easy to understand?
3. Are any questions objectionable?
4. What is your overall impression of the questionnaire?
5. Please answer the questions on the questionnaire and write down about how long it took to answer the whole questionnaire.

Your assistance is greatly appreciated as it will help ensure that this study will gather useful information that will help Boards of Health. Please return all of these sheets in the enclosed self-addressed envelope within a week or let me know as soon as possible if it will be impossible for you to participate. Thank you again for your time.
Appendix H

Marti Franc, RN
Marion County Public Health Nursing Service
Courthouse
Knoxville, IA 50138
(wk) 515-828-2238
(hm) 515-842-7140

As you know, local Boards of Health play an important role in community health matters and the operation of public health nursing agencies, yet little is known about boards and their activities.

I am writing to request your participation in a study of Boards of Health In Iowa. I am a graduate student in nursing at Drake University and a nurse administrator in a county public health nursing agency. Filling out and returning the questionnaire will indicate your informed consent to participate in this study. Please take several minutes to read and answer the questions on the enclosed questionnaire and return to me within two weeks, if at all possible. Even if your term is soon ending, your input will be most useful. The information and opinions you provide will be combined into a report that will be used in planning how to better prepare nurses to work with boards. I will send you a copy of the summary report after it is completed.

Your answers will be kept confidential, only compiled information will be reported. The identification number on the questionnaire will help me keep track of which ones have been returned.

Please contact me at home or at work with any questions you might have. Thanks for your time and input.

Sincerely,
Appendix I

Martí Franc, RN
Marion County Public Health Nursing Service
Knoxville, IA 50138
(wk) 515-826-2238
(hm) 515-842-7140

About four weeks ago I sent you a questionnaire about your Board of Health activities. Since I have not received your completed questionnaire, I'm sending another one with a request that you answer the questions and use the enclosed envelope to return it to me within two weeks.

I'm gathering important information from this study that will be useful to county supervisors, state personnel, public health nurses, and Board of Health members. Your input will be most helpful, even if your term has expired.

As you may recall, I plan to share the results with boards around the state and will keep individual comments and results strictly confidential. The identification number on questionnaires is used to help me keep track of which ones have been returned.

Thank you in advance for your participation and I look forward to hearing from you. If you have recently returned the first questionnaire, please disregard this correspondence.

Sincerely,
Appendix J

To be completed by the Investigator:

Date Submitted: 10-29-90
Proposal Title: County Board of Health Member Characteristics Related to Board Functions
Investigator: Marti Franc, RN
Faculty research advisor (for student research): Marion Lipman, RN
Return to: Marti Franc
Name
101 E. Montgomery
Street Address or Campus Office
Knoxville, IA 50131
City, State, Zip if off campus

To be completed by the Human Subjects Research Review Committee Chairperson:

Date Received: 1/8/90

Decision:

☑ Approval, no risk
☐ Approval, minimal risk
☐ Approval, subjects at risk, but benefits outweigh risks
☐ No approval. Subjects at risk or proposal does not adequately address risks, benefits and procedures.

Reasons for Disapproval:

☐

Reviewer Suggested:

Suggested Changes: Could make questions more pointed at #9
"In what ways might communication between human &
boards of health be facilitated?"

Human Subjects Review Committee Chair: Hilda L. Williams (1990-1991)
Date: 1/8/90
Appendix K

Counties categorized by population, according to 1890 Census Bureau data

A. <10,000

B. 10-15,000
Allamakee, Appanoose, Calhoun, Cherokee, Chickasaw, Dickinson, Emmet, Franklin, Greene, Grundy, Guthrie, Hancock, Harrison, Humbolt, Iowa, Keokuk, Louisa, Lyon, Madison, Mills, Monona, Montgomery, Palo Alto, Sac, Shelby, Union, Winnebago

C. 15-20,000

D. 20-40,000
Benton, Boone, Bremer, Buchanan, Carroll, Dallas, Fayette, Jasper, Lee, Mahaska, Marion, Marshall, Muscatine, Plymouth, Sioux, Wapello, Warren, Winneshiek

E. >40,000
Black Hawk, Cerro Gordo, Clinton, Des Moines, Dubuque, Johnson, Linn, Polk, Pottawattamie, Scott, Story, Webster, Woodbury
Appendix L

Numbers of respondents who ranked each function from one (most important) to ten (least important).

Functions:
A. Advise agency management
B. Oversee management/finance
C. Assess community health needs
D. Exercise political influence
E. Review/approve policies
F. Planning and budgeting
G. Appoint administrator
H. Improve agency image
I. Oversee agency programs
J. Appoint advisory committee

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Appendix M

Specific board memberships listed by study respondents, grouped under categories by the author. Numbers in parentheses indicate how many listed that board if there were more than one.

Church: 27

School: school board (7), college (4), preschool, daycare.


State and Local Government: city council (2), soil conservation commission (2), land use, planning and zoning (3), county compensation board, fire (2), housing, hunger task force, Department of Transportation, economic development (3), board of adjustment (2), condemnation, Board of Supervisors (4), township trustee, community betterment, mayor (2), environmental protection (2), solid waste, county crime commission.

Civic: local tourism, League of Women Voters (2), library (4), Lions, United Way (2), Chamber of Commerce (6), Jaycees (3), Kiwanis, Rotary, ladies aid (2), American Legion, museum, symphony, music, Optimists, March of Dimes, arts council, YMCA (3), Soroptomist, community theater, unspecified civic (2).

Professional: Board of Realtors, Iowa Academy of Family Physicians, Dental Hygiene Asso., nursing (4), Osteopathic Medical Asso., other professional.

Others: work activity center, Farm Bureau (5), creamery, coop elevator, PFA, county club (2), AFS chapter, credit union, Area Agency on Aging (2), Small Business Asso., food coop, Veterans Affairs, bank, cemetery, JTPA.
Appendix N

The following are comments written by subjects in response to the question, How do you think boards can be more successful in carrying out their activities? Comments are grouped under headings by the author.

Better Communication

closer liaison with state department of health
provide state funding to back up established programs
stay more informed with nursing agency

We need more local power. If we feel action needs to take place - it should with our recommendation!

by their administrator keeping them well informed
clearer definition of powers/authorities/responsibilities

when the legislature gives us a mandate to enforce, also give us the money and legal authority to do so

less influence from the state

Boards of Supervisors need to be informed and supportive of programs and operations

have resources and funds

be more active in city and county matters

more financial help from state and federal governments

good communication of county medical, political, communities

orientation from Iowa Department of Public Health and county government

have a better relationship with Board of Supervisors who control ultimate power

to be in closer contact with state agencies to be more aware of policy changes and policy direction (especially environmental concerns)
Agency Oversite:

We probably could spend more time with the agency, do independent assessments, and ask more questions in regards to the effectiveness and productivity of services.

more PR

closer liason with referring agencies

more critical evaluation of P.H. programs - do we need to provide this particular service? are others providing this service? etc

more info re: public health nursing issues

improve communication between administrator and public

informing the public - some people do not even know how or who to contact for help

qualified nurse administrator and sanitarain

It is helpful to be more informed on evaluation and performance review of employees.

better knowledge of monies available from the county

marketing - need improved strategies to market services to community

cooperate with the administrator and understand the problems encountered

From reports board members ask questions - need of staff to give reports at our monthly meetings. Board members must be interested in staff and the work they do.

This board and the nursing staff have a good working relationship - but could use better communication within the office.

Each board member should spend at least one full day in the field with the director of each department. We need to be in touch with the realities of the job and its employees.
Improving Board Function:

As an individual I help with the paperwork at immunization clinics every two weeks, sometimes other clinics.

receive training about our responsibilities and the department of health

need people who will serve on board and come to meetings

Have a better orientation from the Board of Health. Have a flow chart of the organization from the Co. Board of Supervisors to the community nurses and an explanation of funding.

better orientation to public health's role

better attendance with more input

get more people to become actively involved

highly motivated board members with varying backgrounds

training for new members

I think our board needs more specifically defined objectives and goals.

training would be helpful - legal ramifications and authority training

Boards, by and large, are not well trained here! Everything is controlled from the state and by Co. Bd. of Supervisors. Very little function for Board of Health.

by being as well informed as possible and not being hesitant in acting

I think consolidation and better organization of financial and utilization data would make it easier to view how the agency is performing. Also orientation of new board members.
Boards must be unified in purpose and must support their nurse administrators and nursing staff in their duties.

stay in policy making realm

better training
Appendix O

The following comments resulted from the invitation at the end of the questionnaire to use the additional space for comments about the study or Board of Health matters. They are presented in no particular order.

With the advent of private home health care services, public health nursing needs to reassess its role - are we spending our tax resources in the most advantageous way? Are we meeting needs not met by the private sector (are we duplicating private sector efforts?) - What of new public health issues (AIDS, STD's, etc) are we addressing them? If we had to, what service or program is most dispensable?

At this point in time I am very concerned about AIDS especially in our young people. I believe we need more in school health education on how we can stop and head off this disease for the next generation!

We have special problems here in that we are a very large county, so much of our time is spent driving. State rules and regulations! Want all agencies to comply but do not offer any monetary cooperation.

It is hard to find dedicated people who will participate and come to the meetings - I do not know how we can inspire interest - but I feel this board does a great service for the county.

our board is doing a super job

I think it is important to keep the legislature informed of the tremendous need for them to continue with the state grants to public health nurses, immunizations, well elderly, WIC, MCH, community assessments, and others.

Our county health nurse is very knowledgable and handles all things well.

I think our board does fine.

I think our board is quite successful.
At this time I feel we have a well informed board and carry out activities well - following through with all the proposals placed before them.

In the past ten years our board has become quite active. We have appointed a county sanitarian who is now involved in food inspections, swimming pool inspections, abandoned well closures, water testing and issuing of septic tank installation and well drilling permits and of course inspections of these. Plus many other programs that benefit the health of our young people as well as the old.

The duties - and therefore the importance - of the county Board of Health has changed and increased greatly since I first went on the Board. I think one of the most important aspects of the Board is to hire competent, dedicated personnel for our nursing and health service. We spend a lot of time interviewing and discussing every new applicant. Serving the needs of the people of the county (primarily the elderly) is the top priority.

The role of public health has changed greatly and we need to be prepared to work on these many projects.

I feel that we have had a well qualified Board, which includes a doctor, accountant, school administrator, retired banker, and normally others involved in the business of health care. Our services have expanded greatly in the 12 years I have served as secretary, under the administration of 4 different nurse administrators. I feel a competent administrator is most important and she must have a good relationship with the Board of Supervisors as well as with the nurses and other employees. Board members can make suggestions and recommendations as well as approve actions, but the administrator is definitely in charge.