

2016 ASTHO PROFILE SURVEY



Top Findings

The Top Findings report consists of the most significant, timely, and relevant findings from the 2016 ASTHO Profile Survey.

The ASTHO Profile of State and Territorial Public Health is the only comprehensive source of information on state and territorial public health agency activities, structure, and resources. Launched in 2007 and fielded every two to three years, the Profile Survey aims to define the scope of state and territorial public health services, identify variations in practice among state and territorial public health agencies, and contribute to the development of best practices in governmental public health.

This report highlights the structures, functions, and resources of state and territorial health agencies from the 2016 ASTHO Profile Survey.



**ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
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ASTHO thanks the Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation for their generous support of the Profile.

STATE PUBLIC HEALTH: WHO WE ARE

- Each state health agency (SHA) is led by a **state health official (SHO)**, often known as the state health secretary or commissioner of health. In 2016, 66 percent of SHOs were **appointed** by the governor, 14 percent were appointed by a parent agency secretary, 10 percent were appointed by a board or commission, and 10 percent were appointed by another entity. Once appointed, 74 percent require **confirmation** by the legislature, governor, or a board or commission.
- **SHO tenure** is highly variable. As of September 2016, the range in length of time SHOs had been in their position was two months to nearly 15 years. As of September 2016, SHOs' average tenure was 2.7 years (median = 1.7 years). Since 2012, average tenure decreased from 3.4 years, while median tenure remained stable (1.8 years in 2012).
- SHOs represent a variety of **backgrounds**. As of 2016, 64 percent of SHOs hold a medical **degree**, and 44 percent hold an MPH. This is a decrease from 2012, when 71 percent of SHOs held a medical degree and 48 percent held an MPH.
- In 2016, 29 SHAs (58%) were freestanding/independent agencies, while 21 (42%) were a unit of a larger combined health and human services organization—often referred to as an umbrella organization. Five states changed **agency structures** from 2012 to 2016 (three from being under umbrella agencies to freestanding, and two changed in the opposite direction).
- For agencies housed under a larger umbrella agency, the top **three areas of responsibility for parent agencies** in 2016 were Medicaid (91%), state mental health authority combined with substance abuse (81%), public assistance (76%), and substance abuse (76%). There have been large increases from 2012 to 2016 for SHA responsibility for substance abuse (from 50% to 76%) and state mental health authority without substance abuse programs (from 30% to 57%).

- The number of agencies **governed by a board of health** or similar entity has remained stable over time at just over 50 percent. In 2016, 18 SHAs (36%) reported having a board of health, while nine (18%) reported having an entity that, while not called a board of health, performs similar functions. In 2012, these proportions were 45 percent and 8 percent, respectively.
- SHAs **collaborate with many different entities**, including local public health departments, hospitals, and healthcare delivery partners. In 2016, at least 90 percent of agencies reported exchanging information and working together on projects with hospitals, physician practices/medical groups, and community health centers.
- These levels of **collaboration** have remained largely stable from 2012 to 2016. However, there was a notable increase over time in one area—the percentage of agencies that reported **exchanging information with health insurers** (72% in 2012, 92% in 2016). This trend is undoubtedly partially attributable to the rapid increase in the number of states implementing **All-Payer Claims Databases (APCD)**. These are electronic systems that aggregate claims and administrative data from public and private payers, allowing policymakers to identify and act upon trends. The APCD Council reports that 23 states have achieved some level of implementation and 12 more are investigating this—up from 10 in 2014.^{1,2} Other contributing factors include implementation of the HiTECH Act and Affordable Care Act and concomitant federal and state regulation.
- The number of states **sharing resources with other states** on a continuous, recurring (non-emergency) basis has risen substantially, from 9 percent in 2012 to 27 percent in 2016. In both years, **all-hazards response** and **epidemiology** were the top two shared services and functions, laying the groundwork for two areas that often require a multi-state response. Factors leading to this increase may reflect growing recognition of the importance of mutual aid agreements of both a formalized and informal nature between states, and incentives produced through supportive language inserted in cooperative agreement objectives issued by the federal government.

- States report many competing priorities, but **chronic disease prevention**, which includes activities such as heart disease, cancer, and tobacco prevention and control programs, consistently emerges as the **top priority** for SHAs. This priority substantially increased from 14.5 percent in 2012 to 23.9 percent in 2016.
- Other SHA priorities include **clinical services/consumer care**, which includes clinical programs, such as tuberculosis (TB) treatment and emergency medical services (11.4% in 2012, 9.4% in 2016), and **quality improvement/performance management**, which includes efforts to improve organizational performance and efficiency (13.3% in 2012, 8.6% in 2016).
- From 2012 to 2016, the **estimated total number of FTEs** for the public health workforce for the 50 states and D.C. decreased by 3 percent (from 100,468 to 97,230). Explanations for this decline include decreases in direct service provision, decreases in funding, and increases in the amount of funding distributed as pass-throughs and grants/contracts to third parties, such as local health departments and nonprofits.
- By 2020, SHAs expect the percentage of health agency employees who are **eligible for retirement** to increase from 17 percent to 25 percent.



STATE PUBLIC HEALTH: WHAT WE DO

- Nationwide, state and territorial health agencies engage in a variety of **activities to promote population health**. These include: preventing diseases through screenings, primary prevention services, and vaccine management and inventory distribution; and conducting lab testing, collecting data in real-time, and engaging in other environmental health activities to protect the public's health.

Health promotion activities include: treatment for TB (60%), STDs (54%) and HIV/AIDS (32%); maternal and child health services, such as those for children and youth with special healthcare needs (54%), the Women, Infants, and Children (WIC) program (44%), and home visits (39%); and other clinical services, such as oral health services (39%), substance abuse education/prevention services (37%), and pharmacy services (27%).

Prevention includes: screenings for diseases and conditions, such as newborn screenings (70%), HIV/AIDS (60%), and other STDs (60%); population-based primary prevention services such as tobacco prevention (84%), HIV prevention (82%), and STD counseling and partner notification (82%); and vaccine management and inventory distribution for childhood (96%) and adult immunizations (90%).

Activities aimed at health protection include: laboratory testing of select agents and dangerous pathogens (92%) and foodborne illness (92%), influenza typing (92%), and vector-borne illness (90%); public health registry maintenance for childhood immunization (94%), birth defects (76%), and cancer (76%); other data collection, epidemiology, and surveillance for foodborne illness (100%), communicable/infectious disease (98%), and perinatal events or risk factors (98%); and other environmental health activities including environmental epidemiology (90%), food safety training and education (80%), and radiation control (70%).

- From 2010 to 2016, states reported a marked decline in directly performing many of these services and activities; for example, 17 of 18 clinical service activities surveyed have decreased, 12 of 14 maternal and child health services surveyed have decreased, and 16 of 17 primary prevention activities surveyed have decreased. The increase in the number of individuals covered by Medicaid and insurance during this time is one possible explanation for these observed changes over time. In addition, these numbers only reflect decreases in activities directly performed by SHAs; agencies may also be contracting out these activities to third parties in lieu of performing them directly.
- The total number of **environmental health activities** directly performed by SHAs has also decreased from an average of 42 percent in 2010 to 37 percent in 2016. Notable decreases in environmental health activities include the number of SHAs directly performing poison control (decrease of 25% from 2010 to 2016) and vector control (decrease of 16% from 2010 to 2016). These changes are probably due to funding cuts and transferring these services to local health departments and other state agencies.
- SHAs continue to provide assistance and support through technical assistance to a variety of partners and organizations. In 2016, technical assistance was frequently provided for quality improvement, performance, and accreditation to hospitals (85%) and to local public health agencies (81%). These proportions are just slightly lower than those reported in 2012.
- The top **federal initiatives administered** by virtually all SHAs in 2016 were: Maternal and Child Health/Title V, Preventive Health and Health Services Block Grant, CDC Public Health Emergency Preparedness cooperative agreement, Section 317 immunization funding, and the WIC program. Participation in these programs has remained very high since 2012.
- The total amount of **federal funding appropriated to SHAs** exceeded \$14.3 billion in 2015. Nearly half of federal funding originates from USDA for the WIC program (45%); the next highest percentage comes from CDC (16%), followed by Medicaid (14%), and HRSA (10%).
- While SHAs vary widely in their reliance on federal funding, 80 percent of states receive more than 40 percent of their funds from federal sources. In 2015, SHAs received an average of \$280 million in federal funding. States ranged from receiving a minimum of \$26 million to a maximum of \$1.8 billion in federal funding.

STATE PUBLIC HEALTH: HOW WE DO IT

- As of 2016, 20 out of 51 (40%) of SHAs achieved **accreditation** through the Public Health Accreditation Board's voluntary national accreditation program, and that number continues to rise. Public health accreditation involves measuring health agency performance against a set of developed standards, and rewarding or recognizing health departments that meet them. Since Profile data was collected in 2016, an additional eight SHAs have become accredited; a majority of states (56%) are now accredited.³
- Accredited states and those pursuing accreditation were most likely to report experiencing the following **benefits**: 85 percent say accreditation stimulated quality and performance improvement opportunities, 82 percent say accreditation stimulated greater collaboration across departments or units within their agency, and 76 percent say accreditation strengthened the culture of quality improvement within their agency.
- On average, **electronic data** was most often **collected** within a state system (90%), while 20 percent collected data through health information exchange (HIE)—the electronic movement of health-related information among organizations according to nationally recognized standards.⁴ From 2012 to 2016, the number of states collecting data electronically increased across all areas surveyed—all agencies collect data electronically on lab results, reportable diseases, vital records, and newborn screening.
- **SHA total revenue** fluctuated over time, from \$29.1 billion in 2008 to \$28.6 billion in 2015. The largest dip was seen between 2009 and 2010, when revenue decreased by \$3.4 billion. Between 2014 and 2015, there were decreases in total revenue for federal funds, fees and fines, and other state funds.
- Between 2014 and 2015, the **two largest spending categories** as a proportion of states' total budgets were **clinical services/consumer care** and **WIC**.

- In both 2014 and 2015, SHAs **distributed** approximately \$6 billion (about 20% of their total budget) through **contracts, grants, and awards** to local and regional/district health agencies, tribal health agencies, nonprofit organizations, and other governmental entities. In 2015, more than one-third of SHA contracts, grants, and awards were distributed to independent local health agencies (42%) and to community-based nonprofit organizations (40%).

INSULAR AREAS

- The eight U.S. territories and freely associated states are collectively referred to as the insular areas. The U.S. territories include three island jurisdictions in the Pacific—American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands—and the two Caribbean territories of Puerto Rico and the U.S. Virgin Islands. The remaining insular areas include three sovereign nation states holding compacts of free association with the United States, also known as compact nations: the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands.
- There is wide variability across these jurisdictions on many measures. The uniqueness of each insular area (e.g., geographic, socioeconomic, and systemic differences) can explain much of this variation. Yet despite their individual diversity, the insular areas are collectively distinct from the state and D.C. health departments. Primary differences include their remoteness, relatively close integration with their healthcare systems, and challenges associated with high incidences of both communicable and non-communicable diseases.
- **Insular area health agencies** reported performing **primary prevention activities** most frequently (92%), followed by data collection, epidemiology, and surveillance activities (86%).
- In 2016, insular area health agencies reported a total of **6,523 FTEs**. The occupational classification with the greatest average number of staff was public health nurses (average = 216, median = 32), followed by office and administrative support (average = 164, median = 19), and behavioral health staff (average = 150, median = 17).
- The **average budget** for insular area health agencies for 2014 was \$59.5 million (median = \$27.8 million), and the average budget for 2015 was \$61.5 million (median = \$32.3 million). In 2015, the average per capita expenditure on public health in the insular areas was \$389 million (median = \$197 million).



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ASTHO is the national nonprofit organization representing public health agencies in the United States, its territories and freely associated states, the District of Columbia, and the more than 100,000 public health professionals that these 59 agencies employ.

ASTHO members, the chief health officials of these jurisdictions, develop and influence public health policy and ensure excellence in governmental public health practice. ASTHO's primary function is to serve as an advocate and voice for state and territorial public health agencies, develop public health leadership at the executive level, and provide capacity building and technical assistance to state and territorial health agencies.



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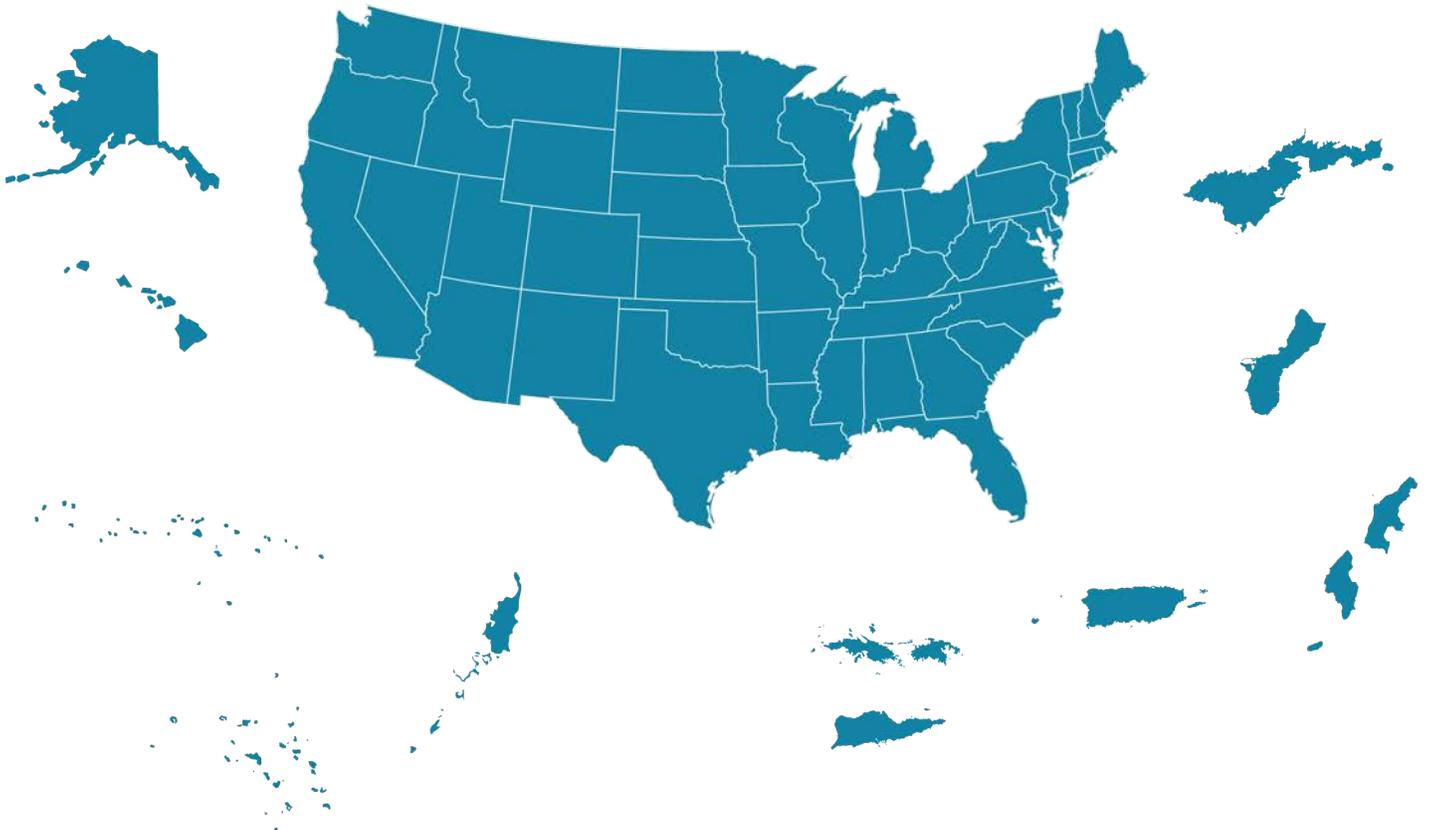
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