



**LakeCounty**

Health Department and  
Community Health Center

# 2017-2019 Strategic Plan

**HEALTHY CHOICES. HEALTHIER PEOPLE.  
HEALTHIEST COMMUNITIES.**

## LETTER FROM THE EXECUTIVE DIRECTOR

# A Case for Positive Change

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**Mark Pfister**  
Executive Director

**Timothy Sashko**  
President  
Board of Health

**Mallory Bejster**  
Chair  
Governing Council

Welcome to the Lake County Health Department and Community Health Center's 2017-2019 Strategic Plan.

Over the past several years, we have undergone positive changes as an organization. We have reorganized our leadership team, received Public Health Accreditation Board certification, and we have assessed and identified the Lake County health priorities. I am excited about the direction we are headed.

Our leadership team is working to unify our staff to truly become one cohesive and effective agency. We recently met with our two governing boards, the Board of Health and Governing Council, to examine our mission and vision statements to assure that they reflect who we are as an organization and clearly articulate our role in improving health for all Lake County.

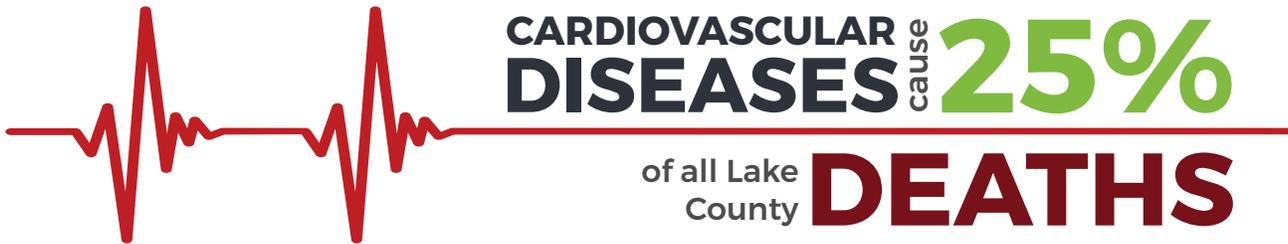
We have worked in close partnership with the Live Well Lake County steering committee since its founding in 2011 to identify key health issues affecting our residents. In the fall of 2016, four Community Health Assessments (CHA) and a Community Health Improvement Plan (CHIP) were completed with the community and approved by the Illinois Department of Public Health. This community-driven effort has identified four health issues demanding our attention: obesity, cardiovascular disease/hypertension, behavioral health capacity, and diabetes. These chronic health conditions impact our quality of life and the future of Lake County communities.

Implementation of the CHIP to address these chronic health conditions is underway. Additionally, we are improving the monitoring of key performance metrics across our programs to measure our impact on the identified health issues. We are making changes to enhance the quality of service and care we provide. We are developing a health equity policy and training our staff on the social determinants of health. We are shaping policy, improving systems, and advocating for environmental change to enhance Lake County.

This strategic plan is built upon five 'Health Impact in 3' goals. We are focused and determined to accomplish them. It is our hope that each year, we will show improvement in addressing the needs of our residents. We look forward to sharing the success of our efforts with you as we strive to ensure the highest level of health for all residents in Lake County, Illinois.

# Health Indicators in Lake County

based on 2015 Lake County, Illinois survey data<sup>1</sup>

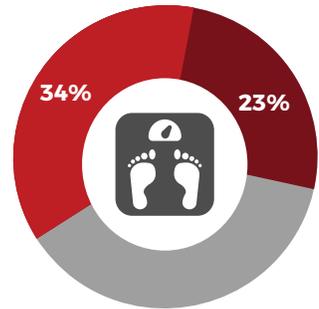


1 in 3 Lake County adults may have been diagnosed with **HYPERTENSION** 

**18%**

may have been diagnosed with **DEPRESSION**

About **320,000** Lake County adults are **OVERWEIGHT** or **OBESE**



Over 31,000 Lake County adults may have been diagnosed with **DIABETES**  the **#4** cause of early death in Lake County

**73,000 MAY HAVE PRE-DIABETES**

**37%** of surveyed Lake County residents ranked **SUBSTANCE USE** as the **#1 HEALTH ISSUE** facing their community

The **#10** cause of death in Lake County **SUICIDE**

<sup>1</sup> Live Well Lake County Community Health Assessment. Waukegan, 2016, <http://www.livewelllakecounty.org/community-health-assessment>.

# LAKE COUNTY HEALTH DEPARTMENT AND COMMUNITY HEALTH CENTER

## OUR MISSION

Promoting the health and well-being of all who live, work, and play in Lake County

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## PROACTIVE SUSTAINABILITY

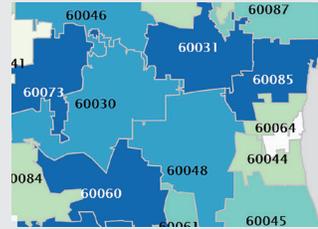
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The ongoing State of Illinois budget impasse and potential changes to the Affordable Care Act require that we plan and prepare for potential shifts in reimbursement for services we currently provide.

## OUR VISION

Healthy Choices. Healthier People.  
Healthiest Communities.



### CLINICAL PROGRAMS

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Patients utilizing our clinical services face a number of challenges in their journey toward better health. Our emerging work addressing social determinants of health in our community health centers builds upon the evidence based model of the patient centered medical home (PCMH).

### PREVENTION AND EDUCATION

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Whether West Nile, pertussis, or sexually transmitted infections, our prevention programs are combatting many emerging threats to our communities.

### SUMMARY OF GOALS

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Our 2017-2019 goals reflect our focus on aligning our programs with a focus on data driven prevention, quality care and service to Lake County residents.

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Since 2011, the Live Well Lake County steering committee has helped lead our community-driven planning and implementation efforts.

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# Strategic Plan Overview

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## THE PROCESS

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### Establishing Priorities

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The Community Health Assessment (CHA) identified the top ten health issues in Lake County. Live Well Lake County members then selected four as priorities for the Community Health Improvement Plan (CHIP): obesity, cardiovascular disease/hypertension, behavioral health capacity and diabetes. Because we are a health department, we adopted a fifth priority of reducing the burden of infectious disease.

To address these priorities, Health Department leaders formed the foundation of our Health Impact in Three Years (HI-3) strategy.

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### Strategic Plan Working Group

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Next, we formed a core group of leaders whose programs align with the identified priorities. This working group evaluated our strategy, then divided into teams to develop the short and long term projects and activities needed to address these priorities. These projects and activities will be built into work plans. We will track progress monthly.

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### Mission & Vision, Executive Approval

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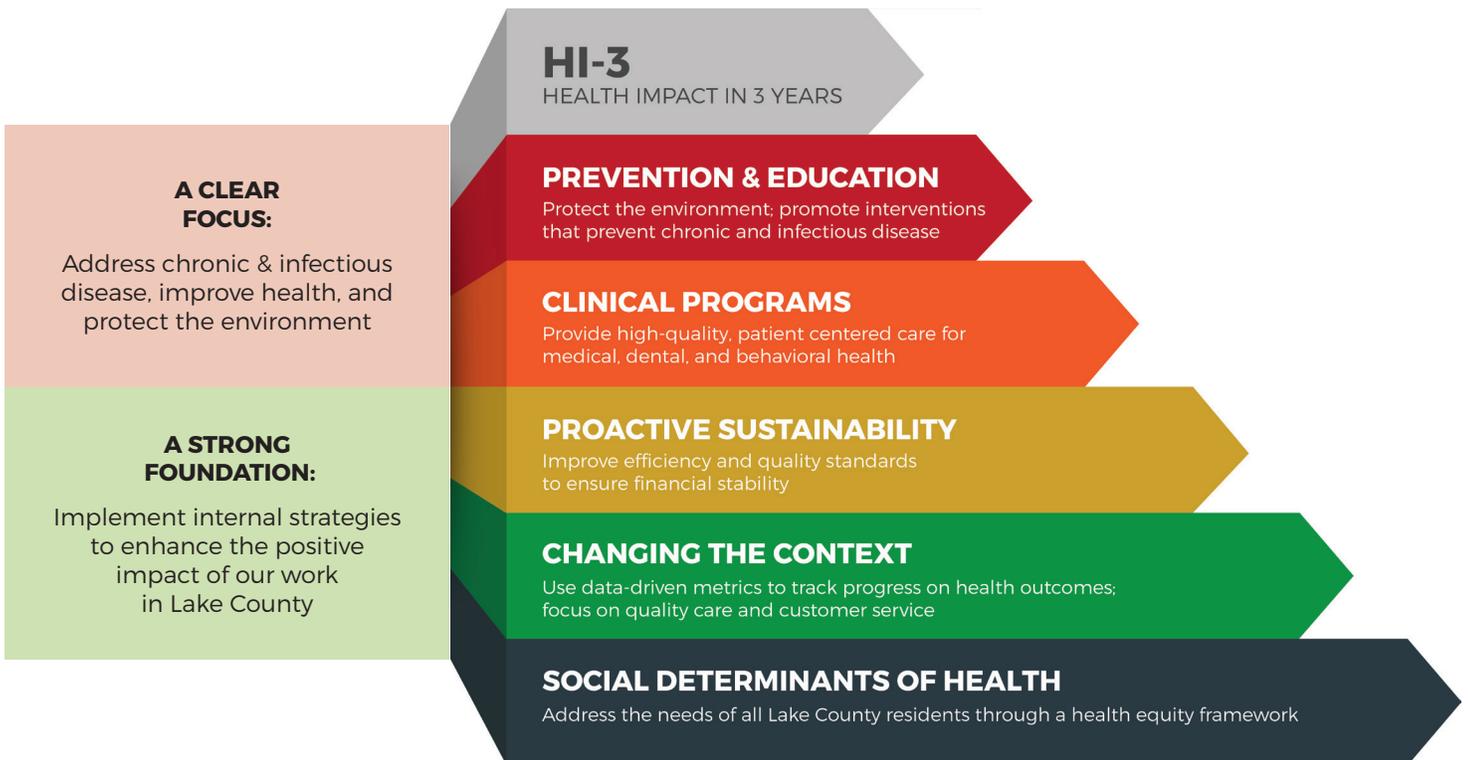
For many years, the Health Department and the Community Health Center have held separate mission statements. The board of health and governing council met to review these statements, and the Health Department held focus groups to gather feedback. New mission and vision statements were written to unify the organization and reflect our new focus on addressing social determinants of health.

In February 2017, the board of health and governing council met and discussed the updated mission and vision statements and our proposed goals.

# HEALTH IMPACT IN 3 YEARS (HI-3)

Approximately 133 million Americans suffer from chronic diseases like heart disease, diabetes, and mental health disorders.<sup>1</sup> In Lake County, 7 of the top 10 causes of death are chronic diseases, and these mostly preventable conditions affect a higher percentage of our African American and Hispanic populations.<sup>2</sup>

To change this reality, the Health Department intends to work with community partners to address the social, economic, and environmental causes of health inequity. We will use data to verify we are doing the right things, maximizing our resources, and providing quality care and services. We will work with our local, state, and federal policy, system and environmental leaders to advocate for the healthiest Lake County.



Our HI-3 framework unifies our Health Department and drives our work on obesity, cardiovascular disease, behavioral health capacity, diabetes, and infectious disease prevention. Our commitment to work with the community to address the social determinants of health, our focus on data-driven progress, and our emphasis on quality equip us to accomplish our vision:

**Healthy Choices. Healthier People. Healthiest Communities.**

<sup>1</sup> *Healthy Communities, Healthy Behaviors: Using Policy, Systems, And Environmental Change To Combat Chronic Disease*. National Association Of County & City Health Officials, Washington, D.C., 2011, p. 1, [http://archived.naccho.org/topics/HPDP/mcah/upload/issuebrief\\_pse\\_webfinal.pdf](http://archived.naccho.org/topics/HPDP/mcah/upload/issuebrief_pse_webfinal.pdf).  
<sup>2</sup> *Live Well Lake County Community Health Assessment*. Waukegan, 2016, <http://www.livewelllakecounty.org/community-health-assessment>.

## STRATEGIC PRIORITY ONE

# Social Determinants of Health



Many leading health agencies across the nation have begun discussing the impact *place* has on individual and population health outcomes. As a part of this dialogue, we use two important terms to help shape our efforts—**social determinants of health** and **health equity**.

Social determinants of health (SDoH)	
Definition	Examples
The structural determinants and conditions in which people are born, grow, live, work, and age <sup>1</sup>	<ul style="list-style-type: none"> <li>• Socioeconomic status</li> <li>• Education</li> <li>• Physical environment</li> <li>• Employment</li> <li>• Social support networks</li> <li>• Access to healthcare</li> </ul>

Health equity	
Definition	Requires
Attainment of the highest level of health for all people <sup>2</sup>	<ul style="list-style-type: none"> <li>• Valuing everyone equally</li> <li>• Societal efforts to address avoidable inequalities</li> <li>• Addressing historical and contemporary injustices</li> <li>• Eliminating health and healthcare disparities</li> </ul>

1 Marmot, Michael et al. "Closing The Gap In A Generation: Health Equity Through Action On The Social Determinants Of Health". The Lancet, vol 372, no. 9650, 2008, pp. 1661-1669.

2 Heiman, Harry J. and Samantha Artiga. Beyond Health Care: The Role Of Social Determinants In Promoting Health And Health Equity. The Henry J. Kaiser Family Foundation. The Kaiser Commission On Medicaid And The Uninsured, Menlo Park, 2015, <http://files.kff.org/attachment/issue-brief-beyond-health-care>.

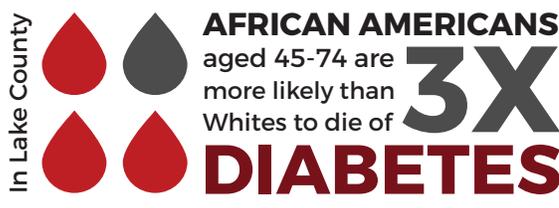
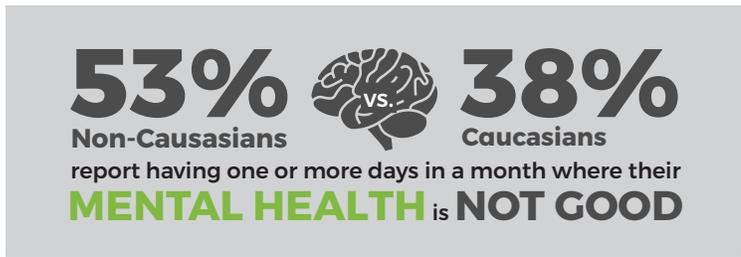
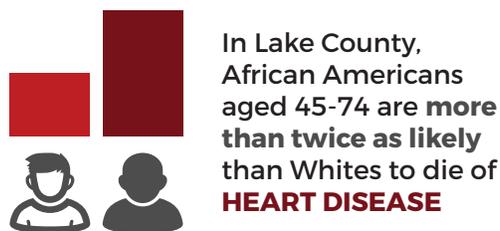
Achieving health equity in our communities can be a challenging journey, but one we agree is necessary to prevent disease and to provide the best care and service to Lake County residents.

In Lake County we have examined key indicators that influence our residents' health to identify areas where inequity persists:

- The average age of death for residents
- The walkability and bikeability of our neighborhoods and cities
- The availability of jobs that help individuals earn a living wage
- Local access to fresh foods and vegetables
- Crime statistics
- The educational outcomes of students at our schools

## WHERE WE ARE NOW

Based on our Community Health Assessment (CHA) we know there is opportunity to improve health outcomes for our residents across all socioeconomic levels.<sup>1</sup>



<sup>1</sup> Live Well Lake County Community Health Assessment. Waukegan, 2016, <http://www.livewelllakecounty.org/community-health-assessment>.

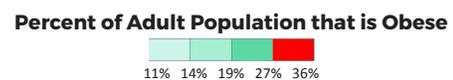
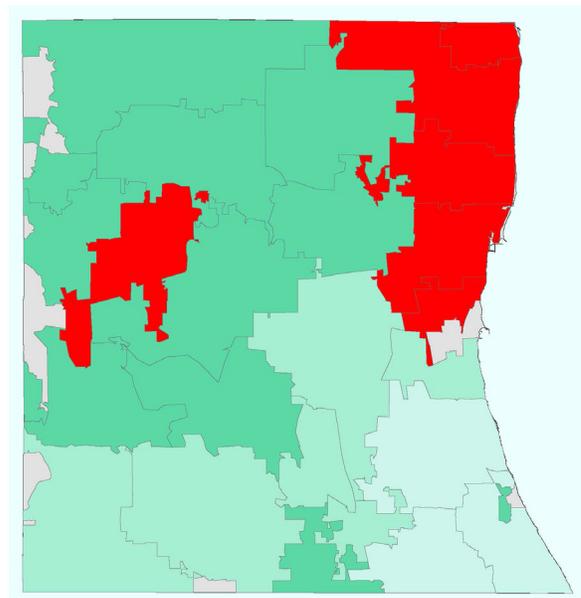
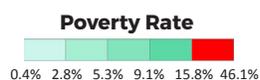
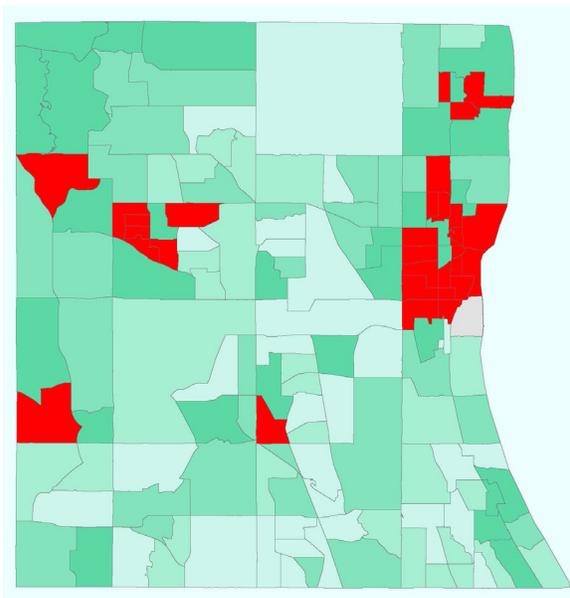
## STRATEGIC PRIORITY ONE

# Social Determinants of Health

### WHERE WE ARE NOW

Social determinants of health and health equity are the driving forces behind all Lake County Health Department and Community Health Center efforts under this strategic plan.

The health, social, and economic indicators we have identified highlight the need to change our approach. We are engaging the community and their policy makers around interventions that address policy, system and environmental factors impacting residents of Lake County.



The 2010 census and drivers license data highlight a correlation between poverty and obesity in certain Lake County communities. For more health and demographic data, visit [www.LiveWellLakeCounty.org](http://www.LiveWellLakeCounty.org)



## OUR SOLUTION

In January 2017, our Health Equity team, alongside several community partners, launched the Together Summit. We brought in a health equity thought leader to discuss the role that place has in shaping health outcomes. The event was attended by over 200 community leaders. It ignited a county wide conversation on how SDoH impacts Lake County residents and how we as a community can make health equity a reality for all. Continued implementation of this strategic plan will build upon the momentum from this event.

Moving forward, the Health Department will implement a health equity policy along the lines of the federal Healthy People 2020 policy. Healthy People 2020 highlights the importance of creating "social and physical environments that promote good health for all."<sup>1</sup>

In addition to assessing our patients for SDoH, we will also focus internally on educating our staff. We have the responsibility to prepare them to be mindful and engaged with our community partners in developing interventions that address the needs of all Lake County residents.

## GOALS

- Develop educational materials and train all staff on social determinants of health, their impact on Lake County residents, and strategies to improve the quality of life for all
- Develop and implement a health equity policy that assesses the current health equity culture and identifies training needs
- Assess 100% of new clients for social determinants of health upon their first visit to LCHD/CHC

<sup>1</sup> Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. *Healthy People 2020: An Opportunity To Address Societal Determinants Of Health In The United States*. 2010, <http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm>.

## STRATEGIC PRIORITY TWO

# Changing the Context

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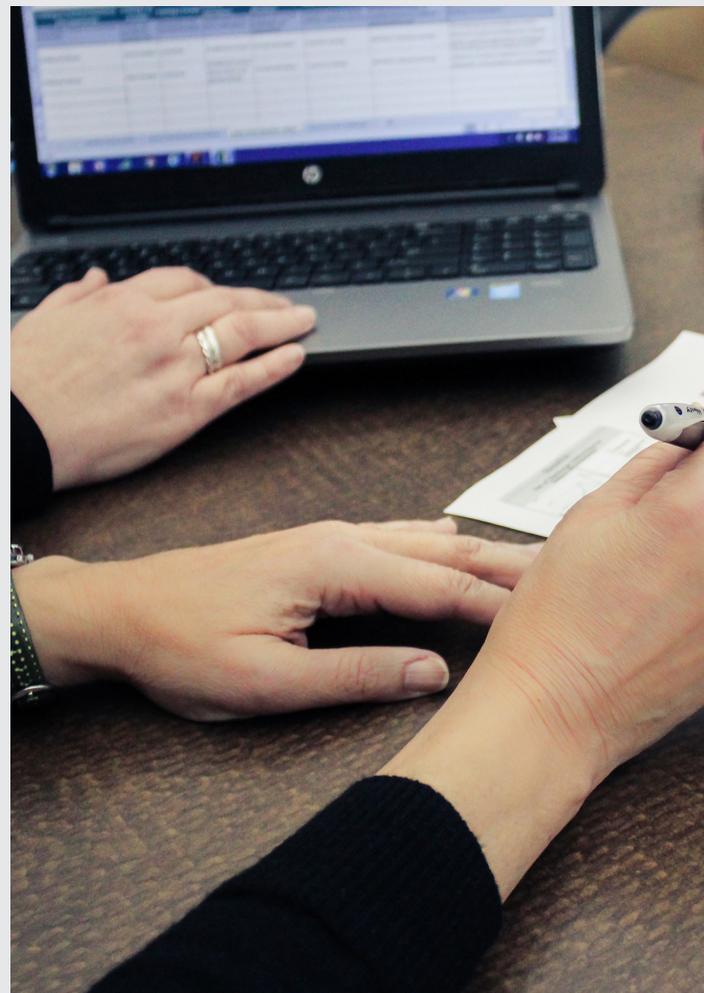
The Health Department has a tremendous opportunity to enhance the quality of services provided to the residents of Lake County.

Currently we are among only 11% of the nation's public health departments offering both traditional public health services (e.g., immunizations, communicable disease prevention, environmental health) *as well as* comprehensive medical and behavioral health services.<sup>1</sup> This complexity in our service to Lake County has led us to a new system using key performance indicators, or KPIs, to measure meaningful data across our organization and ensure we are making a meaningful impact through our work.

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### WHERE WE ARE NOW

The LCHD/CHC launched a baseline performance management system in 2013. We are in the process of moving to a new organizational quality model in order to achieve a data-driven culture. As we expand upon our patient centered medical home concept, the need to monitor key metrics to reach our strategic goals has greatly increased.



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<sup>1</sup> 2016 National Profile Of Local Health Departments. National Association Of County And City Health Officials, Washington, D.C., 2017, p. 81, <http://nacchoprofilestudy.org/wp-content/uploads/2017/01/Main-Report-Final.pdf>.



## OUR SOLUTION

Launching a Quality Management System (QMS) will assist our strategic efforts and renew our focus on the customer. The QMS tool will help drive our quality to higher standards. KPI metrics will be tracked in three major categories: **financial**, **operational**, and **quality**.

### Financial KPIs

Budget and grant metrics each program monitors to ensure they are effectively managing the resources used to run programs

### Operational KPIs

Volume, productivity, and statistical metrics each program monitors to assure efforts are in line with program goals

### Quality KPIs

Customer service and outcome metrics displayed through monthly dashboards to track progress towards goals

To implement this QMS system and build a culture of quality, we will launch quality training initiatives for our staff and enhance the role our quality improvement council.

## GOALS

- Provide staff with enhanced quality training and relaunch the quality improvement council
- Improve the use of performance metrics to assure that they drive programs to reach their goals

## STRATEGIC PRIORITY THREE

# Proactive Sustainability

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The Health Department has not been insulated to recent changes in health care. The expansion of Medicaid under the Affordable Care Act has positively impacted the residents of Lake County.

Over 50,000 people in Lake County gained insurance through the Affordable Care Act,<sup>1</sup> and many of those individuals were our patients. Higher standards in managed care contracting and quality accreditation have increased our need to drive an efficient revenue cycle. We are working to improve our entire process, starting with how our patients are registered, how clinicians document the care they provide, and how we work with managed care organizations to collect payment for services rendered. Revenue cycle touches many of our programs and our goal is to streamline our process to ensure our long-term sustainability.

1 Uninsured rates in Lake County, Illinois dropped from 11% in 2013 to 3% in 2016. "Illinois County-Level Data Table". Enroll America, 2016, <https://www.enrollamerica.org/research-maps/maps/state-profiles/illinois/>.

## WHERE WE ARE NOW

Health Department leaders have identified an opportunity based on key financial metrics to improve our financial performance and maximize funding streams available due to the state's Medicaid expansion.

The ongoing State of Illinois budget impasse and potential changes to the Affordable Care Act require that we plan and prepare for potential shifts in reimbursement for services we currently provide.



## GOALS

- Reduce the dollar amount of bad debt write offs by 50%
- Reduce the dollar amount of managed care organization rejections by 50%

## OUR SOLUTION

Health Department leaders launched a revenue cycle project in September 2016. The project focuses on standardization, training and improvement across the organization. Front-end, middle, and back-end teams were created to drive the project and include staff from our clinical operations, finance, prevention, organization development, and strategic initiatives programs.

As we onboard staff, enhanced training efforts will assist in reducing billing rejections and write offs for programs across the agency. Over the next three years this effort will help us increase our ability to use funds available through managed care contracting to enhance care.

### Front End Activities

Appointment Scheduling  
Patient Registration  
Insurance Verification  
Point of Service Collections  
Financial Counseling

### Middle Activities

Coding  
Charge Entry

### Back End Activities

Billing  
Third-Party Follow Up/Accounts  
Receivable  
Management  
Rejections  
Payment Posting  
Post-Payment Review

## STRATEGIC PRIORITY FOUR

# Clinical Programs

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Our patients face a number of challenges in their journey toward better health. Our emerging work addressing social determinants of health in our community health centers builds upon the evidence based model of the **patient centered medical home (PCMH)**.

The PCMH model uses a team of providers to give care to the "whole person." It includes partnering with patients and their families to understand and respect each patient's unique needs, culture, values and preferences. We see four key benefits to this approach:

- Care is personalized and focused on the whole individual
- Patients have greater access to their PCMH care team when health needs arise
- Increased care coordination makes it easier for patients to utilize other LCHD/CHC services and specialty care
- Staff are better equipped to make referrals to social service providers in and around Lake County and advocate for change to strengthen and improve communities



### WHERE WE ARE NOW

Many of our primary care and behavioral health programs have lacked the integration required to truly improve health outcomes for our patients. Over the past year our clinical operations team has worked diligently to integrate our primary care and behavioral health services. These integration efforts have achieved improved results. However, we anticipate through enhanced PCMH we can achieve greater outcomes for our patients and clients.

Quality training has begun in our clinical programs and through a focus on quality and PCMH, we can improve the lives of those individuals we serve.



## OUR SOLUTION

Pilot PCMH teams have been launched at our North Chicago Community Health Center in the first quarter of 2017. Based on the results of the pilot, it is expected that we will continue to rollout the tested PCMH model across all of our six sites over the next three years.

Teams will consist of physicians, advance practice nurses, care coordinator nurses, and other needed care personnel focused on assessing needs and providing excellent care to improve health outcomes for all patients. We are training providers and staff on new standard practice guidelines to assure quality. These guidelines include obesity, cardiovascular disease, and diabetes to date.

## GOALS

- Reduce the percentage of LCHD/CHC patients with poorly controlled diabetes
- Reduce the percentage of LCHD/CHC patients with poorly controlled hypertension
- Reduce the percentage of behavioral health clients who are obese
- Reduce the percentage of LCHD/CHC adult and pediatric patients who are obese

## STRATEGIC PRIORITY FIVE

# Prevention and Education

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Working to prevent disease and educating the public on interventions that improve health outcomes are the bedrock of public health.

We believe the health of Lake County residents is at its best when we work together. Our integration with other county agencies, townships, municipalities and partnerships with nonprofit organizations help advance our emerging work to improve the social and environmental conditions in Lake County communities, and ultimately, to improve our residents' health.



## WHERE WE ARE NOW

Our partnership with Live Well Lake County (LWLC) is one of the driving forces of prevention and education in Lake County. Our staff helped create LWLC's CHIP, and we co-lead many of its action teams to address the four identified health priorities. Work is underway to mobilize these action teams to accomplish the CHIP objectives.

Whether West Nile, pertussis, or sexually transmitted infections, our prevention programs are combatting many emerging threats to our communities. The diversity of Lake County's population requires that we continually monitor for potential outbreaks to assure the public's health. Potential changes to regulations and funding also require we adjust policy to prepare for impacts on Lake County residents.



## OUR SOLUTION

In the next three years, we will begin more cross pollination of our public health and clinical work to enhance our prevention and education efforts across all LCHD/CHC programs.

We will leverage our role as an influencer of state and federal policy to shape chronic and infectious disease interventions. For example, our tobacco program is advocating to raise the minimum age for tobacco product sales to 21.

We will build on the momentum of the January 2017 Together Summit and continue to lead county efforts to impact policy, system and environmental change.

## GOALS

- Reduce pertussis incidence rates
- Improve childhood immunization compliance
- Reduce the rate of HIV infection
- Reduce risks of food borne illness at food service facilities
- Increase the number of municipalities conducting a minimum level of mosquito control

# Summary of 2017-2019 Goals

## Social Determinants of Health

GOAL	CURRENT	TARGET
Train all LCHD/CHC staff on social determinants of health, their impact on Lake County residents, and strategies to improve quality of life for all.	0%	100%
Develop and implement health equity policy for LCHD/CHC operations that outlines assessment of health equity culture, training, and activities	Not Completed	Completed
Assess 100% of new clients for social determinants of health at their first visit at the LCHD/CHC	0%	100%

## Changing the Context / Clinical Programs

GOAL	CURRENT	TARGET
Reduce percentage of Hispanic LCHD/CHC patients with poorly controlled diabetes (A1C value > 9)	27.2%	21.6%
Reduce percentage of African American LCHD/CHC patients with poorly controlled diabetes (A1C value > 9)	21.9%	19.0%
Reduce percentage LCHD/CHC patients with poorly controlled diabetes (A1C value > 9)	24.4%	20.2%
Reduce the percentage of LCHD/CHC adult patients with obesity (BMI $\geq$ 30)	TBD	41.0%
Reduce the percentage of LCHD/CHC pediatric patients obesity (BMI $\geq$ 95th percentile)	24.2%	23.5%
Reduce the percentage of LCHD/CHC behavioral health patients with obesity (BMI $\geq$ 30)	34.6%	33.6%
Reduce percentage of Hispanic LCHD/CHC patients with poorly controlled hypertension (BP reading>140/90)	28.8%	27.9%
Reduce percentage of African American LCHD/CHC patients with poorly controlled hypertension (BP reading>140/90)	44.5%	43.2%
Reduce percentage of LCHD/CHC patients with poorly controlled hypertension (BP reading>140/90)	22.9%	22.2%

## Proactive Sustainability

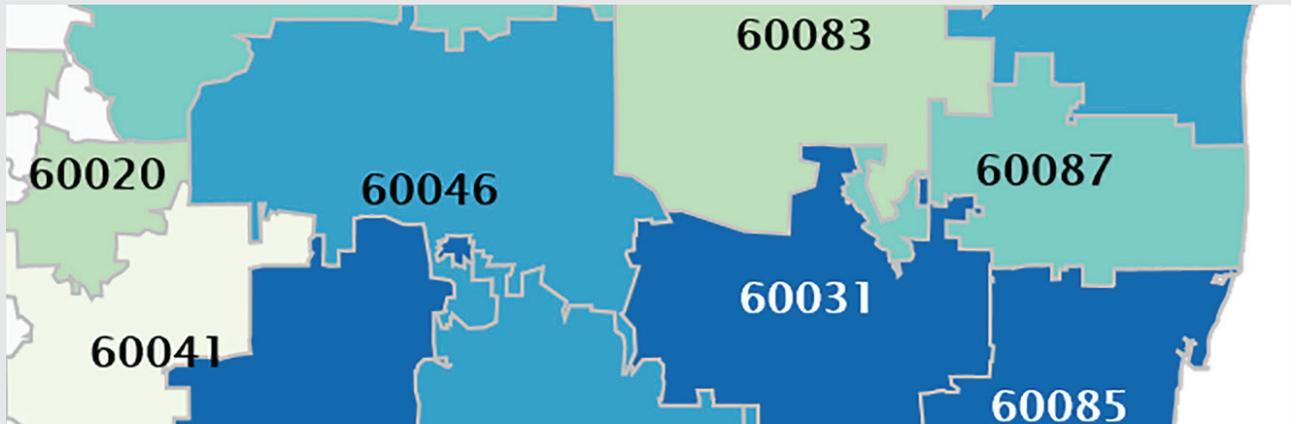
GOAL	CURRENT	TARGET
Reduce the dollar amount of bad debt write offs by 50%	\$1,083,308	\$541,654
Reduce the dollar amount of managed care organization rejections by 50%	\$2,205,425	\$1,102,713

## Prevention and Education

GOAL	CURRENT	TARGET
Minimize the incidence of pertussis in Lake County by shortening the time between an initial healthcare evaluation and a lab report	4.4 days	4.0 days
Minimize the incidence of pertussis in Lake County by shortening the time between a lab report and a closed case	18.3 days	16.4 days
Increase childhood immunization compliance to reduce the number of schools that fail to meet a 95% protection rate for measles	23 schools	12 schools
Increase childhood immunization compliance to reduce the number of schools that fail to meet a 95% protection rate for pertussis	21 schools	10 schools
Reduce the rate of HIV infection in Lake County by 5%	5.64 per 100,000 residents	5.36 per 100,000 residents
Increase the percentage of LCHD/CHC patients treated within 30 days after testing positive for gonorrhea	91%	96%
Increase the percentage of LCHD/CHC patients treated within 30 days of testing positive for chlamydia	96%	97%
Decrease the percentage of food service facilities with food borne illness factors	23%	21%
Reduce the percentage of surface discharging system samples that fail the fecal coliform effluent standard	19%	15%
Increase the percentage of municipalities and townships that are conducting at least minimum level of service mosquito control efforts	65%	85%

# Live Well Lake County

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The Live Well Lake County (LWLC) steering committee formed in 2011 to collaboratively improve the health and well-being of Lake County residents. It is comprised of representatives from a variety of community-based organizations, government agencies, health care systems, and academic institutions.

Throughout 2015 and 2016, the Health Department conducted four community health assessments that extensively involved partners and stakeholders in the community. The assessment findings formed the Community Health Assessment (CHA). In 2016, based on assessment findings, the committee prioritized four community health issues that the Community Health Improvement Plan (CHIP) attempts to address.

LWLC includes six action teams that help support and expedite action plans utilizing evidence-based programs and models in the community to address the identified community health issues. These teams include:

- Be Active: Walking
- Eat Well
- Diabetes Prevention and Management
- Tobacco Prevention and Cessation
- Health Literacy
- Behavioral Health Capacity
  - Telepsychiatry
  - School-Based Behavioral Health Services
  - Integrating Primary Care into Behavioral Health
  - Behavioral Health Public Awareness

LWLC identifies and recruits organizations and individuals who work on and provides assistance in developing and implementing their action plans. Each action team is led by three co-chairs: one LCHD/CHC representative and two community members. Action teams are supported by the LCHD/CHC through subject matter expertise, health equity education, technical assistance with effective group development and sustainability, and technical assistance with developing objectives, on-going evaluation and development of evidence-based strategies.

## LIVE WELL LAKE COUNTY GOALS

## CURRENT TARGET

By 2031, reduce prevalence of Lake County adults who have been diagnosed with diabetes by 10%	6%	5%
By 2021, reduce the average annual count of emergency room visits due to diabetes by 10%	1686 per year	1518 per year
By 2031, reduce prevalence of Lake County adults who are obese by 10%	23%	21%
By 2031, reduce prevalence of Lake County adults who are overweight by 10%	34%	31%
By 2031, reduce prevalence of Lake County adults who have been diagnosed with hypertension by 10%	35%	32%
By 2021, reduce the average annual count of emergency room visits due to hypertension by 10%	1742 per year	1568 per year
By 2021, reduce the percentage of youth feeling so sad or hopeless almost every day for 2+ weeks in a row that they stop doing some usual activities by 10%	28%	25%
By 2021, reduce the average annual count of emergency room visits due to mental health diagnoses by 10%	12,453 per year	11,208 per year
By 2021, reduce the percentage of adults who report having a day or more in the past month where their mental health status prevented them from carrying on usual activities by 10%	14%	13%
By 2021, reduce tobacco use among Lake County adults to 12%	14%	12%

For more information, visit [www.LiveWellLakeCounty.org](http://www.LiveWellLakeCounty.org).

# Conclusion

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Over the next three years, the Health Department will realign its operations to achieve its HI-3 goals. This will require a cultural shift for LCHD/CHC. These efforts will help facilitate the shift in policy, system and environmental change needed to improve health outcomes for all Lake County residents.

We will focus on analyzing the impact of social determinants of health and will use a health equity lens to advocate for change. Our strategic plan working group will help guide the way and we will use data to monitor our progress on this journey. We look forward to sharing our progress and thank you for your continued support as we strive to achieve the highest level of health for all Lake County residents.



**Lake County Health Department  
and Community Health Center**

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**ABOUT THE LAKE COUNTY HEALTH DEPARTMENT**

The Lake County Health Department is a public health accredited, state-certified public health department and a Joint Commission accredited Community Health Center established by referendum in 1956. Today, our budget of approximately \$70 million supports 60 separately funded programs. Approximately 1000 professionals assist our daily mission of health promotion, illness prevention and protection of the environment. The Health Department is governed by a 12-member Board of Health. Members are appointed by the Lake County Board, and are Lake County residents of various backgrounds. We are proud to be among the top 6 percent of approximately 2,800 local health departments nationwide by population serviced.

As the largest human service provider in Lake County, we believe that services must be available without barriers. No residents are turned away due to an inability to pay. We also believe in providing services in an environment of mutual respect, free of discrimination or bias.

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