ASTHO Profile of State Public Health

Volume Two

ASTHO Profile of State Public Health, Volume Two is a publication of the Association of State and Territorial Health Officials. It describes the structure, functions and resources of state and territorial health agencies and highlights their contributions to public health.

To view this publication online, visit ASTHO'S Web site at **www.astho.org.**

Vision

Healthy people thriving in a nation free of preventable illness and injury.

Mission

To transform public health within states and territories to help members dramatically improve health and wellness.

Design by Belmont, Inc.
Alexandria, VA

Printed by Linemark, Inc.
Upper Marlboro, MD

ASTHO Profile of State Public Health

Volume Two

September 2011

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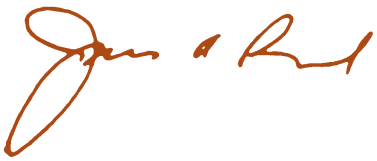
Acknowledgements

We are grateful to many for their substantial contributions to the development, production and publication of this report. The Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention provided leadership, vision and generous financial support. The data harmonization partners, led by Debra Perez at the Robert Wood Johnson Foundation, and including Carolyn Leep and Reba Novich at the National Association of County & City Health Officials, Ginger Fenton at the National Association of Local Boards of Health, and Jeff Jones at the University of Kentucky College of Public Health all made unique and important contributions to this project. Nikki Lawhorn analyzed the data and drafted the report. Katherine Barbacci managed the data collection, conducted follow-up and supported this project in countless ways. Joan Hutcheson, Lucas Maloney, and JP Leider provided editorial support. PCE Systems developed the Web-based survey. Belmont, Inc. designed the publication, and Linemark printed it.

Most important, we thank the state and territorial health officials and their staff in the 53 health agencies that responded to the survey. They invested substantial effort in answering the lengthy questionnaire that forms the basis of this dataset. The 2010 ASTHO Profile Survey was conducted at a time when many state and territorial health agencies were challenged to improve and expand services while drastically cutting budgets. We appreciate their dedication to their work and their willingness to make time for this important effort.



Jim Pearsol, MEd
Chief Program Officer, Public Health Performance

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A Letter from the Executive Director

I am pleased to present the *ASTHO Profile of State Public Health, Volume Two,* the product of ASTHO's second comprehensive state public health survey. This publication is an unparalleled data source on state and territorial health agency structure, organization, responsibilities, resources, planning and quality improvement activities, and information exchange methods.

Reliable and comprehensive data is one of the best ways to demonstrate the value of public health to this nation. This report helps our members, their staff, policy-makers, researchers, and public health practitioners understand and articulate the importance and scope of state public health and the best way to improve it. At ASTHO, we rely heavily upon research results and high-quality data to inform public policy and respond to inquiries from our federal and state partners. I invite you to do the same.

I thank ASTHO's members for devoting time and effort to completing the exhaustive survey. This research on state and territorial health agencies would not be possible without them. Additionally, this research and the resulting improvements in public health policy and practice would not be possible without the leadership and support of our funding partners. I would like to thank Dr. Thomas Frieden, director of the Centers for Disease Control and Prevention and Dr. Risa Lavizzo-Mourey, chief executive officer of the Robert Wood Johnson Foundation for their vision and support of this important work.

We welcome your feedback on this report and the entire survey. Please feel free to comment on the survey scope and questions and to suggest what future analyses would be most valuable to you.

Paul E Jarris

Paul E. Jarris, M.D., MBA
Executive Director, ASTHO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

Dear Colleague:

The Centers for Disease Control and Prevention (CDC) is pleased to support the Association of State and Territorial Health Officials (ASTHO) in its work to develop the *ASTHO Profile of State Public Health, Volume Two*. This report makes a significant contribution to our understanding of the governmental public health enterprise. For policy-makers, researchers, and public health practitioners at the federal, state, and local levels, this report will substantially advance understanding about both state and territorial public health practice and the relationship of these practices to all sectors of the public health system.

State and territorial public health agencies are critical to the governmental public health enterprise. Their key mission is to ensure public health prevention services are in place to protect the health of the entire community. CDC supports these efforts while also promoting capacity development and performance improvement to strengthen the national public health system on all levels. Over the last year, CDC has worked with the Robert Wood Johnson Foundation to develop an agenda for Public Health Systems and Services Research. ASTHO's Profile data in this report is a key resource that supports this agenda andanswers important research questions identified by public health officials.

I commend ASTHO and the 53 state and territorial health agencies that completed the Profile survey for their dedication and contributions to the nation's health. CDC is proud to support this work and foster integration and collaboration among public health professionals in improving public health practice.

Sincerely,

Thomas R. Frieden, M.D., MPH
Director, CDC, and Administrator,
Agency for Toxic Substances and Disease Registry

Robert Wood Johnson Foundation

Dear Colleague:

We are pleased to support the *ASTHO Profile of State Public Health, Volume Two.* This report provides a critical source of evidence to enable public officials and policy-makers to make well-informed decisions to strengthen America's public health system.

This profile is part of a collaboration of ASTHO, the National Association of City and County Health Officials and the National Association of Local Boards of Health—with leadership from the National Coordinating Center for Public Health Services and Systems Research (PHSSR) at University of Kentucky—to develop a complete picture of U.S. governmental public health. This collaboration will help to surface best practices to organize, manage, finance and structure public health systems and services, and to answer questions relevant to public health practice and policy-making, including those emerging in our work with the Centers for Disease Control and Prevention to develop a national agenda for PHSSR. In addition, information in the profile on key trends such as the intent of state health agencies to pursue accreditation and collaboration with partners in health care and other fields informs the system-level changes that are needed to improve the nation's health.

We appreciate what a difficult period it is for public health, as budget cuts are resulting in layoffs and in the paring back or elimination of entire programs and services. That 53 agencies invested the time to answer this questionnaire is a testament to their dedication and also to the leadership of ASTHO to ensure the success of this effort. I would like to thank and commend all who have contributed to this invaluable resource.

Risa Lavizzo-Mourey, M.D., M.B.A.
President and CEO
Robert Wood Johnson Foundation

Executive Summary

The *ASTHO Profile of State Public Health, Volume Two* highlights findings from the 2010 ASTHO Profile Survey. This report describes the structure, functions and resources of state and territorial health agencies and indicates what data are available for public use. Where appropriate, the 2010 findings are compared to data from the 2007 ASTHO Profile Survey.

Most of the report illustrates findings from the 50 states and the District of Columbia. However, chapter seven uses data from the Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands to illustrate some of the similarities and differences among state and territorial health agencies.

This dataset—whether used on its own, in combination with comparable data from the National Association of County & City Health Officials and the National Association of Local Boards of Health, or with other relevant datasets—gives important insight into how governmental public health is organized at the state and territorial level and the contributions state and territorial health agencies make to public health.

ASTHO is the national nonprofit organization representing public health agencies in the United States, its Territories, and the District of Columbia, and over 100,000 public health professionals these agencies employ. ASTHO members, the chief health officials of these jurisdictions, formulate and influence sound public health policy and ensure excellence in state-based public health practice. ASTHO's primary function is to track, evaluate, and advise members on the impact and formation of public or private health policy which may affect them and to provide them with guidance and technical assistance on improving the nation's health.

The comprehensive survey was developed with guidance from ASTHO's Survey Advisory Workgroup, consisting of state health agency senior staff, researchers, ASTHO staff and former health officials, and representatives from national public health partner organizations. ASTHO staff surveyed senior deputies of all 59 member agencies (50 states, D.C. and 8 territories) between April and November of 2010. They collected data on many areas of public health practice, including public health activities, agency priorities, structure and governance, quality improvement and accreditation readiness, partnerships and collaboration, workforce, finance, health information technology and state health official characteristics.

Top 20

The top 20 includes the most significant, timely and relevant findings from the 2010 ASTHO Profile Survey. They include the following:

1. Nearly all state health agencies have full or shared fiscal and programmatic responsibility for certain federal initiatives, including WIC, the CDC Preventive Health and Health Services Block Grant, and Health Professionals Shortage Area Designations. In cases where they do not have sole responsibility, these agencies often share responsibility with another state agency; a local governmental agency, including local public health agencies; or nonprofit organizations.

2. State health agencies support linkages between people and personal health services. Eighty-four percent of agencies support health disparities or minority health initiatives, and almost three-fourths of them work to address rural health issues. In addition, approximately three-fourths of these agencies provide financial support to primary care providers in their state.

3. An overwhelming majority of state health agencies provide population-based primary prevention services that address the leading sources of morbidity and mortality found in the CDC's list of winnable battles. For example, 88 percent of state health agencies offer tobacco prevention and control services, 84 percent have HIV prevention programs, and 80 percent operate injury prevention programs.

4. State health agencies engage in many activities to evaluate the personal and population-based health services they provide. Over 90 percent of them analyze and interpret data, and a similar number collect, exchange or report data. A large number of them also disseminate research findings, apply these findings to practice and identify relevant research questions and topics.

5. Nearly 30 percent of states (n=14) have a centralized or largely centralized governance structure where local health units are primarily led by state employees and the state retains authority over most fiscal decisions.

6. State health agencies do not generally share resources with each other; when they do share resources, it is typically for all-hazards preparedness or surveillance.

7. Overall, state health agencies have a high level of collaboration with entities in the health care field.

8. In 2010, over two-thirds of state health agencies completed a health assessment, and almost one-half of them completed a health assessment within the last three years.

9. The number of states that developed or participated in developing a health improvement plan within the last three years grew significantly, from 24 percent in 2007 to 37 percent in 2010. Forty-five percent of state health agencies developed or participated in developing a health improvement plan within the last five years.

10. Almost 90 percent of state health agencies have a strategic plan, and 85 percent have implemented them.

11. Seventy-two percent of state health agencies (n=34) plan to seek accreditation through a voluntary national accreditation program. Of that number, 16 (47 percent) plan to seek accreditation within the first two years of the program (2011 to 2012).

12. The state and territorial health agency workforce includes over 100,000 full-time equivalents. Of the over 100,000 state health agency employees, 27,778 work in local health departments and another 17,333 work in regional or district offices.

13. The average number of vacant positions at state health agencies is 288. Presumably due to budget cuts and hiring freezes, state health agencies are only recruiting for 15 percent of these positions.

14. Over the next four fiscal years, the percent of employees eligible for retirement is expected to grow steadily, from 18 percent in FY10 to 27 percent in FY14.

15. Federal funds were the largest source of state health agency revenue for FY08 and FY09.

16. For FY08 and FY09, the two largest spending categories were improving consumer health (which includes clinical services) and WIC.

17. Over 80 percent of state health agencies exchange electronic data with health care providers. Fifty-six percent of them exchange data directly with providers, and another 20 percent use direct data exchange through an intermediary health information exchange entity. Two percent of agencies exchange data with providers through an intermediary only.

18. When specific programs are considered, state health agencies are more likely to send electronic health data to federal agencies than receive data; electronic health data exchange with local health agencies is often bidirectional.

19. The two territories that responded to the 2010 ASTHO Profile Survey (the Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands) have small total expenditures when compared to state averages; however, their modest budgets translate to significant expenditures and full-time equivalents per capita, as much of the public health workforce for the territories are concentrated at the health departments.

20. The Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands ensure access to care through primary care provisions; outreach and enrollment; State Children's Health Insurance Program (SCHIP); addressing health disparities at a policy level; providing many direct clinical services in chronic and infectious disease care, mental health and substance abuse, maternal and child health; and extensive coverage of epidemiology and surveillance activities.

Introduction

From April to November of 2010, the Association of State and Territorial Health Officials (ASTHO) conducted an online survey of state and territorial health agencies to document their structure, functions and resources. Survey links were e-mailed to senior deputies in health agencies in the 50 states, 8 territories, and the District of Columbia. The response rate was 100 percent among the states and D.C., and 90 percent overall. The survey and this report were funded by the Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention.

It should be noted that these data were collected prior to the gubernatorial elections of 2010. In November 2010, many new governors were elected. In the months following the election, new state health officials were named in over half of the states, and some governors initiated reorganizations of state government that are not captured in this survey.

A More Refined Survey Tool

In 2007, ASTHO launched its first profile survey to collect data that would provide a complete and accurate picture of state and territorial public health. The 2010 ASTHO Profile Survey continues this effort with a more refined, comprehensive survey tool that has several distinct differences from the 2007 survey, including:

- Response options for state health agency activities were changed between 2007 and 2010.
- The planning and quality improvement section was expanded in 2010 to gain a better understanding of the scope of quality improvement initiatives at the state level.
- The 2010 survey included a section on health information exchange.
- Within each section of the survey, some questions were added or removed to better capture state and territorial health agency roles and activities.

The 2010 ASTHO Profile Survey includes over 300 questions across the following areas:

- State health agency activities
- Agency structure, governance and priorities
- Workforce
- Finance
- Planning and quality improvement
- Health information exchange
- State and territorial health official authority and qualifications

The questionnaire was designed to be completed in multiple sittings or by several people. State and territorial health agencies that completed the survey were provided with reports outlining their survey responses. In some cases, response errors were noted and the data were corrected.

Report Structure and Focus

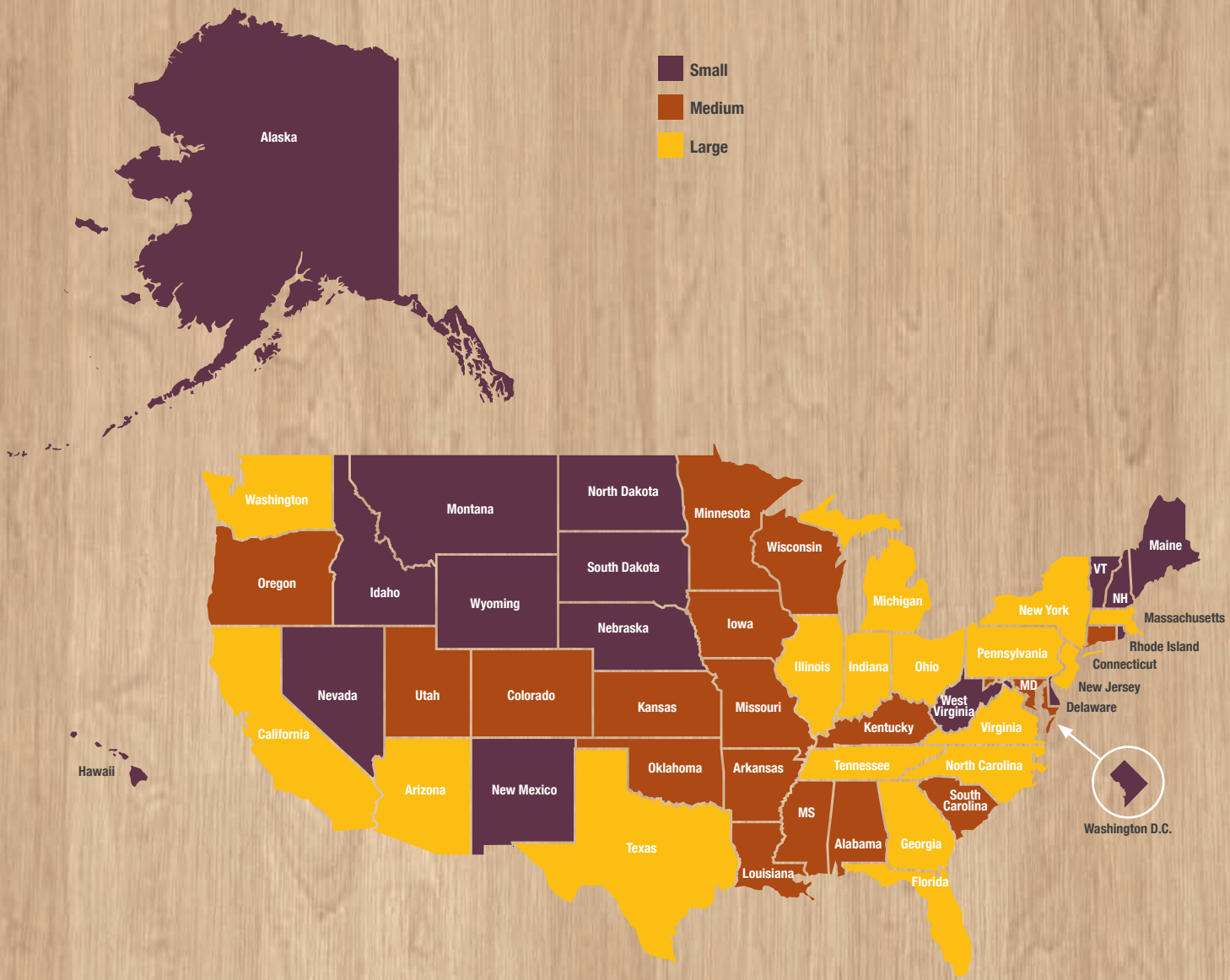
The first six chapters of this report address important roles and activities of state health agencies, including services and activities, organization and structure, quality improvement and accreditation readiness, workforce, finance, and health information technology. Chapter seven includes information on the roles and activities of territorial public health agencies compared to state public health agencies.

When relevant, 2010 and 2007 data are compared. Care was taken to include only those comparisons that represent meaningful differences between 2007 and 2010. Please note, however, that some variations in the data reported between 2007 and 2010 may be due to survey refinement or changes in the particular state and territorial health agencies that responded rather than actual changes in agency practice.

Chapters also include discussion of significant differences based on organizational characteristics, shown in **figures i.1, i.2** and **i.3.**

State health agencies were categorized as small, medium or large based on tertiles of the size of the population served. 2010 population estimates from the U.S. Census Bureau were used to estimate the size of the population served. Small states have a population of up to 2,750,000. The population of medium states ranges from 2,750,001 to 6,250,000. Large states have over 6,250,000 residents.

Figure: i.1: Size of population served.



Regional classifications are based on the U.S. Department of Health and Human Services regions, which were paired to increase the number of state health agencies in each region.

Figure: i.2: Region of the U.S.

Agencies classified as centralized/largely centralized were compared to those classified as decentralized/ largely decentralized. Please see chapter two for further description of state and territorial health agency governance categories. Agencies with a shared or mixed governance structure were not included in the governance comparisons.

Figure: i.3: State and local health agency governance.

1 Chapter One

Public Health Responsibilities

This chapter addresses state health agency activities and responsibilities. The activities, services and programs highlighted in this chapter are an integral part of the responsibilities outlined in the 10 essential public health services.[1]

This chapter begins with a summary of the top state health agency priorities, activities and responsibility for federal initiatives. It also includes discussion of the training and technical assistance provided to public health partners. Agency efforts to monitor health status, diagnose and investigate health problems, and inform and educate communities about health issues are also discussed (essential services one through three).

This chapter also addresses enforcement of laws and regulations to protect health and ensure safety and the linkage of individuals to health services (essential services six and seven). In addition, the chapter provides a review of state health agency comprehensive tobacco control priorities, work site wellness initiatives, funding for obesity prevention, and agency involvement in evaluation and research activities (essential services 9 and 10). The chapter ends with a discussion of the role of legal counsel in public health practice.

Public Health Essential Services

The essential services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure competent public and personal health care workforce
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

Key Findings

- Nearly all state health agencies have full or shared fiscal and programmatic responsibility for federal initiatives, such as Title V Maternal and Infant Health Services, the National Cancer Prevention and Control Program Grant and WIC. In cases where they do not have sole responsibility, state health agencies often share responsibility with another state agency, a local governmental agency including local public health agencies, or nonprofit organizations.

- State health agencies support linkages between people and personal health services. Eighty-four percent of them support health disparities or minority health initiatives, and almost three-fourths of them work to address rural health issues. In addition, approximately three-fourths of them provide financial support to primary care providers in their state.

- An overwhelming majority of state health agencies provide population–based primary prevention services that address the sources of morbidity and mortality are found in the CDC's list of winnable battles. The winnable battles are the six public health priorities where CDC, under the leadership of Dr. Thomas Frieden, has determined that public health can make significant progress in a relatively short time frame: health care-associated infections; HIV; motor vehicle injuries; obesity, nutrition and food safety; teen and unintended pregnancy; and tobacco.[2]

- More state health agencies provide direct clinical services for infectious diseases than for chronic diseases.

- All state health agencies provide laboratory services through a state laboratory. The most common services provided by state health laboratories are testing for likely bioterrorism agents such as anthrax (96 percent), food-borne illness testing (94 percent), and influenza typing (94 percent).

- State health agencies are responsible for enforcing laws and regulations that protect health and ensure safety, including inspection or licensing of a variety of public health system partners; less often, they are involved in oversight of professional licensure activities.

- The top comprehensive tobacco control priorities of state health agencies are state and community interventions (42 percent) and cessation interventions (27 percent).

- Four of the top six work site wellness components relate to tobacco prevention and control.

- State health agencies engage in many activities to evaluate the personal and population-based health services the agencies provide. Over 90 percent of them analyze and interpret data. A similar number collect, exchange or report data. A large number of agencies also disseminate research findings, apply findings to practice, and identify relevant research questions and topics.

State health agencies provide many population-based primary prevention services, helping to inform, educate and empower people about health issues (essential service number three).

State Health Agency Top Priorities

As in 2007, the 2010 ASTHO survey asked state health agencies to rank their top five priorities. In most cases, the top priorities are related to the core functions of public health (assessment, policy development and assurance) and the 10 essential public health services. State health agencies focus on improving public health and public health infrastructure; preparedness; implementation of effective health policies; assurance of access to health care systems and services; increasing the availability and use of data and evidence; and quality improvement, performance management and accreditation related activities. Not surprisingly, agencies also identified health reform implementation as a top priority. **Figure 1.1** lists the areas most commonly included in state health agencies' top five priorities.

Figure 1.1: Top state health agency priorities; states n=49, responses n=231.

Priority	# of Mentions	%
Infrastructure/Capacity/IT/Workforce	40	17%
Quality Improvement	21	9%
Health Promotion/Prevention	18	8%
Obesity, Nutrition and Physical Activity	14	6%
Emergency Preparedness	14	6%
Health Care Reform	13	5%
Communicable Disease Control	13	5%
Environmental Health	11	5%
Tobacco	10	4%
Strategic Planning	10	4%
Disparities	10	4%
Chronic Disease Control	10	4%
Funding and Mitigating Cuts	10	4%
Other Priorities	37	19%

Responsibility for Federal Initiatives

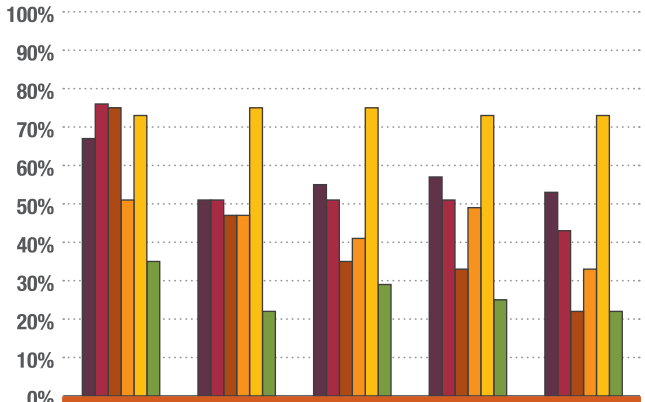
State health agencies often have fiscal and programmatic responsibility for federal initiatives. In cases where they do not have sole responsibility, state health agencies usually share responsibility with another state agency; a local governmental agency, including local public health agencies; or nonprofit organizations. The top 10 federal initiatives for which agencies have responsibility or shared responsibility are shown in **figure 1.2.**

Figure 1.2: Federal initiatives for which state health agencies have responsibility; n=51.

Federal Initiative	#	%
Maternal and Infant Health Services, Prenatal Care, Title V	49	96%
Preventive Health and Health Services Block Grant (CDC)	49	96%
CDC Preparedness Grants	48	94%
National Cancer Prevention and Control Program Grant (CDC)	48	94%
Women Infants and Children Program (USDA)	48	94%
HIV Pharmacies (ADAP)	46	90%
HRSA Preparedness Grants	46	90%
Injury Prevention (CDC)	46	90%
Vital Statistics (NCHS)	46	90%
Health Professionals Shortage Area Designations (HPSA)	45	88%

Technical Assistance and Training

Provision of technical assistance to and training of public health system partners is an important state health agency role. As shown in **figure 1.3**, agencies provide technical assistance to a variety of partners on a range of different topics. State health agencies more frequently indicated that they provide technical assistance to local public health agencies than any other entity. The most common topics of technical assistance are quality improvement, performance management and accreditation.



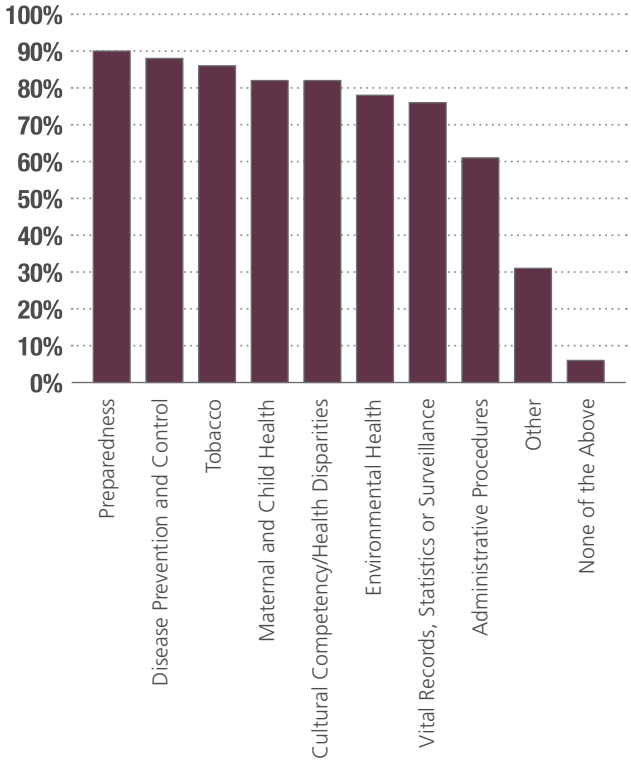
	QI/PM/ Accreditation	Data Management	Public Health Law	Policy Development	Workforce Issue
Emergency Responders	67%	51%	55%	57%	53%
Hospitals	76%	51%	51%	51%	43%
Laboratories	75%	47%	35%	33%	22%
Statewide Nonprofit/Community Based Organizations	51%	47%	41%	49%	33%
Local Public Health Agencies	73%	75%	75%	73%	73%
Other	35%	22%	29%	25%	22%

Figure 1.3: Topics of state health agency-provided technical assistance to public health system partners; n=51.

State health agencies that serve small populations provide less technical assistance than those that serve larger populations. More agencies in centralized states provided workforce technical assistance to laboratories than those in decentralized states (43 percent compared to 15 percent). In contrast, more agencies in decentralized states provide public health law and policy development technical assistance to local public health agencies.

In addition to providing technical assistance, state health agencies also provide training to local health agencies. The top three training topics are preparedness, disease prevention and control, and tobacco prevention and control **(see figure 1.4).**

Figure 1.4: Topics of state health agency-provided local health agency personnel training; n=49.



Access to Health Care Services

The seventh essential service of public health agencies is to link people to needed personal health services and ensure the provision of health care when otherwise unavailable. Eighty-four percent of state health agencies support health disparities or minority health initiatives, and almost three-fourths of them work to address rural health issues **(see figure 1.5).** Approximately three-fourths of agencies provide financial support to primary care providers in their state. Just over half of them are responsible for ensuring that their communities have access to emergency medical services. Fewer agencies are involved with ensuring access to insurance, including the State Children's Health Insurance Program (SCHIP), (31 percent); state provided health insurance not supported by federal funds (10 percent); and regulation of the insurance industry (6 percent).

Figure 1.5: State health agency activities to ensure access to health care services; n=51.

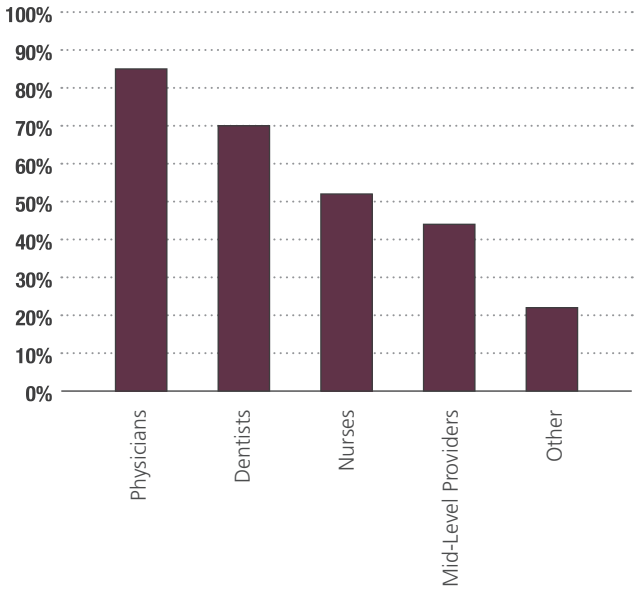
State Health Agency Activities to Ensure Access to Health Care Services	#	%
Health Disparities or Minority Health Initiatives	43	84%
Provide Financial Support to Primary Care Providers	38	75%
Rural Health	37	73%
Emergency Medical Services	26	51%
Institutional Certifying Authority for Federal Reimbursement	25	49%
Outreach and Enrollment for Medical Insurance	20	39%
State Children's Health Insurance Program (SCHIP)	16	31%
Faith-based Health Programs	15	29%
Tribal Health	14	27%
State Provided Health Insurance (Not Supported by Federal Funds)	5	10%
Health Insurance Regulation	3	6%

More state health agencies in decentralized states ensure access to tribal health services than agencies in centralized states (40 percent compared to 7 percent). A greater proportion of agencies in the Mountain/ Midwest region indicate they ensure access to SCHIP, while more agencies in the South report they ensure access to faith-based programs. There are no differences observed in ensuring access to health care services by size of population served.

State Health Agency-Sponsored Loan Repayment Programs

Many state health agencies sponsor loan repayment programs to recruit and retain health professionals. Often, beneficiaries of these programs serve in health professional shortage areas. Most beneficiaries are not placed in state health agencies. The distribution of loan repayment programs across specific occupational categories is shown in **figure 1.6**. Of the 27 state health agencies that report having a loan repayment program, 85 percent sponsor a loan repayment program for physicians and 70 percent sponsor a loan repayment program for dentists. Among those agencies that report sponsoring a loan repayment program for other primary care workers, the most commonly sponsored are registered nurse practitioners, physician assistants, clinical social workers, and certified nurse midwives.

Figure 1.6: State health agency-sponsored loan repayment programs by occupational category; n=27.



State health agencies that serve smaller populations less frequently indicated they sponsored loan repayment programs for nurses compared to those that serve larger populations (18 percent compared to at least 67 percent). Agencies in the South had the lowest sponsorship of loan repayment programs for physicians.

Population-Based Primary Prevention Services

State health agencies provide many population-based primary prevention services. In doing so, they help to inform, educate and empower people about health issues (essential service number three). **Figure 1.7** shows the 10 most common areas of population-based primary prevention services provided directly by state health agencies. Not surprisingly, almost all of those services are related to the sources of morbidity and mortality found in the CDC's list of winnable battles.

Immunization Services

Over 90 percent of state health agencies are responsible for vaccine order management and inventory distribution of childhood and adult immunizations **(see figure 1.8)**. In contrast, less than one-half of them administer childhood and adult immunizations (46 percent and 42 percent respectively). Eighty-five percent of agencies in centralized states provide childhood and adult vaccine administration compared to 22 percent of those in decentralized states, where such services are often provided directly by health care providers or local health departments. State health agencies less frequently report involvement in immunization services related to international travel.

Figure 1.7: Population-based primary prevention services provided directly by the state health agency; n=51.

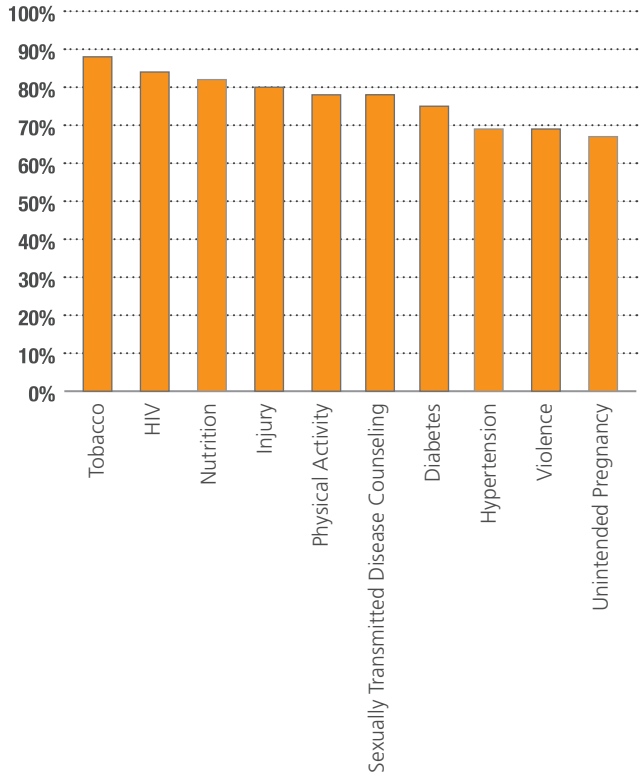
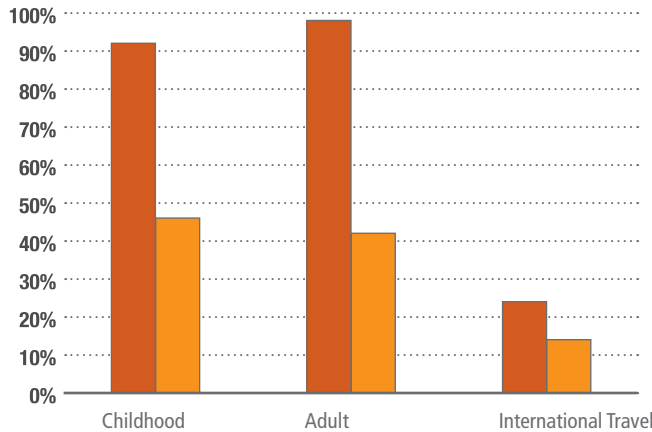


Figure 1.8: Immunization services performed directly by the state; n=50.



	Childhood Immunization	Adult Immunization	International Travel Immunization
Vaccine order management and Inventory distribution (2010)	92%	98%	24%
Administration of vaccine to population (2010)	46%	42%	14%

Figure 1.9: State health agency screening for diseases and conditions; n=51.

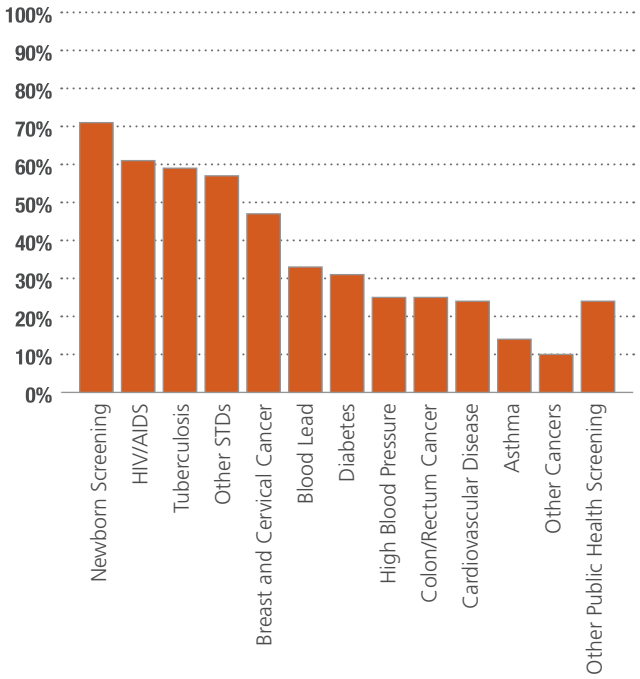


Figure 1.10: Other individual clinical services provided directly by state health agencies; n=51.

Clinical Services	#	%
Oral Health	29	57%
Rural Health	21	41%
Pharmacy	19	37%
Sexual Assault Victims Services	17	33%
Mental Health Education and Prevention Services	16	31%
State Nursing Home Eligibility Determination	16	31%
Substance Abuse Education and Prevention Services	16	31%
Domestic Violence Victims Service	13	25%
Managed Care (Medical Homes)	12	24%
Mental Health Treatment Services	12	24%
Disability	9	18%
Physical Therapy	9	18%
Substance Abuse Treatment Services	9	18%
Child Protection Services/ Medical Evaluation	8	16%
Home Health Care	8	16%
Correctional Health	7	14%
Disability Determination	6	12%

Screening for Diseases and Conditions

State health agencies commonly indicate that they screen individuals for diseases and conditions **(see figure 1.9).** Over 70 percent of them provide newborn screening services. Around 60 percent screen for tuberculosis and sexually transmitted diseases, including HIV/AIDS.

As the size of the population served increases, state health agencies report they provided screening for breast, cervical, colon and rectum cancer with decreasing frequency. Nearly 60 percent of state health agencies in centralized states provide blood lead screening compared to 26 percent of those in decentralized states. Agencies in centralized states more frequently indicate they provide screenings for breast and cervical cancer, tuberculosis, and other public health screenings, including newborn and hepatitis screenings, compared to those in decentralized states.

Other Clinical Services Provided to Individuals

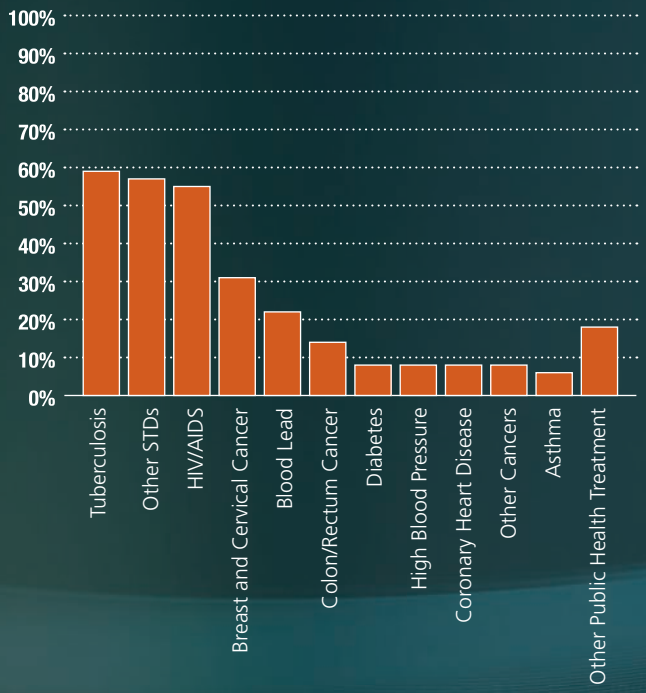
In addition to providing population-based services, state health agencies provide direct clinical services to individuals **(see figure 1.10).** Oral health services are the most common (57 percent) followed by rural health and pharmacy services. Fewer state health agencies that serve small populations provide mental health, substance abuse education and child protection services compared to those that serve larger populations. State health agencies that serve large populations are the only ones to report not providing home health care services; a smaller percentage also provide rural health and sexual assault victim services. More agencies in centralized states provide oral health, pharmacy, and home health care services than those in decentralized states. There are no differences observed based on geographic region.

Treatment for Diseases

State health agencies provide a significant number of disease treatment services. **Figure 1.11** shows some of the diseases for which they provide direct patient care. Most commonly, they provide care for infectious diseases such as tuberculosis and sexually transmitted diseases (STD), including HIV/AIDS. State health agencies less commonly indicate they provide care for chronic diseases such as cancer, diabetes, high blood pressure, heart disease and asthma.

State health agencies in centralized states more frequently report they provide treatment services for colon and rectum cancer, HIV/AIDS and tuberculosis compared to those in decentralized states. There are no differences based on size of population served or geographic region.

Figure 1.11: State health agency provision of disease treatment services; n=51.

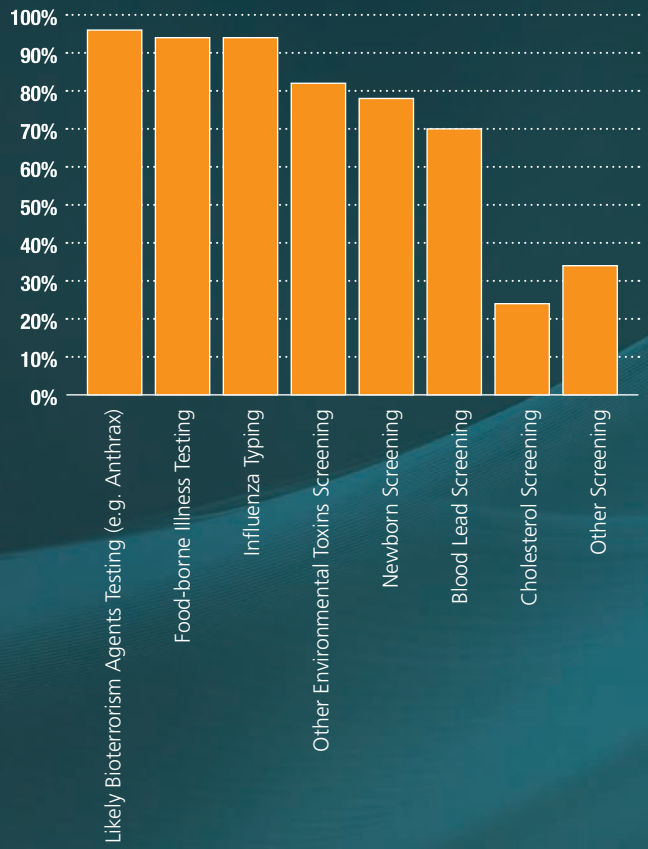


State Laboratory Services

All state health agencies provide laboratory services through a state laboratory. The most common services provided by state-health laboratories are related to population-based services and activities such as testing for likely bioterrorism agents (96 percent) and food-borne illness (94 percent) and influenza typing (94 percent). State laboratories less frequently indicate they run individual-based laboratory services such as cholesterol screening.

Fewer state laboratories in states with small populations provide newborn and blood lead screening services compared to state laboratories in states with medium- and large-sized populations. State laboratories in centralized states and southern states more frequently provide cholesterol screenings than their counterparts.

Figure 1.12: State laboratory services; n=50.

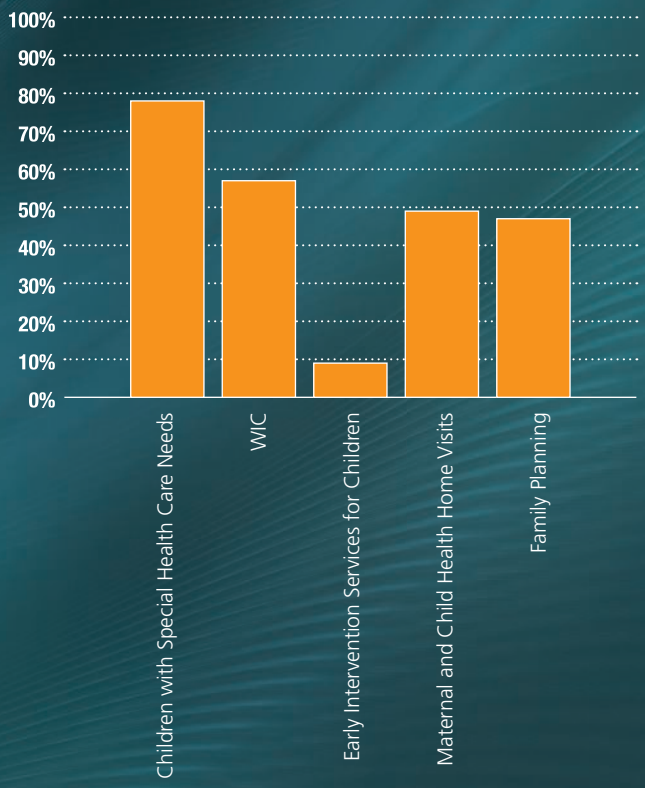


Maternal and Child Health Services

The five most common maternal and child health services that state health agencies provide directly are shown in **figure 1.13.** Almost 80 percent of them provide services to children with special health care needs. Those services include direct patient care; case management; health care coordination; family support services; transition services; and access to pharmaceuticals, medical equipment and supplies. Fifty-seven percent of state health agencies administer the U.S. Department of Agriculture's WIC program; about a half of them are involved in early intervention services for children, maternal and child health home visits and family planning services.

State health agencies that serve large populations less frequently indicated they provide maternal and child health services compared to agencies that serve small and medium populations. State health agencies in centralized states more frequently indicated they provide WIC, family planning and home visits compared to those in decentralized states.

Figure 1.13: Maternal and child health services; n=51.



Epidemiology and Surveillance

State health agencies are involved in a variety of data collection, epidemiologic and surveillance activities. Almost all of them collect data related to risk factors and disease incidence, including chronic and infectious diseases, exposures and access to care. The most common data collection activities are shown in **figure 1.14.**

There are no differences in epidemiology and surveillance activities based on size of population served, governance classification or geographic region.

Figure 1.14: State health agency data collection, epidemiology and surveillance activities; n=51.

State Health Agency Data Collection, Epidemiology and Surveillance Activities	#	%
Behavioral Risk Factors	49	96%
Communicable/ Infectious Diseases	49	96%
Reportable Diseases	49	96%
Vital Statistics	49	96%
Cancer Incidence	48	94%
Chronic Diseases	48	94%
Perinatal Events or Risk Factors	48	94%
Food-borne Illness	47	92%
Morbidity Data	47	92%
Environmental Health	45	88%
Injury	45	88%
Syndromic Surveillance	41	80%
Adolescent Behavior	40	78%
Uninsured, Outreach and Enrollment for Medical Insurance	26	51%

Regulation, Inspection and Licensing

In addition to providing population-based services, state health agencies also enforce laws and regulations that protect health and ensure safety (essential service six). These activities include inspection or licensing of a variety of public health system partners such as entities that provide direct care, including hospitals (42 states), clinics (23 states) and hospice facilities (36 states). In 42 states, the state health agency is responsible for regulating hospitals. State health agencies also regulate, inspect and license entities that process and serve food; recreational sites such as beaches, campgrounds and public swimming pools; water sources; waste disposal sites and entities; and tobacco retailers.

Less frequently state health agencies are involved in oversight of professional licensure activities **(see figure 1.15)**. Slightly less than one-quarter of them are involved in overseeing professional licensure for nurses, physicians, physician assistants, dentists and pharmacists. Over 50 percent of state health agencies report oversight of professional licensure for other occupations, including emergency medical technicians and paramedics, podiatrists, speech and language therapists, administrators of long-term care facilities, and radiology technicians.

There are no differences in professional licensure activities based on size of population served, governance classification or geographic region.

Legal Counsel

Almost two-thirds of state health agencies have their own legal department that employs attorneys **(see figure 1.16)**. Agencies that serve large populations and those in decentralized states more frequently reported that they have their own legal department compared to their counterparts. Nearly 60 percent of state health agencies report legal counsel is assigned by the attorney general. Regarding **figure 1.16** respondents were given the opportunity to select as many responses as were applicable.

Figure 1.15: State health agencies oversight of professional licensure; n=50.

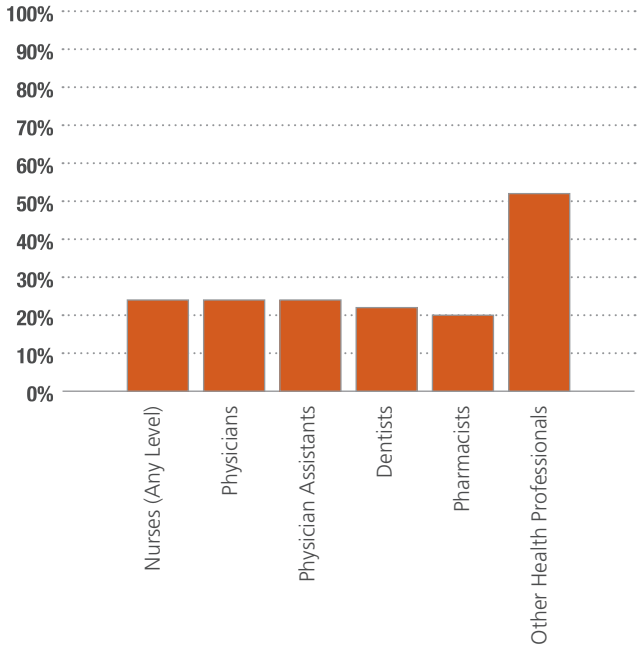


Figure 1.16: State health agency legal counsel; n=48.

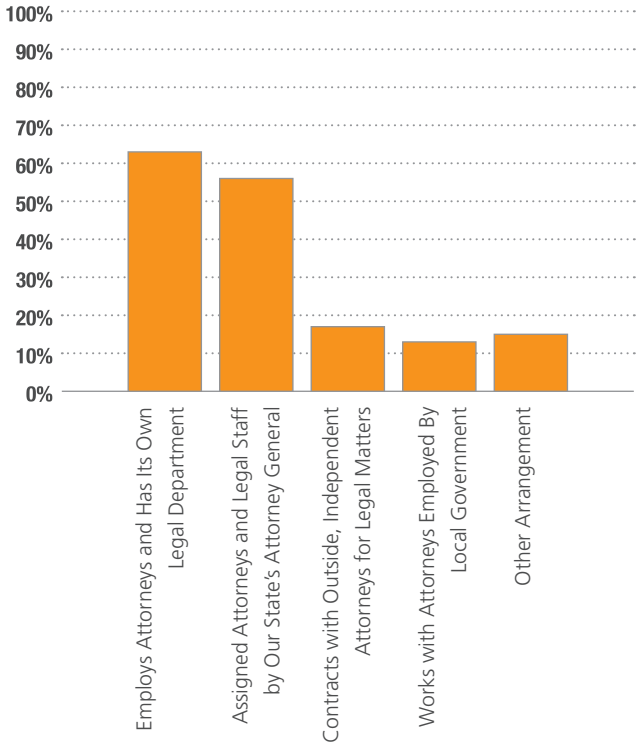


Figure 1.17: Services provided by state health agency legal counsel; n=48.

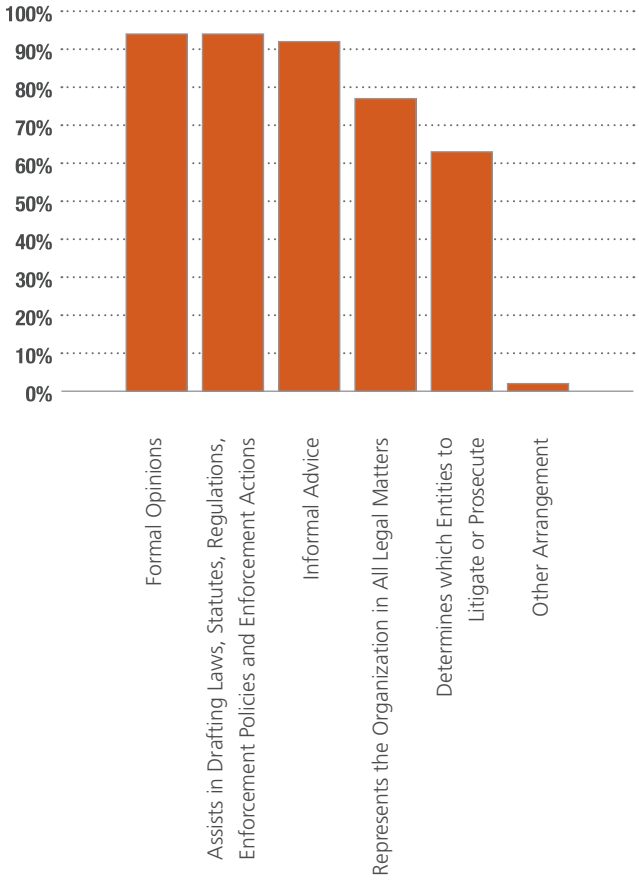
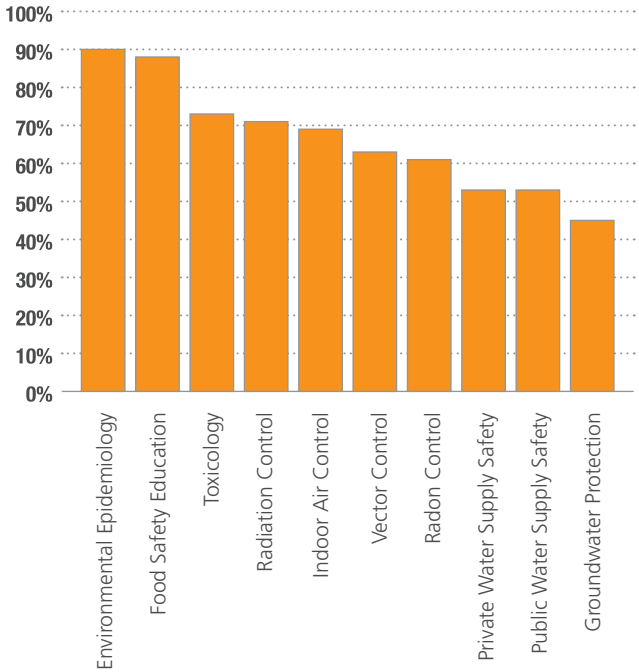


Figure 1.18: State health agency involvement in environmental health services; n=51.



For almost all state health agencies, legal counsel does the following: (1) provides formal opinions on laws, statutes, regulations, enforcement policies and enforcement actions for use in possible litigation or other legal actions involving the agency; (2) assists in drafting their laws, regulations, enforcement policies and enforcement actions; and (3) informally advises them on the legality/constitutionality of various laws, statutes, regulations, enforcement policies and enforcement actions **(see figure 1.17)**.

Almost three-fourths of state health agencies report that legal counsel represents them in all legal matters pertaining to their activities. Just over 60 percent of state health agencies report that legal counsel determines which entities to litigate against or prosecute for violation of the agency's regulatory responsibilities. Only one agency reports another arrangement. A greater proportion of state health agencies that serve smaller populations report that legal counsel determines entities to litigate compared to those that serve larger populations.

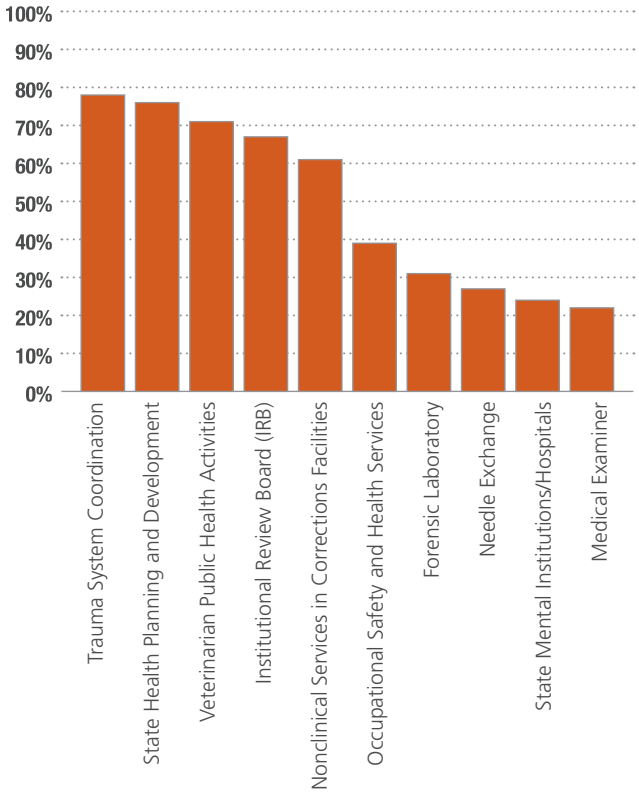
Environmental Health Activities

Around 90 percent of state health agencies are involved in environmental epidemiology and food safety education. Many of them are also involved in toxicology, radiation control and indoor air quality. The top 10 most frequently reported environmental health activities are shown in **figure 1.18**.

Other Public Health Activities

Other services commonly provided directly by the state are shown in **figure 1.19.** Most often, state health agencies are responsible for coordination of the trauma system (78 percent). They are also frequently involved in state health planning and development, veterinarian public health activities, convening of institutional review boards, and provision of nonclinical services in corrections facilities (e.g. epidemiology, surveillance, HIV/STD prevention).

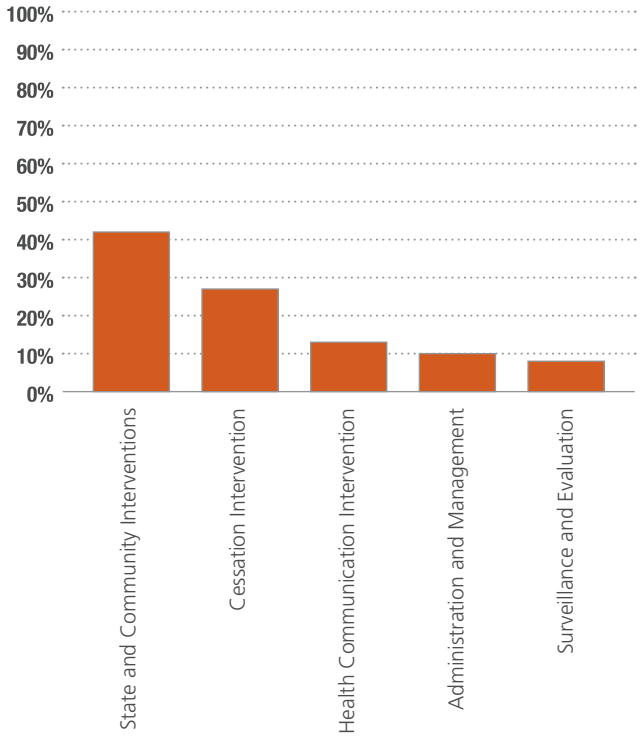
Figure 1.19: Other public health activities conducted directly by state health agencies; n=51.



Comprehensive Tobacco Control Priorities

Figure 1.20 shows the percentage of state health agencies that ranked each comprehensive tobacco control priority as their top tobacco control priority. State and community interventions were ranked as the top priority most often (42 percent) followed by cessation intervention (27 percent). While still a priority, surveillance, evaluation, administration and management were less frequently ranked as the top priority.

Figure 1.20: State health agency comprehensive tobacco control priorities; n=48.

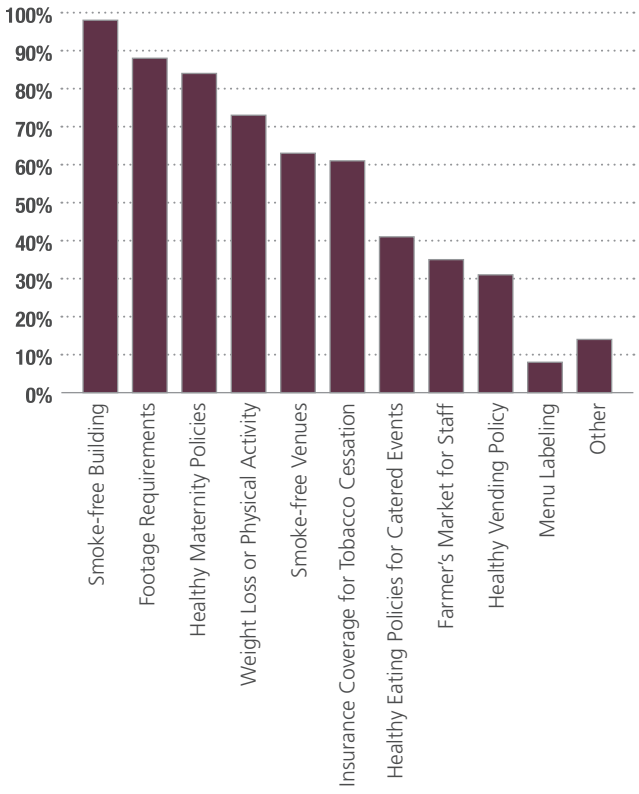


Around 90 percent of state health agencies are involved in environmental epidemiology and food safety education, and many work on toxicology, radiation control and indoor air quality as well.

Work site Wellness

As expected, many state health agencies have work site wellness policies that protect their workers and help prevent morbidity and mortality **(see figure 1.21)**. Four of the top six work site wellness components are related to tobacco prevention and control; nearly all state health agencies have a smoke-free building (98 percent), and almost 90 percent have footage requirements for outdoor smoke-free areas. A smaller number of agencies have a policy which requires a smoke-free venue for off-site meetings (63 percent) or insurance coverage for tobacco cessation treatment (61 percent). In comparison, healthy eating policies such as a healthy eating for catered event, healthy vending and menu labeling are less common. An example of ASTHO's Healthy Food Policy can be found at **http://www.astho.org/Events/Policies/ASTHO-Event-Policies/.**

Figure 1.21: Top state health agency work site wellness components; n=49.



Funding for Obesity Prevention

Ninety percent of state health agencies receive funding from the CDC to prevent obesity. Almost a half of agencies report receipt of obesity prevention funding from the state general fund. Six percent of them report they do not have funding for an obesity prevention program.

Research and Evaluation Activities

State health agencies engage in many activities to evaluate personal and population-based health services and research new insights and innovative solutions to health problems (essential services 9 and 10). Many agencies are involved in research and evaluation activities **(see figure 1.22).** Over 90 percent of state health agencies analyze and interpret data, and a similar number collect, exchange or report data. A large number of state health agencies also disseminate research findings, apply these findings to practice and identify relevant research questions and topics. Approximately a half of agencies develop research protocols, help other organizations apply for funding or recruit study participants.

Figure 1.22: State health agency involvement in research activities; n=47.

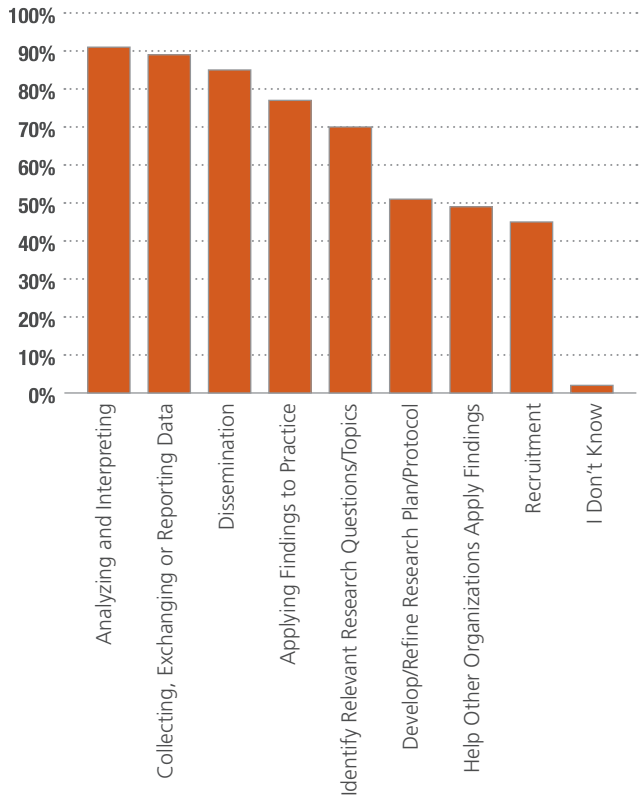


Figure 1.23 shows the average, minimum and maximum number of research and evaluation activities in which state health agencies have participated over the past 12 months. On average, each agency participated in approximately 32 studies over the past 12 months; slightly more than half of those studies were led by the state health agency, and approximately 70 percent included participation by a researcher based at a university or research institute. On average, about one-third of state health agency studies involving a researcher based at a university or research institute also involved a formal research agreement to conduct joint studies on a recurring basis.

There are no differences in research participation by size of population served, governance classification or geographic region.

Figure 1.23: Types of research studies involving state health agencies.

Type of Research Study	#	Mean	Med.	Min.	Max.
All Studies	36	32.1	12	2	217
Studies Led by State Health Agency	21	17.9	7	1	114
Studies Including Participation with a Researcher Based at a University or Research Institute	32	22.8	7.5	1	151
Studies Including a Formal Agreement to Conduct Joint Studies on a Recurring Basis	19	10.7	5	1	50

In addition to providing population-based services, state health agencies also enforce laws and regulations that protect health and ensure safety (essential service six).

2 Chapter Two

Structure, Organization and Governance

The organizational structure of state health agencies varies. Some are independent in the sense that they are separate from Medicaid or human services programs, while others are part of a larger umbrella or super agency. Organizational structure has implications for how state health agencies function and provide services in their jurisdictions.

This chapter addresses the organization, structure and governance of state health agencies. The term governance is used in reference to state boards of health, which guide state health agencies in some states, and to the extent of state governmental authority over local health agencies. This chapter explores findings from the 2010 ASTHO Profile Survey on health agency structure and when applicable compares those findings to data collected in the 2007 ASTHO Profile Survey.

Other topics covered in this chapter are the number of regional or district and local health agencies and state health agency governance relationships with local and regional or district health departments. The chapter also describes the role of the state health official with a discussion of whom they report to and how they are appointed and confirmed. Additionally, the chapter includes a discussion on state health agency rule making and statutory authority and resource sharing, regionalization and partnerships. The chapter concludes with an overview of the role of state boards of health.

Key Findings

- All state health agencies report the same organizational structure in 2007 and 2010.
- States health agencies do not generally share resources with each other; however, when they do share resources, it is typically for all-hazards preparedness or surveillance.
- Four states report the presence of laws that prevent regionalization.
- Overall state health agencies report a high level of collaboration with entities in the health care field.

State Health Agency Structure

State health agency structure describes the placement of a state health agency within the larger departmental/agency organizational structure for the state. For example, in states where the public health agency is part of a larger umbrella agency, the larger agency may also be responsible for Medicaid, services for the aging population, substance abuse or mental health services, or public assistance, in addition to providing public health services.

Fifty-five percent of state health agencies are free-standing, independent agencies; the remaining state health agencies are part of a super or umbrella agency. States with medium and large populations more frequently report free-standing, independent agencies (71 percent of medium-sized states and 65 percent of large states). There are no structural differences based on governance classification or U.S. region.

Of the 23 state health agencies that are a part of a super or umbrella agency, each cited responsibilities of the larger agency that are separate from the statutory responsibility of the public health administration. **Figure 2.1** shows the major areas of responsibility of other agencies for state health agencies that reported data in both 2010 and 2007. In 2010 and 2007, the top three areas of responsibility were long-term care, Medicaid and public assistance.

The most common areas of responsibility in the "other" category for 2010 and 2007 were similar: provision of services for the aging/elderly; child and family services, including child welfare; services for individuals with disabilities; and licensure/certification of health care professionals and facilities. When region is considered, 40 percent of southern and western state health agencies report umbrella agency responsibility for state mental health authority without substance abuse compared to less than 10 percent of states in other regions. Only one-third of states in the Mountain/Midwest region report umbrella agency responsible for long-term care compared to one-half of states in other regions (50 percent–67 percent in other regions). There were no differences in major areas of responsibility by organizational structure or size of population served.

Number of Regional/District and Local Health Agencies

State health agencies responding to the survey reported 2,790 local health departments and 261 regional or district offices in the United States and Washington, DC[3]. In 2010, within a single state, the maximum number of state-run local health agencies was 94; the maximum number of independent local health agencies was 351, over 3 times as large. In comparison, the maximum number of independent and state-run regional or district health agencies was much smaller at 20 and 33 respectively. Summary statistics for 2010 are shown in **figure 2.2.**

Figure 2.1: Major areas of responsibility of other administrations within umbrella agency; n=19 out of 23 State health agencies that were a part of an umbrella agency in 2010 and 2007.

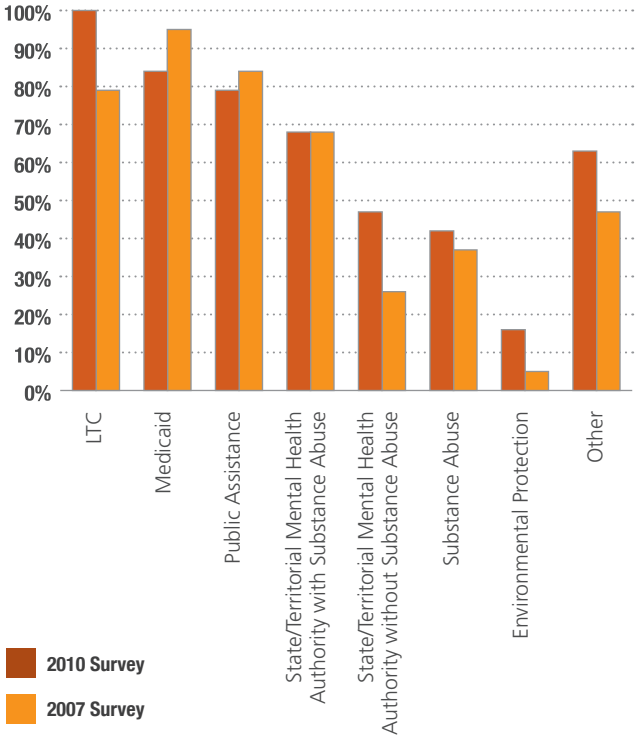


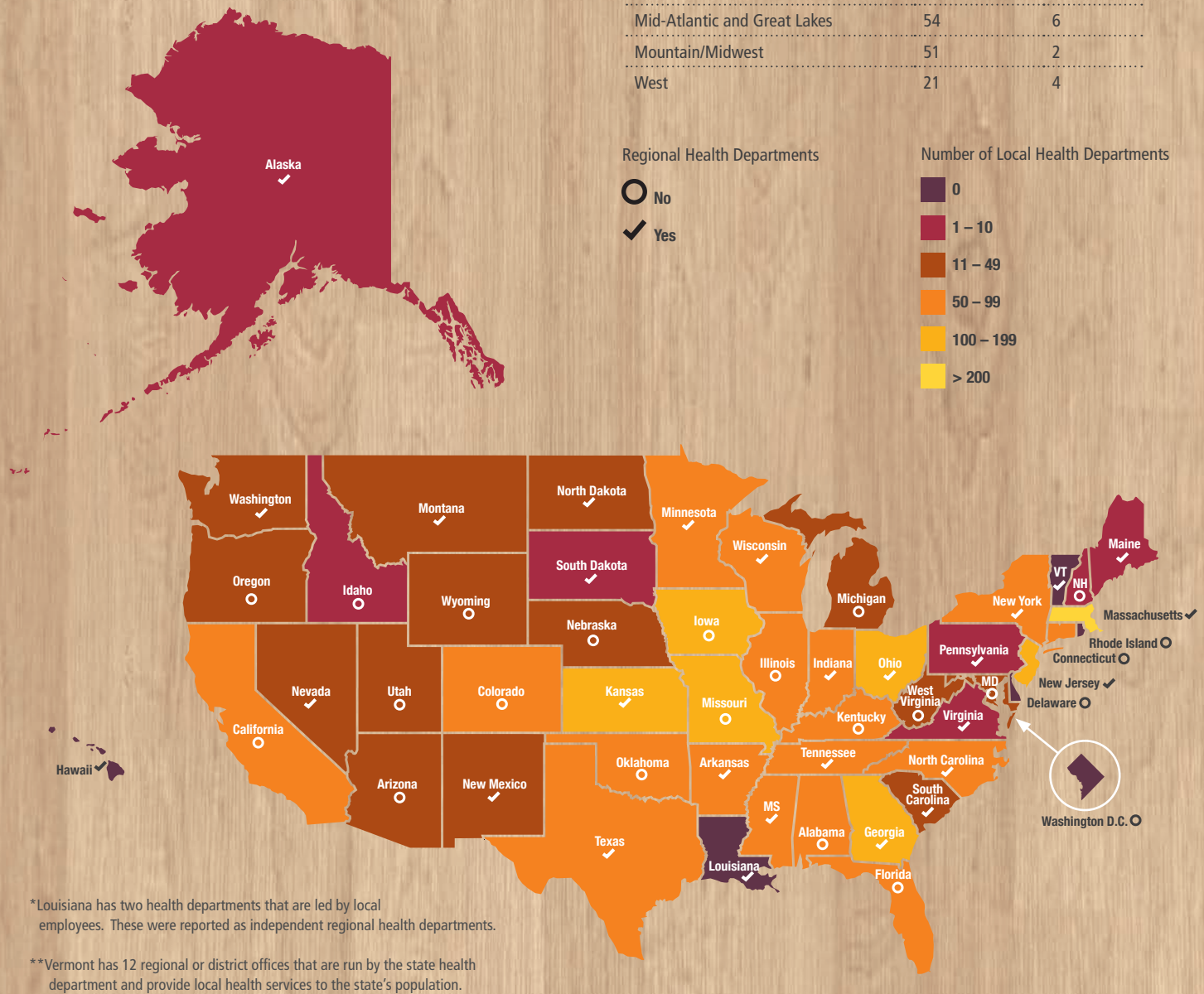
Figure 2.2: Number of local and regional health departments 2010; n=49.

Type of Health Departments	Mean	Med.	Min.	Max.
Local Health Departments	56.9	49	0	351
Regional or District Health Departments	5.3	4	0	33

The number and type of local and regional or district health departments in each state is often related to governance classification and structure. Decentralized states tend to report fewer regional or district local health agencies than centralized states. On average, free-standing, independent agencies have more local health agencies compared to super or umbrella agency state health agencies. When the size of the population served is considered, the number of local health agencies increases as state population increases. State health agencies in western states have fewer local health agencies than state health agencies in other regions **(see figure 2.3).**

Figure 2.3: Average number of local and regional health agencies by state health agency characteristics; n=49.

State Health Agency Characteristic	Mean Number of Health Agencies	
Structure	**Local**	**Regional**
Free-standing, Independent Agencies	69	5
Super Agency/Umbrella Agency	43	5
Population Size		
Small	16	5
Medium	63	3
Large	87	8
Region		
New England	87	8
South	71	6
Mid-Atlantic and Great Lakes	54	6
Mountain/Midwest	51	2
West	21	4



*Louisiana has two health departments that are led by local employees. These were reported as independent regional health departments.

**Vermont has 12 regional or district offices that are run by the state health department and provide local health services to the state's population.

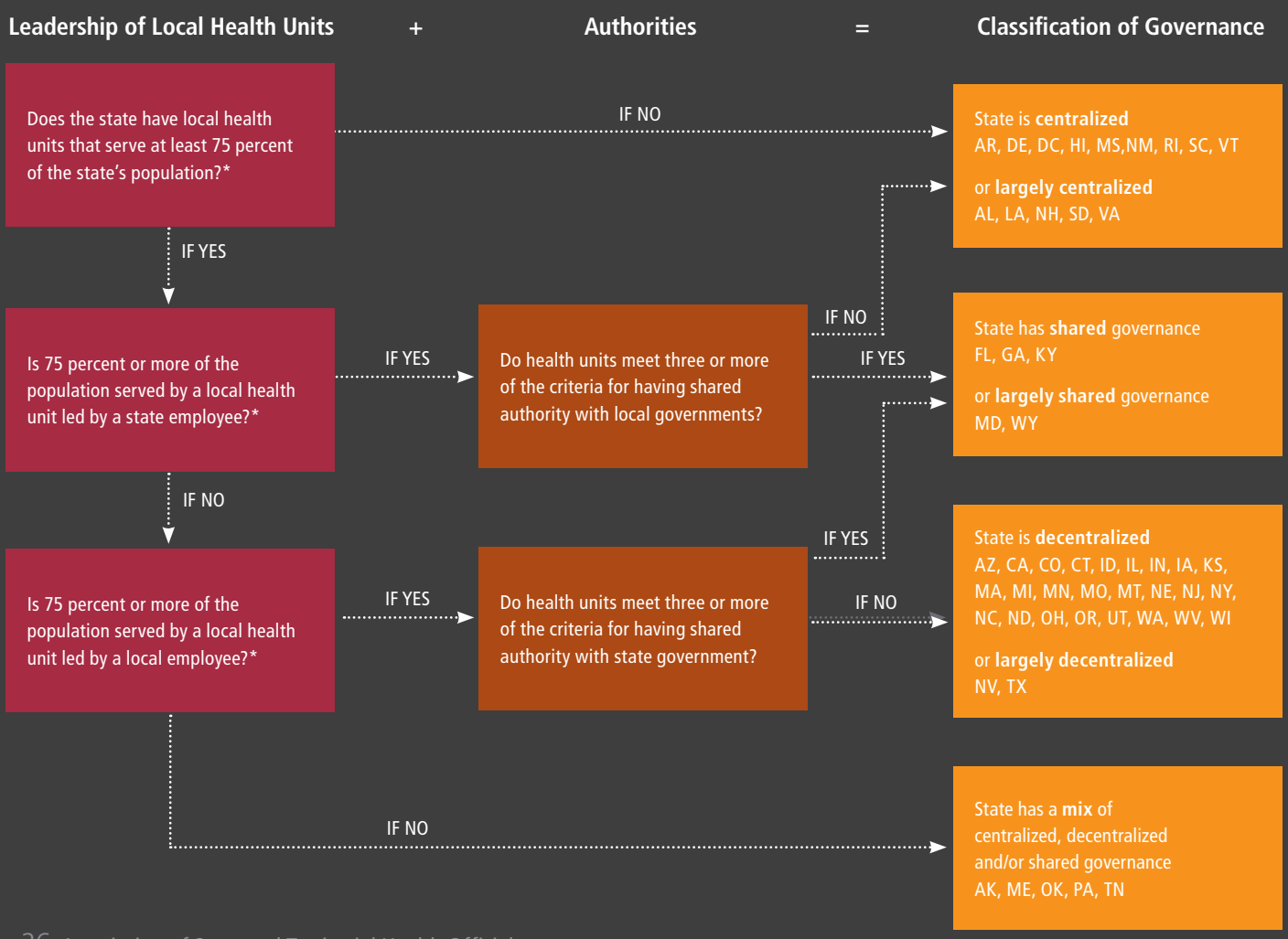
Governance Structure

The relationship between state health agencies and regional/local public health agencies differs across states. These structural differences have important implications for the delivery of essential public health services. Identifying these differences is important for understanding the roles, responsibilities, and authorities across levels of government for services provided within the community. ASTHO engaged the National Opinion Research Center (NORC) at the University of Chicago to develop a uniform and objective classification of state health agency governance to explain the ways in which public health structure influences health departments' operations, financing and performance.

The classification system may also provide a mechanism for understanding how accreditation standards will apply in different states. The following decision tree **(see figure 2.4)** was developed to aid classification of states and the District of Columbia according to their governance structure.

Nearly 30 percent of states (n=14) have a centralized or largely centralized governance structure where local health units are primarily led by employees of the state and the state retains authority over most decisions relating to budget, public health orders, and the selection of local health officers.

Figure 2.4: State and local health department governance classification system.



Five states have a shared governance system where local health units may be led by state or local government employees. If they are led by state employees, the local government can make fiscal decisions, issue public health orders and/or select local health official. In shared states where local health departments are led by local employees, the state health agency retains authority over most decisions relating to budget, public health orders, and the selection of local health officials.

Over a half of states (n=27) have a decentralized/ largely decentralized system where local health units are primarily led by employees of local governments, and the local governments retain authority over certain decisions.

Ten percent of states have a mixed governance structure where some local health units are led by state employees and by local government employees. No one arrangement predominates in the state. In summary, 26 state health agencies (more than half) provide all or some of the public health services offered at the community level. See **figure i.3** (in the introduction) for a map of states and their governance classification.

Criteria for state-led health units having shared authority with local government:

- Local governmental entities have authority to make budgetary decisions.
- Local government can establish taxes for public health or establish fees for services AND this revenue goes to local government.
- 50 percent or less of local heath unit budget is provided by state public health agency.
- Local governmental entities can issue public health orders.
- Local chief executives are appointed by local officials.
- Local chief executives are approved by local officials.

Criteria for local-led health units having shared authority with state government:

- State governmental entities have authority to make budgetary decisions.
- Local government can not establish taxes for public health nor establish fees for services OR this revenue goes to state government.
- More than 50 percent of local heath unit budget is provided by state public health agency.
- Local governmental entities can not issue public health orders.
- Local chief executives are appointed by state officials.
- Local chief executives are approved by state officials.

* If the majority (75 percent or more) but not all of the state population meets this designation, then the state is largely centralized, decentralized, or shared.

State Health Officials

Half of state health officials report directly to the governor, and nearly one-third report to the secretary for health and human services. Other individuals and entities state health officials report to include administrators/directors of an umbrella agency or director of the health division of an umbrella agency. One state health official reports to the governor and the agency director. **Figure 2.6** below shows the entities to whom state health officials directly report.

In 63 percent of decentralized state health agencies the state health official reports to the governor compared to 31 percent of centralized states. State health officials are more likely to report to the governor in states with medium- and large-sized populations (53 percent and 65 percent, respectively, compared to 31 percent). For states with a small population, the state health official reports to the secretary of state for health and human services most often. Among state health agencies in the Mountain/Midwest region, the state health official more commonly reports to the governor, compared to agencies in other regions. Only state health agencies in the South indicate that the state health official reports to a board or commission.

Almost two-thirds of state health agencies report that the state health official is appointed by the governor. State health officials are appointed by the state health and human services secretary in almost 20 percent of states **(see figure 2.7)**.

Figure 2.6: Individuals/organizations to whom the state health official directly reports; n=51.

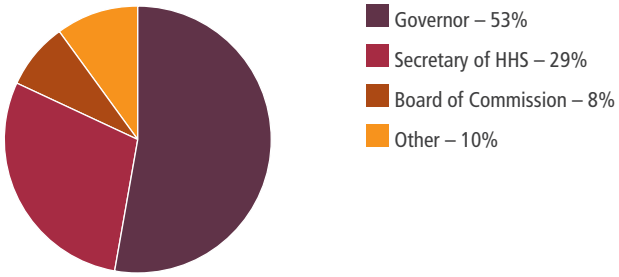
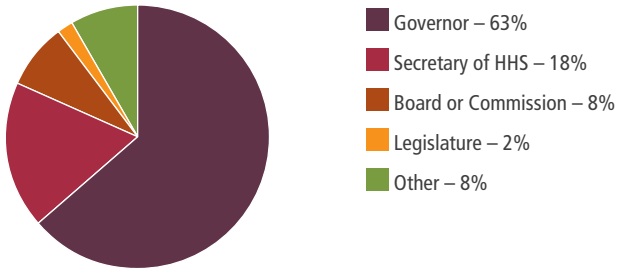


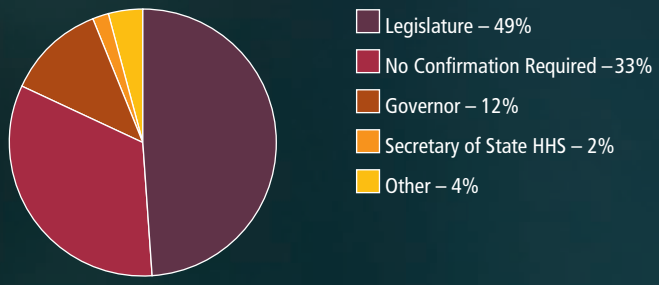
Figure 2.7: Appointment of the state health official; n=49.



State health agencies responding to the survey reported 2,790 local health departments and 261 regional or district offices in the United States and Washington, D.C.

For nearly one-half of state health agencies, the state health official's appointment must be confirmed by the legislature. In contrast, for almost one-third of state health agencies, state health officials do not have to be confirmed **(see figure 2.8).**

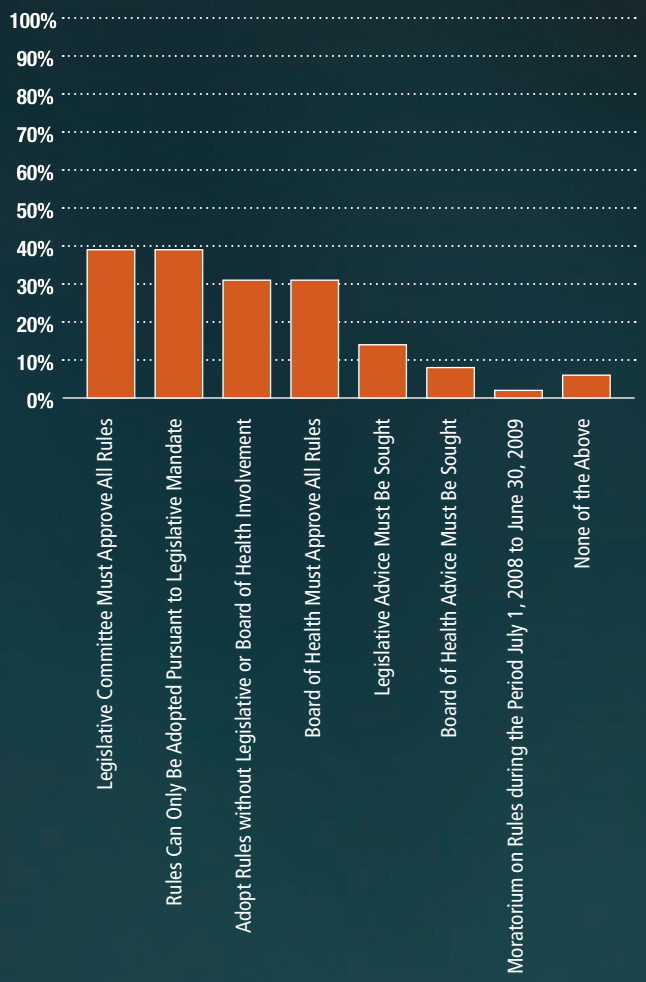
Figure 2.8: Confirmation of state health official appointment; n=49.



State Health Agency Authority

In some situations, state health agencies are obligated to assume authority for the provision of local public health services. Seventy-four percent of states report an obligation to assume authority when local health agencies cannot perform their duties or when there is no coverage by a local health department. Almost 40 percent report an obligation to assume authority under other circumstances. Other reasons for state assumption of authority include emergency response or when issues are cross-jurisdictional. Eighty-five percent of state health agencies report that the obligation is legal while just over 10 percent characterize the obligation as professional. Rule making authority refers to the power of state health agencies to create regulations. The most common approaches to rule adoption are shown in **figure 2.9.**

Figure 2.9: State public health agency rule making authority; n=49.

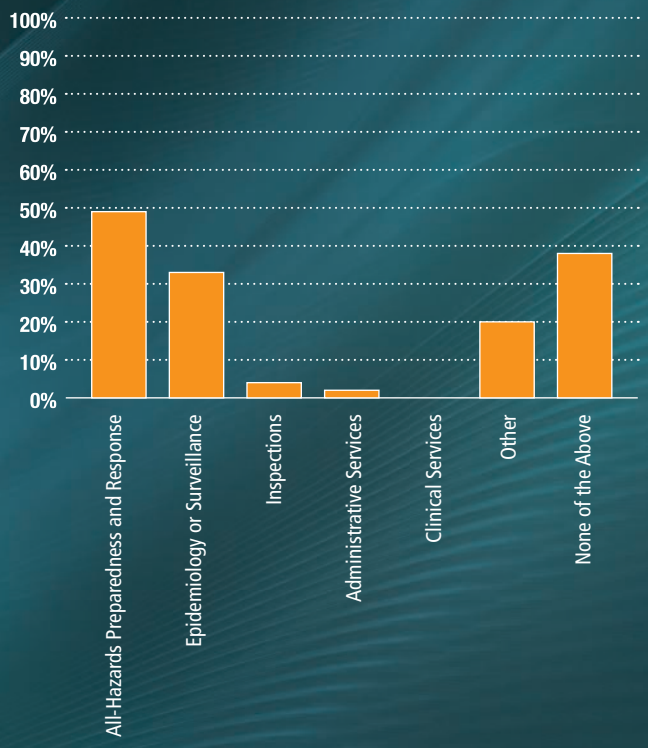


Twenty-six state health agencies (more than half) provide all or some of the public health services offered at the community level.

Shared Resources

While state health agencies do not frequently share resources with each other, they often facilitate sharing of resources between smaller jurisdictions, such as local and regional health departments. Ninety percent of states do not currently share resources (funding, staff or equipment) with other states on a continuous, recurring basis. In contrast, 63 percent of states report facilitation or the sharing of resources between local health departments. **Figure 2.10** displays the services and functions for which agencies share resources with other states. Twenty-two states report sharing resources with neighbors for all-hazards preparedness and response. One-third of states report sharing resources for epidemiology and surveillance. Less than 10 percent of states share resources for inspections and clinical and administrative services. Almost 20 percent of states share resources for other services and functions, of which laboratories is the most common.

Figure 2.10: Services and functions for which agencies share resources with other states; n=45.



A greater proportion of decentralized states share resources with other states, facilitate sharing with local health departments, and share resources for epidemiology/surveillance compared to centralized states. Regionally, Southern and Mountain/ Midwestern states more frequently indicated they facilitate sharing among local health departments. There are no noteworthy differences based on size of population served.

The nature of agreements to share services or functions with other states can be formal or informal. Forty-three percent of states use a combination of formal written agreements and informal agreements. The same number use formal written agreements only while three states report using informal agreements only.

Regionalization

Almost three-fourths of states (n=37) have no laws or regulations that prohibit regionalization of local jurisdictions within the state. Thirty percent of states have state laws and regulations that require or facilitate regionalization. Examples include laws that regulate emergency response, laws to specifically create regions or districts, provision of authority for interlocal agreements and funding incentives. Four states report laws that prohibit regionalization; in those cases, state statute specifies or creates a position or other entity at the county level such as a board of health, health officer, health department or county commission.

Partnerships

States collaborate with a number of different types of governmental and nongovernmental agencies and organizations. State health agency collaborative activities with other agencies/organizations in the past year are displayed in **figure 2.11.** Overall, state health agencies report a high level of collaboration with local public health agencies and entities in the health care field. The vast majority of state health agencies exchange information with hospitals, physician practices/medical groups, community health centers, and other health providers (86 percent to 98 percent). The percent of state health agencies collaborating with those organizations is also very high (78 percent to 100 percent). Providing financial resources to those types of organizations is less commonly reported (37 percent to 78 percent); however, 80 percent of state health agencies provide financial resources to hospitals.

Figure 2.11: Activities done in collaboration with other agencies/organizations in the past year; n=51.

	Exchange Information		Work Together On Activities Or Projects		State Health Agency Provides Financial Resources		State Health Agency Has The Leadership Role Within The Partnership		No Relationship Yet	
	#	%	#	%	#	%	#	%	#	%
Local Public Health Agencies	46	90%	45	88%	45	88%	37	73%	0	0
Hospitals	50	98%	51	100%	41	80%	29	57%	0	0
Physician Practices/Medical Groups	45	88%	43	84%	19	37%	19	37%	0	0
Community Health Centers	49	96%	47	92%	35	69%	16	31%	0	0
Other Health Care Providers	44	86%	40	78%	23	45%	17	33%	2	4%
Health Insurers	39	76%	39	76%	5	10%	6	12%	5	10%
Regional Cancer Society	41	80%	44	86%	13	25%	7	14%	0	0
Emergency Responders	46	90%	48	94%	3	6%	29	57%	1	2%
Land Use Agencies	25	49%	21	41%	1	2%	3	6%	13	25%
Economic and Community Development Agencies	28	55%	24	47%	5	10%	4	8%	11	22%
Housing Agencies	29	57%	26	51%	4	8%	4	8%	9	18%
Utility Companies/Agencies	18	35%	17	33%	1	2%	3	6%	17	33%
Environmental and Conservation Organizations	35	69%	32	63%	4	8%	4	8%	6	12%
Cooperative Extensions	32	63%	31	61%	7	14%	6	12%	6	12%
Schools	46	90%	48	94%	30	59%	19	37%	0	0
Parks and Recreations	33	65%	36	71%	3	6%	2	4%	4	8%
Transportation	28	55%	30	59%	2	4%	1	2%	4	8%
Community-Based Organizations	46	90%	46	90%	34	67%	22	43%	0	0
Faith Communities	40	78%	40	78%	20	39%	11	22%	2	4%
Other Voluntary or Nonprofit Organizations, e.g., Libraries	40	78%	37	73%	14	27%	8	16%	2	4%
Universities	48	94%	50	98%	35	69%	17	33%	0	0
Business	41	80%	39	76%	6	12%	1	2%	3	6%
Media	46	90%	35	69%	9	18%	14	27%	0	0
Tribal Government Agencies/or Other Tribal Community	34	67%	33	65%	26	51%	16	31%	1	2%

Board of Health

Over one-half of states (n=26) report having a board of health. Board of health enforcement and adjudicatory powers are shown in **figure 2.12.**

The organizational structure of boards of health varies across states. Eighteen boards of health have committees or subcommittees; the most common committees are shown in **figure 2.13.** Committees specified for the "other" option include audit, data, nominating, care management, substance abuse and Preventive Health and Health Services Block Grant.

Thirty-one percent of state health agencies with a board of health report monthly meetings of their board, and 38 percent have quarterly meetings. Five state health agencies meet bimonthly (six times a year); the remaining agencies meet eight or nine times a year or as needed. The role of the state health official on the board of health varies by state. The most common role is a nonvoting advisor (42 percent). Other roles include secretary, executive officer of the board of health, or state health officer does not serve on the board of health. **Figure 2.14** identifies the common roles of the state health official on the board of health.

Figure 2.12: Board of health enforcement and adjudicatory powers; n=26 out of 26 state health agencies with a board of health.

Board of Health Enforcement and Adjudicatory Powers, 2010	%	%
Adjudication Powers Are Reserved for an Administrative Law Judge or Hearing Officer	8	31%
Hears Appeals of Agency Enforcement Actions	6	23%
A Hearing Officer Is Present during Adjudicatory Proceedings	3	12%
Must Approve Agency Enforcement Actions	2	8%
The Full Board Makes a Binding Adjudication after Receiving a Panel's Recommendation	2	8%
A Panel of Members Can Make a Binding Adjudication	1	4%
Only the Full Board Can Make a Binding Adjudication	1	4%
Board of Health Has No Role in Enforcement/Adjudication	12	46%

Figure 2.13: Board of health committees and subcommittees; n=18 out of 26 state health agencies with a board of health.

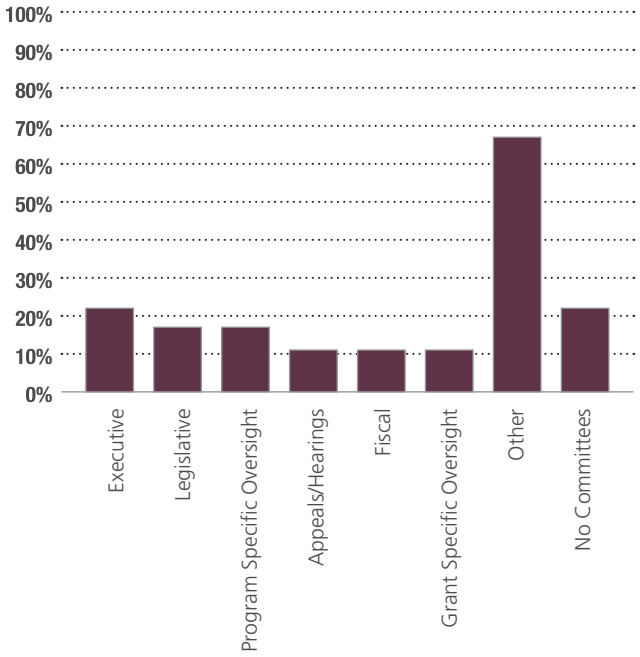
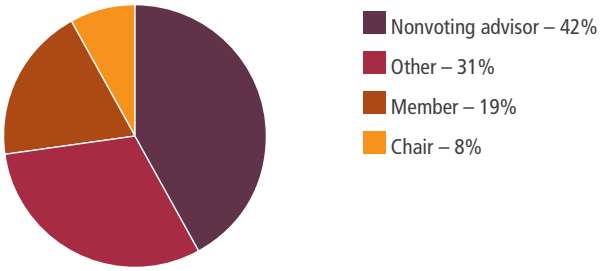


Figure 2.14: Role of state health official on the state board of health; n=26 out of 26 state health agencies with a board of health.



3 Chapter Three

Quality Improvement and Accreditation Readiness

Implementation of performance management and quality improvement practices has allowed public health systems to plan, implement, study and assess the performance of their programs and services. In the last decade, performance management and quality improvement activities have grown in importance as the field of public health moves toward adoption of voluntary national accreditation.

This chapter provides an overview of state health agency readiness and intention to apply for voluntary national accreditation. It also provides a description of state health agency performance management systems and quality improvement efforts and processes, including staff involvement in quality improvement. Finally, the chapter provides an overview of state health agency implementation of health impact assessments and use of the CDC's *Guide to Community Preventive Services.*

Accreditation Prerequisites

The Public Health Accreditation Board (PHAB) established a voluntary national accreditation program for state, local and tribal health agencies. Accreditation through PHAB provides an opportunity for public health agencies to measure their performance and demonstrate accountability.[4] PHAB's formal accreditation program was launched in 2011. Preparation for accreditation requires an

Key Findings:

- In 2010, over two-thirds of state health agencies reported completing a health assessment, with almost half of them reporting completion of a health assessment within the last three years. Fewer state health agencies had a health improvement plan in 2010 than in 2007. However, compared to 2007, the number of states that developed or participated in developing a health improvement plan within the last three years grew substantially (from 24 percent to 37 percent). Almost 90 percent of state health agencies have a strategic plan, and 85 percent of state health agencies have implemented them.
- Seventy-two percent of state health agencies plan to seek accreditation through a voluntary national accreditation program; of those, 47 percent plan to seek accreditation within the first two years of the program (2011–12).
- The most common approach to quality improvement is plan-do-study-act (also known as plan-do-check-act) followed by lean, balanced scorecard, Baldrige Performance Excellence Criteria, and Six Sigma.
- Eighty-eight percent of state health agencies set measurable objectives, and 82 percent obtained baseline data to provide a basis on which to improve.
- Fifty-seven percent of state health agencies have staff whose job description includes monitoring performance and quality improvement work throughout the agency.

investment in quality improvement and planning. In fact, all of the prerequisites for accreditation are quality improvement and planning related activities: (1) a state health assessment, (2) a state health improvement plan, and (3) an agency-wide strategic plan.

Health Assessments

As of 2010, over two-thirds of state health agencies completed a health assessment, with almost one-half of them completing a health assessment within the last three years **(see figure 3.1)**. States that serve large populations are more likely to have conducted a state health assessment in the last three years (71 percent compared to 44 percent and 31 percent of states that serve small- and medium-sized populations, respectively). Almost one-quarter of state health agencies had not completed a health assessment and do not plan to complete one in the next year.

State Health Improvement Plans

For those state health agencies that reported data for 2010 and 2007, fewer of them had a state health improvement plan in 2010 (n=30) compared to 2007 (n=40). However, compared to 2007, the number of states that developed or participated in developing a state health improvement plan within the last three years grew **(see figure 3.2)**. Based on 2010 data, more decentralized states completed a state health improvement plan in the last three years than centralized states (50 percent and 23 percent, respectively). In 2010, nearly 40 percent of states responding to both the 2010 and 2007 surveys had not developed a state health improvement plan compared to almost 20 percent of states in 2007. The 2010 survey did not collect data that would explain this dramatic shift; it may be that with the onset of accreditation and the increasing emphasis on quality improvement, respondents had a more stringent definition of a state health improvement plan in 2010 than they did in 2007.

Of the 26 state health agencies that had a state health improvement plan in 2007 and 2010, there was a decrease in the percent of those that plan to update their health improvement plan in the next three years (79 percent in 2010 compared to 96 percent in 2007). As shown in **figure 3.3**, in 2010, state health agencies less frequently developed a state health improvement plan using the results of a state health assessment (58 percent compared to 83 percent) and linking their state health improvement plan to local health-improvement plans compared to 2007 (63 percent in 2010 and 71 percent in 2007).

Figure 3.1: State Health Agency State Health Assessments; n=50.

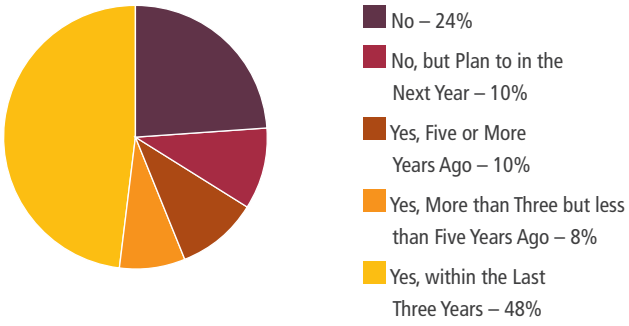
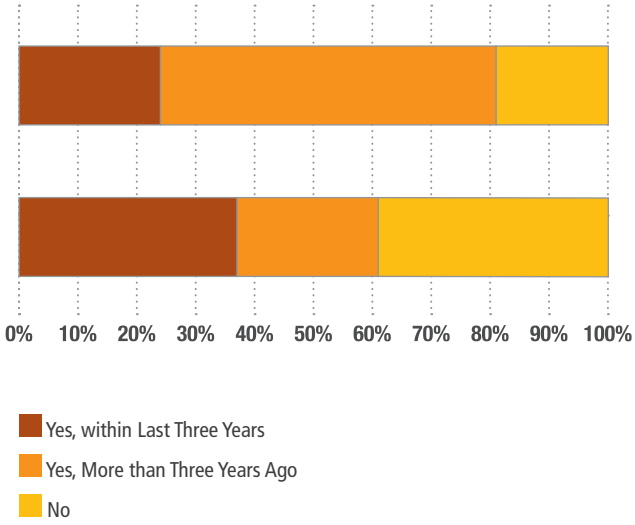


Figure 3.2: State health agency state health improvement plans; n=49.



Strategic Plans

In the 2010 survey, almost 85 percent of state health agencies had a strategic plan. Of the states that reported data for 2010 and 2007 (n=45), 84 percent of states had a strategic plan in 2010 compared to just over three-fourths of state health agencies in 2007.

In the 2010 survey, state health agencies were asked to report on the implementation status of their strategic plan. Eighty-four percent of states with a strategic plan had implemented it. **Figure 3.4** below shows the implementation status of state health agencies strategic plans in 2010.

Intention to Apply for Accreditation

Seventy-two percent of state health agencies plan to seek accreditation through a voluntary national accreditation program; of this group, 16 plan to seek accreditation within the first two years of the program (2011–12). **Figure 3.5** displays the groups with whom state health agencies have discussed voluntary national accreditation. Compared to centralized states, decentralized states more frequently report discussing voluntary accreditation with other state entities.

Performance Management Systems

A performance management system is comprised of four components: performance standards, performance measures, reporting of progress and quality improvement.[5] Over the last few years, the definitions of these four components have been refined to better reflect consensus. The following definitions are adapted from the PHAB acronyms and glossary of terms:[6]

Figure 3.3: State health improvement plan (SHIP) details. n=ranges from 24–26 out of 26 Agencies that had a state health improvement plan in 2007 and 2010.

***includes state health improvement plans linked to some local plans.**

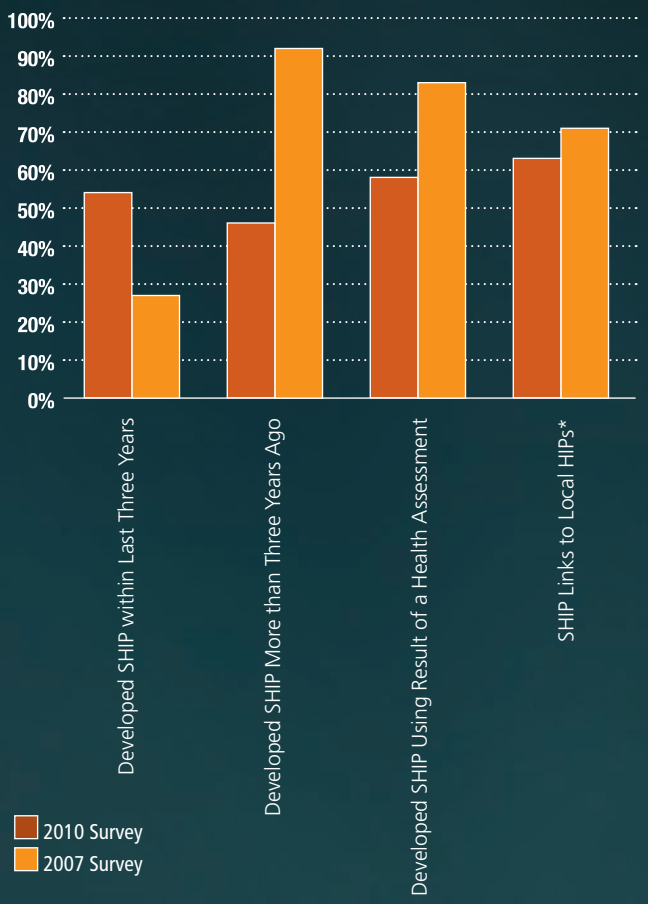


Figure 3.4: Status of strategic plan; n= 38 out of 39 state health agencies with a strategic plan.

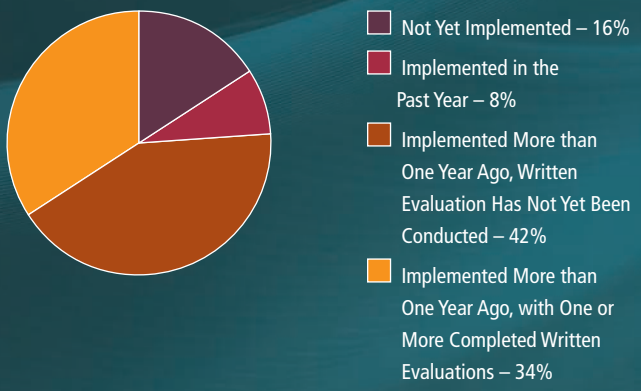


Figure 3.5: Groups with whom state health agency discussed voluntary national accreditation; n=49.

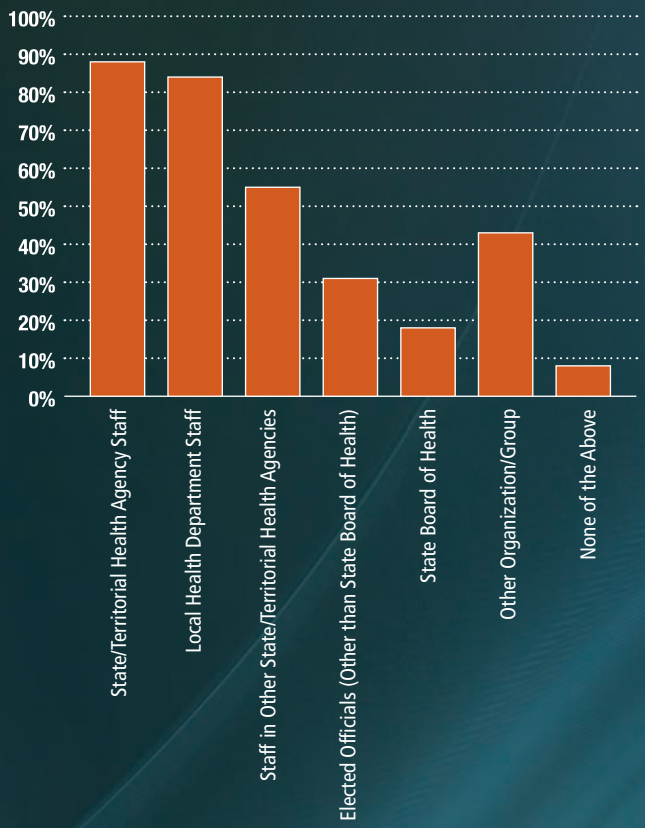
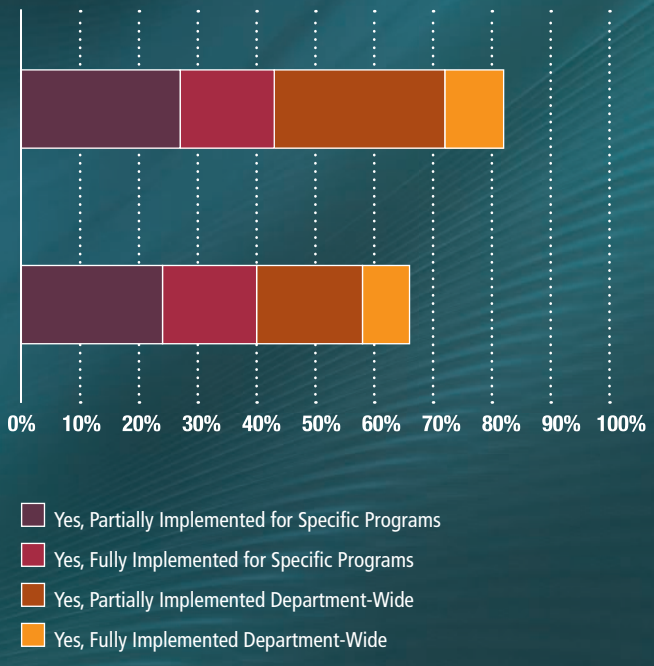


Figure 3.6: State health agency implementation of a formal performance management plan; n=49.



Performance standards are generally accepted, objective forms of measurement that serve as a rule or guideline against which an organization's level of performance can be compared. Standards may be set by benchmarking against similar organizations, or they may be based on national, state/territory, or scientific guidelines such as the Healthy People 2010 and 2020.

Performance measures are any quantitative measures or indicators of capacities, processes or outcomes relevant to the assessment of an established performance goal or objective.

Reporting of progress refers to documentation and reporting of progress in meeting standards and targets and sharing of such information through feedback.

Quality improvement is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization. The intent is to improve the level of performance of key processes and outcomes within an organization. The ASTHO survey defined quality improvement as a formal, systematic approach (such as plan-do-check-act) applied to the processes underlying public health programs and services to achieve measurable improvements.

For state health agencies reporting data in 2010 and 2007, the percent of those with a formal performance management plan decreased to fewer than 70 percent in 2010 compared to 82 percent in 2007. Fewer state health agencies implemented a performance management plan department wide or for specific programs in 2010 than those in 2007.

State Health Agency Quality Improvement Efforts

For state health agencies reporting data in 2010 and 2007, 22 percent of them did not have a quality improvement process in place in 2010 compared to 27 percent in 2007. Similar to the findings for performance management plans above, state health agencies less frequently indicated implementation of a quality improvement process department-wide in 2010 compared to 2007. However, in 2010, they more frequently implemented a quality improvement process for a specific program **(see figure 3.7).** Again, the 2010 survey did not collect data that would explain this trend. It is possible that respondents in 2010 had a more nuanced understanding of what quality improvement consists of and were therefore less likely to report quality improvement activities. It is also possible that quality improvement activity actually decreased due to budget cuts during the interval between the surveys. Of the nine state health agencies in small states that engaged in quality improvement processes, seven did partial program implementation. In contrast, state health agencies that serve medium and large populations report full implementation for specific programs and department-wide implementation in some cases. There are many different frameworks and approaches to quality improvement in public health. **Figure 3.8** shows the frameworks and approaches used by state health agencies in the last year. Importantly, state health agencies were able to indicate use of more than one framework. The most common approach was plan-do-study-act (also known as plan-do-check-act) followed by lean, balanced scorecard, Baldrige Performance Excellence Criteria and Six Sigma. Almost 30 percent report they do not use a specific framework or approach, while almost 20 percent report using a specific framework or approach other than those listed. Other items listed include specific approaches such as business process reengineering or Lean Six Sigma; state-based performance management systems such as Oklahoma's Step Up Performance Management System; priority-specific approaches such as the CDC's winnable battles; or disease/clinical-specific approaches, including NIATX, which is used in behavioral health care settings.

Figure 3.7: State health agency quality improvement processes; n=49.

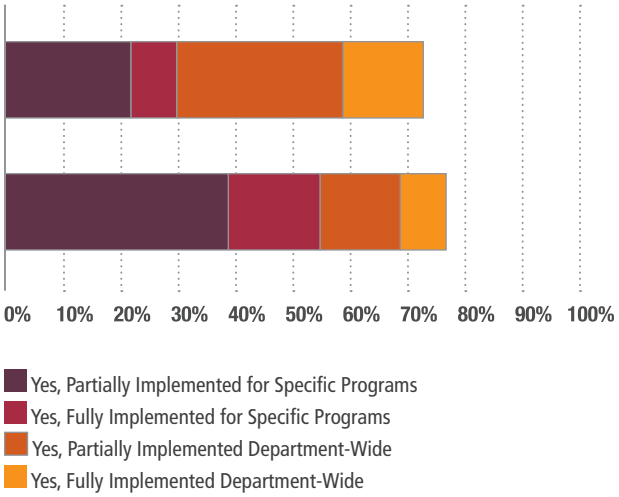
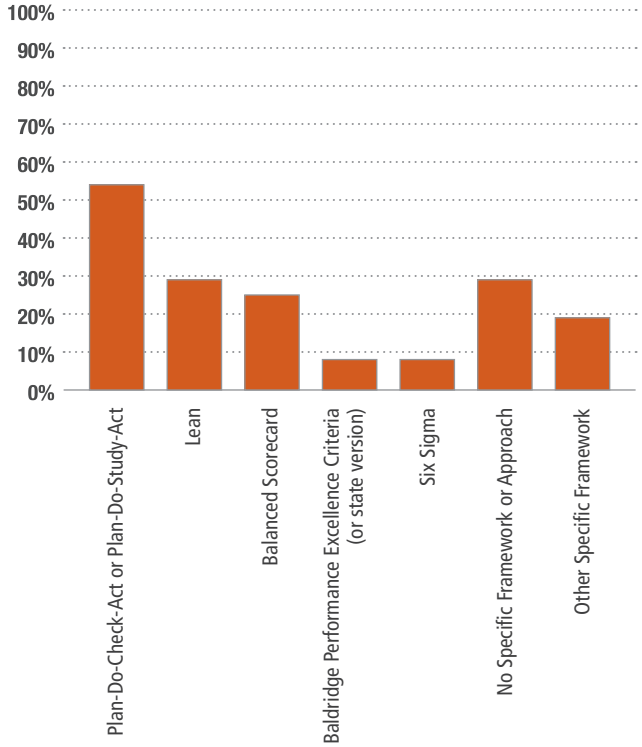


Figure 3.8: Quality improvement frameworks/approaches used by state health agencies in past year among agencies who indicated any level of quality improvement implementation; n=37.

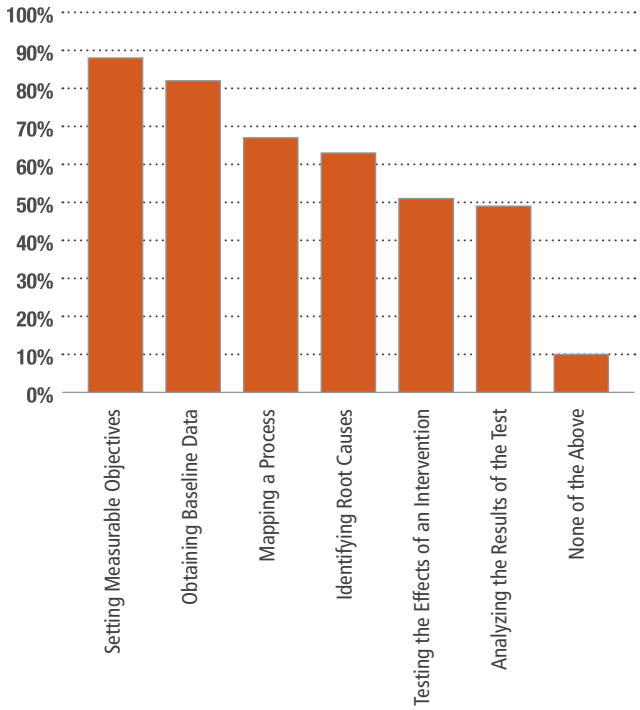
***Note: State health agencies could indicate use of one or more frameworks.**



While not all state health agencies are using a specific framework or approach to quality improvement, they are incorporating elements of quality improvement efforts into their activities. Eighty-eight percent of them set measurable objectives, and 82 percent obtain baseline data. Decentralized state health agencies and those in states that serve large populations more frequently report use of many of the common quality improvement elements. Other common elements include mapping a process, identifying root causes, testing the effects of an intervention and analyzing the results of the test. Ten percent of state health agencies have not used any of the above mentioned elements of quality improvement in their activities in the past year.

Over the past few years, state health agencies have participated in varying numbers of formal projects to improve quality of a service, process or outcome. Just over one-third of state health agencies participated in one to three projects in the last 12 months. Another 30 percent participated in three to six formal quality improvement projects. All states serving large populations implemented at least one formal quality improvement project. Fourteen percent of state health agencies did not participate in a formal quality improvement project in the last year.

Figure 3.9: Elements of quality improvement efforts used in past year; n=49.



As of 2010, over two-thirds of state health agencies completed a health assessment, with almost one-half of them completing a health assessment within the last three years.

Staff Involvement in Quality Improvement

Fifty-seven percent of state health agencies have staff with job descriptions that allot time to monitor performance and quality improvement work throughout the agency. Three-quarters of state health agencies reported that 25 percent or less of their staff have formal training in quality improvement methods. For two state health agencies 76 percent to 100 percent of their staff has formal quality improvement training. Large states more frequently dedicate quality improvement staff than smaller states (88 percent compared to 41 percent of state health agencies serving medium and small populations). Thirteen percent of state health agencies report that none of their staff have formal training in quality improvement methods.

State health agencies have different approaches for supporting or encouraging staff involvement in quality improvement efforts. The most common approaches are shown in **figure 3.10**. Twelve percent of state health agencies use other approaches, including development of a performance management system, an informal quality improvement network for staff, and strong support of quality improvement initiatives by the state health official. In general, a greater proportion of decentralized state health agencies and those that serve large populations incorporate approaches to encourage or support staff involvement in quality improvement efforts.

Health Impact Assessments

A health impact assessment is a combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.[7] Less than 25 percent of state health agencies ever participated in a health impact assessment. Of the seven states that did participate in the last year, the mean number of health impact assessments was two. The range of health impact assessments conducted in the past year was one to three. Staff of 26 percent of state health agencies attended a health impact assessment training in the past year.

State Health Agency Use of CDC's Guide to Community Preventive Services

Most state health agencies have used CDC's *Guide to Community Preventive Services* (the "Community Guide"). Over 80 percent of them use the Community Guide for program planning and grant writing. State health agencies that serve medium and large populations more frequently indicate use of the Community Guide for program planning (94 percent compared to 69 percent of agencies that serve small populations). Seventy-three percent of state health agencies use it for policy development. More state health agencies in the South use the guide for policy development than agencies in other regions. Forty-eight percent use the Community Guide for priority setting. State health agencies in the Mountain/Midwest region more frequently use it for priority setting than agencies in other regions. Ten percent of states use the Community Guide for another purpose, including identification of best practices, grant implementation, training, resource allocation and community education.

Figure 3.10: State health agency approaches to encourage/ support staff involvement in quality improvement efforts; n=49.

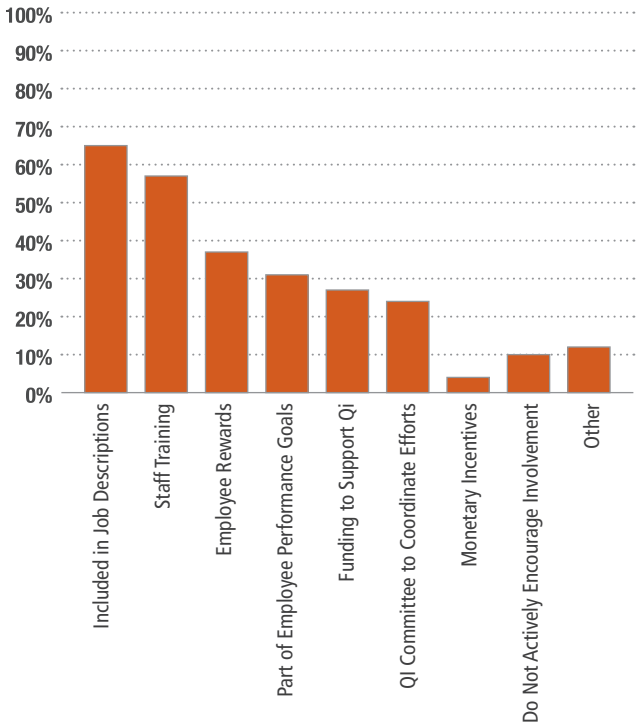
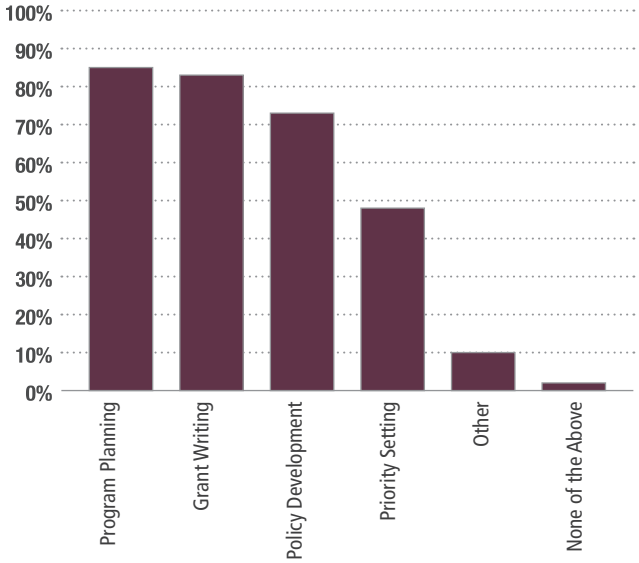


Figure 3.11: State health agency use of CDC's Guide to Community Preventive Services; n=48.



4 Chapter Four

State Health Agency Workforce

This chapter addresses state health agency workforce. Information on the number of full-time equivalents, salary and fringe benefits by occupational classification are also presented. Limited demographic information about individuals who make up the state health agency workforce is also addressed, including their age and union membership.

The overview of individuals in the workforce is followed by a description of state health agency turnover rates, vacant positions, recruitment and expected retirement rates over the next few fiscal years. State health agency use of public health competencies is also discussed.

The chapter ends with a description of state health officials, including how they are appointed, term length, tenure, salary and qualifications.

Number of Employees at State Health Agencies

In 2010, respondent state health agencies had a total of 106,815 staff members and 102,760 full-time equivalents (n=47). The total number of full-time equivalents for all states and the District of Columbia is estimated to be approximately 107,000.[8]

Key Findings:

- The state health agency workforce includes over 100,000 full-time equivalents, comparable to numbers reported by state health agencies in 2007.
- Of the over 100,000 state health agency employees, 27,778 work in local health departments and another 17,333 work in regional or district offices.
- Administrative and clerical personnel make up the largest portion of the state health agency workforce followed by public health nurses.
- The average number of vacant positions at state health agencies is 288. There are over 12,500 vacancies in state health agencies across the country, but the agencies are only recruiting for 15 percent of all vacant positions. Budget cuts and hiring freezes are likely explanations.
- Over the next four fiscal years, the percent of employees eligible for retirement is expected to grow steadily from 18 percent in FY10 to 27 percent in FY14.
- Over 60 percent of state health agencies use the Core Competencies for Public Health Professionals, and nearly one-third of them use competencies for more specialized fields, including nursing, informatics and leadership.
- In general, state health officials have significant public health experience before taking office; the average official has worked in public health for 15 years.

Of the over 100,000 state health agency employees, 27,778 work in local health departments and another 17,333 work in regional or district offices. There is wide variation in the number of those employed by state health agencies that cannot be accounted for by the size of the population served. The number of full-time equivalents per 100,000 population ranges from 5.39 to 271.17; the average is 50.86 (median is 32.26). ASTHO has been tracking the impact of the recession on the state health agency workforce with a longitudinal series of budget cuts surveys. More information is available on ASTHO's Web site at www.astho.org/Research/Data-and-Analysis/.

Figures 4.1 and **4.2** show the mean number of employees for each employment category. Staff is defined as any individual employed by a state health agency and can include full- time employees, part-time workers, contractual workers and hourly/temporary workers. Because of modifications to the 2010 survey, 2007 and 2010 data on employment categories are not directly comparable, and potential trend analysis is limited. Categories for 2010 survey data on staff types are not mutually exclusive. For instance, an individual could plausibly fall into both the part-time worker and contractor categories.

Figure 4.1: Number of full-time equivalents and staff in 2010 (n=47). States that did not respond for both staff and full-time equivalents were excluded.

	2010 Survey			
Employment Category	#	Mean	Median	Total
Staff Members	47	2,273	1,324	106,815
Full-time Equivalents	47	2,186	1,224	102,760

Figure 4.2: Number of state health agency employees in each employment category.

***Note: categories are not mutually exclusive; not all states responded to all employment categories.**

	2010 Survey		
Employment Category	#	Mean	Median
Part-time Workers	43	104	29
Contractual Workers	24	296	92
Hourly/Temporary Workers	38	226	55

Figure 4.3: Number of full-time equivalents (FTEs) employed by a subset of state health agencies, 2007 to 2010; n=46. Included were state health agencies that reported FTEs for 2007 and 2010.

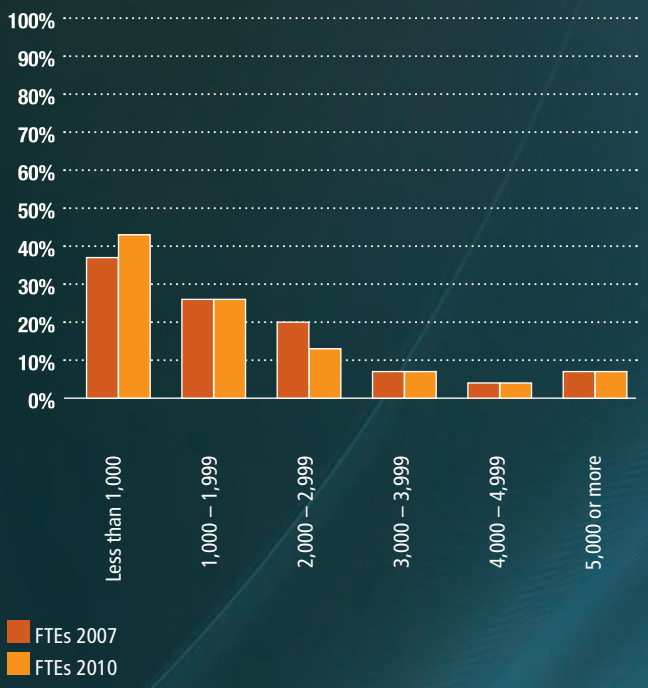


Figure 4.4: Average number of full-time equivalents and average number of full-time equivalents per 100,000 population for states that serve small, medium, and large populations.

	Average Number of Full-Time Equivalents		Average Number of Full-Time Equivalents per 100,000 Population	
State Size	#	Mean	#	Mean
Small	16	876	16	82
Medium	17	2,045	17	47
Large	16	3,537	16	27

Data on the number of state health agencies' full-time equivalents were categorized according to size of the full-time equivalent workforce. **Figure 4.3** shows the percentage of state health agencies that fall into each workforce size category for agencies that reported full-time equivalents data in 2007 and 2010 (n=46). A growing number had employed fewer than 1,000 employees (43 percent compared to 37 percent in 2007). Additionally, between 2007 and 2010, there was a reduction in the number of state health agencies that reported employing 2,000 to 2,999 employees. Twenty-four percent of reporting agencies moved between full-time equivalent size categories from 2007 to 2010. Twenty-two state health agencies had a full-time equivalent total change of greater than 10 percent (increase or reduction) from 2007 to 2010.

Figure 4.4 shows the average number of full-time equivalents and average number of full-time equivalents per 100,000 population for states that serve small, medium and large populations. As the size of the state population increases, the average number of full-time equivalents also increases. State health agencies that serve medium- and large-sized populations more frequently report having relatively more full-time equivalents than those that serve small populations. The same is true of state health agencies in centralized states compared to those in decentralized states. In contrast, the average number of full-time equivalents per 100,000 population decreases as total state population increases.

Learn about the impact of the recession on the state health agency workforce at www.astho.org/Research/Data-and-Analysis/.

State Health Agency Employee Salary Range and Employee and Fringe Benefits

Figure 4.5 shows the average number of full-time equivalents, salary range, and employee and fringe benefits as a percentage of salary for common state health agency occupational classifications. Salary range is the average of the minimum and maximum salary reported. In 2010 and 2007, administrative and clerical personnel comprised the largest portion of the state health agency workforce followed by public health nurses. On average, public health managers, dentists, and physicians are the highest paid agency employees; they also have the widest salary range. Employee and fringe benefits measured by percentage of salary are similar across all occupational classifications.

State health agencies report that the average employee is 47 years old and the median is 49 years old; the average years of service is 12. These findings are consistent with findings from the 2007 ASTHO State Public Health Workforce Survey. Employees in New England generally have longer tenure compared to those in other regions. On average, new employees are slightly younger; for fiscal years 2007–09, the average age of new employees was 40. Based on findings from the state health agencies that responded to both the 2010 survey and the 2007 ASTHO State Public Health Workforce Survey (n=25), the average age of new employees has decreased since 2004. Employees at state health agencies that serve medium-sized populations typically have younger employees than those serving small and large-sized populations. Union membership varies across state health agencies: from a low of 3 percent of the current state health agency workforce to a high of 98 percent. The mean is 68 percent. State health agencies in New England and the western regions have higher union membership compared to agencies in other regions.

Figure 4.5: Average number of full-time equivalents, salary range, and employee and fringe benefits as a percentage of salary for common state health agency occupational classifications.

Occupational Classifications	#	Average Number of Full-Time Equivalents	Average Salary Range	Average Employee and Fringe Benefits (as a percentage of salary)
Administrative or Clerical Personnel	45	415.9	$22,678 - $66,228	38.9%
Public Health Nurse	43	256.3	$43,085 - $85,025	38.0%
Environmental Health Worker	40	144.2	$35,329 - $85,743	37.4%
Social Worker	30	102.0	$35,069 - $67,605	36.1%
Laboratory Worker	43	94.3	$27,029 - $82,516	38.6%
Public Health Manager	42	90.3	$51,338 - $133,955	37.1%
Health Educator	44	57.4	$37,423 - $70,430	38.5%
Epidemiologist/Statistician	45	57.9	$40,706 - $85,910	37.9%
Public Health Informatics Specialist	32	42.4	$41,649 - $88,197	37.2%
Nutritionist	44	35.6	$38,758 - $69,046	38.4%
Public Health Physician	37	30.6	$99,446 - $173,726	35.9%
Public Health Dentist	23	10.2	$83,639 - $124,391	35.9%
Public Information Specialist	39	8.7	$52,100 -$78,181	38.0%
Primary Care Office Director	32	3.0	$57,410 - $82,974	36.7%
Preparedness Director	42	1.0	$80,021 -$110,930	36.8%

Descriptions and Examples of Occupational Classifications from the 2010 ASTHO Profile Survey

Administrative or clerical personnel. Support staff providing assistance in agency programs or operations.

Public health nurse. Registered nurse conducting public health nursing (e.g. school nurse, community health nurse, nurse practitioner).

Environmental health worker. Environmental health specialists, scientists and technicians, including registered and other sanitarians.

Laboratory worker. Laboratorians; laboratory scientists; laboratory technicians; and microbiologists planning, designing and implementing laboratory procedures.

Public health manager. Health service managers, administrators, and health directors overseeing the operations of a department/division.

Social worker. Behavioral health professional (e.g. community organizers, HIV/AIDS counselors and public health social workers).

Epidemiologist/Statistician. Conducts ongoing surveillance, field investigations, analytic studies and evaluation of disease occurrence and disease potential, and makes recommendations on appropriate interventions.

Health educator. Designs, implements; evaluates; and provides consultation on educational programs and strategies to support and modify health-related behaviors of individuals, families, organizations and communities and to promote the effective use of health programs and services.

Public health informatics specialist. Also known as public health information systems specialists or public health informaticists.

Nutritionist. Dietitian developing, implementing and evaluating population-based strategies to assure effective interventions related to nutrition and physical activity behaviors, the nutrition environment and food and nutrition policy. May directly provide nutrition services.

Public health dentist. Dentist who identifies persons or groups at risk of illness or disability and develops, implements and evaluates programs or interventions designed to prevent, treat or improve such risks. May provide direct dental services.

Public health physician. Physician who identifies persons or groups at risk of illness or disability and develops, implements and evaluates programs or interventions designed to prevent, treat or improve such risks. May provide direct medical services.

Public information specialist. Also known as public information officer.

Preparedness director. Oversees all planning and development of protocols, trainings and exercises to further the public health system's emergency response capabilities in the areas of biologic, chemical, radiological, explosive and environmental emergencies; assesses the public health needs of the population in a variety of large-scale public health emergencies; and serves as a subject-matter expert.

Primary care office director. Identifies health professional shortage areas and medically underserved areas/populations which allow primary care providers to receive federal funding, recruit National Health Corps providers and receive enhanced reimbursement from Medicare and Medicaid; addresses recruitment and retention issues of primary care providers to increase access to care; works with HRSAs bureaus to address primary care provider shortages; works with or is the state/territorial office of rural health; works with the state office of minority health.

State health agencies were also asked to provide compensation information about their leadership other than the state health official. Average salary range and employee and fringe benefits as a percentage of salary for state health agency leadership are shown in **figure 4.6**. On average, the chief medical officer is the highest paid member of agency leadership, while the chief information officer and local health department liaison are the lowest paid. Average employee and fringe benefits are similar across all state health agency leadership categories.

Figure 4.6: Average salary range and employee and fringe benefits as a percentage of salary for state health agency leadership.

Occupational Classifications	#	Average Salary Range	Average Employee and Fringe Benefits
Senior Deputy	41	$88,835 - $130,069	36.0%
Chief Medical Officer	26	$138,545 - $199,613	36.9%
Chief Financial Officer	39	$84,839 - $112,459	36.4%
Chief Information Officer	38	$67,522 - $106,513	36.6%
State/Territorial Epidemiologist	37	$97,581 - $148,413	34.8%
State/Territorial Laboratory Director	37	$78,346 - $113,175	35.8%
Local Health Department Liaison	23	$67,871 - $110,069	36.4%

The total number of full-time equivalents for all states and the District of Columbia is estimated to be approximately 107,000.

State Health Agency Vacancies and Retirement

Approximately 11 percent of state health agency workforce positions are vacant; the average number of vacant positions within agencies is 288. **Figure 4.7** shows the number of vacant positions by state. State health agencies are only actively recruiting for about 15 percent of the vacant positions. According to the ASTHO budget cuts survey research brief, Budget Cuts Affect the Health of America's People (May 2011), agencies are often unable to recruit for vacant positions due to hiring freezes. Over the next four fiscal years, the mean percentage of current full-time classified employees who will be eligible for retirement is expected to increase from 18 percent in FY10 to 27 percent in FY14 **(see figure 4.8).**

Figure 4.8: Mean percentage of current full-time classified equivalents who will be eligible for retirement from FY10 – FY14; n=33-36.

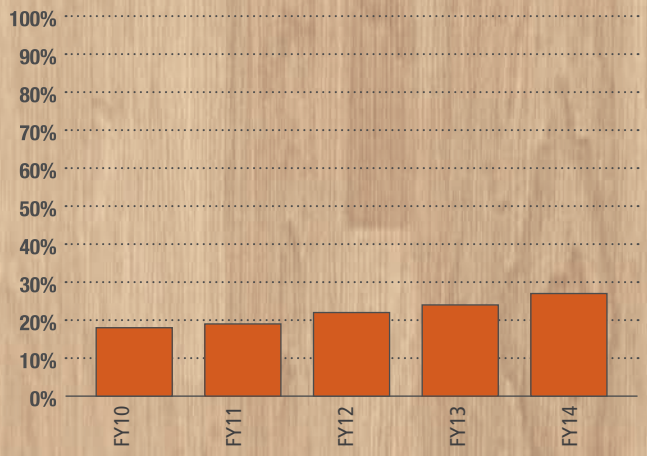
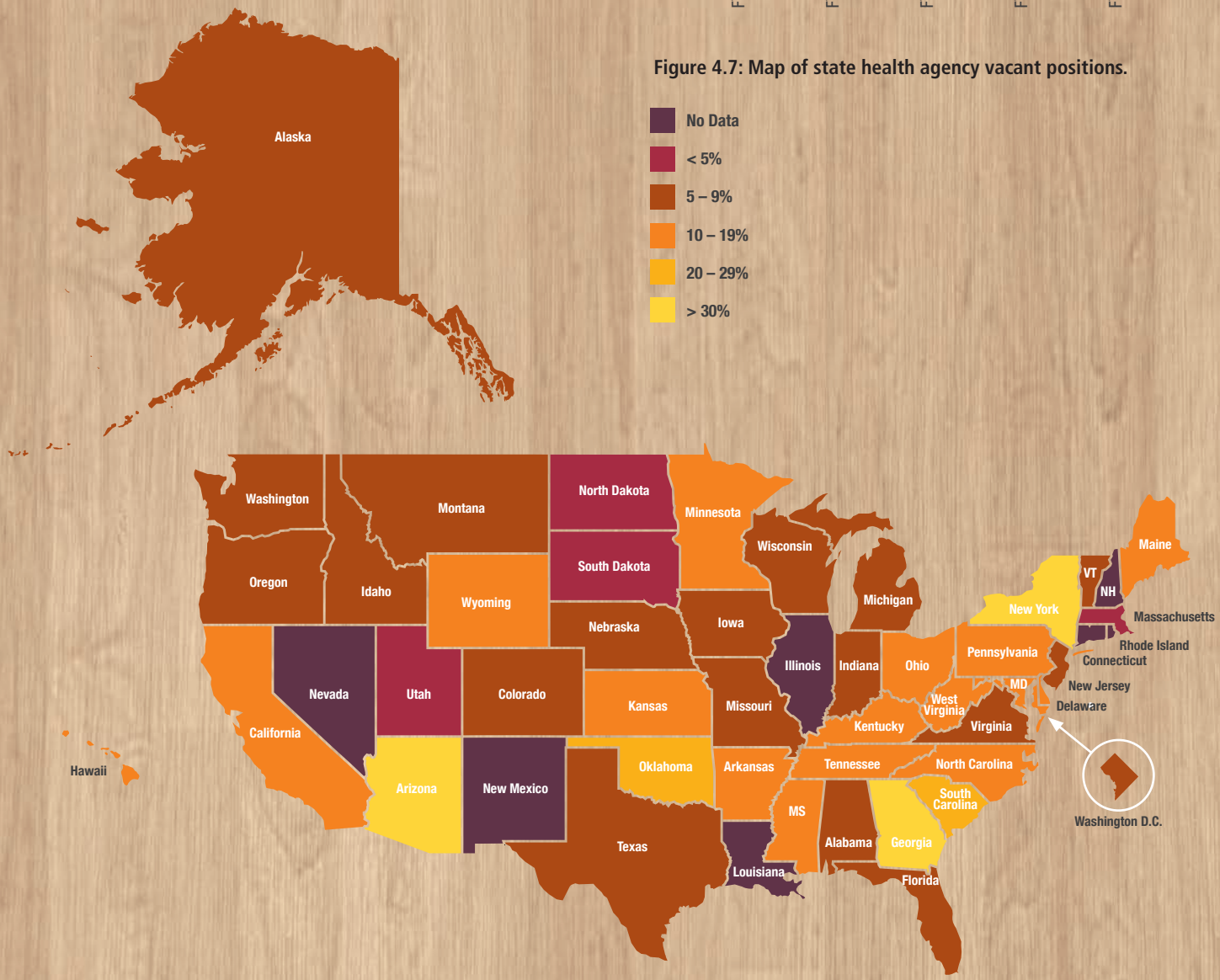


Figure 4.7: Map of state health agency vacant positions.

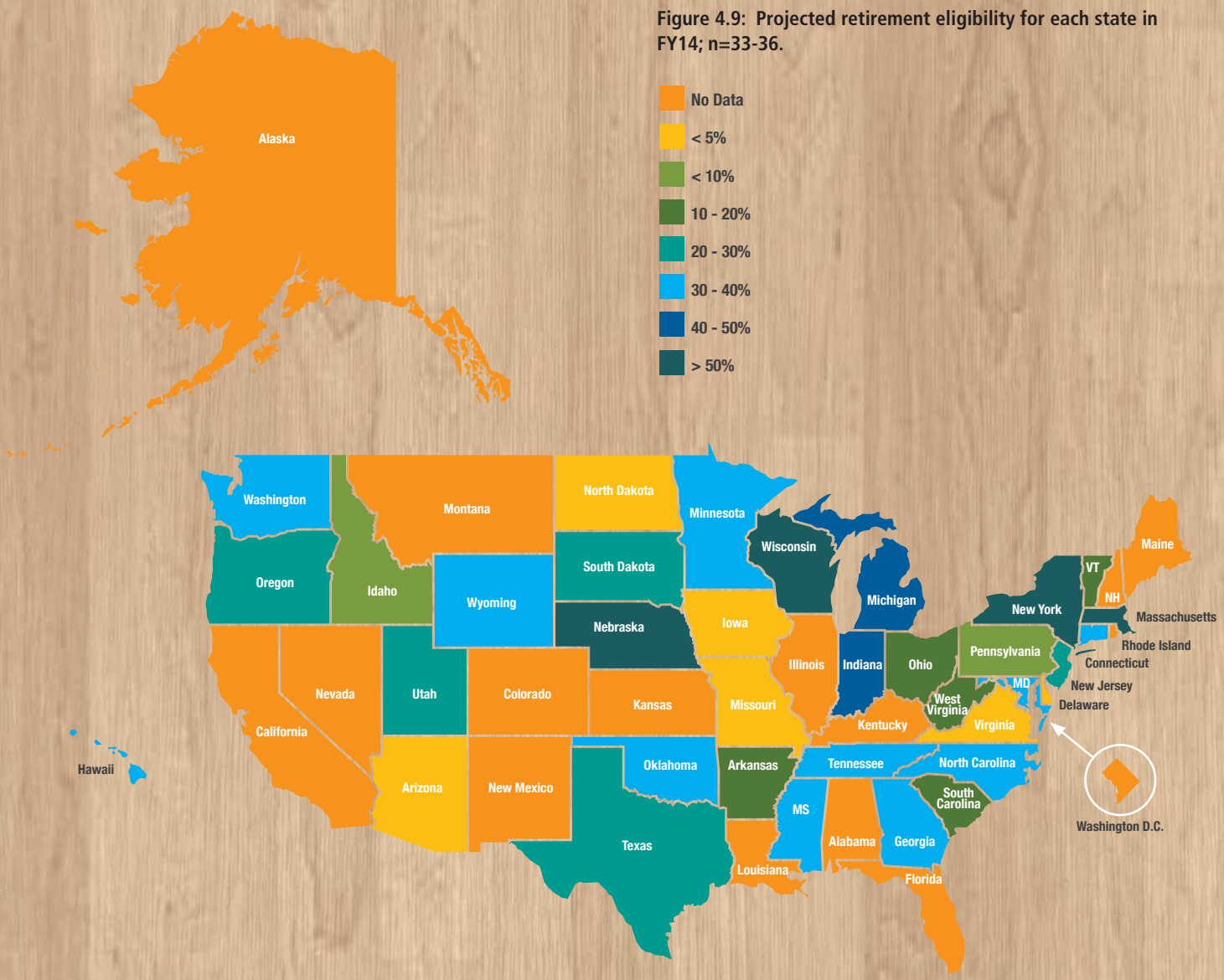


Workforce Development

In 2007, state health agencies that responded to both the 2010 survey and the 2007 ASTHO State Public Health Workforce Survey forecasted a retirement rate of 21 percent in 2010 and 27 percent in 2012. However, data from the 2010 survey suggest those projections may have been high. In 2010, states that responded to both surveys expected a retirement rate of 19 percent in 2010 and 23 percent in 2012. It should be noted that the 2007 estimates were made before the economic downturn, and it is possible that some full-time equivalents have opted not to retire. **Figure 4.9** shows the projected retirement eligibility for each state in FY14.

State health agencies are committed to workforce development. The Core Competencies for Public Health Professionals reflect the desirable skills and characteristics of public health workers to effectively deliver essential public health services. The competencies are designed to serve as a starting point or reference for organizations to guide their workforce development efforts (e.g., recruitment, training, performance management and workforce planning) and for public health professionals to manage their career development and learning. Over 60 percent of state health agencies use the core competencies, and nearly all agencies are familiar

Figure 4.9: Projected retirement eligibility for each state in FY14; n=33-36.



with them. In addition, nearly one-third of state health agencies use other public health competencies for more specialized fields, including nursing, informatics and leadership. Decentralized states more frequently indicate using the National Leadership Network competencies; there are no differences in the use of competencies by size of population served or geographic region. **Figure 4.10** shows some of the most common public health competencies. The most frequently reported uses of competencies are developing training plans and creating job descriptions.

State Health Officials

State health official tenure is wide ranging. The average tenure of officials is almost four years; however, the range is less than three months to almost 18 years. The mean number of years in public health before becoming a state health official is just under 15 years; the average total number of years in public health is slightly higher (just over 15 years). Ninety-four percent of state health officials had executive management experience before assuming this role. State health agencies that serve small populations are the only ones to report having a state health official with no prior executive management experience.

State health officials have varied levels of educational attainment **(see figure 4.11)**. A similar number of state health agencies have a state health official with an M.D. in 2010 compared to 2007. Since 2007, the percentage of state health officials with an MPH has increased from 33 percent to 38 percent; the percentage of state health officials with an MBA increased from 8 percent to 10 percent. In fact, increases were reported across all degrees with the exception of a J.D. and "other." State health officials in states with medium-sized populations are the only ones to report having a Ph.D. Other responses to educational attainment include a Doctor of Public Health; Master of Science in Public Health; nursing degrees (RN, BSN and MSN); master's degrees in social work, public policy or divinity; and doctoral degrees in public health, osteopathic medicine, dentistry and veterinary medicine.

Figure 4.10: Public health competencies; n=49.

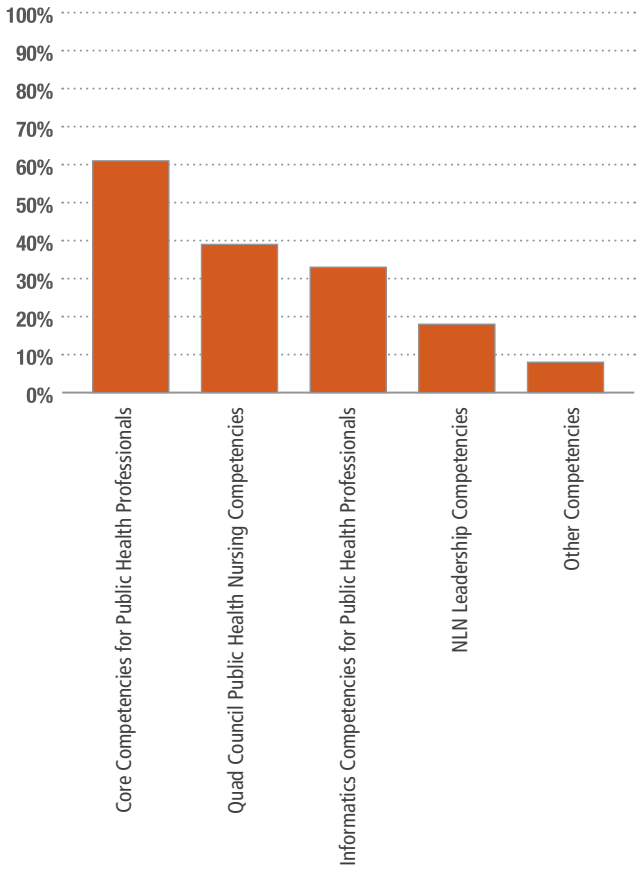


Figure 4.11: Educational attainment of the current state health official; n=50.

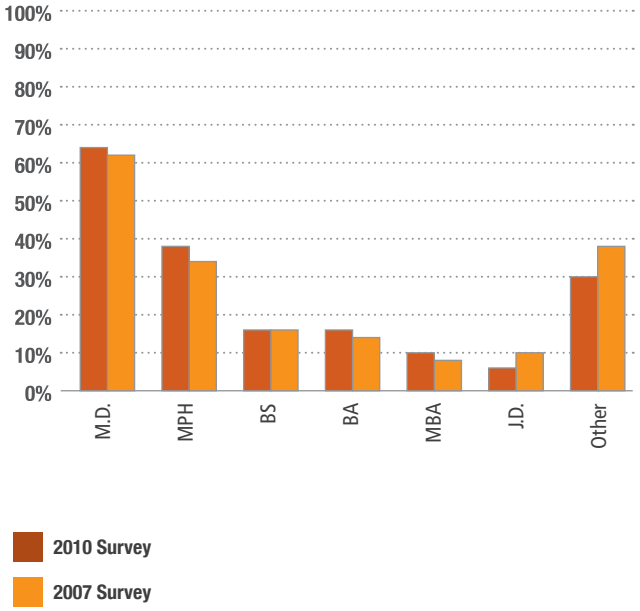


Figure 4.12: Average and median state health official salary based on tertile of number of full-time equivalents and total FY09 Revenue; n=35.

Category	Average State Health Official Salary	Median State Health Official Salary
Number of Full-time Equivalents		
Small*	$132,580	$127,020
Medium	$144,690	$141,270
Large**	$ 196,420	$200,000
Revenue		
Small*	$136,730	$127,020
Medium	$127,020	$146,000
Large**	$177,600	$169,660

*Small refers to the third of the 51 states and DC with the lowest number of full-time equivalents or smallest revenue.

**Large refers to the third of the 51 states and D.C. with the highest number of full-time equivalents or largest revenue.

Figure 4.13: Average and median state health official salary by U.S. region; n=35.

Region	Average State Health Official Salary	Median State Health Official Salary
South	$193,240	$200,000
West	$157,130	$141,550
Mid-Atlantic and Great Lakes	$142,300	$145,000
Mountain/Midwest	$141,190	$133,000
New England	$139,320	$139,610

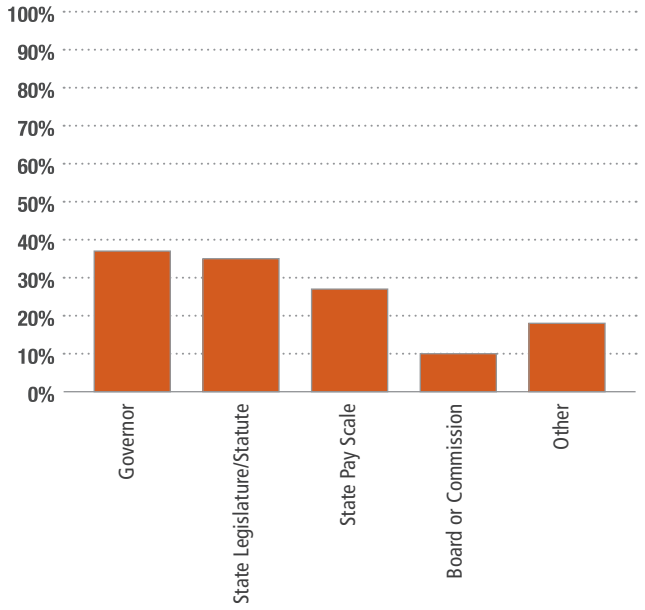
For over one-half of state health agencies, the state health official is required by statute to have an M.D. or D.O. State health agencies in the New England region are more likely to report that the state health official is required to have an MPH. Twenty percent of state health agencies have a requirement of experience in public health. Almost one-third of states report no official statutory requirement for the state health official.

On average, state health officials are paid more if they serve in a centralized state ($166,920 compared to $147,020 in decentralized states) or a Southern state. Average state health official salary is shown in **figures 4.12** and **4.13.**

The mean state health official salary is $158,694 (median is $151,942), and the range is $63,000 to $287,800. On average, state health officials are paid almost $200 per full-time equivalent (range is $7.81 to $653.85; n=45).

State health agencies reported several different methods for setting the state health official salary, including the governor, state legislature/statute, state pay scale and board or commission **(see figure 4.14).** Other methods include discretion of the secretary/department director, state budget, review of qualifications and experience, public hearing process and state division of personnel.

Figure 4.14: State method for determining state health official salary; n=49.




5
Chapter Five

State Health Agency Finance

In 2010, state health agencies were asked to report on revenue, expenditures and dollars distributed to local and regional health agencies and nonprofit organizations. This chapter examines state health agency funding sources; expenditures; and dollars distributed to health agencies and community-based organizations for fiscal years 2008 and 2009 and examines differences between those two years. It also provides an overview of the state health agency budget approval process.

State Agency Revenue

Total state health agency revenue reported for FY08 was $30.3 billion and $31.5 billion for FY09 (n=48). Accounting for the three states without revenue data, the total revenue for the 50 states and the District of Columbia is estimated to be approximately $33 billion for FY08 and approximately $34 billion for FY09.[9]

Figure 5.2 shows total state health agency revenue by funding source for fiscal years 2008 and 2009. For FY08, federal funding was nearly $13 billion; in FY09, it rose to just over $14 billion, which is more than double the total revenue from state general funds in FY09. Between FY08 and FY09, there were increases in total revenue for all sources with the exception of state general funds.

Key Findings:

- Average revenue per capita in FY08 was $116; the average increased by $10 to $126 in FY09.
- Between FY08 and FY09, there were increases in total revenue for all sources except state general funds.
- Federal funds were the largest source of state health agency revenue for FY08 and FY09.
- Between FY08 and FY09, average and total state health agency expenditures increased across almost all categories; the two largest spending categories were improving consumer health—which includes clinical services and maternal and child health programs—and WIC.
- Around 60 percent of federal funding for state health agencies directly supports the work of local health departments and community-based organizations; state health agencies funded local health departments in the amount of $5.3 billion and another $2.5 billion was sent to communities via grants for nonprofit health organizations.

Figure 5.1: Revenue Category Descriptions

State General Funds. Includes revenues received from state general revenue funds to fund state operations. Excludes federal pass-through funds.

Federal Funds. Includes all federal grants, contracts and cooperative agreements, including WIC voucher dollars and EPA funding (only if administered by state health agency). Excludes state Medicare and Medicaid programs for all eligible applicants and providers, SCHIP, mental health and substance abuse.

Medicare and Medicaid. Medicare and Medicaid transfers or reimbursements for public health purposes or direct clinical services actually provided by the health department (e.g. nursing home inspections, lead testing, immunizations outreach to Medicaid recipients, home health Medicare, and Elderly/Disabled Medicaid Waivers). Excludes Medicare and Medicaid (third-party payment) programs for the state's eligible population.

Fees and Fines. Includes fines, regulatory fees and laboratory fees.

Other Sources. Includes tobacco settlement funds, payment for direct clinical services (except Medicare and Medicaid), foundation and other private donations.

Other State Funds. Includes revenues received from the state that are not from the state general fund.

Figure 5.2: Total state health agency revenue FY08 and FY09 by source of funding in millions; n=48.

*Note: not all states reported revenue for each funding category.

Figure 5.3: Percentage of state health agency revenue by funding source FY09; n=48.

*Note: not all states reported revenue for each funding category.

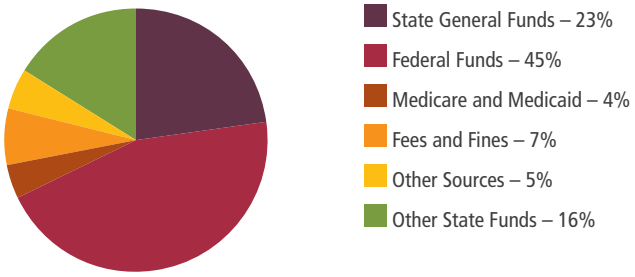


Figure 5.4: Average state health agency revenue FY08 and FY09 by source of funding in millions; n=48.

*Note: not all states reported revenue for each funding category.

	FY08 (in millions)				FY09 (in millions)			
	Mean	Median	Min.	Max.	Mean	Median	Min.	Max.
Federal Funds	$282	$193	$28.47	$1,556	$295	$197	$24.41	$1,974
State General Funds	$164	$66	$0.98	$1,702	$148	$62	$1.29	$1,187
Fees and Fines	$45	$18	$0.47	$363	$49	$19	$0.51	$350
Other Sources	$35	$18	$0.19	$207	$38	$20	$1.45	$227
Medicare and Medicaid	$31	$17	$0.57	$144	$35	$19	$1.75	$198
Other State/Territory Funds	$171	$11	$0.79	$3,523	$167	$7	$0.07	$3,399

In FY09, the largest source of state health agency revenue was federal funds followed by state general funds **(see figure 5.3)**. Medicare and Medicaid revenue was the smallest revenue source state health agencies reported for FY09. As noted in **figure 5.1**, reimbursements to third-party providers for clinical services to the Medicaid-eligible population were excluded from the state health agency revenue and expenditures.

Average revenue per capita in FY08 was $116; it increased by $10 to $126 dollars in FY09.[10] **Figure 5.4** shows the average, median, minimum and maximum revenue for fiscal years 2008 and 2009 by source of funding. Other sources of funding specified by agencies include tobacco settlement funds; WIC rebates; donations; and private and foundation funds.

For both fiscal years, the largest state health agency expenditure category was improving consumer health (clinical services) followed by WIC and infectious disease.

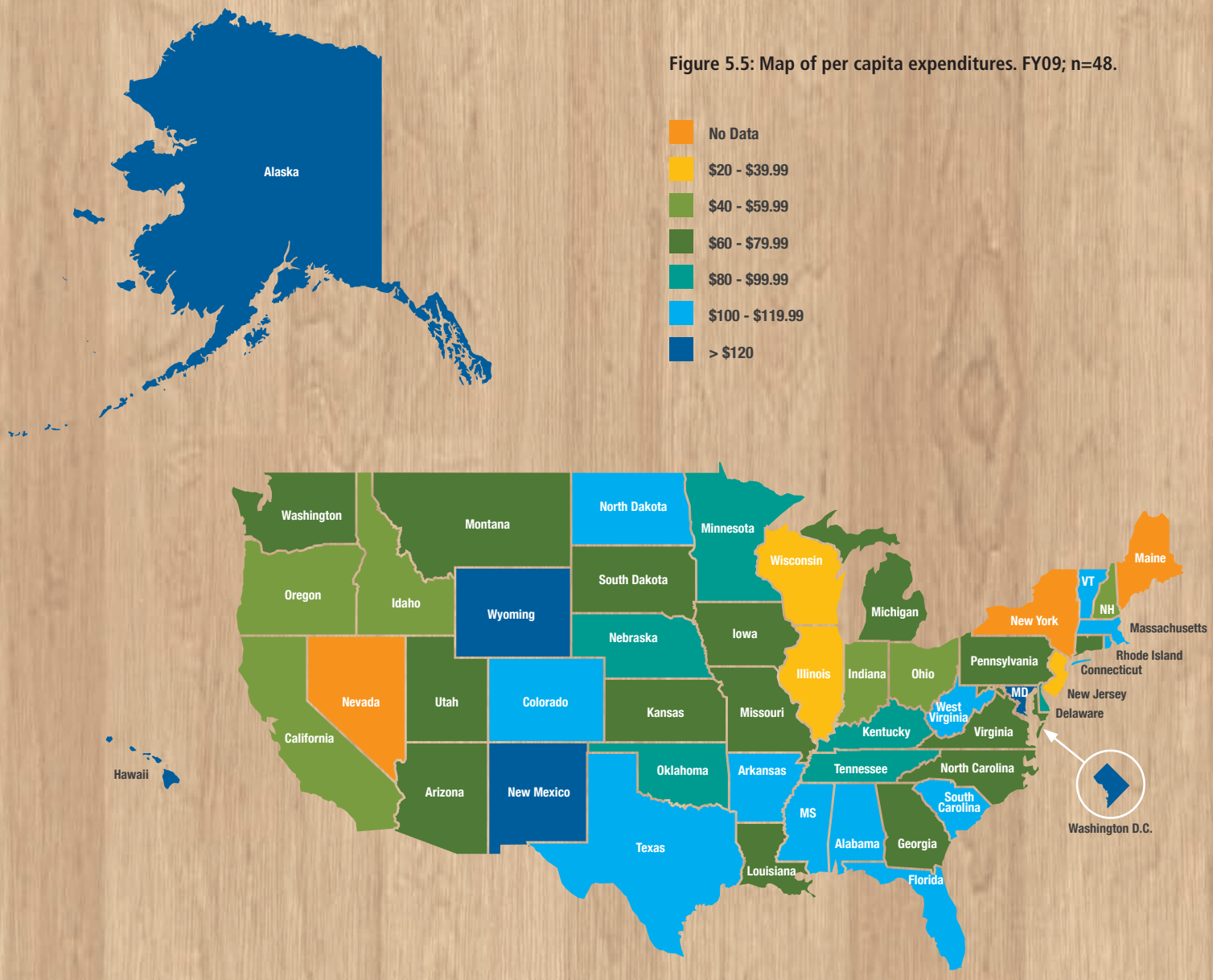


Figure 5.5: Map of per capita expenditures. FY09; n=48.

State Health Agency Expenditures

In FY08, total state health agency expenditures were $21.8 billion and rose to $22.5 billion in FY09. Estimated total expenditures were approximately $24 billion for FY08 and $25 billion for FY09[11].

For all respondents, average per capita expenditures were $94 for FY08 and $98 for FY09[12]. FY09 per capita expenditures were categorized based on spending range and are shown in **figure 5.5** for all states and Washington, D.C.

Figure 5.6 shows the mean and median per capita expenditures for state health agencies based on structure and governance classification. The average and median expenditures per capita for all states and D.C. are shown for comparison purposes. For FY08 and FY09, since they fund both central office and all district or local offices, centralized states spent more money per capita than decentralized states; the same is true of free-standing/independent agencies compared to umbrella agencies.

Figure 5.6: Per capita expenditures by governance and structure; n= 48.

	FY08		FY09	
	Mean	Median	Mean	Median
States and D.C.	$94	$79	$98	$79
Centralized States	$184	$115	$186	$116
Decentralized States	$66	$66	$69	$68
Free-standing/Independent Agency	$102	$81	$108	$84
Under a Larger Agency (Umbrella or Super Agency)	$84	$78	$86	$77

About 60 percent of federal funding for state health agencies directly supports the work of local health departments and community-based organizations.

Figure 5.7 Expenditure Category Descriptions

Chronic Disease. Includes chronic disease prevention such as heart disease, cancer, and tobacco prevention control programs, and substance abuse prevention. Includes programs such as disease investigation, screening, outreach and health education. Also includes safe and drug free schools, health education related to chronic disease and nutrition education (excluding WIC).

Infectious Disease. Includes TB prevention, family planning education and abstinence programs, and AIDS and STD prevention and control. Also includes immunization programs (including the cost of vaccine and administration), infectious disease control, veterinary diseases affecting human health and health education related to infectious disease.

Injury Prevention. Includes childhood safety and health programs, safety programs, consumer product safety, firearm safety, fire injury prevention, defensive driving, highway safety, mine and cave safety, on-site safety and health consultation, workplace violence prevention, child abuse prevention, occupational health, safe schools, boating and recreational safety.

WIC. Includes all expenditures related to the WIC program, including nutrition education and voucher dollars.

Environmental Protection. Includes lead poisoning programs, nonpoint source pollution control, air quality, solid and hazardous waste management, hazardous materials training, radon, water quality and pollution control (including safe drinking water, safe fishing, swimming) water and waste disposal systems, mining regulation effects, reclamation, mine and cave safety, pesticide regulation and disposal, nuclear power safety. Also includes food service inspections and lodging inspections.

Improving Consumer Health. Includes all clinical programs such as funds for Indian Health Care, Access to Care, pharmaceutical assistance programs, Alzheimer's disease, adult day care, medically handicapped children, AIDS treatment, pregnancy outreach and counseling, chronic renal disease, breast and cervical cancer treatment, TB treatment, emergency health services, genetic services, state/territory assistance to local health clinics (prenatal, child health, primary care, family planning direct services), refugee preventive health programs, student preventive health services and early childhood programs.

All Hazards Preparedness and Response. Includes disaster preparedness programs, bioterrorism, disaster preparation and disaster response including costs associated with response such as shelters, emergency hospitals and clinics.

Quality of Health Services. Includes quality regulatory programs such as health facility licensure and certification; equipment quality such as x-ray, mammogram etc.; regulation of emergency medical system such as trauma designation; health-related boards or commissions administered by the health agency; physician and provider loan program; licensing boards and oversight when administered by the health agency; provider and facility quality reporting; and institution compliance audits. Also includes the development of health access planning and financing activities.

Health Data. Includes surveillance activities, data reports and collections costs, report production, analysis of health data (including vital statistics analysis), monitoring of disease and registries, monitoring of child health accidents and injuries, and death reporting.

Health Laboratory. Includes costs related to administration of the state/territorial health laboratory including chemistry lab, microbiology lab, laboratory administration, building-related costs and supplies.

Vital Statistics. Includes all costs related to vital statistics administration, including records maintenance, reproduction, generation of statistical reports and customer service at the state/territory level.

Administration. Includes all costs related to department management, executive office (state/territorial health official), human resources, information technology and finance; also includes indirect costs such as building-related costs (rent, supplies, maintenance and utilities), budget, communications, legal affairs, contracting, accounting, purchasing, procurement, general security, parking, repairs and facility management. Also includes expenses related to health reform and policy (only if they are not already embedded in program areas), such as the development of health access planning and financing, participation in state/territorial health plan reform and federal reform efforts such as health reform advisory committees, and payment and benefit reform.

Other. Includes forensic examination and infrastructure funds to local public health agencies.

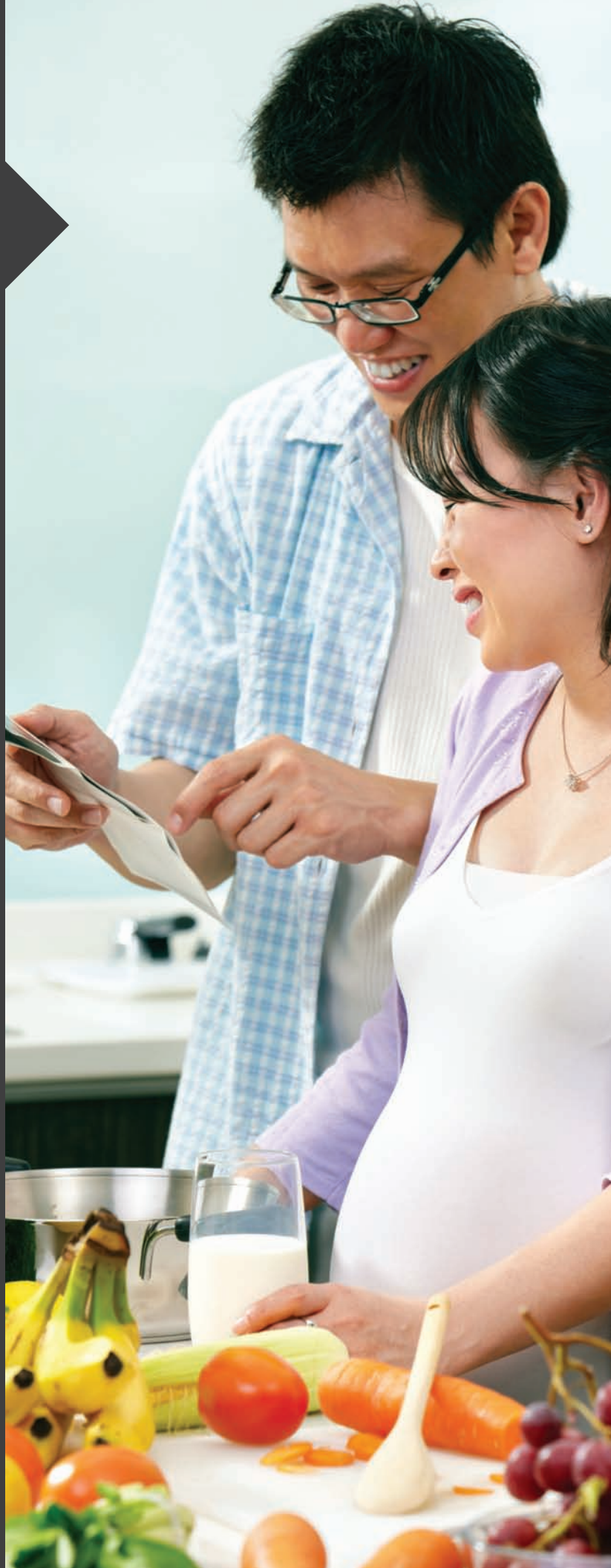


Figure 5.8: Total state health agency expenditures for FY08 and FY09 by category in millions; n=48 but not all states reported revenue for each funding category.

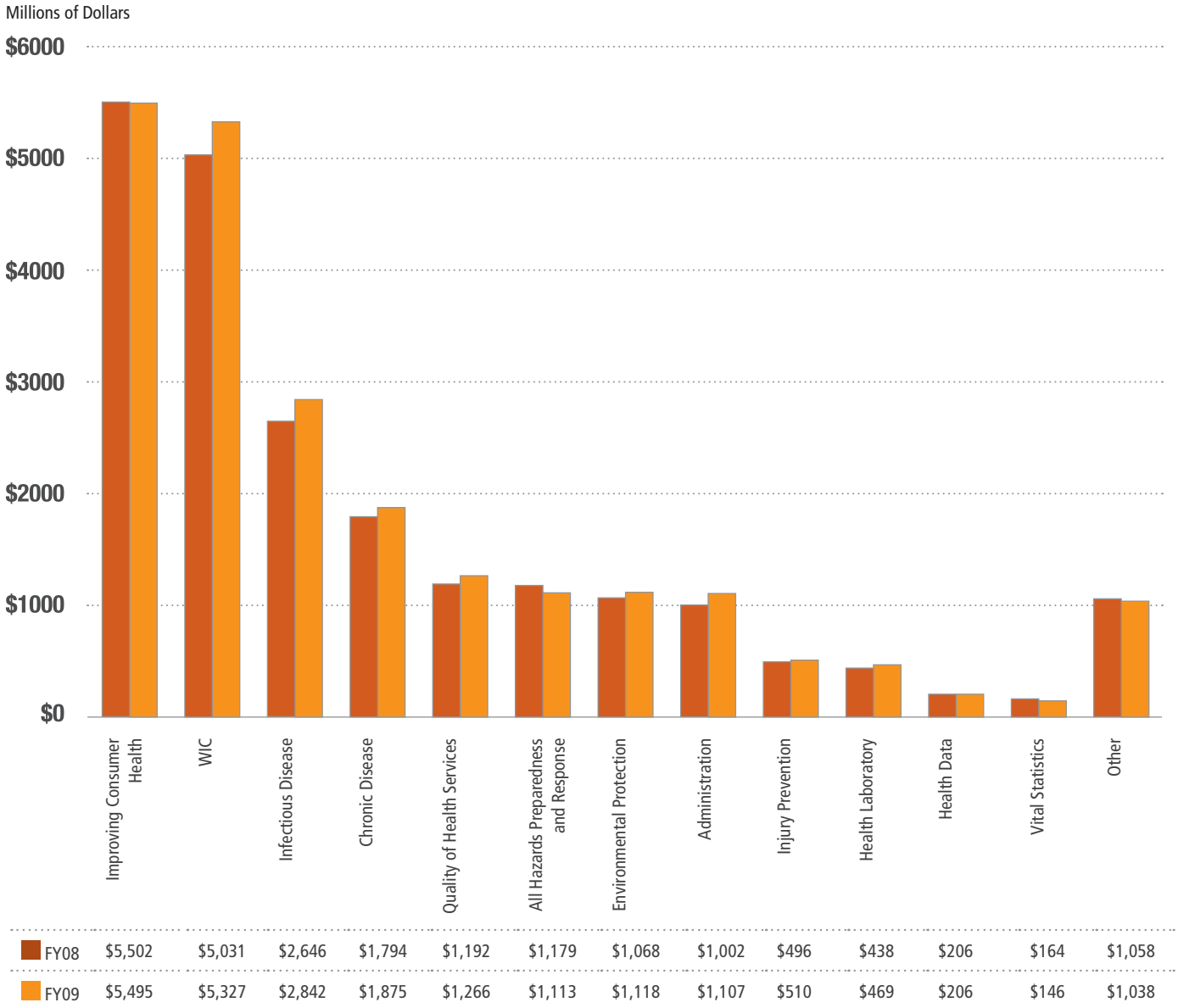


Figure 5.8 shows total state health agency expenditures for FY08 and FY09 by expense category. For both fiscal years, the largest state health agency expenditure category was improving consumer health (clinical services) followed by WIC and infectious disease. Chronic disease expenditures ranked fourth for both fiscal years, with agencies spending about $1.8 billion each fiscal year. With the exception of a few categories (improving consumer health, all-hazards preparedness and response, health data and vital statistics), state health agency expenditures increased across all spending categories. In the "other" category, agencies identified funding for local health infrastructure and medical examiner services as the most common expenditures.

In FY09, the top state health agency expenditure categories by percent of total expenditures were improving consumer health (24 percent), and WIC (24 percent). As noted in **figure 5.8**, the "improving consumer health" category included all clinical services provided by state health agencies. As a percentage of total expenditures, state health agencies spent the lowest amount of funds on health laboratories, health data and vital statistics **(see figure 5.9).**

Figure 5.9: Percentage of state health agency expenditures by category FY09; n=48.

*Note: not all states reported expenditures for each category.

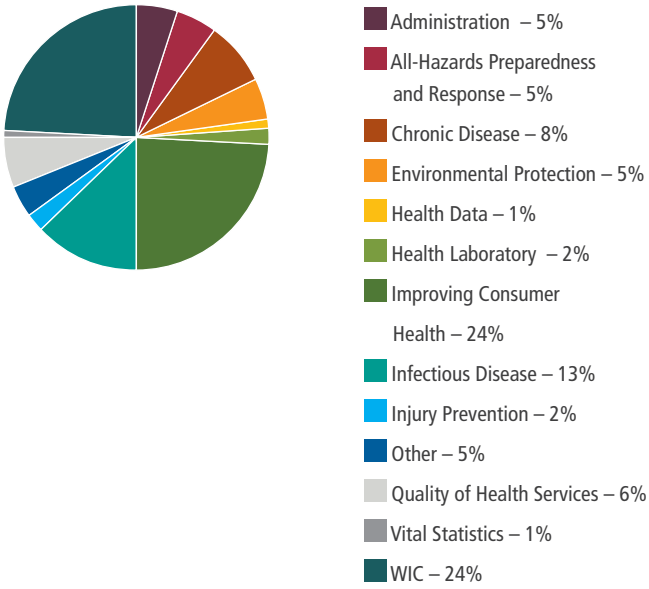


Figure 5.10 shows the average, minimum and maximum expenditures by category for fiscal years 2008 and 2009. For most categories, average expenditures increased or remained approximately the same between FY08 and FY09.

Figure 5.10: Average state health agency expenditures for FY08 and FY09 by expenditure category in millions; n=48.

*Note: not all states reported expenditures for each category.

	FY08 (in millions)				FY09 (in millions)			
	Mean	Median	Min.	Max.	Mean	Median	Min.	Max.
Improving Consumer Health (includes clinical services)	$117	$64	$0.65	$992	$114	$64	$0.03	$1,073
WIC	$112	$83	$3.54	$802	$118	$87	$3.64	$816
Infectious Disease	$56	$22	$1.25	$832	$59	$21	$1.14	$797
Chronic Disease	$39	$17	$2.42	$300	$40	$18	$2.91	$230
Quality of Health Services	$30	$16	$0.45	$158	$31	$16	$0.41	$172
All-Hazards Preparedness and Response	$26	$18	$2.79	$130	$24	$17	$2.59	$115
Environmental Protection	$23	$7.3	$0.17	$211	$24	$7.3	$0.15	$234
Administration	$21	$16	$0.44	$77	$23	$19	$0.57	$76
Injury Prevention	$12	$1.9	$0.11	$267	$12	$1.7	$0.01	$270
Health Laboratory	$10	$8	$0.45	$44	$11	$8	$0.05	$49
Health Data	$5	$3	$0.07	$28	$5	$3	$0.04	$25
Vital Statistics	$4	$3	$0.23	$21	$3	$3	$0.06	$12
Other	$48	$22	$1.13	$196	$47	$18	$1.12	$202

Figure 5.11 Contract Recipient Type Descriptions

State-run local health agencies. Includes expenditures passed through the state health agency onto local public health agencies that are led by state government staff.

Independent local health agencies. Includes expenditures passed through the state health agency onto local public health agencies that are led by local government staff.

State-run regional or district health offices. Includes expenditures passed through the state health agency onto regional or district public health offices that are led by state employees.

Independent regional or district health offices. Includes expenditures passed through the state health agency onto regional or district public health offices that are led by nonstate employees.

Nonprofit health organizations. Includes expenditures passed through the state health agency onto nonprofit health organizations.

State Health Agency Contracts to Local Health Agencies and Community-based Organizations

In order to track and monitor funding from state health agencies to local health agencies and community-based organizations, state health agencies were asked to report dollars distributed for fiscal years 2008 and 2009 (**see figure 5.12**). About 60 percent of federal funding for state health agencies directly supports the work of local health departments and community-based organizations.

For FY08 ad FY09, more money was distributed to independent local health agencies than any other recipient type. In total, state health agencies funded local health departments for $5.3 billion and sent $2.5 billion in grants to communities for nonprofit health organizations.

The remainder of funding for state health agencies was used, among other things, to provide statewide services, including those that are of direct benefit to the local public health service delivery system, local communities, and all residents of the state, such as:

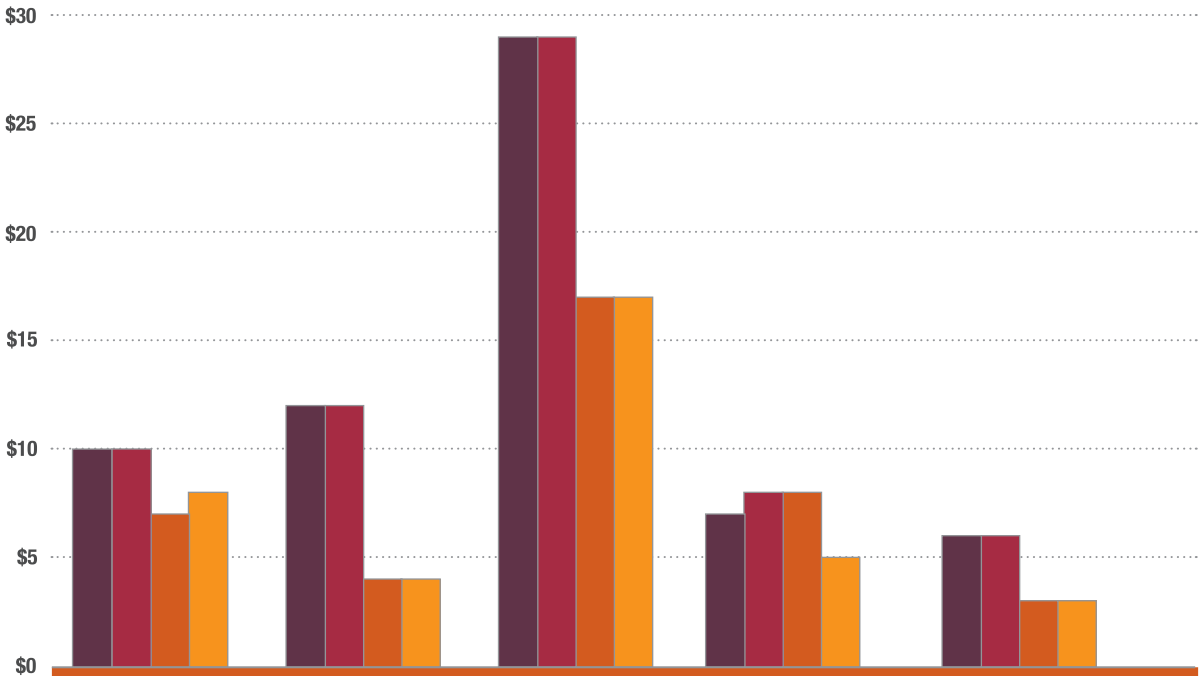
- Guidance, coordination and support for community-based prevention services.
- Outbreak management support.
- Preparedness support, coordination and asset management.
- Vital statistics support.
- Shared disease tracking, reporting and epidemiology services.
- Health information technology systems.
- Subject matter experts.
- Training support to local health departments.

Budget Approval Process

Nearly all state health agencies involve the legislature and governor in their budget approval process (**see figure 5.13**). For most states, the state budget office is also involved in approving the annual budget. Less often, the secretary of the health and human services agency or the board of health is involved. Almost 10 percent of state health agencies reported involvement of another entity in the budget approval process. Other entities identified include the state health official, the office of budget and management, mayor (Washington, D.C.), and the chief executive officer.

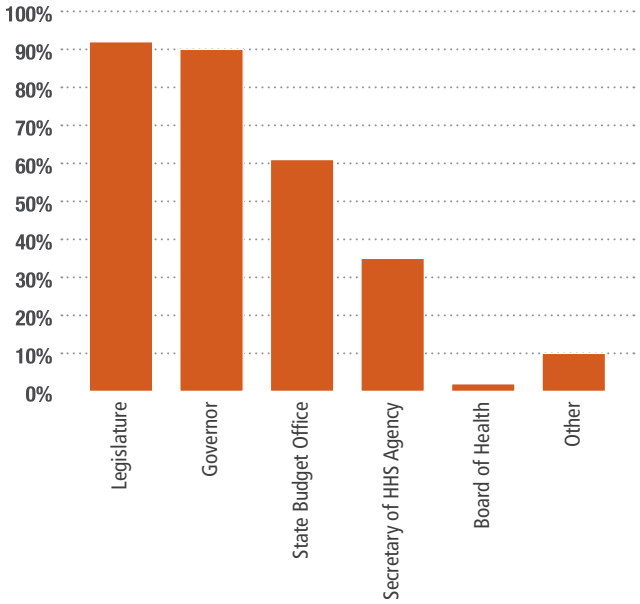
Figure 5.12: Mean and median state health agency contracts for FY08 and FY09 by recipient type, dollars per capita.

*Note: not all states reported expenditures for each category.



	Independent local health agencies (n=34)	Nonprofit health organizations (n=27)	State-run local health agencies (n=10)	State-run regional or district health offices (n=7)	Independent regional or district health offices (n=7)
Average FY08	$10	$12	$29	$7	$6
Average FY09	$10	$12	$29	$8	$6
Median FY08	$7	$4	$17	$5	$3
Median FY09	$8	$4	$17	$5	$3

Figure 5.13: Entities involved in the budget approval process; n=49.



6 Chapter Six

Public Health Information Systems and Health Information Technology

Health information technology supports the electronic use and exchange of health information between health care providers across the health care system; it includes the use of electronic health records[13]. Health information exchange is the electronic movement of health-related information among organizations according to nationally recognized standards[14]. As more health care providers adopt health information technologies, public health agencies will have greater opportunity to exchange data directly.

This chapter includes detailed information on state health agency use of public health information systems and how they interact electronically with the health care system and other public health entities. Topics include state health agency leadership and their responsibility for health information technology and health information exchange issues; entities with which state health agencies exchange data and how that data is exchanged; and how agencies use health information exchange for specific programs.

Key Findings

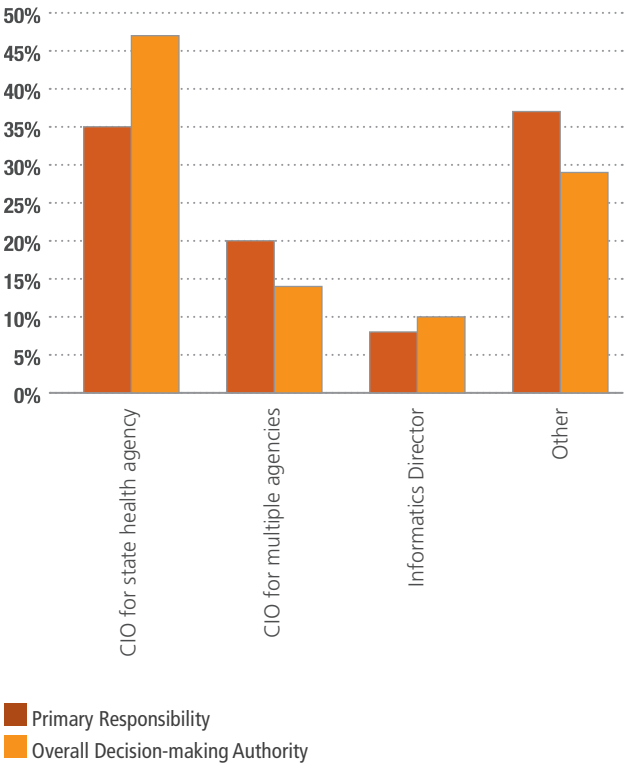
- Over 80 percent of state health agencies exchange electronic data with providers. Fifty-six percent of them exchange data directly with providers, and another 20 percent use direct data exchange through an intermediary health information exchange entity. Two percent of agencies exchange data with providers through an intermediary only.
- State health agencies more frequently indicate they receive electronic health data from other entities in the public health enterprise than send data.
- When specific programs are considered, a greater proportion of agencies report sending electronic health data to federal agencies than receiving data; although, such data exchange with local health departments is often bidirectional.
- While state health agencies may use other methods for electronic health data exchange, almost all of them rely on direct data entry for electronic health data exchange with some of their systems.
- Over 80 percent of state health agencies report having an electronic syndromic surveillance system and 90 percent of them have an electronic communicable disease reporting system.
- State health agencies use GIS for a range of services; most GIS data is geocoded and displayed at the ZIP code level.
- Almost all state health agencies use geocoded data to produce static maps, and a large majority report using geocoded data for interactive Web-based maps.

Also discussed are electronic syndromic surveillance and electronic communicable disease reporting systems and mandatory cancer registries. The chapter ends with an overview of state health agency use of geographic information system data.

Responsibility for Health Information Exchange and Health Information Technology

Figure 6.1 shows the individual who has primary responsibility for decisions regarding health information exchange or health information technology issues and the individual who has overall decision-making authority regarding public health information management systems. Almost all "other" responses for decision-making authority were from decentralized states. In many cases, the individual who has primary responsibility for decisions is not the same person who has overall decision-making authority.

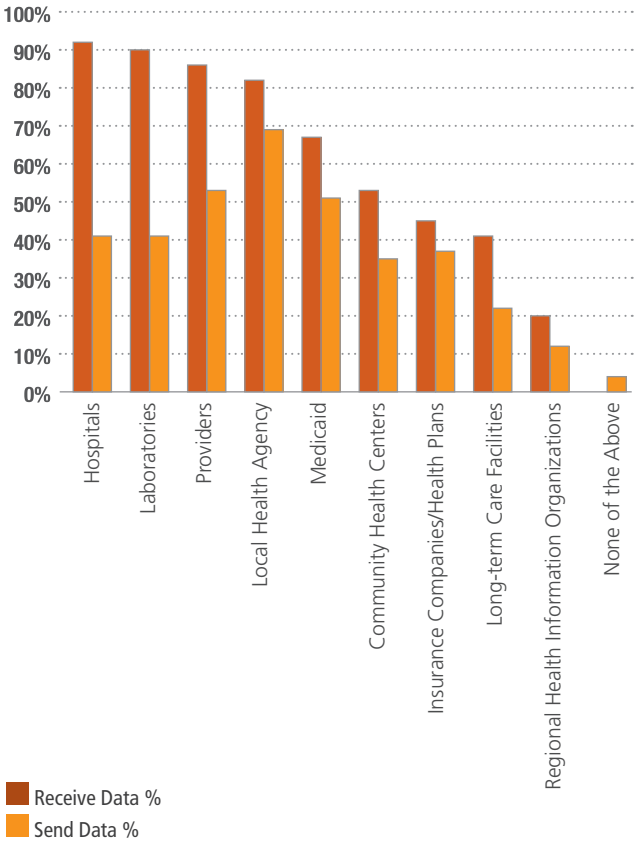
Figure 6.1: Responsibility for health information exchange or health information technology issues; n=49.



Data Exchange with Other Entities in the Public Health System

State health agencies often exchange data with health care entities such as hospitals, hospital systems, health care providers and provider groups. Fifty-six percent of agencies exchange data directly with providers, and another 20 percent use direct data exchange through an intermediary health information exchange entity. Two percent of state health agencies exchange data with providers through an intermediary only. State health agencies that serve large populations engage in direct data exchange more often than those that serve smaller populations. State health agencies in the Mountain/Midwest region are less likely to engage in direct data exchange. Less than 20 percent of agencies do not exchange data electronically with providers. **Figure 6.2** shows the entities with which state health agencies send or receive electronic health information, including electronic health records or other health IT systems. State health agencies are more likely to receive data than send data.

Figure 6.2: Entities with which state health agencies exchange electronic health information; n=49.



Receiving Data. Over 90 percent of state health agencies receive data from hospitals and laboratories; in contrast just over 40 percent of them send data to hospitals and laboratories. Eighty-six percent of them receive data from providers such as physicians and other health professionals. A slightly smaller number of state health agencies receive data from local health agencies (82 percent). They also frequently receive data from Medicaid, community health centers, insurance companies and long-term care facilities.

State health agencies that serve smaller populations receive information from local health departments less often than those that serve medium and large populations. Those in centralized states receive information from insurance companies/health plans more often than those in decentralized states (62 percent compared to 31 percent). In contrast, state health agencies in centralized states less often receive information from other providers, long-term care facilities and local health agencies. State health agencies in the South receive data from Medicaid more often than those in other regions.

Sending Data. Nearly 70 percent of state health agencies send data to local health agencies and slightly more than a half send data to Medicaid and other health care providers. Other entities with which state health agencies frequently send data are laboratories, hospitals, insurance companies and community health centers. Very few agencies send data to long-term care facilities or regional health information organizations.

State health agencies that serve smaller populations send information to Medicaid and local health agencies less often than those serving larger populations. Agencies in decentralized states send information to local health departments more often than those in centralized states (76 percent compared to 46 percent). State health agencies in the South more frequently indicate that they send data to Medicaid than those in other regions.

Method for Data Exchange. State health agencies use several methods for sending or receiving electronic health information. Those methods are shown in **figure 6.3.** Almost all state health agencies rely on direct data entry for data exchange. Over 80 percent of them use batch file exchange using Health Level Seven International (HL7) or another format. Sixty-four percent of state health agencies report real-time exchange using HL7. Almost one-half of them report using all of the above methods. Fewer than 10 percent of them report use of another method such as secure file transfer protocol, URL encoding or database to database.

Figure 6.3: Methods used by state health agencies to send or receive information with entities shown in figure 6.2; n=45.

*Percent includes agencies who reported yes to using a particular method and those that reported all of the above.

Method	%*
Direct Data Entry	96%
Batch File Exchange Using HL7	87%
Batch File Exchange Using Format other Than HL7	82%
Real-time Exchange Using HL7	64%
All of the Above	47%
Other	9%

Ninety percent of state health agencies have an electronic communicable disease reporting system. Of those systems, 91 percent exchange data through a Web-based interface and about 60 percent use system-to-system messaging.

Figure 6.4: State health agencies' program areas that exchange data with federal agencies or local health agencies; n=49.

State Health Agencies Program Areas	Send Data to Federal Agencies	Receive Data from Federal Agencies	Send Data to Local Health Agencies	Receive Data from Local Health Agencies
Adult Immunization	45%	12%	55%	69%
Case Management	41%	8%	43%	51%
Childhood Immunization	53%	18%	59%	78%
Electronic Health Record (Personal Health Services)	4%	2%	14%	14%
Food Service Inspections	16%	10%	29%	45%
Geographic Coded Data for Mapping Analysis	33%	12%	33%	29%
Health Care Systems Data (e.g., bed availability)	33%	12%	20%	20%
Laboratory Results	73%	27%	63%	53%
Maternal and Child Health Reporting	61%	14%	41%	51%
Medicaid Billing	24%	14%	20%	29%
On-site Waste Water Treatment Systems	12%	4%	16%	24%
Outbreak Management	55%	27%	53%	63%
Reportable Diseases	94%	39%	69%	78%
Vital Records	84%	53%	51%	47%
Water Wells (Licensing and/or Testing)	24%	4%	20%	22%
WIC	84%	33%	59%	73%

Data Exchange for Specific Programs

State health agencies also exchange program specific data with federal and local health agencies. Figure 6.4 shows the program areas for which data is exchanged. State health agencies more frequently send data to federal agencies than receive it from these agencies. As expected, a large majority of state health agencies send reportable disease, vital records, and WIC data to federal agencies (84 percent to 94 percent). Data exchange with local health agencies is bidirectional depending on program area. The most common areas of data exchange between state health agencies and local health agencies are immunizations, reportable diseases, WIC, laboratory results and outbreak management.

A greater proportion of state health agencies that serve medium and large populations exchange immunization and outbreak management data with federal and local health agencies than those serving smaller populations; they also more frequently exchange laboratory results and reportable disease and WIC data with local health agencies. State health agencies in decentralized states less frequently exchange case management information with local health agencies. State health agencies in centralized states less frequently exchange geocoded information and reportable diseases information with local health agencies compared to those in decentralized states; they also less frequently indicate that they exchange outbreak management information with local health agencies.

When region is considered, state health agencies in the New England region tend to exchange immunization data with local health agencies less often than their counterparts in other regions. Proportionately more state health agencies in the South exchange Medicaid information with local health agencies.

Figure 6.5: Methods used by state health agencies to send or receive program specific information shown in Figure 6.4; n=46.

Method	%
Batch File Exchange Using Format other than HL7	85%
Direct Data Entry	83%
Batch File Exchange Using HL7	72%
Real-time Exchange Using HL7	46%
Other	13%

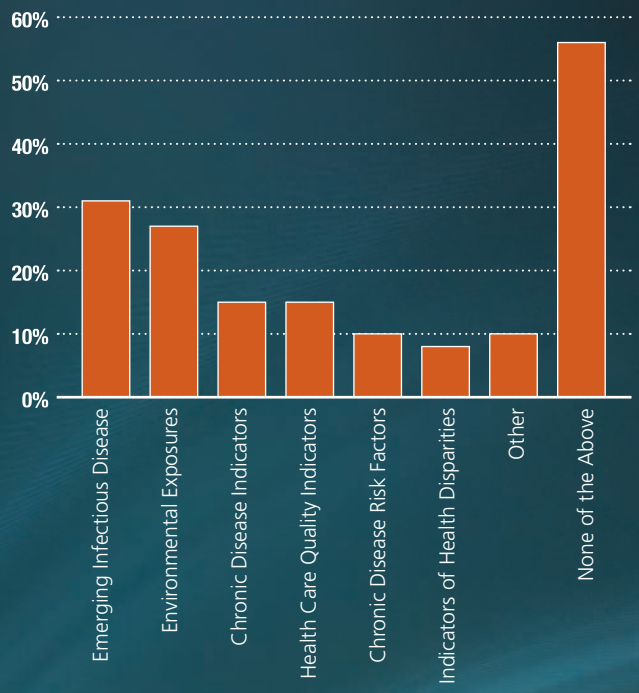
State health agencies use several methods for sharing programmatic data with federal agencies and local health agencies **(see figure 6.5)**. The most common method for sharing program specific data is batch file exchange using a format other than HL7 (85 percent) followed by direct data entry (83 percent) and batch file exchange using HL7 (72 percent). Real-time exchange using HL7 is used less frequently (46 percent).

Health Information Exchanges

State health agencies use electronic health information exchange to monitor exposures, indicators, disease and risk factors. **Figure 6.6** shows the most common areas state health agencies monitor using health information exchange. Agencies serving large populations more frequently monitor environmental exposures and chronic disease risk factors than their counterparts who serve smaller populations. State health agencies serving smaller populations less frequently use health information exchange to monitor emerging infectious diseases than agencies serving medium and large populations.

State health agencies sometimes use health information exchanges to communicate information. Thirty-one percent of them use the information exchanges to provide notification of communicable disease outbreaks, drug warnings or environmental risks. About one-quarter of state health agencies use the information exchanges to communicate

Figure 6.6: Areas monitored using health information exchanges; n=48.



vaccination guidelines and requirements or disease case definitions and diagnostic guidelines or criteria. Health information exchanges are rarely used to promote health behaviors (4 percent). Other information communicated by the information exchanges includes food and lead safety recalls and health policy guidelines.

Electronic Syndromic Surveillance Systems

Over 80 percent of state health agencies have an electronic syndromic surveillance system. Agencies in the West less frequently indicate having an electronic syndromic surveillance system than those in other regions. Of those agencies with systems, about 40 percent have bidirectional reporting and exchange capability. Sixty-three percent of electronic syndromic surveillance systems exchange data through system-to-system messaging and 42 percent rely on a Web-based interface. Seven percent of state health agencies had another mechanism for exchanging data including manual data input, batch file exchange and e-mail.

Electronic Communicable Disease Reporting Systems

Ninety percent of state health agencies have an electronic communicable disease reporting system. Of those systems, 91 percent exchange data through a Web-based interface and about 60 percent use system-to-system messaging. Almost 60 percent of state health agencies receive electronic laboratory communicable disease reports from clinical laboratories in real time. Over 80 percent of agencies rely on system-to-system messaging to receive electronic laboratory result data and about 60 percent use a Web-based interface. Fourteen percent of state health agencies had another mechanism for receiving electronic laboratory result data such as HL7 messaging, paper reports and manually inputting data.

Registries

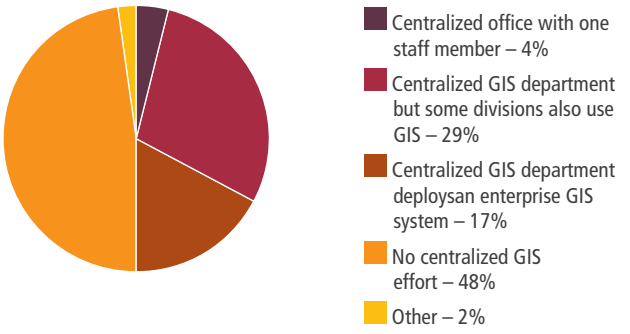
Almost all state health agencies are involved in registry maintenance. Over 90 percent of them maintain childhood immunization and cancer registries. Eighty-two percent of them maintain birth defects registries.

Eighty-two percent of agencies have a mandatory electronic cancer registry (n=41). Of those, 37 percent have bidirectional data reporting and exchange capabilities. Sixty-three percent of those with electronic cancer registry exchange data through a Web-based interface, and 55 percent exchange data via system-to-system messaging. Twenty percent of state health agencies report another mechanism such as direct data entry, encrypted e-mail and file transfer.

Geographic Information Systems (GIS)

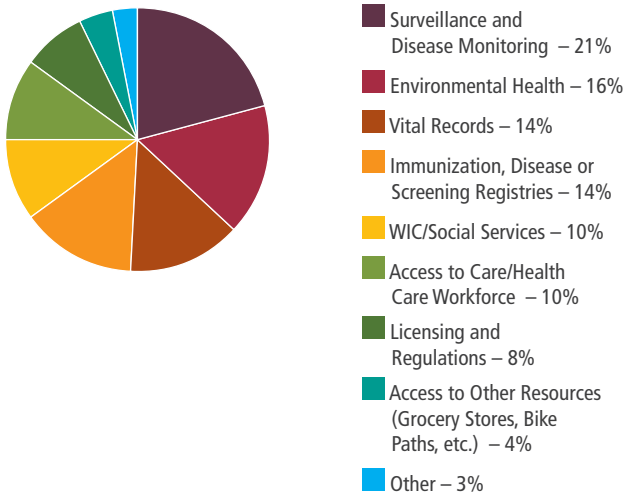
State health agencies report different resources for GIS-related activities **(see figure 6.7)**. One-half of agencies have a centralized office or department that supports GIS work. In some cases, the centralized office does all GIS work. More commonly, there is a centralized GIS department that supports use of GIS for programs (36 percent). Almost one-half of state health agencies report that staff in various departments use GIS with no centralized GIS effort.

Figure 6.7: State health agencies GIS resources; n=48.



State health agencies use GIS for a range of services. The most common use is surveillance and disease monitoring, followed by environmental health and vital records. **Figure 6.8** shows the most common services for which agencies use GIS.

Figure 6.8: State health agencies use of GIS by service; n=47.



Most public health data is geocoded and displayed at the ZIP code level **(see figure 6.9)**. There is also a significant amount of data geocoded at the street address, census tract, and latitude and longitude levels; however, data is less often displayed at those levels. State health agencies in the New England region less frequently indicate that they have data geocoded to the latitude and longitude level.

Almost all state health agencies use geocoded data to produce static maps (96 percent) and 65 percent report using geocoded data for interactive Web-based maps. State health agencies that serve medium-sized populations more frequently indicate that they use interactive Web maps than those serving small and large populations. Over one-fourth of agencies use geocoded data for other geospatial analysis not necessarily using maps. Only 2 percent of state health agencies report no use of geocoded data.

Agency needs with respect to GIS vary. Nearly 30 percent of state health agencies have adequate resources to meet their GIS needs. However, many agencies are unable to meet current needs for the following reasons: lack adequate staff and experience to meet current needs (65 percent); lack the IT infrastructure (hardware/software/IT support) to meet current needs (33 percent); and lack of data (19 percent).

Figure 6.9: Level of geocoding and display of public health data; n=45.

Level	Geocoded	Displayed
ZIP Code	78%	71%
Street Address	71%	40%
Census Tract	64%	47%
Latitude and Longitude	62%	31%
Other	18%	31%

State health agencies often exchange data with health care entities such as hospitals, hospital systems, health care providers and provider groups. Fifty-six percent of agencies exchange data directly with providers, and another 20 percent use direct data exchange through an intermediary health information exchange entity.

7 Chapter Seven

Territorial Public Health Agencies

This chapter provides an overview of the structure, functions and resources of territorial health agencies. Unlike previous chapters in this report, this chapter utilizes case examples of the two U.S. territories that responded to the 2010 ASTHO survey: the Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands. This chapter also uses data from state health agencies as comparators.

US Territories

The population and geography of the eight U.S. territories are shown in **figure 7.1.** Puerto Rico is the largest territory both in geographic size and population.

Pacific Island Health Officers Association (PIHOA)

The six U.S.-affiliated Pacific Islands are also members of the Pacific Island Health Officers Association. The association's mission is to provide a unifying voice and credible authority on health issues of regional significance.[16] It works to strengthen cross-cutting public health infrastructure with priority initiatives that address health workforce development, quality assurance, health data systems, public health planning and public health laboratories.

An Overview of the Territories

Summaries of the Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands are provided in **figures 7.2** and **7.3**. Of the two, the U.S. Virgin Islands' population is larger by almost

Figure 7.1: Population and geographic size of U.S. territories.[15]

Territory	Population	Geography (miles² land)
American Samoa	65,628	77
Federated States of Micronesia	106,836	271
Guam	178,430	210
Commonwealth of the Northern Mariana Islands	88,662	179
Puerto Rico	3,725,789	3,425
Republic of Palau	20,956	177
Republic of the Marshall Islands	67,182	70
U.S. Virgin Islands	109,825	134

Figure 7.2: Summary characteristics of the Commonwealth of the Northern Mariana Islands.[17]

Characteristics	Northern Mariana Islands	Comparison
Population	88,662	1/10 the total Delaware population
Population Density	495 people per mile2	State of Delaware
Per Capita Spending	$474 ($42.1 million total FY09)	50% of Delaware state health agency funding
Number of Full-time Equivalents	576	89% of Delaware state health agency workforce

25 percent, though it has a smaller land mass. The Northern Mariana Islands and the U.S. Virgin Islands are roughly 2 and 2.5 times the landmass of Washington, D.C., respectively. Both territories provide a considerable amount of population-based and clinical health services to their constituents; however they have different agency structures and relationships with local health departments. While the Northern Mariana Islands operates one regional and one local health department, the U.S. Virgin Islands has six independent local health departments. Both territories have small total expenditures when compared to state averages; however, these modest budgets translate to significant expenditures per capita and full-time equivalents per capita, as much of the public health workforce for the territories are concentrated at the health departments.

Revenue and Expenditure Comparisons

Though comparably sized, the Northern Mariana Islands and the U.S. Virgin Islands reported somewhat different streams of revenue. As **figure 7.4** illustrates, in FY09 territorial general funds accounted for 66 percent of the Northern Mariana Islands' total revenue and 58 percent for the U.S. Virgin Islands. Federal funds accounted for most of the remaining dollars. A high percentage of funding from state general funds is uncommon; in FY09, the average federal funding as a percentage of total revenue for states was 40 percent, while the average state general funding level was 20 percent. The disparity appears to be due to utilization of other (nongeneral fund) dedicated state and territorial dollars, and of fees and fines. Where the Northern Mariana Islands reported no revenue from fees and fines or other state/territorial funds and the U.S. Virgin Islands reported 5 percent of revenue from other state/territorial funds, the state average is 7 percent for fees and fines and 23 percent for other state/territorial funds.

While the total spending of the reporting territories is relatively small—$42.1 million for Northern Mariana Islands and $50.4 million for the U.S. Virgin Islands—per capita expenditures are substantially greater than the national average due to the small population of these territories. Of both territories, only the U.S. Virgin Islands reported expenditures using the ASTHO Profile Survey's expenditure categories. As shown in **figure 7.5**, emergency preparedness, health data and improving consumer health were comparable to national averages. Expenditures in infectious disease, injury prevention, and quality of health services were below national averages. WIC was substantially lower than the state averages or median; the U.S. Virgin Islands reported no expenditures in environmental protection, health laboratory or vital statistics. Chronic disease expenditures were greater than the state averages, and administrative expenditures were reported as an order of magnitude greater than the national average. An explanation for this difference is not provided. However, the U.S. Virgin Islands did not report any expenditures in the provided "other" category; it is plausible that other types of expenditures are included in the administrative category. However, the U.S. Virgin Islands also supports 180 administrative and clerical full-time equivalents, with additional position types potentially being funded out of this budget category.

Administrative and clerical workers constituted the largest percentage of the U.S. Virgin Islands workforce, well above the states' average **(see figure 7.6).** Public health nurses and managers make up the second largest portions of the workforce at 10 percent and 7 percent respectively, with slightly fewer health educators, nutritionists and physicians. The Northern Mariana Islands did not report full-time equivalent position totals.

Figure 7.3: Summary characteristics of the U.S. Virgin Islands.[18]

Characteristics	U.S. Virgin Islands	Comparison
Population	109,825	Roughly the total of Cambridge, MA (1/60th of MA population)
Population Density	820 people per mile^2	State of Massachusetts
Per Capita Spending	$458 ($50.4 million total FY09)	Four times MA per capita (7% of MA total)
FTEs	507 total	1/5 size of MA state health agency workforce

Figure 7.4: Territorial sources of revenue, FY08 & FY09.

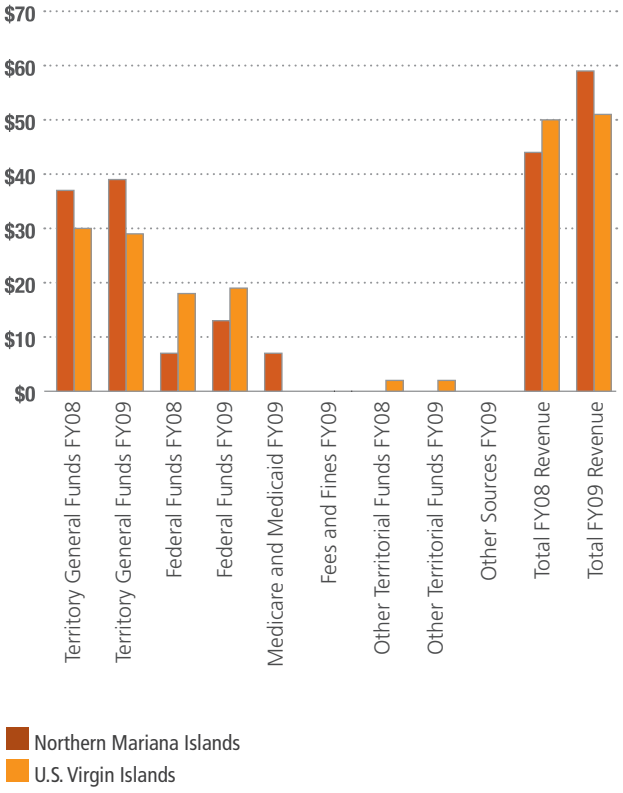
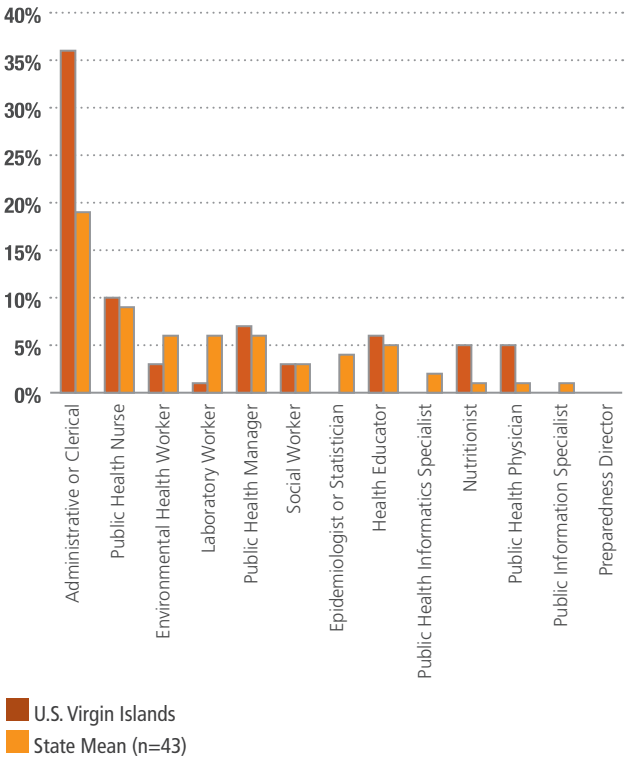


Figure 7.5: Per capita spending by area, the U.S. Virgin Islands compared to states average and median, FY09.

	U.S. Virgin Islands	State Avg (n=48)	State Med (n=48)
Chronic Disease	$59	$39	$17
Infectious Disease	$34	$56	$22
Injury Prevention	$4	$12	$2
WIC	$17	$83	$83
Environmental Protection	-	$23	$7
Improving Consumer Health	$63	$64	$64
All-Hazards Preparedness	$34	$18	$18
Quality of Health Services	$6	$16	$16
Health Laboratory	-	$10	$8
Vital Statistics	-	$4	$3
Health Data	$4	$5	$3
Administration	$238	$21	$16
Other	-	$48	$22

Figure 7.6: Workforce breakdown by position type as percent of total reported full-time equivalents, Virgin Islands compared to state average, FY09.

*Note: Percentages may not total 100 percent due to other position types not reported or shown.



Collaborations and Responsibilities

Both the Northern Mariana Islands and the U.S. Virgin Islands have robust partnerships with several local entities **(see figure 7.7).** Of the 22 entities identified in the 2010 survey, the Northern Mariana Islands reported relationships with 16 and the U.S. Virgin Islands reported 19. The most common types of collaborations were work together (16 Northern Mariana Islands, 13 U.S. Virgin Islands) and exchange information (16 Northern Mariana Islands, 15 U.S. Virgin Islands). The Northern Mariana Islands provided a leadership role in 15 of the collaboration categories, and the U.S. Virgin Islands provided a leadership role in five categories. In providing financial resources, the Northern Mariana Islands reported 16 collaborations and the U.S. Virgin Islands reported two.

The Northern Mariana Islands and the U.S. Virgin Islands, though similar in size and spending, vary in scope of responsibilities **(see figure 7.8)**. The major difference in responsibilities between them are in environmental health; professional licensure; and regulation, inspections and licensing. The Northern Mariana Islands has no environmental health responsibilities (likely falling to the Commonwealth's Division of Environmental Quality), while the U.S. Virgin Islands has responsibility for food safety education, hazmat response and mosquito control. The U.S. Virgin Islands has responsibility for professional licensure of 14 categories (e.g., nurses and physicians), while the Northern Mariana Islands has responsibility for professional licensure of nurses only. In regulation, inspections, and licensing, Northern Mariana Islands has no responsibilities and the U.S. Virgin Islands is responsible for tobacco retailers, childcare facilities, hospitals and food service establishments, among others.

While the total spending of the reporting territories is relatively small—$42.1 million for Northern Mariana Islands and $50.4 million for the U.S. Virgin Islands—per capita expenditures are substantially greater than the national average due to the small population of these territories.

Figure 7.7: Territory collaboration with local entities.

Collaborations	Northern Mariana Islands	U.S. Virgin Islands
Local Public Health Agencies	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information, Work Together, State/Territory Leadership Role
Hospitals	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information, Work Together
Physician Practices/Medical Groups	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information, Work Together
Community Health Centers		Exchange Information, Work Together
Other Health Providers		Exchange Information
Health Insurers	Exchange Information, Work Together State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information
Regional Cancer Society	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Work Together
Emergency Responders	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information, Work Together
Land use agencies	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information
Economic and Community Development	No Relationship Yet	Exchange Information
Housing Agencies	No Relationship Yet	
Utility Companies/Agencies	No Relationship Yet	
Environmental/Conservation Agencies	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information
Cooperative Extensions	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information, State/Territory Leadership Role
Schools	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information, Work Together
Parks and Recreation	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Work Together
Community-based Organizations	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role
Faith Communities	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role
Universities	Exchange Information, Work Together, State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information, Work Together
Business	Exchange Information, Work Together State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information, Work Together, State/Territory Leadership Role
Media	Exchange Information, Work Together State/Territory Provides Financial Resources, State/Territory Leadership Role	Exchange Information, Work Together
Tribal Government		No Relationship Yet

Figure 7.8: Responsibilities of the Northern Mariana Islands and Virgin Islands health agencies.

Responsibilities	Northern Mariana Islands	U.S. Virgin Islands
Access to Health Care Services	Faith-based Programs, Health Disparities, Outreach and Enrollment, State/Territorial Health Insurance (not federal), SCHIP	Health Disparities, Outreach and Enrollment, SCHIP
Data, Epidemiology, and Surveillance	Chronic Disease, Communicable/Infectious Disease, Food-borne Illness, Morbidity, Perinatal Events/Risk Factors, Reportable Diseases, Syndromic Surveillance, Vital Statistics, Environmental Health, Insurance Outreach	Chronic Disease, Communicable/Infectious Disease, Morbidity, Perinatal Events/Risk Factors, Reportable Diseases, Syndromic Surveillance, Vital Statistics Environmental Health, Insurance Outreach
Environmental Health		Food Safety Education, Hazmat Response, Mosquito Control
Laboratory Services	Cholesterol Screening	Blood Lead Screening, Cholesterol Screening, Newborn Screening
Maternal and Child Health	Comprehensive Primary Care Clinics, Early Intervention Services, Family Planning, Non-WIC Nutritional Assessment, Obstetrical Care, Prenatal Care, School Health Services (Noncomprehensive), Special Health Care Needs, Well-Child Services, WIC	Comprehensive Primary Care Clinics, Early Intervention Services, Family Planning, Obstetrical Care Prenatal Care, School Health Services (Non-Comprehensive), Special Health Care Needs, Well-Child Services, WIC
Other Clinical Services	Child Protection, Comprehensive Primary Care (Adult), Correctional Health, Domestic Violence, Mental Health Education and Prevention Services, Mental Health Treatment, Oral Health, Pharmacy, Physical Therapy, Sexual Assault Victims Services, Substance Abuse Education, Substance Abuse Treatment	Comprehensive Primary Care (Adult), Home Health Care, Mental Health Education and Prevention Services, Mental Health Treatment, Oral Health, Substance Abuse Education, Substance Abuse Treatment
Other Public Health Activities	Mental Health, State/Territorial Health Planning and Development, State/Territorial Mental Institutions/ Hospitals, State/Territorial Tuberculosis Hospitals, Substance Abuse Facilities, Trauma System Coordination, Veterinarian Public Health Activities	Forensics Laboratory, Mental Health, State/Territorial Health Planning and Development, State/Territorial Mental Institutions/Hospitals, Substance Abuse Facilities
Primary Prevention	Diabetes, HIV, Hypertension, Injury, Mental Illness, Nutrition, Physical Activity, Sex Education, STD Counseling/Partner Notification, Substance Abuse, Suicide, Tobacco, Unintended Pregnancy, Violence	Diabetes, HIV, Mental Illness, Nutrition, STD Counseling/Partner Notification, Substance Abuse, Tobacco, Unintended Pregnancy
Professional Licensure	Nurses (any level)	Dentists, Nurses (any level), Pharmacists, Physician Assistants, Physicians
Regulation, Inspection and Licensing		Tobacco Retailers, Childcare Facilities, Clinics, Food Processing, Food Service Establishments, Hospitals, Housing (inspections), Laboratories, Nursing Homes, Schools
Registry Maintenance	Birth Defects, Childhood Immunization, Diabetes	Childhood Immunization, Diabetes
Screening	Asthma, Blood Lead, Breast/Cervical Cancer, Diabetes, High Blood Pressure, HIV/AIDS, Newborn, Other Cancer Screenings, Other STDs, Tuberculosis	Asthma, Blood Lead, Breast/Cervical Cancer, Diabetes, High Blood Pressure, HIV/AIDS, Newborn, Other STDs, Tuberculosis
Treatment	Asthma, Blood Lead, Breast/Cervical Cancer, Colon/Rectum Cancer, Coronary Heart Disease Diabetes, HIV/AIDS, Other Cancers, Tuberculosis, Other STDs	Asthma, Breast/Cervical Cancer, Coronary Heart Disease, Diabetes, High Blood Pressure, HIV/AIDS, Tuberculosis, Other STDs
Vaccine Administration	Adult, Child, Travel	Adult, Child, Travel
Vaccine Ordering	Adult, Child, Travel	Adult, Child, Travel

Conclusion

The findings included in this report highlight the important roles and activities that state and territorial health agencies undertake to protect and promote our nation's health. Through their programs and activities these agencies work hard to ensure that the 10 essential public health services are provided in communities. State health agencies conduct state health assessments (essential service 1: monitor health status to identify and solve community health problems) and engage in public health systems and services research (essential service 10: research for new insights and innovative solutions to health problems), while addressing the multiple health problems that impact people's daily lives, and building the public health system to address future challenges.

State and territorial health agencies support linkages between people and health services. Whether they directly provide population-based primary prevention services or work with other partners to ensure those services are provided, these agencies are addressing the CDC's winnable battles.

In addition to providing services and programming, state and territorial health agencies engage in many activities to evaluate their performance against benchmarks and national standards. Through the adoption of quality improvement and performance management processes, they become more efficient and effective. They are adopting and implementing evidence-based practices and policies that improve population health. In addition, many of them are preparing for accreditation through the National Public Health Accreditation Board and have taken formal steps to evaluate their performance.

State and territorial health agencies are working hard to do more with less. There are over 100,000 full-time employees who work for state and territorial health agencies, but many agencies face workforce shortages due to retirement, vacancies and hiring freezes. Budget cuts continue to be problematic. Perhaps partly due to these shortages, state and territorial health agencies report sharing resources with other jurisdictions for some essential public health services; they also report a high level of collaboration with their public health systems partners. State and territorial health agencies continue to become more efficient with the adoption of health information technology. A growing number exchange electronic data with other agencies and health care providers.

State and territorial health agencies are facing a challenging future. Over the next few years, agency budget cuts may continue, while threats to health are not likely to subside. With an increasing focus on the social determinants of health, expectations of health agencies will probably continue to increase. The functions of state health agencies have increased over the past decade and may continue to do so over the current one. The increasing emphasis on quality improvement and government efficiency will also challenge state and territorial health agencies to continue to improve their performance. This report documents the strong foundation on which the state and territorial public health system will build.

References

CHAPTER ONE

1. U.S. Centers for Disease Control and Prevention. 10 Essential Public Health Services. http://www.cdc.gov/nphpsp/essentialServices.html. Accessed: Aug. 3, 2011
2. U.S. Centers for Disease Control and Prevention. Winnable Battles. http://www.cdc.gov/WinnableBattles/. Accessed: Aug. 3, 2011

CHAPTER TWO

3. Two states did not respond to the questions on the number of local health departments and number of regional or district offices. For that reason, the total numbers reported may not be directly comparable to those published by the National Association of County & City Health Officials.

CHAPTER THREE

4. Public Health Accreditation Board. Accreditation: Why it's Important Now. http://www.phaboard.org/index.php/accreditation/why_its_important_now/. Accessed: Aug. 3, 2011
5. Public Health Foundation. From Silos to Systems: Using Performance Management to Improve the Public's Health. http://www.turningpointprogram.org/Pages/pdfs/perform_manage/Silos_to_Sytems_FINAL.pdf. Accessed: Aug. 3, 2011
6. Public Health Accreditation Board. Acronyms and Glossary of Terms. http://www.phaboard.org/assets/documents/Glossary-07-15-2009.doc. Accessed: Aug. 3, 2011
7. World Health Organization. Health Impact Assessment. 2011. http://www.euro.who.int/en/what-we-do/health-topics/environmental-health/health-impact-assessment. Accessed: Aug. 3, 2011

CHAPTER FOUR

8. The average percent change in full-time equivalents from 2007 to 2010 was calculated and multiplied by the 2007 totals for states that did not report data in 2010 to estimate total full-time equivalents.

CHAPTER FIVE

9. State population and mean revenue per capita (for states that responded) were used to estimate the total revenue for states that did not report data in 2010.
10. Average revenue per capita was calculated using 2009 population estimates from the U.S. Census Bureau.
11. State population and mean expenditures per capita (for states that responded) were used to estimate the total expenditures for states that did not report data in 2010.
12. Average expenditures per capita were calculated using 2009 population estimates from the U.S. Census Bureau.

CHAPTER SIX

13. U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology. Health IT. http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204. Accessed: Aug. 3, 2011
14. U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology. Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms. http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10731_848133_0_0_18/10_2_hit_terms.pdf. Accessed: Aug. 3,2011

CHAPTER SEVEN

15. http://www.census.gov/geo/www/tiger/glossry2.pdf & 2010 U. S. Census
16. Pacific Island Health Officers Association. About Pacific Island Health Officers Association. http://www.pihoa.org/. Accessed: Aug. 3, 2011
17. U.S. Central Intelligence Agency. The World Factbook. https://www.cia.gov/library/publications/the-world-factbook/geos/ps.html. Accessed: Aug. 3, 2011
18. Ibid.

State Profiles

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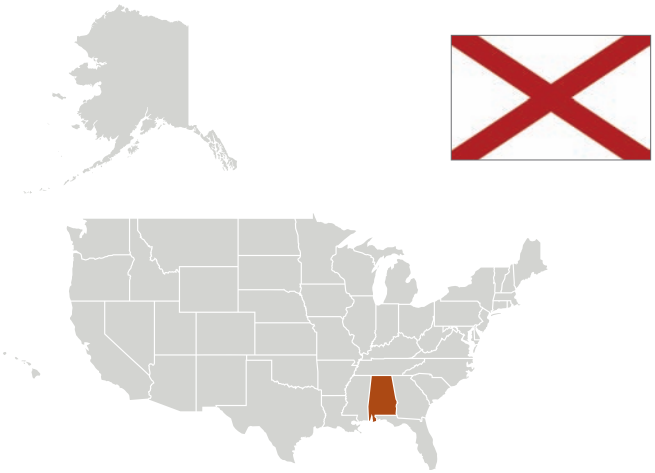
Alabama

Alabama Department of Public Health



Agency Mission

To serve the people of Alabama by assuring conditions in which they can be healthy.

Top 5 Priorities for State/Territorial Health Agency

1. Funding to maintain public health services
2. Tobacco control
3. Infant mortality
4. Obesity
5. Trauma system funding

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a largely centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 2

Number of state-run local health agencies

(led by state government staff): 65

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

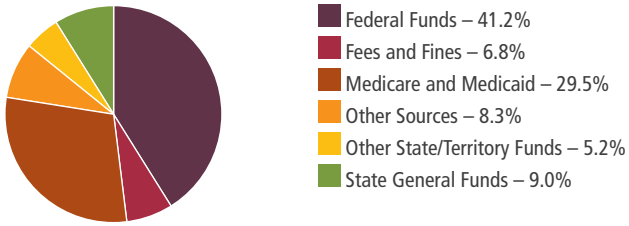
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

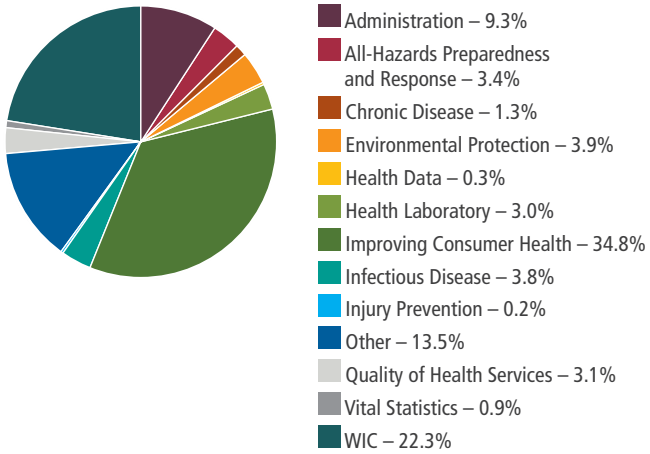
The state/territorial health agency has 4,300 full-time equivalents, including 2,270 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)



Total Expenditures FY08*: $530,525,970
Total Expenditures FY09**: $540,067,189

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Alaska

Alaska Department of Health and Social Services
Division of Public Health

Agency Mission

The mission of the Alaska Division of Public Health is to protect and promote the health of all Alaskans.

Top 5 Priorities for State/Territorial Health Agency

1. Prevent and control epidemics and spread of infectious disease
2. Protect against environmental hazards impacting human health
3. Prevent and control chronic disease and disabilities
4. Minimize loss of life and suffering from injuries and disasters
5. Assure access to early preventive services

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a mixed relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 2

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 22

State Organizational Structure

The health agency does not report directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

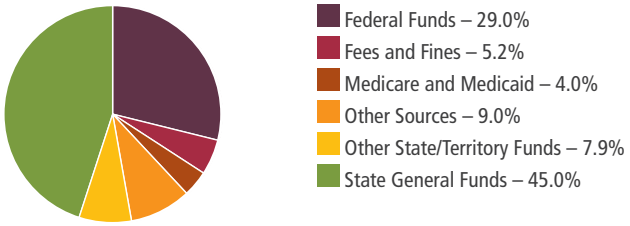
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

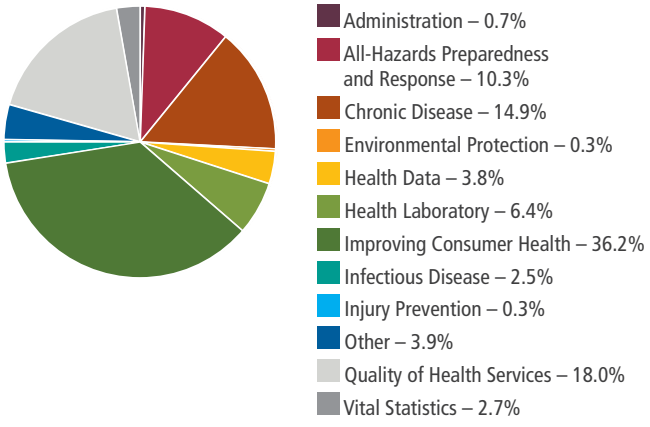
The state/territorial health agency has 508 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

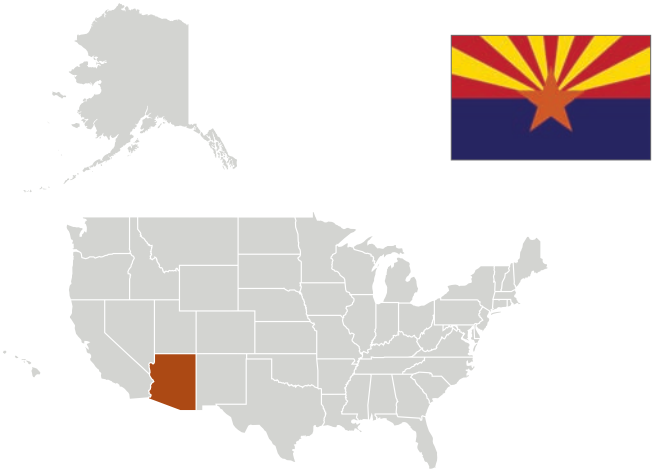


Total Expenditures FY08* : $80,334,720
Total Expenditures FY09**: $84,318,898

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Arizona

Arizona Department of Health Services



Agency Mission

Promote and protect healthy people and healthy communities throughout Arizona.

Top 5 Priorities for State/Territorial Health Agency

1. Motor vehicle accidents and injuries
2. Tobacco cessation and prevention
3. Health care acquired infections
4. Teen pregnancy prevention
5. Physical activity/nutrition

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 15

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

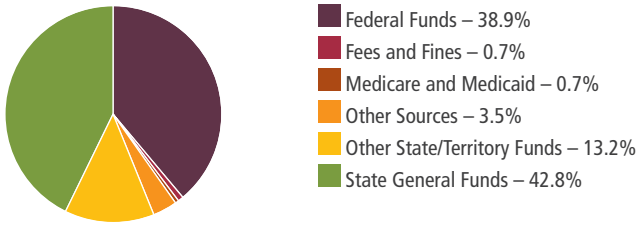
■	Health Assessment
	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

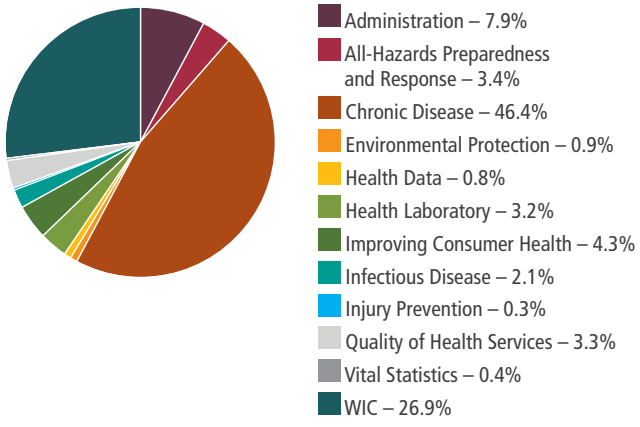
The state/territorial health agency has 1,690 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

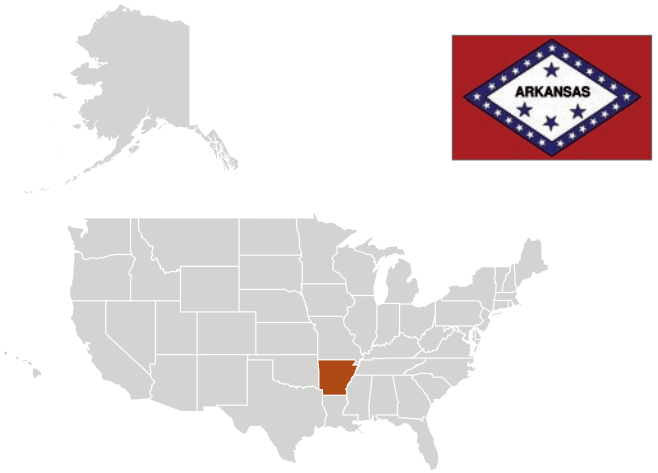


Total Expenditures FY08*: $544,620,900
Total Expenditures FY09**: $495,709,500

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Arkansas

Arkansas Department of Health



Agency Mission

To protect and improve the health and well-being of all Arkansans.

Top 5 Priorities for State/Territorial Health Agency

1. Improve outcomes and reduce health disparities
2. Strengthen clinical and other public health services
3. Secure adequate financial and human resources
4. Communicate public health value and contribution
5. Strengthen community engagement, partnerships and policy

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 94

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 5

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

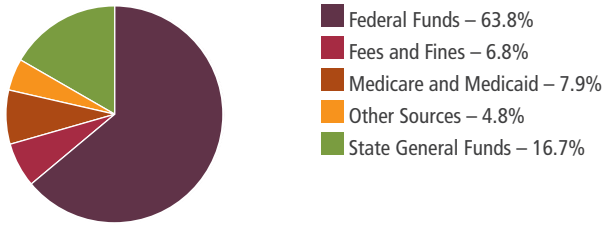
	Health Assessment
	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

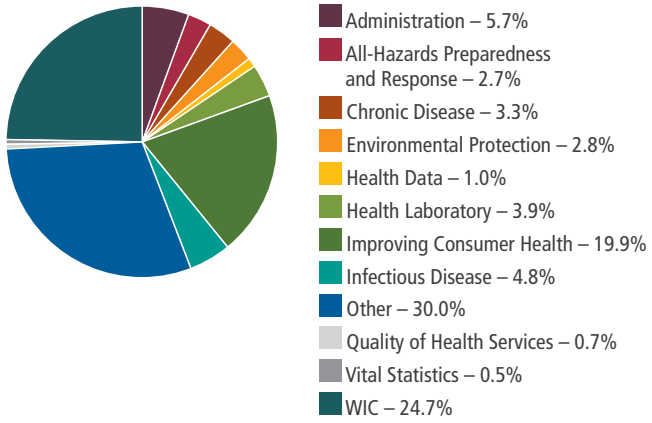
The state/territorial health agency has 2,809 full-time equivalents, including 1,984 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)



Total Expenditures FY08*: $320,133,521
Total Expenditures FY09**: $325,926,535

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

California

California Department of Public Health

Agency Mission

The California Department of Public Health is dedicated to optimizing the health and well-being of the people in California.

Top 5 Priorities for State/Territorial Health Agency

1. Eliminate health disparities and improve health equity
2. Public health emergency preparedness and response
3. Improve quality and availability of data
4. Promote quality of workforce and improve work environment
5. Improve quality of business practices

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 61

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

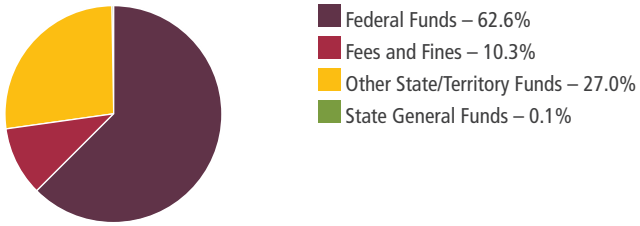
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

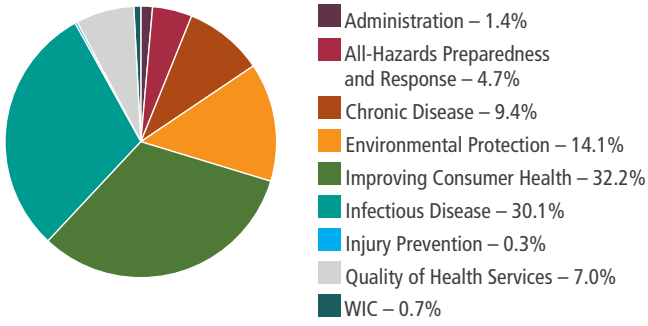
The state/territorial health agency has 4,162 full-time equivalents, including 1,967 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

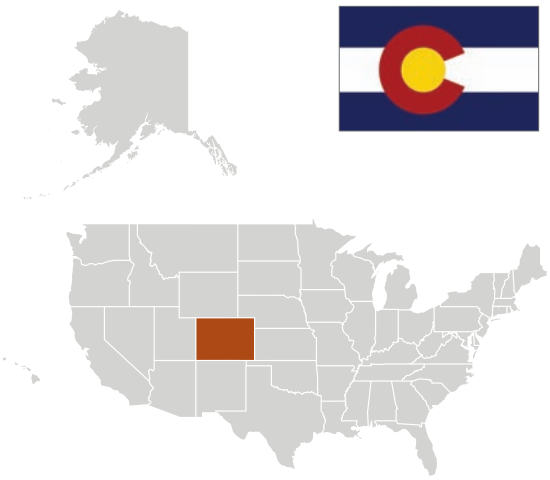


Total Expenditures FY08*: $1,596,920,880
Total Expenditures FY09**: $1,659,392,104

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Colorado

Colorado Department of Public Health and Environment



Agency Mission

The mission of the Colorado Department of Public Health and Environment is to protect and improve the health of Colorado's people and the quality of its environment.

Top 5 Priorities for State/Territorial Health Agency

1. Transition to new administration/governor
2. Protection of state resources for state and local public health programs
3. Continued work in tobacco cessation and control and obesity prevention/reduction activities
4. Implementation of health care reform and American Recovery and Reinvestment Act grants
5. Ongoing implementation of Colorado's Public Health Act (Senate Bill 08-194)

Structure and Relationship with Local Health Departments

The state health agency is a free standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 54

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The state health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

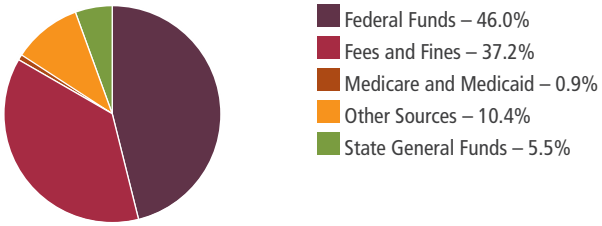
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

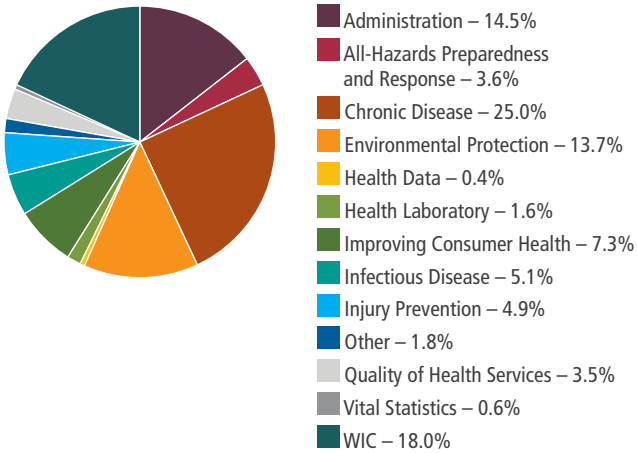
The state/territorial health agency has 1,224 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)



Total Expenditures FY08*: $399,330,856
Total Expenditures FY09**: $508,455,737

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Commonwealth of the Northern Mariana Islands

Commonwealth of the Northern Mariana Islands Department of Public Health

Agency Mission

To provide compassionate, quality health care and promote health for all people in the Commonwealth of the Northern Mariana Islands.

Top 5 Priorities for State/Territorial Health Agency

1. Noncommunicable disease prevention
2. Health workforce development and capacity building
3. Performance improvement of programs and services
4. Stabilizing and improving the financial status of the Department of Public Health
5. Restructuring of the Department of Public Health

Structure and Relationship with Local Health Departments

The territorial health agency is a free-standing/independent agency and has a centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of territory-run local health agencies

(led by territory government staff): 1

Number of independent regional or district offices

(led by nonterritory employees): 0

Number of territory-run regional or district offices

(led by territory employees): 1

Governmental Organizational Structure

The health agency reports directly to the governor. The territory does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

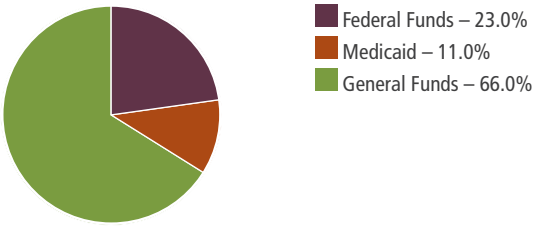
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

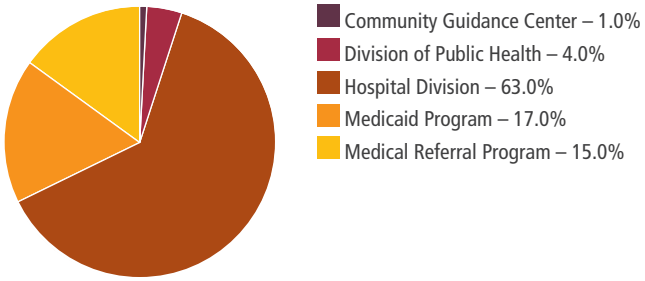
The territorial health agency has 576 full-time equivalents.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

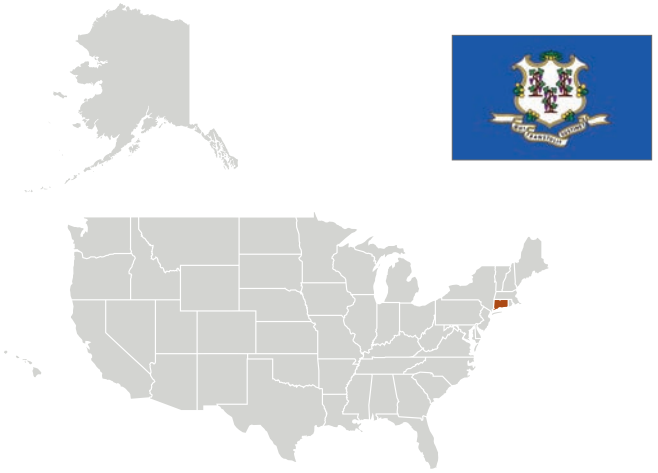


Total Expenditures FY08*: $36,997,510
Total Expenditures FY09**: $39,211,820

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Connecticut

Connecticut Department of Public Health



Agency Mission

To protect and improve the health and safety of the people of Connecticut by assuring the conditions in which people can be healthy; promoting physical and mental health; and preventing disease, injury and disability.

Top 5 Priorities for State/Territorial Health Agency

1. Assuring safe and adequate drinking water
2. Assuring children's health and safety
3. Assuring health care regulatory oversight
4. Eliminating health inequalities
5. Improving IT infrastructure, data collection and analysis

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 80

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

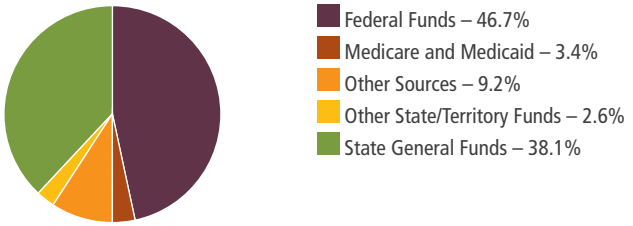
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

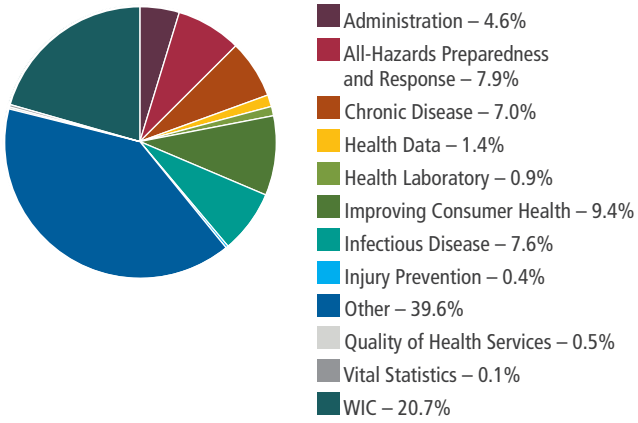
The state/territorial health agency has 816 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

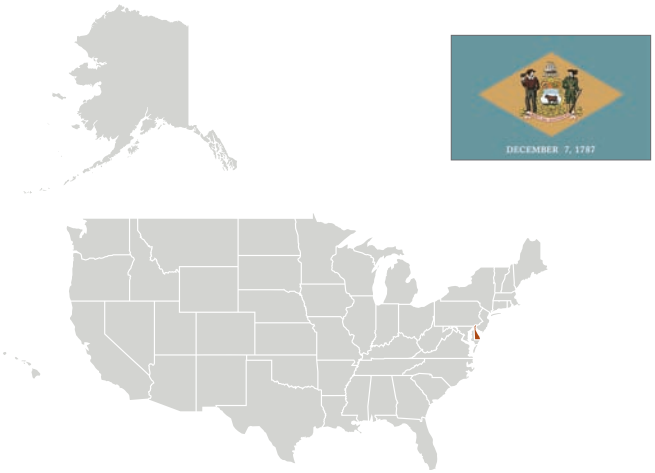


Total Expenditures FY08*: $238,842,489
Total Expenditures FY09**: $232,118,704

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Delaware

Delaware Department Health and Social Services
Division of Public Health



Agency Mission

The mission of the division is to protect and promote the health of the people. The division's responsibilities include the following: monitor and assess the health status of the population of the state, use scientific knowledge as the basis to promote public policy to protect the health of the people, perform duties and functions as may be necessary to assure the protection of the public's health.

Top 5 Priorities for State/Territorial Health Agency

1. Reducing health disparities
2. Encouraging healthy lifestyles
3. Developing a performance management system
4. Focusing on core services
5. Implementing health reform

Structure and Relationship with Local Health Departments

The state health agency is part of a larger agency and has no local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

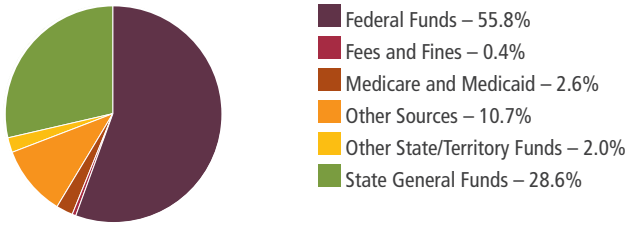
■	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

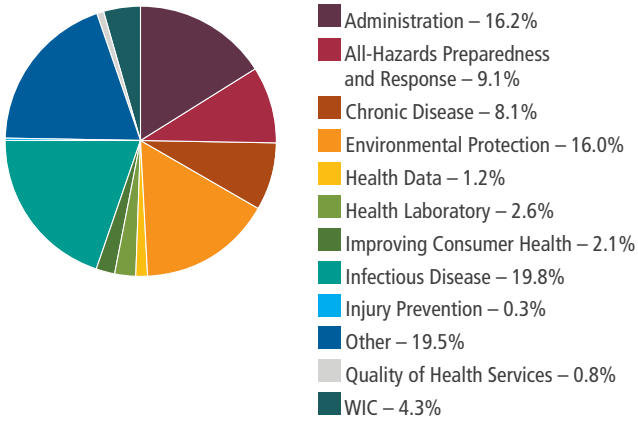
The state/territorial health agency has 645 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

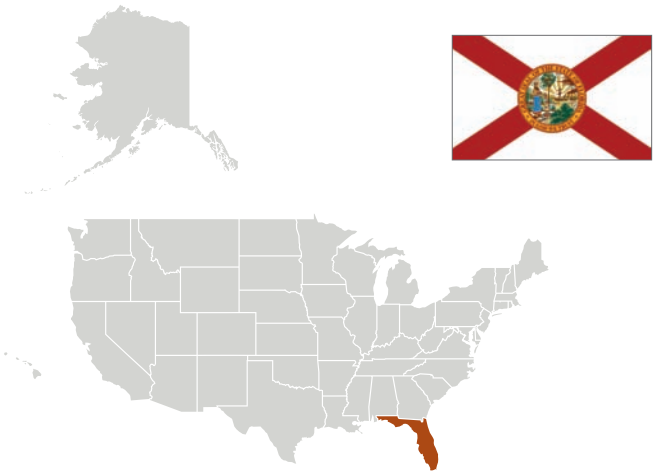


Total Expenditures FY08*: $87,859,116
Total Expenditures FY09**: $84,695,497

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Florida

Florida Department of Health



Agency Mission

Promote, protect and improve the health of all people in Florida.

Top 5 Priorities for State/Territorial Health Agency

1. Control infectious diseases
2. Promote healthy behaviors
3. Monitor health status to identify community health problems
4. Diagnose and investigate health problems and health hazards
5. Develop partnerships to address health issues

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a shared relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 67

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

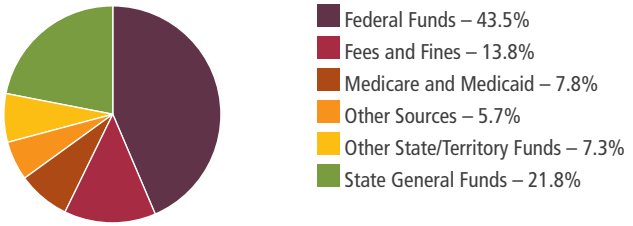
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

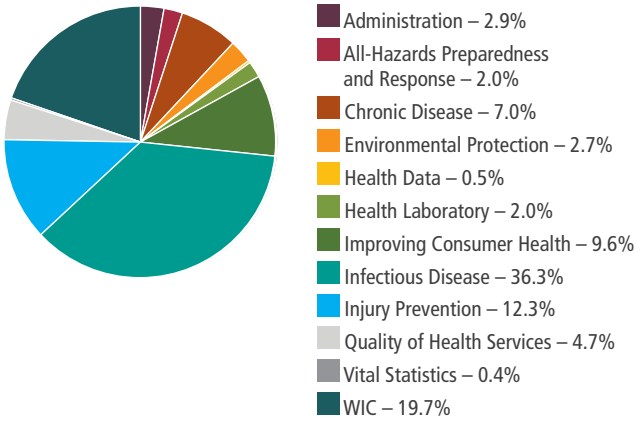
The state/territorial health agency has 15,364 full-time equivalents, including 11,427 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

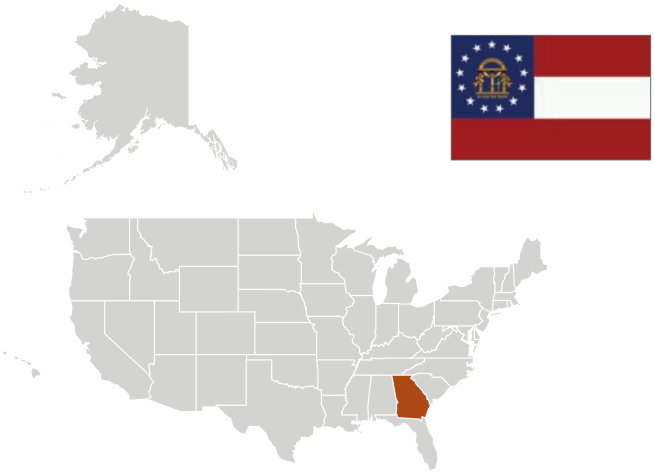


Total Expenditures FY08*: $2,113,161,734
Total Expenditures FY09**: $2,196,115,426

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Georgia

Georgia Department of Community Health
Division of Public Health



Agency Mission

Created and established to safeguard and promote the health of the people of the state and empowered to employ all legal means appropriate to that end.
Not in statute: To protect, promote and improve the health and safety of Georgia.

Top 5 Priorities for State/Territorial Health Agency

1. Development of new public health strategic direction and planning
2. Development of crisis standards or care during severe pandemic
3. Revise coastal evaluation plan – medical special needs patients
4. Address obesity through physical activity and nutrition initiatives
5. Revise maternal and child health Title V planning and initiatives

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a shared relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 159

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 18

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

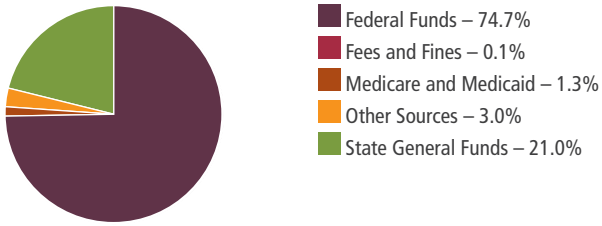
■	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

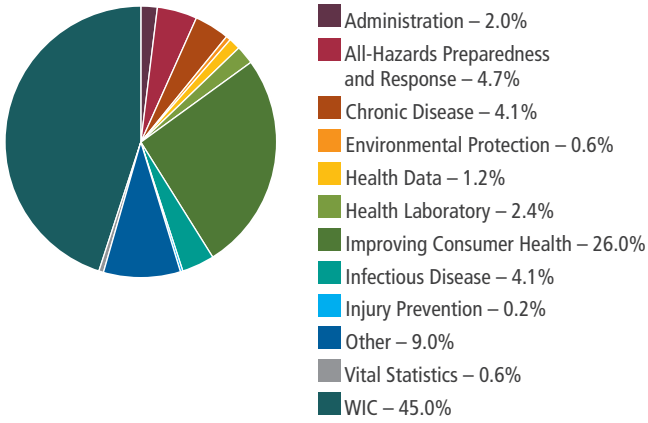
The state/territorial health agency has 1,023 full-time equivalents, including 425 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

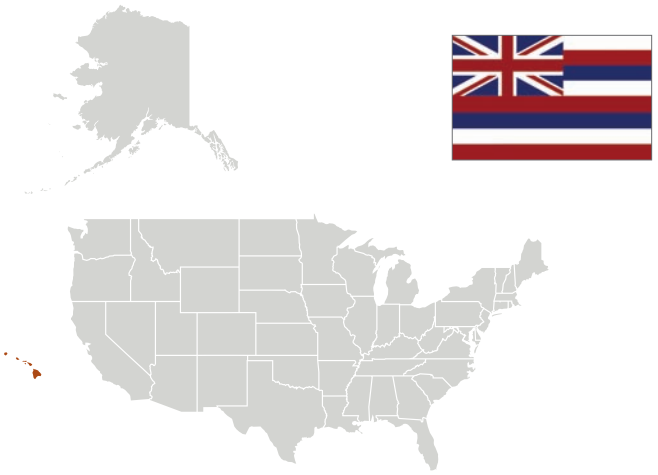


Total Expenditures FY08*: $762,408,806
Total Expenditures FY09**: $717,270,707

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Hawaii

Hawaii Department of Health



Agency Mission

The mission of the Department of Health is to protect and improve the health and environment for all people in Hawaii.

Top 5 Priorities for State/Territorial Health Agency

1. Aligning behavioral health services to appropriate safety net
2. Finalizing contracts for new long term care facility
3. Protecting tobacco settlement money for prevention
4. Reorganizing agency for maximum efficiency, effectiveness
5. Modernizing IT – online services, electronic medical records

Structure and Relationship with Local Health Departments

The Hawaii Department of Health is a free-standing/ independent agency and has no local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 3

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

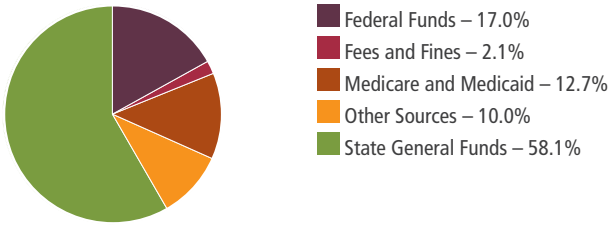
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

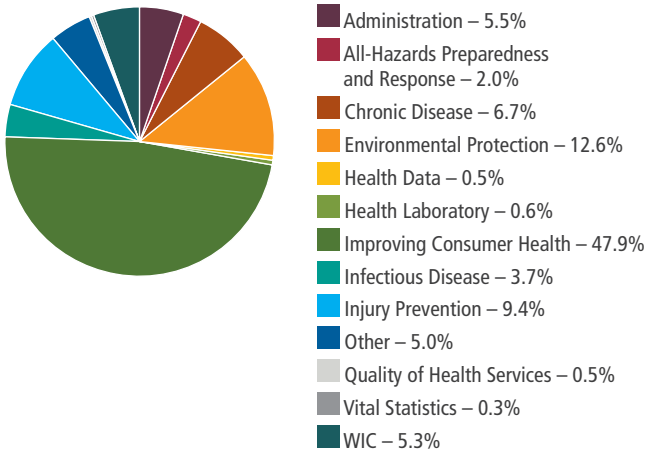
The state/territorial health agency has 2,677 full-time equivalents, including 431 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

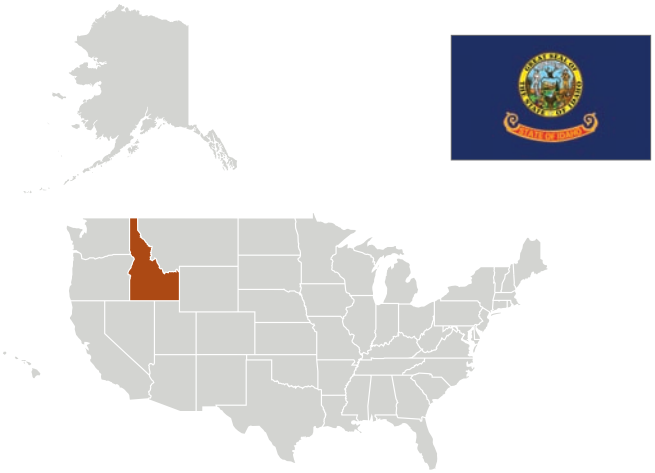


Total Expenditures FY08*: $785,404,649
Total Expenditures FY09**: $688,596,343

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Idaho

Idaho Department of Health and Welfare
Public Health Division



Agency Mission

Protect the health and safety of Idahoans.

Top 5 Priorities for State/Territorial Health Agency

1. Infectious disease prevention
2. Early detection of population protection measures
3. Data guided planning
4. Evidence based program planning
5. Health policy

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 7

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

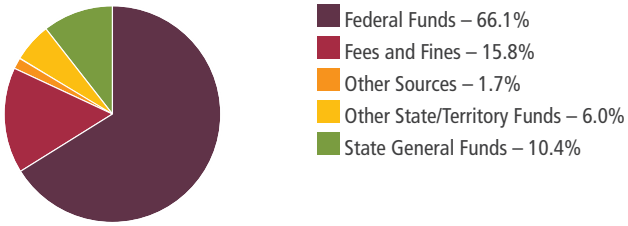
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

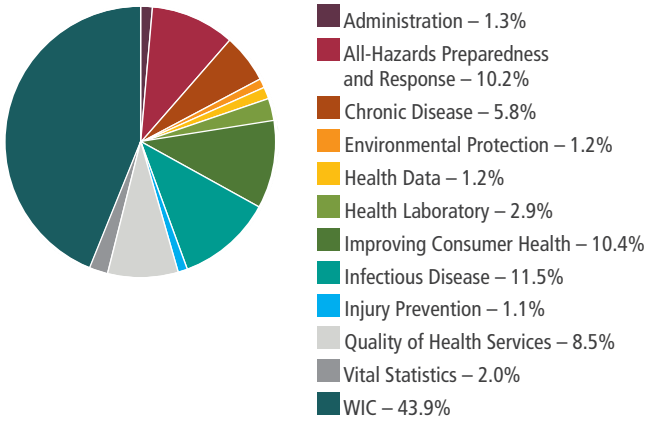
The state/territorial health agency has 206 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

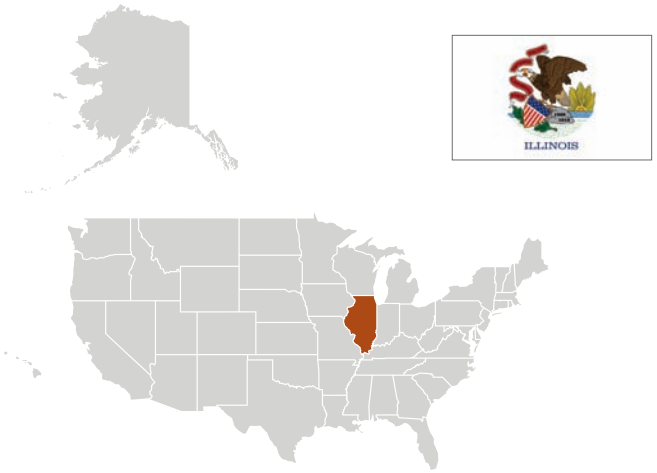


Total Expenditures FY08*: $81,190,888
Total Expenditures FY09**: $86,281,389

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Illinois

Illinois Department of Public Health



Agency Mission

To partner with the citizens and communities of Illinois to protect, promote and improve the health of all Illinoisans.

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 96

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

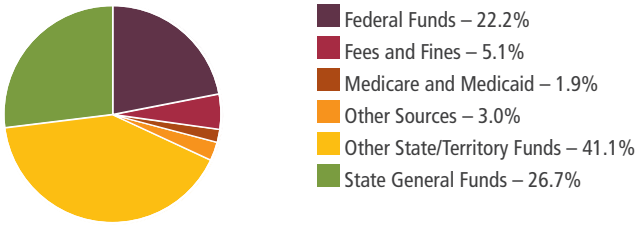
State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

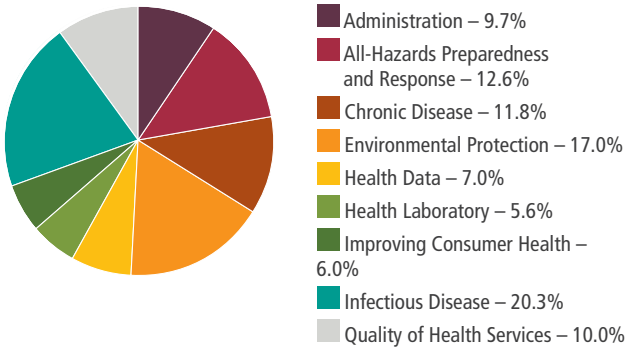
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

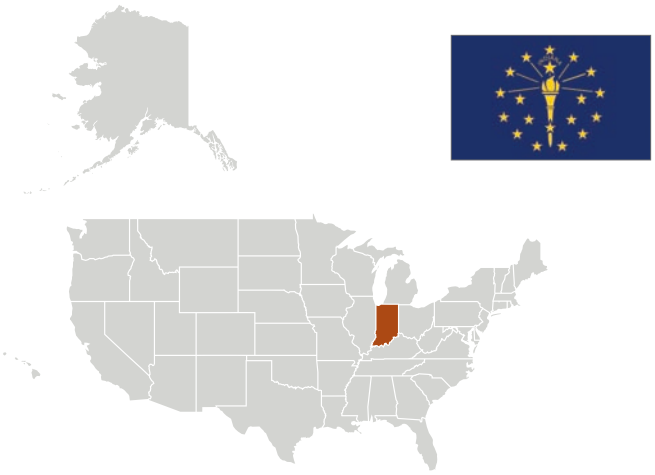


Total Expenditures FY08*: $359,275,000
Total Expenditures FY09**: $361,745,000

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Indiana

Indiana State Department of Health



Agency Mission

The Indiana State Department of Health supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities.

Top 5 Priorities for State/Territorial Health Agency

1. Health information exchange
2. Shared services
3. Trauma system development and injury prevention
4. Obesity rates
5. Tobacco cessation

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies
(led by local government staff): 93
Number of state-run local health agencies
(led by state government staff): 0
Number of independent regional or district offices
(led by nonstate employees): 0
Number of state-run regional or district offices
(led by state employees): 10 Preparedness Offices

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

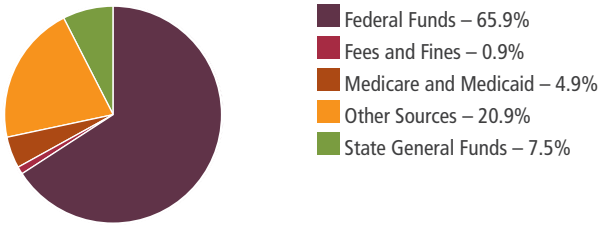
■	Health Assessment
■	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

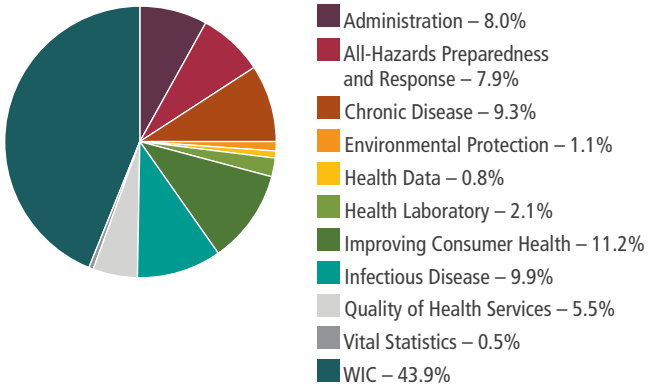
The state/territorial health agency has 833 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

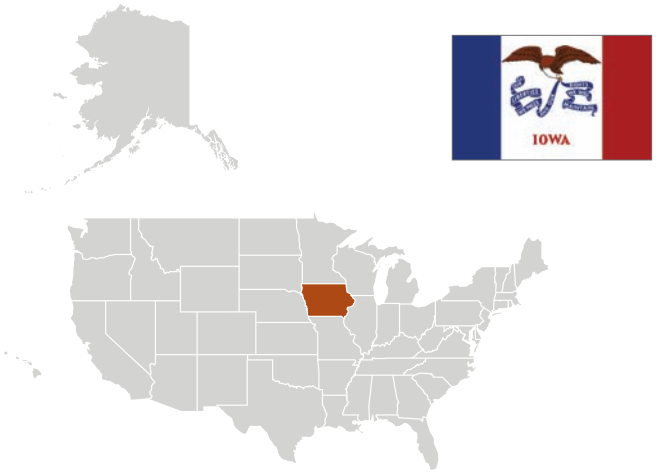


Total Expenditures FY08*: $327,913,342
Total Expenditures FY09**: $333,060,689

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Iowa

Iowa Department of Public Health



Agency Mission

Promote and protect the health of Iowans.

Top 4 Priorities for State/Territorial Health Agency

1. Wellness/obesity – prevention of chronic disease
2. Public Health Modernization Act
3. Preparedness
4. Co-occurring disorders (mental health/substance abuse)

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 101

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

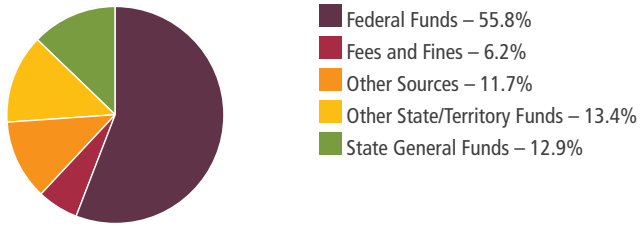
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

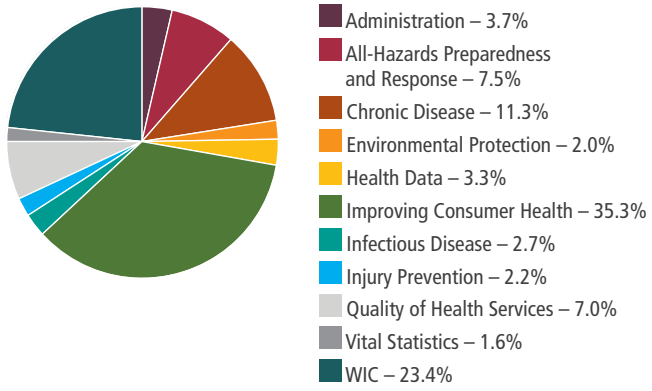
The state/territorial health agency has 502 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

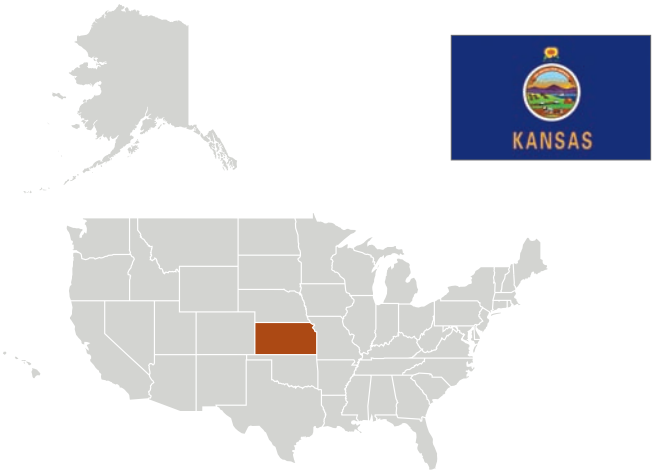


Total Expenditures FY08*: $196,430,563
Total Expenditures FY09**: $217,548,074

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Kansas

Kansas Department of Health and Environment



Agency Mission

To protect the health and environment of all Kansans by promoting responsible choices.

Top 5 Priorities for State/Territorial Health Agency

1. Focusing on population health in health reform
2. Obesity
3. Tobacco use
4. Developing environmental health capacity
5. Developing and maintaining strong epidemiological capacity

Structure and Relationship with Local Health Departments

The state health agency is a free standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 100

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 6

State Organizational Structure

The state health agency reports directly to the governor. The state does not have a state board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years

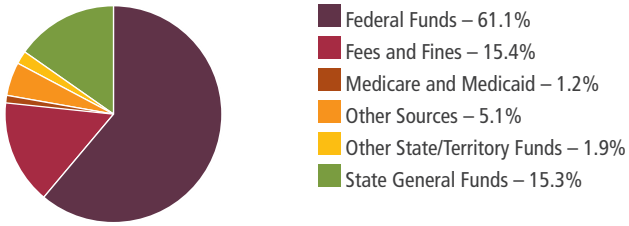
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

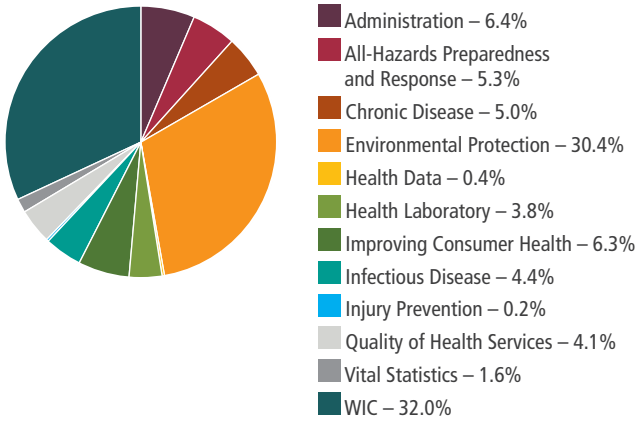
The state/territorial health agency has 260 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)



Total Expenditures FY08*: $210,989,474
Total Expenditures FY09**: $207,215,389

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Kentucky

Kentucky Department for Public Health

Agency Mission

To promote and protect the health and safety of Kentuckians through professional services.

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a shared relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 57

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

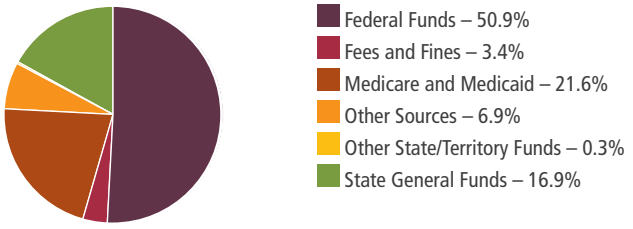
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

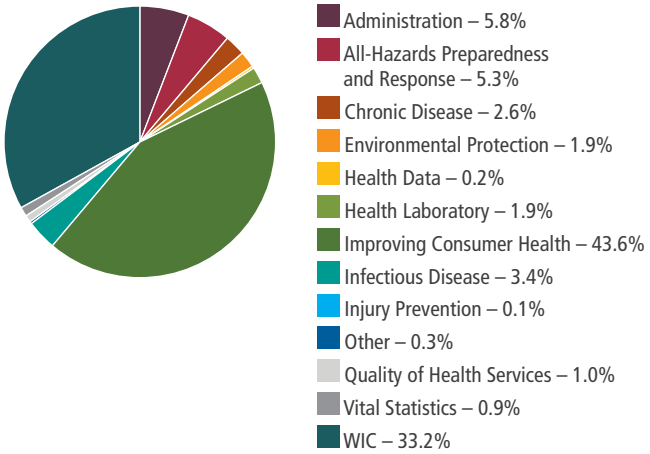
The state/territorial health agency has 431 full-time equivalents, including 27 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

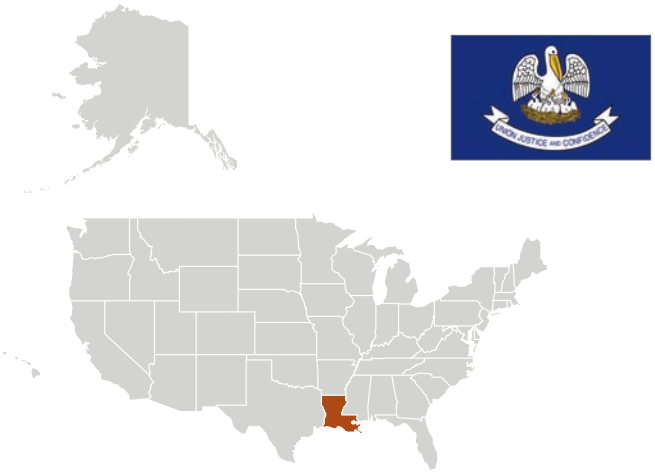


Total Expenditures FY08*: $366,060,747
Total Expenditures FY09**: $385,928,798

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Louisiana

Louisiana Department of Health and Hospitals
Office of Public Health



Agency Mission

The mission of the Office of Public Health is to promote health through education that emphasizes the importance of individual responsibility for health and wellness; enforce regulations that protect the environment and to investigate health hazards in the community; collect and distribute information vital to informed decision-making on matters related to individual, community, and environmental health; provide for leadership for the prevention and control of disease, injury, and disability in the state; provide assurance of essential preventive health care services for all citizens and a safety net for core public health services for the underserved.

Top 5 Priorities for State/Territorial Health Agency

1. Strategic planning
2. Winnable battles
3. Maternal and child health infant mortality reduction
4. Infectious disease control
5. Preventive health screenings

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a largely centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 2

Number of state-run regional or district offices

(led by state employees): 9

State Organizational Structure

The health agency does not report directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

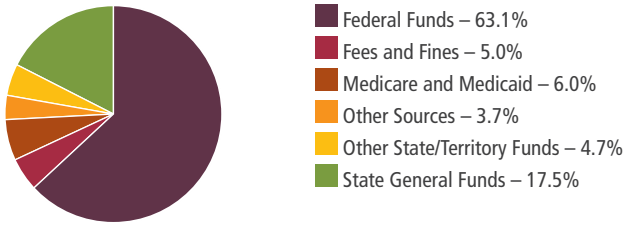
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

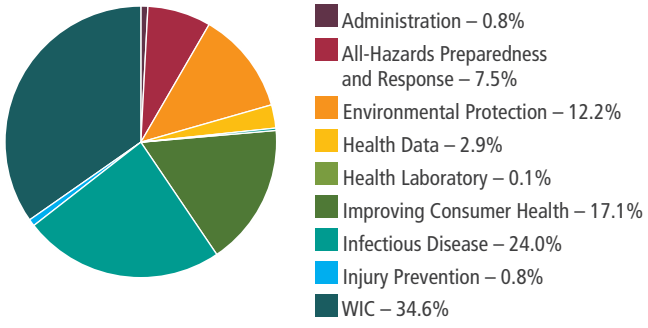
The state/territorial health agency has 1,778 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

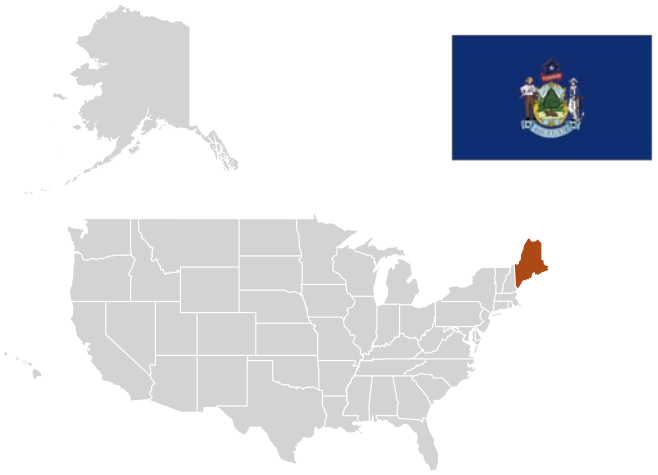


Total Expenditures FY08*: $308,005,213
Total Expenditures FY09**: $336,902,935

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Maine

Maine Center for Disease Control and Prevention



Agency Mission

Our mission at Maine Center for Disease Control and Prevention is to develop and deliver services to preserve, protect and promote the health and well-being of the citizens of Maine.

Top 5 Priorities for State/Territorial Health Agency

1. Provide leadership to assure healthy conditions where people live, work and play
2. Monitor the status of health and effectively communicate it
3. Provide expert, rapid response to health threats
4. Foster a culture of excellence in customer service
5. Put systems in place to assure fiscal accountability

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a mixed relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 1

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 8

State Organizational Structure

The health agency does not report directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

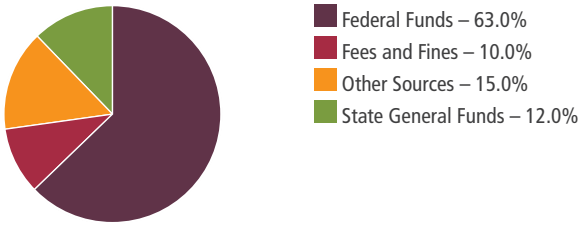
■	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

The state/territorial health agency has 424 full-time equivalents, including 183 state workers assigned to local/regional offices.

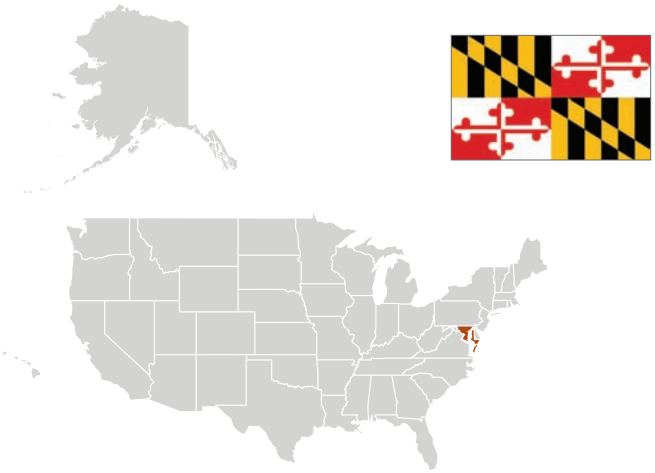
State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Maryland

Maryland Department of Health and Mental Hygiene



Agency Mission

The mission of the Maryland Department of Health and Mental Hygiene is to protect, promote and improve the health and well-being of all Maryland citizens in a fiscally responsible way.

Top 5 Priorities for State/Territorial Health Agency

1. Position Maryland's public health programs for health care reform
2. Leverage health information technology innovation
3. Enhance Maryland's public health capacity to reduce health disparities
4. Improve integration of and engagement between public health programs
5. Support the implementation of health reform in Maryland

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a largely shared relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 1

Number of state-run local health agencies

(led by state government staff): 23

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

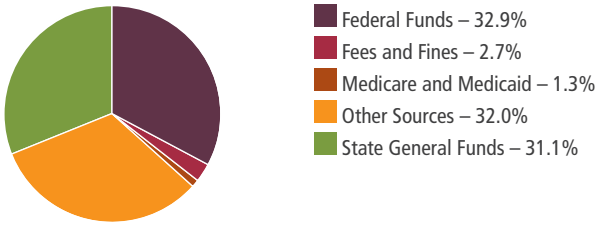
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

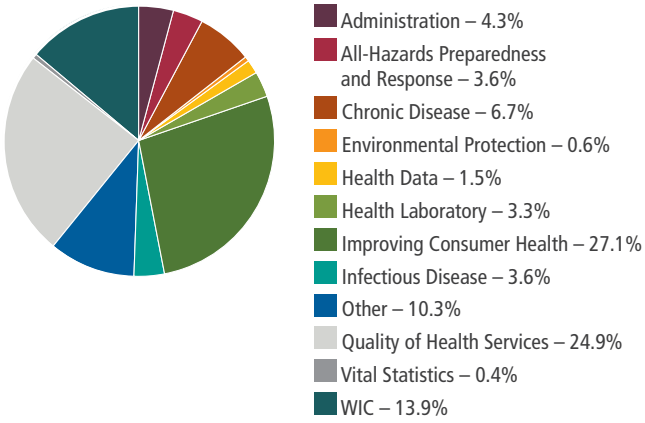
The state/territorial health agency has 9,054 full-time equivalents, including 3,553 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

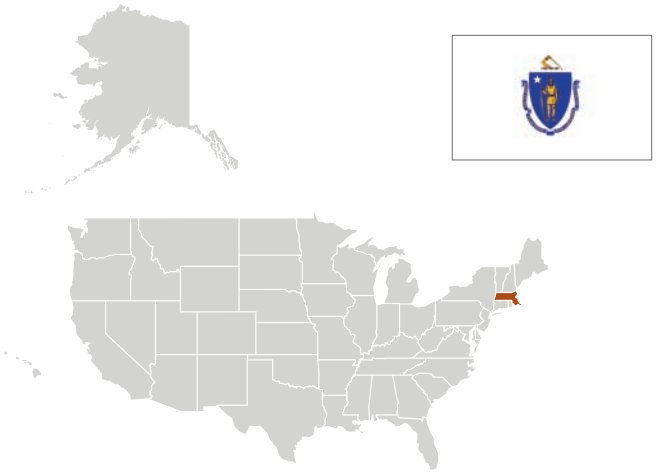


Total Expenditures FY08*: $658,456,342
Total Expenditures FY09**: $691,010,574

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Massachusetts

Massachusetts Department of Public Health



Agency Mission

We believe in the power of prevention. We work to help all people reach their full potential for health. We ensure that the people of the Commonwealth receive quality health care and live in a safe and healthy environment. We build partnerships to maximize access to affordable, high quality health care. We are especially dedicated to the health concerns of those most in need. We empower our communities to help themselves. We protect, preserve and improve the health of all the Commonwealth's residents.

Top 5 Priorities for State/Territorial Health Agency

1. Supporting successful implementation of health reform
2. Promoting wellness – in schools, communities, workplaces
3. Managing chronic disease
4. Eliminating health disparities
5. Strengthening state and local public health infrastructure

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 351

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 5

State Organizational Structure

The health agency does not report directly to the governor. The state has a public health council, which is similar to a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

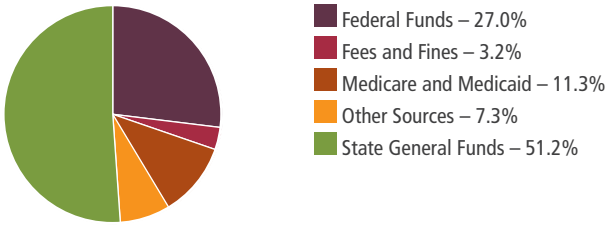
■	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

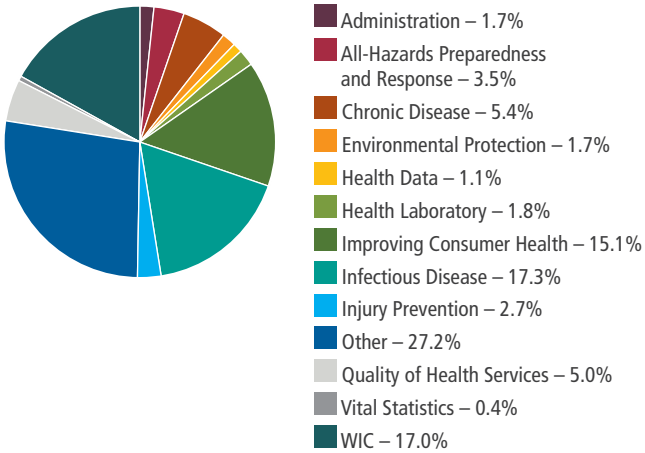
The state/territorial health agency has 2,902 full-time equivalents, including 180 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

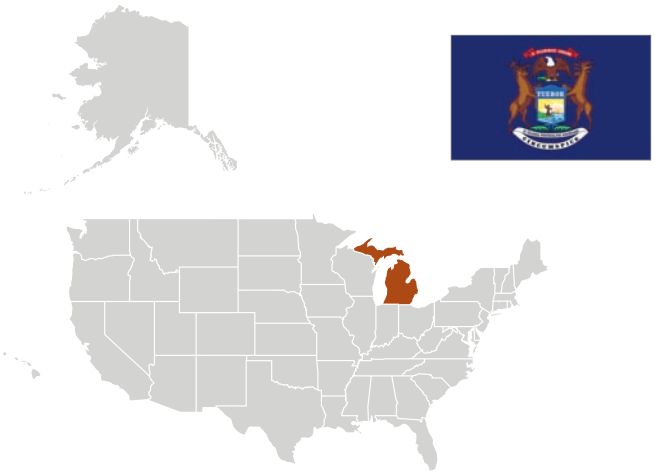


Total Expenditures FY08*: $734,903,320
Total Expenditures FY09**: $741,584,609

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Michigan

Michigan Department of Community Health



Agency Mission

Michigan Department of Community Health will protect, preserve and promote the health and safety of the people of Michigan with particular attention to providing for the needs of vulnerable and underserved populations.

Top 5 Priorities for State/Territorial Health Agency

1. Reducing health disparities
2. Reducing causes of chronic diseases
3. Primary care initiative – chronic disease care and management
4. Biotrust – repository of newborn screening bloodspots
5. Oversight of state/local public health services during recession

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 45

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

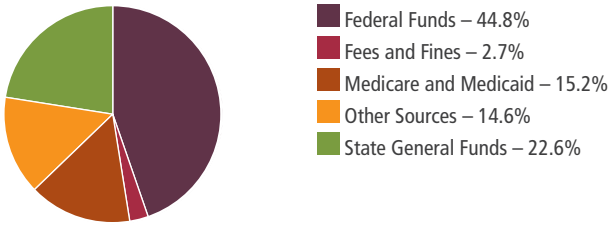
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

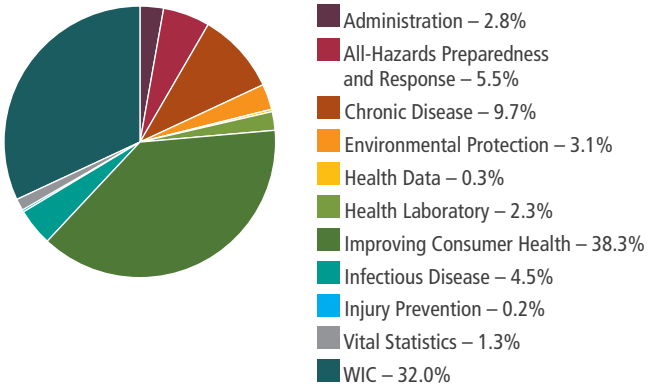
The state/territorial health agency has 535 full-time equivalents, including 23 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

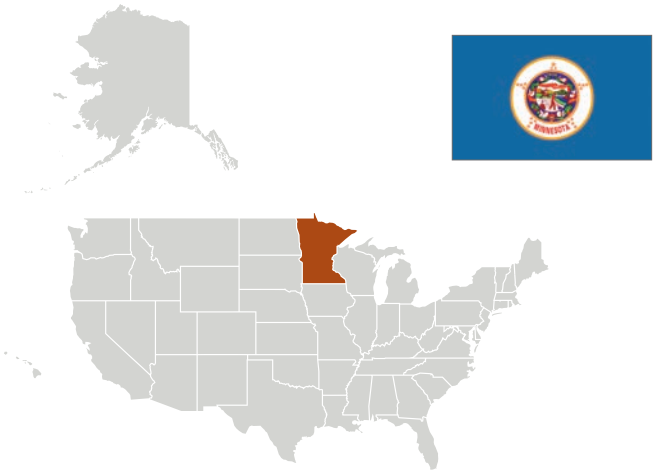


Total Expenditures FY08*: $670,707,900
Total Expenditures FY09**: $693,644,200

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Minnesota

Minnesota Department of Health



Agency Mission

Protect, maintain and improve the health of all Minnesotans.

Top 5 Priorities for State/Territorial Health Agency

1. Budget reductions
2. H1N1 response
3. Health reform
4. Obesity
5. Public health accreditation

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 52

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 8

State Organizational Structure

The health agency reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

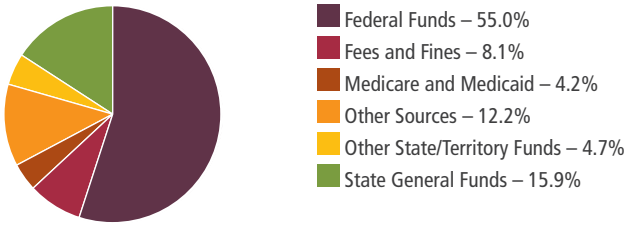
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

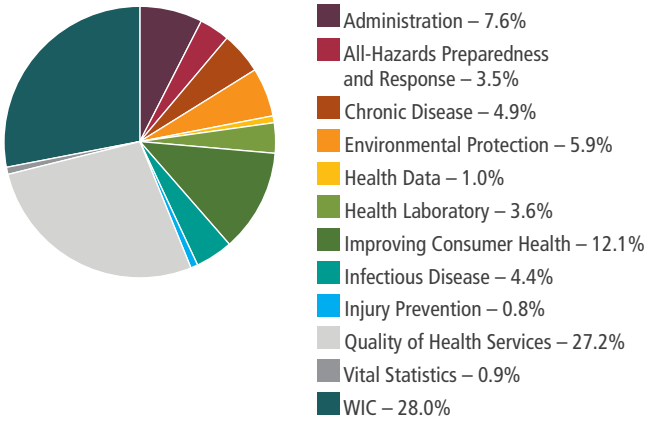
The state/territorial health agency has 1,414 full-time equivalents, including 201 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

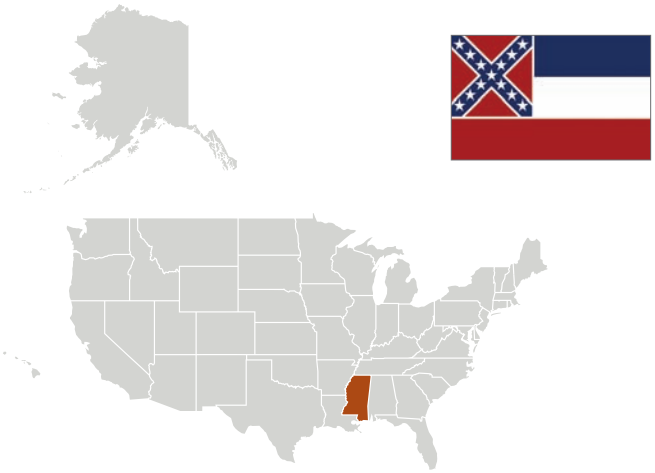


Total Expenditures FY08*: $445,158,440
Total Expenditures FY09**: $450,858,580

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Mississippi

Mississippi State Department of Health



Agency Mission

The Mississippi State Department of Health's mission is to promote and protect the health of the citizens of Mississippi.

Top 5 Priorities for State/Territorial Health Agency

1. Infant mortality
2. TB
3. HIV/STD
4. Chronic disease implemented locally
5. Immunizations

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 81

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 9

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

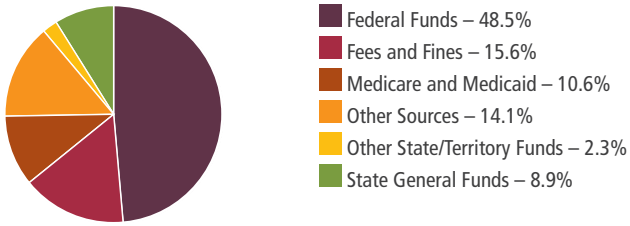
■	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

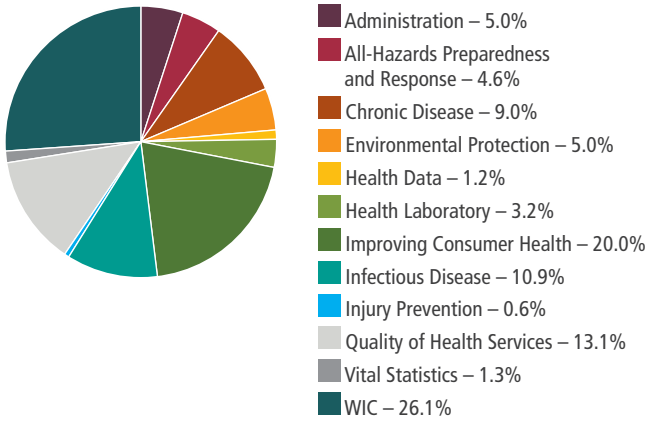
The state/territorial health agency has 2,389 full-time equivalents, including 1,474 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

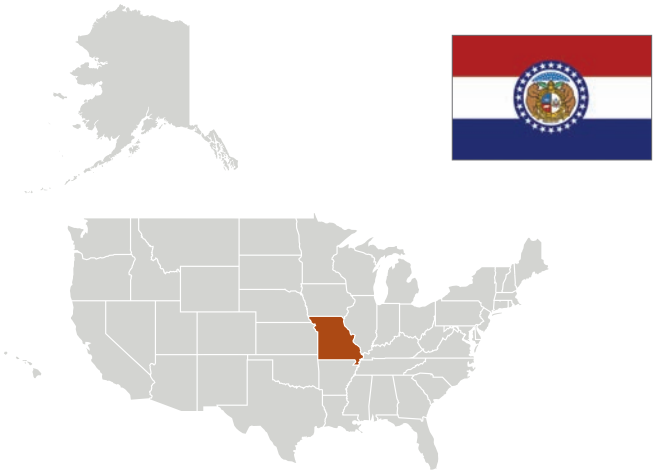


Total Expenditures FY08*: $299,683,056
Total Expenditures FY09**: $324,214,496

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Missouri

Missouri Department of Health and Senior Services



Agency Mission

To be the leader in promoting, protecting and partnering for health.

Top 5 Priorities for State/Territorial Health Agency

1. Enhance prevention and wellness efforts by targeting areas most likely to improve population health and reduce disparities while supporting resource allocation decisions with a solid base of evidence
2. Systematically increase Missouri's performance management and quality improvement capacity to ensure that public health goals are achieved with maximum efficiency and effectiveness
3. Increase community health through the reduction of individual and environmental risk factors
4. Promote health education, engagement and interaction through targeted communication and data dissemination while assuring meaningful use of public health data in health information exchanges
5. Ensure a systems approach to health and wellness in Missouri by identifying and integrating parallel efforts throughout the public health, aging and regulatory continuum in the state

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 115

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

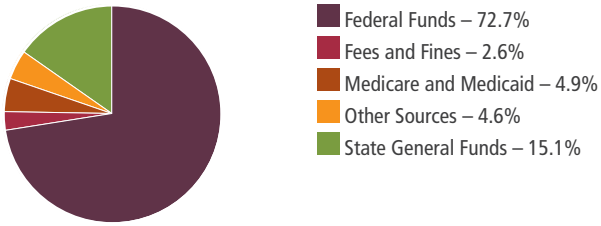
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

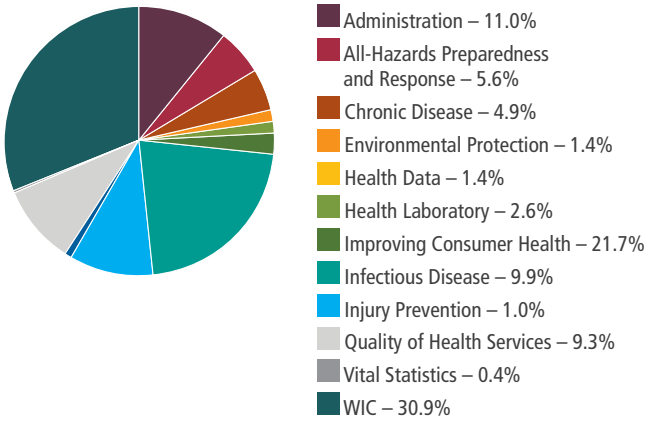
The state/territorial health agency has 1,803 full-time equivalents, including 760 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

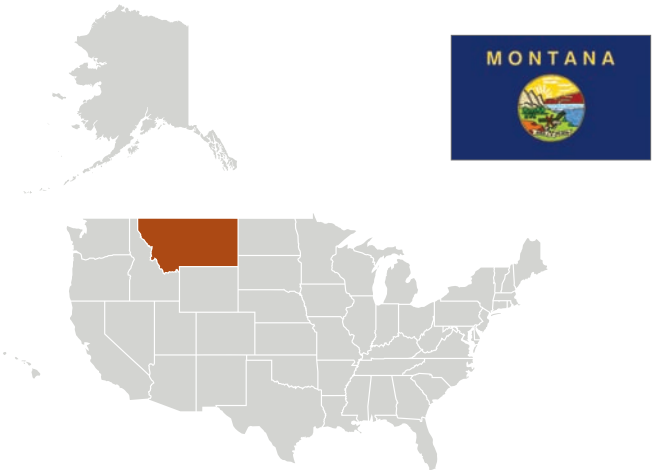


Total Expenditures FY08*: $364,148,290
Total Expenditures FY09**: $386,669,336

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Montana

Montana Department of Public Health and Human Services



Agency Mission

Our mission is to improve and protect the health, well-being and self-reliance of all Montanans.

Top 5 Priorities for State/Territorial Health Agency

1. Meet increasing demands with declining resources
2. Improve communication
3. Enhance and develop the workforce
4. Achieve operational efficiencies
5. Enhance health information technology

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 48 local county health agencies; 7 local tribal health agencies

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 2

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

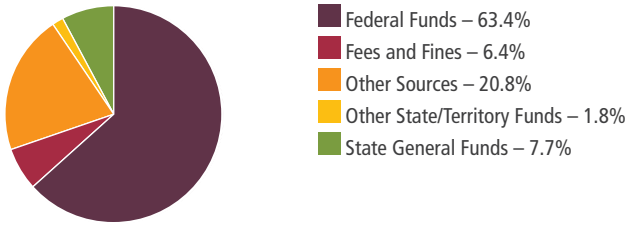
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

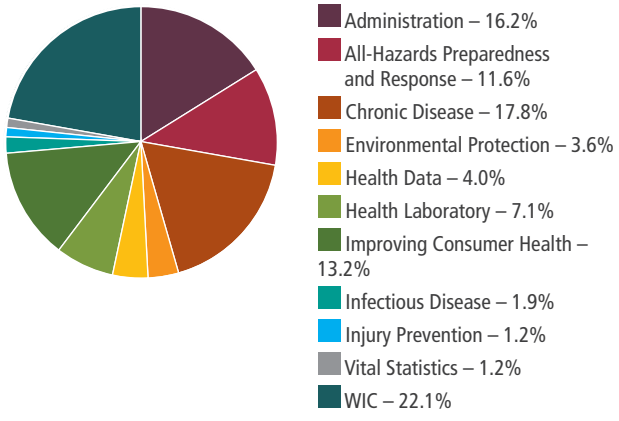
The state/territorial health agency has 199 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

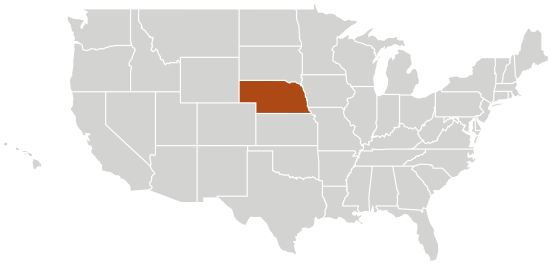


Total Expenditures FY08*: $61,581,797
Total Expenditures FY09**: $61,524,332

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Nebraska

Nebraska Department of Health and Human Services
Division of Public Health



Agency Mission

We help Nebraskans live better lives through effective public health assessment, planning, policy development and intervention.

Top 5 Priorities for State/Territorial Health Agency

1. Address health disparities
2. Create a culture of wellness
3. Become a trusted source of state health data
4. Devise a media and education plan
5. Provide budget transparency

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 25

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

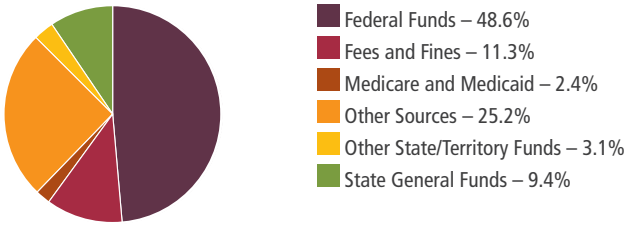
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

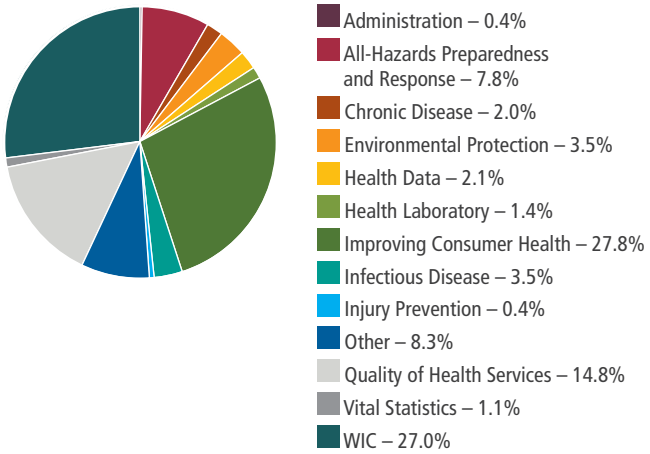
The state/territorial health agency has 469 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

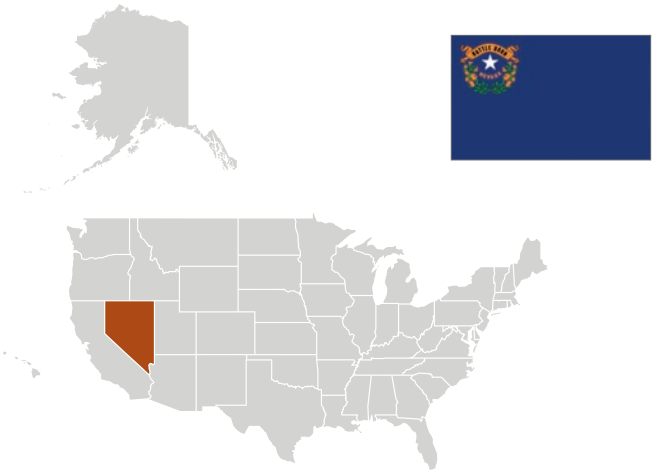


Total Expenditures FY08*: $145,161,726
Total Expenditures FY09**: $145,756,384

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Nevada

Nevada Department of Health and Human Services
Nevada State Health Division



Agency Mission

The Health Division shall take such measures as may be necessary to prevent the spread of sickness and disease, and shall possess all powers necessary to fulfill the duties and exercise the authority prescribed by law and to bring actions in the courts for the enforcement of all health laws and lawful rules and regulations.

Top 5 Priorities for State/Territorial Health Agency

1. Hospital acquired infection
2. Budget
3. Fitness and wellness
4. Obesity
5. Tobacco

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a largely decentralized relationship with local health departments.

Number of independent local health agencies
(led by local government staff): 12
Number of state-run local health agencies
(led by state government staff): 0
Number of independent regional or district offices
(led by nonstate employees): 3
Number of state-run regional or district offices
(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

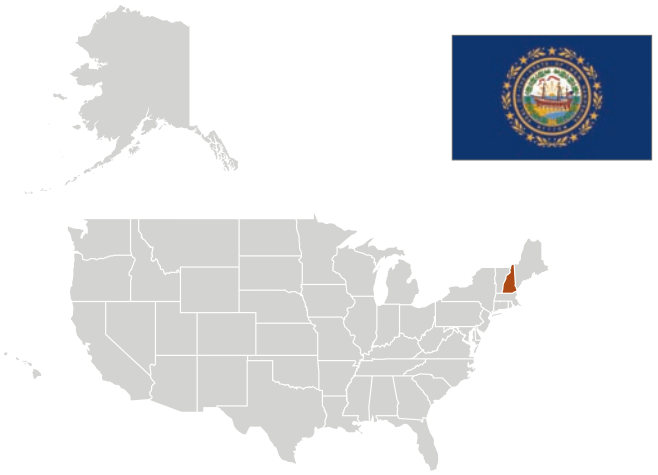
State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

	Health Assessment
	Health Improvement Plan
	Strategic Plan

New Hampshire

New Hampshire Department of Health and Human Services
Division of Public Health Services



Agency Mission

The New Hampshire Division of Public Health Services is committed to being a responsive, expert leadership organization that promotes optimal health and well-being for all people in New Hampshire and protects them from illness and injury.

Top 5 Priorities for State/Territorial Health Agency

1. Strengthen approaches to population health
2. Focus on chronic disease prevention, diagnosis, treatment/intervention
3. Develop and implement a public health management system
4. Improve effectiveness and resource allocation
5. Develop and implement a health message strategy

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a largely centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 5

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

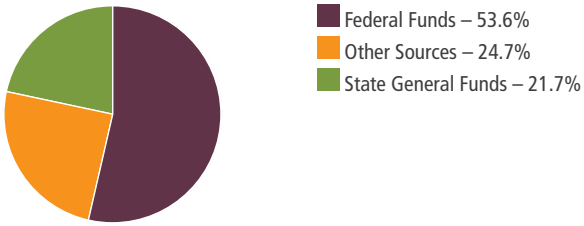
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

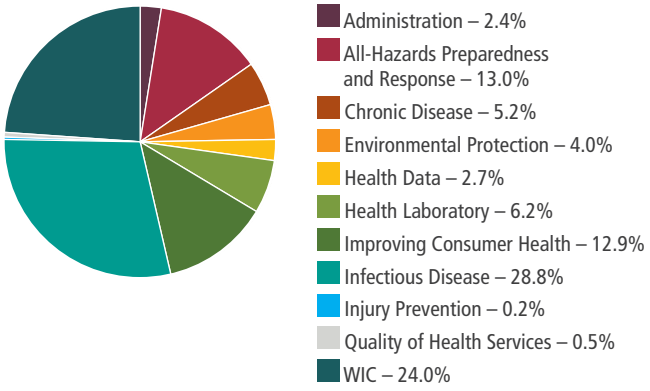
The state/territorial health agency has 249 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

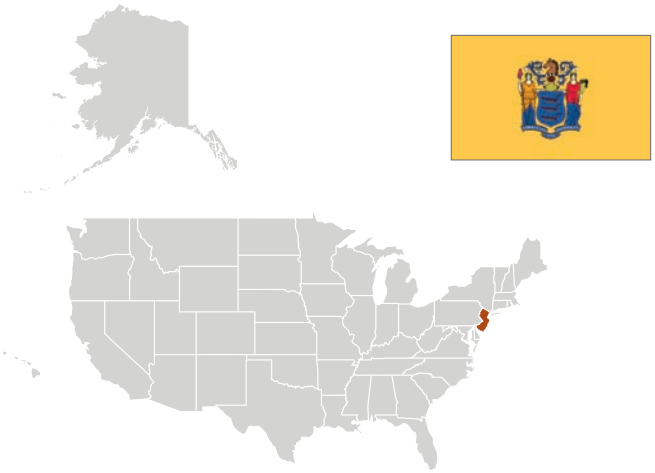


Total Expenditures FY08*: $77,500,699
Total Expenditures FY09**: $75,007,890

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

New Jersey

New Jersey Department of Health and Senior Services



Agency Mission

Our mission is to foster accessible and high-quality health and senior services to help all people in New Jersey achieve optimal health, dignity and independence. We work to prevent disease, promote and protect well-being at all life stages and encourage informed choices that enrich quality of life for individuals and communities.

Top 5 Priorities for State/Territorial Health Agency

1. Funding for mandated services
2. Staff resources
3. Ability to complete accurate data entry
4. Public health infrastructure
5. State and federal grant availability

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 114

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 20

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

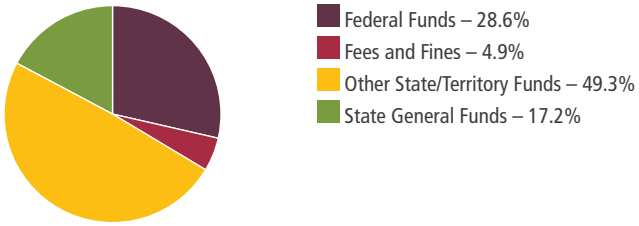
■	Health Assessment
■	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

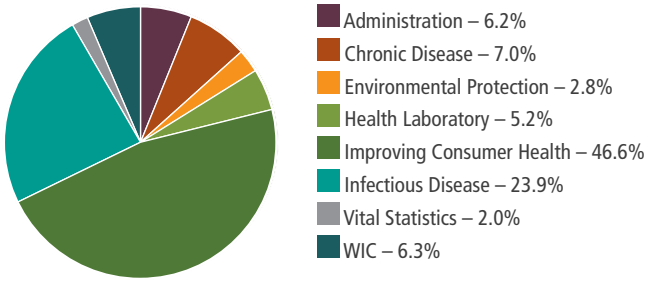
The state/territorial health agency has 1,762 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

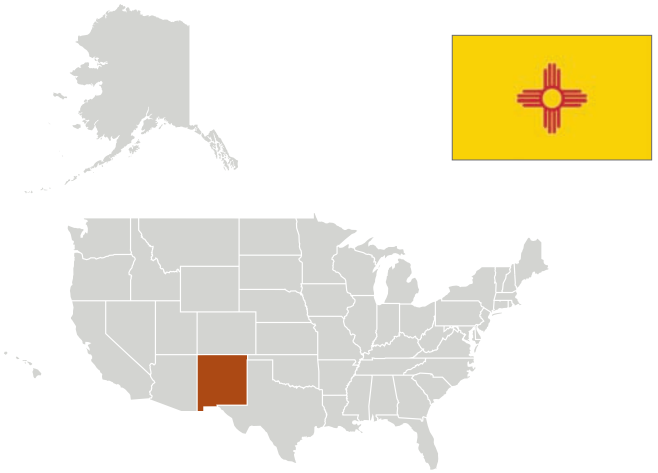


Total Expenditures FY08*: $230,319,505
Total Expenditures FY09**: $253,019,297

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

New Mexico

New Mexico Department of Health



Agency Mission

The mission of the Department of Health is to promote health and sound health policy, prevent disease and disability, improve health services systems and assure that essential public health functions and safety net services are available to New Mexicans.

Top 5 Priorities for State/Territorial Health Agency

1. Protect the health of the public
2. Prepare for and address public health emergencies
3. Sustain essential public health services with budget/staff cuts
4. Plan and partner to assure success of health care reform in New Mexico
5. Absorb additional cuts by reprioritizing as full-time equivalents as necessary

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 34

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 4

State Organizational Structure

The state health official reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

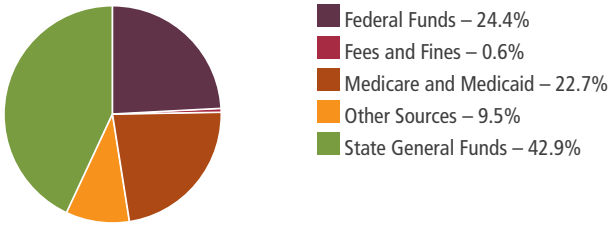
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

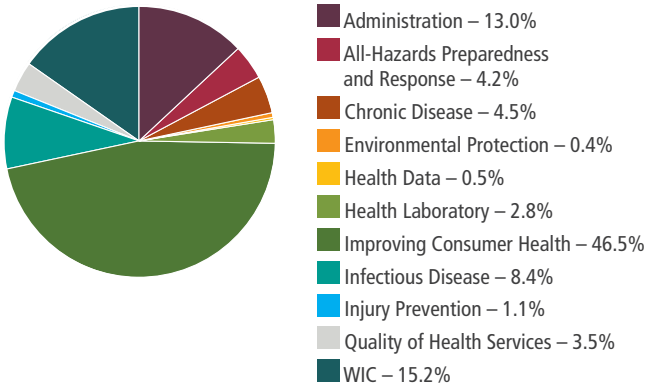
The state/territorial health agency has 4,032 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

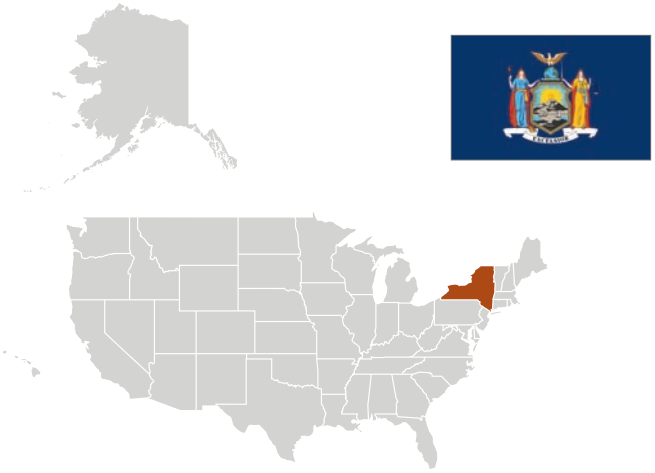


Total Expenditures FY08*: $406,230,575
Total Expenditures FY09**: $400,092,427

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

New York

New York State Department of Health



Agency Mission

The New York State Department of Health protects and promotes the health of the people of New York by preventing and reducing threats to public health and by assuring access to affordable, high-quality health services.

Top 5 Priorities for State/Territorial Health Agency

1. Obesity prevention
2. Tobacco prevention and control
3. Protecting human health in our environment
4. HIV/AIDS prevention
5. Health care reform

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 58

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 13

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

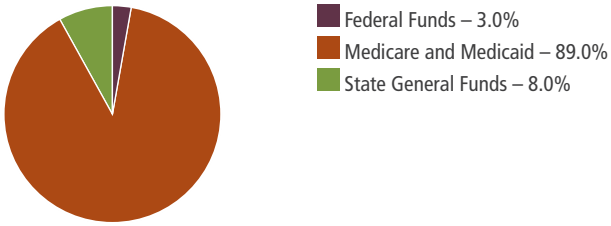
■	Health Assessment
■	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

The state/territorial health agency has 3,864 full-time equivalents, including 956 state workers assigned to local/regional offices.

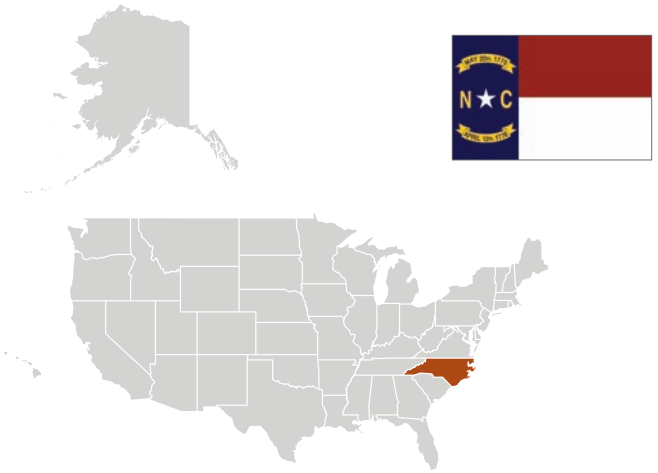
State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



North Carolina

North Carolina Department of Health and Human Services
Division of Public Health



Agency Mission

The general assembly declares that the mission of the public health system is to promote and contribute to the highest level of health possible for the people of North Carolina by preventing health risks and disease; identifying and reducing health risks in the community; detecting, investigating, and preventing the spread of disease; promoting healthy lifestyles; promoting a safe and healthful environment; promoting the availability and accessibility of quality health care services through the private sector; and providing quality health care services when not otherwise available.

Top 5 Priorities for State/Territorial Health Agency

1. Reduce chronic diseases and prevent obesity
2. Public health preparedness
3. Quality improvement
4. Strengthen core public health
5. Healthy children and families

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 85

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 6

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

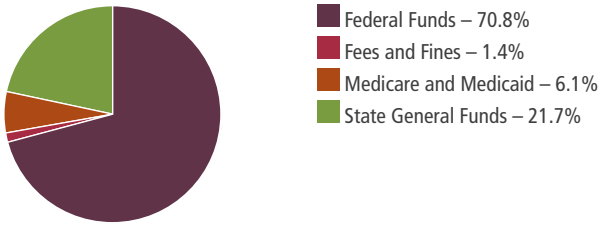
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

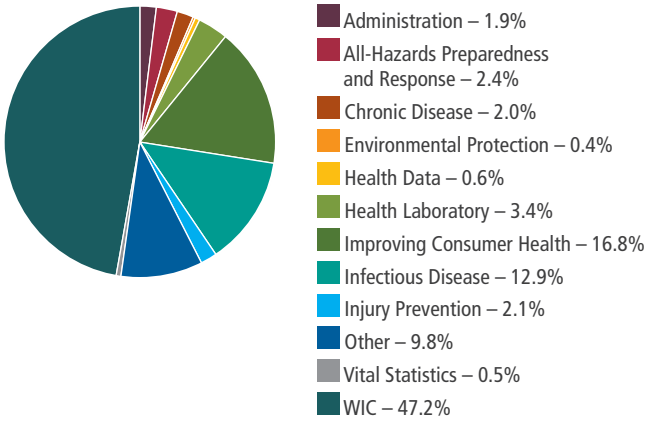
The state/territorial health agency has 1,850 full-time equivalents, including 920 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

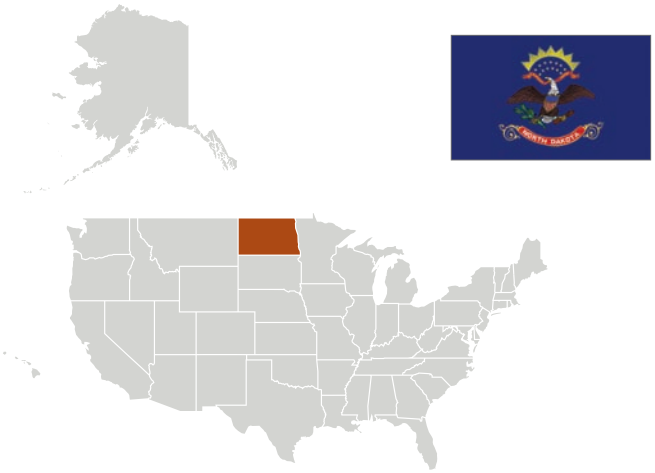


Total Expenditures FY08*: $699,430,875
Total Expenditures FY09**: $720,401,593

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

North Dakota

North Dakota Department of Health



Agency Mission

Protect and enhance the health and safety of all North Dakotans and the environment in which we live.

Top 5 Priorities for State/Territorial Health Agency

1. Address environmental and public health effects of increased energy development in western North Dakota
2. Adjust to new federal funding scenarios for public health, including health reform
3. Implement and monitor the effects of new immunization funding legislation
4. Improve rural health by further developing the emergency medical services system
5. Establish a statewide call-a-nurse system

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 28

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 8

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

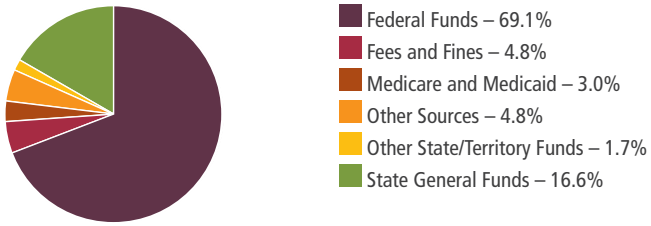
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

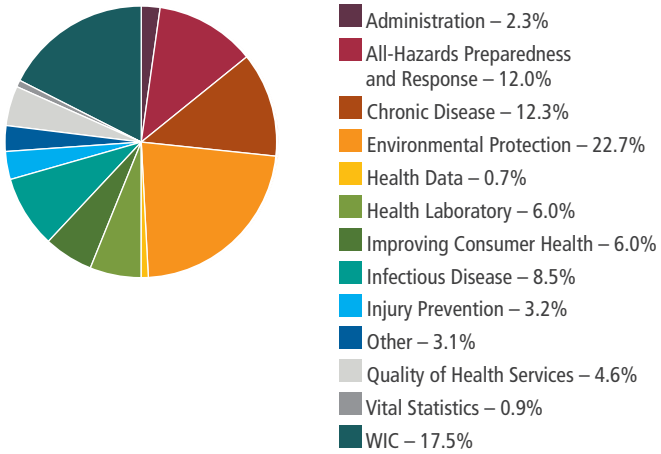
The state/territorial health agency has 335 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

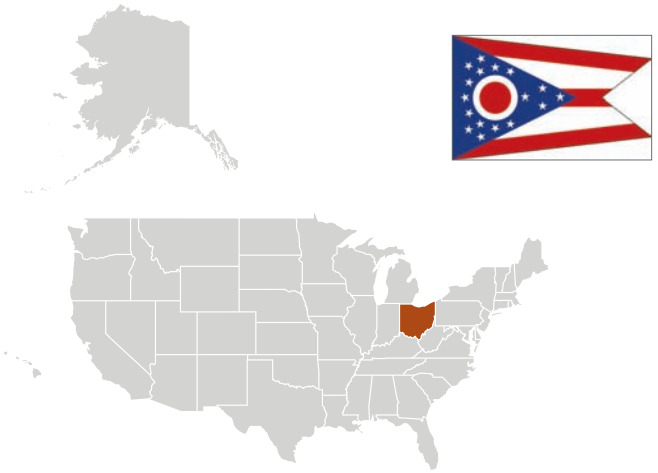


Total Expenditures FY08*: $65,776,649
Total Expenditures FY09**: $71,676,997

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Ohio

Ohio Department of Health



Agency Mission

To protect and improve the health of all Ohioans.

Top 5 Priorities for State/Territorial Health Agency

1. Protect health of Ohioans: public health preparedness, infection control, radiation
2. Protection, alcohol testing
3. Improve health of all Ohioans: diabetes, child and family services
4. Cardiovascular disease
5. Assure access to quality health care: oral health, long-term care

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 127

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 4

State Organizational Structure

The health agency reports directly to the governor.
The state has a public health council, which is limited to enacting rules specified by statute.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

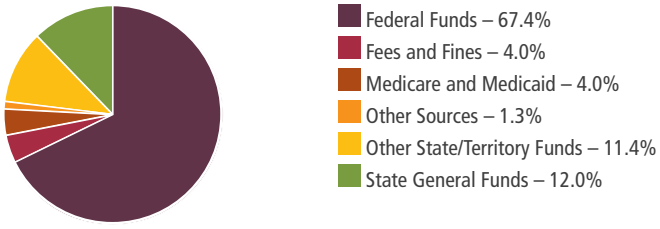
■	Health Assessment
	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

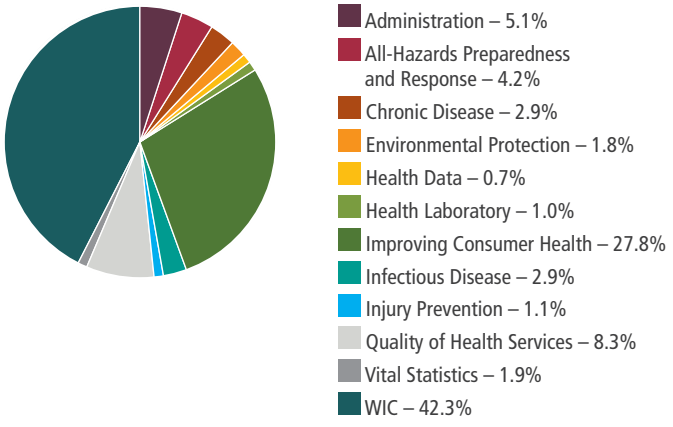
The state/territorial health agency has 1,196 full-time equivalents, including 245 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

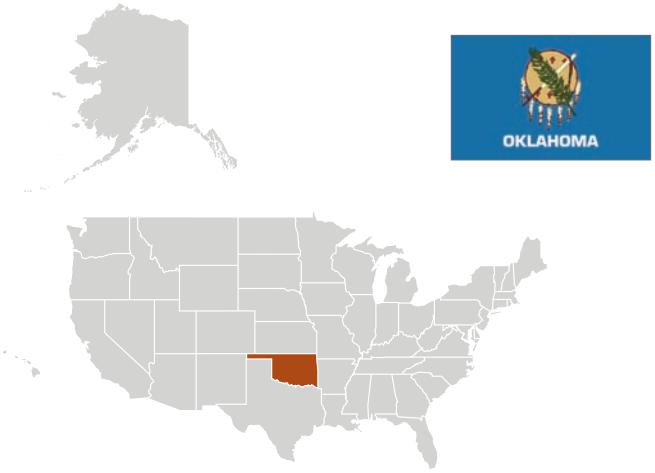


Total Expenditures FY08*: $621,294,323
Total Expenditures FY09**: $621,479,046

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Oklahoma

Oklahoma State Department of Health



Agency Mission

To protect and promote health of the citizens of Oklahoma, to prevent disease and injury, and to assure the conditions by which our citizens can be healthy.

Top 5 Priorities for State/Territorial Health Agency

1. Tobacco, obesity, cardiovascular disease
2. Children's health (including infant mortality and prenatal care)
3. Disease prevention (preventable hospitalizations, immunization, occupational deaths)
4. Mandates (inspection, disease control, sanitation)
5. Emergency preparedness

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a mixed relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 2

Number of state-run local health agencies

(led by state government staff): 68

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

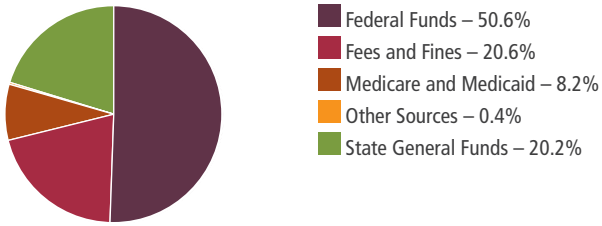
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

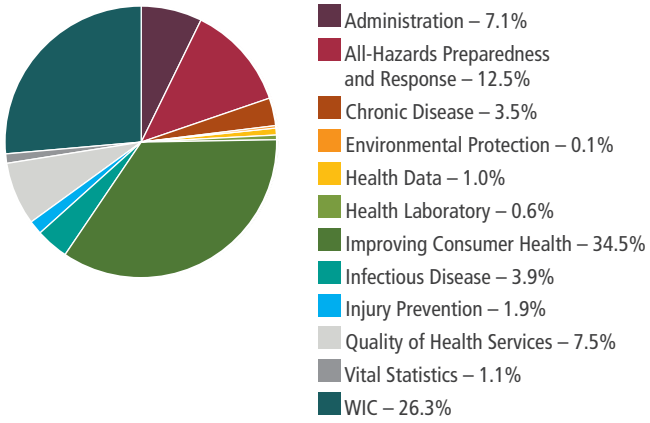
The state/territorial health agency has 2,101 full-time equivalents, including 1,202 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

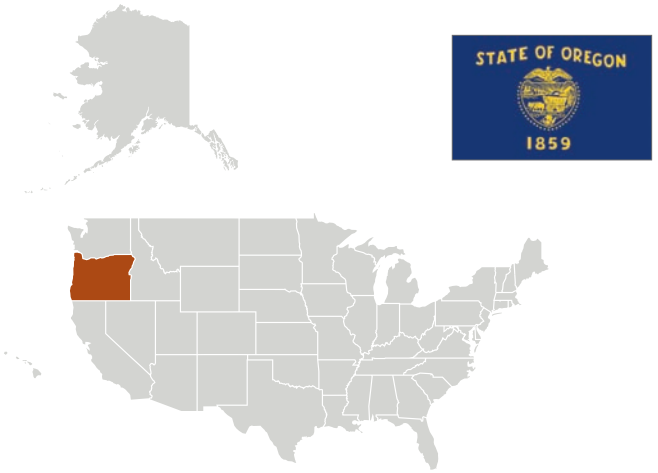


Total Expenditures FY08*: $353,617,579
Total Expenditures FY09**: $346,560,074

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Oregon

Oregon Health Authority
Public Health Division



Agency Mission

To protect and promote the health of all the people of Oregon.

Top 5 Priorities for State/Territorial Health Agency

1. Funding for obesity prevention and wellness
2. Tobacco prevention and education
3. Environmental health, including climate change
4. Injury prevention
5. Overall public health system capacity at state and local level

Structure and Relationship with Local Health Departments

The health agency is part of a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 34

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The division does not report directly to the governor. Although Oregon does not have a board of health, the Oregon Health Policy Board and the Oregon Public Health Advisory Board carry out some oversight and advisory functions that typically would be provided by a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

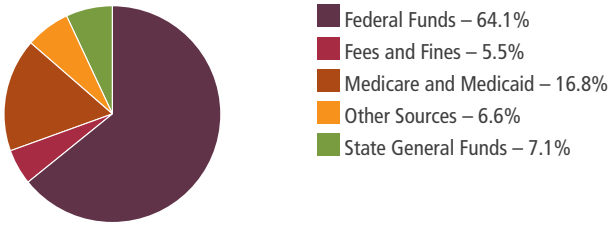
	Health Assessment
■	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

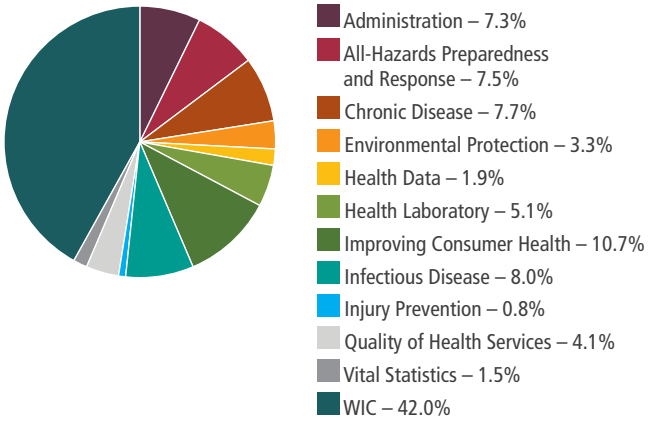
The state/territorial health agency has 680 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

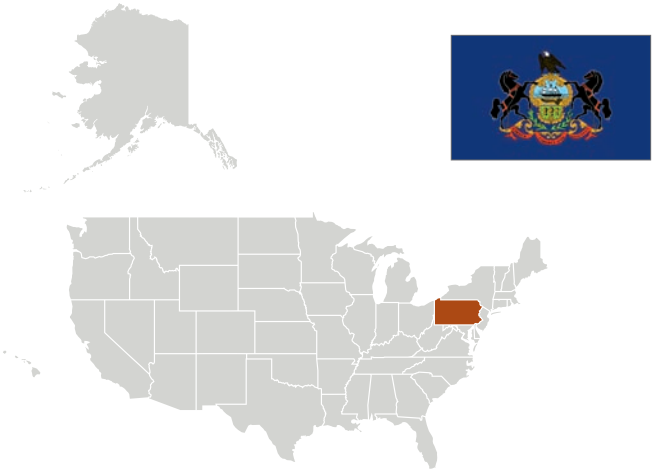


Total Expenditures FY08*: $204,382,291
Total Expenditures FY09**: $206,682,619

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Pennsylvania

Pennsylvania Department of Health



Agency Mission

The Department's mission is to promote healthy lifestyles, prevent injury and disease and to assure the safe delivery of quality health care for all Commonwealth citizens.

Top 5 Priorities for State/Territorial Health Agency

1. Monitoring the state's population's health
2. Health system reform
3. Assuring preparedness for a health emergency
4. Using data guided planning
5. Developing effective health policy

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a mixed relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 10

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 6

State Organizational Structure

The health agency reports directly to the governor. The state has a health policy board.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

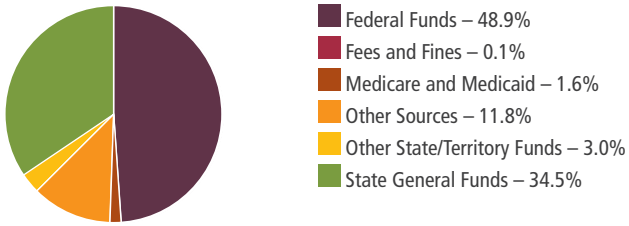
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

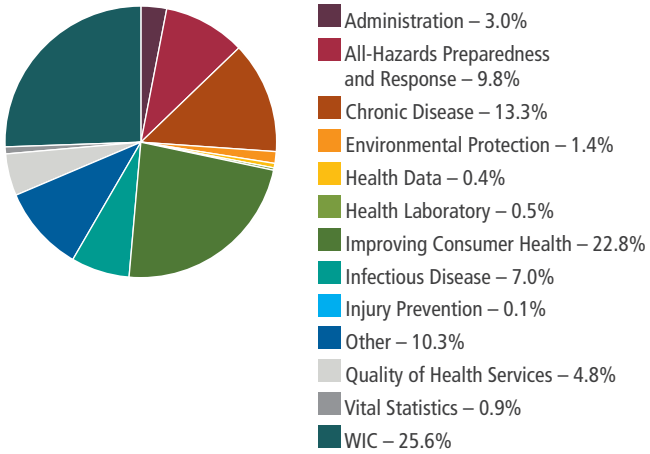
The state/territorial health agency has 1,336 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

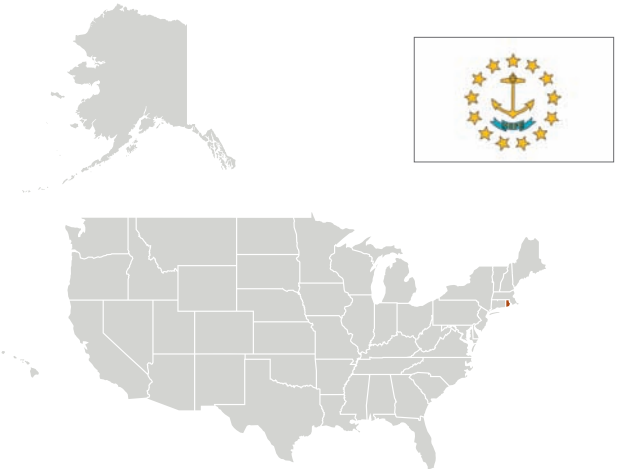


Total Expenditures FY08*: $854,509,000
Total Expenditures FY09**: $880,868,000

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Rhode Island

Rhode Island Department of Health



Agency Mission

The department of health shall take cognizance of the interests of life and health among the peoples of the state, shall make investigations into the causes of disease, the prevalence of epidemics and endemics among the people, the sources of mortality, the effect of localities, employments and all other conditions and circumstances on the public health, and do all in its power to ascertain the causes and the best means for the prevention and control of diseases or conditions detrimental to the public health, and adopt proper and expedient measures to prevent and control diseases and conditions detrimental to the public health in the state.

Top 5 Priorities for State/Territorial Health Agency

1. Improve primary care
2. Transform from *sick care* to *well-care*
3. Create an environment where it is easy to do what is healthy
4. Improve agency and staff communications
5. Improve quality of care and reduce medical errors

Structure and Relationship with Local Health Departments

The Rhode Island Department of Health is a free-standing/independent agency and has no local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor.
The health agency does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

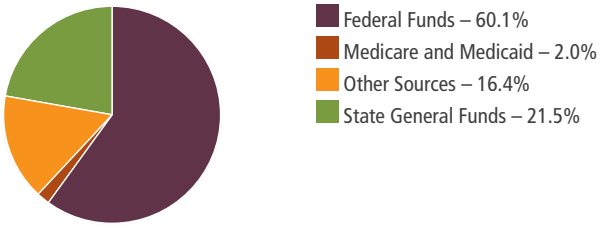
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

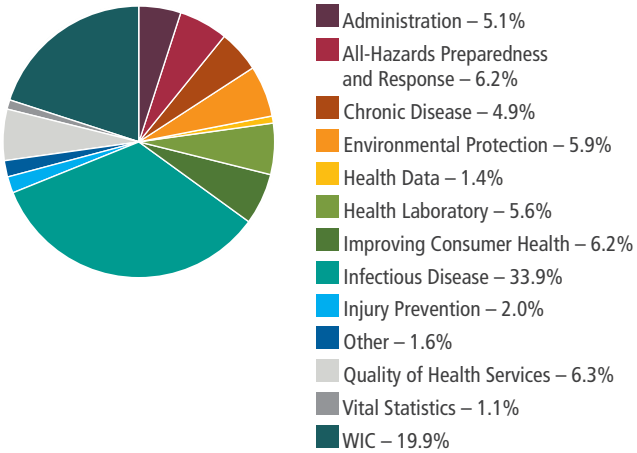
The state/territorial health agency has 365 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)



Total Expenditures FY08*: $126,755,012
Total Expenditures FY09**: $122,192,176

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

South Carolina

South Carolina Department of Health and Environmental Control

Agency Mission

We promote and protect the health of the public and the environment.

Top 5 Priorities for State/Territorial Health Agency

1. Infectious disease prevention
2. Water/food/air protection
3. Chronic disease prevention
4. Public health preparedness and response
5. Assuring the provision of local public health services

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 46

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 8

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

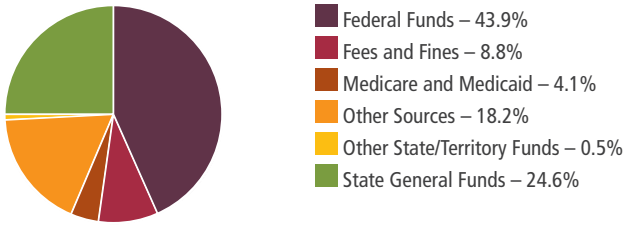
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

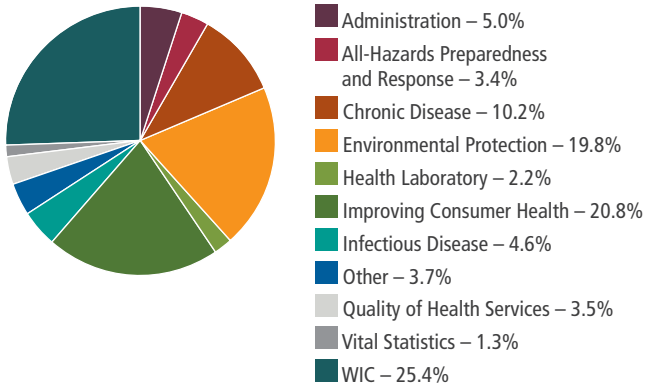
The state/territorial health agency has 3,735 full-time equivalents, including 2,159 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

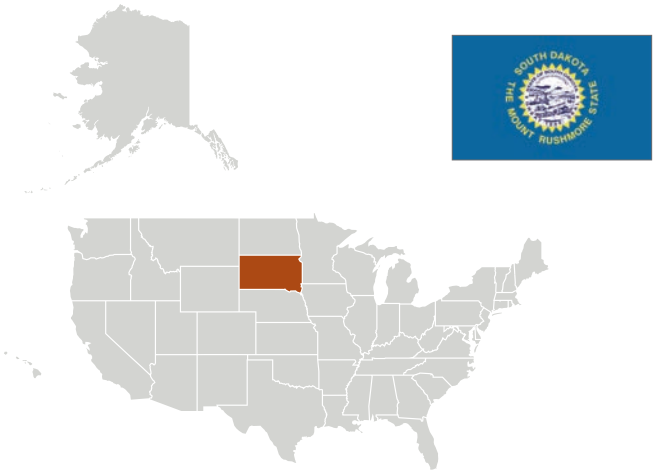


Total Expenditures FY08*: $531,487,774
Total Expenditures FY09**: $534,549,970

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

South Dakota

South Dakota Department of Health



Agency Mission

The mission of the South Dakota Department of Health is to promote, protect and improve the health and well-being of all South Dakotans.

Top 4 Priorities for State/Territorial Health Agency

1. Improve birth outcomes and health of infants, children and adolescents
2. Strengthen health care delivery system
3. Improve the health behaviors to reduce chronic disease
4. Strengthen response to current and emerging public health threats

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a largely centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 1

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 7

State Organizational Structure

The health agency reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

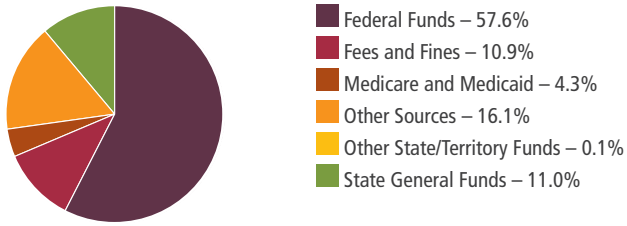
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

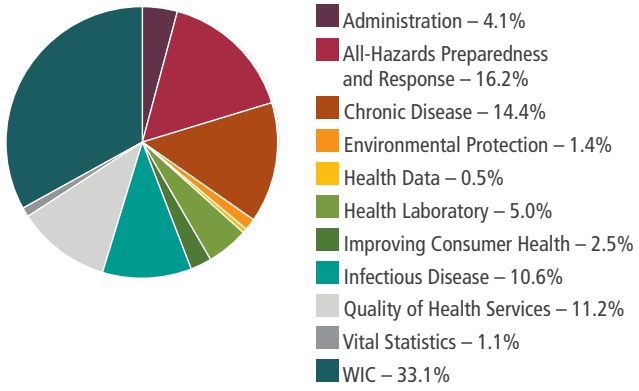
The state/territorial health agency has 401 full-time equivalents. There are no state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)



Total Expenditures FY08*: $48,152,746
Total Expenditures FY09**: $52,927,398

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Tennessee

Tennessee Department of Health

Agency Mission

To promote, protect and improve the health of persons living in, working in, or visiting the State of Tennessee.

Top 5 Priorities for State/Territorial Health Agency

1. Funding (state dollars/federal match)
2. Workforce development, succession planning and staff training
3. Information technology upgrade
4. Personnel and employee classifications and hiring practices
5. Preparedness

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a mixed relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 6

Number of state-run local health agencies

(led by state government staff): 89

Number of independent regional or district offices

(led by nonstate employees): 6

Number of state-run regional or district offices

(led by state employees): 7

State Organizational Structure

The health agency reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

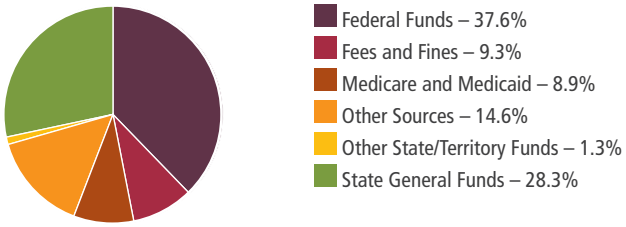
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

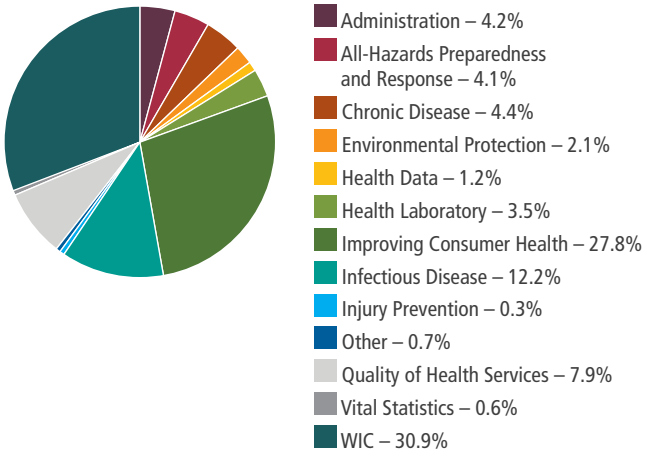
The state/territorial health agency has 2,573 full-time equivalents, including 1,474 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

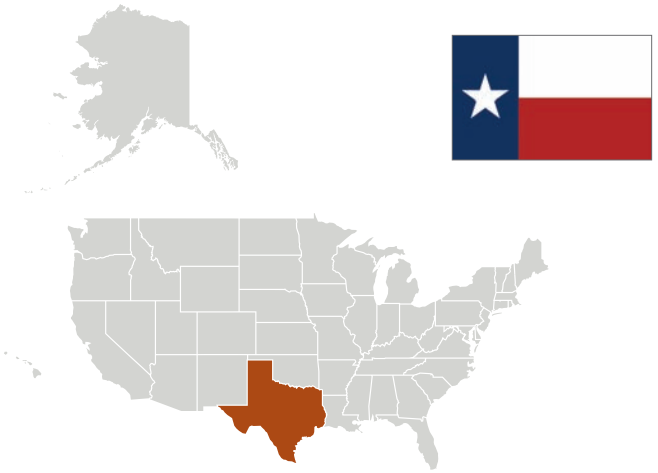


Total Expenditures FY08*: $557,600,699
Total Expenditures FY09**: $527,854,440

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Texas

Texas Department of State Health Services



Agency Mission

To improve health and well-being in Texas.

Top 5 Priorities for State/Territorial Health Agency

1. Prevent and prepare for health threats
2. Build capacity for improving community health
3. Promote recovery of persons with infectious diseases and mental illness
4. Protect consumers
5. Develop and expand integrated services

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a largely decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 62

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 8

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

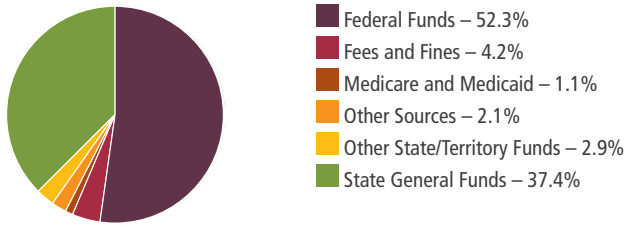
■	Health Assessment
	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

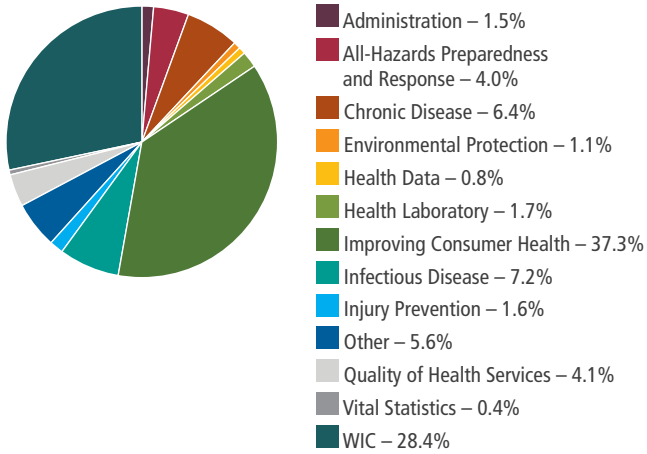
The state/territorial health agency has 12,104 full-time equivalents, including 9,343 state workers assigned to local/regional offices (includes staff assigned to state-operated mental health facilities).

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

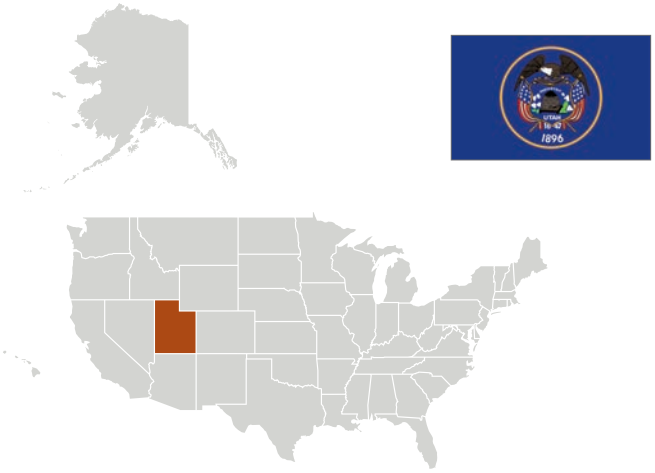


Total Expenditures FY08*: $2,672,014,166
Total Expenditures FY09**: $2,873,015,908

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Utah

Utah Department of Health



Agency Mission

To protect the public's health through preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

Top 5 Priorities for State/Territorial Health Agency

1. Implement and integrate public health into health reform
2. Improve relationships with local health departments
3. Work to realize e-Health=Utah (HIT effort)
4. Maintain our public health efforts despite decreasing financial resource
5. Reduce obesity and other health disparities

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 12

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

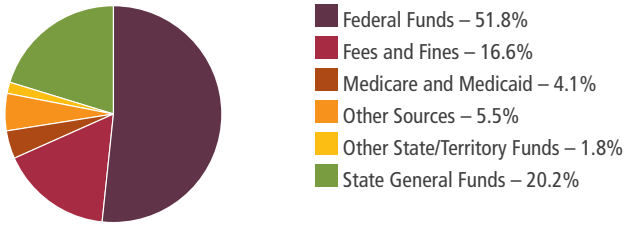
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

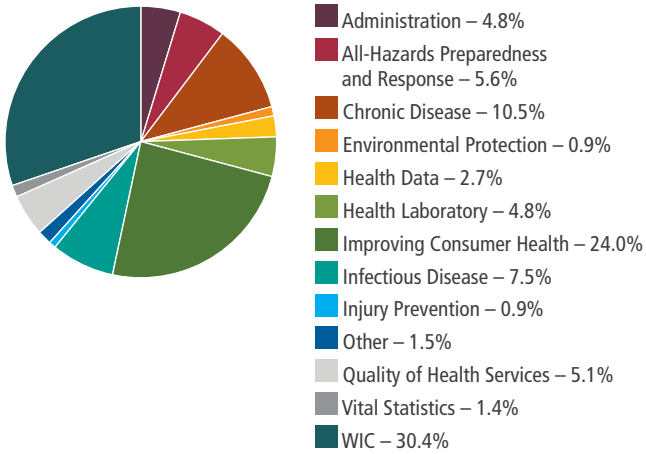
The state/territorial health agency has 1,057 full-time equivalents, including 4 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

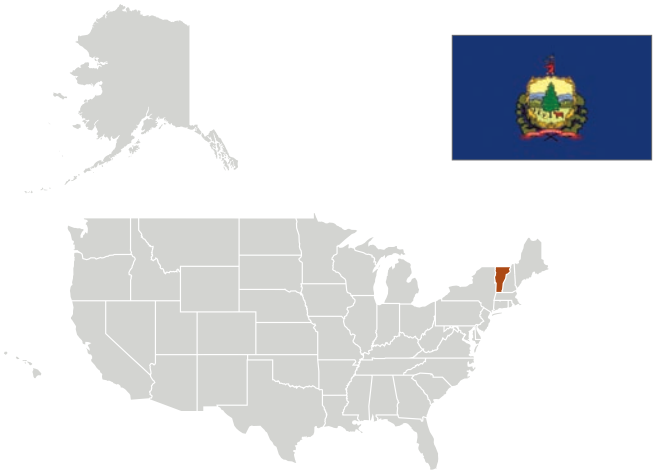


Total Expenditures FY08*: $173,993,524
Total Expenditures FY09**: $185,883,200

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Vermont

Vermont Department of Health



Agency Mission

To protect and promote optimal health for all Vermonters.

Top 5 Priorities for State/Territorial Health Agency

1. Defining/describing role of public health in health care reform
2. Strengthening department-wide program integration
3. Improving immunization coverage rates
4. Public health infrastructure funds: develop central/district office prevention teams
5. Modernize EMS system, vital records and physician licensing

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a centralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 0

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 12

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

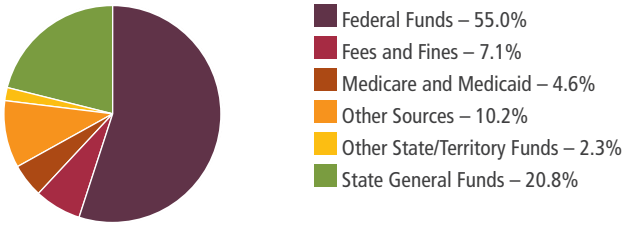
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

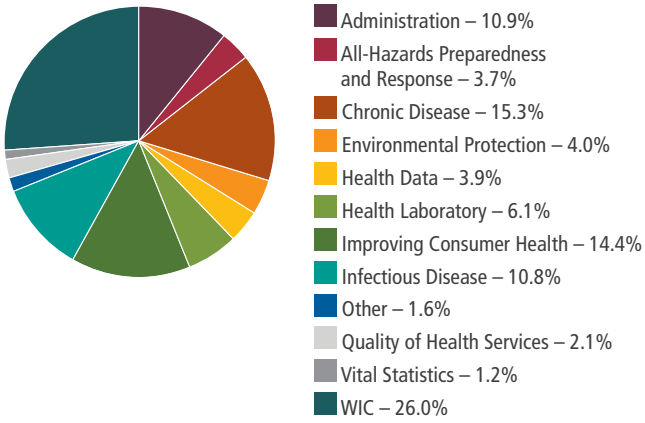
The state/territorial health agency has 430 full-time equivalents, including 148 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)



Total Expenditures FY08*: $70,477,572
Total Expenditures FY09**: $70,140,742

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Virgin Islands

Virgin Islands Department of Health

Structure and Relationship with Local Health Departments

The Virgin Islands Department of Health is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 6

Number of territory-run local health agencies

(led by territory government staff): 0

Number of independent regional or district offices

(led by nonterritory employees): 0

Number of territory-run regional or district offices

(led by territory employees): 0

Governmental Organizational Structure

The health agency reports directly to the governor. The Department of Health operates a medical board and various other boards.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

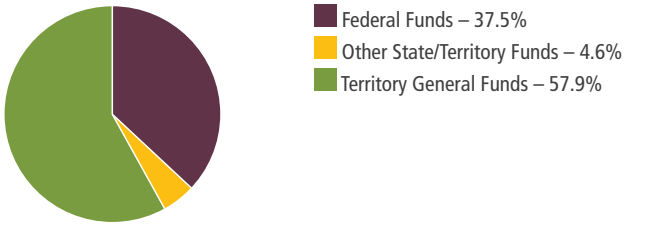
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

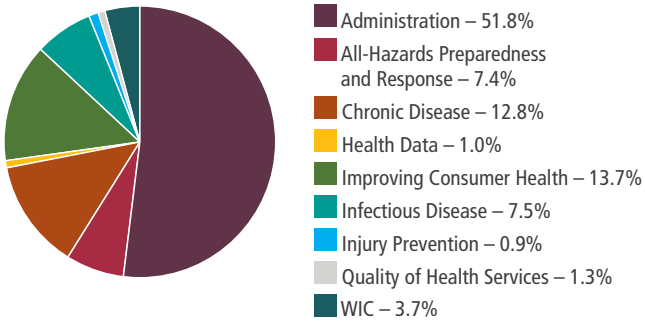
The state/territorial health agency has 507 full-time equivalents, including 513 workers assigned to local/regional offices. Some of the workers assigned to local/regional offices may be part-time employees.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

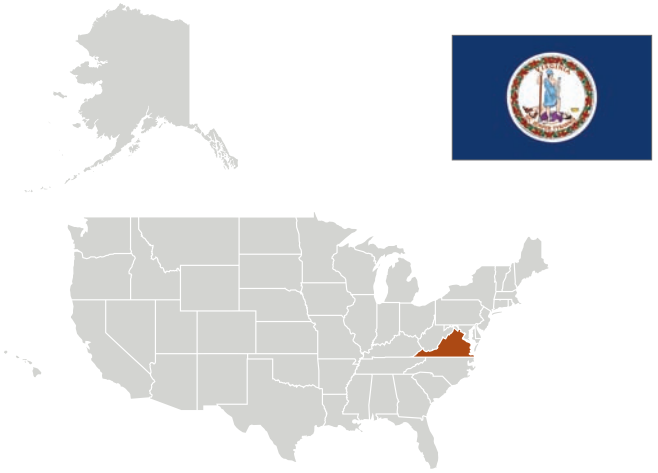


Total Expenditures FY08*: $52,605,507
Total Expenditures FY09**: $50,399,335

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Virginia

Virginia Department of Health



Agency Mission

The Virginia Department of Health is dedicated to promoting and protecting the health of Virginians.

Top 5 Priorities for State/Territorial Health Agency

1. Reduce infant mortality rate
2. Reduce obesity rate
3. Increase immunization rate
4. Decrease smoking rate
5. Increase access to safe, affordable drinking water

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a largely centralized relationship with local health departments. The Virginia Department of Health has 35 health districts that represent 119 local health departments.

Number of independent local health agencies

(led by local government staff): 2

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 33

State Organizational Structure

The health agency does not report directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

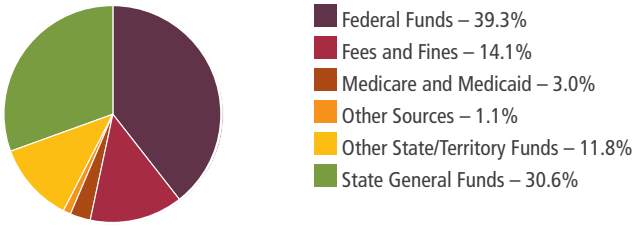
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

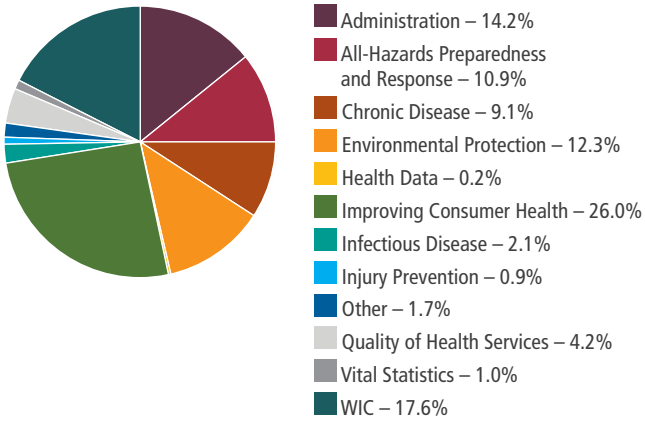
The state/territorial health agency has 3,898 full-time equivalents, including 3,293 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

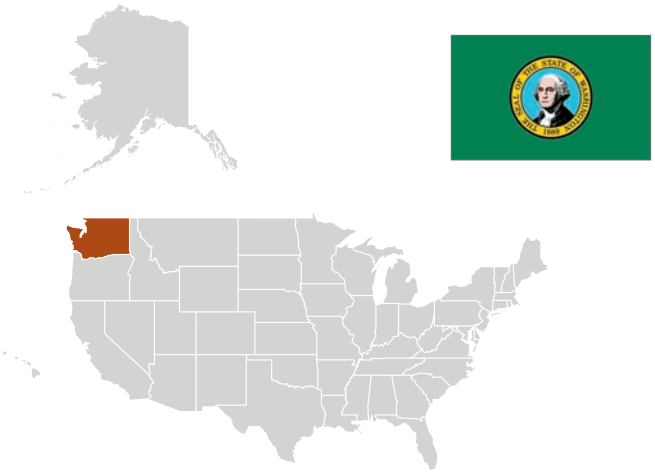


Total Expenditures FY08*: $521,840,066
Total Expenditures FY09**: $534,794,644

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Washington

Washington State Department of Health



Agency Mission

The Department of Health works to protect and improve the health of people in Washington State.

Top 5 Priorities for State/Territorial Health Agency

1. Enhance the most effective and important elements of prevention, early detection and swift responses
2. Pursue policy and system efforts to foster communities and environments that promote healthy starts and ongoing wellness
3. Partner with the health care system to improve access to quality, affordable and integrated health care
4. Enhance the use of performance management tools throughout the agency
5. Promote and support coordinated leadership throughout the state's public health system

Structure and Relationship with Local Health Departments

The state/territorial health agency is a free-standing/independent agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 35

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 4

State Organizational Structure

The health agency reports directly to the governor. The state has a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

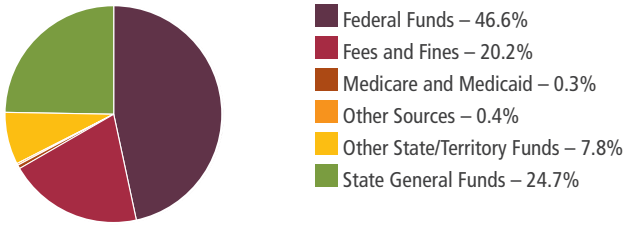
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

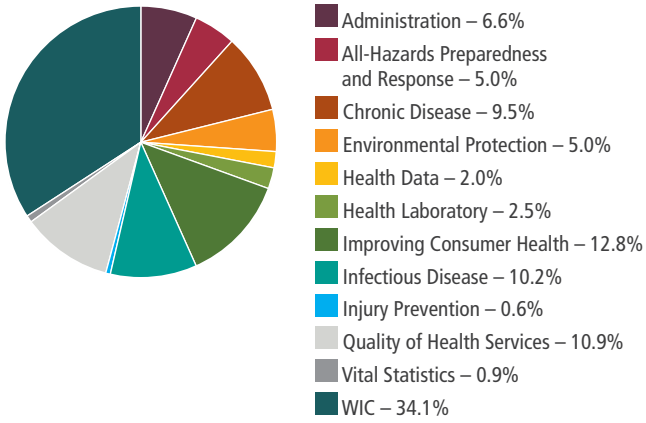
The state/territorial health agency has 1,497 full-time equivalents. Of that total, 265 are assigned to local/regional offices including the public health laboratory.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

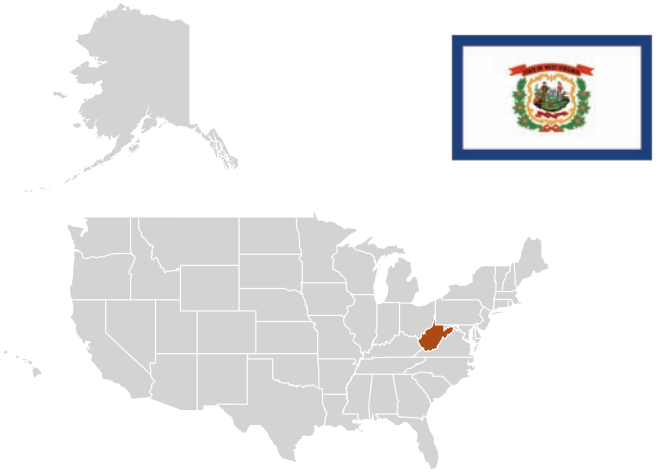


Total Expenditures FY08*: $463,736,912
Total Expenditures FY09**: $496,097,841

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

West Virginia

West Virginia Department of Health and Human Resources
Bureau of Pubic Health



Agency Mission

To help shape the environments within which people and communities can be safe and healthy.

Top 5 Priorities for State/Territorial Health Agency

1. Reduce the prevalence of chronic diseases in West Virginia
2. Maintain a competent, well-trained workforce to provide public health services
3. Maximize the use of all financial and human resources
4. Assure the infrastructure is in place to protect against threats
5. Assure safe drinking water to all West Virginia residents

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 49

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The health agency does not report directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

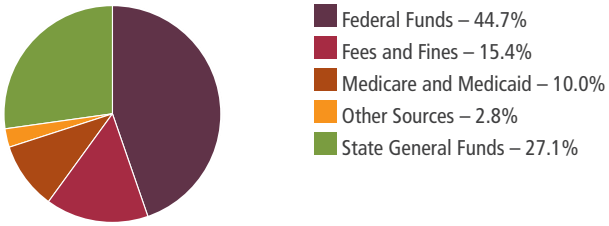
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

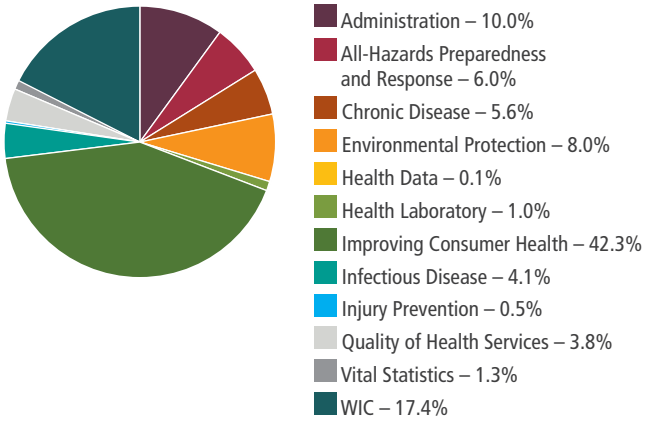
The state/territorial health agency has 749 full-time equivalents, including 42 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

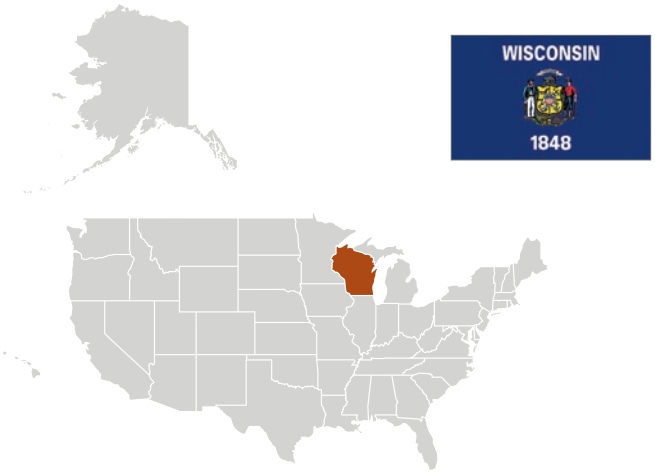


Total Expenditures FY08*: $205,297,043
Total Expenditures FY09**: $215,913,718

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Wisconsin

Wisconsin Department of Health Services
Division of Public Health



Agency Mission

Protecting and promoting the health and safety of the people of Wisconsin.

Top 5 Priorities for State/Territorial Health Agency

1. Improve healthy birth outcomes and eliminate racial and ethnic disparities
2. Strengthen emergency medical services program
3. Food safety and recreational licensing program improvements
4. Nutrition, physical activity, obesity and tobacco prevention
5. Promote competent, sufficient, diverse workforce

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a decentralized relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 92

Number of state-run local health agencies

(led by state government staff): 0

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 5

State Organizational Structure

The health agency does not report directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

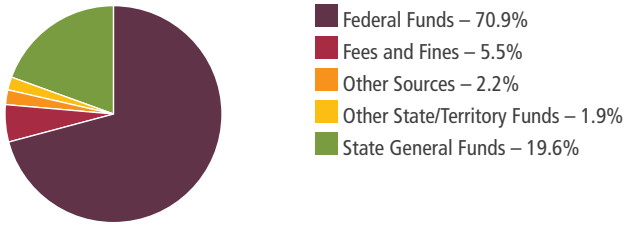
■	Health Assessment
■	Health Improvement Plan
■	Strategic Plan

State/Territorial Health Agency Workforce

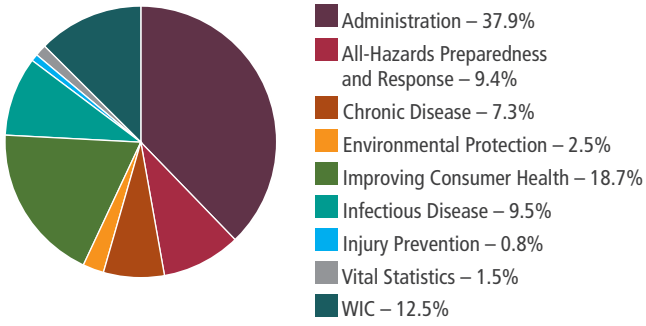
The state/territorial health agency has 407 full-time equivalents, including 62 state workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

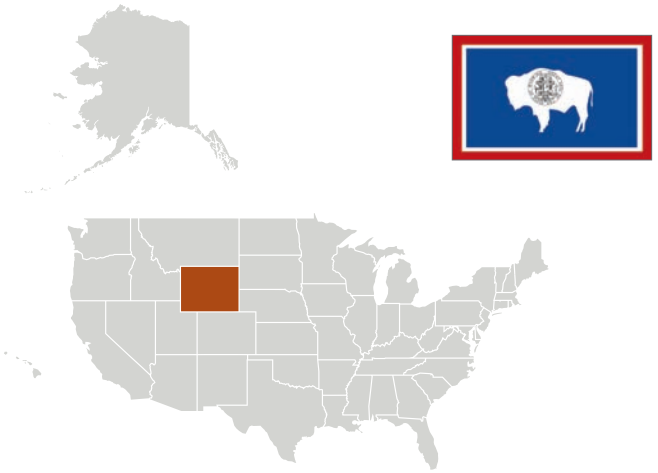


Total Expenditures FY08*: $139,341,989
Total Expenditures FY09**: $131,127,379

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Wyoming

Wyoming Department of Health



Agency Mission

Our mission is to promote, protect and enhance the health of all Wyoming citizens.

Top 5 Priorities for State/Territorial Health Agency

1. Attaining workforce stability/recruitment and retention
2. Developing effective health policy, assuring adequate public health funding
3. Using evidence-based program planning
4. Ensuring the discipline of public health is understood
5. Assuring a local public health presence throughout the state

Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency and has a largely shared relationship with local health departments.

Number of independent local health agencies

(led by local government staff): 4

Number of state-run local health agencies

(led by state government staff): 19

Number of independent regional or district offices

(led by nonstate employees): 0

Number of state-run regional or district offices

(led by state employees): 0

State Organizational Structure

The state health official reports directly to the governor. The state does not have a board of health.

State/Territorial Health Planning

The state/territorial health agency has developed the following within the past five years:

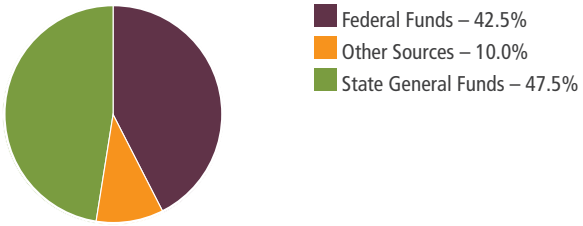
	Health Assessment
	Health Improvement Plan
	Strategic Plan

State/Territorial Health Agency Workforce

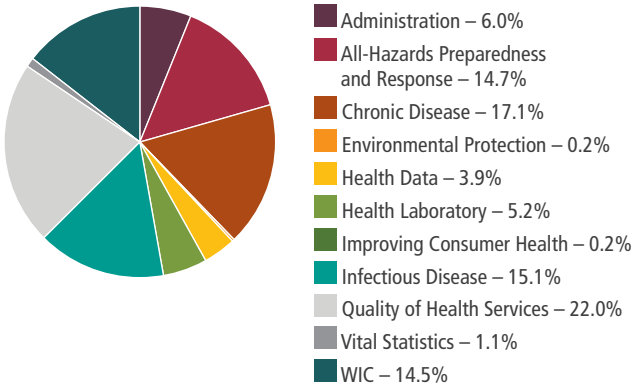
The state/territorial health agency has 1,485 full-time equivalents, including 95 state/territorial health agency workers assigned to local/regional offices.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)

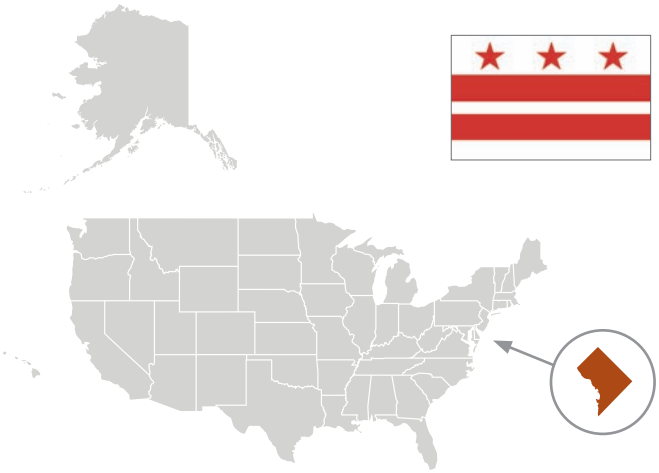


Total Expenditures FY08*: $62,337,413
Total Expenditures FY09**: $65,572,021

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

Washington D.C.

District of Columbia Department of Health



Agency Mission

The Mission of the Department of Health is to promote and protect the health, safety and quality of life of residents, visitors and those doing business in the District of Columbia. Our responsibilities include identifying health risks; educating the public; preventing and controlling diseases, injuries and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources.

Top 3 Priorities for the Health Agency

1. Public health systems enhancement
2. Health and wellness promotion
3. HIV/AIDS prevention and awareness

Structure and Relationship with Local Health Departments

The health agency is a free-standing/independent agency and has no local health departments.

Governmental Organizational Structure

The health agency reports directly to the mayor.
The health agency has a board of health.

Agency Health Planning

The health agency has developed the following within the past five years:

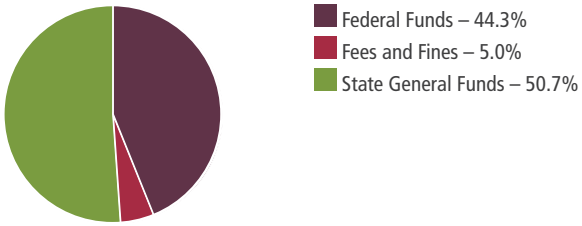
	Health Assessment
	Health Improvement Plan
	Strategic Plan

Health Agency Workforce

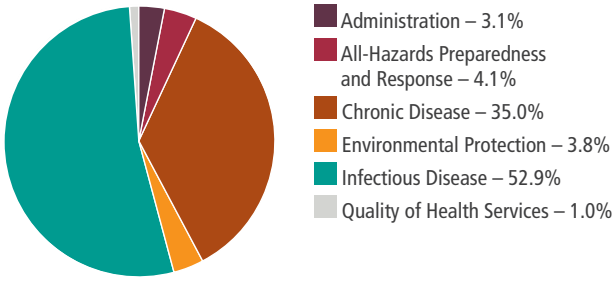
The health agency has 836 full-time equivalents.

State/Territorial Public Health Agency Finance

Sources of Funding (FY09)



Expenditures (FY09)



Total Expenditures FY09**: $169,869,468

*FY08 was defined as 7/1/07 – 6/30/08.
**FY09 was defined as 7/1/08 – 6/30/09.

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ASTHO Profile of State Public Health,
Volume Two
2011