

# ASTHO PROFILE OF STATE AND TERRITORIAL PUBLIC HEALTH VOLUME 4



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# Acknowledgements

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The members of the Survey Advisory Workgroup provided thoughtful recommendations and useful suggestions for further improvement of the survey throughout the process.

There are a number of individuals and special skills needed to produce this publication and we offer many thanks for their efforts. Thank you to Katie Sellers, former chief of ASTHO's science and strategy team, for her leadership, guidance, and dedication to the Profile. Emily Peterman and KaRon Campbell verified and cross-checked all of the data in the report. Maggie Carlin provided valuable contextual information on the U.S. territories and freely associated states. Jane Esworthy, Leslie Erdelack, and Virgie Townsend provided editorial support. Qualtrics programmed and hosted the web-based survey. Porter Novelli designed the publication, and Linemark printed it.

Most importantly, we would like to thank the staff of the 57 state and territorial health agencies that responded to the survey. Multiple staff members in each participating agency put a substantial amount of effort into answering the comprehensive questionnaire that forms the basis of this dataset. We appreciate their dedication to their work and their willingness to make time for this important effort.



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# A Letter from the Executive Director

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As we celebrate ASTHO's 75th anniversary this year, I am especially honored to share the *ASTHO Profile of State and Territorial Public Health, Volume Four*, which provides a comprehensive look at the structures, functions, and resources of state and territorial health agencies. The report also details some exciting developments and continued challenges for state and territorial health agencies.

In this one of a kind report, you'll learn specifics about state and territorial health officials and their tenure, health agency structures and priorities, and the public health workforce. You will also see the many activities that state and territorial health agencies oversee to promote population health—the span of activities is impressive and important. The report also highlights how health agencies operate and measure performance, and includes information about public health agencies in the U.S. territories and freely associated states.

We remain continuously grateful to ASTHO's members for devoting their time and effort to completing this survey. The Profile report would not be possible without their generosity and willingness to share their experiences.

We welcome your feedback on this report and the survey. Please feel free to provide comments and suggestions on our survey scope, questions, or what future analyses would be most valuable to you. Reliable and comprehensive data is one of the best ways to demonstrate the value of public health to this nation. Thank you for reading and for supporting state and territorial public health.

Sincerely,

A handwritten signature in black ink, appearing to read 'MRF', with a long, sweeping horizontal line extending to the right.

Michael R. Fraser, PhD, MS, CAE, FCPP  
Executive Director  
Association of State and Territorial Health Officials

# A Letter from CDC

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Dear Colleagues:



The Centers for Disease Control and Prevention (CDC) is pleased to have supported the Association of State and Territorial Health Officials (ASTHO) in its development of the *ASTHO Profile of State and Territorial Public Health, Volume Four*. CDC congratulates ASTHO on the release of this valuable resource, which contains comprehensive data about state and territorial health agency responsibilities, organization and structure, workforce, planning, and quality improvement activities.

We commend the state and territorial health agencies for completing the Profile Survey and for their dedication and contributions to public health. Their input significantly increases our understanding of the nation's state and territorial health agencies and the important roles they play. We anticipate that the report will present policymakers, researchers, and public health practitioners at the federal, state, and local levels with many opportunities to inform policy, practice, and research, and will foster integration and collaboration among public health professionals to improve public health practice and population health outcomes.

Sincerely,

A handwritten signature in black ink that reads "José T. Montero". The signature is written in a cursive style and is underlined with a single horizontal line.

José T. Montero, MD, MHCDS  
Director, Office for State, Tribal, Local and Territorial Support  
Deputy Director, CDC

# A Letter from RWJF

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Dear Colleagues:



We are pleased to support the *ASTHO Profile of State and Territorial Public Health, Volume Four*. This report provides the nation's most comprehensive look at state and territorial public health services, providing critical support to public officials and policymakers seeking to collaborate across sectors for the benefit of America's public health system.

The ASTHO Profile is key to sharing best practices across regions, and provides the most complete picture of governmental public health in the United States. While the Profile identifies and promotes best practices in the management, finance, and organization of public health services, we believe its impact goes far beyond practice.

This effort answers the most pressing questions in public health practice and policymaking. It envisions a more collaborative public health environment, where health becomes a greater cultural value among our leaders and the public. It fosters the kind of cross-sector thinking that will transform our health systems, integrate health within the decisions and opportunities presented to us each day, and ultimately make communities healthier.

Our sincere gratitude to the agencies and their staff who took the time, and were given the opportunity, to respond to the call for what works, and may work, in public health. ASTHO and its health officers serve a critical role in protecting our citizenry and ensuring that everyone who lives in America has a fair and just opportunity to live a healthy life. It is enough that you dedicate your passion to the wellbeing of others, but we are doubly grateful that you seed the future of public health practice. I look forward to continuing our work together building a national Culture of Health.

Sincerely,

A handwritten signature in black ink, which appears to read "Richard Besser". The signature is fluid and cursive.

Richard Besser, MD  
President and CEO  
Robert Wood Johnson Foundation



# Executive Summary

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The *ASTHO Profile of State and Territorial Public Health, Volume Four* highlights findings from the 2016 ASTHO Profile Survey. ASTHO is the national nonprofit organization representing public health agencies in the United States, its territories and freely associated states, the District of Columbia, and the more than 100,000 public health professionals that these 59 agencies employ. ASTHO members, the chief health officials of these jurisdictions, develop and influence public health policy and ensure excellence in governmental public health practices. ASTHO's primary function is to serve as an advocate and voice for state and territorial public health agencies, develop public health leadership at the executive level, and provide capacity building and technical assistance to state and territorial health agencies.

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

This report describes the structures, functions, and resources of state and territorial health agencies from the 2016 ASTHO Profile Survey. When appropriate, it compares state health agencies by governance classification, geographic region, and state population size. Also, when applicable, it compares the 2016 findings for state health agencies with data from the 2012, 2010, and 2007 ASTHO Profile Surveys. Data from the territories and freely associated states—who responded to a modified version of the survey—are included in a separate chapter of the report.

**Part I—State Public Health: Who We Are** is comprised of two chapters. The first chapter describes the structure and governance of state health agencies, including the number of local and regional health departments in each state, and the appointment of the health official. The second chapter provides a detailed picture of the roughly 97,000 employees at state health agencies, including information on the positions, salaries, and demographics of state health agency workers, trends in retirements and vacancies, and information about the qualifications of state health officials.

**Part II—State Public Health: What We Do** outlines the public health activities that state health agencies conduct. State health agencies promote population health by directly providing services such as disease treatment, maternal and child health services, and other clinical services. Agencies prevent disease by conducting screening services and population-based primary prevention services. State health agencies also work to protect the public's health by conducting a number of laboratory services such as influenza typing, maintaining disease registries, and conducting data collection for epidemiologic activities, and disease surveillance. Additionally, this chapter includes information on various federal programs that state health agencies have responsibility for, as well as the technical assistance agencies provide to a number of different related parties.

**Part III—State Public Health: How We Do It** is composed of three chapters that examine how state health agencies are able to accomplish the myriad activities they perform by describing planning and quality improvement and health information management at state health agencies, as well as state health agency finance. The chapter on planning and quality improvement describes states' progress toward accreditation as well as the status of quality improvement and performance management in state health agencies. The chapter on health information management discusses the status of informatics and health information exchanges at agencies, as well as the electronic collection and dissemination of data. The final chapter in this section, on state health agency finance, provides insight into the expenditure categories at state health agencies, the various revenue and funding sources for public health, and funds distributed from state health agencies.

**Part IV—Insular Areas** provides an overview of the seven territories and freely associated states—collectively known as the insular areas—that responded to a modified version of the survey. This chapter provides information on their activities, workforce, structure, quality improvement, and health information management efforts.

**Individual Agency Profiles** provides a one-page summary of the governance structure, finances, relationship with local health departments, top priorities, workforce, and accreditation status for each state and insular area health agency that responded to the survey.

To view or download the complete Profile report or request access to Profile data, visit [www.astho.org/profile](http://www.astho.org/profile).

ASTHO thanks the Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation for their generous support of the Profile.

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# Top Findings

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



## State Public Health: Who We Are

- ▶ Each state health agency (SHA) is led by a state health official (SHO), often known as the state health secretary or commissioner of health. In 2016, 66 percent of SHOs were appointed by the governor, 14 percent were appointed by a parent agency secretary, 10 percent were appointed by a board or commission, and 10 percent were appointed by another entity. Once appointed, 74 percent require confirmation by the legislature, governor or a board or commission.
- ▶ SHO tenure is highly variable. As of September 2016, the range in length of time SHOs had been in their position was two months to nearly 15 years. As of September 2016, SHOs' average tenure was 2.7 years (median=1.7 years). Since 2012, average tenure decreased from 3.4 years while median tenure remained stable (1.8 years in 2012).
- ▶ SHOs represent a variety of backgrounds. As of 2016, 64 percent of SHOs hold a medical degree, and 44 percent hold an MPH. This is a decrease from 2012, when 71 percent of SHOs held a medical degree and 48 percent held an MPH.
- ▶ In 2016, 29 state public health agencies (58%) were freestanding/independent agencies, while 21 (42%) were a unit of a larger combined health and human services organization—often referred to as an umbrella organization.
- ▶ For agencies housed under a larger umbrella agency, the top three areas of responsibility for parent agencies in 2016 were Medicaid (91%), state mental health authority combined with substance abuse (81%), public assistance (76%), and substance abuse (76%). There have been large increases from 2012 to 2016 for SHA responsibility for substance abuse (from 50% to 76%) and state mental health authority without substance abuse programs (from 30% to 57%).
- ▶ The number of agencies governed by a board of health or similar entity has remained stable over time at just over 50 percent. In 2016, 18 SHAs (36%) reported having a board of health while nine (18%) reported having an entity that, while not called a board of health, performs similar functions. In 2012, these proportions were 45 percent and 8 percent, respectively.
- ▶ SHAs collaborate with many different entities, including local public health departments, hospitals, and healthcare delivery partners. In 2016, at least 90 percent of agencies reported exchanging information and working together on projects with hospitals, physician practices/medical groups, and community health centers.
- ▶ These levels of collaboration have remained largely stable from 2012 to 2016. However, there was a notable increase over time in one area—the percentage of agencies that reported exchanging information with health insurers (72% in 2012, 92% in 2016). This trend is undoubtedly partially attributable to the rapid increase in the number of states implementing All-Payer Claims Databases (APCD). These are electronic systems that aggregate claims and administrative data from public and private payers, allowing policymakers to identify and act upon trends. The APCD Council reports that 23 states have achieved some level of implementation and 12 more are investigating this—up from 10 in 2014.<sup>1,2</sup> Other contributing factors include implementation of the HiTECH Act and Affordable Care Act and concomitant federal and state regulation.
- ▶ The number of states sharing resources with other states on a continuous, recurring (non-emergency) basis has risen substantially, from 9 percent in 2012 to 27 percent in 2016. In both years, all-hazards response and epidemiology were the top two shared services and functions, laying the groundwork for two areas that often require a multi-state response. Factors leading to this increase may reflect growing recognition of the importance of Mutual Aid agreements of both a formalized and informal nature between states, and incentives produced through supportive language inserted in cooperative agreement objectives issued by the federal government.
- ▶ States report many competing priorities, but chronic disease prevention, which includes activities such as heart disease, cancer, and tobacco prevention and control programs, consistently emerges as the top priority of state health agencies. This priority substantially increased from 14.5 percent in 2012 to 23.9 percent in 2016.
- ▶ Other SHA priorities include clinical services/consumer care, which includes clinical programs such as TB treatment and emergency medical services (11.4% in 2012, 9.4% in 2016) and quality improvement/performance management, which includes efforts to improve organizational performance and efficiency (13.3% in 2012, 8.6% in 2016).
- ▶ From 2012 to 2016, the estimated total number of FTEs for the public health workforce for the 50 states and District of Columbia decreased by 3 percent (from 100,468 to 97,230). Explanations for this decline include decreases in direct service provision, decreases in funding, and increases in the amount of funding distributed as pass-throughs and grants/contracts to third parties, such as local health departments and nonprofits.
- ▶ By 2020, SHAs expect the percentage of health agency employees who are eligible for retirement to increase from 17 percent to 25 percent.

### NOTES

- 1 The Source on Healthcare Price and Competition. "Issue Brief: All Payer Claims Databases." Available at [sourceonhealthcare.org/legislative-topics-payer-claims-databases/](http://sourceonhealthcare.org/legislative-topics-payer-claims-databases/). Accessed August 14, 2017.
- 2 APCD Council. "Standards." Available at [www.apcdouncil.org/standards](http://www.apcdouncil.org/standards). Accessed August 14, 2017.



## State Public Health: **What We Do**

- ▶ Nationwide, state and territorial health agencies engage in a variety of activities to promote population health. These include: preventing diseases through screenings, primary prevention services, and vaccine management and inventory distribution; and conducting lab testing, collecting data in real-time, and engaging in other environmental health activities to protect the public's health.
  - Health promotion activities include: treatment for tuberculosis (60%), STDs (54%) and HIV/AIDS (32%); maternal and child health services such as those for children and youth with special healthcare needs (54%), WIC (44%), and home visits (39%); and other clinical services such as oral health services (39%), substance abuse education/prevention services (37%), and pharmacy services (27%).
  - Prevention includes: screenings for diseases and conditions such as newborn screenings (70%), HIV/AIDS (60%) and other STDs (60%); population-based primary prevention services such as tobacco prevention (84%), HIV prevention (82%), and STD counseling and partner notification (82%); and vaccine management and inventory distribution for childhood (96%) and adult immunizations (90%).
  - Activities aimed at health protection include: laboratory testing of select agents and dangerous pathogens (92%) and foodborne illness (92%), influenza typing (92%), and vector-borne illness (90%); public health registry maintenance for childhood immunization (94%), birth defects (76%), and cancer (76%); other data collection, epidemiology, and surveillance for foodborne illness (100%), communicable/infectious disease (98%), and perinatal events or risk factors (98%); and other environmental health activities including environmental epidemiology (90%), food safety training and education (80%), and radiation control (70%).
- ▶ From 2010 to 2016, states reported a marked decline in directly performing many of these services and activities; for example, 17 of 18 clinical service activities surveyed have decreased, 12 of 14 maternal and child health surveyed have decreased, and 16 of 17 primary prevention activities surveyed have decreased. The increase in the number of individuals covered by Medicaid and insurance during this time is one possible explanation for these observed changes over time. In addition, these numbers only reflect decreases in activities directly performed by state health agencies; agencies may also be contracting out these activities to third parties in lieu of performing them directly.
- ▶ The total number of environmental health activities directly performed by state health agencies has also decreased from an average of 42 percent in 2010 to 37 percent in 2016. Notable decreases in environmental health activities include the number of state health agencies directly performing poison control (decrease of 25% from 2010 to 2016) and vector control (decrease of 16% from 2010 to 2016). These changes are probably due to funding cuts and transferring these services to local health departments and other state agencies.
- ▶ SHAs continue to provide assistance and support through technical assistance to a variety of partners and organizations. In 2016, technical assistance was frequently provided for quality improvement, performance, and accreditation to hospitals (85%) and to local public health agencies (81%). These proportions are just slightly lower than those reported in 2012.
- ▶ The top federal initiatives administered by virtually all SHAs in 2016 were: Maternal and Child Health/Title V, Preventive Health and Health Services Block Grant, CDC Public Health Emergency Preparedness cooperative agreement, Section 317 Immunization Funding, and the Women Infants and Children (WIC) program. Participation in these programs has remained very high since 2012.
- ▶ The total amount of federal funding appropriated to SHAs exceeded \$14.3 billion in 2015. Nearly half of federal funding originates from USDA for the WIC program (45%); the next highest percentage comes from CDC (16%), followed by Medicaid (14%), and HRSA (10%).
- ▶ While SHAs vary widely in their reliance on federal funding, 80 percent of states receive more than 40 percent of their funds from federal sources. In 2015, SHAs received an average of \$280 million in federal funding. States ranged from a minimum of \$26 million, to receiving a maximum of \$1.8 billion in federal funding.

## State Public Health: How We Do It

- ▶ As of 2016, 20 out of 51 (40%) SHAs achieved accreditation through the Public Health Accreditation Board's (PHAB) voluntary national accreditation program, and that number continues to rise. Public health accreditation involves measuring health agency performance against a set of developed standards, and rewarding or recognizing health departments that meet them. Since Profile data was collected in 2016, an additional eight SHAs have become accredited; a majority of states (56%) are now accredited.<sup>3</sup>
- ▶ Accredited states and those pursuing accreditation were most likely to report experiencing the following benefits: 85 percent say accreditation stimulated quality and performance improvement opportunities, 82 percent say accreditation stimulated greater collaboration across departments or units within their agency, and 76 percent say accreditation strengthened the culture of quality improvement within their agency.
- ▶ On average, electronic data was most often collected within a state system (90%), while 20 percent collected data through a health information exchange (HIE)—the electronic movement of health-related information among organizations according to nationally recognized standards.<sup>4</sup> From 2012 to 2016, the number of states collecting data electronically increased across all areas surveyed—all agencies collect data electronically on lab results, reportable diseases, vital records, and newborn screening.
- ▶ SHA total revenue fluctuated over time, from \$29.1 billion in 2008 to \$28.6 billion in 2015. The largest dip was seen between 2009 and 2010, when revenue decreased by \$3.4 billion. Between 2014 and 2015, there were decreases in total revenue for federal funds, fees and fines, and other state funds.
- ▶ Between 2014 and 2015, the two largest spending categories as a proportion of states' total budgets were clinical services/consumer care and WIC.
- ▶ In both 2014 and 2015, SHAs distributed approximately \$6 billion (about 20% of their total budget) through contracts, grants, and awards to local and regional/district health agencies, tribal health agencies, nonprofit organizations, and other governmental entities. In 2015, more than one-third of SHA contracts, grants, and awards were distributed to independent local health agencies (42%) and to community-based nonprofit organizations (40%).

## Insular Areas

The eight U.S. territories and freely associated states are collectively referred to as the insular areas. The U.S. territories include three island jurisdictions in the Pacific—American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands—and the two Caribbean territories of Puerto Rico and the U.S. Virgin Islands. The remaining insular areas include three sovereign nation states holding compacts of free association with the United States, also known as compact nations: the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands.

There is wide variability across these jurisdictions on many measures. The uniqueness of each insular area (e.g., geographic, socioeconomic, and systemic differences) can explain much of this variation. Yet despite their individual diversity, the insular areas are collectively distinct from the state and D.C. health departments. Primary differences include their remoteness, relatively close integration with their healthcare systems, and challenges associated with high incidences of both communicable and non-communicable diseases.

- ▶ Insular area health agencies reported performing primary prevention activities most frequently (92%), followed by data collection, epidemiology, and surveillance activities (86%).
- ▶ In 2016, insular area health agencies reported a total of 6,523 FTEs. The occupational classification with the greatest average number of staff was public health nurses (mean=216, median=32), followed by office and administrative support (mean=164, median=19), and behavioral health staff (mean=150, median=17).
- ▶ The average budget for insular area health agencies for 2014 was \$59.5 million (median=\$27.8 million), and the average budget for 2015 was \$61.5 million (median=\$32.3 million). In 2015, the average per capita expenditure on public health in the insular areas was \$389 (median=\$197).

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## NOTES

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Public Health Accreditation Board. "Accreditation Activity as of September 19, 2017." Available at [www.phaboard.org/news-room/accreditation-activity/](http://www.phaboard.org/news-room/accreditation-activity/). Accessed October 1, 2017.

4

HIMSS. "The National Alliance for Health Information Technology Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms." Available at: [www.himss.org/national-alliance-health-information-technology-report-office-national-coordinator-health](http://www.himss.org/national-alliance-health-information-technology-report-office-national-coordinator-health). Accessed June 6, 2017.

# Introduction

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This report marks the 2017 release of the Association of State and Territorial Officials (ASTHO) Profile Survey. The *ASTHO Profile of State and Territorial Public Health, Volume Four* is the only comprehensive source of information about state, territorial, and freely associated state public health agency activities, structure, and resources. The Profile Survey aims to define the scope of state and territorial public health services, identify variations in practice among state and territorial public health agencies, and contribute to the development of best practices in governmental public health. The Profile drives improvement at state and territorial health agencies, educates policymakers, enables the sharing of best practices among state and territorial health agencies, and is a resource to the field of public health systems and services research (PHSSR).

This is the fourth survey in a series. State and territorial health agencies completed prior surveys in 2007, 2010, and 2012. In April 2016, ASTHO launched the fourth version, sending a link for the web-based survey to senior deputies from the 50 states, D.C., and eight territories and freely associated states. The 129-question instrument covered the following topic areas:



Along with general instructions, senior deputies received recommendations on which staff and departments should complete each section of the survey. Multiple personnel could complete the surveys in multiple sittings. ASTHO held question-and-answer webinars several weeks prior to the launch of the survey and midway through the survey administration period to clarify instructions, resolve technical issues, and respond to item-specific questions. In addition, ASTHO held individual phone calls with leadership from each of the insular areas to provide clarification and assist in completion of the survey instrument.

Senior deputies were asked to complete the survey by May 31, 2016. However, the survey administration system remained open through September 2016 to allow as many

states, territories, and freely associated states to complete the survey as possible. At the close of survey administration, the Profile Survey response rate was 98 percent among the 50 states and D.C., and 97 percent among all states, territories, and freely associated states.

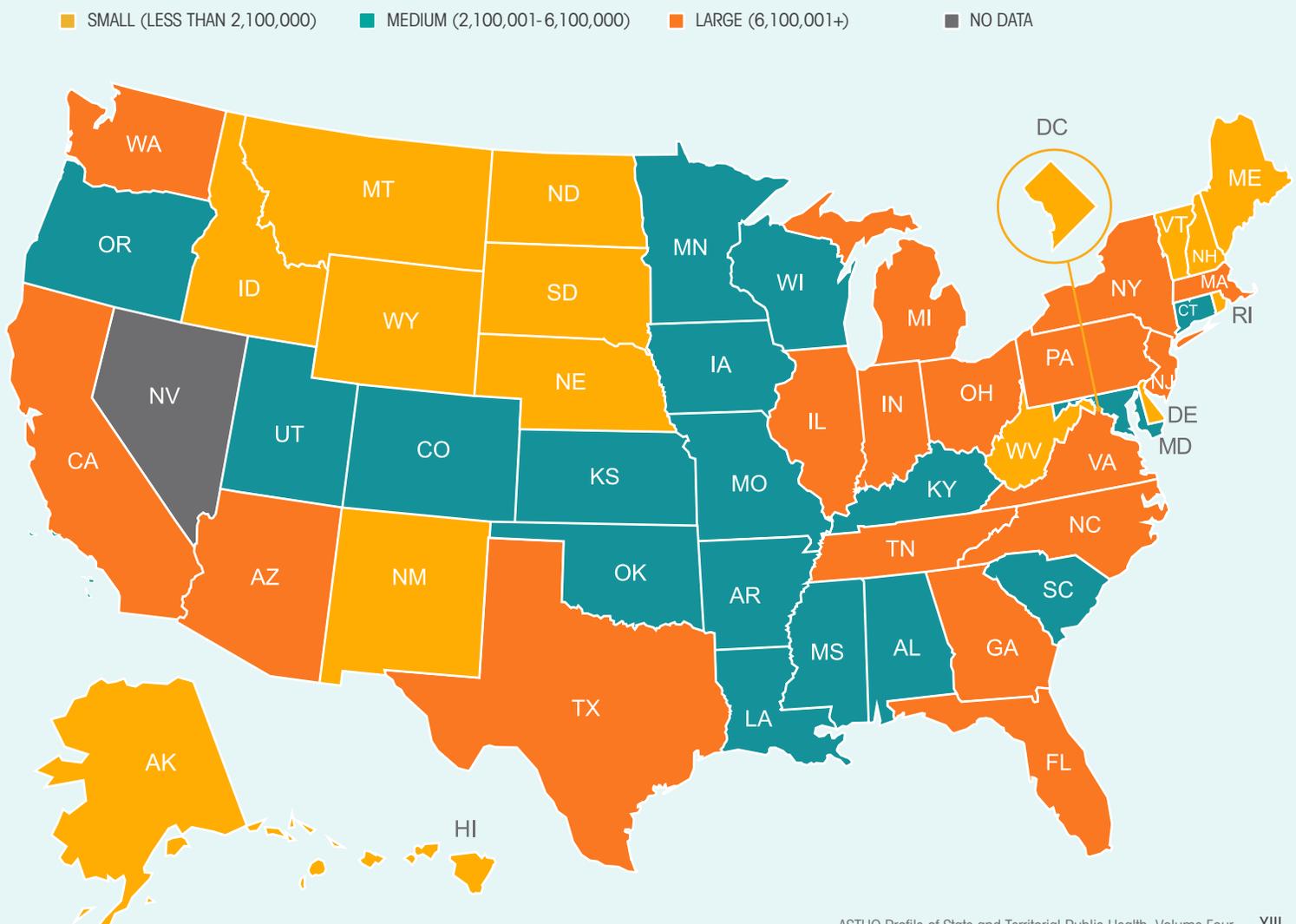
ASTHO's Survey Research team conducted extensive follow up with the states, territories, and freely associated states through the remainder of 2016 to verify responses. When response errors were identified, ASTHO's Survey Research team worked with the agency to correct them. In instances where the state, territory, or freely associated state did not respond to multiple follow-up attempts, the Survey Research team used its expertise to determine whether or not to retain the data.

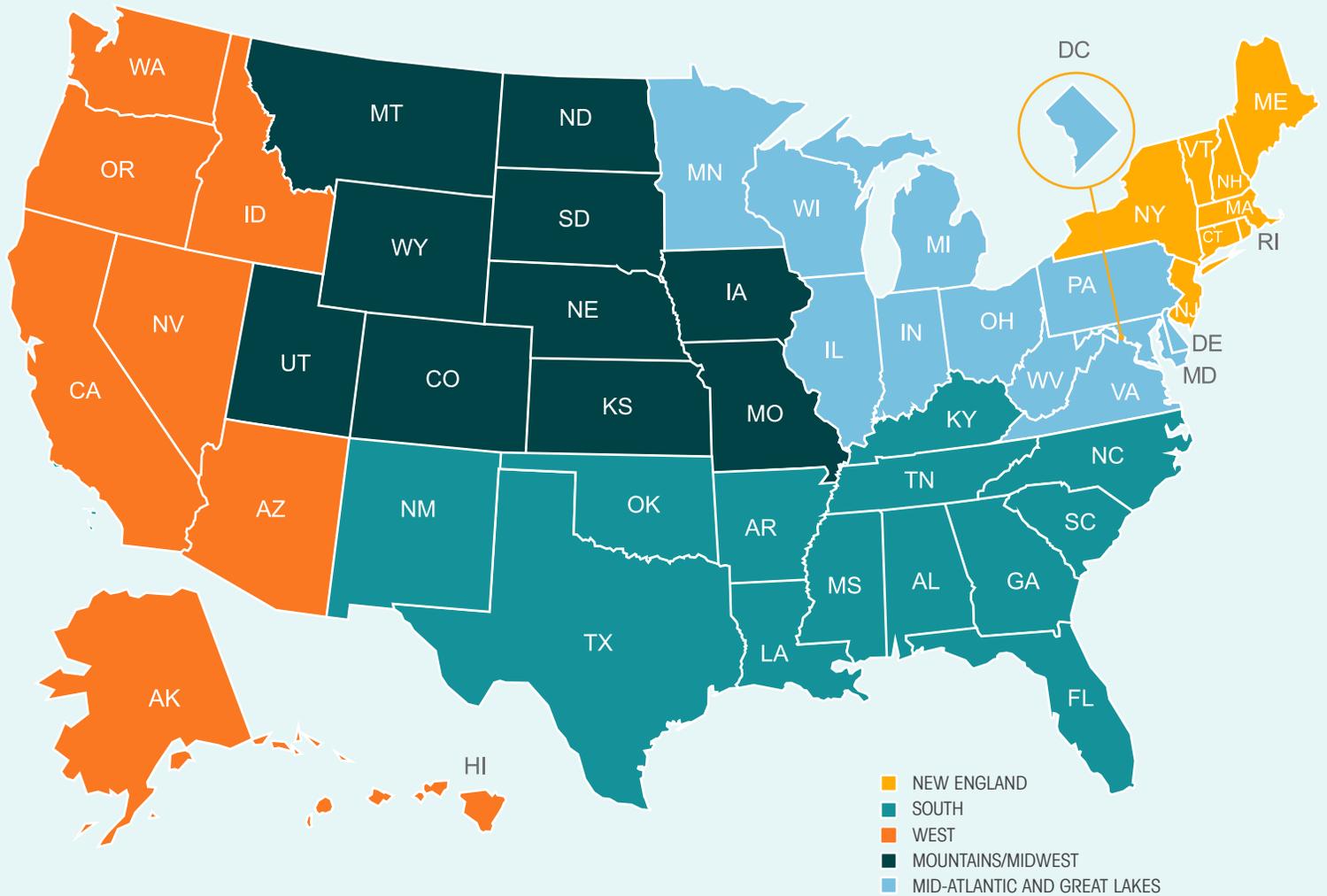
## Differences Between Surveys

In an effort to continuously improve the Profile Survey and the quality of the data, ASTHO made several notable changes to the survey from the 2012 version. ASTHO convened a Survey Advisory Workgroup consisting of state health agency senior staff, researchers, ASTHO alumni, representatives from national public health partner organizations, and ASTHO staff. The workgroup reviewed initial drafts of the survey instrument, made recommendations on content, formatting, survey administration, and analyses, and pilot-tested the survey. Staff also leveraged the expertise of two of ASTHO's peer networks, the Human Resources and Workforce Development Directors Peer Network and the Chief Financial Officers Peer Network, in making modifications to the workforce and finance sections of the instrument. Findings from these meetings and the 2012 Profile Survey evaluation report were used to make revisions to the 2016 survey instrument, including the following:

- ▶ Adding a series of questions about the nature of collaborations with other agencies and organizations to collect more in-depth information about state health agency partnerships.
- ▶ Changing the occupational classifications in the workforce section to better reflect current jobs in state public health. Each occupational classification definition included a description of the tasks associated with the position, as well as common titles for individuals with the given position.
- ▶ Modifying the planning and quality improvement section to ask additional questions about experienced and anticipated benefits of state health agency accreditation.
- ▶ Redesigning the health information management section to collect the most useful information on health information exchanges and Meaningful Use public health objectives.
- ▶ Making small changes in expenditure and funding sources definitions in the finance section for additional clarity.
- ▶ Including several evaluation questions (e.g., number of staff and estimate of time needed to complete the survey) at the end of the instrument for internal quality improvement purposes.

**FIGURE 0.1** STATE POPULATION SIZE





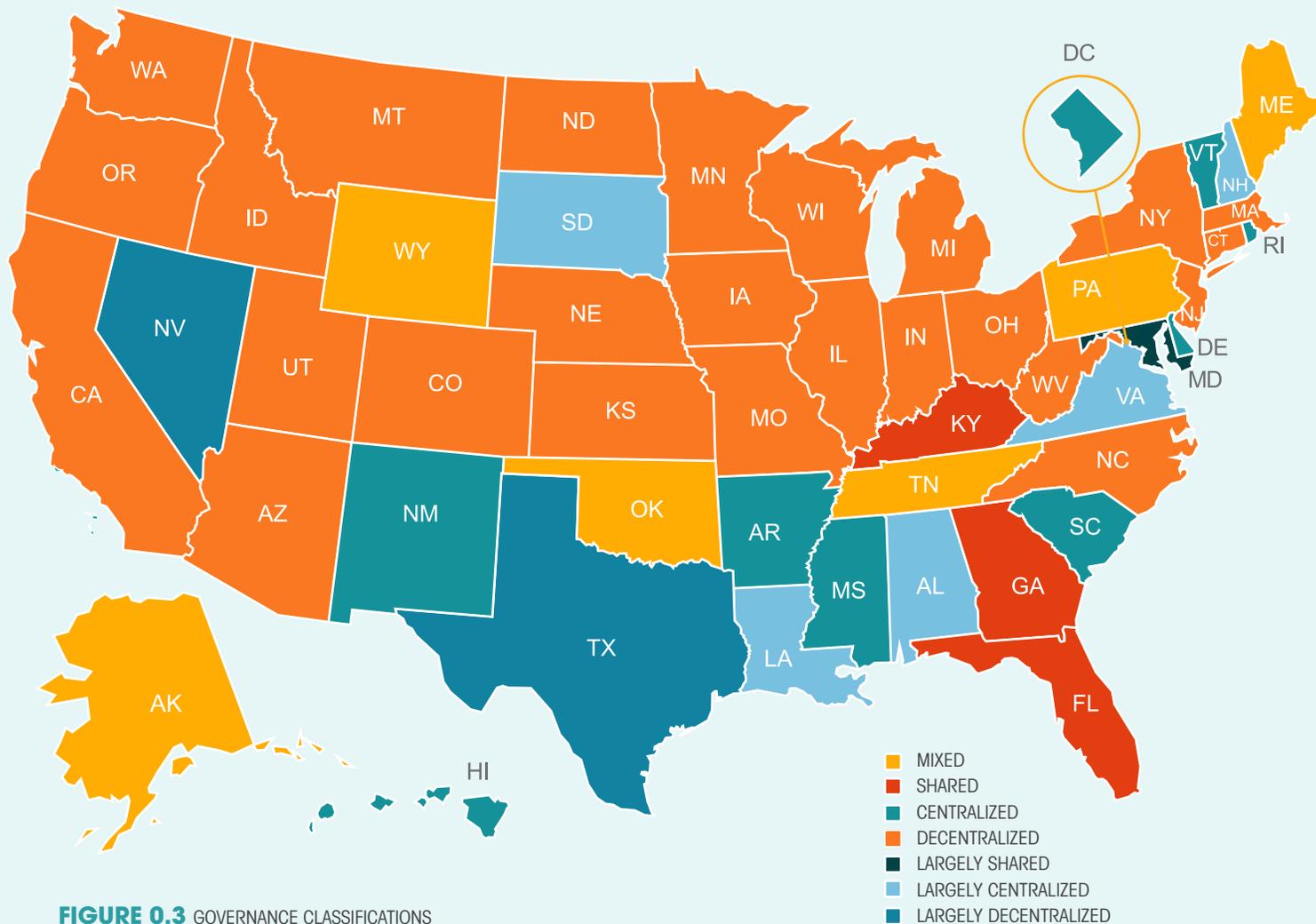
**FIGURE 0.2** COMBINED HEALTH AND HUMAN SERVICES REGIONAL CLASSIFICATION

## Structure of Report

The report is structured to provide a narrative of state and territorial health agencies, and has been divided into several sections:

- ▶ **Part I—State Public Health: Who We Are** provides background on the structure and composition of state public health agencies. Within this section is Chapter 1: State Health Agency Structure, Governance, and Priorities, and Chapter 2: State Health Agency Workforce.
- ▶ **Part II—State Public Health: What We Do** describes the roles and responsibilities of state health agencies and contains Chapter 3: State Health Agency Activities.
- ▶ **Part III—State Public Health: How We Do It** reviews the mechanisms state health agencies use to accomplish the activities described in Part II. Chapters in this section include Chapter 4: Planning and Quality Improvement, Chapter 5: Health Information Management, and Chapter 6: State Health Agency Finance.
- ▶ **Part IV—Insular Areas** explores the activities, workforce, and structure of the U.S. territories and freely associated states.
- ▶ The final section of the report, **Individual Agency Profiles**, contains a one-page summary of key information about each agency from the report.

When possible, 2016 data are compared with data from 2012, and in some instances, data from 2010 and 2007 as well. Care has been taken to include only those comparisons that represent meaningful differences between data from 2016 and data collected in prior rounds of the survey. Although it is possible that some variations in the data reported between 2007, 2010, 2012, and 2016 may be due to survey refinement or changes within the particular health agencies that responded to each question rather than actual changes in health agency practices, we have tried to minimize this possibility in the development of the questionnaire.



**FIGURE 0.3** GOVERNANCE CLASSIFICATIONS

When relevant, chapters also include discussion of notable differences based on three organizational characteristics:

- ▶ **Size of population served.** State health agencies were categorized as small, medium, or large based on tertiles of the size of the population served. To estimate the size of the population served, 2016 population estimates from the U.S. Census Bureau<sup>5</sup> were used. **Figure 0.1** displays a map of states by population size.
- ▶ **Region of the United States.** Regional classifications are based on HHS regions,<sup>6</sup> which were paired into five regions to increase the number of state health agencies for comparison in each region. **Figure 0.2** displays a map of states by HHS region.
- ▶ **State health agency governance.** State health agencies classified as centralized/largely centralized were compared with state health agencies classified as decentralized/largely decentralized. Chapter 1 provides more detailed information on governance categories. State health agencies with a shared or mixed governance structure were not included in the governance comparisons. A map of states by governance structure is displayed in **Figure 0.3**.

## Additional Information

The *ASTHO Profile of State and Territorial Public Health, Volume Four* is available online as a downloadable PDF on ASTHO's website at <http://www.astho.org/Profile>. Also available on the page is additional information about the Profile Survey, including an interactive map with key data on state and territorial health agencies, a downloadable questionnaire, codebook, individual agency profiles, infographics, an animated video, and links to materials from prior rounds of the survey. ASTHO also encourages researchers who are interested in conducting analyses using Profile Survey data to visit <http://www.astho.org/Research.aspx> for details on how to request data and the process for obtaining a data use agreement. General inquiries about the Profile Survey or this report may be sent to [profile@astho.org](mailto:profile@astho.org).

## NOTES

- 5 U.S. Census Bureau. "Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2016 (NST-EST2016-01)." Available at [www.census.gov/data/tables/2016/demo/popest/nation-total.html](http://www.census.gov/data/tables/2016/demo/popest/nation-total.html). Accessed February 14, 2017.
- 6 HHS. "Regional Offices." Available at [www.census.gov/data/tables/2016/demo/popest/nation-total.html](http://www.census.gov/data/tables/2016/demo/popest/nation-total.html). Accessed February 14, 2017.

**PART I**

STATE PUBLIC HEALTH

**WHO WE ARE**



# STATE HEALTH AGENCY STRUCTURE, GOVERNANCE, AND PRIORITIES

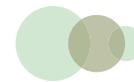
This chapter addresses the structure, governance, and priorities of state public health agencies. The manner in which a state health agency is structured varies; some state health agencies are part of a larger agency, while others are not. States also vary in the extent of state governmental authority over local health agencies, the rules surrounding the state health official's appointment, and the types of partnerships and collaborations they engage in with other governmental and nongovernmental entities. This chapter will explore the structure of agencies, comparing 2016 data with 2012, 2010, and 2007 data, when possible, and will note differences in structure by agency characteristics when applicable.

### KEY FINDINGS

- ▶ In 2016, 29 state public health agencies (58%) were freestanding/independent agencies, while 21 (42%) were a unit of a larger combined health and human services organization—often referred to as an umbrella organization.
- ▶ In 2016, 50 state public health agencies reported having a total of 2,795 local health departments and 312 regional or district offices.
- ▶ Eighteen state health agencies (36%) reported having a state board of health. An additional nine states (18%) reported having an entity that performs similar functions.
- ▶ Approximately one-quarter of state health agencies share resources with each other, typically for all-hazards preparedness and response (67%) and epidemiology or surveillance (52%). Both of these trends have been steadily rising since information collection began. Factors leading to this increase may reflect growing recognition of the importance of Mutual Aid agreements between states and incentives inserted in cooperative agreement objectives.
- ▶ State health agencies collaborate with many different entities, including local public health departments, hospitals, and healthcare delivery partners. In 2016, at least 90 percent of state health agencies reported exchanging information and working together on projects with hospitals, physician practices/medical groups, and community health centers.
- ▶ In 2016, 66 percent of SHOs were appointed by the governor, 14 percent were appointed by a parent agency secretary, 10 percent were appointed by a board or commission, and 10 percent were appointed by another entity.
- ▶ Chronic disease has been the top priority for state health agencies from 2010 to 2016. The percentage of priorities related to chronic disease prevention and treatment substantially increased from 14.5 percent in 2012 to 23.9 percent in 2016. Other state health agency priorities include clinical services/consumer care, and quality improvement/performance management.

## AGENCY STRUCTURE

The structure of a state public health agency refers to the agency's placement within the larger departmental/organizational structure of the state. The location of the state health agency will affect how agencies operate in terms of budgeting, decisionmaking, and programmatic responsibility. State public health agencies can either be freestanding/independent agencies or a unit of a larger combined health and human services organization, also referred to as an umbrella agency or super agency. State public health agencies located within a larger agency often reside in that agency with other programs such as Medicaid and Medicare, public assistance, and substance abuse and mental health services.



In 2016, 29 state public health agencies (58%) were freestanding/independent agencies, while 21 (42%) were a unit of a larger umbrella agency. These proportions are the same as for 2012, and have remained almost identical to the percentages for 2007 and 2010 (in both 2007 and 2010, 56% were freestanding/independent agencies and 44% were under a larger agency). Centralized/largely centralized<sup>1</sup> states are slightly more likely than decentralized/largely decentralized<sup>2</sup> states to have freestanding/independent agencies (64% and 58%, respectively). More than twice as many state health agencies in the South are freestanding/independent agencies (N=9) than are under a larger agency (N=4). States with medium and large populations are more likely to have freestanding/independent agencies (65% of medium-sized states and 77% of large states) than states with small populations (31%).

States that reported that public health was under an umbrella agency (N=21) were asked the major areas of responsibility for the parent agency versus the statutory responsibility of the state public health agency. **Figure 1.1** shows the other major areas of responsibility of the parent agency that reported data in 2007, 2010, 2012, and

2016. In 2016, the top three areas of responsibility were Medicaid (91%), state mental health authority combined with substance abuse (81%), public assistance (76%), and substance abuse (76%). While state health agency responsibility for substance abuse and state mental health authority without substance abuse programs have shown large increases from 2012 to 2016, long-term care and other responsibilities have shown sharp decreases from 2012 to 2016. These changes in areas of responsibility are likely due to agency restructuring, which can occur for a number of reasons like cost-saving or a desire to streamline services. Centralized/largely centralized states are more likely to provide all services than decentralized/largely decentralized states, with the exception of environmental protection (no centralized/largely centralized agencies have responsibility for this function, while 27% of decentralized/largely decentralized agencies do).

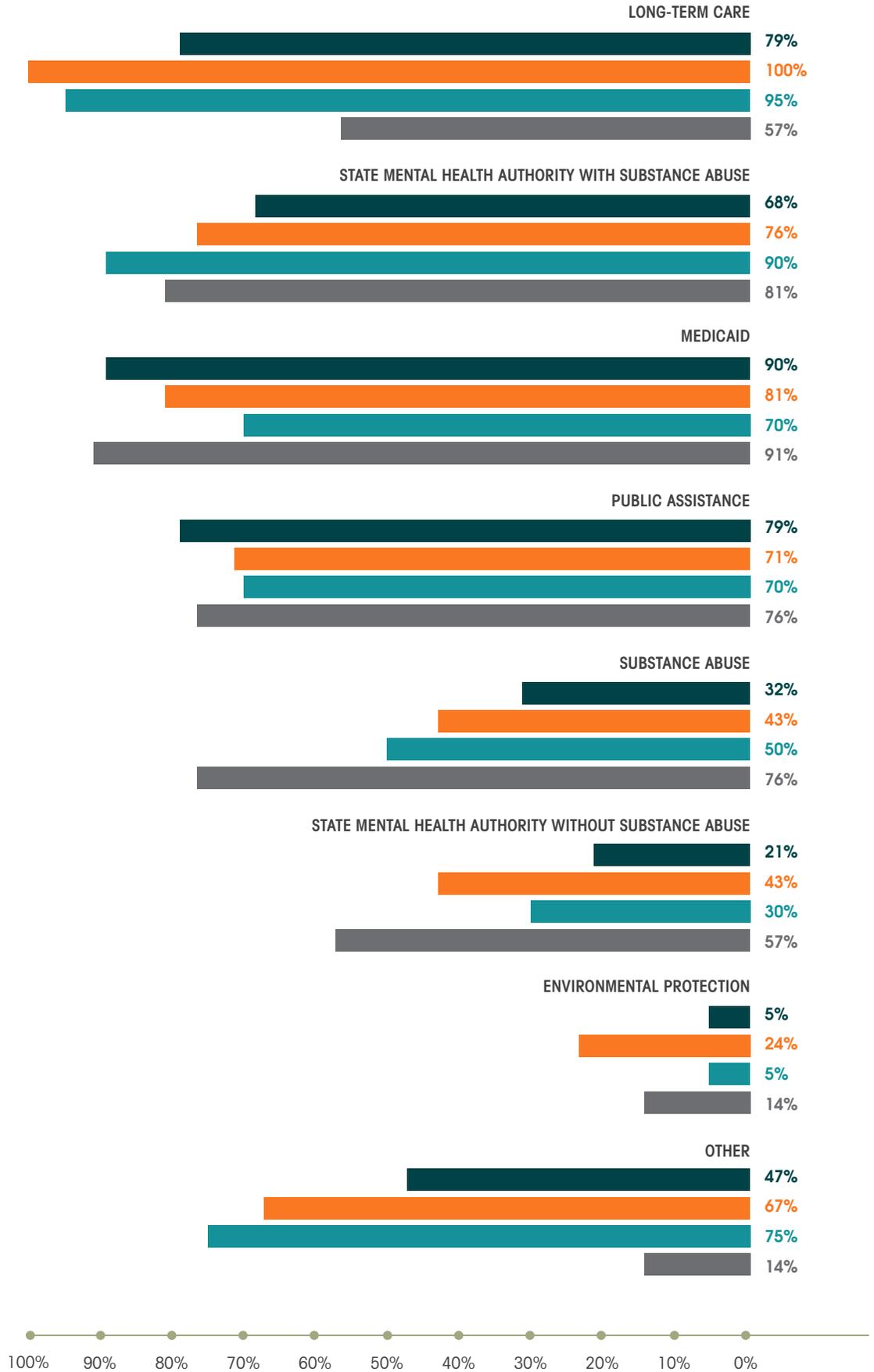
### NOTES

- 1 "Centralized/largely centralized" refers to a governance structure in which state employees primarily lead local health units and the state retains authority over most decisions related to the budget, issuing public health orders, and selecting the local health official. See page 23 for more detailed information about governance classifications.
- 2 "Decentralized/largely decentralized" refers to a governance structure in which local government employees primarily lead local health units and the local governments retain authority over most key decisions. See page 23 for more detailed information about governance classifications.

**FIGURE 1.1**

RESPONSIBILITIES  
OF LARGER  
UMBRELLA  
AGENCIES  
2007-2016  
(N=19-21)

- 2007
- 2010
- 2012
- 2016



# NUMBER AND TYPES OF LOCAL HEALTH DEPARTMENTS

**TABLE 1.1** NUMBER OF LOCAL AND REGIONAL HEALTH DEPARTMENTS, 2010-2016 (N=48)

	2010				2012				2016			
	MEAN	MEDIAN	MIN	MAX	MEAN	MEDIAN	MIN	MAX	MEAN	MEDIAN	MIN	MAX
Independent local health departments	44.40	20	0	351	43.79	19.50	0	351	42.06	14	0	351
State-run local health departments	11.25	0	0	94	13.38	0	0	94	13.84	0	0	128
Independent regional or district offices	0.92	0	0	20	1.60	0	0	21	1.80	0	0	20
State-run regional or district offices	4.29	0	0	33	4.60	1.50	0	33	4.44	0	0	68

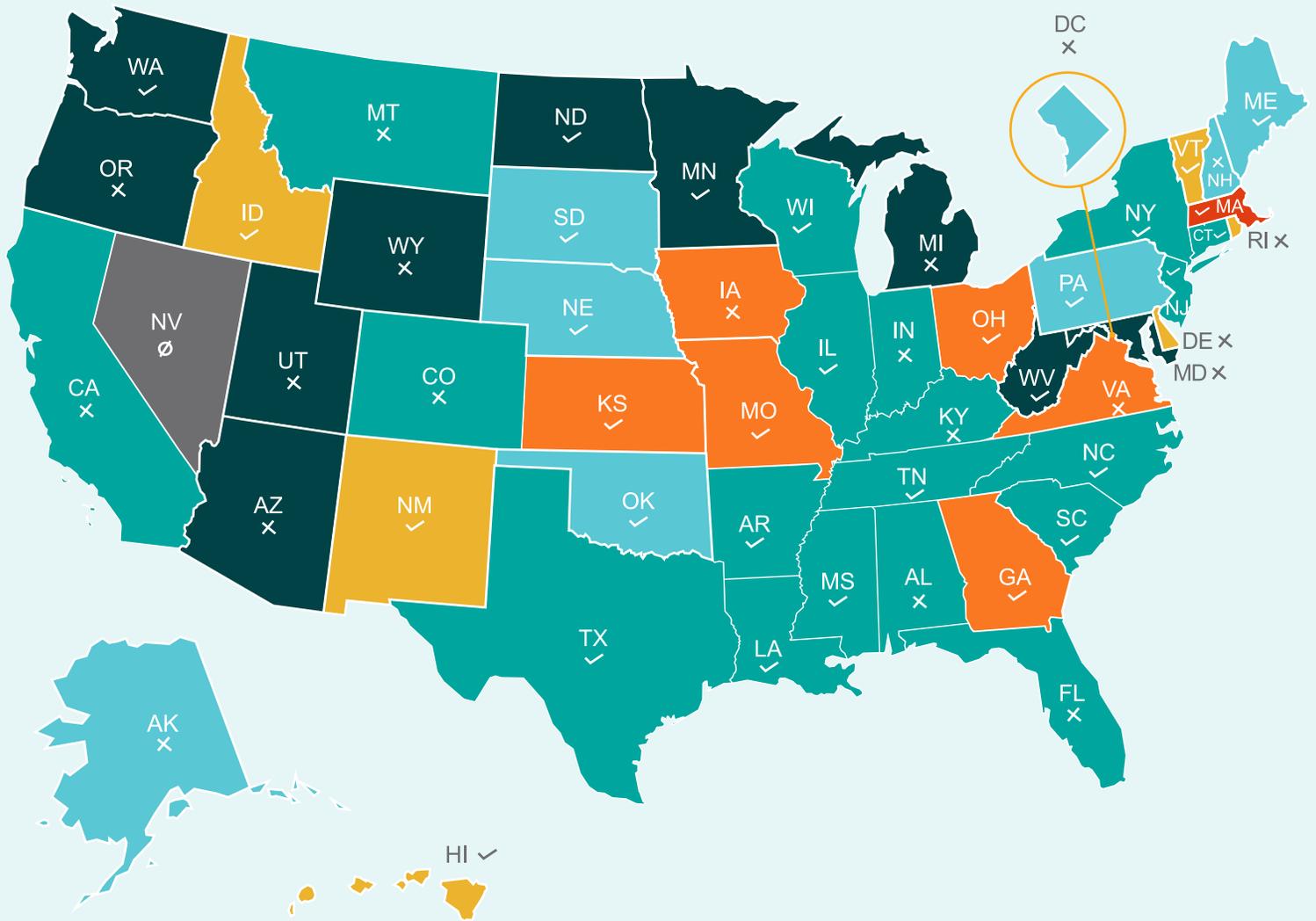
In 2016, 50 state public health agencies reported having a total of 2,795 local health departments and 312 regional or district offices. These numbers are quite similar to those reported by 48 states in 2012 (2,744 local health departments and 298 regional or district offices). **Table 1.1** displays the mean, median, minimum, and maximum number of independent local health departments

(led by staff employed by local government), state-run local health departments (led by staff employed by state government), independent regional or district offices (led by non-state employees), and state-run regional or district offices (led by state employees). The average number of local and regional health departments has not changed notably over time.

**TABLE 1.2**

AVERAGE NUMBER OF TYPES OF LOCAL AND REGIONAL HEALTH DEPARTMENTS BY STATE HEALTH AGENCY CHARACTERISTIC

SHA Characteristic	Mean Number of Health Departments			
	Local Health Departments		Regional Health Departments	
Governance (N=40)	Independent Local	State-Run Local	Independent Regional	State-Run Regional
Centralized/largely centralized	0.64	35.29	0.36	3.79
Decentralized/largely decentralized	71.23	0	3.04	2.35
Region (N=50)				
New England	69.50	0	4.63	5.13
South	28.46	40.15	1.31	10.15
Mid-Atlantic and Great Lakes	46.08	12.67	0.17	2.33
Mountains/Midwest	47.70	1.8	2.7	2.2
West	21	0	1	1
Population Size (N=50)				
Small	9.31	1.19	2.25	2.19
Medium	39.71	22.88	1.47	7.24
Large	75.24	16.71	1.71	3.76



The number of local and regional health departments shows an expected relationship with governance classification. Decentralized/largely decentralized states report many more independent local health departments than centralized/largely centralized states do, while centralized/largely centralized states report many more state-run local health departments than decentralized/largely decentralized states do. This finding, along with regional and population trends, is displayed in **Table 1.2**. Other notable findings include that the South has a greater average number of state-run local health departments (40.15) than all other regions (averages for the other four regions range from 0-12.67), and large states have significantly more independent local health departments on average (75.24) as compared with small (mean=9.31) and medium (mean=39.71) states. The number of local health departments by state is displayed in **Figure 1.2**.

**FIGURE 1.2**  
 MAP WITH NUMBER OF LOCAL HEALTH DEPARTMENTS BY STATE AND Y/N REGIONAL HEALTH DEPARTMENTS

**NUMBER OF LOCAL HEALTH DEPARTMENTS**

- 0
- 1-10
- 11-49
- 50-99
- 100-199
- 200+
- NO DATA

**REGIONAL HEALTH DEPARTMENTS**

- ✓ YES
- X NO
- ∅ NO DATA

## GOVERNANCE STRUCTURE

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The relationship between state health agencies and regional/local public health departments differs across states. These structural differences have important implications for the delivery of essential public health services. Identifying these differences is integral to understanding the roles, responsibilities, and authorities across levels of government for services provided within the community. ASTHO developed a uniform, objective classification of state health agency governance to describe the ways in which public health structure influences health agency operations, financing, and performance. The following decision tree in **Figure 1.3** 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/largely centralized governance structure in which state employees primarily lead local health units and the state retains

authority over most decisions related to the budget, issuing public health orders, and selecting the local health official. Four states (8%) have a shared governance system in which state or local government employees lead local health units. If state employees lead them, the local government has the authority to make key decisions. In states with a shared governance system, local employees lead local health departments and the state health agency has the authority to make key decisions. Over half of states (N=27) have a decentralized/largely decentralized system in which local government employees primarily lead local health units while the local governments retain authority over most key decisions. Ten percent of states (N=5) have a mixed governance structure in which state employees lead some local health units, while local government employees lead others. In states with a mixed governance structure, no one arrangement predominates in the state.

## BOARD OF HEALTH

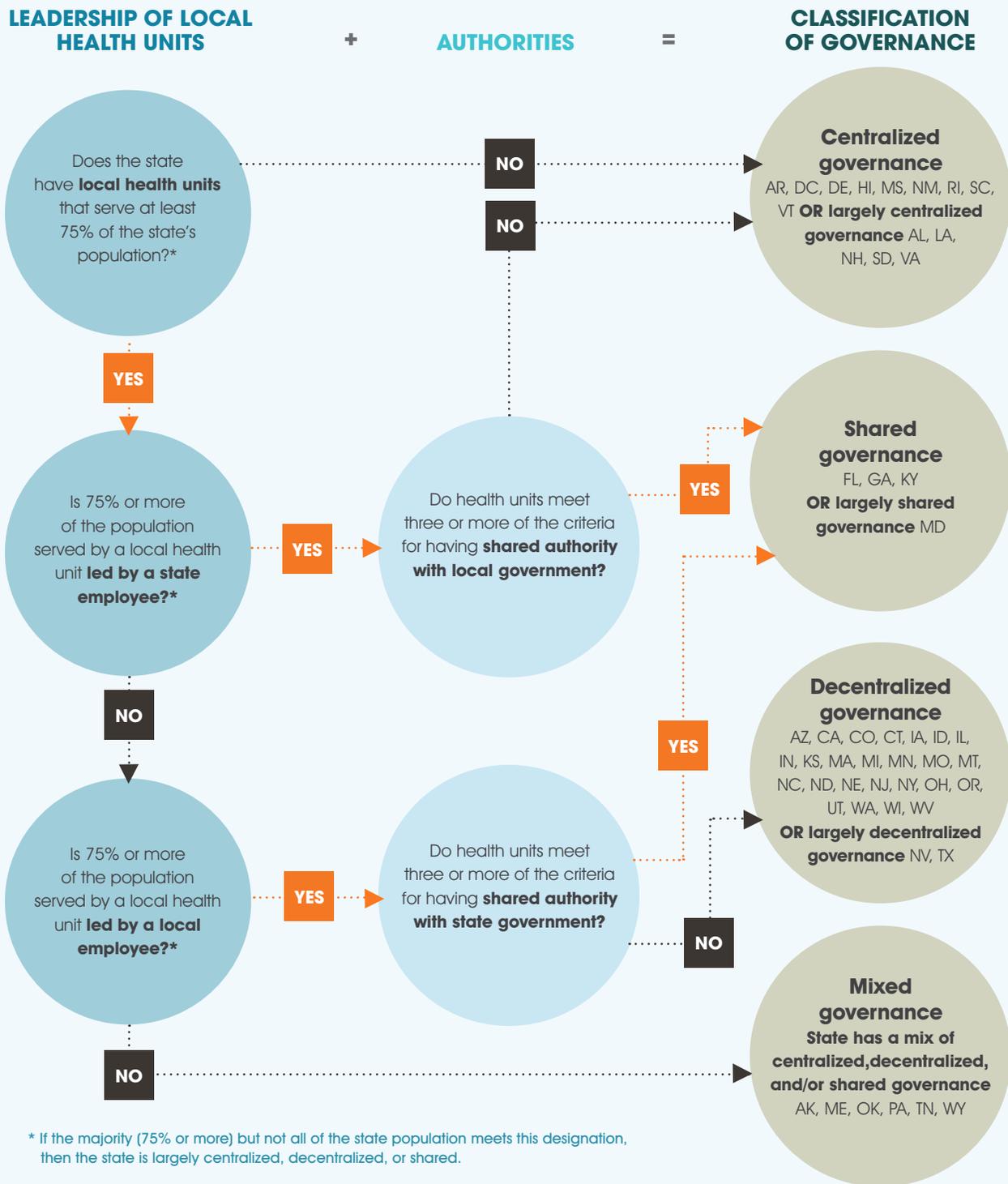
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Eighteen state health agencies (36%) report having a state board of health. In addition, nine states (18%) report having an entity that performs similar functions, even though it is not called a board of health. In 2012, a greater proportion of agencies (45%) reported having a board of health, while 8 percent reported having a similar entity. There are no

notable differences in board of health status by agency structure or geographic region. Large and medium states are more likely to have a board of health or similar entity (64% and 59%, respectively) than are small states (37%).



**FIGURE 1.3** STATE AND LOCAL HEALTH DEPARTMENT GOVERNANCE CLASSIFICATION SYSTEM



**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% or less of local health unit budget is provided by state public health agency
- Local governmental entities can issue public health orders
- Local chief executives are appointed and approved by local officials

**WITH STATE GOVERNMENT**

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

# RESOURCE SHARING

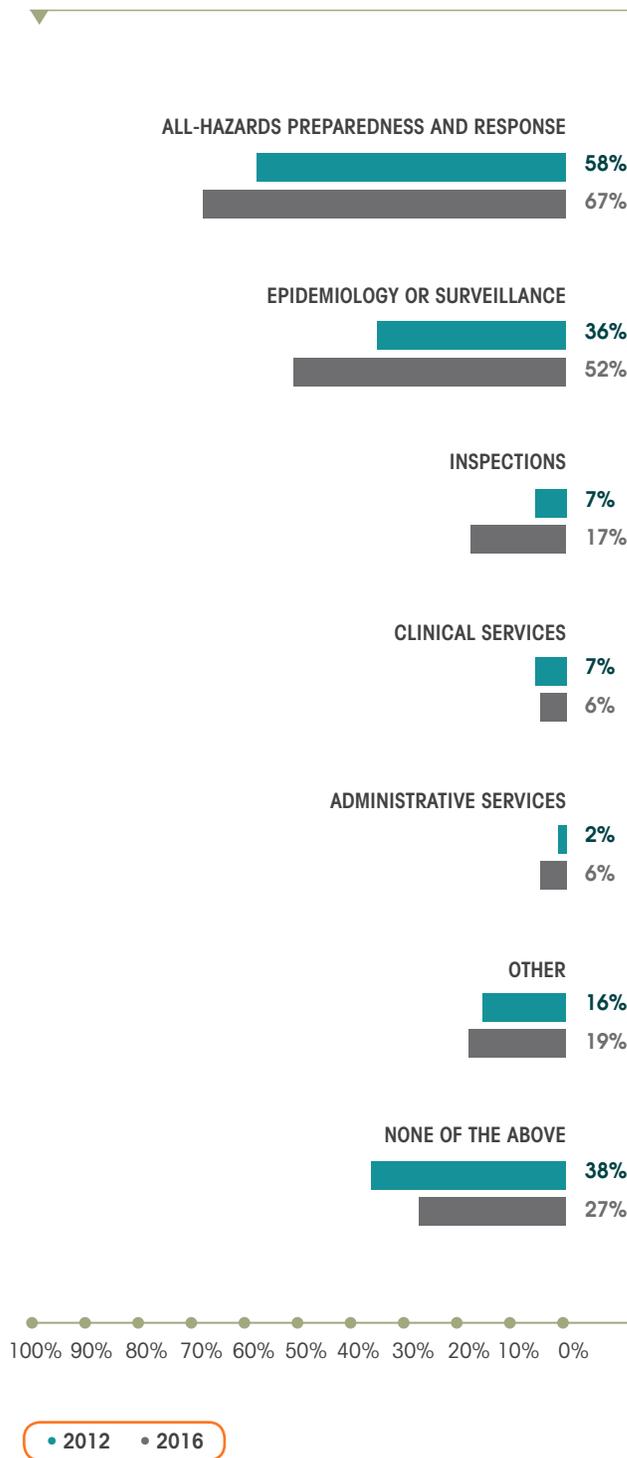
An increasingly popular topic in public health is states sharing resources, such as staff, funding, or equipment, with other state, local, or tribal health agencies. Resource sharing, when done effectively, can fill gaps in services, assist with running programs and providing services more efficiently, and encourage collaboration between agencies in other areas. Of the 49 responding states in 2016, 13 (27%) report sharing resources with other states on a continuous, recurring (non-emergency) basis. This represents a significant increase from 2012, when only four of 46 states (9%) reported resource sharing. Factors leading to this increase may reflect growing recognition of the importance of Mutual Aid agreements of both a formalized and informal nature between states, and incentives produced through supportive language inserted in cooperative agreement objectives issued by the federal government. Medium size states are more likely to share resources (41%) than small (20%) and large (18%) states.

While approximately one-quarter of state health agencies report sharing resources with other states, nearly three-quarters of states (N=35) report facilitating the sharing of resources among local health departments on a continuous, recurring basis. This percentage has remained fairly stable since 2012. States that are decentralized/largely decentralized report facilitating local sharing more frequently as compared with centralized/largely centralized states (76% and 57%, respectively). More than half of states in New England, the South, the Mid-Atlantic and Great Lakes, and in the Mountains and Midwest facilitate local health department resource sharing, while only 29 percent of states in the West facilitate local health department resource sharing.

With regard to population size, medium and large states (both 82%) are more likely to facilitate local sharing than are small states (47%). While approximately one-third of states (35%) do not have any laws or regulations related to resource sharing between local health departments on a continuous, recurring basis, three states have laws or regulations that prohibit such sharing, five states have laws or regulations requiring sharing, and 57 percent have laws and regulations that facilitate resource sharing. This represents an increase from 2012, when 41 percent of states had laws and regulations that facilitate the sharing of resources. Of the 28 states that have laws facilitating resource sharing, 68 percent are decentralized/largely decentralized states. In addition, medium and large states are more likely to have laws facilitating resource sharing (63% and 71%, respectively) than small states (37%).

**FIGURE 1.4**

SHARED SERVICES AND FUNCTIONS BETWEEN STATE HEALTH AGENCIES, 2012-2016 (N=45-48)



The services and functions for which states are most likely to share resources with other states are displayed in **Figure 1.4**. When states do share resources with other states, they are most likely to do so for all-hazards preparedness and response (67%) and epidemiology or surveillance (52%), laying the groundwork for two areas that often require a multi-state response. These represent increases from 2012, when 58 percent shared resources for all-hazards preparedness and response and 36 percent shared resources for epidemiology and surveillance. Sharing resources for inspections also rose from 7 percent in 2012 to 17 percent in 2016.

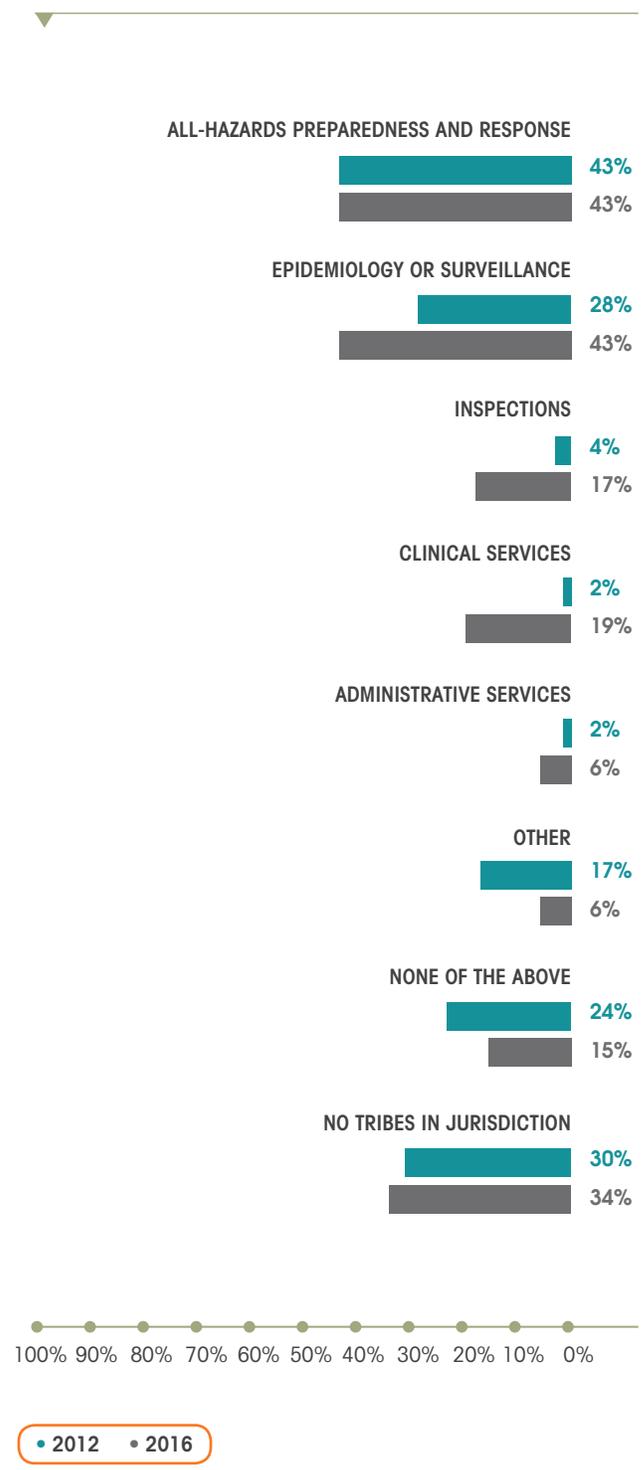
Among states that share resources with other states, 70 percent report having some sort of agreement in place. Of the 35 states reporting agreements, 49 percent report formal, written agreements, 43 percent report some formal and some informal agreements, and 8 percent report having an informal agreement. States in New England (71%) are more likely to take part in some formal and some informal agreements than agencies in the other four regions (values range from 29% to 40%). Medium size states (77%) are more likely to take part in formal, written agreements than are small (36%) and large (27%) states.

Similar to trends for resource sharing among states, when states share resources with tribes, they are most likely to do so for all-hazards preparedness and response and epidemiology and surveillance (both 43%). The percentage of state health agencies that share resources with tribes for a variety of functions and services is displayed in **Figure 1.5**. As with sharing resources among states, the percentage of states sharing resources for epidemiology and surveillance or inspections increased from 2012 to 2016; increases in sharing were noted in all but one category of services and functions.

In contrast to resource sharing among states, when states share resources with tribes (N=25), they are likely to engage in some formal and some informal agreements (64%) followed by formal, written agreements (32%), and then informal agreements (4%). From 2012 to 2016, the percentage of states sharing resources with tribes through formal, written agreements decreased by 20 percent, while the percentage of states sharing resources with tribes through some formal and some informal agreements increased by 35 percent. Decentralized/largely decentralized states are significantly more likely to share resources with tribes through formal, written agreements than are centralized/largely centralized states (36% and 14%, respectively).

**FIGURE 1.5**

SHARED SERVICES AND FUNCTIONS BETWEEN STATE HEALTH AGENCIES AND TRIBES, 2012-2016 (N=46-47)



## PARTNERSHIPS

In addition to sharing resources with other states, local health departments, and tribes, state health agencies collaborate with many types of governmental and nongovernmental agencies. State health agency collaborative activities with other agencies/organizations are displayed in **Table 1.3**. In general, state health agencies report being highly collaborative with local public health agencies, hospitals, and many other entities in the healthcare field. At least 90 percent of state health agencies report exchanging information with hospitals, physician practices/medical groups, community health centers, health insurers, and emergency responders. At least 90 percent also report exchanging information with primary/secondary schools, community-based organizations, higher education (e.g., universities, medical schools, community colleges), media, continuing education (e.g., pharmacy, medical, nursing), and law enforcement. The percentage of state health agencies that report working together on projects with these organizations is also very high. There is a large variation in whether the state health agency provides financial resources to these organizations and whether they have the leadership role within that particular partnership.

These levels of collaboration have remained largely stable from 2012 to 2016. However, there was a notable increase over time in one area—the percentage of agencies that reported exchanging information with health insurers (72% in 2012, 92% in 2016). This trend is undoubtedly partially attributable to the rapid increase in the number of states implementing All-Payer Claims Databases (APCD). These are electronic systems that aggregate claims and administrative data from public and private payers, allowing policymakers to identify and act upon trends. The APCD Council reports that 23 states have achieved some level of implementation and 12 more are investigating this—up from 10 in 2014.<sup>3,4</sup> Other contributing factors include implementation of the HITECH Act and Affordable Care Act and concomitant federal and state regulation.

In 2016, ASTHO asked respondents a new series of follow-up questions about the nature of the collaborations in which they participate. These questions were based on a review of elements key to successful collaborations: memorandums of understanding (MOUs); a designated body with a charter; a common understanding of population health concepts, definitions, and principles across the partners in the formal partnerships; and specified health objectives and targets.<sup>5</sup>

Respondents were asked to indicate whether any of the collaborations that they listed were formal partnerships. This was defined as partnerships governed by an MOU or other written agreement involving more than one sector outside of public health (e.g., a partnership among the state health agency, education, and business groups). A majority of state health agencies (84%) reported being part of one or more formal partnerships. When asked how many of these formal partnerships had adopted a statement of mission and goals, 38 percent of state health agencies reported that most or all partnerships had done so; 37 percent reported that some had done so; 19 percent reported that few had done so; and 5 percent of states were unsure.

When asked how many of their partnerships had a designated body with a charter, fewer reported that most or all did (17%). However, 38 percent reported that some did, 30 percent reported that few did, and one state reported that none had a designated body and charter. Twelve percent of respondents were unsure whether or not any of their partnerships had a designated body and charter. Only medium-sized states (13%) reported that all partnerships had a designated body and charter.

When asked if there was a common understanding of population health concepts, definitions, and principles across the partners involved in formal partnerships, results varied as shown in **Figure 1.6**. Medium (19%) and large (21%) states were more likely than small (0%) states to report a common understanding in all partnerships.

### NOTES

- 3 The Source on Healthcare Price and Competition. "Issue Brief: All Payer Claims Databases." Available at [www.sourceonhealthcare.org/legislative-topics-payer-claims-databases/](http://www.sourceonhealthcare.org/legislative-topics-payer-claims-databases/). Accessed August 14, 2017.
- 4 APCD Council. "Standards." Available at [www.apcdouncil.org/standards](http://www.apcdouncil.org/standards). Accessed August 14, 2017.
- 5 Pestronk RM, Elligers JJ, Laymon B. "Public health's role: Collaborating for healthy communities." *Health Prog.* 2013. 94(1):20-5. Available at [www.ncbi.nlm.nih.gov/pubmed/23393725](http://www.ncbi.nlm.nih.gov/pubmed/23393725).

**TABLE 1.3** ACTIVITIES IN COLLABORATION WITH OTHER AGENCIES/ORGANIZATIONS, 2016 (N=43-49)

\* CONTINUES ON THE NEXT PAGE

Collaborating Agencies/Organizations	Exchange Information		Work Together on Projects		State Health Agency Provides Financial Resources		State Health Agency Has Leadership Role in the Partnership		No Relationship Yet		Organization Does Not Exist in Jurisdiction	
	N	%	N	%	N	%	N	%	N	%	N	%
Local public health agencies	43	88%	43	88%	42	86%	32	65%	0	0%	6	12%
Hospitals	49	100%	49	100%	39	80%	26	53%	0	0%	0	0%
Physician practices/medical groups	44	92%	45	94%	23	48%	19	40%	1	2%	0	0%
Community health centers	43	94%	45	98%	38	83%	19	41%	0	0%	0	0%
Other healthcare providers	41	89%	39	85%	23	50%	18	39%	1	2%	2	4%
Health insurers	44	92%	43	90%	10	21%	9	19%	0	0%	1	2%
Emergency responders	48	98%	47	96%	31	63%	27	55%	0	0%	0	0%
Land use/planning agencies	28	65%	27	63%	4	9%	3	7%	6	14%	3	7%
Economic and community development agencies	32	71%	30	67%	6	13%	4	9%	7	16%	3	7%
Housing agencies	29	63%	36	78%	15	33%	6	13%	6	13%	2	4%
Utility companies/agencies	21	48%	18	41%	4	9%	2	5%	17	39%	5	11%
Environmental and conservation agencies	32	73%	34	77%	7	16%	6	14%	8	18%	0	0%
Cooperative extensions	33	72%	34	74%	14	30%	6	13%	8	17%	2	4%
Primary/secondary schools	44	92%	47	98%	28	58%	14	29%	0	0%	0	0%
Parks and recreation	37	80%	36	78%	10	22%	5	11%	4	9%	1	2%
Transportation	40	85%	41	87%	10	21%	7	15%	3	6%	0	0%
Community-based organizations	46	96%	48	100%	43	90%	31	65%	0	0%	0	0%
Faith communities	38	81%	44	94%	24	51%	12	26%	3	6%	0	0%
Other voluntary or nonprofit organizations (e.g., libraries)	38	86%	38	86%	19	43%	13	30%	4	9%	0	0%
Higher education (e.g., universities, medical schools, community colleges)	48	98%	49	100%	31	63%	24	49%	0	0%	0	0%

**TABLE 1.3** ACTIVITIES IN COLLABORATION WITH OTHER AGENCIES/ORGANIZATIONS, 2016 (N=43-49)

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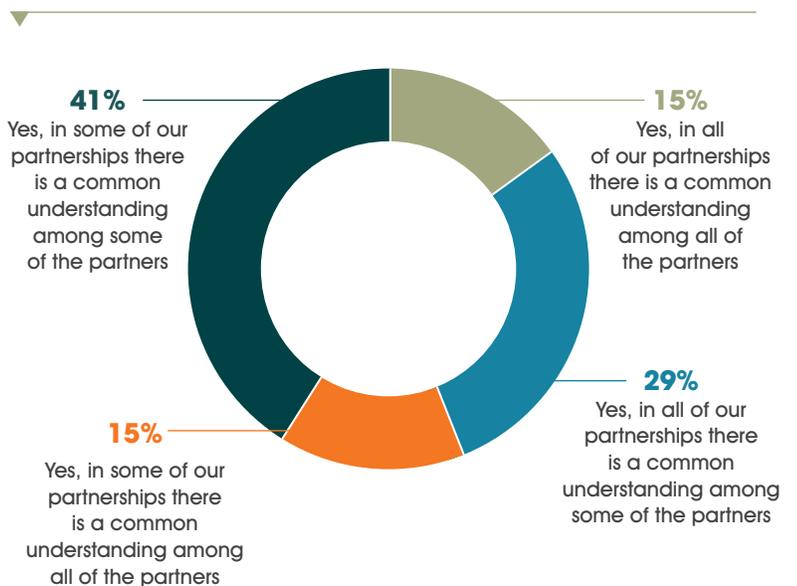
Collaborating Agencies/Organizations	Exchange Information		Work Together on Projects		State Health Agency Provides Financial Resources		State Health Agency Has Leadership Role in the Partnership		No Relationship Yet		Organization Does Not Exist in Jurisdiction	
	N	%	N	%	N	%	N	%	N	%	N	%
Business	35	81%	38	88%	12	28%	9	21%	2	5%	0	0%
Media	42	96%	30	68%	11	25%	5	11%	0	0%	0	0%
Tribal government agencies or other tribal community	31	67%	31	67%	22	48%	14	30%	2	4%	12	26%
Continuing education (e.g., pharmacy, medical, nursing)	41	91%	39	87%	17	38%	12	27%	1	2%	1	2%
State boards of health	30	63%	31	65%	12	25%	9	19%	0	0%	16	33%
Local boards of health	33	69%	25	52%	17	35%	13	27%	1	2%	13	27%
Food banks	37	82%	35	78%	11	24%	6	13%	5	11%	0	0%
Energy agencies	22	51%	22	51%	0	0%	2	5%	15	35%	3	7%
Law enforcement	45	96%	45	96%	9	19%	8	17%	1	2%	0	0%
Justice system	37	80%	36	78%	4	9%	10	22%	4	9%	0	0%

Approximately three-quarters (73%) of state health agencies with formal partnerships reported that, in some formal partnerships, both their health objectives and targets have been specified. Approximately one-quarter (27%) reported that health objectives and targets had been specified in all partnerships. States in the Mid-Atlantic and Great Lakes (38%) and the South (39%) were more likely to report that the health objectives and targets had been specified in all formal partnerships than were states in the other three geographic regions (values in other regions ranged from 13-17%).

Similarly, when asked if the tools they will use to track and monitor progress have been specified, 71 percent reported that they had in some partnerships, while 27 percent reported that they had in all partnerships; two states were unsure. States in the Mid-Atlantic and Great Lakes (50%) were more likely to report that the tools had been specified in all partnerships than were states in the other four regions (values ranged from 17-25%).

**FIGURE 1.6**

FORMAL PARTNERSHIPS WITH A COMMON UNDERSTANDING OF POPULATION HEALTH CONCEPTS, DEFINITIONS, AND PRINCIPLES ACROSS PARTNERS, 2016 (N=41)

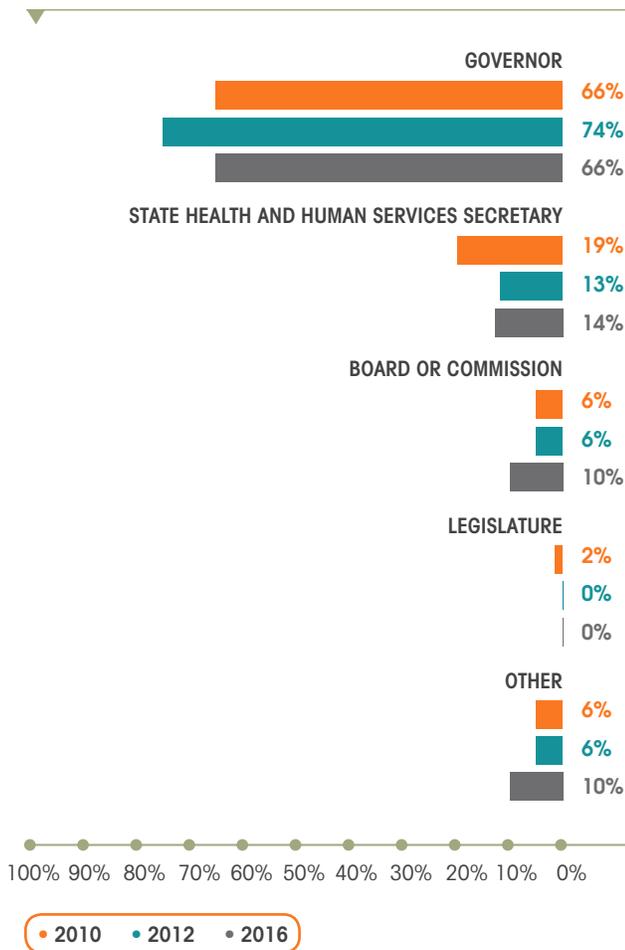


# STATE HEALTH OFFICIALS

Resource sharing, collaborations, and partnerships cannot occur without support from the highest level at a state public health agency—the state health official. All state health agencies are led by a state health official (SHO), also known as a state health secretary or commissioner of health. As of 2016, 33 of 50 state health agencies (66%) report that the governor appoints the SHO. Other SHOs are appointed by the state health and human services (HHS) secretary, boards or commissions, or legislature. While the proportion of governor-appointed SHOs rose from 2010 to 2012 by 8 percentage points, the proportion in 2016 reverted to 2010 levels. A graph showing who appointed the SHO in 2010, 2012, and 2016 is displayed in **Figure 1.7**. SHOs in decentralized/largely decentralized states are more likely to be governors' appointees (73% vs. 50%). Only centralized/largely centralized medium-sized states in the South have SHOs appointed by a board or commission.

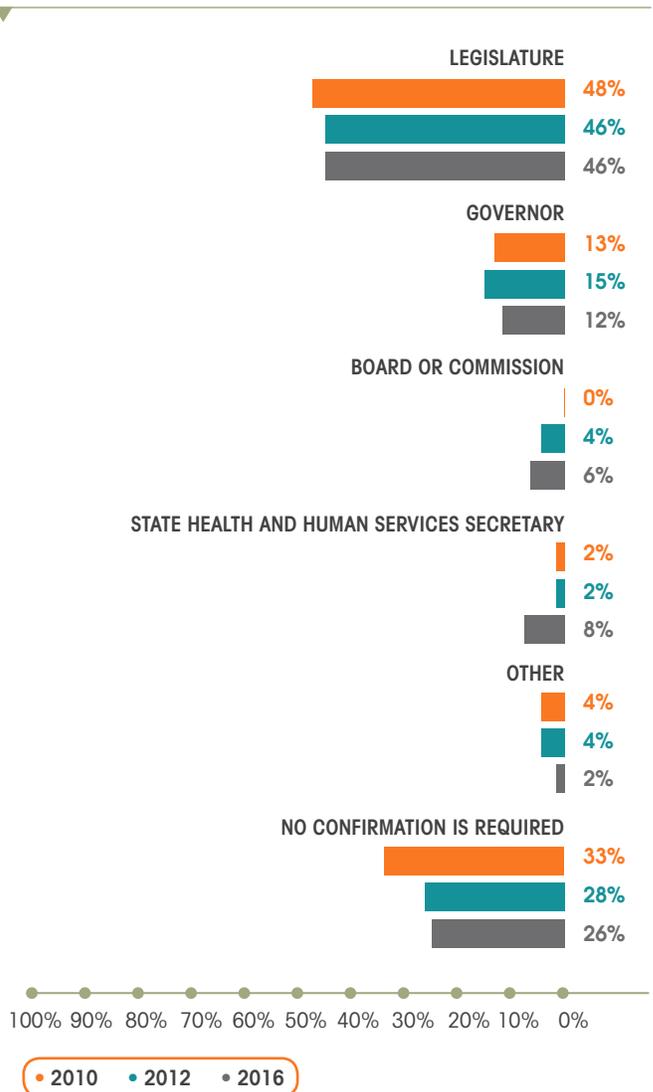
**FIGURE 1.7**

APPOINTMENT OF THE STATE HEALTH OFFICIAL, 2010-2016 (N=47-50)



**FIGURE 1.8**

CONFIRMATION OF STATE HEALTH OFFICIAL, 2010-2016 (N=46-50)

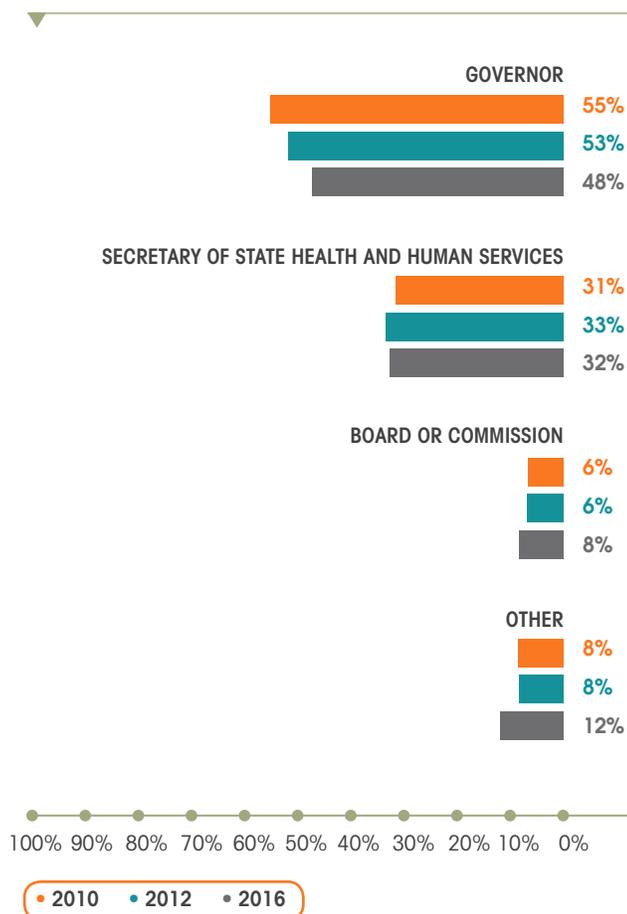


Once the SHO is appointed, 74 percent of state health agencies require confirmation of the appointment by the legislature, governor, board or commission, HHS secretary, or another entity. The percentage of state health agencies that require confirmation of the SHO by each of these entities among states in 2010, 2012, and 2016 is displayed in **Figure 1.8**. Only decentralized/largely decentralized states (12%) report having SHOs confirmed by the state HHS secretary. While the entity responsible for confirming the SHO generally varies across regions, all seven Mountain and Midwest states that require confirmation of the SHO require it from the legislature. Confirmation by the governor is more often required in large states (24%) than in medium (12%) or small (0%) states.

When SHOs are appointed, only eight states (16%) appoint them to a specific term. In contrast, 10 states appointed them

**FIGURE 1.9**

STATE HEALTH OFFICIAL DIRECT REPORT, 2010-2016 (N=49-50)



to a specific term in 2010 and 2012. The appointment of SHOs to a specific term shows some variation by state size (19% of small, 24% of medium, and 6% of large states have SHOs with a set term).

When SHOs are appointed to a specific term, the term length varies from two to six years, with an average term of 4.1 years. This is slightly longer than the average set term in 2012 (3.9 years), but still shorter than the average set term in 2010 (4.5 years). Centralized/largely centralized states have SHOs with official term lengths somewhat longer than those of decentralized/largely decentralized states (an average of 4.8 years and 3.5 years, respectively). The state with the longest set term is in the South region (6 years), while states in the Mid-Atlantic and Great Lakes have the shortest set term lengths on average (3 years). Small and medium-sized states have longer set terms (average length=4.3 years and 4.5 years, respectively) than do large states (average

length=2 years). When SHOs are appointed to a specific term, the term is set by law in seven of eight states, rather than by contract. In 2012, all 10 states with SHOs appointed to a specific term had the term set by law.

Almost half of SHOs (48%) report directly to the governor, while about one-third (32%) report to the state HHS secretary. As shown in **Figure 1.9**, the percentage of SHOs that directly report to various entities has not changed substantively over time. SHOs in decentralized/largely decentralized states are twice as likely to report directly to the governor (58%) as SHOs from centralized/largely centralized states. Only SHOs in the South (31%) report directly to a board or commission. In the Mountain and Midwest states, 70 percent of SHOs report directly to the governor, while 63 percent report to the state HHS secretary in New England. Only medium-sized states have SHOs that report directly to a board or commission (24%). Large states are more likely to have SHOs that report to the governor (65%) than medium (47%) and small (31%) states.

When asked who is involved in the budget approval process, the legislature (92%), governor (88%), and state budget office (86%) were the top three entities selected. Other entities involved in the budget approval process are the state HHS secretary (34%), board of health (2%), and other (12%). This distribution is fairly similar to the distributions for 2010 and 2012, with the exception of the state budget office's involvement, which increased from 68 percent of agencies in 2012 to 86 percent of agencies in 2016. Large states are more likely than small or medium-sized states to have the state budget office involved in the budget approval process. The reverse trend is found for the state HHS secretary, such that large states are less likely than small or medium-sized states to have the state HHS secretary involved in the budget approval process.

Just as the SHO is most frequently appointed by and reports directly to the governor, the SHO can be removed from his or her position at the will of the governor in the majority of states (84%). This percentage has remained fairly stable since 2010. This is more often the case in decentralized/largely decentralized states (92%) than in centralized/largely centralized states (64%). In some instances, the SHO can be removed by board or commission action (only in the South; 38%), legislative action (only in New England; 13%), or termination of contract (only in the Mid-Atlantic and Great Lakes; 8%). A board or commission can only remove the SHO in medium-sized states (29%).

## STATE HEALTH AGENCY PRIORITIES

The SHO's portfolio is large and diverse. They must strategize and prioritize the many important topics that come to their attention during their tenure. Senior deputies, who responded to the Profile Survey on the SHO's behalf, were asked to list the top five priorities for their state public health agency for the current fiscal year. The most common top priorities for 2010, 2012, and 2016 were categorized thematically and are displayed in **Table 1.4**.

Although responses varied by state, several common themes emerged. As in 2010 and 2012, chronic disease prevention was the most frequently cited category of priorities. This largely reflects the greater public health focus on chronic diseases in the U.S.—where chronic diseases such as heart disease, cancer, and stroke remain the leading preventable causes of death among adults.<sup>6</sup>

The percentage of priorities related to chronic disease prevention and treatment substantially increased from 14.5 percent in 2012 to 23.9 percent in 2016. In 2016, clinical services/consumer care (e.g., clinical programs such as tuberculosis (TB) treatment and emergency medical services) and quality improvement/performance management (e.g., efforts to improve organizational performance and efficiency) were the second and third most frequently cited priorities at 9.4 percent and 8.6 percent, respectively. Priorities displaying a decrease in frequency over time included funding, health and healthcare reform, and communication. Despite the fact that there has been increased resource sharing among states, infectious disease and all-hazards preparedness and response have also both decreased as agency priorities during this time.

\* Please see pages 32-33 for definitions of state health agency priorities.

SHOs cannot address these priorities alone. In the next chapter, we will describe the men and women that comprise the state public health agency workforce and explore the integral role they play in the agency's success.

**TABLE 1.4** STATE HEALTH AGENCY TOP PRIORITIES, 2010-2016

CATEGORY	2010: N (%)	2012: N (%)	2016: N (%)
Chronic disease	45 (17.6%)	37 (14.5%)	61 (23.9%)
Clinical services/ consumer care	26 (10.2%)	29 (11.4%)	24 (9.4%)
Quality improvement/ performance management	22 (8.6%)	34 (13.3%)	22 (8.6%)
Health data/health information technology	17 (6.7%)	9 (3.5%)	17 (6.7%)
General public health initiatives	13 (5.1%)	16 (6.3%)	17 (6.7%)
Infectious disease	15 (5.9%)	12 (4.7%)	12 (4.7%)
Health equity	9 (3.5%)	12 (4.7%)	10 (3.9%)
Workforce development	8 (3.1%)	12 (4.7%)	9 (3.5%)
All-hazards preparedness and response	13 (5.1%)	13 (5.1%)	8 (3.1%)
Public health infrastructure	10 (3.9%)	8 (3.1%)	8 (3.1%)
Environmental health	10 (3.9%)	2 (0.8%)	7 (2.7%)
Funding	12 (4.7%)	9 (3.5%)	7 (2.7%)
Quality of health services	4 (1.6%)	5 (2.0%)	6 (2.4%)
Accreditation	1 (0.4%)	6 (2.4%)	6 (2.4%)
Partnerships/ collaboration	6 (2.4%)	5 (2.0%)	6 (2.4%)
Health and healthcare reform	18 (7.1%)	13 (5.1%)	6 (2.4%)
Injury prevention	4 (1.6%)	7 (2.7%)	4 (1.6%)
Health laboratory	0 (0.0%)	1 (0.4%)	1 (0.4%)
Communication	8 (3.1%)	6 (2.4%)	1 (0.4%)
Missing	14 (5.5%)	18 (7.1%)	23 (9.0%)
Total	255 (100%)	255 (100%)	255 (100%)

### NOTES

6

National Center for Health Statistics. "Leading Causes of Death." Available at [www.cdc.gov/nchs/fastats/leading-causes-of-death.htm](http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm). Updated March 17, 2017. Accessed August 8, 2017.



# DEFINITION OF STATE HEALTH AGENCY PRIORITIES

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## Chronic Disease

Includes chronic disease prevention activities such as heart disease, cancer, and tobacco prevention control programs, as well as substance abuse prevention. These are provided under disease investigation, screening, outreach, and health education programs. Also includes safe and drug-free schools, health education related to chronic disease, and nutrition education (excluding WIC).

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## Clinical Services/Consumer Care

Includes all clinical programs such as access to care, pharmaceutical assistance programs, Alzheimer's disease, adult day care, medically handicapped children, AIDS treatment, pregnancy outreach and counseling, family planning education and abstinence programs, chronic renal disease, breast and cervical cancer treatment, TB treatment, emergency health services, genetic services, state 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. Also includes funds for Indian healthcare.

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## Quality Improvement/Performance Management

Includes use of a deliberate and defined improvement process focused on activities that are responsive to community needs and improving population health. Includes continuous and ongoing efforts to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve community health. Also includes systematic processes that help an organization achieve its mission and strategic goals.

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## Health Data/Health Information Technology

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.

## General Public Health Initiatives

Includes efforts to improve targeted and general health outcomes delivered through wellness initiatives, public health programming, fostering cultures of health, and worksite wellness programs.

## Infectious Disease

Includes immunization programs (including the cost of vaccines and administration), infectious disease control, veterinary diseases affecting human health, and health education and communications related to infectious disease.

## Health Equity

Includes efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. Includes efforts to reduce health disparities.

## Workforce Development

Includes efforts to improve health outcomes by enhancing the training, skills, and performance of state public health agency workers.

## 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, and distribution of medical countermeasures (vaccination clinics and points of distribution).

## Public Health Infrastructure

Includes utilizing the systems, competencies, frameworks, relationships, and resources that enable state public health agencies to perform their core functions and essential services. Infrastructure categories encompass human, organizational, informational, legal, policy, and fiscal resources.

## Environmental Health

Includes lead poisoning programs, non-point source pollution control, air quality, solid and hazardous waste management, hazardous materials training, radon, water quality and pollution control (including safe drinking water, fishing advisories, and swimming), water and waste disposal systems, pesticide regulation and disposal, and nuclear power safety. Also includes food service and lodging inspections.

## Funding

Includes state health agency efforts to maintain current levels of federal and non-federal funding, advocate for increased funding, and/or address budget cuts.

## Quality of Health Services

Includes quality regulatory programs such as health facility licensure and certification, equipment quality (e.g., x-ray, mammogram, etc.), regulation of emergency medical systems such as trauma designation, health related boards or commissions administered by the health agency, physician and provider loan programs, licensing boards and oversight when administered by the health agency, provider and facility quality reporting and institution compliance audits. Also includes the financing of activities and programs in this area.

## Accreditation

Includes measurement of state health agency performance against a set of nationally recognized, practice-focused and evidenced-based standards in order to improve and protect the public's health by advancing the quality and performance of state health agencies.

## Partnerships/Collaboration

Includes two or more organizations or entities working together to address emerging epidemics, develop the public health workforce, communicate public health information, translate science to practice, and evaluate effective public health services.

## Health and Healthcare Reform

Includes efforts to improve national health and healthcare policy.

## 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, onsite safety and health consultation, workplace violence prevention, child abuse prevention, occupational health, safe schools, and boating and recreational safety.

## Health Laboratory

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

## Communication

Includes both internal and external communications by and with state and territorial health agencies, disseminating information, and communicating the value of public health.



# STATE HEALTH AGENCY WORKFORCE

This chapter describes the workforce of state public health agencies, detailing the workforce's size, salaries by occupational categories, and employee demographics. It includes information on vacancies, turnover rates, and projected retirements. This chapter also describes state health officials' qualifications, tenures, and salaries. Throughout the chapter, 2016 data will be compared with 2012, 2010, and 2007 data when possible, and we will note differences in state health agency workforce by governance structure, region, and state population size when applicable.

### KEY FINDINGS

#### Workforce and Occupational Trends

- Based on the figures reported in 2016, the public health workforce is estimated to be 97,230 full-time equivalents (FTEs) for the 50 states and District of Columbia.<sup>1</sup> From 2012 to 2016, the estimated total number of FTEs has decreased by more than 3,000. Explanations for this decline include decreases in direct service provision and decreases in funding.
- The number of staff and FTEs is related to state population size, so smaller states tend to have the lowest number of staff and FTEs and larger states tend to have the highest number of staff and FTEs.
- The occupational classifications with the greatest average number of staff are office and administrative support, business and financial operations, and behavioral health.

#### SHO Tenure and Educational Attainment

- The length of time that SHOs have held their positions is highly variable. As of September 2016, the range in length of time state health officials had been in their position was two months to nearly 15 years. Sixty-four percent of SHOs hold an MD or a DO. Of those, 52 percent also have an MPH.

#### Demographics

- The majority of employees at state health agencies are female (70%), white (72%), and non-Hispanic/Latino (92%). There are some differences in the racial composition of state health agency staff, with Southern states having the highest proportion of black/African-American employees (28%) and Western states having the highest proportion of Asian employees (15%).

#### Vacancies and Retirement

- On average, 14 percent of positions at state health agencies are currently vacant. Of that 14 percent, however, active recruitment is occurring for only 25 percent of those vacancies.
- From 2016 to 2020, the percentage of state health agency employees who are eligible for retirement is expected to increase from 17 to 25 percent.

#### Workforce Development

- State health agencies prioritize workforce development. More than three-quarters of state health agencies have a workforce development plan in place, and more than half have a workforce development director.

### NOTES

- 1 One survey respondent did not respond to this item. State population and the average number of FTEs per 100,000 population for their responses in 2010 and 2012 were used to estimate their number of FTEs for 2016.

# NUMBER OF STATE HEALTH AGENCY EMPLOYEES

In 2016, the 49 state health agencies that responded to the Profile Survey reported a total of 96,902 FTEs and 101,009 staff members (this includes temporary and contract workers). Based on the reported figures, the total number of public health FTEs for the 49 responding states<sup>2</sup> and the District of Columbia is estimated to be 97,230.<sup>3</sup> From 2010 to 2012, the estimated number of FTEs among all states and D.C. decreased by approximately 6,000. From 2012 to 2016, the total estimated total number of FTEs decreased by about 3,000 as shown in **Table 2.1**. Explanations for this decline include decreases in direct service provision, decreases in funding, and increases in the amount of funding distributed as pass-throughs and grants/contracts to third parties, such as local health departments and nonprofits.

**TABLE 2.1** ESTIMATED NUMBER OF STATE HEALTH AGENCY FULL-TIME EMPLOYEES, 2010-2016<sup>4</sup>

	2010			2012			2016		
	MEAN	MEDIAN	TOTAL	MEAN	MEDIAN	TOTAL	MEAN	MEDIAN	TOTAL
Number of FTEs (N=50)	2,129	1,210	106,459	2,010	1,152	100,468	1,945	1,090	97,230

The number of FTEs per 100,000 for each state is displayed in **Figure 2.1**. On average, centralized/largely centralized states tend to have more staff and FTEs than decentralized/largely decentralized states, likely due to their including local health departments as part of their agency. Southern states have the most staff and FTEs on average, while states in the Mountains and Midwest have the lowest number of staff and FTEs. Looking at the raw data alone, the number of staff and FTEs is related to state population size such that smaller states tend to have the lowest number of staff and FTEs, while larger states tend to have the highest number of staff and FTEs. **Table 2.2** displays the average number of FTEs and the average number of FTEs per 100,000 population for states that serve small, medium, and large populations. As the size of the population increases, the average number of FTEs per 100,000 population decreases.

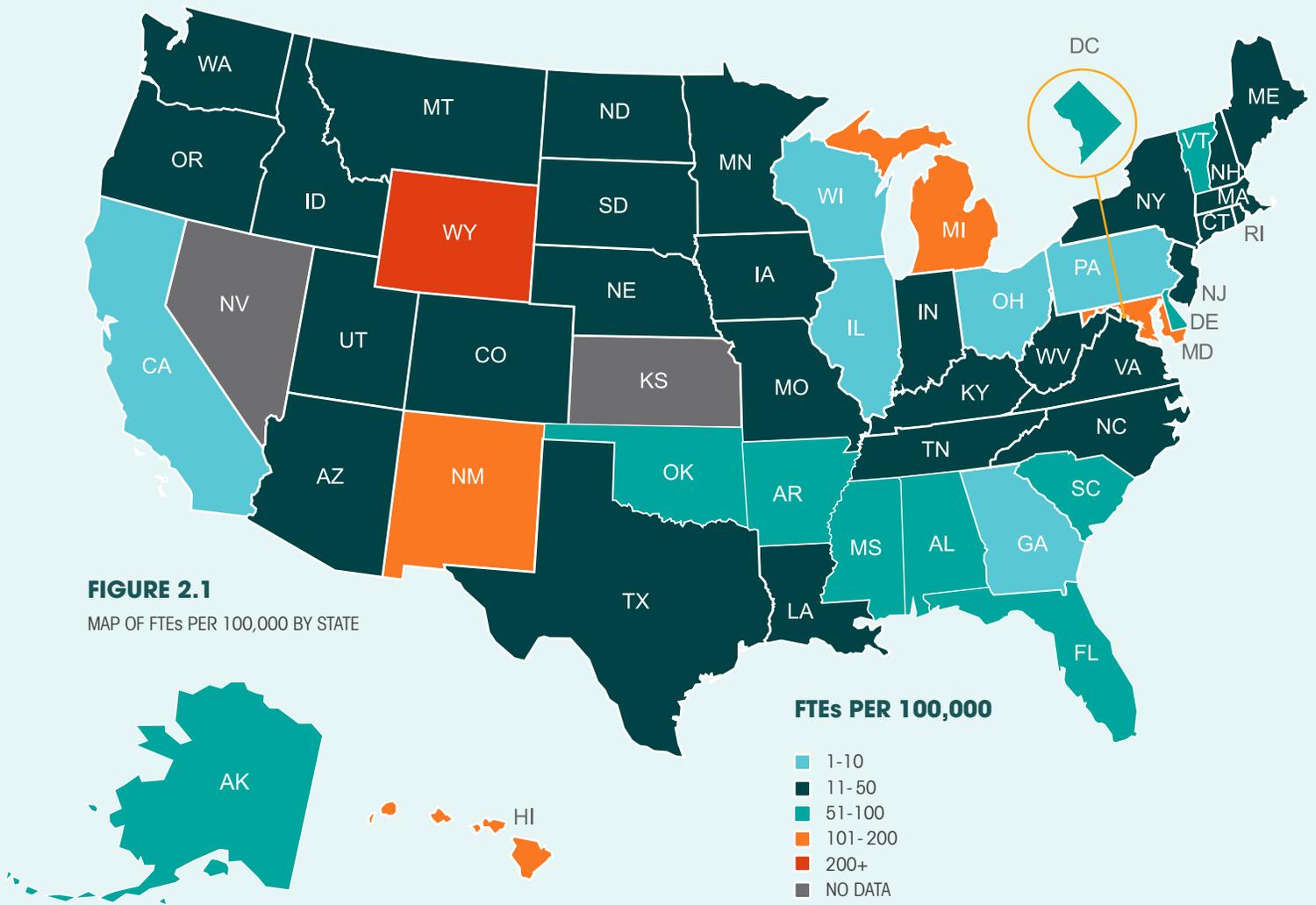
**TABLE 2.2**

ESTIMATED AVERAGE NUMBER OF FTES AND AVERAGE NUMBER OF FTES PER 100,000 POPULATION BY STATE SIZE (N=50)<sup>5</sup>

State Size	Mean Number of FTES	Mean Number of FTES per 100,000 Population
Small (N=16)	853	76
Medium (N=16)	1,833	41
Large (N=17)	3,085	23

## NOTES

- 2** One state did not respond to this question in any survey round, and so was excluded from this analysis.
- 3** One survey respondent did not respond to this item. State population and the average number of FTEs per 100,000 population for their responses in 2010 and 2012 were used to estimate their number of FTEs for 2016.
- 4** For states that did not respond at a given time point, state population and the average number of FTEs per 100,000 population for their responses in the other two survey rounds were used to estimate the number of FTEs for the missing data point.
- 5** One survey respondent did not respond to this item. State population and the average number of FTEs per 100,000 population for their responses in 2010 and 2012 were used to estimate their number of FTEs for 2016.



**FIGURE 2.1**  
MAP OF FTEs PER 100,000 BY STATE

**FTEs PER 100,000**

- 1-10
- 11-50
- 51-100
- 101-200
- 200+
- NO DATA

Respondents were also asked to classify workers by employment category (e.g., part-time, hourly worker) and assignment (e.g., central office, regional, or district office). Results are displayed in **Table 2.3**.

Union membership rates vary across states. In 2016, union membership in state health agencies ranged from a low of 0 percent to a high of 100 percent. Of the 46 states reporting percentages for collective bargaining, 43 percent of employees have union representation. New England states have the greatest average percentage of employees represented by unions (90%), while Southern states have the lowest percentage (14%). Although the average union membership percentage for 2016 appears much lower than union membership in 2010 and 2012 (73%), this is likely due to the increased response rate.<sup>6</sup> There are no trends in union membership by governance classification or state size.

**TABLE 2.3**

NUMBER OF STATE HEALTH AGENCY EMPLOYEES BY CATEGORY AND ASSIGNMENT

Employment Category/Assignment	N	MEAN	MEDIAN	MIN	MAX
Hourly/temporary or as-needed	41	146	38	2	2,426
Part-time workers	44	119	34	0	823
Assigned to the central office	38	1,057	876	15	4,201
Assigned to local health departments	22	1,152	58	0	10,213
Assigned to regional or district offices	31	748	180	0	9,397

STATE HEALTH AGENCY WORKFORCE

**NOTES**

- 6 Improvements to the clarity of the question allowed for more responses to be retained in 2016 than in 2010 and 2012.

# STATE HEALTH AGENCY EMPLOYEE OCCUPATIONAL CLASSIFICATIONS AND SALARY RANGES

State health agency employees fulfill a variety of roles that span occupational classifications. **Table 2.4** displays the average number of FTEs for the most common occupational classifications in state public health agencies and the average salary range for each position.

\* Please see pages 46-47 for descriptions and examples of occupational classifications.

**TABLE 2.4** AVERAGE NUMBER OF FTEs AND SALARY RANGE BY STATE HEALTH AGENCY OCCUPATIONAL CLASSIFICATION

OCCUPATIONAL CLASSIFICATION	N	MEAN NUMBER OF FTEs	MEDIAN NUMBER OF FTEs	MEAN SALARY RANGE
Office and administrative support	46	310.2	160	\$23,642-\$64,455
Business and financial operations	46	276.7	90.6	\$31,737-\$102,077
Behavioral health staff	45	230.9	0	\$33,450-\$78,749
Public health nurse	46	157.7	56.5	\$45,829-\$84,969
Environmental health worker	46	143.3	61	\$37,436-\$92,183
Lab worker	46	83	58	\$29,606-\$88,680
Epidemiologist/statistician	46	63.5	46	\$40,733-\$97,498
Health educator	34	51.6	27	\$37,519-\$66,661
Nutritionist	46	49.3	17	\$59,227-\$73,880
Agency leadership	46	43.3	18.5	\$71,488-\$175,617
Nurse practitioner	42	35.1	0	\$64,251-\$95,311
Public health informatics specialist	44	23.4	6.5	\$44,468-\$83,241
Preparedness staff	46	20.1	18	\$43,353-\$95,121
Public health physician	43	15.4	4	\$116,042-\$176,715
Oral health professional	45	13.9	3	\$51,582-\$111,267
Quality improvement specialist	44	6.5	2.5	\$52,836-\$88,417
Public information specialist	45	5.8	4	\$47,607-\$80,127
Physician assistant	41	0.6	0	\$76,477-\$102,023

In 2016, the occupational classifications with the greatest number of employees at state health agencies were office and administrative support, business and financial operations, and behavioral health staff. In 2016, the highest paid state public health agency professionals were public health physicians, agency leadership, and oral health professionals.

States were also asked to provide salary range information for leadership staff (other than the SHO). Responses from states are shown in **Table 2.5**. In 2016, as in 2012, among all leadership positions, the chief medical officer was the highest paid staff member on average.

**TABLE 2.5**

SALARY RANGE OF STATE HEALTH AGENCY LEADERSHIP

OCCUPATIONAL CLASSIFICATION	N	MEAN SALARY RANGE
Senior deputy	47	\$104,136-\$145,928
Chief medical officer	39	\$153,168-\$194,867
Chief science officer	6	\$119,107-\$150,647
Chief financial officer	42	\$80,462-\$120,878
Chief information officer	35	\$87,407-\$130,048
State epidemiologist	45	\$114,576-\$154,019
State lab director	40	\$91,274-\$124,841
Local health department liaison	30	\$84,664-\$117,807

# STATE HEALTH OFFICIALS

As of September 2016, SHOs' average tenure was 2.7 years, the median tenure was 1.7 years, and the range was from two months to nearly 15 years.<sup>7</sup> Although the average SHO tenure has decreased by more than a year from 2012 (3.4 years), the median tenure has remained similar (median tenure of 1.8 years in 2012). SHOs in the Mountains and Midwest tended to have the longest tenures (almost 4 years), while SHOs in New England tended to have the shortest tenures (almost 1.5 years on average). On average, SHOs have been in the public health profession for 14.2 years. SHOs in centralized/largely centralized states tend to have been in the public health profession for fewer years than SHOs from decentralized/largely decentralized states (11.8 and 16.1 years, respectively).

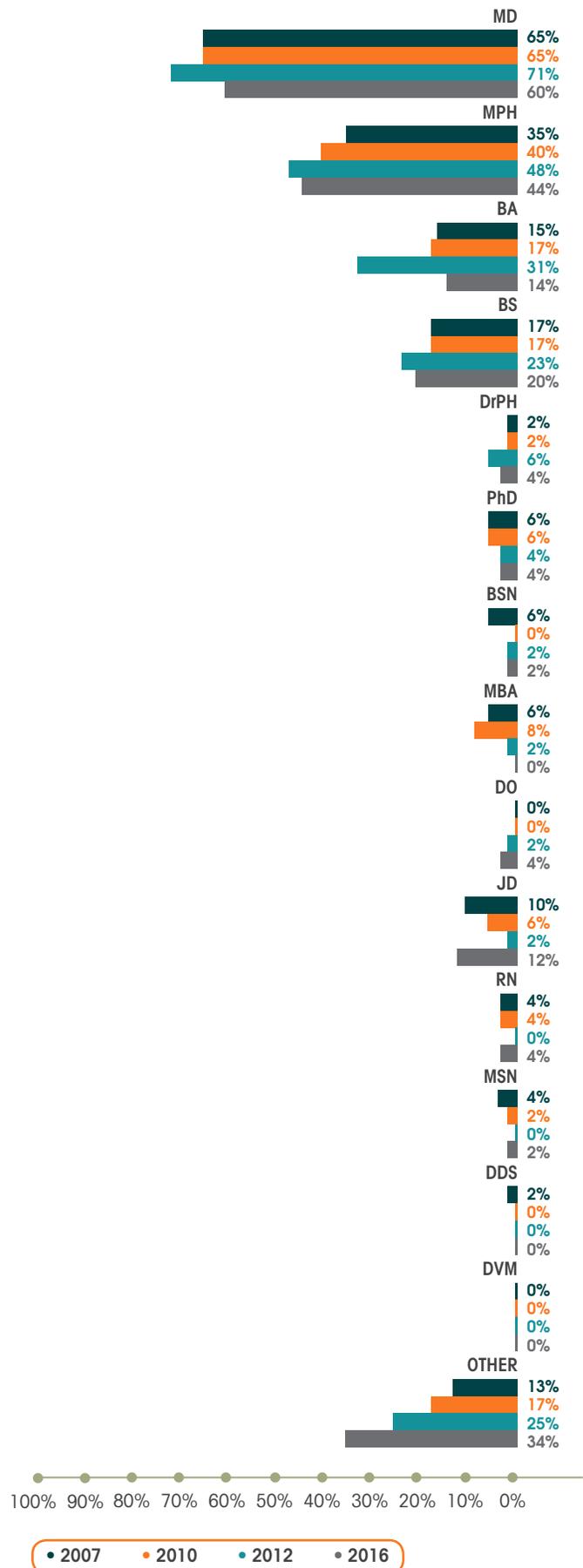
The average number of years of public health experience before becoming a SHO is 11.8 years. This represents a significant decline from 2010 and 2012, when the average number of years of public health experience was 15.9 years and 16.9 years, respectively. A total of 96 percent of SHOs had executive management experience before becoming the state health official, a percentage that has remained fairly stable over time.

ASTHO has been tracking SHOs' levels of educational attainment since 2007. The educational qualifications of the current SHO are displayed in **Figure 2.2**. Nearly one-quarter of states (24%) report no statutory requirements for the SHO's education level. More than half of states (52%) have the official statutory requirement that the SHO possess an MD or DO. In the West, only one state requires this.

In 2016, 64 percent of SHOs had an MD or DO. Of those, 52 percent also had an MPH. Overall, 48 percent of SHOs had an MPH or a DrPH. The percentage of SHOs with an MD decreased by 11 percent, from 71 percent in 2012 to 60 percent in 2016; the percentage of SHOs with an MPH decreased from 48 percent in 2012 to 44 percent in 2016.

**FIGURE 2.2**

STATE HEALTH OFFICIAL EDUCATIONAL QUALIFICATIONS, 2007-2016 (N=48-50)



**NOTES**

**7** Since December 6, 2016, 18 new SHOs have been appointed.



**TABLE 2.6**

AVERAGE SHO SALARY BY U.S. REGION (N=48)

REGION	MEAN SHO SALARY	MEDIAN SHO SALARY
New England	\$143,641.38	\$138,000
South	\$186,980.23	\$189,000
Mid-Atlantic and Great Lakes	\$161,520.41	\$161,000
Mountains and Midwest	\$158,443.90	\$155,570
West	\$181,342.43	\$186,336

On average, SHOs in 2016 were paid a salary of \$167,815 (median salary=\$170,002). SHO salaries range from a minimum of \$99,216 to a maximum of \$250,000. While the average salary has increased by about \$5,500 since 2012, the range of salaries has become narrower at both the high and low end such that the lowest paid SHO is being paid approximately \$5,000 more than in 2012, while the highest paid SHO receives a salary that is nearly \$18,000 less than the maximum salary in 2012. SHOs in the South receive the highest salaries, while SHOs in New England receive the lowest salaries, as shown in **Table 2.6**. SHOs from medium-sized states tend to receive a higher average salary than SHOs from small or large states. For SHOs that have an MD, 16 percent of states provide a salary differential (an increased salary for having a medical degree).

SHOs' salaries are determined through one of several methods: governor's discretion (46%), state legislature's discretion (38%), state pay scale (34%), board or commission (12%), or another method (10%).

From 2012 to 2016, the percentage of SHO salaries that the state legislature or state pay scale determined increased by 9 percent each, while the percentage determined by the governor decreased by 9 percent. A greater percentage of centralized/largely centralized states' SHO salaries are determined by the state legislature, board, or commission, while a greater percentage of decentralized/largely decentralized states' SHO salaries are determined by the state pay scale. Governors in New England are less likely to determine SHO salaries than those in other regions (New England mean=25%; other regions range from 42-60%).

# STATE HEALTH AGENCY EMPLOYEE DEMOGRAPHICS

In 2016, 70 percent of state health agency employees were female.<sup>8</sup> This percentage is almost equivalent to the percentages for 2010 and 2012. Decentralized/largely decentralized state health agencies have a greater percentage of male employees (35%) than centralized/largely centralized states (25%). There are no trends in gender of state health agency employees by region or state size.

State health agencies were asked to provide the percentage of staff by racial category. Responses are presented in **Table 2.7**. Nearly three-quarters of all state health agency employees are white, with the next largest percentage being black/African-American (16.6%). The state health agency workforce’s racial composition remained fairly stable from 2012 to 2016. Employees in decentralized/largely decentralized states are more likely to be white than those in centralized/largely centralized states (78.2% versus 62.3%). Employees at centralized/largely centralized states are more than twice as likely to be black/African-American (24.8%) as employees at decentralized/largely decentralized states (10.7%). The Mountains and Midwest have the greatest percentage of white employees (89.4%; other regions range from 65-75%), the South (27.8%) and the Mid-Atlantic and Great Lakes (21.2%) have the greatest percentages of black/African-American employees (other regions range from 4-14%), and the West has the greatest percentage of Asian employees (15.3%; other regions range from 2-6%). State size does not show consistent patterns with racial categories of state health agency employees.

State health agencies were also asked about their employees’ ethnicities. Of the responding agencies (N=39-42), 7 percent of employees in 2016 were Hispanic/Latino. States in New England and the South had the greatest percentage of Hispanic/Latino employees (both 10%), while states in the Mid-Atlantic and Great Lakes had the fewest (2%). Small (9%) and large (7%) states had a greater percentage of Hispanic/Latino employees than medium states (3%).

State health agencies report that the average age of employees is 47 and the median age of employees is 48.

**TABLE 2.7**

MEAN PERCENTAGE OF STATE HEALTH AGENCY STAFF BY RACIAL CATEGORY, 2016

RACIAL CATEGORY	N	MEAN PERCENTAGE
White	42	72.0%
Black/African-American	41	16.6%
American Indian/Alaska Native	39	0.9%
Asian	41	5.0%
Native Hawaiian/Other Pacific Islander	22	0.4%
Another race	34	3.8%
Two or more races	21	0.8%

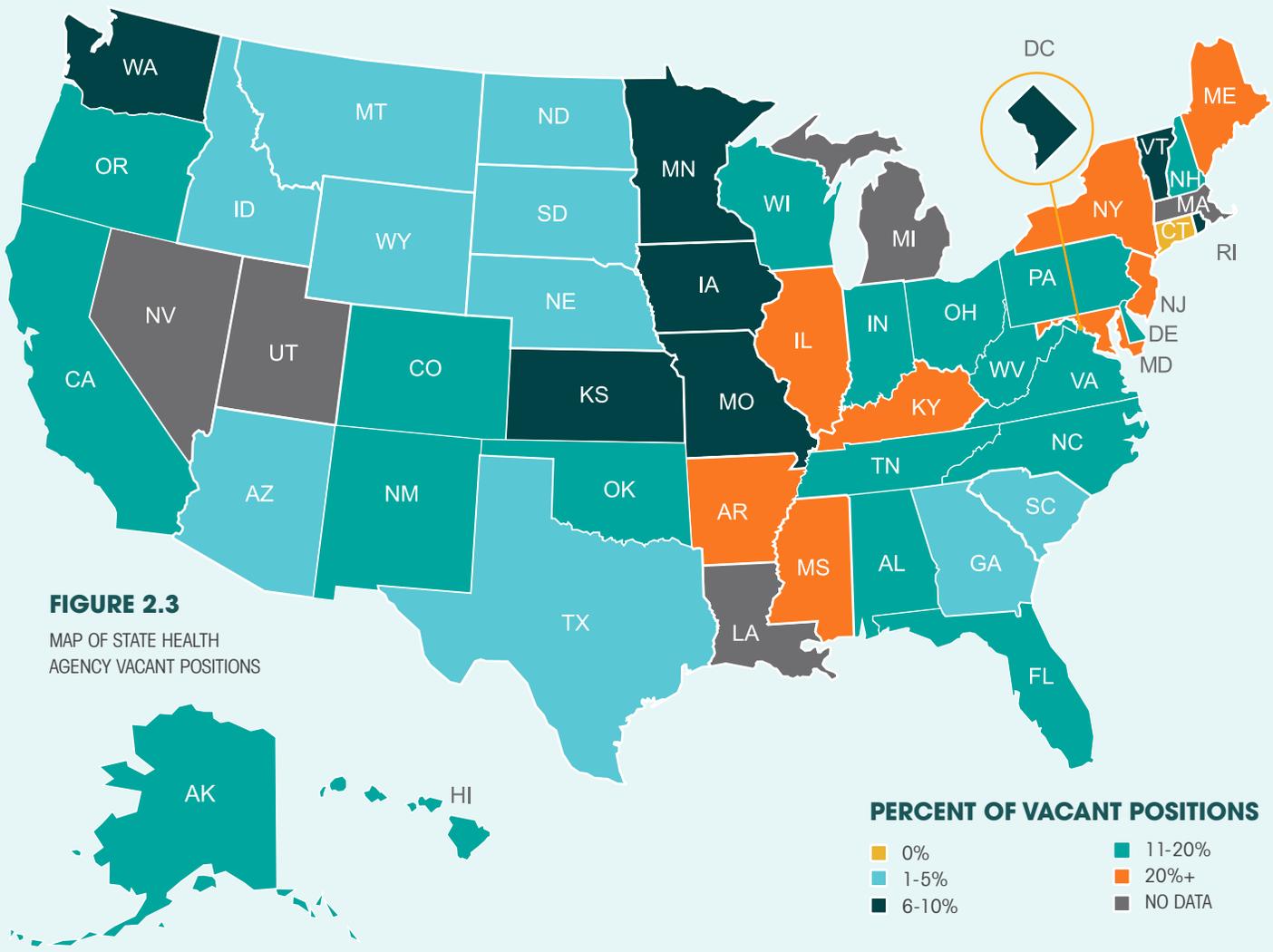
These numbers are almost identical to the average ages in 2010 and 2012. The state health agency workforce is generally older than the average U.S. workforce, which has a median age of 42 years.<sup>9</sup> The average number of years of service by a state health agency employee is 12. These findings are consistent with results from the 2007, 2010, and 2012 ASTHO Profile Surveys. Average age of employees, median age, and average number of years of service do not vary substantially by governance classification. While the average age of employees is fairly constant across regions, employees in the West tend to have the fewest years of service (average=10 years), while employees in New England tend to have the most (average=14 years). There are also trends in average age of employees by state size such that medium and large states tend to have older employees than small states.

In addition to being asked about the average age of current employees, agencies were also asked to report the average age of new employees. Over the past three fiscal years, the average age of new state health agency employees was 41 (2013), 40 (2014), and 39 (2015). States in New England have the oldest average new employees (mean age = 42), while states in the Mountains and Midwest have the youngest (mean age=38). Smaller states tend to have younger new employees (mean age=37) than medium and large states (mean age=40 for both).

## NOTES

**8** N=47, as two states did not respond to this item.

**9** U.S. Department of Labor, Bureau of Labor Statistics. “Labor Force Statistics from the Current Population Survey.” Available at [www.bls.gov/cps/cpsaat11b.htm](http://www.bls.gov/cps/cpsaat11b.htm). Accessed March 3, 2017.

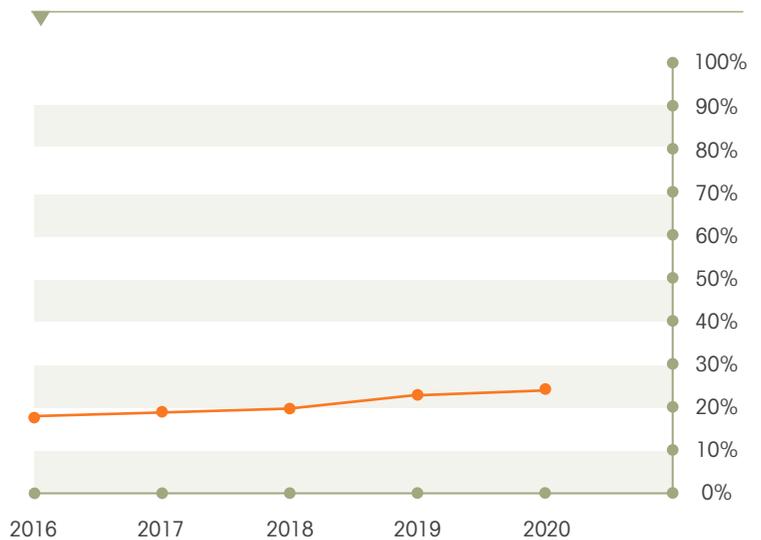


## VACANCIES AND RETIREMENTS

In 2015, an average of 198 nontemporary employees separated from state health agencies.<sup>10</sup> While lower than the averages for 2009–2011 (yearly range from 263 to 275), these numbers reflect a steady increase from 2013 (155) and 2014 (179). On average, states in the South and Mid-Atlantic and Great Lakes had more employees separate from the state health agency than other regions (South mean for 2015=235; Mid-Atlantic and Great Lakes mean for 2015=242; other regions’ means range from 122 to 168). On average, medium-sized states had a greater number of separations (mean=282) than small (mean=62) and large (mean=195) states.

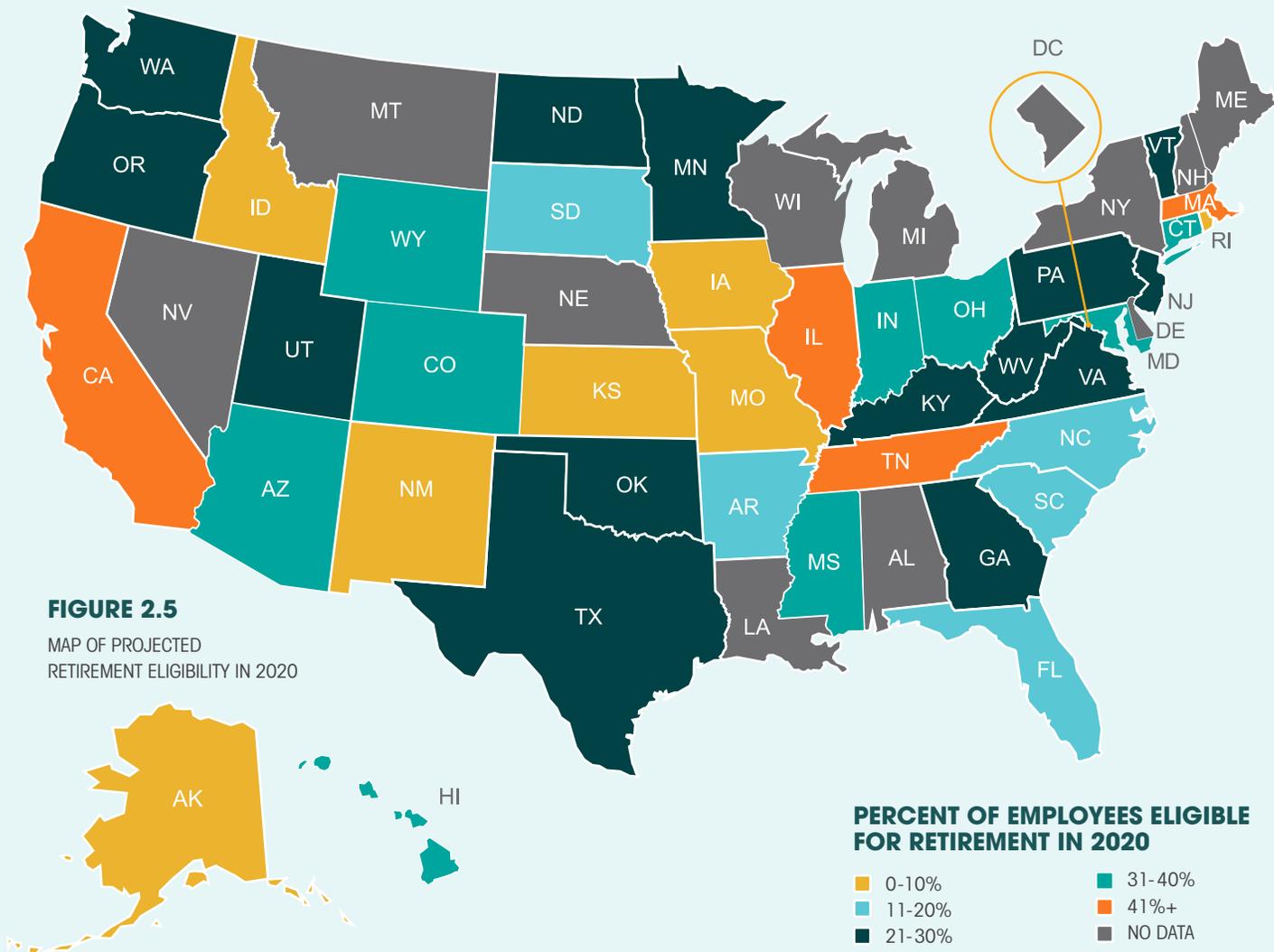
**FIGURE 2.4**

AVERAGE PERCENTAGE OF FULL-TIME CLASSIFIED EMPLOYEES ELIGIBLE FOR RETIREMENT, 2016-2020 (N=38-40)



**NOTES**

**10** This number includes retirements.



In 2016, 14 percent of state health agency positions were vacant. This percentage is slightly higher than the percentage of vacant positions in 2010 (11%) and 2012 (12%). New England states have the highest percentage of vacancies (21%), while states in the Mountains and Midwest have the lowest percentage of vacancies (7%). Larger states have a greater percentage of vacancies (18%) than small (10%) and medium (14%) states. **Figure 2.3** shows the percentage of vacant positions by state.

The average number of vacant positions at state health agencies in 2016 was 365, and the median number of vacancies was 138. While the average number of vacant positions increased from 282 in 2010 to 304 in 2012 to 365 in 2016, this is likely a function of six more states responding

to this item in 2016 than 2010 or 2012. State health agencies in the Mountains and Midwest have fewer vacant positions on average than state health agencies in other regions (mean Mountains and Midwest=72; other regions' means range from 178-552 vacancies). Larger states have more vacancies (587) than small (113 vacancies) and medium (396 vacancies) states. Despite the large number of vacancies, state health agencies are only actively recruiting for an average of 90 positions, or 25 percent of vacancies.

From 2016 to 2020, the percentage of state health agency employees that are eligible for retirement is expected to increase from 17 to 25 percent as shown in **Figure 2.4**. **Figure 2.5** shows the projected retirement eligibility percentage for each state in 2020.



## WORKFORCE DEVELOPMENT

The Core Competencies for Public Health Professionals<sup>11</sup> describe the desirable skills and characteristics of public health workers that enable them to deliver the essential public health services effectively. They are designed to serve as a starting point to guide organizations' workforce development efforts (e.g., recruitment, training, performance management, and workforce planning) and help public health professionals manage their career development and learning. More than three-quarters (76%) of state health agencies have created a health department workforce development plan that addresses staff training needs and core competency development. This is an increase of 17 percent from 2012. All New England states have created a workforce development plan. Of the 76 percent of states with a workforce development plan, 16 percent have been fully implemented, 53 percent have been partially implemented, and 31 percent have not yet been implemented. More than half (54%) of state health agencies also report having a designated workforce development director. Centralized/largely centralized states and Southern and Western states are most likely to have a designated workforce development director.

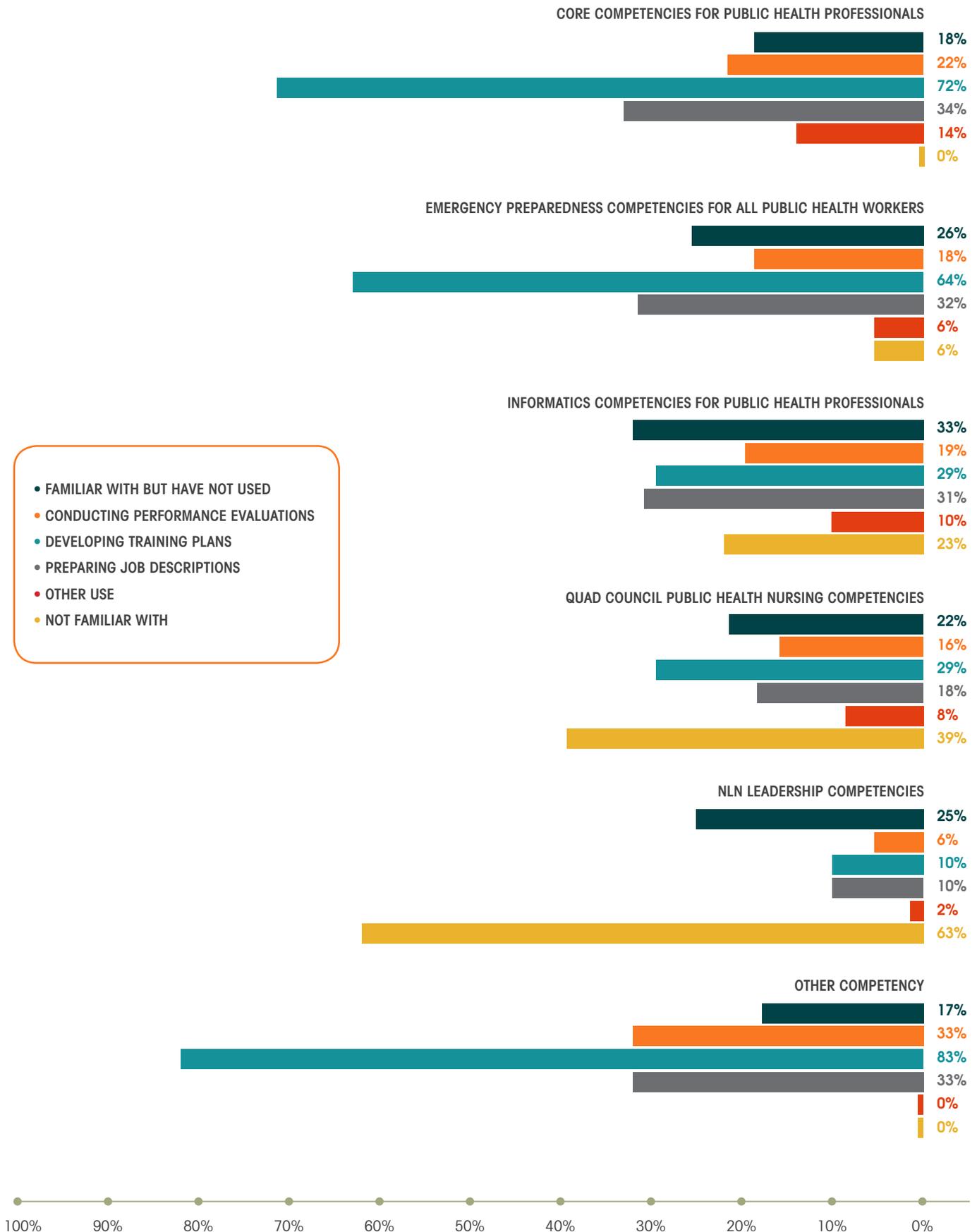
Respondents were also asked to indicate their familiarity with and use of various public health core competencies in the course of managing agency personnel. Results are displayed in **Figure 2.6**. More than half of state health agencies have used core competencies for public health professionals, emergency preparedness competencies for all public health workers, or another competency to develop training plans. Respondents were least familiar with the National League for Nursing (NLN) leadership competencies (only 37% were familiar with this competency). In general, when states used any of the competencies, it was most often for developing training plans. However, 29 percent of state health agencies also reported using the informatics competencies for public health professionals to prepare job descriptions.

In this chapter and the first section of the Profile Report, discussion has centered on the structure of state health agencies and the individuals who work in state public health. In the next section of the report, *State Health Agencies: What We Do*, focus moves to the myriad services and activities that state health agencies provide throughout the country.

### NOTES

- 11 Public Health Foundation. "About the Core Competencies for Public Health Professionals." Available at [www.phf.org/programs/corecompetencies/Pages/About\\_the\\_Core\\_Competencies\\_for\\_Public\\_Health\\_Professionals.aspx](http://www.phf.org/programs/corecompetencies/Pages/About_the_Core_Competencies_for_Public_Health_Professionals.aspx). Accessed March 3, 2017.
- 12 For more information on the Core Competencies for Public Health Professionals, see [www.phf.org/programs/corecompetencies/Pages/About\\_the\\_Core\\_Competencies\\_for\\_Public\\_Health\\_Professionals.aspx](http://www.phf.org/programs/corecompetencies/Pages/About_the_Core_Competencies_for_Public_Health_Professionals.aspx). For information on Informatics Competencies for Public Health Professionals, see [www.nwcphp.org/documents/training/tools-resources/informatics\\_competencies.pdf](http://www.nwcphp.org/documents/training/tools-resources/informatics_competencies.pdf). For information on NLN leadership competencies, see [www.nln.org/facultyprograms/Competencies/index.htm](http://www.nln.org/facultyprograms/Competencies/index.htm).

**FIGURE 2.6** FAMILIARITY WITH AND USE OF PUBLIC HEALTH CORE COMPETENCIES<sup>12</sup>



# DESCRIPTIONS AND EXAMPLES OF 2016 OCCUPATIONAL CLASSIFICATIONS

## Agency Leadership

Oversees the operations of the overall agency or a major subdivision of public health services. Includes all top agency executives regardless of education or licensing, such as health commissioners, health officers, public health administrators, deputy directors, bureau chiefs, and division directors.

## Behavioral Health Staff

Develops and implements strategies to improve community mental health status. May also provide direct behavioral health services to clients regarding mental, social, and behavioral issues. Includes psychiatrists, psychologists, public health social workers, HIV/AIDS counselors, behavioral counselors, community organizers, social services counselors, and mental health and substance abuse counselors.

## Business and Financial Operations Staff

Performs specialized work in areas of business, finance, accounting, human resources, information technology, and legal issues. Includes financial analysts, human resources specialists, grant and contracts managers, legal personnel, computer system analysts, and network and database administrators.

## Environmental Health Worker

Investigates, monitors, and identifies problems or risks that may affect the environment (e.g., food safety, air and water quality, and solid waste) and consequently, the health of an individual or group. Includes environmentalists, environmental health specialists, scientists, engineers, occupational health workers or technicians, sanitarians, and inspectors.

## Epidemiologist/Statistician

Conducts ongoing surveillance, field investigations, analytic studies, and evaluation of disease occurrence and disease potential to make recommendations on appropriate interventions. May also collect data and report vital statistics. Includes epidemiologists, biostatisticians, and public health scientists and researchers.

## Health Educator

Develops and implements educational programs and strategies to support and modify health-related behaviors of individuals and communities, and promotes the effective use of health programs and services. Includes health educators, health education coordinators, and health education specialists.

## Laboratory Worker

Plans, designs, and implements laboratory testing procedures, and performs analyses that provide data to diagnose, treat, and monitor disease and environmental hazards. Includes laboratorians, laboratory scientists, laboratory technicians, laboratory aides or assistants, and medical technologists.

## Nurse Practitioner

Licensed nurse 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 to clients.

## Nutritionist

Develops and implements interventions related to nutrition, the nutrition environment, and food and nutrition policy. May also provide nutritional counseling and evaluate the effectiveness of current interventions. Includes dietitians, nutritionists, WIC lactation staff, and WIC nutrition staff.

## Office and Administrative Support

Performs administrative tasks and clerical duties. Includes administrative assistants, secretaries, receptionists, office clerks, maintenance staff, and operators.

## Oral Health Professional

Diagnoses and treats problems with teeth, gums, and the mouth. May also educate individuals or groups on proper oral health activities such as diet choices affecting oral health. Includes public health dentists, dental hygienists, and dental assistants.



## Other

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### Physician Assistant

Licensed professional 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 to clients.

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### Preparedness Staff

Manages or develops the plans, procedures, and training programs involving the public health response to all-hazards events. Includes emergency preparedness coordinators, incident managers, emergency preparedness managers, and emergency preparedness specialists.

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### Public Health Informatics Specialist

Public health professional who applies informatics principles and standards to improve population health. Includes public health information systems specialists and public health informaticists.

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### Public Health Nurse

Registered nurse conducting public health nursing. Includes school nurses and community health nurses.

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### Public Health Physician

Licensed 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 to clients. Includes licensed physicians and preventative medicine physicians, but not psychiatrists and psychologists.

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### Public Information Specialist

Serves as communications coordinator or spokesperson for the agency to provide information about public health issues to the media and public. Includes public information officers and public information specialists.

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### Quality Improvement Specialist

Works collaboratively within public health agency to lead and establish appropriate performance management and quality improvement systems. May also play a lead role in systems assessment and preparing the agency for national public health accreditation. Includes performance management and quality improvement directors, performance improvement managers, and performance improvement directors.

# PART II

STATE PUBLIC HEALTH

# WHAT WE DO





## Chapter 3

# STATE HEALTH AGENCY ACTIVITIES

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This chapter describes the variety of activities and services that state health agencies provide. It explores state health agencies' involvement in worksite wellness programs, health insurance exchanges, health impact assessments, and research studies. It will also discuss their responsibility for federal initiatives, training for local health agency personnel, and technical assistance.

As in previous chapters, 2016 data will be compared with 2012, 2010, and 2007 data when possible, and the section will note differences in the state health agency workforce by governance structure, region, and state population size when applicable. However, rather than note differences by agency characteristic for each of the 205 public health activities on which data was collected, this section provides an index of each public health activity category. Each index is the sum of the number of activities performed by each state. The percentage of activities performed in a given category is then compared by agency characteristic. For example, the 2016 Profile Survey had 14 items about maternal and child health (MCH) services, so the MCH index was calculated by summing the number of those 14 MCH services performed by each state.



## KEY FINDINGS

- ▶ From 2010 to 2016, the percentage of states performing activities to ensure access to healthcare services decreased. The number of agencies engaged in the State Children's Health Insurance Program (SCHIP) showed the greatest decrease (31% in 2010 to 16% in 2016), followed by agencies engaged in rural health initiatives (73% in 2010 and 2012; 59% in 2016).
- ▶ Of the 17 primary prevention activities surveyed, STD counseling and partner notification is the only service that has seen an increase from 2010 (78%) to 2016 (82%). Among the 16 other primary prevention services that have decreased during this time period, eight of these activities have seen an increase in the number of states performing them from 2012 to 2016. However, this slight increase is still lower than 2010 numbers.
- ▶ Overall, of the 15 screening activities surveyed, 10 have decreased in frequency from 2010 to 2016. Breast and cervical cancer screenings showed the greatest decrease, dropping from 47 percent of state health agencies performing this service directly in 2010 to 18 percent in 2016.
- ▶ All clinical services showed a decrease in state health agencies directly performing them from 2010 to 2016, with the exception of substance abuse education and prevention services, which increased from 31 percent in 2010 to 37 percent in 2016. Sexual assault victim services showed the largest decrease from 2010 to 2016 with a 20 percent drop.
- ▶ From 2010 to 2016, almost all surveyed treatment activities decreased in frequency. Both HIV/AIDS and breast/cervical cancer had the greatest decreases in the number of states providing treatment (both decreased by 23%).
- ▶ There has also been a decline in the percentage of state health agencies providing MCH services. Of the 14 MCH services surveyed, 12 have seen decreases in the number of states directly performing the activity from 2010 to 2016. The most notable decrease was observed for services for children with special healthcare needs, with 79 percent of state health agencies performing this service directly in 2010 but only 54 percent in 2016.
- ▶ From 2010 to 2016, states reported a marked decline in directly performing many services and activities; the increase in the number of individuals covered by Medicaid and insurance during this time is one possible explanation for these observed changes over time. In addition, these numbers only reflect decreases in activities directly performed by state health agencies; agencies may also be contracting out these activities to third parties in lieu of performing them directly.
- ▶ The average number of total environmental health activities that state health agencies performed directly has decreased from 2010 (42%) to 2016 (37%). Notable decreases in specific activities include the number of state health agencies directly performing poison control (25% decrease from 2010 to 2016) and vector control (16% decrease from 2010 to 2016). These changes are probably due to funding cuts and transferring these services to local health departments and other state agencies.
- ▶ Thirty-four percent of state health agencies have started to engage with the One Health approach in their programming, while an additional 18 percent are exploring integrating One Health into their activities.
- ▶ The mean number of research studies that state health agencies engaged in has risen, from an average of 46 in 2012 to an average of 52 in 2016.

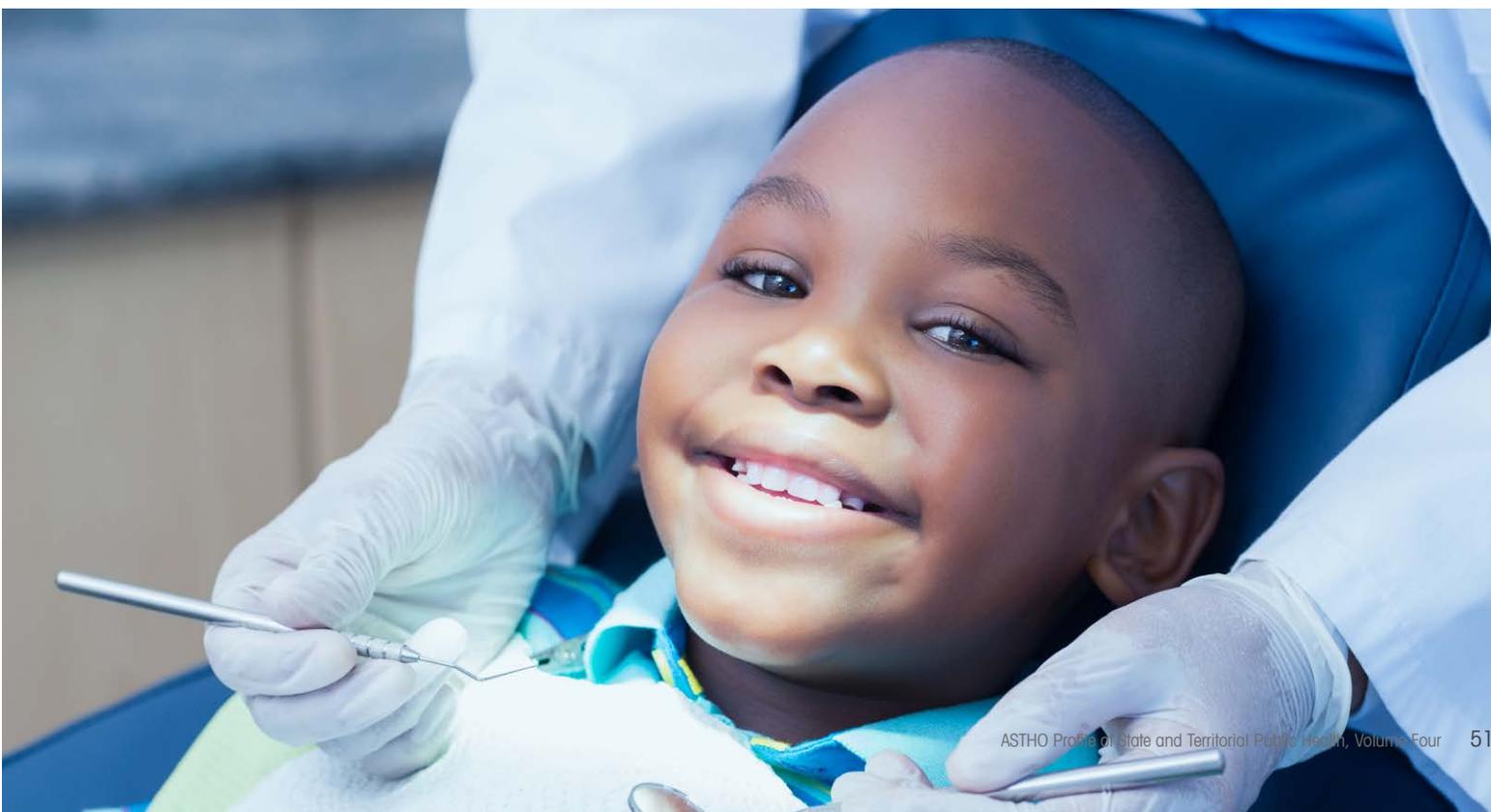
## RESPONSIBILITY FOR FEDERAL INITIATIVES

State health agencies often have programmatic and financial responsibility for federal initiatives. When they do not have sole responsibility, state health agencies typically share responsibility with another state health agency, local governmental agency (e.g., a local health department), or nonprofit organization.

The 10 federal initiatives for which state health agencies most frequently report having responsibility in 2016 are displayed in **Table 3.1**. Participation in these programs has remained very high since 2012.

**TABLE 3.1** STATE HEALTH AGENCY RESPONSIBILITY FOR FEDERAL INITIATIVES, 2016 (N=50)

FEDERAL INITIATIVE	N	%
Maternal and child health/Title V program	49	98%
Preventive Health and Health Services Block Grant (CDC)	49	98%
CDC Public Health Emergency Preparedness (PHEP) cooperative agreement	48	96%
Immunization funding, Section 317 program	48	96%
Women, Infants, and Children program (USDA)	48	96%
Hospital Preparedness Program (HPP) cooperative agreement (ASPR)	46	92%
Vital statistics (NCHS)	45	90%
Injury prevention (CDC)	44	88%
HIV pharmacies (ADAP)	44	88%
National Comprehensive Cancer Control Program grant (CDC)	41	82%



## TECHNICAL ASSISTANCE AND TRAINING

**TABLE 3.2** TECHNICAL ASSISTANCE PROVIDED BY STATE HEALTH AGENCIES TO PARTNERS, 2016 (N=48)

STATE HEALTH AGENCY PARTNER	N	QI/PERFORMANCE/ACCREDITATION	DATA MANAGEMENT	PUBLIC HEALTH LAW	POLICY DEVELOPMENT	WORKFORCE ISSUES	NONE OF THESE TOPICS
Emergency medical services	48	73%	67%	60%	60%	56%	6%
Providers	46	76%	63%	54%	54%	50%	4%
Hospitals	48	85%	67%	52%	65%	42%	2%
Laboratories	44	80%	46%	46%	41%	27%	9%
Local public health agencies	48	81%	75%	71%	75%	75%	13%
Nonprofits/community-based organizations	45	53%	40%	44%	62%	38%	18%

State health agencies provide technical assistance and training to a variety of partners on a number of different topics. As shown in **Table 3.2**, technical assistance is most frequently provided to hospitals and local public health departments, most often on the topic of quality improvement (QI)/performance and accreditation; the frequencies for both of these are just slightly lower than those reported in 2012.

In addition to providing technical assistance, state health agencies provide training to local health department personnel. As shown in **Figure 3.1**, the topics for which the most state health agencies provided training to local health

department personnel in 2016 were disease prevention and control, tobacco, preparedness, and MCH. These were also the top training areas in 2010 and 2012. On average, decentralized/largely decentralized states provided training on a greater percentage of topics (83% of topics) than centralized/largely centralized states (58% of topics). Southern states were more likely to provide training on a greater percentage of topics compared to other regions (94% of topics in South; 57-76% of topics in other regions). Small states provided training on a smaller percentage of topics (52%) than medium and large states (83% and 86%, respectively).

## ACCESS TO HEALTHCARE SERVICES

Access to healthcare services is an essential first step in receiving the appropriate care to prevent illness and treat diseases and conditions. **Figure 3.2** shows the percentage of state health agencies that engage in activities to ensure access to healthcare services. In 2016, health disparities/minority health initiatives, rural health initiatives, and outreach and enrollment for medical insurance were the three activities performed by the most state health agencies to ensure access. From 2010 to 2016, the percentage of states performing almost all of these activities decreased. The number of agencies engaged in SCHIP showed the greatest decrease (31% in 2010 to 16% in 2016), followed by agencies engaged in rural health initiatives (73% in 2010 and 2012; 59% in 2016). Outreach and enrollment for medical insurance—which was only one of two activities that increased—showed the greatest increase from 2010 (39%)

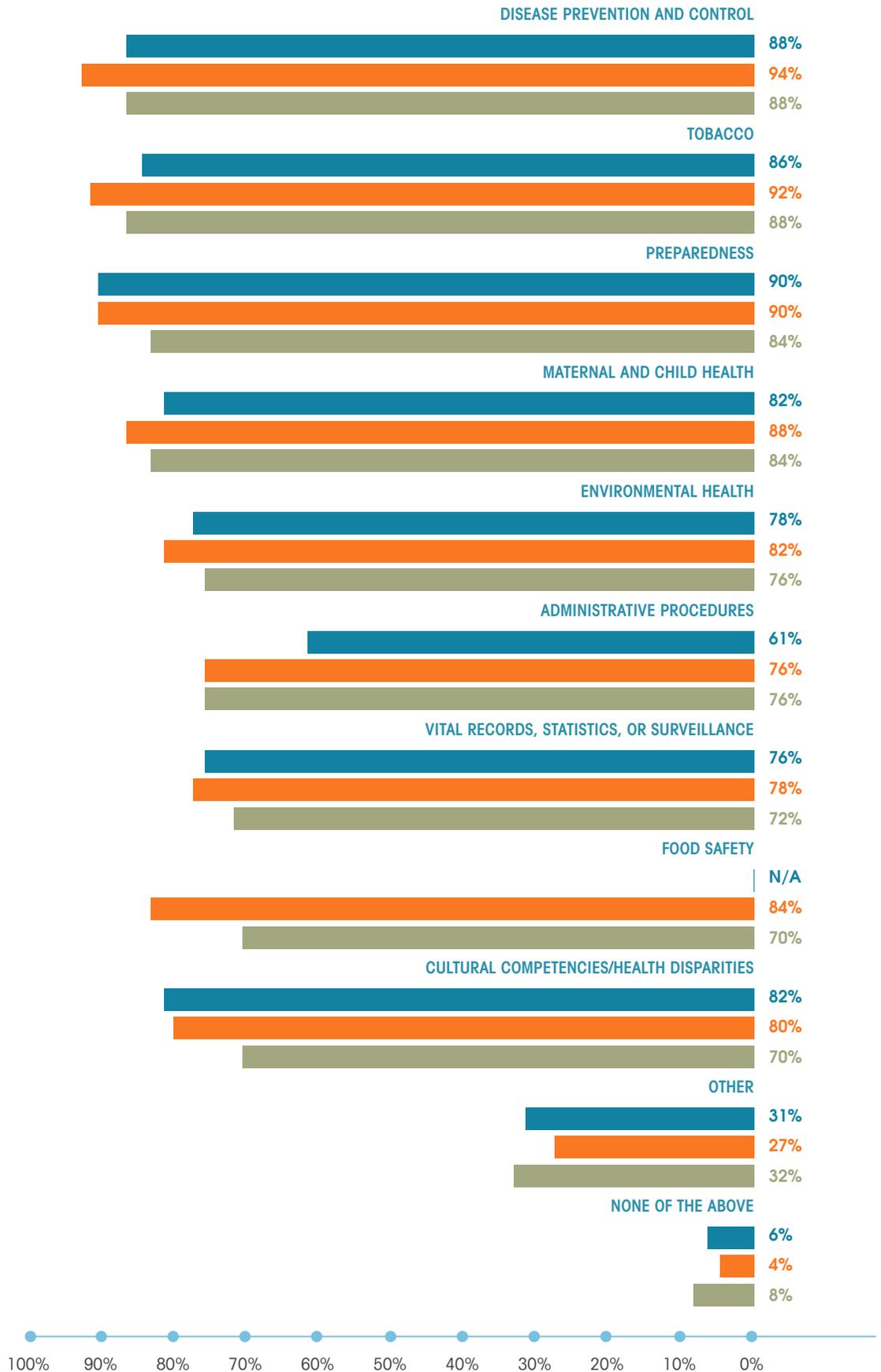
to 2016 (41%). In addition to these activities, 80 percent of state health agencies also reported providing financial support to primary care providers in 2016.

Many states sponsor loan repayment programs to increase the supply of select positions in the community. As shown in **Table 3.3**, around two-thirds of states have loan repayment programs to increase the supply of physicians, and more than half have programs to increase the supply of dentists. From 2010 to 2016, the number of states with loan repayment programs increased for all positions surveyed. Decentralized/largely decentralized states (55% average for all positions) are more likely to have loan repayment programs than centralized/largely centralized states (30% average for all positions). All states in the Mountains and Midwest region (N=9) have a loan repayment program for physicians.

**FIGURE 3.1**

STATE HEALTH AGENCY TRAINING PROVIDED TO LOCAL HEALTH DEPARTMENT PERSONNEL, 2010-2016 (N=49-50)

- 2010
- 2012
- 2016

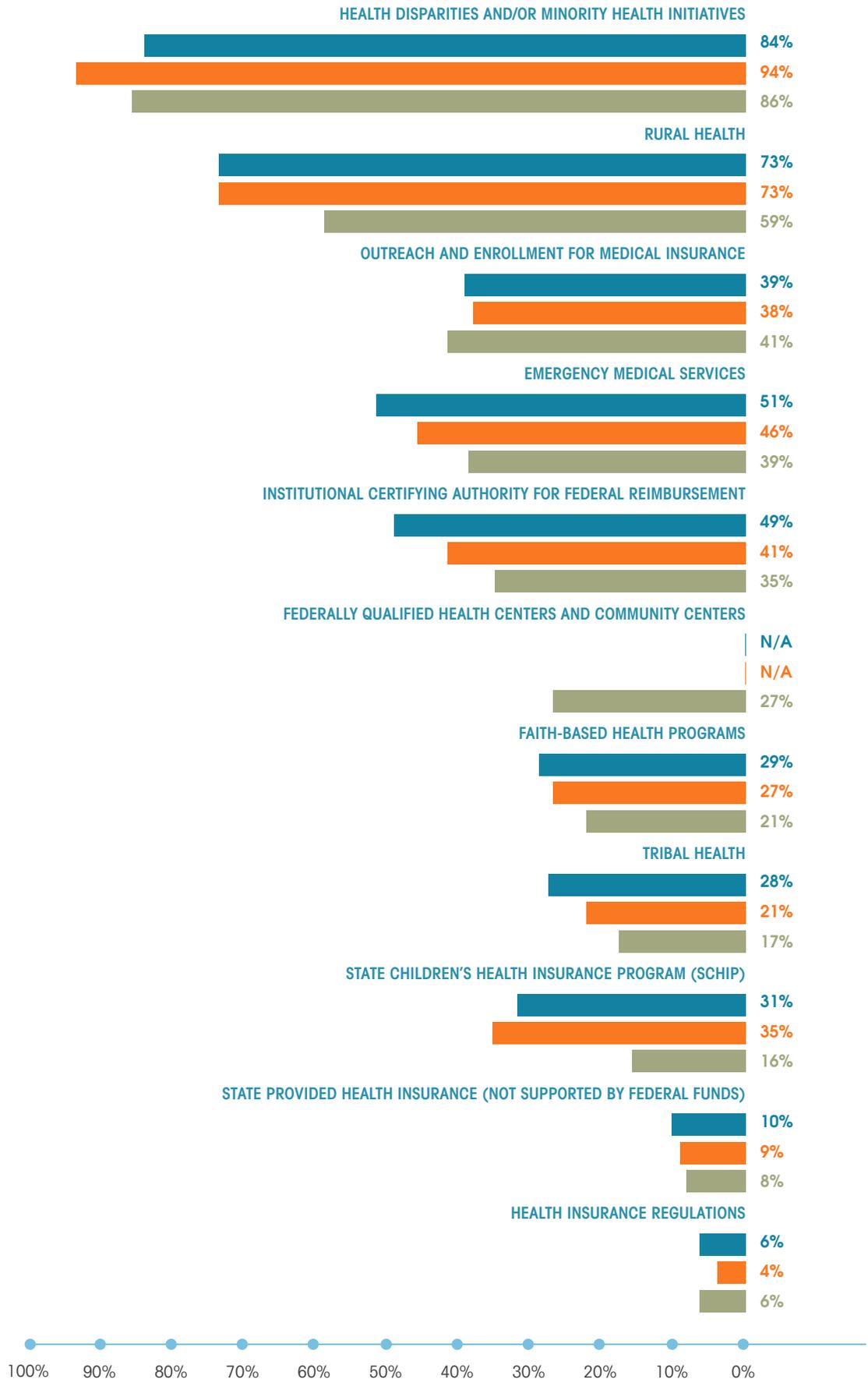


**Note:** Food safety did not appear on the 2010 Profile Survey.

**FIGURE 3.2**

STATE HEALTH AGENCY ACCESS TO HEALTHCARE SERVICES, 2010-2016 (N=47-51)

- 2010
- 2012
- 2016



**Note:** Federally qualified health centers and community centers appeared only on the 2016 Profile Survey.



**TABLE 3.3** STATE-SPONSORED LOAN REPAYMENT PROGRAMS TO INCREASE THE SUPPLY OF PROVIDERS, 2010-2016 (N=27-48)

PROVIDER TYPE	2010		2012		2016	
	N	%	N	%	N	%
Physicians	23	85%	33	70%	30	63%
Dentists	19	70%	26	55%	26	54%
Mid-level providers	12	44%	18	38%	17	35%
Nurses	14	52%	17	36%	17	35%
Other primary care providers	6	22%	15	32%	12	25%

## POPULATION-BASED PRIMARY PREVENTION SERVICES

State health agencies provide a variety of population-based primary prevention services. **Figure 3.3** displays the percentage of state health agencies that directly performed population-based primary prevention services from 2010 to 2016. Of the 17 activities surveyed, STD counseling and partner notification is the only primary prevention service that increased from 2010 (78%) to 2016 (82%). Among the 16 primary prevention services that decreased during this time period, eight of these activities increased in the number of states performing them from 2012 to 2016. However, this slight increase is still lower than 2010 numbers. Asthma prevention has shown a particularly substantial decrease over time, from 65 percent of states performing this service directly in 2010 to 44 percent in 2012 to 30 percent in 2016. One possible explanation is that asthma is being absorbed into

other comprehensive state strategies and initiatives (e.g., indoor air policies and tobacco-free buildings).

Looking at population-based primary prevention activities overall, centralized/largely centralized states on average perform more population-based primary prevention services (65%) than decentralized/largely decentralized states (51%). On average, Western states perform the most population-based primary prevention services (68%), while states in the Mid-Atlantic and Great Lakes perform the fewest (41%). Performance of population-based primary prevention services does not vary significantly by state population size. Only the number of the prevention services provided was measured, and no information was collected about the quantity or intensity of each service provided.

FIGURE 3.3

POPULATION-BASED PRIMARY PREVENTION SERVICES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=47-51)

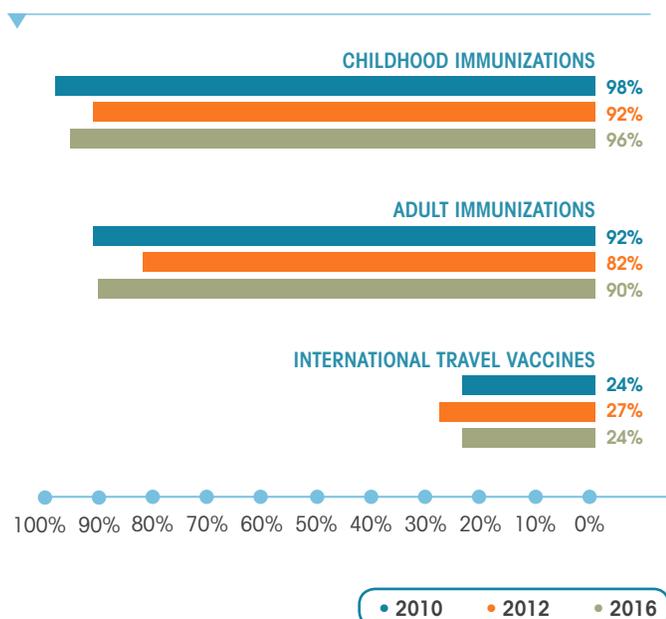


## IMMUNIZATION SERVICES

More than 90 percent of state health agencies are responsible for vaccine order management and inventory distribution for both childhood and adult immunizations. In contrast, approximately one-quarter conduct order management for international travel immunizations directly (see **Figure 3.4**).

**FIGURE 3.4**

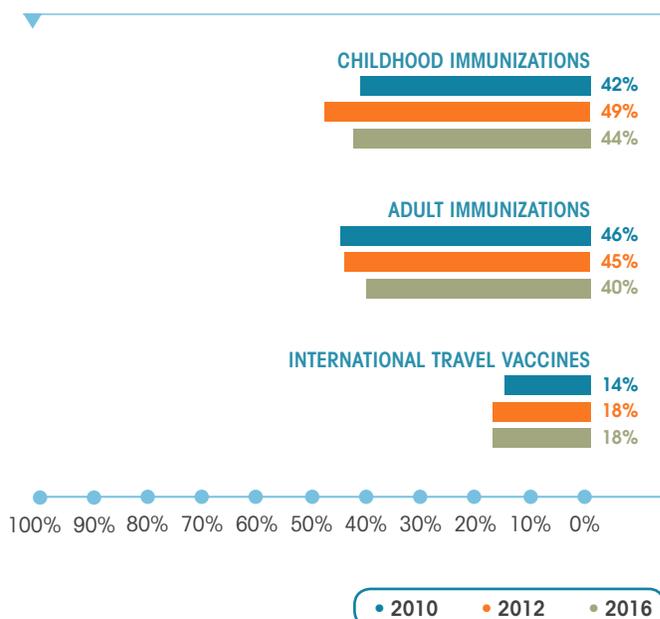
VACCINE ORDER MANAGEMENT PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=49-50)



When it comes to administering vaccines, less than half of state health agencies directly administer childhood and adult vaccines, and less than one-quarter directly administer international travel vaccines to populations (see **Figure 3.5**).

**FIGURE 3.5**

VACCINE ADMINISTRATION TO POPULATION PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=49-50)



## SCREENING FOR DISEASES AND CONDITIONS

**Figure 3.6** displays the percentage of state health agencies that directly perform screenings for diseases and conditions. The four diseases and conditions that most state health agencies directly screen for are newborn screenings, tuberculosis, HIV/AIDS, and other STDs. From 2010 to 2016, blood lead screenings showed the greatest increase in frequency of performance, rising from 33 percent of state health agencies performing this service directly in 2010 to 42 percent in 2016. Overall, of the 15 screening activities surveyed, 10 have decreased in frequency over this time period. Breast and cervical cancer screenings showed the greatest decrease in frequency of performance, dropping from 47 percent of state health agencies performing this

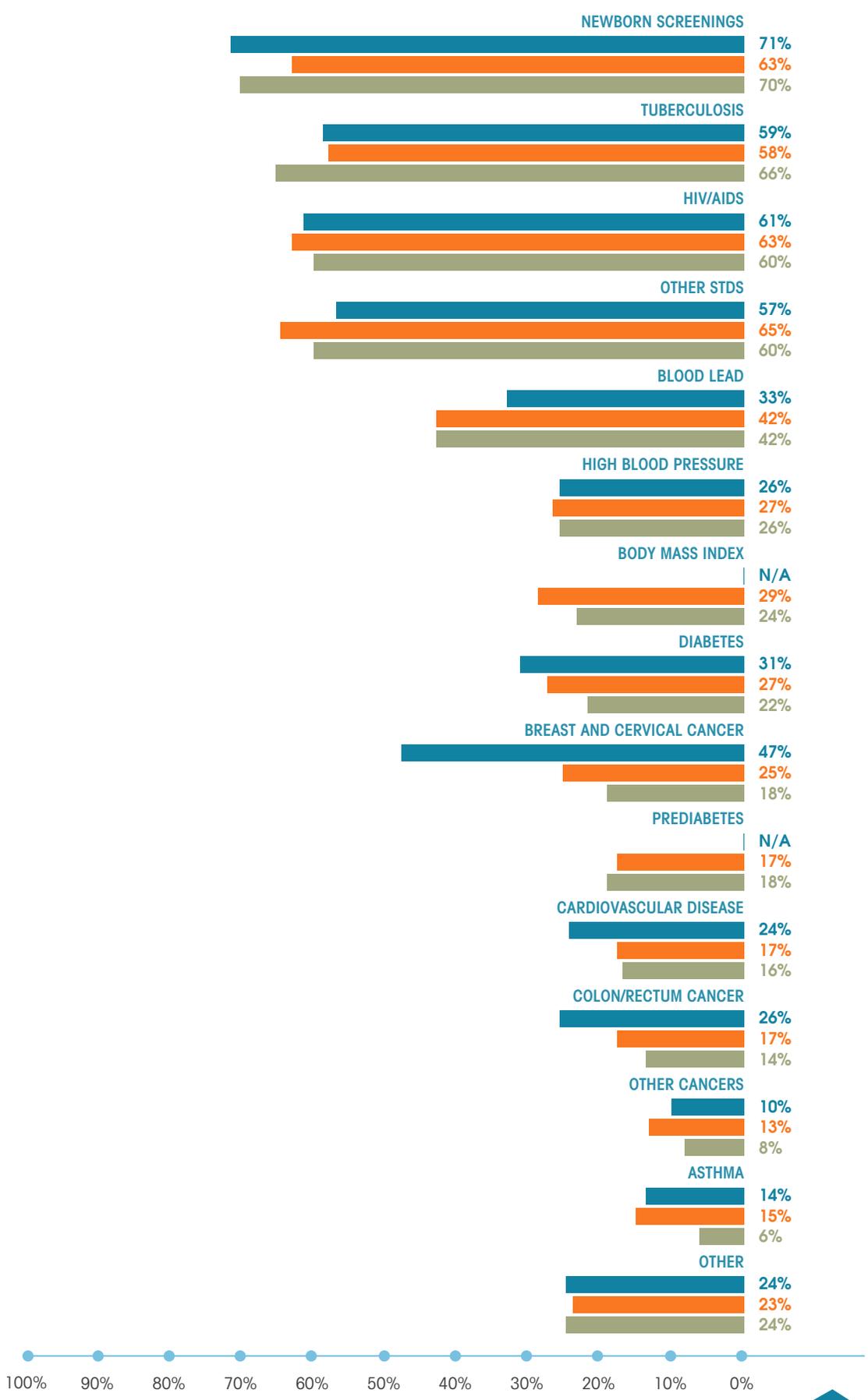
service directly in 2010 to 18 percent in 2016. Although this may seem counterintuitive due to Medicaid expansion, it is possible that this decrease is due to better linkages with federally qualified health centers.

Overall, centralized/largely centralized states performed more of the 15 screening activities (44%) than decentralized/largely decentralized states (19%), perhaps because local health departments may be conducting some screenings at the local level. Southern states performed substantially more screening activities (52%) than states in other regions (percentages ranged from 21-26%).

**FIGURE 3.6**

SCREENING FOR DISEASES AND CONDITIONS PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=48-51)

- 2010
- 2012
- 2016



**Note:** Body mass index and prediabetes did not appear on the 2010 Profile Survey.

FIGURE 3.7

OTHER CLINICAL SERVICES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=47-51)

• 2010 • 2012 • 2016



## OTHER CLINICAL SERVICES PROVIDED TO INDIVIDUALS

State health agencies provide a variety of clinical services directly to individuals. As shown in **Figure 3.7**, oral health, substance abuse education and prevention services, and rural health were the three clinical services that the most state health agencies performed directly in 2016. All clinical services showed a decrease in state health agencies performing them directly from 2010 to 2016, with the exception of substance abuse education and prevention services, which increased from 31 percent in 2010 to 37 percent in 2016. Sexual assault victim services

showed the largest decrease from 2010 to 2016 (decrease of 20%). Domestic violence victim services and managed care/medical homes both dropped 18 percent from 2010 to 2016. On average, centralized/largely centralized states performed a greater percentage of all clinical services listed (20%) than decentralized/largely decentralized states (10%). Southern states also performed a greater percentage of clinical services (26% on average) than states in other regions (percentages ranged from 7-12%).

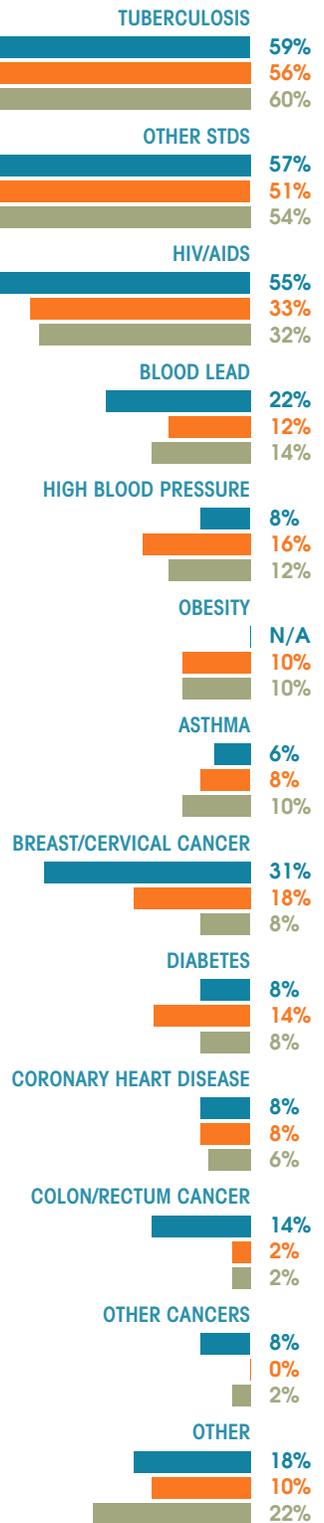
# TREATMENT FOR DISEASES

In addition to screening for diseases, state health agencies provide a variety of treatment services. **Figure 3.8** displays the percentage of state health agencies that directly provided treatment for select diseases and conditions from 2010 to 2016. During this time period, the greatest percentage of state health agencies provided treatment services for tuberculosis, HIV/AIDS, and other STDs. From 2010 to 2016, almost all surveyed treatment activities decreased in frequency. Both HIV/AIDS and breast/cervical cancer had the greatest decreases in the number of states providing treatment (both decreased by 23%). The increase in the number of individuals covered by Medicaid and insurance during this time is one possible explanation for these observed changes over time.

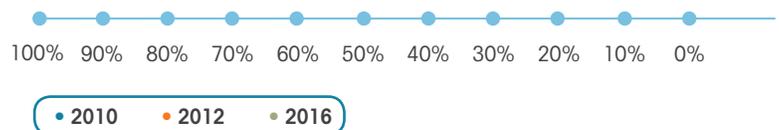
On average, centralized/largely centralized states directly performed 2.8 out of 13 (21%) treatment services for diseases, while decentralized/largely decentralized states performed 1.8 out of 13 treatment services (14%). On average, Southern states performed a greater percentage of disease treatment services directly than states from other regions (30% for the South; range of 12-17% for other regions).

**FIGURE 3.8**

TREATMENT FOR DISEASES AND CONDITIONS PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=46-50)



**Note:** Obesity only appeared on the 2012 and 2016 Profile Surveys.





## STATE LABORATORY SERVICES

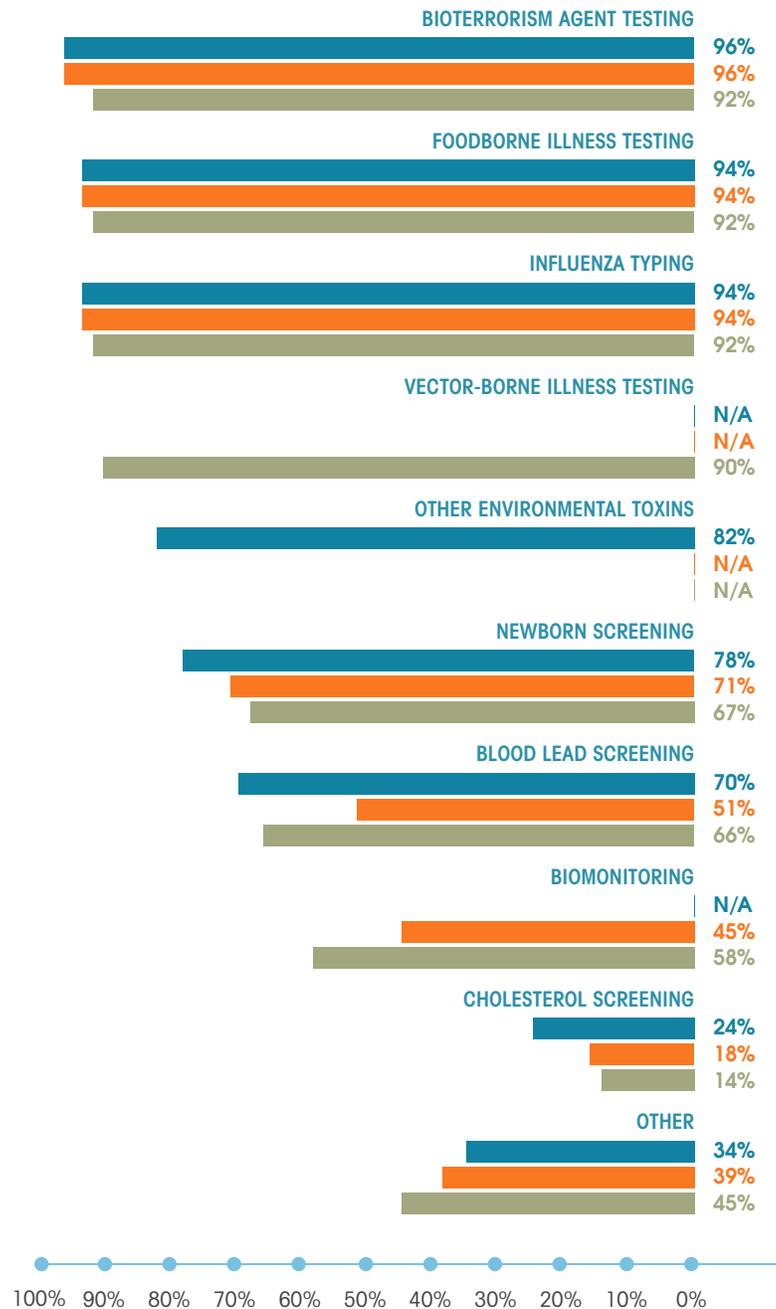
The laboratory services that state health agencies performed directly from 2010 to 2016 are displayed in **Figure 3.9**. The three lab services performed the most are bioterrorism agent testing, foodborne illness testing, and influenza typing. The percentage of state health agencies performing each of these activities remained stable from 2010 to 2016. Blood lead screening, which showed a notable decrease from 69 percent in 2010 to 51 percent in 2016, increased in 2016 to 66 percent of state health agencies performing this service directly. On average, medium and large states performed a greater percentage of lab services (72% of lab services for both) than small states (56%).

**FIGURE 3.9**

LABORATORY ACTIVITIES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=49-50)



**Note:** Other environmental toxins only appeared on the 2010 Profile Survey; biomonitoring only appeared on the 2012 and 2016 Profile Surveys; vector-borne illness testing only appeared on the 2016 Profile Survey.



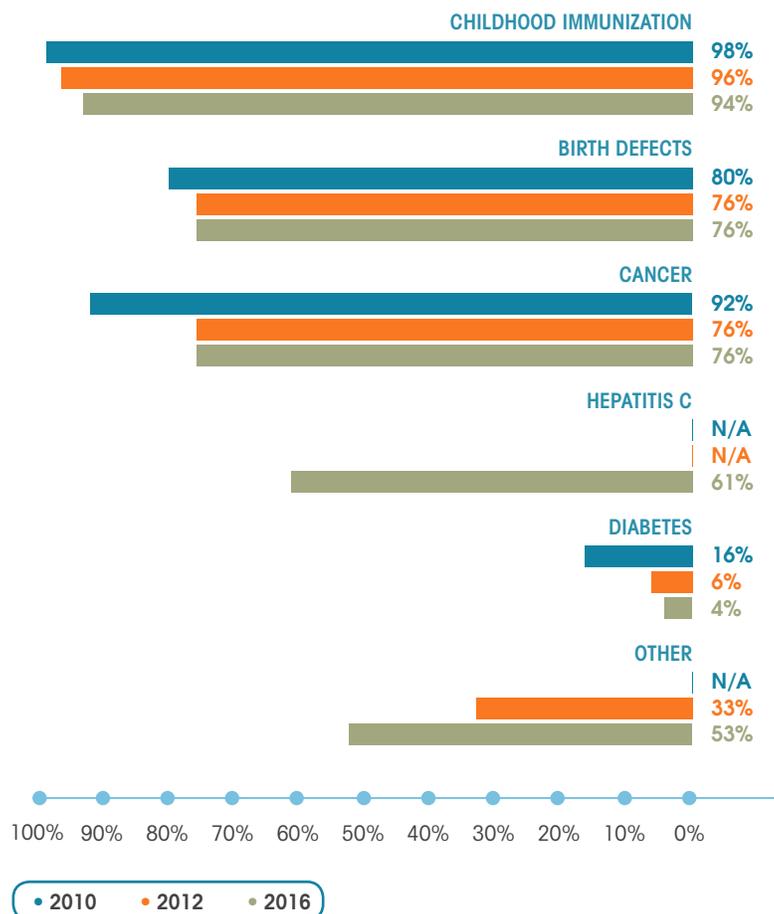


## REGISTRY MAINTENANCE

State health agencies maintain registries in response to state and federal mandates and to promote the health and well-being of their residents. The percentage of state health agencies that performed these activities directly from 2010 to 2016 is displayed in **Figure 3.10**. The three registries maintained by the most state health agencies between 2010 and 2016 were childhood immunization, birth defects, and cancer. All have shown some decrease in the percentage of state health agencies performing these activities during this time period. Other registries that state health agencies maintained include HIV/AIDS, tuberculosis, and trauma registries. Decentralized/largely decentralized states are more likely to maintain registries (64%) than centralized/largely centralized states (44%). On average, large states are more likely to maintain registries (67%) than medium or small states (59% and 47%, respectively).

**FIGURE 3.10**

REGISTRY MAINTENANCE ACTIVITIES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=49-51)



**Note:** Other did not appear on the 2010 Profile Survey; Hepatitis C only appeared on the 2016 Profile Survey.

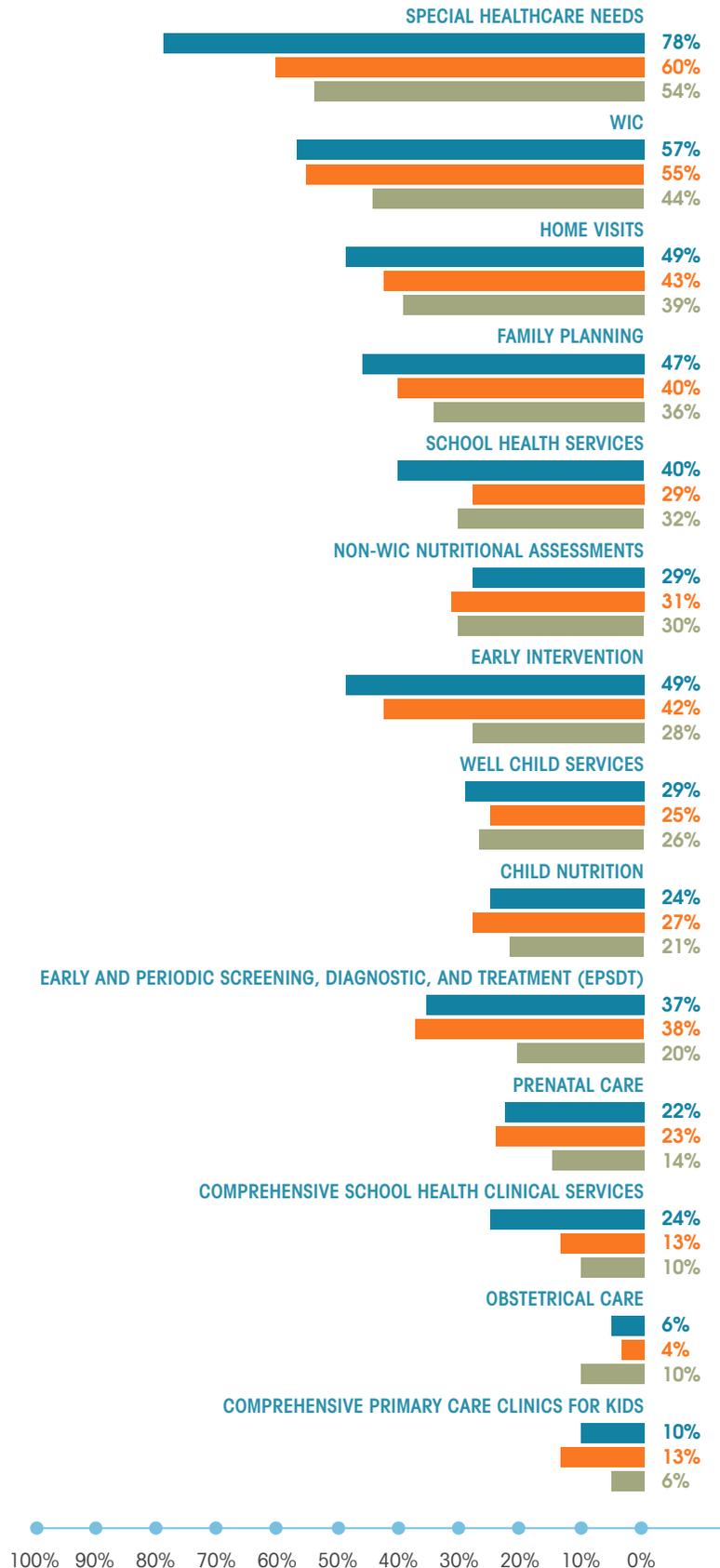
# MATERNAL AND CHILD HEALTH SERVICES

The MCH services that state health agencies performed in 2016 are displayed in **Figure 3.11**. The three most common MCH services that state health agencies provided between 2010 and 2016 were services for children with special healthcare needs, the U.S. Department of Agriculture’s Women, Infants, and Children (WIC) program, and home visits. Overall, there was a decline in the percentage of state health agencies providing MCH services. Of the 14 MCH services surveyed, 12 have seen decreases in the number of states directly performing them from 2010 to 2016. The most notable decrease was observed for services for children with special healthcare needs, with 78 percent of state health agencies performing this service directly in 2010 but only 54 percent in 2016.

On average, centralized/largely centralized states performed a greater percentage of MCH services directly (47%) than decentralized/largely decentralized states (12%). Southern states provided more MCH services on average than states in other regions (50% in South; 14-24% in other regions).

**FIGURE 3.11**

MATERNAL AND CHILD HEALTH ACTIVITIES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=48-51)



• 2010 • 2012 • 2016

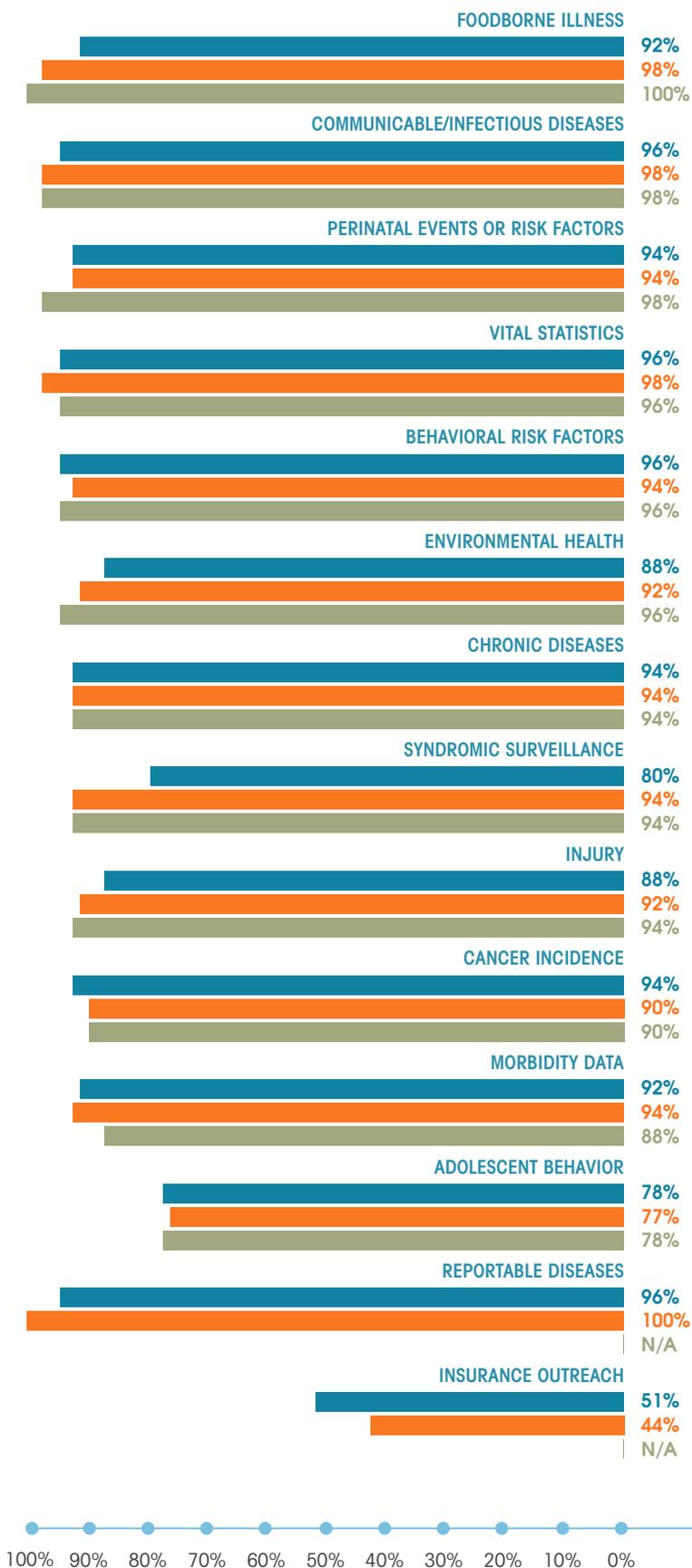
# DATA COLLECTION, EPIDEMIOLOGY, AND SURVEILLANCE ACTIVITIES

State health agencies often serve on the front lines for data collection, epidemiology, and surveillance activities as displayed in **Figure 3.12**. The majority of state health agencies perform data collection, epidemiology, and surveillance activities, and a number of these activities remained relatively stable from 2010 to 2016. All state health agencies reported directly performing foodborne illness activities in 2016, and 98 percent of state health agencies reported performing communicable/infectious disease and perinatal events or risk factors activities in 2016. Environmental health activities showed a steady increase in the number of states directly performing these activities over time (88% in 2010 to 96% in 2016), as did injury activities (88% in 2010 to 94% in 2016). There were no notable differences in the number of activities performed across governance classification, region, or population size.

**FIGURE 3.12**

DATA COLLECTION, EPIDEMIOLOGY, AND SURVEILLANCE ACTIVITIES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=49-51)

• 2010 • 2012 • 2016



**Note:** Reportable diseases and insurance outreach were not included in the 2016 Profile Survey.



## REGULATION, INSPECTION, AND LICENSING

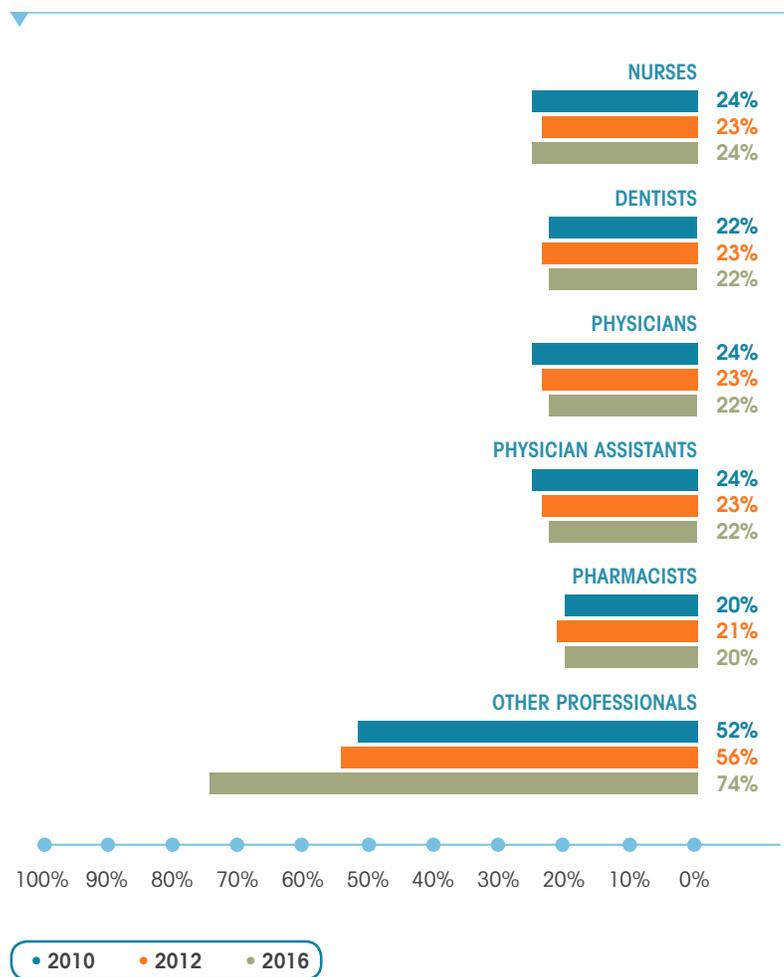
State health agencies enforce the laws and regulations that protect health and ensure safety. **Figure 3.13** shows the 15 most commonly performed regulation, inspection, and licensing activities from 2010 to 2016. The three regulatory activities performed by the most state health agencies in 2016 were regulation, inspection, and licensing of labs, food service, and trauma systems. Out of the top 15 most common activities, 10 have decreased in frequency from 2010 to 2016. Although regulation, inspection, and licensing of labs is still the most commonly performed activity, it has seen the largest decrease from 2010 (90%) to 2016 (76%). The regulation, inspection, and licensing of public swimming pools is the one activity that consistently increased in frequency from 2010 (63%) to 2016 (74%).

Looking at all of the regulation, inspection, and licensing activities together, states in New England performed a greater percentage of these activities on average than other regions (52% in New England; 38-48% for other regions). Medium and large states on average also performed a greater percentage of regulation, inspection, and licensing activities (45% and 46%, respectively) than small states (38%).

State health agencies are also involved in overseeing professional licensure activities. **Figure 3.14** displays the percentage of state health agencies that directly performed professional licensure activities between 2010 and 2016. Overall, the percentage of state health agencies performing the various professional licensure activities remained stable from 2010 to 2016, with about one-quarter of state health agencies directly performing

**FIGURE 3.14**

PROFESSIONAL LICENSURE ACTIVITIES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=47-50)



professional licensure activities. States in New England tended to perform more professional licensure activities than states in other regions (46% in New England; 20-37% in other regions). The category “other professionals” included emergency medical technicians, social workers, and nurse aides, among many others.

**FIGURE 3.13**

TOP 15 REGULATION, INSPECTION, AND LICENSING ACTIVITIES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=47-51)

• 2010 • 2012 • 2016



## ENVIRONMENTAL HEALTH ACTIVITIES

Human health is inextricably linked to the environments in which we live, so state health agencies are key players in promoting environmental health. **Table 3.4** shows the percentage of state health agencies that performed select environmental health activities between 2010 and 2016. Overall, the average number of total environmental health activities that state health agencies performed directly decreased from 2010 (42%) to 2016 (37%). These changes are likely due to funding cuts and transferring these services to local health departments and other state agencies. Notable decreases in specific activities include the number of state health agencies directly performing poison control (25% decrease from 2010 to

2016) and vector control (16% decrease from 2010 to 2016). Outdoor air quality was the one activity that saw a significant increase in the number of state health agencies performing it, rising from 14 percent in 2010 to 24 percent in 2016.

Looking at environmental health activities overall, states in New England performed a greater percentage of environmental health activities than states in other regions (46% in New England; 32-39% in other regions). On average, small states performed a lower percentage of environmental health activities (33%) than medium and large states (40% and 38%, respectively).

**TABLE 3.4** ENVIRONMENTAL HEALTH ACTIVITIES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=48-51)

	2010	2012	2016
	Percentage of State Health Agencies	Percentage of State Health Agencies	Percentage of State Health Agencies
Environmental epidemiology	90%	94%	90%
Food safety training/education	88%	84%	80%
Radiation control	71%	69%	70%
Toxicology	73%	69%	60%
Radon control	61%	63%	60%
Indoor air quality	69%	65%	56%
Private water supply safety	53%	47%	52%
Public water supply safety	53%	49%	50%
Vector control	63%	56%	47%
Groundwater protection	45%	47%	42%
Surface water protection	35%	29%	37%
Hazmat response	37%	35%	24%
Outdoor air quality	14%	27%	24%
Hazardous waste disposal	22%	16%	20%
Collecting unused pharmaceuticals	18%	12%	18%
Animal control	18%	16%	12%
Land use planning	14%	12%	10%
Poison control	33%	12%	8%
Noise pollution	8%	8%	8%
Other pollution prevention	8%	10%	7%
Coastal zone management	0%	2%	6%
Mosquito control	37%	N/A	N/A
Air pollution	22%	N/A	N/A

**Note:** Air pollution and mosquito control only appeared on the 2010 Profile Survey.

## OTHER PUBLIC HEALTH ACTIVITIES

Other public health activities that state health agencies provided directly between 2010 and 2016 are displayed in **Table 3.5**. During this time period, the three other public health activities directly performed by the most state health agencies were trauma system coordination, state health planning and development services, and veterinarian services, all of which have remained relatively stable. The largest decreases

over time were seen for health consultations for childcare environments (69% in 2012 to 53% in 2016) and forensics laboratories (31% in 2010 to 15% in 2016). On average, states in the Mid-Atlantic and Great Lakes region performed a lower percentage of other public health activities than states in other regions (25% in Mid-Atlantic and Great Lakes; 33-39% in other regions).

**TABLE 3.5** OTHER PUBLIC HEALTH ACTIVITIES PERFORMED DIRECTLY BY STATE HEALTH AGENCIES, 2010-2016 (N=48-51)

	2010	2012	2016
	Percentage of State Health Agencies	Percentage of State Health Agencies	Percentage of State Health Agencies
Trauma system coordination	78%	88%	84%
State health planning and development	77%	77%	78%
Veterinarian services	71%	81%	76%
Institutional Review Board	67%	63%	68%
Nonclinical services in correctional facilities	61%	63%	63%
Health consultations for childcare environments	N/A	69%	53%
Occupational safety and health services	39%	27%	34%
Support for veterans and military personnel and their families	N/A	23%	23%
State mental health institutions/hospitals	24%	27%	22%
Medical examiner	22%	25%	20%
Needle exchange	28%	13%	16%
Forensics laboratory	31%	22%	15%
State mental health authority with substance abuse	20%	21%	12%
Eldercare services	16%	16%	12%
Substance abuse facilities	16%	8%	8%
State tuberculosis hospitals	14%	13%	6%
State mental health authority without substance abuse	10%	10%	4%
Agriculture regulation	4%	6%	4%

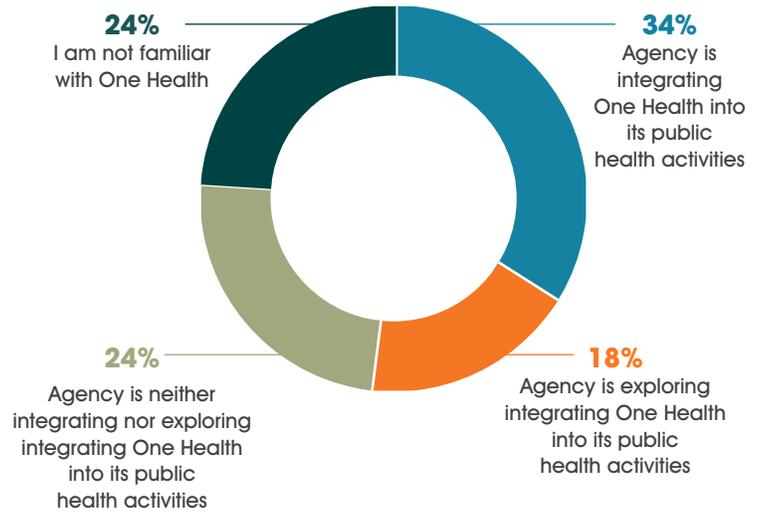
**Note:** Health consultations for childcare environments and support for veterans and military personnel and their families did not appear on the 2010 Profile Survey.

## ONE HEALTH ACTIVITIES

In recent years, the field of public health has paid increased attention to One Health, the connection between human health and the health of animals and the environment. As seen in **Figure 3.15**, 34 percent of state health agencies have started to engage with this One Health approach in their programming, while an additional 18 percent are exploring integrating One Health into their activities. Decentralized/largely decentralized states are more likely to be integrating One Health (39%) than centralized/largely centralized states (14%). States in New England are least likely to be integrating One Health (13%), while states in the Mountains and Midwest region are most likely to do so (50%). Large states are more likely to be integrating One Health (47%) than small or medium states (25% and 29%, respectively).

**FIGURE 3.15**

STATE HEALTH AGENCY ENGAGEMENT IN ONE HEALTH, 2016 (N=50)

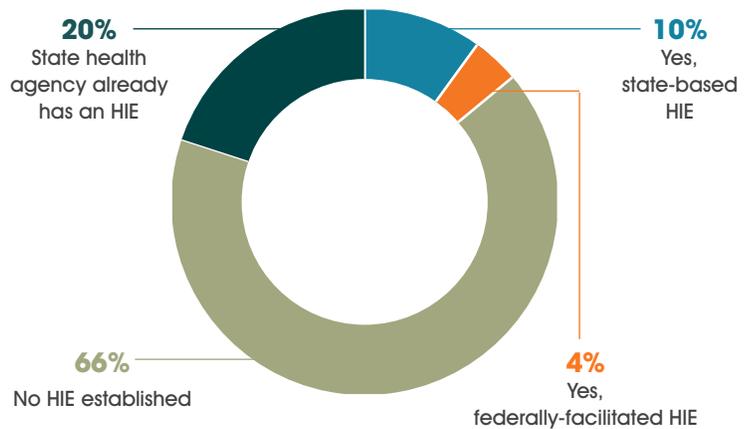


## HEALTH INSURANCE EXCHANGES

Health insurance exchanges (HIEs) are services set up to facilitate the purchase of health insurance in each state in accordance with the Affordable Care Act (ACA). In 2016, state health agencies were asked whether their state was currently establishing an HIE. As depicted in **Figure 3.16**, while 20 percent of agencies already had an HIE and 14 percent were engaged in state-based or federally-facilitated exchanges, 66 percent of states reported not currently being involved in establishing an HIE. Centralized/largely centralized states are less likely to be establishing HIEs (71%) than decentralized/largely decentralized states (58%). Western states are more likely to be working to establish HIEs than any other region (43% in the West; 0-10% in other regions), while states in New England are more likely to already have an HIE (37% in New England; 10-25% in other regions).

**FIGURE 3.16**

ESTABLISHMENT OF HEALTH INSURANCE EXCHANGES BY STATE HEALTH AGENCIES, 2016 (N=50)





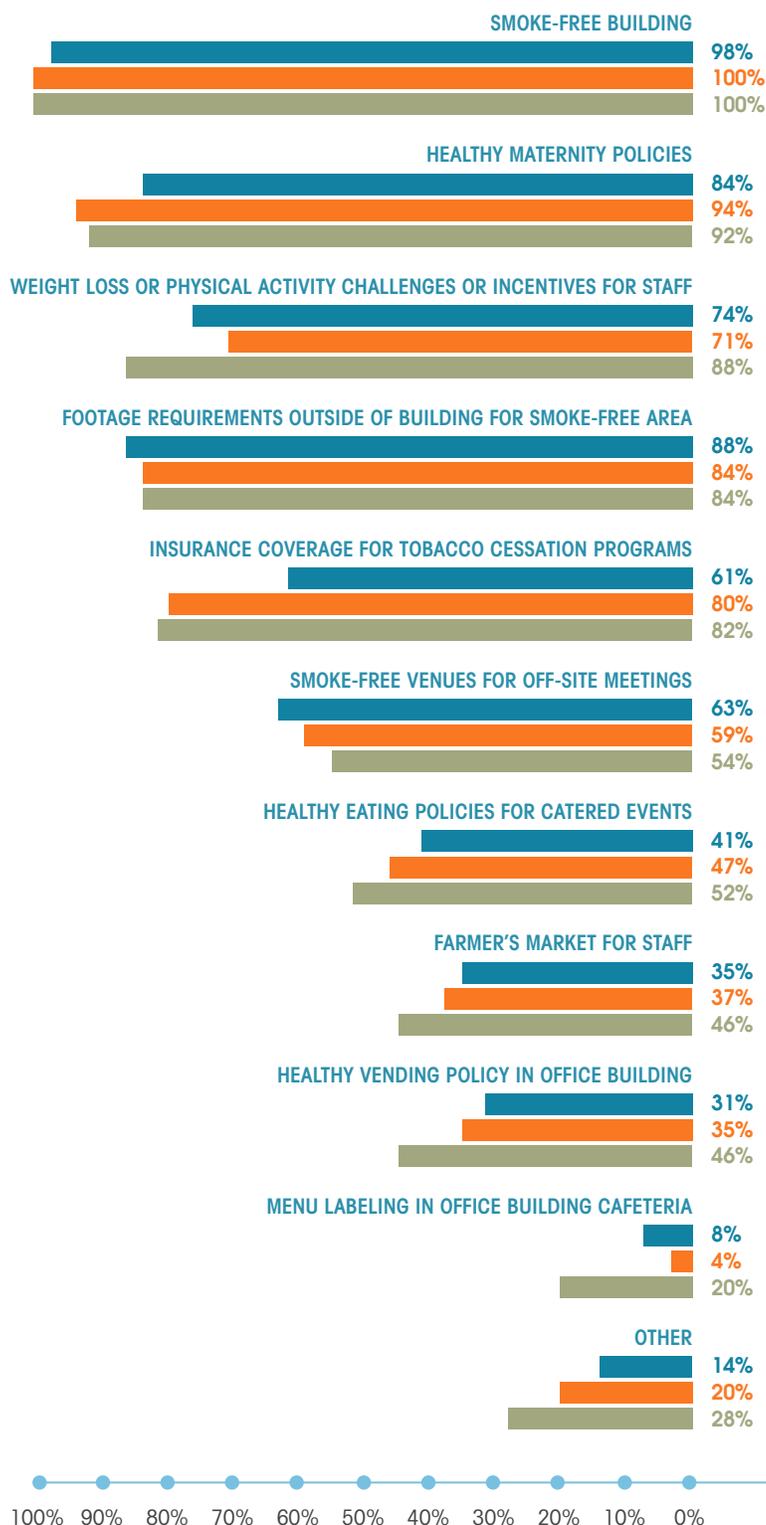
## WORKSITE WELLNESS

Worksite wellness programs can help state health agencies support the physical and emotional well-being of their employees while serving as a model for other agencies and businesses in their communities. Components of state health agencies' worksite wellness programs between 2010 and 2016 are shown in **Figure 3.17**. The majority of worksite wellness activities have either increased or remained the same between 2010 and 2016, with the exception of smoke-free venues for offsite meetings and footage requirements outside of building for smoke-free areas. The greatest increase was in insurance coverage for tobacco cessation programs (61% in 2010 to 82% in 2016) and healthy vending policies in office buildings (31% in 2010 to 46% in 2016). On average, states in New England tended to offer more worksite wellness activities than states in other regions (73% in New England; 56-67% in other regions). Small states tended to offer fewer worksite wellness program components (60%) than medium and large states (65% and 64%, respectively).

**FIGURE 3.17**

COMPONENTS OF WORKSITE WELLNESS PROGRAMS IMPLEMENTED AT STATE HEALTH AGENCIES, 2010-2016 (N=49-50)

• 2010 • 2012 • 2016



# RESEARCH ACTIVITIES

State health agencies promote research and disseminate research findings in various ways. **Figure 3.18** shows the types of research activities that state health agencies participated in between 2012 and 2016. Between 2012 and 2016, the number of state health agencies engaging in research activities remained relatively stable. The most common research activities that states performed included collecting, exchanging, or reporting data for a study; disseminating research findings to key stakeholders; and analyzing and interpreting study data and findings. Significantly more decentralized/largely decentralized states (64%) reported participating in activities to help other organizations apply research findings to practice than centralized/largely centralized states (43%). Western states were less likely to engage in identifying topics/questions relevant to public health practice than states in other regions (45% in the West; 75-89% in other regions). Small states were less likely to engage in recruiting study sites and/or study participants (38%) than medium or large states (56% and 59%, respectively).

In 2016, the number of research studies that state health agencies engaged in over the past two years ranged from a minimum of zero to a maximum of 668 (mean=52; median=13), an increase from the number of studies conducted in 2012 (range=1-427; mean=46; median=15). On average, the state health agency led 54 percent of the studies in 2016, compared to 41 percent of studies in 2012. Decentralized/largely decentralized states have participated in more studies (mean=84; median=36) than centralized/largely centralized states (mean=18; median=14). New England states have participated in the largest average number of studies (mean=113; median=27) compared to states in other regions (means=21-46; medians=5-20). On average, large states have participated in more research studies in the past two years (mean=106; median=35) than medium and small states (means=6-36; medians=4-33).

When states participated in research studies in 2016, they conducted an average of 38 studies with researchers based at a university or research institute, an increase from the average of 27 studies in 2012. For those state health agencies that collaborated with researchers, 61 percent of studies in 2016 involved a formal research agreement between the agency and the university or research institute to conduct joint studies on a reoccurring basis, which was double the number of studies with a formal research agreement in 2012 (30%).

**FIGURE 3.18**

PARTICIPATION IN RESEARCH STUDIES IN PAST TWO YEARS BY STATE HEALTH AGENCIES, 2012-2016 (N=48-49)



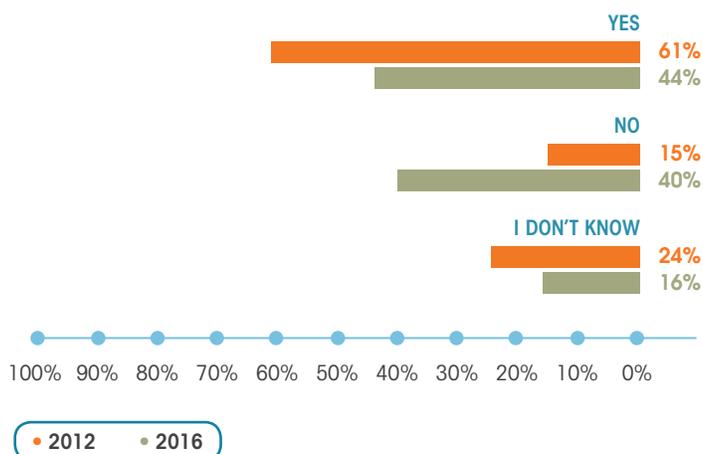
## HEALTH IMPACT ASSESSMENTS

Health impact assessments (HIAs) are the process by which an agency systematically evaluates a project or policy's potential health effects. In 2012 and 2016, the Profile Survey asked state health agencies if anyone in the agency had attended an HIA training in the past two years. The number of state health agencies that reported participation in HIA training decreased between 2012 (61%) and 2016 (44%). By 2016, the number of agencies that had participated in training was almost equal to the number of agencies that had not participated as shown in **Figure 3.19**. Individuals from Western states were most likely to have participated in an HIA training (67%), while individuals from states in the Mountains and Midwest region were least likely to have done so (20%).

The survey also asked states if their state health agency had participated in an HIA in the past two years. In both 2012 and 2016, fewer than half of state health agencies had participated, though the average number of HIAs increased slightly during this time (three in 2012 to four in 2016). States in the Mid-Atlantic and Great Lakes region conducted the fewest HIAs (mean=2), while Western states conducted the most (mean=5). Small states conducted fewer HIAs (mean=2) than medium and large states (mean=4 for both). Of those states in which a staff member participated in HIA training, half also reported state health agency participation in an HIA advisory committee in 2016. All Western states participated in an HIA advisory committee (0-57% in other regions).

**FIGURE 3.19**

PARTICIPATION IN HIA TRAINING IN PAST TWO YEARS  
BY ANYONE IN STATE HEALTH AGENCY, 2012-2016 (N=46-48)



This chapter has explored the range of state health agencies' roles and responsibilities and the services and activities that they provide. The next section of the report, *State Health Agencies: How We Do It*, addresses the tools and techniques that state health agencies use to provide these services that protect the nation's health.



**PART III**

**STATE PUBLIC HEALTH**

**HOW WE DO IT**





## Chapter 4

# PLANNING AND QUALITY IMPROVEMENT

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State health agencies play an integral role in quality improvement (QI), which HRSA defines as “systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.”<sup>1</sup> State health agencies are also increasingly involved in public health accreditation, developing a set of public health standards, measuring health agency performance against those standards, and rewarding or recognizing health departments that meet them. This chapter describes state health agencies’ completion of accreditation prerequisites and intentions to apply for accreditation, state health agencies’ performance management systems and QI efforts, staff involvement in QI, and use of the U.S. Community Preventive Services Task Force’s Guide to Community Preventive Services (“The Community Guide”). When available, we compare 2016 data with 2012, 2010, and 2007 data, and describe differences in state health agency planning and QI efforts by governance structure, region, and state population size.

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### NOTES

- 1** HRSA. “Quality Improvement.” Available at [www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf](http://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf). Accessed June 23, 2017.



## KEY FINDINGS

- ▶ In 2016, 94 percent of state health agencies reported completing a state health assessment, with 54 percent of those having done so within the last three years.
- ▶ The percentage of state health agencies that reported developing or participating in developing a state health improvement plan within the last three years has steadily increased from 23 percent in 2007 to 64 percent in 2016.
- ▶ As of 2016, 96 percent of state health agencies have developed an agency-wide strategic plan, and 71 percent of state health agencies have done so within the last three years.
- ▶ At the time the survey was completed, 40 percent of state health agencies had achieved accreditation through the Public Health Accreditation Board's (PHAB) voluntary national accreditation program. As of September 2017, eight additional state health agencies have achieved accreditation.<sup>2</sup> Of the 13 states that plan to apply for accreditation but have not yet registered in e-PHAB, 69 percent intend to do so within the next two years.
- ▶ Accredited states and those pursuing accreditation were most likely to report having already experienced the following benefits: Greater quality and performance improvement opportunities within their agency (85%), greater collaboration across departments or units within their agency (82%), stronger culture of QI in their agency (76%), increase in their agency's capacity to identify and address health priorities (73%), and strengthening their agency's relationship with key partners in other sectors (70%).
- ▶ The percentage of state health agencies with a formal performance management plan steadily increased over time (67% in 2010, 75% in 2012, and 90% in 2016).
- ▶ The three most common QI frameworks or approaches in state health agencies are Plan-Do-Check-Act or Plan-Do-Study-Act (76%), Lean (58%), and Six Sigma (32%).
- ▶ The most common ways that state health agencies support or encourage staff involvement in QI efforts is through staff training on QI methods (84%), a QI committee to coordinate QI efforts (64%), and job descriptions that include QI-related responsibilities (64%).
- ▶ State health agencies most commonly used the Community Guide in the past two years for program planning (78%), grant writing (68%), and policy development (50%).

## NOTES

- <sup>2</sup> Public Health Accreditation Board. Accreditation Activity as of September 19, 2017. Available at [www.phaboard.org/news-room/accreditation-activity/](http://www.phaboard.org/news-room/accreditation-activity/). Accessed October 3, 2017.

# ACCREDITATION PREREQUISITES

PHAB established a voluntary national accreditation program for state, local, and tribal health agencies in 2011. PHAB accreditation provides agencies with the opportunity to measure their performance and demonstrate accountability. There are three prerequisites for submitting an application for accreditation, all of which relate to planning and QI: (1) conduct a state health assessment,

(2) create a state health improvement plan, and (3) develop an agency-wide strategic plan. The three prerequisites are interconnected; the state health assessment informs the state health improvement plan, which informs the agency strategic plan. To be eligible for accreditation, these three prerequisites must have been completed within the past five years.

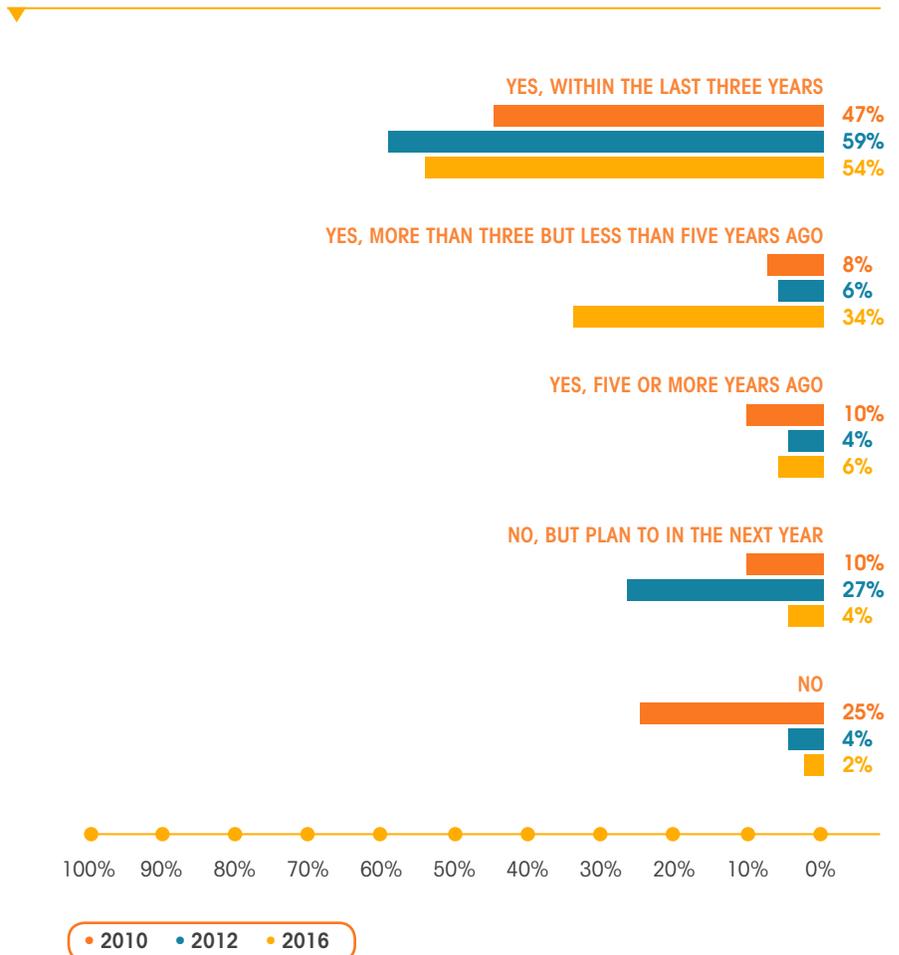
# STATE HEALTH ASSESSMENTS

State health assessments provide information to state health agencies about the health of the population they serve and identify areas for health improvement, contributing factors to higher health risks or poorer health outcomes among targeted populations, and community resources to improve health status. As of 2016, 94 percent of state health agencies have developed a state health assessment, and 54 percent of those have done so within the last three years.

From 2010 to 2016, the percentage of state health agencies that developed a state health assessment in the last five years increased from 55 percent in 2010 to 65 percent in 2012 to 84 percent in 2016. Additionally, from 2012 to 2016, the percentage of state health agencies that plan to develop a health assessment in the next year decreased from 27 to 4 percent, reflecting the increase in state health agencies that have already developed a state health assessment (see **Figure 4.1**). All Western states have completed a state health assessment in the last five years.

**FIGURE 4.1**

DEVELOPMENT OF STATE HEALTH ASSESSMENT BY STATE HEALTH AGENCIES, 2010-2016 (N=49-50)



# STATE HEALTH IMPROVEMENT PLANS

State health improvement plans are long-term, systematic plans to address the priorities and issues that the state health assessment identified. The state health improvement plan's purpose is to describe how state health agencies and the communities they serve will work together to improve the state's health. The community, stakeholders, and partners can use the state health improvement plan to set priorities, direct the use of resources, and develop and implement projects, programs, and policies.

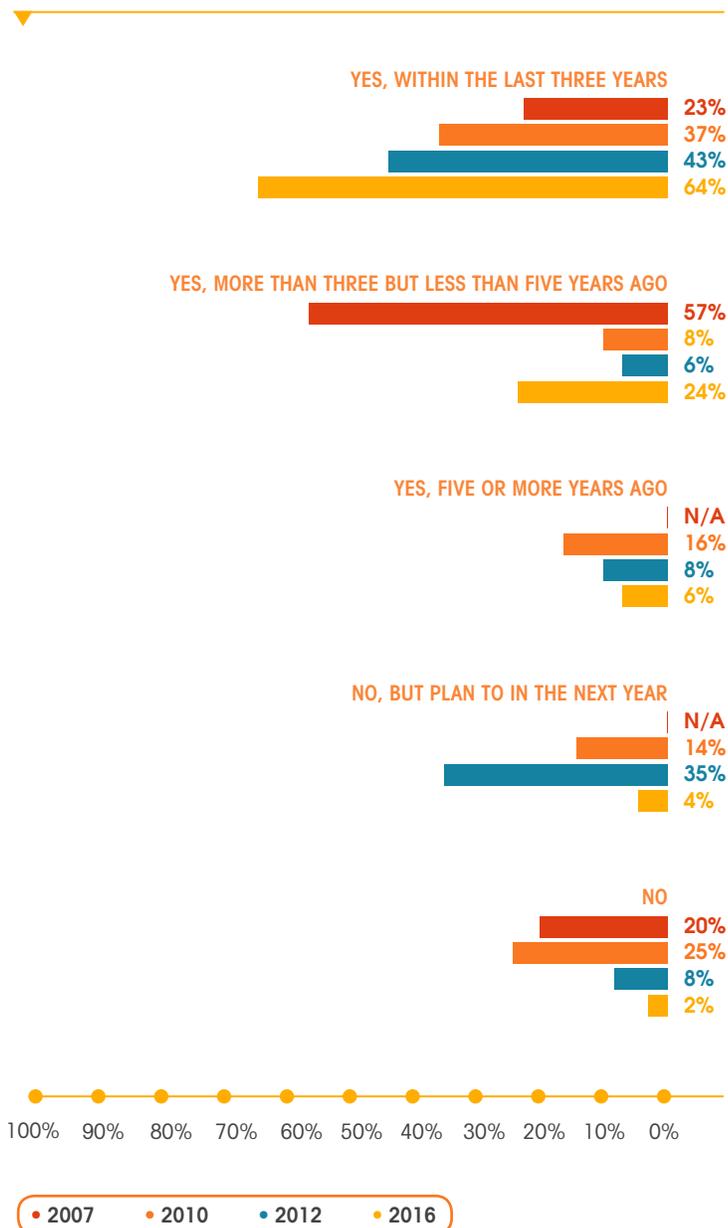
As of 2016, 97 percent of state health agencies had developed or participated in developing a state health improvement plan, with 88 percent having done so within the last five years. From 2007 to 2016, the percentage of state health agencies that developed or participated in developing a state health improvement plan in the last three years continually increased, from 23 percent in 2007 to 64 percent in 2016. As with state health assessments, the percentage of state health agencies that plan to develop or participate in developing a state health improvement plan in the next year decreased substantially from 2012 (35%) to 2016 (4%), reflecting the increase in the number of states that have already developed one (see **Figure 4.2**).

Decentralized/largely decentralized states are somewhat more likely than centralized/largely centralized states to have developed or participated in developing a state health improvement plan in the last three years (69% of decentralized/largely decentralized vs. 57 percent centralized/largely centralized). Development of or participation in developing a state health improvement plan within the last three years shows a positive relationship with size, such that small states (50%) are less likely than medium states (65%), which in turn are less likely than large states (77%), to have developed or participated in developing a state health improvement plan in the last three years.

Of the 47 states reporting a state health improvement plan in 2016, 41 (87%) intend to update the plan within the next three years. Eighty-nine percent of state health agencies with a health improvement plan have one that was developed using a state health assessment's results.

**FIGURE 4.2**

DEVELOPMENT OR PARTICIPATION IN DEVELOPMENT OF A STATE HEALTH IMPROVEMENT PLAN, 2007-2016 (N=49-51)



**Note:** In 2007, the response options were "Yes, within the last three years," "Yes, more than three years ago," and "No." "Yes, more than three years ago" responses from 2007 were categorized under "Yes, more than three years ago but less than five years ago" in this figure.

Decentralized/largely decentralized states are more likely to have developed their state health improvement plan using state health assessment results than centralized/largely centralized states (96% of decentralized/largely decentralized states vs. 75% of centralized/largely centralized states). Additionally, the larger the state, the more likely they are to have developed their state health improvement plan using state health assessment results (79% of small states, 88% of medium states, and 100% of large states have done so).

State health agencies were also asked whether their state health improvement plan was linked to local health improvement plans. In 2016, 69 percent of state health agencies with state health improvement plans had plans that were linked to local health improvement plans. **Figure 4.3** displays the percentage of state health agencies with state health improvement plans linked to local health improvement plans from 2007 to 2016. The percentage of all state health agencies with state health improvement plans linked to local health improvement plans decreased from 30 percent in 2007 to 17 percent in 2010, but then increased in 2012 (21%) and 2016 (26%). The percentage of agencies with state health improvement plans linked to some plans increased from 2007 to 2010, decreased from 52 percent in 2010 to 21 percent in 2012, but then increased to 32 percent in 2016. States in New England are more likely than states in other regions to have state health improvement plans linked to local health improvement plans (50% of New England states vs. 22-33% of states in other regions). Medium and large states are more likely to have state health improvement plans linked to some plans (44% and 47%, respectively) than small states (11%).

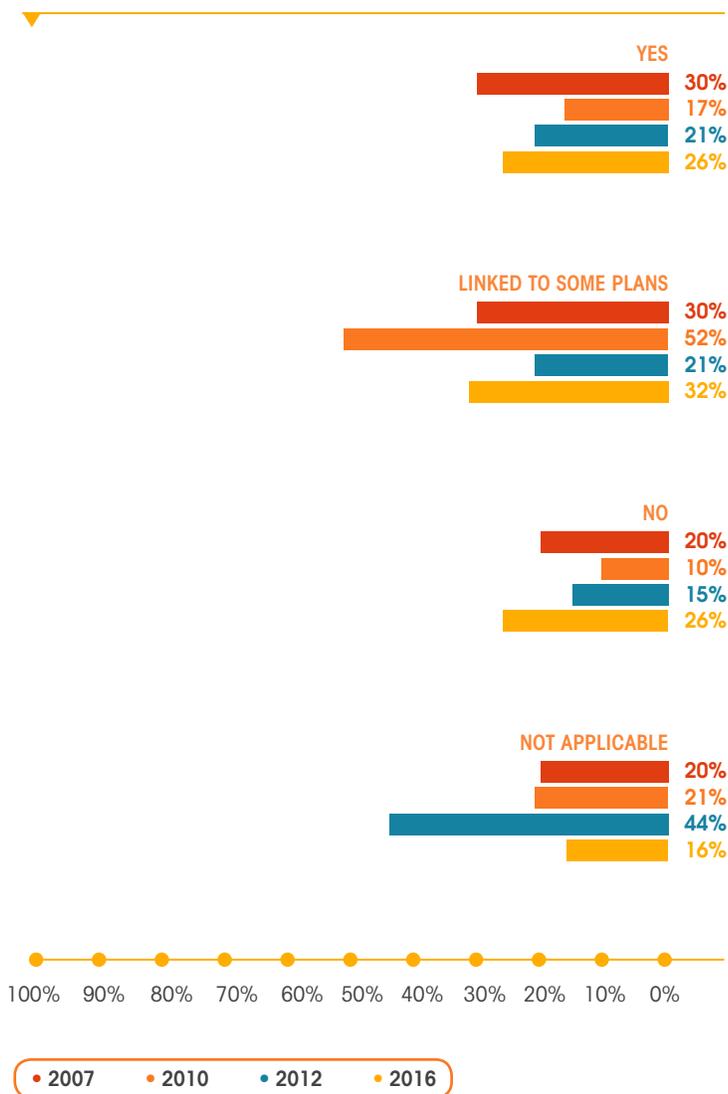
## AGENCY-WIDE STRATEGIC PLANS

Strategic planning is a process for defining and determining an agency's roles, priorities, and direction over three to five years. A strategic plan sets forth what an agency plans to achieve, how it will achieve it, and how it will know if it has achieved it. The strategic plan provides a guide for making decisions on allocating resources and taking action to pursue strategies and priorities.

As of 2016, 96 percent of state health agencies had developed an agency-wide strategic plan, and 71 percent of state health agencies had done so within the last three years. A greater percentage of centralized/largely centralized states (86%) had developed a strategic plan in the last three years than decentralized/largely decentralized states (64%).

**FIGURE 4.3**

LINKING OF STATE HEALTH IMPROVEMENT PLANS TO LOCAL HEALTH IMPROVEMENT PLANS, 2007-2016 (N=39-50)



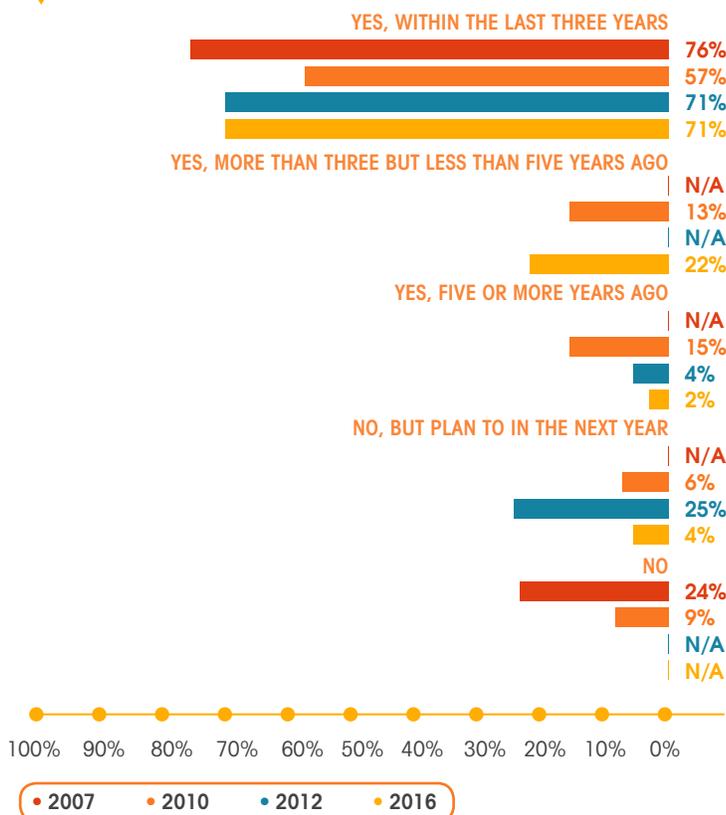
**Note:** In 2007, the response options for this question were "Yes" and "No." "Yes" responses from 2007 were categorized under "Yes, within the last three years" in this figure.

The percentage of state health agencies with strategic plans from 2007 to 2016 is displayed in **Figure 4.4**. From 2007 to 2010, the percentage of state health agencies that had developed an agency-wide strategic plan in the last three years decreased from 76 percent to 57 percent. However, this number increased to near 2007 levels in 2012, with 71 percent having developed an agency-wide strategic plan in the last three years, remaining level at 71 percent in 2016. As with state health assessments and state health improvement plans, the percentage of state health agencies that plan to develop an agency-wide strategic plan in the next year decreased from 2012 to 2016, reflecting the increase in the number of states that have already developed an agency-wide strategic plan.

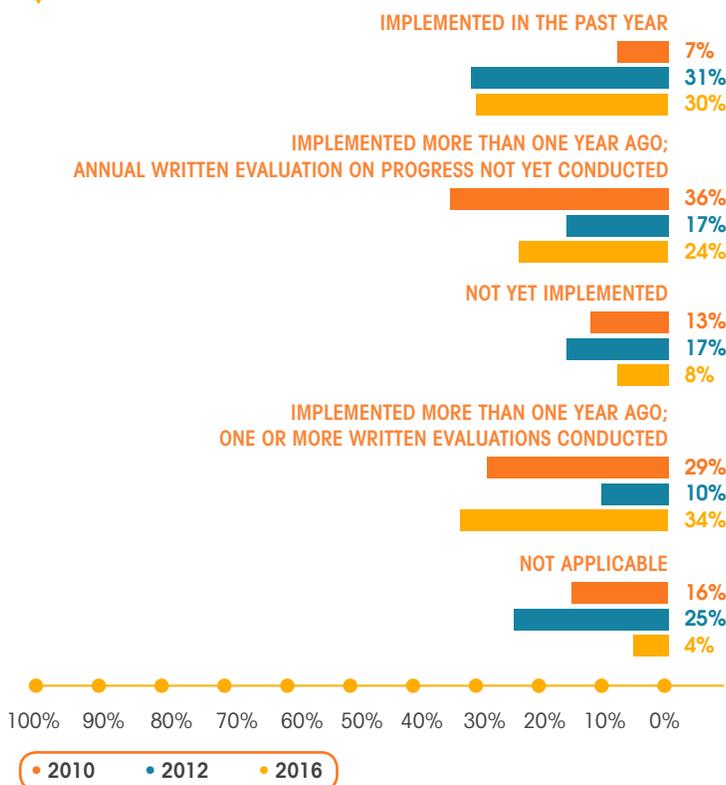
Thirty percent of state health agencies that completed a strategic plan in 2016 had implemented their agency-wide strategic plan in the past year, and another 24 percent had implemented the plan more than one year ago, though an annual written evaluation on progress had not yet been conducted. Implementation status for state health agencies from 2010 to 2016 is displayed in **Figure 4.5**. From 2012 to 2016, the percentage of state health agencies that had not yet implemented an agency-wide strategic plan decreased from 17 percent to 8 percent.

A greater percentage of centralized/largely centralized states (50%) implemented a strategic plan within the past year than decentralized/largely decentralized states (16%). A greater percentage of Southern states (58%) implemented plans in the past year than states in other regions (percentages range from 18-29% for the other four regions).

**FIGURE 4.4** STATE HEALTH AGENCY DEVELOPMENT OF AGENCY-WIDE STRATEGIC PLAN, 2007-2016 (N=44-49)



**FIGURE 4.5** STATE HEALTH AGENCY IMPLEMENTATION OF AGENCY-WIDE STRATEGIC PLAN, 2010-2016 (N=46-50)





## INTENTION TO APPLY FOR ACCREDITATION

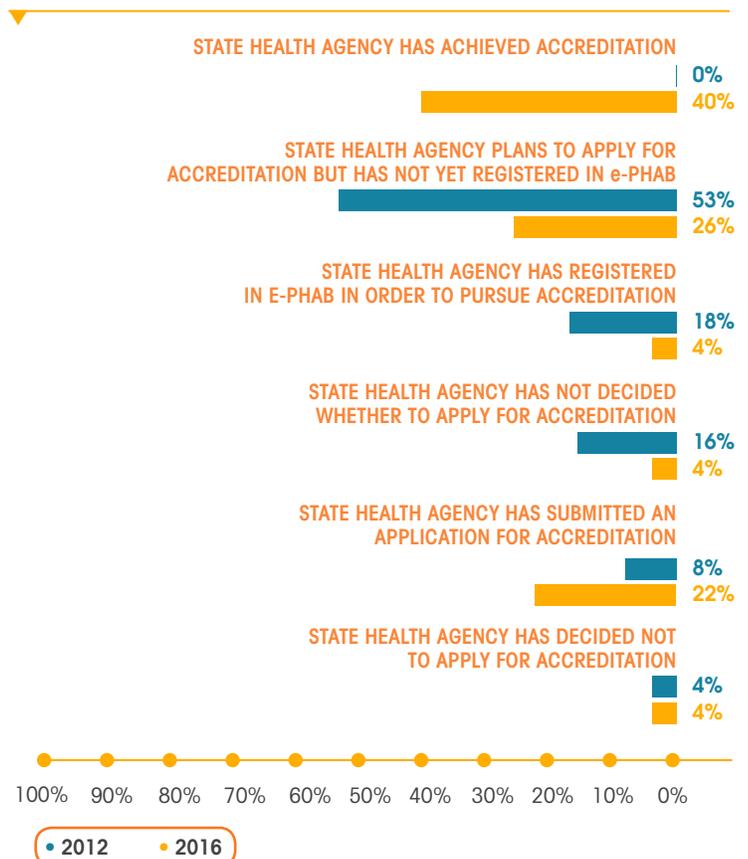
State health agencies that choose to pursue accreditation are at different stages in the process. Forty percent of state health agencies have already achieved accreditation, and another 26 percent plan to apply for accreditation but have not yet registered in e-PHAB. As of September 2017, eight additional state health agencies have achieved accreditation.<sup>3</sup> **Figure 4.6** shows the progression of states through the accreditation process from 2012 to 2016. There are no notable differences in accreditation status by governance classification, region, or state size.

Thirteen states plan to apply for accreditation, but have not yet registered in e-PHAB. Sixty-nine percent intend to do so within the next two years (see **Figure 4.7**). Only two state health agencies indicated that they do not intend to apply for accreditation, with one saying that the fees are too high and one indicating that the standards are not appropriate for their agency. Both states also reported that the time and effort to pursue accreditation exceeds the benefits to their agencies.

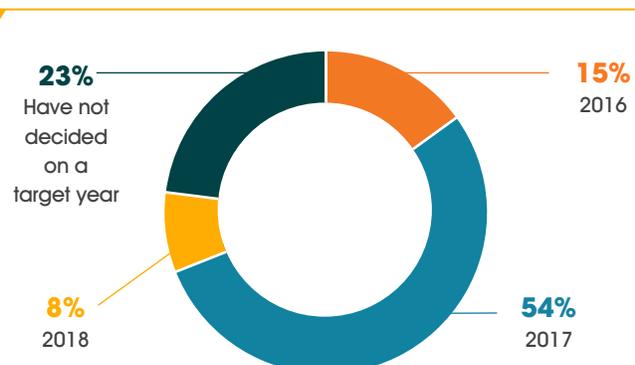
### NOTES

- 3 Public Health Accreditation Board. "Accreditation Activity as of September 19, 2017." Available at [www.phaboard.org/news-room/accreditation-activity/](http://www.phaboard.org/news-room/accreditation-activity/). Accessed October 3, 2017.

**FIGURE 4.6** STATE HEALTH AGENCY PARTICIPATION IN PHAB ACCREDITATION PROGRAM, 2012-2016 (N=49-50)



**FIGURE 4.7** ANTICIPATED YEAR OF LETTER OF INTENT SUBMISSION FOR ACCREDITATION, 2016 (N=13)



## BENEFITS OF ACCREDITATION

In 2016, ASTHO asked respondents whose state health agencies had achieved accreditation or were pursuing accreditation to respond to a series of items on the potential benefits of accreditation, either anticipated or already experienced. Results for states that had already achieved accreditation, submitted an application for accreditation, or registered in e-PHAB to pursue accreditation are displayed in **Table 4.1**. States were most likely to report having already experienced the following benefits: Accreditation stimulated quality and performance improvement opportunities within

their agency (85%), stimulated greater collaboration across departments or units within their agency (82%), strengthened the culture of QI in their agency (76%), increased their agency's capacity to identify and address health priorities (73%), and strengthened their agency's relationship with key partners in other sectors (70%). While states anticipated that their agencies would experience an array of accreditation benefits, more than half (52%) anticipated that it would increase the extent to which information from performance management system influences decisions.

**TABLE 4.1** ACCREDITED/IN-PROCESS STATE HEALTH AGENCIES' PERCEIVED BENEFITS OF ACCREDITATION, 2016 (N=33)

Accreditation Benefit	Agency has already experienced accreditation benefit		Anticipate agency will experience accreditation benefit		Agency has not experienced accreditation benefit and does not anticipate that it will		Don't know	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Stimulate quality and performance improvement opportunities within our agency	28	85%	5	15%	0	0%	0	0%
Strengthen the culture of QI in our agency	25	76%	8	24%	0	0%	0	0%
Increase the extent to which information from performance management system informs decisions	16	48%	17	52%	0	0%	0	0%
Increase our agency's capacity to identify and address health priorities.	24	73%	5	15%	0	0%	4	12%
Improve our agency's overall capacity to provide high-quality programs and services to our customers	17	52%	13	39%	1	3%	2	6%
Increase the extent to which our agency uses evidence-based practices for public health programs and/or business practices	17	52%	10	30%	2	6%	4	12%
Improve our agency's financial status (e.g., by making agency more efficient or increasing competitiveness for funding opportunities, etc.)	3	9%	13	39%	5	15%	12	36%
Increase the extent to which the agency has identified and addressed gaps in employee training and workforce development	20	61%	11	33%	1	3%	1	3%
Stimulate greater collaboration across departments or units within our agency	27	82%	6	18%	0	0%	0	0%
Strengthen our agency's relationship with key partners in other sectors	23	70%	2	6%	1	3%	7	21%
Increase the public's working knowledge of our agency's roles and responsibilities	10	30%	11	33%	3	9%	9	27%
Improve our board of health or governing entity's knowledge of our agency's roles and responsibilities	13	39%	8	24%	2	6%	10	30%



State health agencies that plan to apply for accreditation, but have not yet registered in e-PHAB were asked a similar series of questions about anticipated potential benefits. Responses are displayed in **Table 4.2**. State health agencies were most likely to report that they anticipated experiencing the following accreditation benefits: Stimulating quality and

performance improvement opportunities within their agency (92%), strengthening the culture of QI in their agency (92%), and increasing the extent to which the agency has identified and addressed gaps in employee training and workforce development (83%).

**TABLE 4.2** PERCEIVED BENEFITS OF ACCREDITATION AMONG STATE HEALTH AGENCIES WITH PLANS TO APPLY FOR ACCREDITATION, 2016 (N=12)

Accreditation Benefit	Anticipate agency will experience accreditation benefit		Agency has not experienced accreditation benefit and does not anticipate that it will		Don't know	
	Frequency	%	Frequency	%	Frequency	%
Stimulate quality and performance improvement opportunities within our agency	11	92%	0	0%	1	8%
Strengthen the culture of QI in our agency	11	92%	0	0%	1	8%
Increase the extent to which information from performance management system informs decisions	8	67%	1	8%	3	25%
Increase our agency's capacity to identify and address health priorities	8	67%	2	17%	2	17%
Improve our agency's overall capacity to provide high-quality programs and services to our customers	9	75%	1	8%	2	17%
Increase the extent to which our agency uses evidence-based practices for public health programs and/or business practices	8	67%	2	17%	2	17%
Improve our agency's financial status (e.g., by making agency more efficient or increasing competitiveness for funding opportunities, etc.)	6	50%	2	17%	4	33%
Increase the extent to which the agency has identified and addressed gaps in employee training and workforce development	10	83%	1	8%	1	8%
Stimulate greater collaboration across departments or units within our agency	8	67%	2	17%	2	17%
Strengthen our agency's relationship with key partners in other sectors	7	58%	1	8%	4	33%
Increase the public's working knowledge of our agency's roles and responsibilities	6	50%	1	8%	5	42%
Improve our board of health or governing entity's knowledge of our agency's roles and responsibilities	7	64%	1	9%	3	27%

# PERFORMANCE MANAGEMENT SYSTEMS

A performance management system is made up of four components: Performance standards, performance measures, progress reporting, and QI. 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:<sup>4</sup>

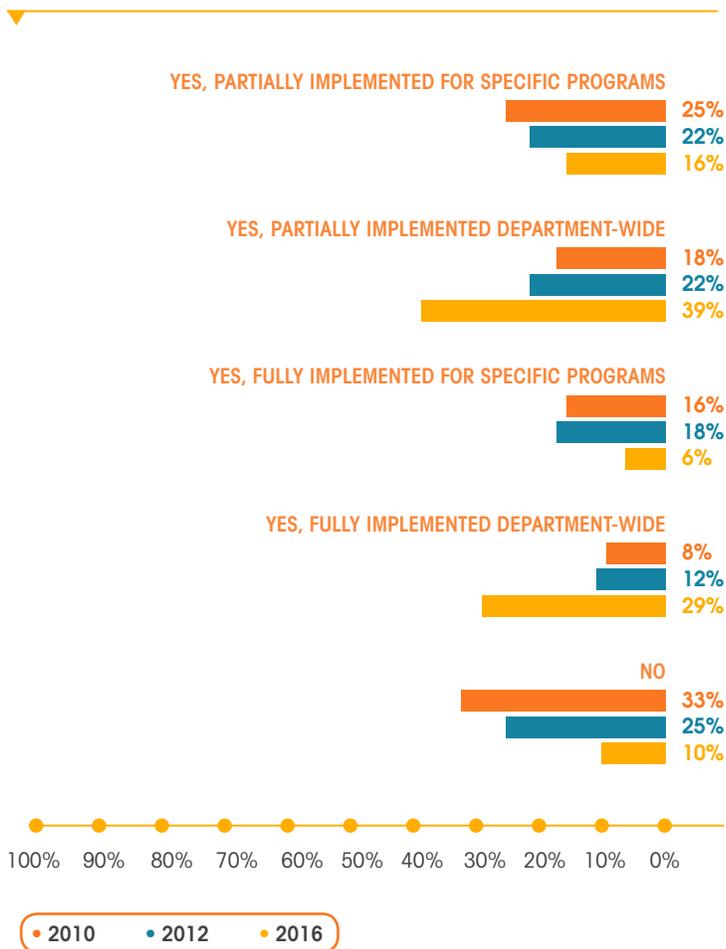
- ▶ **Performance standards** are objective standards or guidelines that are used to assess an organization's performance (e.g., one epidemiologist on staff per 100,000 population served, 80% of all clients who rate health agency services as "good" or "excellent," 100% immunization rate for all children). Standards may be set by benchmarking against similar organizations, or based on national, state, or scientific guidelines.
- ▶ **Performance measures** are any quantitative measures or indicators of capacities, processes, or outcomes relevant to the assessment of an established performance goal or objective (e.g., the number of epidemiologists on staff capable of conducting investigations, percentage of clients who rate health agency services as "good" or "excellent," percentage of immunized children).
- ▶ **Reporting of progress** means documentation and reporting of progress in meeting standards and targets and sharing of such information through feedback.
- ▶ **Quality improvement** refers to a formal, systematic approach (such as Plan-Do-Check-Act) applied to the processes underlying public health programs and services in order to achieve measurable improvements.

The percentage of state health agencies with a formal performance management plan increased from 67 percent in 2010 to 75 percent in 2012 to 90 percent in 2016 (see **Figure 4.8**). State health agencies were more likely to have partially implemented a performance management plan department-wide in 2016 than they were in 2012 (39% vs. 22%), and to have fully implemented a performance management plan department-wide in 2016 than they were in 2012 (29% vs. 12%). Decentralized/largely decentralized states were nearly twice as likely

as centralized/largely centralized states to have partially implemented a formal performance management plan department-wide (56% vs. 29%). A greater percentage of states in the Mid-Atlantic and Great Lakes do not have a formal performance management plan than states in other regions (25% do not have a plan in the Mid-Atlantic and Great Lakes vs. 0%-10% for other regions). Small states (44%) were more likely to have a formal performance management plan implemented department-wide than medium (24%) and large (19%) states.

**FIGURE 4.8**

FORMAL PERFORMANCE MANAGEMENT PROGRAM IN PLACE AT STATE HEALTH AGENCIES, 2010-2016 (N=49)



## NOTES

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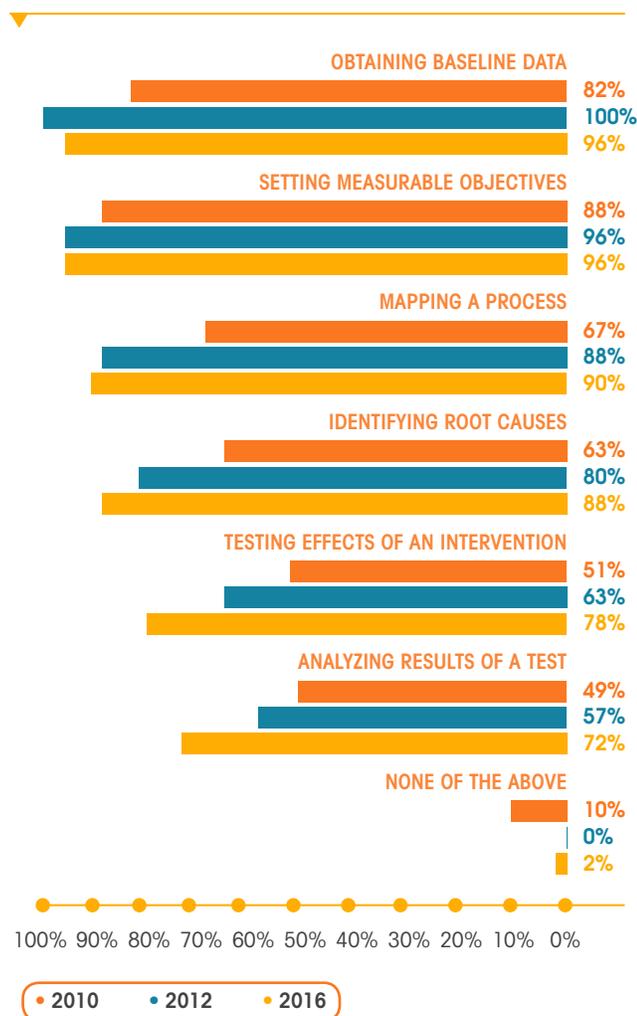
PHAB. "Acronyms and Glossary of Terms, Version 1.0." Accessed May 16, 2017. Available at [www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf](http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf).

# STATE HEALTH AGENCY QUALITY IMPROVEMENT EFFORTS

State health agencies engage in a variety of QI frameworks or approaches. In 2016, the three most commonly used frameworks or approaches were Plan-Do-Check-Act/Plan-Do-Study-Act (76%), Lean (58%), and Six Sigma (32%). **Figure 4.9** shows the QI frameworks or approaches that state health agencies used in 2010, 2012, and 2016. While use of Lean and Six Sigma frameworks have continued to increase over time, use of Plan-Do-Check-Act/Plan-Do-Study-Act increased from 2010 to 2012, but then decreased from 2012 to 2016, though it is still the most commonly used. Use of Balanced Scorecard has shown a consistent decrease over time. In addition, the percentage of state health agencies reporting no specific framework or approach decreased from 28 percent in 2010 to 4 percent in 2012, and remained level at 4 percent in 2016.

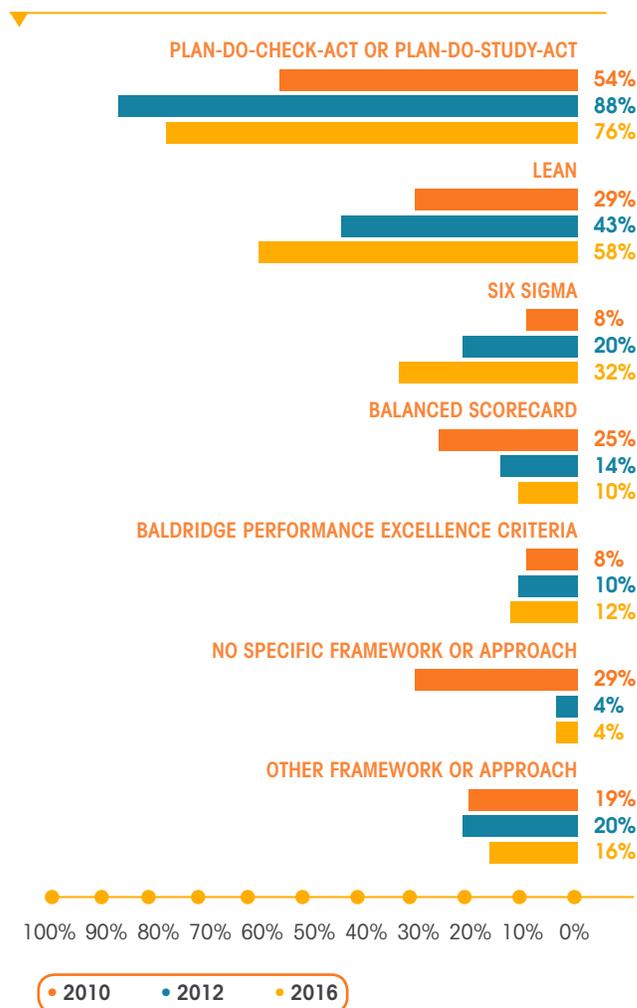
**FIGURE 4.10**

ELEMENTS OF STATE HEALTH AGENCY QUALITY IMPROVEMENT EFFORTS, 2010-2016 (N=49-50)



**FIGURE 4.9**

QUALITY IMPROVEMENT FRAMEWORKS OR APPROACHES USED AT STATE HEALTH AGENCIES, 2010-2016 (N=48-50)



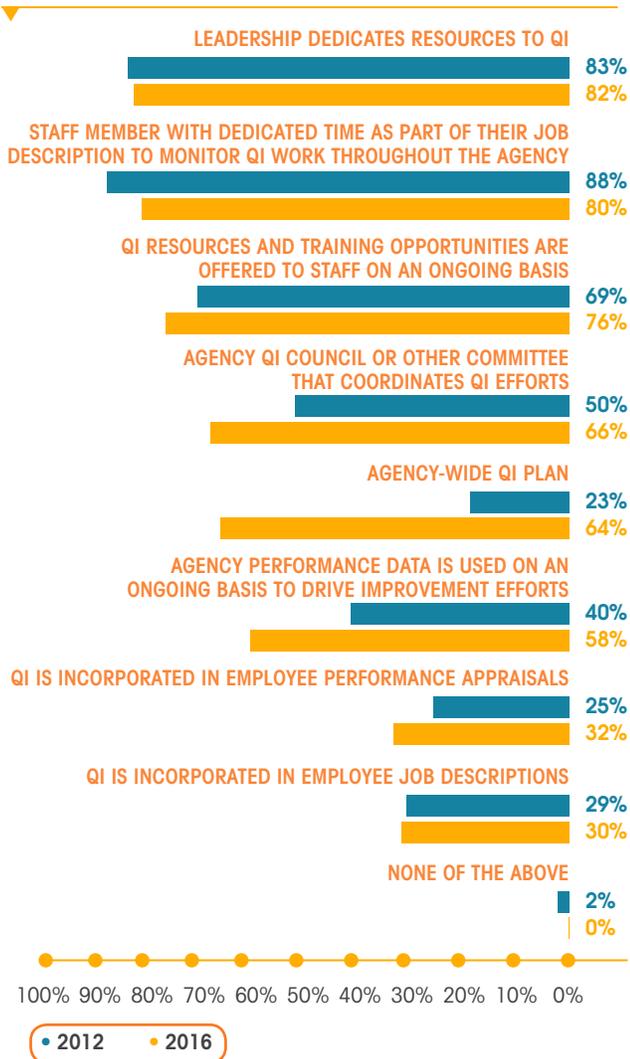
State health agencies indicated that they used a number of techniques in their QI efforts in the past year. The most frequently used techniques were obtaining baseline data (96%), setting measurable objectives (96%), and mapping a process (90%). The percentage of state health agencies using these techniques in 2010, 2012, and 2016 is displayed in **Figure 4.10**. There was an increase in the use of all techniques from 2010 to 2012, with the exception of obtaining baseline data (slight decrease from 2012 to 2016) and setting measurable objectives (remained level from 2012 to 2016).

Forty-seven percent of all state health agencies report implementing formal QI programs agency-wide, while 41 percent report implementing formal QI activities in specific programmatic or functional areas but not agency-wide (see **Figure 4.11**). While the percentage of state health agencies implementing

formal QI programs agency-wide increased from 2012 to 2016, the percentage implementing formal QI activities in specific programmatic or functional areas decreased from 2012 to 2016. Western states were less likely to report formal QI activities for specific programmatic or functional areas than states in other regions (17% for West; 38%-50% for other regions).

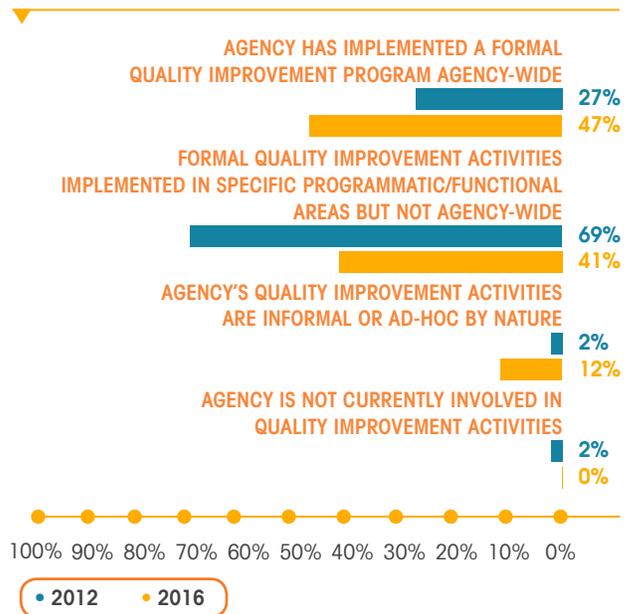
**FIGURE 4.12**

ELEMENTS OF FORMAL, AGENCY-WIDE QUALITY IMPROVEMENT PROGRAMS IN PLACE AT STATE HEALTH AGENCIES, 2012-2016 (N=48-50)



**FIGURE 4.11**

NATURE OF STATE HEALTH AGENCY'S CURRENT QUALITY IMPROVEMENT ACTIVITIES, 2012-2016 (N=49)



State health agencies range in terms of which elements of a formal agency-wide QI program they have in place. As shown in **Figure 4.12**, the most common elements in place are leadership that dedicates resources (e.g., time, funding) to QI (82%), a staff member with dedicated time as part of their job description to monitor QI work throughout the agency (80%), and QI resources and training opportunities that are offered to staff on an ongoing basis (76%). From 2012 to 2016, all elements of formal, agency-wide QI programs increased, with the exception of leadership that dedicates resources to QI and a staff member with dedicated QI-monitoring time, which both decreased over time.

A greater percentage of decentralized/largely decentralized states (77%) have an agency QI council or other committee that coordinates QI efforts than centralized/largely centralized states (50%). Small states are more likely to use performance data on an ongoing basis to drive improvement efforts than medium and large states (75% of small states vs. 53% of medium and 47% of large states).

## STAFF INVOLVEMENT IN QUALITY IMPROVEMENT

In 2016, the most common ways that state health agencies supported or encouraged staff involvement in QI efforts was through training staff on QI methods (84%), a QI committee to coordinate QI efforts (64%), and job descriptions that include QI (64%). Decentralized/largely decentralized states were more likely than centralized/largely centralized states to train staff on QI methods, have a QI committee to coordinate QI efforts, and have a recognition award for staff QI excellence.

Changes in staff involvement in QI efforts at state health agencies from 2010 to 2016 are shown in **Figure 4.13**. Having a QI committee to coordinate QI efforts, job descriptions including QI, recognition awards for staff QI excellence, and participation in QI efforts included as part of employee performance goals all increased from 2012 to 2016. In contrast, training staff on QI methods, monetary incentives, and other methods decreased from 2012 to 2016.

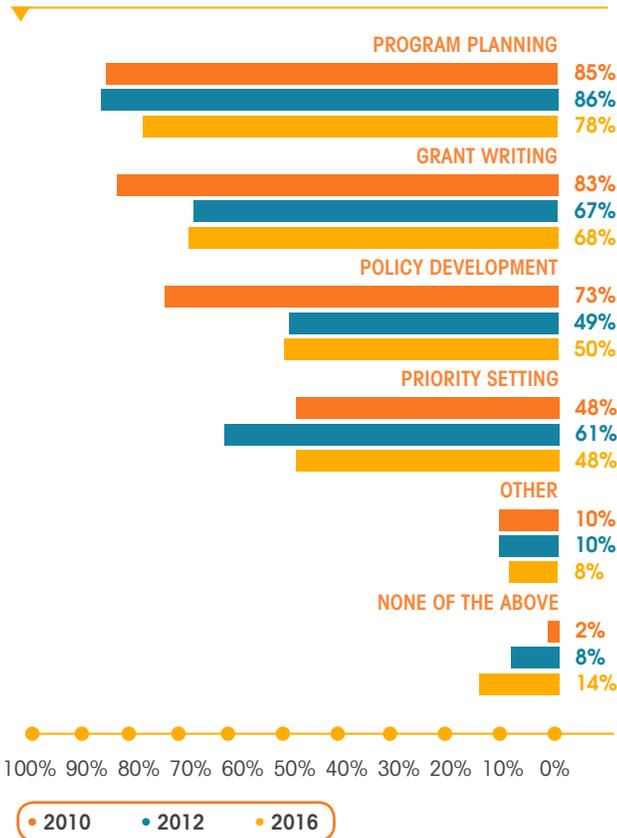
## USE OF THE COMMUNITY GUIDE

Established in 1996 by HHS, the Community Preventive Services Taskforce seeks to identify population health interventions that are scientifically proven to save lives, increase lifespans, and improve quality of life. The task force produces recommendations and identifies evidence gaps to help inform the decisionmaking of federal, state, and local health departments, other government agencies, communities, healthcare providers, employers, schools, and research organizations.<sup>5</sup>

In 2016, state health agencies had most commonly used The Community Guide in the past two years for program planning (78%), grant writing (68%), and policy development (50%). Decentralized/largely decentralized states were more likely than centralized/largely centralized states to use the guide for program planning, grant writing, and priority setting. A greater percentage of states in the Mountains and Midwest (90%) used the guide for grant writing than states in other regions (percentages ranged from 57% to 68%).

**FIGURE 4.14**

USE OF THE COMMUNITY GUIDE AT STATE HEALTH AGENCIES, 2010-2016 (N=48-50)



**FIGURE 4.13**

STAFF INVOLVEMENT IN QUALITY IMPROVEMENT EFFORTS AT STATE HEALTH AGENCIES, 2010-2016 (N=49-50)



Changes in state health agencies' use of The Community Guide from 2010 to 2016 are displayed in **Figure 4.14**. Use of the guide for priority setting decreased from 61 percent in 2012 to 48 percent in 2016.

This chapter has described state health agencies' accreditation readiness and engagement in QI efforts. The next chapter will focus on the increased use of health information systems and technology in state public health agencies.

### NOTES

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HHS. "The Community Guide: What is that Task Force?" Available at [www.thecommunityguide.org/task-force/what-task-force](http://www.thecommunityguide.org/task-force/what-task-force). Accessed June 23, 2017.



## Chapter 5

# HEALTH INFORMATION MANAGEMENT

Health information technology (HIT) supports the electronic use and exchange of health information between providers across the healthcare system, as well as insurers, pharmacies, and public health; it also includes the use of electronic health records (EHRs).<sup>1</sup> Health information exchange (HIE) is the electronic movement of health-related information among organizations according to nationally recognized standards.<sup>2</sup> As more healthcare providers adopt HIT, public health agencies will be more likely to exchange data directly with them. This increase in data exchange will assist in forming and maintaining partnerships between the two. Direct data exchange will also grant both parties access to real-time health information, which will aid in streamlining the delivery and effectiveness of both healthcare and public health programs.

This chapter includes detailed information on state health agencies' use of public health information systems and how they interact electronically with the healthcare system and other public health entities. Topics include state health agency leaders who have responsibility for HIE/HIT issues; entities with which state health agencies exchange data and how that data is exchanged; and how state health agencies use HIE for specific programs. There is also a discussion of informatics office locations, as well as the program areas for which state health agencies collect data electronically and their systems to address the Meaningful Use public health objectives.

### NOTES

- 1 HHS. "AboutHealthIT.gov." Available at [www.healthit.gov](http://www.healthit.gov). Accessed June 8, 2017.
- 2 HIMSS. "The National Alliance for Health Information Technology Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms." Available at: [www.himss.org/national-alliance-health-information-technology-report-office-national-coordinator-health](http://www.himss.org/national-alliance-health-information-technology-report-office-national-coordinator-health). Accessed June 6, 2017.



## KEY FINDINGS

- ▶ Primary responsibility for decisions regarding HIE is widely disbursed in states. Chief information officers (or equivalent) most frequently have primary responsibility for decisions regarding HIE (29%) and overall decisionmaking authority for public health information management systems (55%) at state health agencies.
- ▶ More than half (57%) of state health agencies' informatics offices are located within the agency itself. There are equal numbers of informatics offices located in separate program teams and offices that are centralized at the state level (both 12%). Ten percent of states reported no such office within their agency.
- ▶ The number of state health agencies that collect data electronically has increased from 2012 to 2016. All agencies collected data on lab results, reportable diseases, vital records, and newborn screening in 2016. On average, electronic data was most often collected within a state system (90%), and 20 percent collected data through an HIE.
- ▶ Only 16 percent of state health agencies have an informatics career series, while around half of all state health agencies (49%) neither have, nor plan to have, a career series for informatics.
- ▶ State health agencies are also sharing data. Sixty-five percent of agencies shared data with local health departments, 53 percent shared data with other agencies, 49 percent shared data with clinical providers, and 32 percent shared data with other states.
- ▶ The majority of state health agencies have established systems to meet many Meaningful Use public health objectives. From 2012 to 2016, the number of state health agencies with established systems remained stable for four of the five registries surveyed; the one exception is electronic case reporting of reportable conditions, which decreased by 21 percent.

## PRIMARY RESPONSIBILITY FOR HEALTH INFORMATION EXCHANGE

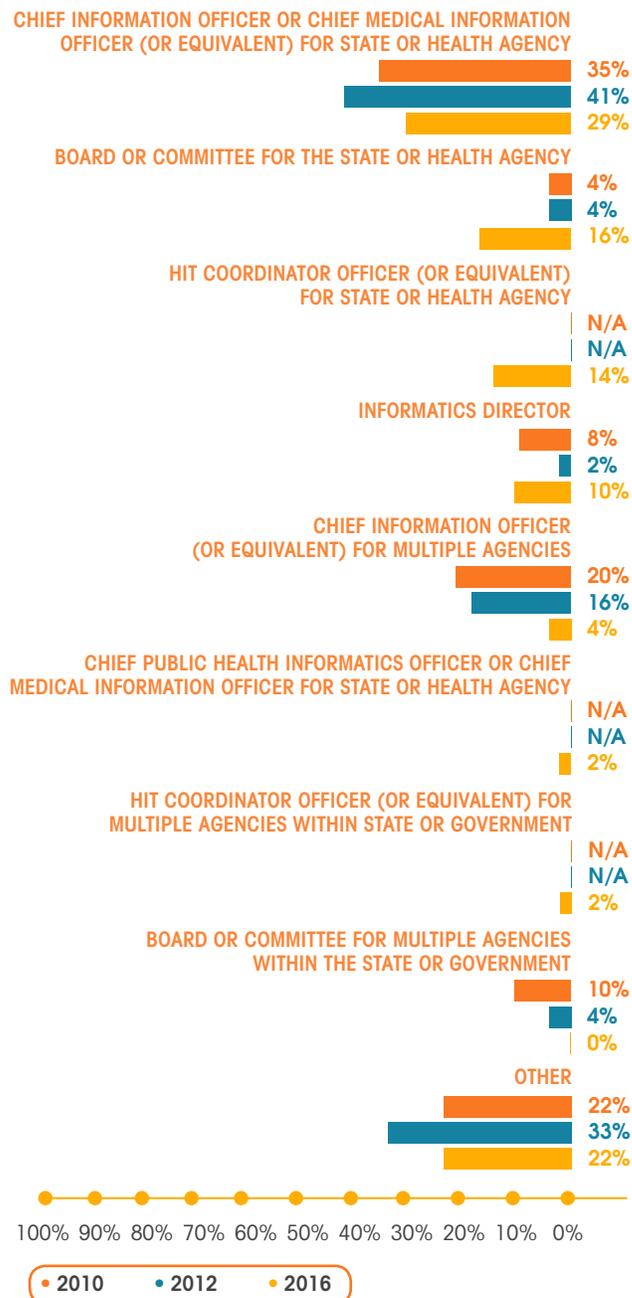
In 2016, 29 percent of state health agencies reported that the chief information officer (or equivalent) for the state health agency held primary responsibility for decisions regarding HIE or HIT issues. In another 16 percent of state health agencies, a board or committee had primary responsibility. From 2010 to 2016, the percentage of state health agencies in which a chief information officer (or equivalent) held primary responsibility decreased, while the percentage of boards or committees with primary responsibility increased four-fold. As shown in **Figure 5.1**, the 2016 Profile Survey added three additional answer options, which may explain the overall decrease in percentages for the majority of answers, as responses were spread across more options in 2016.

Centralized/largely centralized states are nearly twice as likely as decentralized/largely decentralized states (43% vs. 24%) have a chief information officer (or equivalent) exercise primary responsibility for HIE/HIT issues. Western states are more likely to have a board or committee exercise primary responsibility for HIE/HIT issues (43% for West vs. 0-23% for other regions). A greater percentage of small states (40%) than large states (24%) report that the chief information officer (or equivalent) for the state health agency exercises primary responsibility. Medium states are equally likely to have either a chief information officer or a board or committee (both 24%).

**Note:** HIT coordinator officer for state/multiple agencies and chief public health informatics officer only available in 2016 Profile Survey.

**FIGURE 5.1**

PRIMARY DECISIONMAKING AUTHORITY FOR HEALTH INFORMATION EXCHANGE OR HEALTH INFORMATION TECHNOLOGY ISSUES AT STATE HEALTH AGENCIES, 2010-2016 (N=49)





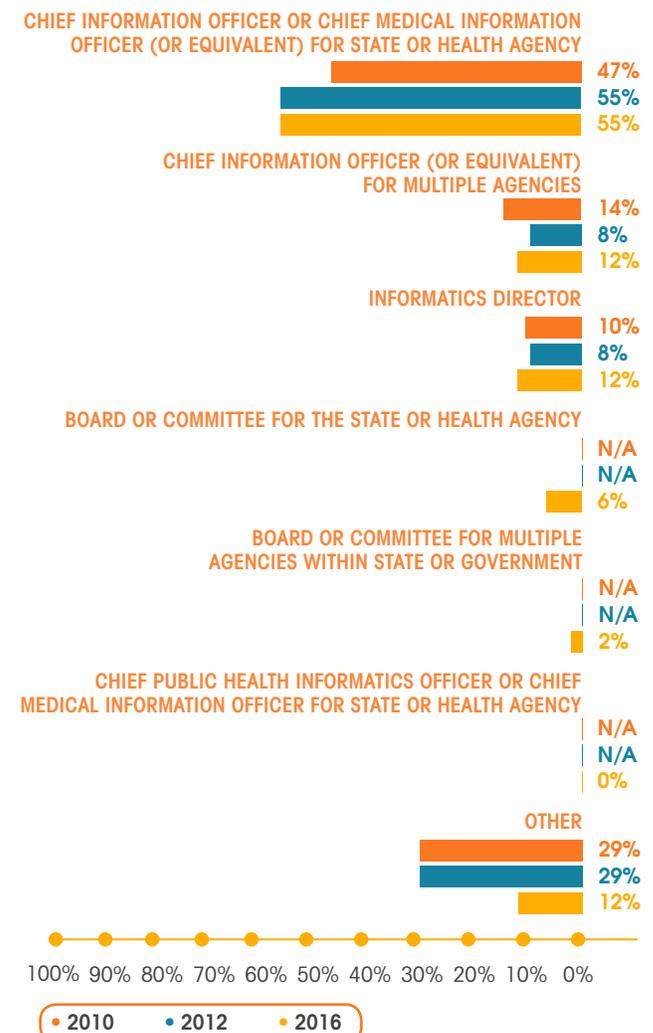
## DECISIONMAKING AUTHORITY FOR PUBLIC HEALTH INFORMATION MANAGEMENT SYSTEMS

In more than half of state health agencies, the chief information officer (or equivalent) has overall decisionmaking authority for state public health information management systems. From 2010 to 2016, the percentage of state health agencies reporting that the chief information officer (or equivalent) had overall decisionmaking authority increased from 47 percent to 55 percent. Three additional answer options were added in 2016, likely affecting the spread of responses and percentages in 2016 (see **Figure 5.2**).

A greater percentage of centralized/largely centralized states report that the chief information officer (or equivalent) has overall decisionmaking authority than decentralized/largely decentralized states (71% vs. 48%). Although the state health agency's chief information officer (or equivalent) is the most common decisionmaking authority in all regions, New England states are also more likely to report that the chief information officer for multiple state agencies exercises decisionmaking authority (37% in New England vs. 0-11% in other regions). Southern states are more likely to report that the informatics director has decisionmaking authority (23% in South vs. 0-17% in other regions). Large states most commonly report that the state health agency's chief information officer (or equivalent) has overall decisionmaking authority (71%) compared to small or medium states (both 47%).

**FIGURE 5.2**

OVERALL DECISIONMAKING AUTHORITY FOR STATE PUBLIC HEALTH INFORMATION MANAGEMENT SYSTEMS, 2010-2016 (N=49)



**Note:** Board or committee for state/multiple agencies and chief public health informatics officer only available in 2016 Profile Survey.

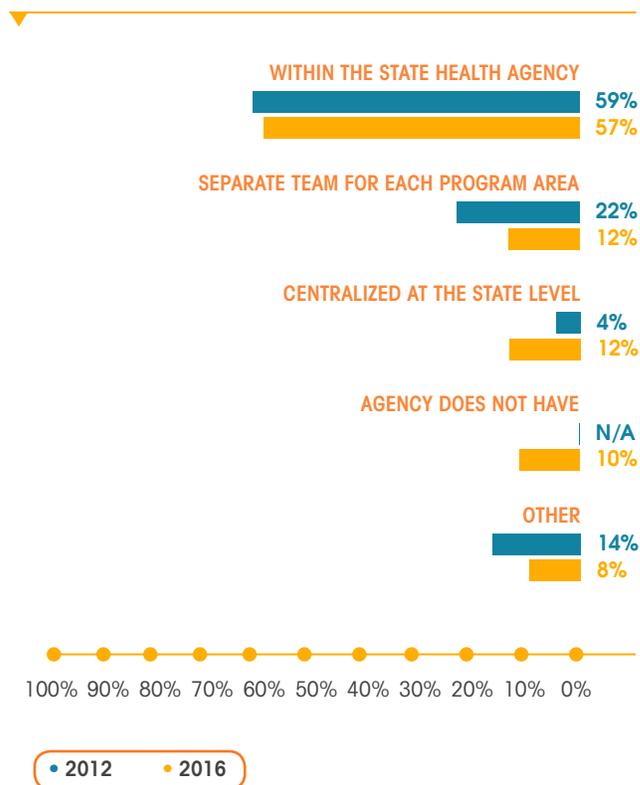
## LOCATION OF INFORMATICS OFFICES

An informatics office's location varies depending on the state health agency. In more than half of state health agencies, the informatics office was located within the agency—a number that has remained largely constant from 2012 to 2016. During this same time period, however, the number of offices located as a separate team housed within each program area decreased, while the number of offices that were centralized at the state level increased. Additionally, 10 percent of state health agencies reported that they did not have an informatics office in 2016 (see **Figure 5.3**). In Western states, it is equally likely that the state health agency will house the informatics office or that they will not have an informatics office at all (both 43%). A greater percentage of large states (71%) have informatics offices located within the state health agency than small (47%) and medium states (53%).

**Note:** "Agency does not have" only available in 2016 Profile Survey.

**FIGURE 5.3**

LOCATION OF INFORMATICS OFFICES AT STATE HEALTH AGENCIES, 2012-2016 (N=49)

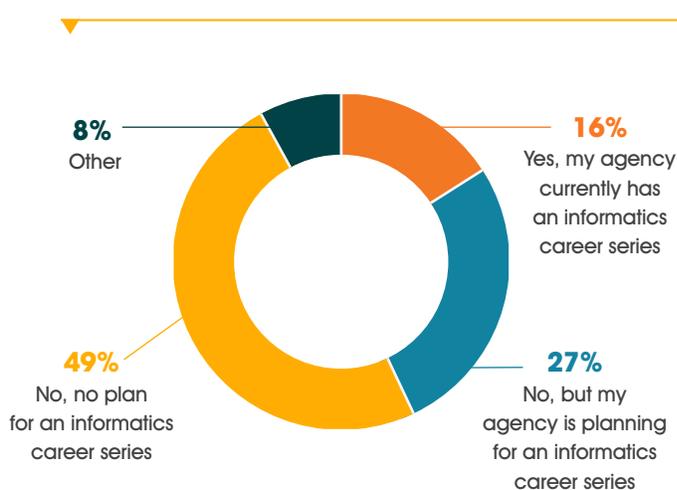


## INFORMATICS CAREER SERIES

In 2016, states were asked whether their public health agencies had a career series specifically for informatics. Almost half of state health agencies indicated that they neither had, nor planned to have, an informatics career series, while only 16 percent of state health agencies indicated that they had an informatics career series (see **Figure 5.4**). Decentralized/largely decentralized states are more likely to be in the process of planning for an informatics career series than centralized/largely centralized states (40% vs. 7%). No New England states report having an informatics career series, and New England states are most likely to neither have, nor plan to have, a career series (75% for New England vs. 29-56% for others). Southern states are most likely to have an informatics career series (31% for South vs. 0-17% for others). Large states (12%) are least likely to have an informatics career series compared to small (20%) and medium states (18%).

**FIGURE 5.4**

STATE HEALTH AGENCIES WITH INFORMATICS CAREER SERIES, 2016 (N=49)





## ELECTRONIC DATA COLLECTION AND EXCHANGE

State health agencies collect, receive, and exchange program-specific information electronically. In 2016, all state health agencies reported electronic data collection for lab results, reportable diseases, vital records, and newborn screening. Lab results, reportable disease, and vital records were also the most common areas for electronic data collection in 2012. As shown in **Figure 5.5**, from 2012 to 2016, the number of states collecting data electronically increased across all areas surveyed. Notable increases include the percentage of states collecting electronic data on food service inspections and onsite wastewater treatment systems (18% increase for both).

Decentralized/largely decentralized states are more likely to collect environmental health data than centralized/largely centralized states (96% vs. 79%). In contrast, centralized/largely centralized states are much more likely to collect EHRs (77% vs. 46%) and onsite wastewater treatment data (69% vs. 36%) than decentralized/largely decentralized states. States in the Mountains and Midwest region are less likely to collect geocoded data for mapping than states in other regions (40% for Mountains/Midwest vs. 86-100% for other regions). Western states are least likely to collect data on Medicaid billing (29% for West vs. 50-85% for other regions). Small states are much less likely to collect geocoded data for mapping (56% for small vs. 94-100% for medium and large) and Medicaid billing (38% for small vs. 53-88% for medium and large).

For state health agencies that did collect electronic data on a specific program in 2016, the Profile Survey gathered further information on how the data was collected and shared (**Table 5.1**). On average, electronic data was most often collected within a state system (90%), and 20 percent of state health agencies received data through an HIE entity—a system designed to share health-related information securely between providers and health systems. Around one-third of state health agencies have the capacity to conduct bidirectional data reporting and exchange (35%), and about half of agencies send data to federal agencies and receive data from them (56%). In terms of sharing electronic data, an average of 65 percent of agencies shared data with local health departments within the state, 53 percent shared data with other agencies within the state, 49 percent shared data with clinical providers, and 32 percent shared data with other states.

Immunization data was most commonly received through an HIE entity (65%), and it had the most bidirectional reporting and exchange capacity (76%). Immunization data was also most often shared with clinical providers (94%) and local health departments within the state (87%). Reportable disease data was most commonly sent to and received from federal agencies (96%). Vital records data was most often shared with other agencies within the state (91%) and with other states (80%).

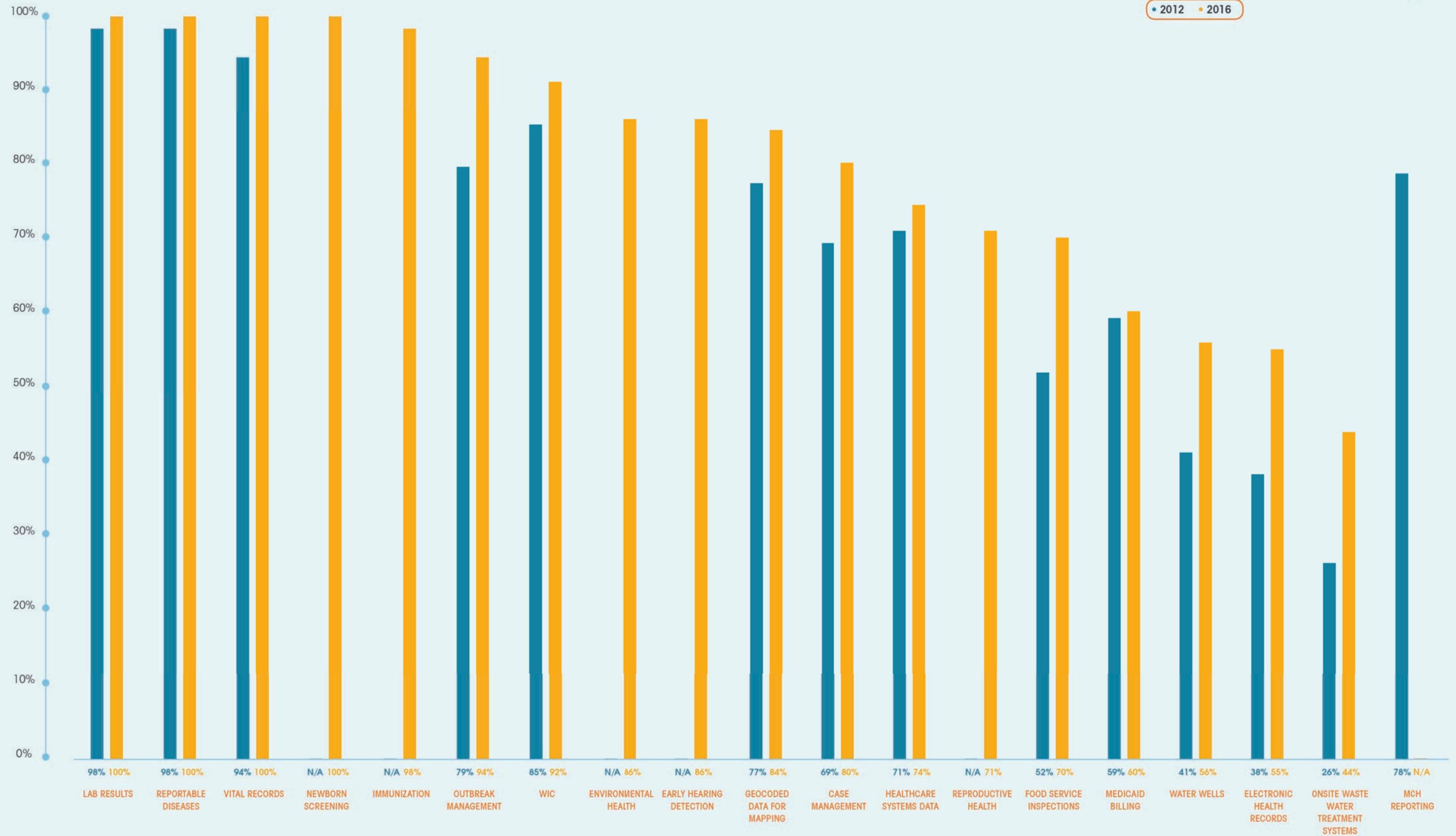
**TABLE 5.1** PROGRAM AREAS FOR WHICH STATE HEALTH AGENCIES COLLECT DATA ELECTRONICALLY, 2016

	Total N	Data Received Through HIE Entity		Bidirectional Data Reporting and Exchange Capacity		Data Collected Primarily with State System		Data Collected Primarily with Local System		Data Shared with Clinical Providers		Data Shared with Local Health Departments within State		Data Shared with Other Agencies within State		Data Shared with Other States		Agency Sends/Receives Data to/from Federal Agencies	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Case management	36	8	22%	10	28%	33	92%	3	8%	19	53%	24	67%	13	36%	8	22%	22	61%
Electronic health record	24	11	46%	13	57%	19	79%	5	21%	14	58%	11	46%	4	17%	1	4%	6	25%
Environmental health	37	4	11%	10	27%	33	89%	4	11%	13	34%	31	82%	26	70%	14	39%	26	72%
Geographic-coded data for mapping analysis	37	2	5%	7	20%	32	91%	3	9%	15	42%	22	61%	24	67%	11	31%	12	34%
Immunization	46	30	65%	35	76%	42	91%	4	9%	43	94%	39	87%	33	72%	25	54%	28	62%
Laboratory results	44	23	52%	22	50%	41	93%	3	7%	30	68%	34	77%	18	41%	21	48%	33	75%
Healthcare systems data (e.g., bed availability)	34	4	12%	12	36%	31	94%	2	6%	19	56%	21	62%	26	77%	9	27%	18	55%
Newborn screening	47	6	13%	15	32%	45	96%	2	4%	37	79%	15	33%	16	34%	10	21%	20	44%
Early hearing detection	40	9	23%	10	25%	37	93%	3	7%	31	78%	18	47%	19	48%	7	18%	20	51%
Reproductive health	30	2	7%	5	17%	25	83%	5	17%	19	63%	19	66%	15	52%	6	20%	16	55%
Medicaid billing	27	2	7%	11	41%	24	89%	3	11%	12	44%	13	48%	14	52%	2	7%	8	30%
Onsite wastewater treatment systems	17	0	0%	6	35%	13	81%	3	19%	1	6%	8	53%	7	47%	3	20%	5	31%
Outbreak management	44	8	18%	14	32%	42	98%	1	2%	20	46%	36	84%	24	56%	23	54%	35	81%
Reportable diseases	46	19	41%	16	36%	44	98%	1	2%	25	56%	38	84%	22	49%	23	51%	43	96%
Food service inspections	31	2	7%	6	19%	28	90%	3	10%	6	20%	22	73%	16	53%	8	27%	15	48%
Vital records	46	5	11%	19	41%	42	91%	4	9%	18	39%	31	71%	42	91%	36	80%	39	85%
Water wells (licensing and/or testing)	25	1	4%	8	32%	22	92%	2	8%	6	24%	15	60%	13	52%	6	24%	8	32%
WIC	44	6	14%	11	25%	36	82%	8	18%	9	21%	26	61%	20	47%	14	33%	34	79%

**FIGURE 5.5**

PROGRAM AREAS FOR STATE HEALTH AGENCY ELECTRONIC DATA COLLECTION, 2012-2016 (N=43-50)

**Note:** Newborn screening, immunization, environmental health, and early hearing detection only available in 2016 Profile Survey; reproductive health and maternal and child health reporting only available in 2012 Profile Survey.



HEALTH INFORMATION MANAGEMENT

HEALTH INFORMATION MANAGEMENT

## MEANINGFUL USE

The Health Information Technology for Economic and Clinical Health (HITECH) Act promotes using EHRs and HIEs to advance high-quality care, reduce costs, facilitate care coordination among providers, and improve population health. Implementing Meaningful Use of EHRs by providers requires a public health infrastructure that can support the receipt and exchange of data with the provider community.

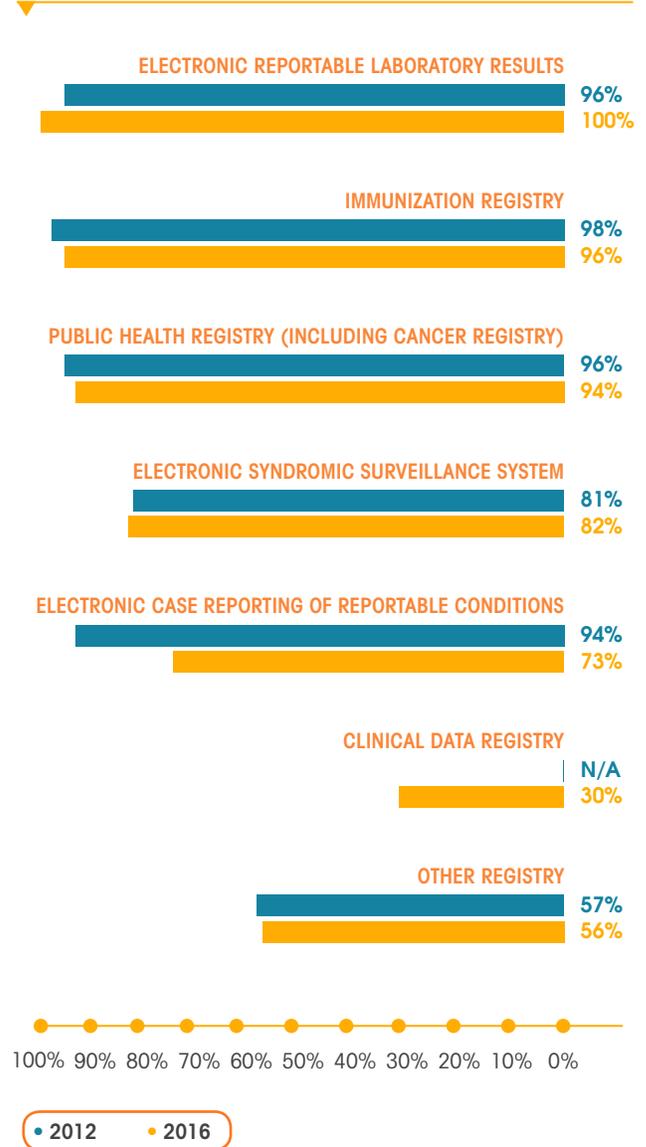
As shown in **Figure 5.6**, the majority of state health agencies have systems in place to address Meaningful Use public health objectives. In 2016, all state health agencies had systems for electronic reportable laboratory results, while only 30 percent of states had systems for clinical data registries. From 2012 to 2016, the number of state health agencies with established systems remained stable for four of the five registries surveyed; the one exception is for the electronic case reporting of reportable conditions, which decreased by 21 percent.

Decentralized/largely decentralized states are more likely to have Meaningful Use systems related to immunization registries (100% vs. 85%) and public health registries (100% vs. 77%) than centralized/largely centralized states. Centralized/largely centralized states are more likely to have systems for electronic syndromic surveillance (92% vs. 73%), electronic case reporting of reportable conditions (85% vs. 62%), and clinical data registries (33% vs. 24%). Western states are least likely to have systems for electronic syndromic surveillance (57% for West vs. 80-92% for other regions). States in the Mountains and Midwest region are most likely to have systems for the electronic case reporting of reportable conditions (90% for Mountains/Midwest vs. 57-86% for other regions), while states in the Mid-Atlantic and Great Lakes are most likely to have systems for clinical data registries (46% for Mid-Atlantic/Great Lakes vs. 17-33% for other regions). Additionally, all large states had immunization and public health registries, but large states are least likely to have systems for electronic case reporting of reportable conditions (59% for large vs. 77-86% for others). Small states are most likely to have systems for electronic syndromic surveillance (93% for small vs. 71-82% for others).

States with Meaningful Use objectives systems also collected additional information on data receipt, reporting, and exchange (see **Table 5.2**). In 2016, a large majority of state health agencies had systems that received Meaningful Use-compliant messages from EHRs (81% on average); however, far less had systems that currently perform bidirectional data reporting and exchange

**FIGURE 5.6**

EXISTENCE OF SYSTEMS FOR MEANINGFUL USE OBJECTIVES, 2012-2016 (N=46-49)



**Note:** Clinical data registry only available in 2016 Profile Survey; electronic case reporting of reportable conditions was labeled "electronic communicable disease reporting system" in 2012; public health registry was labeled "cancer registry" in 2012; electronic reportable laboratory results was labeled "electronic laboratory communicable disease reports" in 2012.

(45% on average). Immunization registries (98%) and electronic syndromic surveillance systems (97%) were the systems most likely to receive Meaningful Use-compliant messages from EHRs. Additionally, immunization registries were most likely to perform bidirectional data reporting and exchange (81%).



**TABLE 5.2** MEANINGFUL USE OBJECTIVES, 2016

	Total N	Agency has System		System Receives Meaningful Use-Compliant Messages from EHRs		System Currently Performs Bidirectional Data Reporting and Exchange	
		N	%	N	%	N	%
Electronic reportable laboratory results	49	49	100%	42	88%	17	38%
Immunization registry	49	47	96%	45	98%	35	81%
Public health registry (including cancer registry)	49	46	94%	34	76%	12	27%
Electronic syndromic surveillance system	49	40	82%	37	97%	13	35%
Electronic case reporting of reportable conditions	48	35	73%	24	69%	12	36%
Clinical data registry	46	14	30%	9	69%	4	33%
Other registry	9	5	56%	2	67%	2	67%

This chapter focused on the electronic use and exchange of health information between providers across multiple systems. In the next and final chapter of this section, attention will turn to state health agency finance and how agencies receive and distribute funds to improve public health.





## Chapter 6

# STATE HEALTH AGENCY FINANCE

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Previous chapters describe how state health agencies are organized, the public health services and activities they provide, and the workforce responsible for safeguarding and improving the nation's public health. This chapter describes how public health is funded. Individual state health agencies use this information to conduct comparisons and inform a broad array of partners and stakeholders, including policymakers, federal grantmakers, and foundations.

In 2016, ASTHO asked state health agencies to report on revenues, expenditures, and dollars distributed to local and regional health agencies and nonprofit organizations for the prior two fiscal years. This chapter describes state health agency funding sources, expenditures, and the dollars distributed to health agencies and community-based organizations primarily for 2014 and 2015, and examines differences between these two years. Information from prior years is used for comparison purposes when applicable, as some definitions have changed between survey iterations. ASTHO also asked states to provide more detailed information on sources of federal funding they received in 2014 and 2015. Not all states provided values for all revenue, expenditure, or organization categories. Therefore, each table and figure below includes a note with the number of states that responded to the question.



## KEY FINDINGS

- ▶ State health agency total revenue decreased by \$2.2 billion (7.7%) from 2014 (\$30.8 billion) to 2015 (\$28.6 billion). Between 2014 and 2015, there were decreases in total revenue for federal funds, fees and fines, and other state funds.
- ▶ Federal funds were the largest source of state health agency revenue for 2014 and 2015, with mean state revenues of \$307 million and \$280 million, respectively. Nearly half (48%) of state health agency revenue in 2015 was from federal funds, while one-quarter was from state funds.
- ▶ State health agency federal revenue for 2014 was just over \$14 billion, while state health agency federal revenue for 2015 exceeded \$14.3 billion. Federal funding originates from a variety of sources, with nearly half (45%) coming from USDA for 2015 and the next highest percentage from CDC (16%).
- ▶ The median per capita expenditure for the states and D.C. in both 2014 and 2015 was \$84.
- ▶ Between 2014 and 2015, there were increases in total expenditures for clinical services/consumer care, quality of health services, chronic disease, health laboratory, injury prevention, vital statistics, and health data. The two largest spending categories were clinical services/consumer care and WIC.
- ▶ In both 2014 and 2015, state health agencies distributed approximately \$6 billion (about 20% of their total budgets) through contracts, grants, and awards to local and regional/district health agencies, tribal health agencies, nonprofit organizations, and other governmental entities. More than one-third of state health agency contracts, grants, and awards were distributed to independent local health agencies (42%) and nonprofit organizations (40%).
- ▶ States vary in terms of funding patterns, sources of funding, expenditure categories, and contract partners.

# STATE HEALTH AGENCY REVENUE

State health agency total revenue has fluctuated over time, from \$29.1 billion in 2008 to \$28.6 billion in 2015 (see **Figure 6.1**). The largest dip was seen between 2009 and 2010, when state health agency revenue decreased by \$3.4 billion.

State health agencies were asked to report revenue for 2014 and 2015 by funding source (see **Table 6.1** for definitions of funding sources). Results are displayed in **Figure 6.2**. Despite the overall 7.7 percent decline in funding, there were increases in total revenue for state general funds and other sources between 2014 and 2015 (funding not included in the federal or state categories; e.g., tobacco settlement funds, payment for direct clinical services other than Medicare and Medicaid, foundation and other private donations).

**FIGURE 6.1**

TOTAL STATE HEALTH AGENCY REVENUE, IN BILLIONS, 2008-2015 (N=46-49)



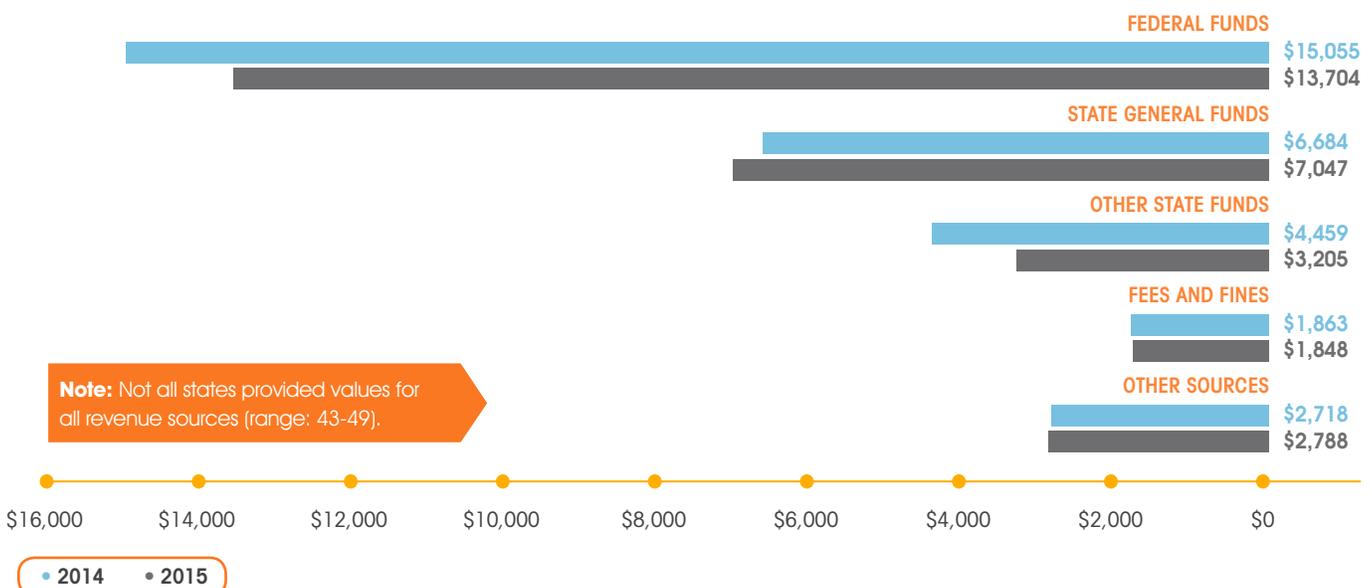
**TABLE 6.1**

FUNDING SOURCE DESCRIPTIONS

Funding Source 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.
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), and foundation and other private donations.
Other state funds	Includes revenues received from the state that are not from the state general fund.

**Note:** Data not available for 2012 and 2013.

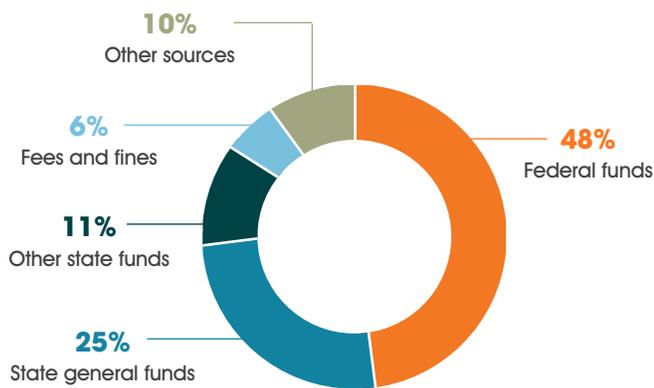
**FIGURE 6.2** TOTAL STATE HEALTH AGENCY REVENUE FOR 2014 AND 2015 BY SOURCE OF FUNDING, IN MILLIONS (N=49)



Conversely, from 2014 to 2015, there were decreases in total revenue for federal funds, fees and fines, and other state funds (i.e., revenues received from the state that are not from the state general fund). Nearly half (48%) of state health agency revenue in 2015 was from federal funds, one-quarter was from state general funds, and 10 percent was from other sources (see **Figure 6.3**).

**FIGURE 6.3**

PERCENTAGE OF STATE HEALTH AGENCY REVENUE BY FUNDING SOURCE FOR 2015 (N=44-49)



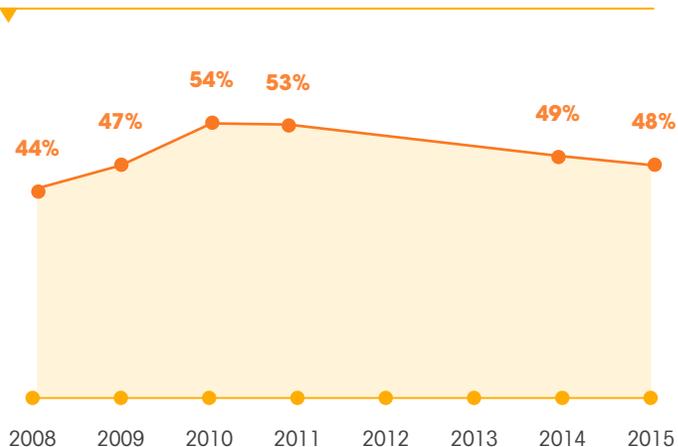
**Note:** Not all states provided values for all revenue sources (range: 44-49).

SHAs receive between 44-54 percent of their total revenue from federal funding, which has also fluctuated from 2008 to 2015. **Figure 6.4** depicts the percentage of revenue from federal funding sources from 2008 to 2015. **Figure 6.5** depicts the average dollar amount of federal funding received by state health agencies, which has decreased significantly from 2014 (\$307 million) to 2015 (\$280 million).

Although the federal proportion of health agency revenue approaches 50 percent across states, this proportion varies between states. **Table 6.2** presents the median, minimum, and maximum percentage of funds that state health agencies receive from federal and state sources. The distribution of federal funding is presented in **Figure 6.6** as a histogram, which shows how states are distributed within this range. In a majority of states (80%), federal funding accounts for 40 percent or more of their total revenue. When comparing reliance on federal funds to state funds by agency characteristic, there are no noteworthy differences in percent of state or federal funding by governance classification, region, or size.

**FIGURE 6.4**

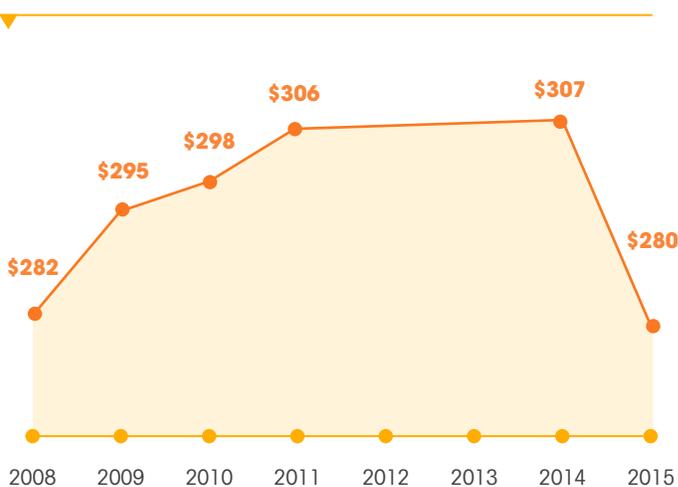
PERCENTAGE OF STATE HEALTH AGENCY REVENUE FROM FEDERAL FUNDS, 2008-2015 (N=46-49)



**Note:** Data not available for 2012 and 2013.

**FIGURE 6.5**

AVERAGE FEDERAL FUNDING REVENUE FOR STATE HEALTH AGENCIES, IN MILLIONS, 2008-2015 (N=46-49)



**Note:** Data not available for 2012 and 2013.

**TABLE 6.2**

PERCENTAGE OF FEDERAL VERSUS STATE FUNDING, 2015 (N=49)

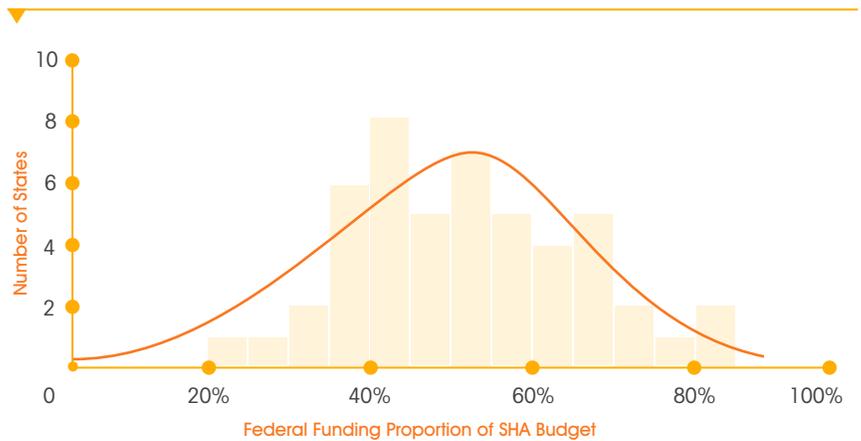
	Federal	State
<b>MEDIAN</b>	52.23%	34.93%
<b>MIN</b>	24.30%	13.29%
<b>MAX</b>	84.62%	74.87%



**Table 6.3** presents the mean, median, minimum, and maximum revenue for 2014 and 2015 by source of funding. For all sources of funding for both fiscal years, the mean exceeds the median, in some cases by a substantial amount, indicating that several state health agencies with particularly high revenues from specific sources skewed (increased) the mean.

**Note:** Not all states provided values for all revenue sources (range: 43-49).

**FIGURE 6.6** DISTRIBUTION OF FEDERAL FUNDING, 2015 (N=49)



**TABLE 6.3** AVERAGE STATE HEALTH AGENCY REVENUE BY SOURCE OF FUNDING FOR 2014 AND 2015, IN MILLIONS (N=49)

	2014				2015			
	MEAN	MEDIAN	MIN	MAX	MEAN	MEDIAN	MIN	MAX
State general funds	\$136	\$53	\$4	\$1,443	\$144	\$58	\$4	\$1,506
Other state funds	\$99	\$16	\$0	\$2,066	\$71	\$14	\$0	\$1,263
Federal funds	\$307	\$197	\$25	\$1,816	\$280	\$180	\$26	\$1,822
Fees and fines	\$41	\$13	\$0	\$786	\$40	\$14	\$0	\$749
Other sources	\$63	\$20	\$0	\$810	\$63	\$25	\$0	\$896

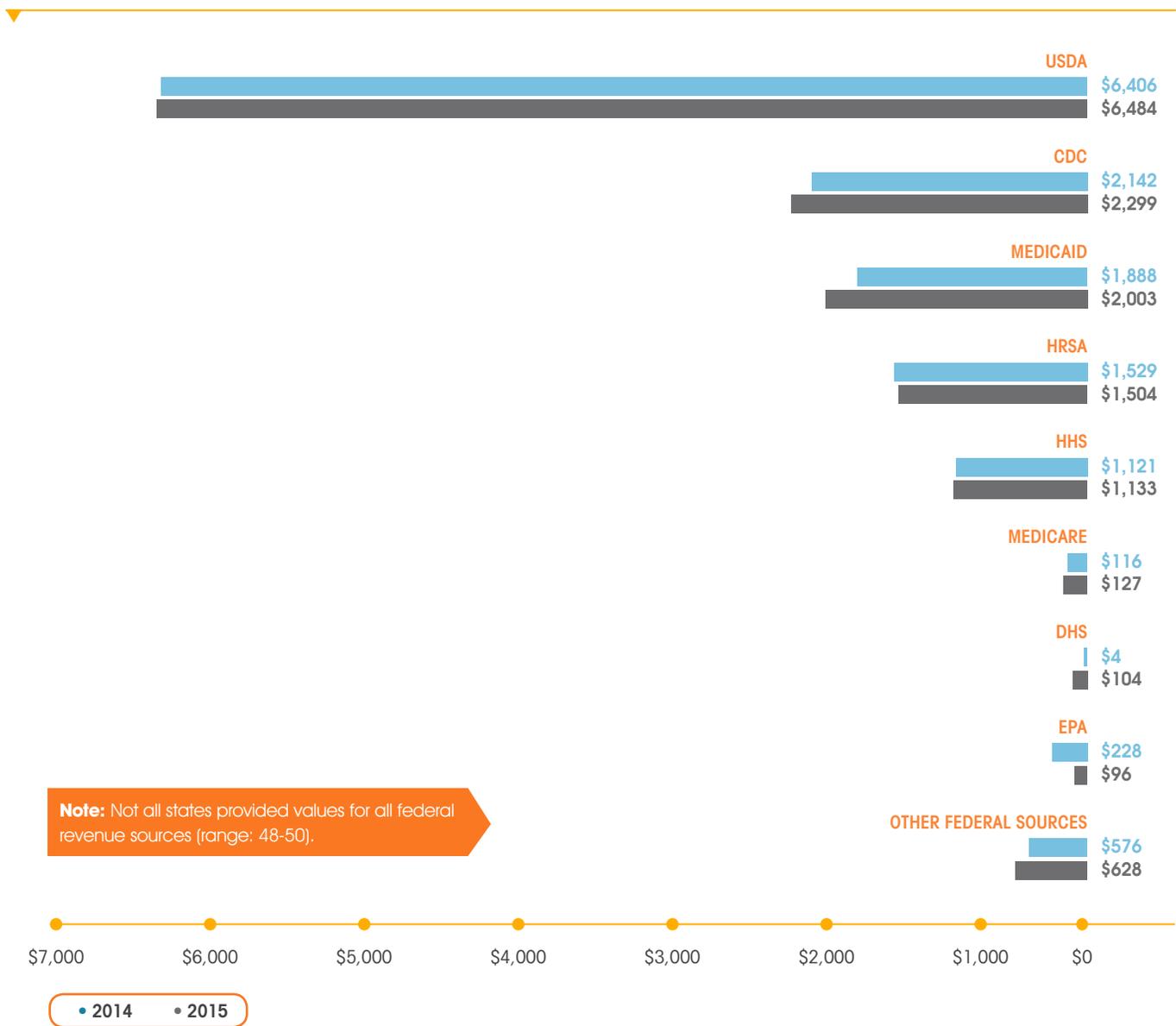
# FEDERAL REVENUE

As shown in **Figure 6.7**, federal funding originates from a variety of sources, with funding from USDA standing out as the largest single source. Between 2014 and 2015, there were increases in total federal revenue from USDA, CDC, Medicaid, HHS, Medicare, the Department of Homeland Security (DHS), and other federal sources (e.g., Department of Energy, Department of Transportation, Department of Housing and Urban Development). However, there were decreases in total federal revenue between 2014 and 2015 from HRSA and EPA. State health agency federal revenue for 2014 was just over \$14 billion, while state health agency federal revenue for 2015 exceeded \$14.3 billion. As shown

in **Figure 6.8**, nearly half (45%) of state health agencies' total federal revenue in 2015 was from USDA; the next highest percentage came from CDC (16%).

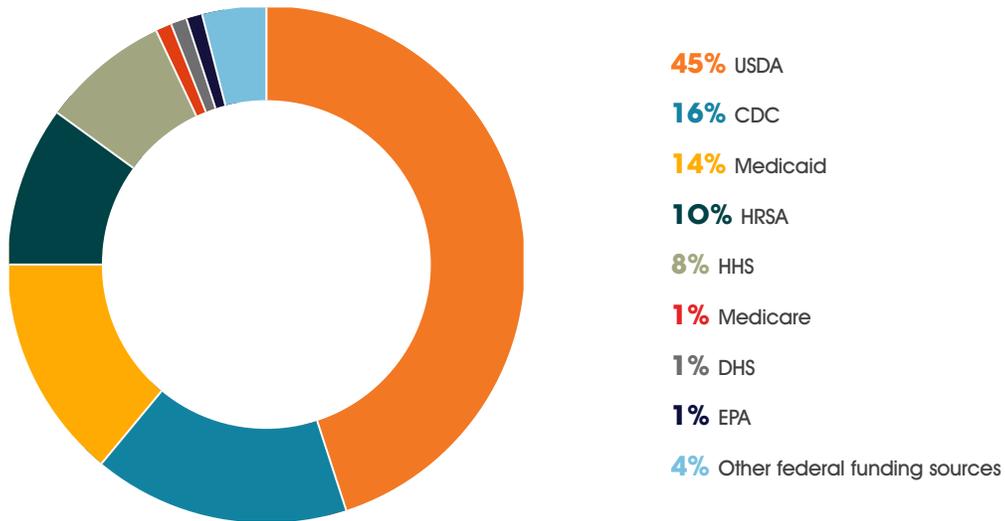
**Table 6.4** presents the mean, median, minimum, and maximum federal revenue for 2014 and 2015 by source of funding. As with all sources of funding, the means equaled or exceeded the medians, in some cases by substantial amounts, indicating that several state health agencies with particularly high federal revenues from specific sources skewed (increased) the mean.

**FIGURE 6.7** STATE HEALTH AGENCY FEDERAL REVENUE BY SOURCE FOR 2014 AND 2015, IN MILLIONS (N=48-50)



**FIGURE 6.8**

PERCENTAGE OF STATE HEALTH AGENCY FEDERAL REVENUE BY FUNDING SOURCE FOR 2015 (N=50)



**TABLE 6.4** AVERAGE STATE HEALTH AGENCY FEDERAL REVENUE BY SOURCE OF FUNDING FOR 2014 AND 2015, IN MILLIONS (N=50)

	2014				2015			
	MEAN	MEDIAN	MIN	MAX	MEAN	MEDIAN	MIN	MAX
CDC	\$45	\$34	\$0	\$173	\$48	\$40	\$0	\$261
HHS	\$27	\$7	\$0	\$286	\$26	\$6	\$0	\$269
HRSA	\$32	\$19	\$0	\$153	\$31	\$17	\$0	\$156
Medicaid	\$51	\$2	\$0	\$1,132	\$57	\$3	\$0	\$940
Medicare	\$4	\$2	\$0	\$16	\$4	\$2	\$0	\$22
USDA	\$139	\$85	\$0	\$1,096	\$141	\$94	\$0	\$1,075
DHS	\$0	\$0	\$0	\$1	\$4	\$0	\$0	\$94
EPA	\$6	\$1	\$0	\$112	\$2	\$1	\$0	\$19
Other federal funding sources	\$14	\$5	\$0	\$176	\$15	\$5	\$0	\$184

**Note:** Not all states provided values for all federal revenue sources (range: 48-50).

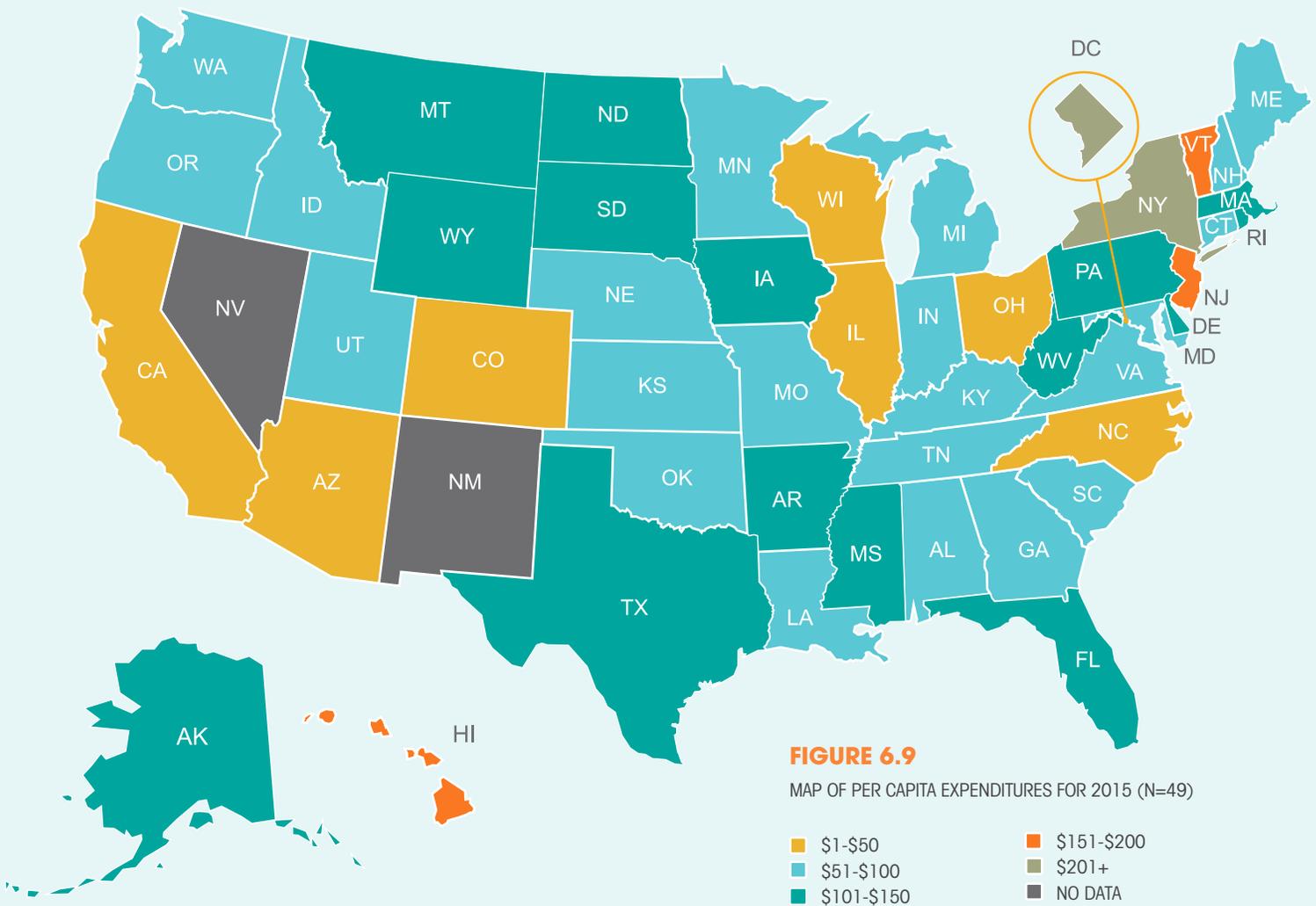
## STATE HEALTH AGENCY EXPENDITURES

In addition to cataloguing sources of funding, ASTHO asked state health agencies to report expenditures for 2014 and 2015 by expense category (see **Table 6.5** for definitions of expenditure categories). State health agency total expenditures were approximately \$30.8 billion in 2014 and \$28.6 billion in 2015. For all respondents, mean per capita expenditures

were \$105 for 2014 and \$100 for 2015. Median per capita expenditures were somewhat lower at \$84 for both 2014 and 2015. Per capita expenditures for 2015, categorized based on spending range, are displayed in **Figure 6.9** for all responding states and D.C.

**TABLE 6.5** EXPENDITURE CATEGORY DESCRIPTIONS

Expenditure Category Descriptions	
Chronic disease	Includes chronic disease prevention such as heart disease, cancer, tobacco prevention and control programs, and substance abuse prevention. Includes programs such as disease investigation, screening, and 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 immunization programs (including the cost of vaccine and administration), infectious disease control, veterinary diseases affecting human health, and health education and communications 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, onsite safety and health consultation, workplace violence prevention, child abuse prevention, occupational health, safe schools, and boating and recreational safety.
WIC	Includes all expenditures related to the WIC program, including nutrition education and voucher dollars.
Environmental health	Includes lead poisoning programs, non-point source pollution control, air quality, solid and hazardous waste management, hazardous materials training, radon, water quality and pollution control (including safe drinking water, fishing advisories, swimming) water and waste disposal systems, pesticide regulation and disposal, and nuclear power safety. Also includes food service inspections and lodging inspections.
Clinical services/consumer care	Includes all clinical programs such as funds for Indian healthcare, access to care, pharmaceutical assistance programs, Alzheimer's disease, adult day care, medically handicapped children, AIDS treatment, pregnancy outreach and counseling, family planning education and abstinence programs, chronic renal disease, breast and cervical cancer treatment, TB treatment, emergency health services, genetic services, state assistance to local health clinics (e.g., 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, and disaster preparation and response, including costs associated with response such as shelters, emergency hospitals and clinics, and distribution of medical countermeasures (vaccination clinics and points of distribution/PODs).
Quality of health services	Includes quality regulatory programs such as health facility licensure and certification, equipment quality (e.g., x-ray, mammogram), 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 administered by the health agency, provider and facility quality reporting, and institution compliance audits. Also includes 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 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, generating statistical reports, and customer service at the state level.
Administration	Includes all costs related to department management, executive office (state health official), human resources, information technology, and finance, in addition to indirect costs such as building-related costs (e.g., 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 participation in state health plan reform and federal reform efforts such as health reform advisory committees, as well as payment reform and benefit reform.
Other	Includes forensic examination and infrastructure funds to local public health agencies.



The mean, median, minimum and maximum per capita expenditures for all states and D.C. are displayed in **Table 6.6** by structure and governance classification. Centralized/largely centralized states have higher average per capita expenditures than decentralized/largely decentralized states. This is due to local health department expenditures that are included

in centralized/largely centralized states, whereas only the state health agency contribution to local health department expenditures is included in decentralized/largely decentralized states. Similarly, freestanding health agencies have higher average per capita expenditures than agencies that are under a larger agency.

**TABLE 6.6** PER CAPITA EXPENDITURES BY GOVERNANCE CLASSIFICATION AND STRUCTURE FOR 2014 AND 2015 (N=49)

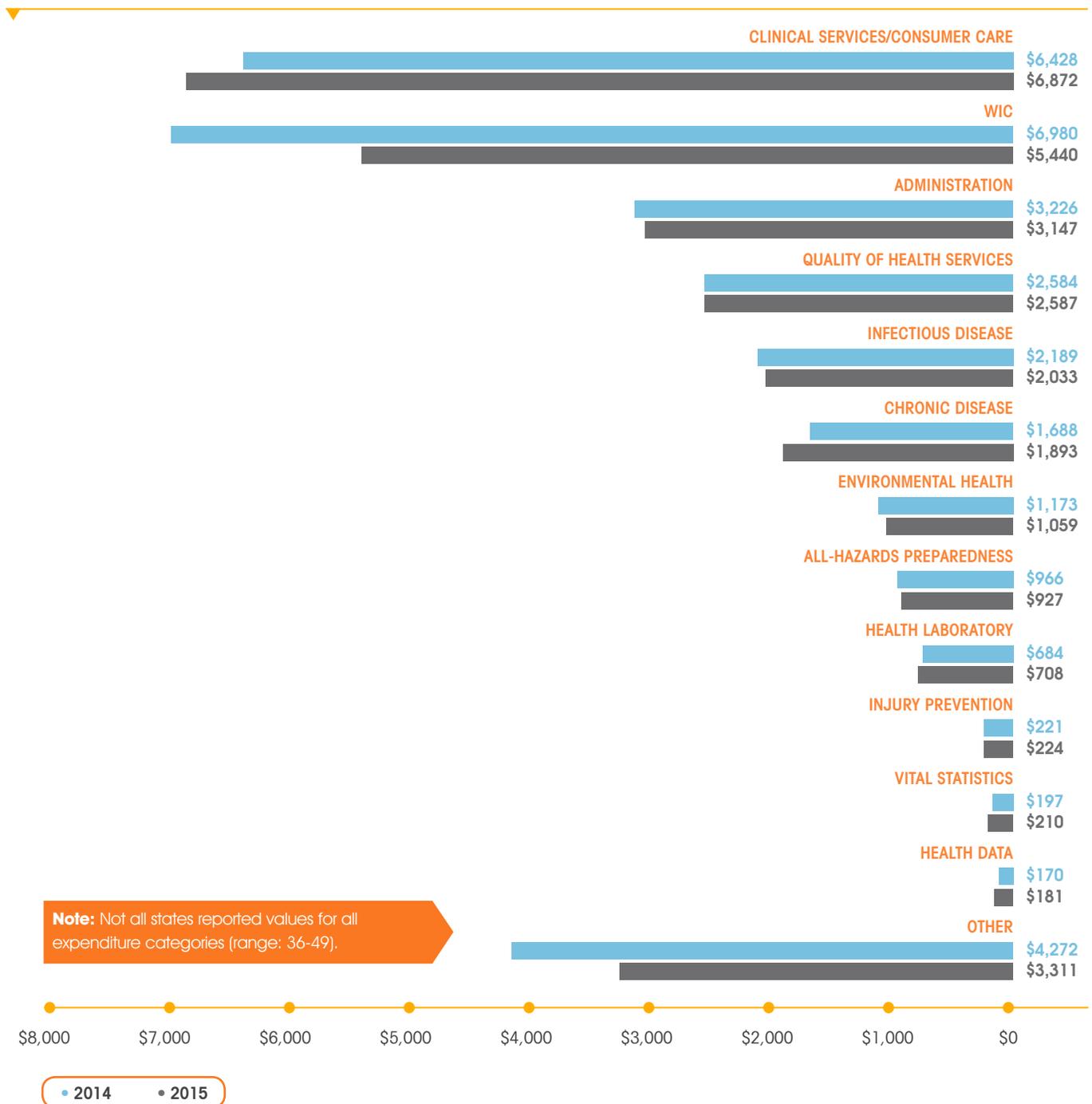
	2014				2015			
	MEAN	MEDIAN	MIN	MAX	MEAN	MEDIAN	MIN	MAX
States and D.C.	\$105	\$84	\$33	\$405	\$100	\$84	\$28	\$361
Centralized/largely centralized	\$143	\$118	\$59	\$405	\$133	\$115	\$65	\$361
Decentralized/largely decentralized	\$88	\$72	\$33	\$250	\$84	\$68	\$28	\$209
Freestanding	\$110	\$93	\$33	\$405	\$109	\$93	\$28	\$361
Under larger agency	\$97	\$77	\$42	\$234	\$87	\$78	\$36	\$189

**Figure 6.10** shows total state health agency expenditures for 2014 and 2015 by expense category. Between 2014 and 2015, there were increases in total expenditures for clinical services/consumer care, quality of health services, chronic disease, health laboratory, injury prevention, vital statistics, and health data. Conversely, there were decreases in total expenditures between 2014 and 2015 for WIC, administration, infectious diseases, environmental health, all-hazards preparedness, and other. In 2015, the greatest percentage of expenditures came from clinical services/consumer care (24%) and WIC (19%). Vital statistics, injury prevention, and health data accounted for the

lowest expenditures, with only 1 percent of total expenditures spent on each of the three categories (see **Figure 6.11**).

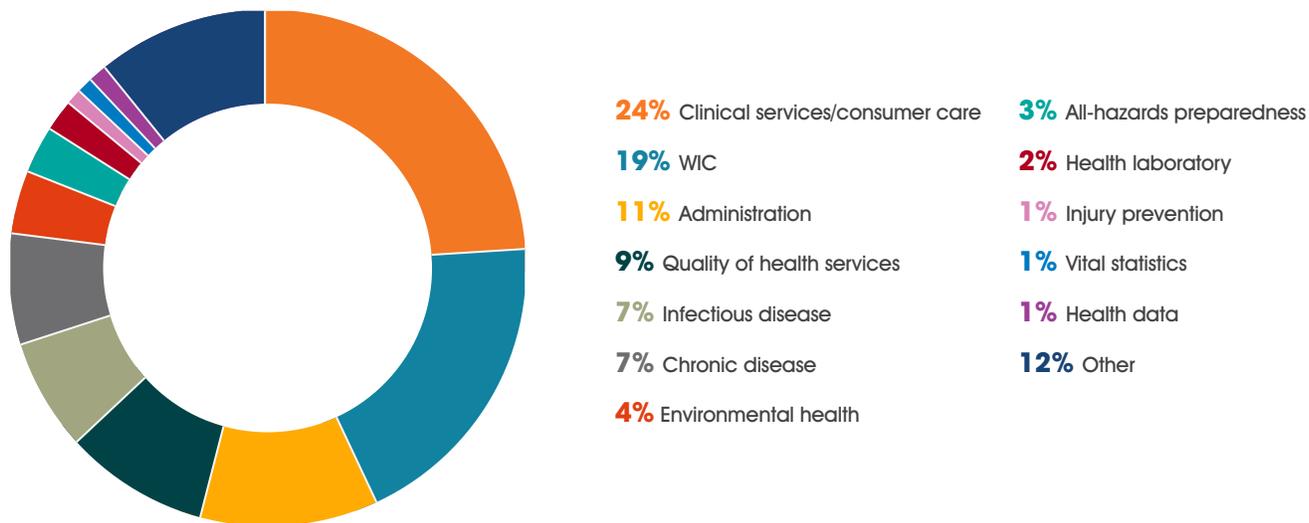
**Table 6.7** presents the mean, median, minimum, and maximum expenditures for 2014 and 2015 by expense category. Once again, the means for all expenditure categories exceeded the medians, in some cases by substantial amounts, indicating that several state health agencies with particularly high expenditures from specific categories skewed (increased) the mean.

**FIGURE 6.10** STATE HEALTH AGENCY EXPENDITURES BY EXPENSE CATEGORY FOR 2014 AND 2015, IN MILLIONS (N=49)



**FIGURE 6.11**

PERCENTAGE OF STATE HEALTH AGENCY EXPENDITURES BY EXPENSE CATEGORY FOR 2015 (N=49)



**Note:** Not all states reported values for all expenditure categories (range: 36-49).

**TABLE 6.7** AVERAGE STATE HEALTH AGENCY EXPENDITURES BY EXPENSE CATEGORY FOR 2014 AND 2015, IN MILLIONS (N=49)

	2014				2015			
	MEAN	MEDIAN	MIN	MAX	MEAN	MEDIAN	MIN	MAX
Clinical services/consumer care	\$143	\$56	\$0	\$1,317	\$153	\$68	\$0	\$1,717
WIC	\$142	\$87	\$0	\$1,333	\$113	\$83	\$0	\$812
Administration	\$67	\$19	\$0	\$2,172	\$66	\$20	\$0	\$2,055
Quality of health services	\$57	\$17	\$0	\$978	\$57	\$17	\$0	\$972
Infectious disease	\$45	\$28	\$2	\$250	\$41	\$25	\$3	\$253
Chronic disease	\$34	\$17	\$1	\$224	\$39	\$17	\$2	\$225
Environmental health	\$24	\$10	\$0	\$305	\$22	\$10	\$0	\$165
All-hazards preparedness	\$20	\$13	\$0	\$84	\$19	\$11	\$0	\$81
Health laboratory	\$14	\$10	\$0	\$112	\$15	\$10	\$0	\$109
Injury prevention	\$5	\$2	\$0	\$44	\$5	\$1	\$0	\$46
Vital statistics	\$4	\$3	\$0	\$23	\$4	\$3	\$0	\$24
Health data	\$4	\$2	\$0	\$18	\$4	\$2	\$0	\$19
Other	\$115	\$17	\$0	\$1,931	\$92	\$14	\$0	\$1,157

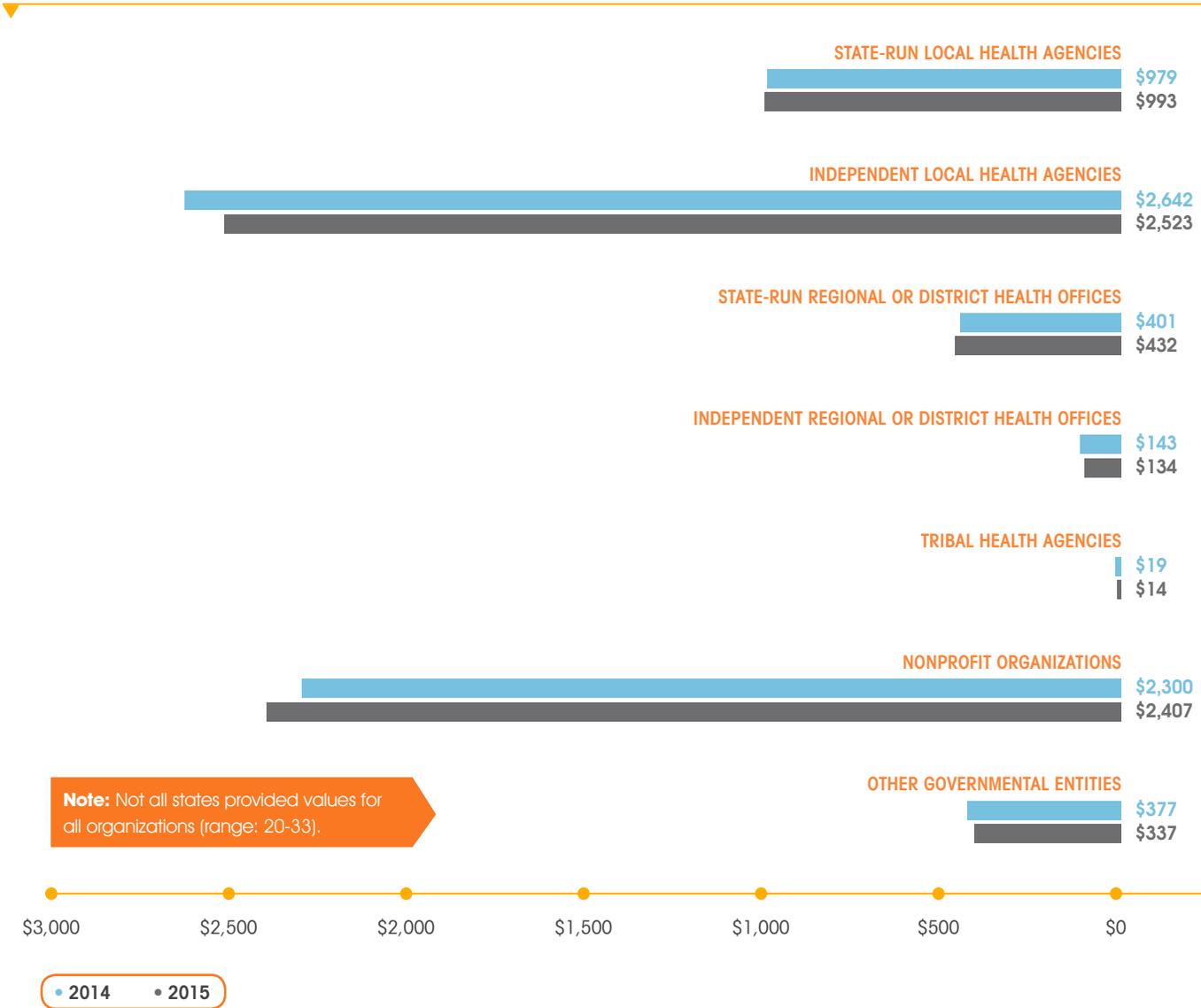
**Note:** Not all states provided values for all expenditure categories (range: 36-49).

# STATE AGENCY CONTRACTS, GRANTS, AND AWARDS TO LOCAL HEALTH DEPARTMENTS AND COMMUNITY-BASED ORGANIZATIONS

ASTHO asked state health agencies to report dollars distributed via contracts, grants, and awards to local health departments and community-based organizations. In both 2014 and 2015, state health agencies distributed approximately \$6.1 billion through contracts, grants, and awards. Between 2014 and 2015, there were slight increases in dollars distributed to state-run local health agencies, state-run regional or district health offices, tribal health agencies, and nonprofit organizations. Conversely, there were slight decreases in dollars distributed to independent local health agencies, independent regional or district

health offices, and other governmental entities (see [Figure 6.12](#)). As shown in [Figure 6.13](#), more than one-third of state health agency contracts, grants, and awards were distributed to independent local health agencies and nonprofit organizations (42% and 40%, respectively). The combined category of local health departments, including both state-run local health departments and independent local health departments, received the greatest proportion (58%) of state health agency contracts, grants, and awards. (See [Table 6.8](#) for definitions of organization types.)

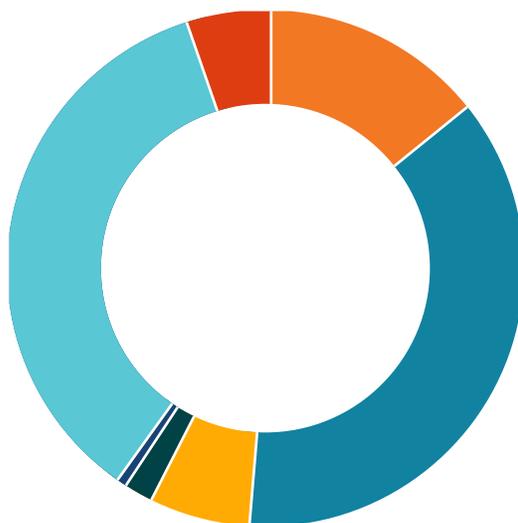
**FIGURE 6.12** STATE HEALTH AGENCY CONTRACTS, GRANTS, AND AWARDS DISTRIBUTED TO LOCAL HEALTH DEPARTMENTS AND COMMUNITY-BASED ORGANIZATIONS FOR 2014 AND 2015, IN MILLIONS (N=33)





**FIGURE 6.13**

PERCENTAGE OF STATE HEALTH AGENCY CONTRACTS, GRANTS, AND AWARDS DISTRIBUTED TO LOCAL HEALTH DEPARTMENTS AND COMMUNITY-BASED ORGANIZATIONS FOR 2015, IN MILLIONS (N=33)



- 16%** State-run local health agencies
- 42%** Independent local health agencies
- 7%** State-run regional or district health offices
- 2%** Independent regional or district health offices
- 0.24%** Tribal health agencies
- 40%** Nonprofit organizations
- 6%** Other government entities

**Note:** Not all states provided values for all organizations (range: 20-33).



**TABLE 6.8** CONTRACTS, GRANTS, AND AWARDS RECIPIENT TYPE DESCRIPTIONS

Contracts, Grants, and Awards Recipient Type Descriptions	
State-run local health agencies	Includes expenditures passed through the state health agency to local public health agencies that are led by staff employed by state government.
Independent local health agencies	Includes expenditures passed through the state health agency to local public health agencies that are led by staff employed by local government.
State-run regional or district health offices	Includes expenditures passed through the state health agency to 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 to regional or district public health offices that are led by non-state employees.
Tribal health agencies	Includes expenditures passed through the state health agency to tribal public health agencies.
Nonprofit organizations	Includes expenditures passed through the state health agency to nonprofit organizations such as community-based organizations.
Other governmental entities	Includes expenditures passed through the state health agency to other governmental entities such as public schools, parks and recreation, and public safety.

**Table 6.9** presents the mean, median, minimum, and maximum dollars that state health agencies distributed through contracts, grants, and awards to local health departments and community-based organizations for 2014 and 2015. Once again, the means for all organizations

exceeded the medians, in some cases by substantial amounts, indicating that several state health agencies with particularly high expenditures to various entities skewed (increased) the mean. Spending was fairly constant from 2014 to 2015.

**TABLE 6.9** AVERAGE DOLLARS DISTRIBUTED BY STATE HEALTH AGENCIES THROUGH CONTRACTS, GRANTS, AND AWARDS DISTRIBUTED TO LOCAL HEALTH DEPARTMENTS AND COMMUNITY-BASED ORGANIZATIONS FOR 2014 AND 2015, IN MILLIONS (N=33)

	2014				2015			
	MEAN	MEDIAN	MIN	MAX	MEAN	MEDIAN	MIN	MAX
State-run local health agencies	\$41	\$0	\$0	\$378	\$43	\$0	\$0	\$376
Independent local health agencies	\$80	\$39	\$0	\$1,241	\$79	\$44	\$0	\$1,149
State-run regional or district health offices	\$20	\$0	\$0	\$222	\$23	\$0	\$0	\$223
Independent regional or district health offices	\$7	\$0	\$0	\$59	\$7	\$0	\$0	\$61
Tribal health agencies	\$.80	\$.01	\$0	\$5	\$.70	\$.01	\$0	\$4
Nonprofit organizations	\$74	\$39	\$0	\$714	\$80	\$45	\$0	\$743
Other governmental entities	\$12	\$6	\$0	\$66	\$11	\$8	\$0	\$63

**Note:** Not all states provided values for all organizations (range: 20-33).

The first three sections of the ASTHO Profile of State and Territorial Public Health have focused on the structure of state health agencies, the professionals who comprise state health agencies, the activities and services that state health agencies perform, and the tools, processes, and resources that state health agencies utilize to perform these functions. The fourth section of the report, *Insular Areas*, will provide an overview of the activities, structure, and workforce of the U.S. territories and freely associated states.



**PART IV**

# **INSULAR AREAS**



## Chapter 7

# INSULAR AREAS

This chapter provides an overview of the structure, functions, and resources of the public health agencies of the U.S. territories and freely associated states, also referred to as the insular areas. The U.S. territories include three island jurisdictions in the Pacific—American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands—and the two Caribbean territories of Puerto Rico and the U.S. Virgin Islands. The remaining insular areas include three sovereign nation states holding compacts of free association with the United States, also known as compact nations: the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands. Together, the Pacific jurisdictions collectively constitute the U.S.-affiliated Pacific Islands (USAPI).

There is wide variability across these jurisdictions on many measures. The uniqueness of each insular area (e.g., geographic, socioeconomic, and systemic differences) can explain much of this variation. Yet despite their individual diversity, the insular areas are collectively distinct from the state and D.C. health departments described in previous chapters. Primary differences include their remoteness, relatively close integration with their healthcare systems, and challenges associated with high incidences of both communicable and non-communicable diseases. In 2016, seven of the eight insular area health agencies responded to the survey, resulting in the highest response rate to date.

### KEY FINDINGS

- ▶ In 2016, the governmental structure of the insular area public health agencies was roughly split between freestanding/independent agencies (57%) and those under an umbrella agency (43%).
- ▶ The average budget for 2014 was \$59.5 million (median = \$27.8 million) and the average budget for 2015 was \$61.5 million (median = \$32.3 million).
- ▶ In 2015, the average per capita expenditure on public health in the insular areas was \$389 and the median was \$197.
- ▶ On average, insular area public health agencies have 375 full-time equivalent employees (FTEs) per 100,000 people.
- ▶ The average number of vacant positions within insular area health agencies is 689 (median=32).
- ▶ The occupational classification with the most FTEs was public health nurses (mean=216, median=32), most likely due to the provision of more clinical services in the insular areas.
- ▶ Insular area health agencies perform the most primary prevention activities (92%) and data, epidemiology, and surveillance activities (86%).
- ▶ Insular area health agencies are involved in a number of planning and quality improvement (QI) activities. About half of insular area agencies plan to apply for accreditation, while the remainder have not yet decided whether to apply (43%).
- ▶ The most common program areas for which agencies collect electronic information include: immunization (100%), laboratory results (86%), reportable diseases (86%), and vital records (86%).

## OVERVIEW OF THE INSULAR AREAS

The island jurisdictions are relatively small in terms of both population and geography (see **Table 7.1**), and the freely associated states often face a different level of access to healthcare and public health resources than those available in the U.S. states and D.C. USAPIs are especially geographically remote (2,500-4,600 miles from Honolulu, Hawaii), which can cause difficulties with transportation, communication, and access to services. For some remote island communities, access to even primary care and basic medications may require travel by boat.

Health agencies in the insular areas represent a variety of structures and priorities, but are collectively distinct from health departments in the states and D.C. Insular area health agencies are often closely integrated with the healthcare system in each jurisdiction and frequently serve as the primary provider of both clinical and public health services and oversight. Communicable and tropical diseases (e.g., dengue, chikungunya, and Zika) are a primary focus for these agencies, as are climate change

and chronic disease prevention and treatment. With increased vulnerability to natural disasters, insular areas also dedicate significant resources to preparedness and recovery. Health officials in the territories generally report to a governor, whereas agencies in the freely associated states are national bodies led by ministers with a presidential reporting structure.

These jurisdictions also vary in their eligibility for federal funding and programming. Although they receive major public health funding streams similar to those in the continental United States, residents' eligibility for federal entitlement programs differs by jurisdiction type. U.S. territories participate in federal entitlement programs such as Medicaid, but often at a reduced rate. The freely associated states and their residents are generally ineligible for federal entitlement programs, and health agencies in these jurisdictions are sometimes unable to participate in other federal grants. However, international organizations also represent these agencies and provide some support.

**TABLE 7.1** POPULATION AND GEOGRAPHIC SIZE OF THE INSULAR AREAS, 2016<sup>1</sup>

U.S. Territories	Population	Geography (miles land)
American Samoa	56,000	77
Commonwealth of the Northern Mariana Islands	55,000	179
Guam	172,000	210
Puerto Rico	3,681,000	3,425
U.S. Virgin Islands	106,000	134
Freely Associated States		
Federated States of Micronesia	105,000	271
Republic of Palau	22,000	177
Republic of the Marshall Islands	53,000	70

### NOTES

1

United Nations Statistics Division. "UN Data". Available at [data.un.org](http://data.un.org). Accessed May 2017.



## INSULAR AREA HEALTH AGENCY STRUCTURE AND GOVERNANCE

In 2016, the governmental structure of the insular area public health agencies was roughly split between freestanding/independent agencies (57%) and those under an umbrella agency (43%). Of the four insular area public health agencies that are under an umbrella agency, the larger agency's most common areas of responsibility were public assistance (75%), environmental protection (50%), and mental health authority with substance abuse (50%). Twenty-eight percent of insular area health agencies have a board of health (Figure 7.1) versus 54 percent of state health agencies.

## INSULAR AREA HEALTH AGENCY BUDGETS

The insular areas reported on their total budgets for 2014 and 2015. The average budget for 2014 was \$59.5 million (median=\$27.8 million), and the average budget for 2015 was \$61.5 million (median=\$32.3 million). In 2015, the average per capita expenditure on public health in the insular areas was \$389 (Table 7.2).

## INSULAR AREA HEALTH AGENCY WORKFORCE

In 2016, the average size of the insular area health agency workforce was 1,088 staff members and 932 FTEs. As depicted in Table 7.3, there was a large range in both the number of staff and FTEs.

FIGURE 7.1

BOARD OF HEALTH FOR INSULAR AREA HEALTH AGENCIES, 2016 (N=7)

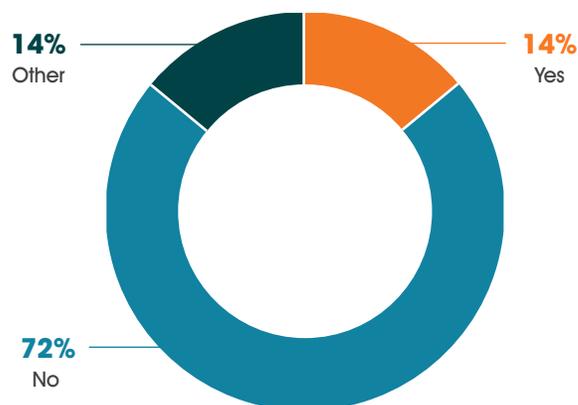


TABLE 7.2

PER CAPITA EXPENDITURES, 2014 AND 2015

	2014 (N=6)	2015 (N=6)
MEAN	\$386	\$389
MEDIAN	\$196	\$197
MIN	\$4	\$4
MAX	\$1,479	\$1,496

TABLE 7.3

NUMBER OF STAFF MEMBERS AND FTEs, 2016 (N=6-7)

Number of:	MEAN	MEDIAN	MIN	MAX	TOTAL
Staff members	1,088	402.5	83	4,919	6,527
FTEs	932	359	50	4,894	6,523

**Table 7.4** provides a breakdown of the average number of FTEs by occupational classification within the insular areas. On average, the occupational classification with the most FTEs was public health nurses (mean=216, median=32), most likely due to the provision of more clinical services in the insular areas.

### Insular Area Health Agency Vacancies and Recruitments

On average, there were 689 vacant positions within the insular areas health agencies in 2016 (median = 32); however, like the average size of the workforce, the range in the number of vacant positions was large (**Table 7.5**). Of those vacancies, health agencies were actively recruiting for an average of 38 positions in 2016.

Less than half (43%) of insular area health agencies have created a health department workforce development plan. A majority (86%) do not have a workforce development director within the agency.

### Insular Area Health Agency Demographics

Insular area health agency personnel are predominantly female (67%). The average age of new hires in the insular areas was 34 years old in 2013 and 2014, and 30 years old in 2015.

### Insular Area Health Officials

As of 2016, 71 percent of all insular area health officials were appointed by the governor.<sup>2</sup> More than half of all health officials (57%) were also appointed for a specific term. All seven health officials had executive management experience prior to becoming the health official.

**TABLE 7.4** NUMBER OF FTEs BY OCCUPATIONAL CLASSIFICATION, 2016

	N	MEAN	MEDIAN	MIN	MAX
Public health nurse	7	216	32	0	1345
Office and administrative support	7	164	19	2	980
Behavioral health staff	6	150	17	0	835
Business and financial operations staff	7	43	15	3	168
Agency leadership	6	42	7	2	221
Environmental health worker	7	38	11	0	218
Nutritionist	7	34	7	0	190
Laboratory worker	6	21	6	1	105
Physician assistant	6	20	1	0	111
Preparedness staff	6	20	7	4	90
Health educator	6	19	8	3	65
Epidemiologist/statistician	7	14	2	0	82
Public health informatics specialist	6	14	5	0	38
Public health physician	7	9	6	2	27
Oral health professional	5	8	5	2	15
QI specialist	6	5	1	0	26
Nurse practitioner	7	4	1	0	23
Public information specialist	7	1	1	0	6

**TABLE 7.5**

NUMBER OF VACANT POSITIONS AND ACTIVE RECRUITMENTS, 2016 (N=6)

	MEAN	MEDIAN	MIN	MAX
Number of vacant positions	689	32	2	3,815
Number of positions being actively recruited	38	23	0	128

## NOTES

2

As independent countries, freely associated states have presidents as heads of state, who appoint insular area health officials.



## INSULAR AREA HEALTH AGENCY ACTIVITIES

Despite the many differences between insular areas and states, insular area health agencies perform many of the same core activities as state health agencies. **Table 7.6** provides a summary of the aggregate number of activities each agency performs by activity type.

### NOTABLE AGENCY ACTIVITIES INCLUDE

- ▶ All insular area health agencies report administering immunizations to children and adults.
- ▶ Insular area health agencies report performing the most primary prevention activities (92%) and data, epidemiology, and surveillance activities (86%).
- ▶ A majority of insular areas perform screenings for diseases or conditions. The least common screenings performed by insular area health agencies are for asthma (50%) and blood lead (33%).
- ▶ All insular areas perform regulation, inspection, or licensing activities for food services. No insular area health agencies report performing regulation or inspection for beaches or solid waste haulers. In at least one insular area, this activity has been ceded to the states rather than being performed directly by the insular area's health agency.
- ▶ Overall, the number of insular area health agencies performing environmental health activities was low (35% of all environmental health activities surveyed on average). However, all agencies perform activities for food safety training/education and vector control.
- ▶ About half of all insular area health agencies report providing some form of technical assistance. Agencies most often provide technical assistance for QI, performance, and accreditation to healthcare providers (71%).
- ▶ Insular areas report high rates of collaboration. They most often collaborate with hospitals and most commonly collaborate by exchanging information.
- ▶ Insular area health agencies report participating in an average of six research studies (median = 2) over the past two years. The most common research activity that agencies engaged in was collecting, exchanging, or reporting data for a study (71%).
- ▶ All insular area health agencies report responsibility for the following federal initiatives: CDC Public Health Emergency Preparedness cooperative agreement; Section 317 Immunization Grant Program; Title V Maternal and Child Health Services Block Grant Program; and CDC's Comprehensive Cancer Control Programs for state, territorial, and tribal organizations.

**TABLE 7.6** TOTAL INSULAR AREA HEALTH AGENCY ACTIVITIES PERFORMED BY ACTIVITY TYPE, 2016

Jurisdiction	Access to Healthcare Services (N=10)		Data, Epidemiology, and Surveillance (N=12)		Environmental Health (N=20)		Laboratory Services (N=8)		Maternal and Child Health (N=14)		Other Clinical Services (N=16)		Other Public Health Activities (N=17)		Primary Prevention (N=17)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Commonwealth of the Northern Mariana Islands	6	60%	12	100%	9	45%	3	38%	10	71%	12	75%	6	35%	16	94%
Federated States of Micronesia	4	40%	12	100%	8	40%	5	63%	10	71%	11	69%	6	35%	16	94%
Guam	7	70%	9	75%	5	25%	2	25%	10	71%	9	56%	3	18%	15	88%
Puerto Rico	2	20%	9	75%	6	30%	4	50%	4	29%	9	56%	6	35%	14	82%
Republic of Palau	1	10%	12	100%	13	65%	6	75%	11	79%	16	100%	11	65%	17	100%
Republic of the Marshall Islands	4	40%	10	83%	4	20%	3	38%	10	71%	15	94%	8	47%	16	94%
U.S. Virgin Islands	5	50%	8	67%	4	20%	6	75%	9	64%	8	50%	5	29%	15	88%

Jurisdiction	Professional Licensure (N=5)		Regulation, Inspection, and Licensing (N=34)		Registry Maintenance (N=5)		Screening (N=15)		Treatment (N=12)		Vaccine Administration (N=3)		Vaccine Ordering (N=3)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Commonwealth of the Northern Mariana Islands	5	100%	21	66%	2	40%	14	93%	12	100%	3	100%	3	100%
Federated States of Micronesia	5	100%	11	31%	2	40%	13	87%	11	92%	2	67%	2	67%
Guam	5	100%	20	63%	2	40%	9	60%	6	50%	2	67%	2	67%
Puerto Rico	4	80%	17	50%	3	60%	8	53%	3	25%	2	67%	2	67%
Republic of Palau	0	0%	17	53%	5	100%	15	100%	9	75%	3	100%	3	100%
Republic of the Marshall Islands	3	60%	3	9%	5	100%	13	87%	11	92%	2	67%	2	67%
U.S. Virgin Islands	4	80%	19	59%	4	80%	15	100%	12	100%	3	100%	3	100%

INSULAR AREAS

# INSULAR AREA HEALTH AGENCY PLANNING AND QUALITY IMPROVEMENT

**TABLE 7.7**

DEVELOPMENT OF HEALTH ASSESSMENTS, HEALTH IMPROVEMENT PLANS, AND STRATEGIC PLANS BY INSULAR AREA HEALTH AGENCIES, 2016 (N=7)

	Health Assessment		Health Improvement Plan		Strategic Plan	
	N	%	N	%	N	%
Yes, within the last three years	4	57%	3	43%	5	71%
Yes, more than three but less than five years ago	1	14%	0	0%	1	14%
Yes, five or more years ago	1	14%	0	0%	0	0%
No, but plan to in the next year	1	14%	4	57%	1	14%
No	0	0%	0	0%	0	0%

## Health Assessments, Health Improvement Plans, and Strategic Plans

Insular area health agencies are involved in a number of planning and QI activities. **Table 7.7** shows the development status of insular area health agencies' health assessments, health improvement plans, and strategic plans.

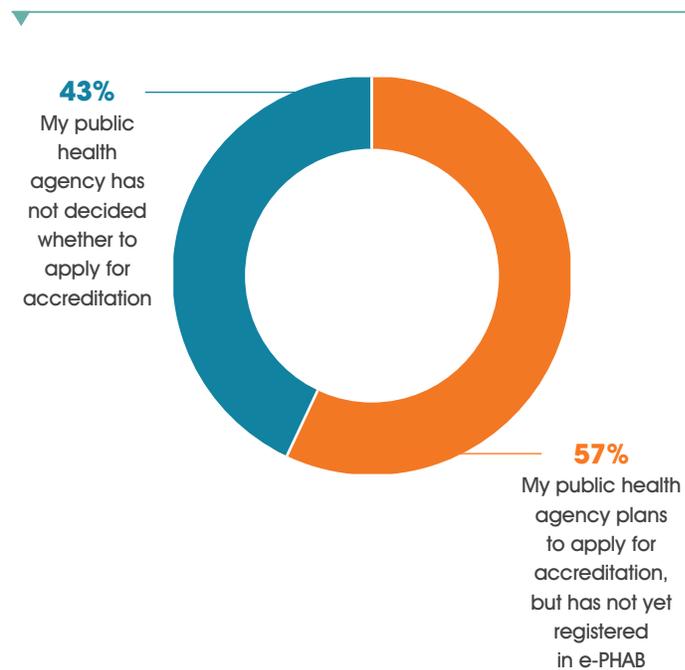
All agencies have either developed or plan to develop a health assessment. All insular area health agencies have either developed a health improvement plan within the last three years (43%), or plan to develop a health improvement plan in the next year (57%). In addition, a majority of insular areas have developed an agency-wide strategic plan within the last three years (71%).

## Accreditation

As depicted in **Figure 7.2**, about half of insular area agencies plan to apply for accreditation but have not yet registered in e-PHAB (57%), while the remainder have not yet decided whether to apply for accreditation (43%).

**FIGURE 7.2**

INSULAR AREA HEALTH AGENCY PARTICIPATION IN PHAB ACCREDITATION PROGRAM, 2016 (N=7)



## Quality Improvement

All but one insular area health agency indicated involvement in QI activities. Of the agencies reporting QI activities, half (N=3) have implemented formal QI programs agency-wide, while two have implemented formal QI activities in specific programmatic or functional areas.

Insular areas most frequently report using the Plan-Do-Check-Act or Plan-Do-Study-Act framework for QI activities (57%), followed by the Balanced Scorecard framework (14%). Forty-three percent of agencies reported not using a specific framework or approach (Figure 7.3).

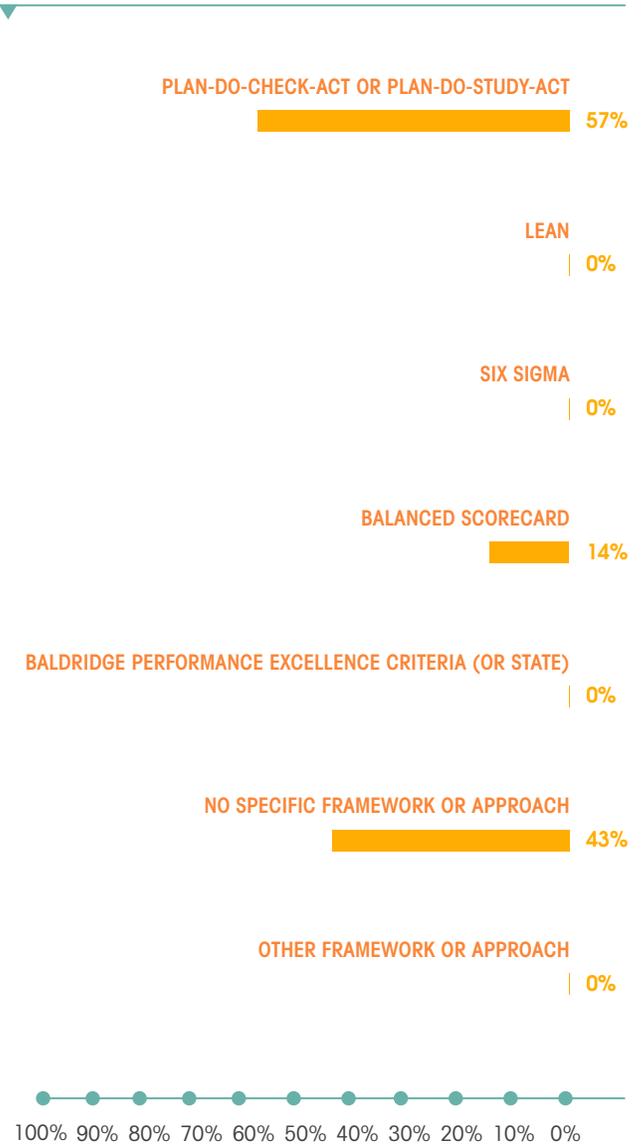
## Performance Management and Competencies

More than half of insular area health agencies (57%) indicated that they do not have a formal performance management program in place. One agency has fully implemented a formal performance management program department-wide, while one agency has fully implemented one for specific programs. One agency has partially implemented a formal performance management program for specific programs.

About half of insular area health agencies are familiar with, but have not used, the various public health competencies surveyed, including: the core competencies for public health professionals; the emergency preparedness competencies for all public health workers; and the informatics competencies for public health professionals. The one exception was Emergency Preparedness Competencies for All Public Health Workers, which was most frequently used for developing training plans (57%). The National League for Nursing Leadership Competencies and Quad Council Competencies for Public Health Nurses were the two competencies with which agencies were most unfamiliar (57% and 43%, respectively).

**FIGURE 7.3**

QUALITY IMPROVEMENT FRAMEWORKS USED IN THE LAST YEAR BY INSULAR AREAS, 2016 (N=7)



# INSULAR AREA HEALTH AGENCY HEALTH INFORMATION MANAGEMENT

Insular area health agencies differ in terms of who has primary decisionmaking responsibility for health information exchange policy and standards. Insular area health agencies were split in terms of who holds overall decisionmaking authority regarding the agencies' public health information management systems.

Forty-three percent of health agencies reported that the chief information officer had overall decisionmaking authority regarding their agency's public health information management systems, while 57 percent reported that the authority was held by someone other than those listed as response options. Other authorities included an IT director and a public health director.

## Electronic Data Collection and Exchange

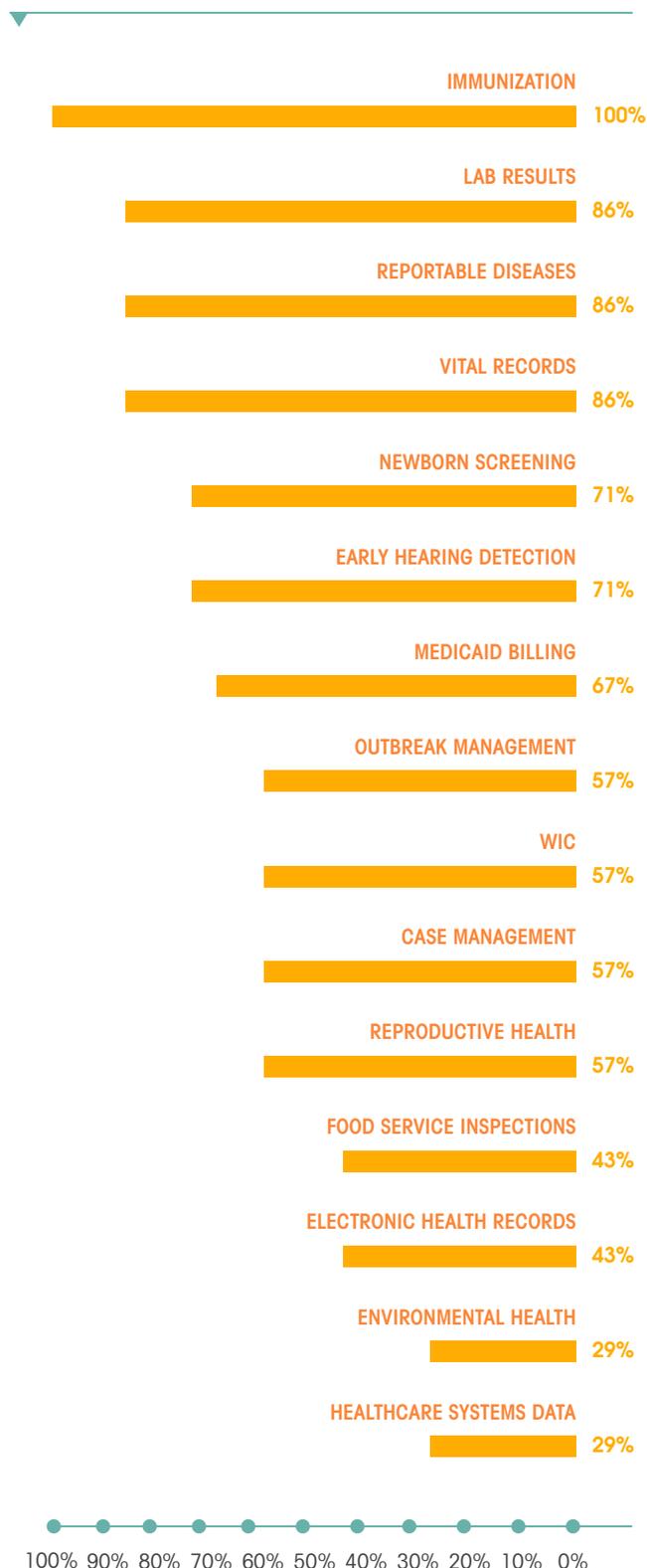
**Figure 7.4** displays the program areas in which insular area health agencies collect electronic information. The most common program areas for which agencies collect electronic information include: immunization (100%), laboratory results (86%), reportable diseases (86%), and vital records (86%). No insular area health agencies reported collecting electronic information on geographic coded data for mapping analysis, onsite wastewater treatment systems, and water wells (licensing or testing).

Insular area health agencies also reported on their activities surrounding Meaningful Use public health objectives. Of those agencies that reported having the electronic health record technology, agencies received Meaningful Use-compliant messages from only the following registries: electronic reportable laboratory results (67%), immunization registries (57%), and public health registries (17%). Insular area health agencies reported having capacity for bidirectional data reporting and exchange only for immunization registries (57%) and public health registries (17%).

The preceding chapters of the ASTHO Profile of State and Territorial Public Health have described the structure, functions, and activities of state and insular area health agencies. The final section of the report, *Individual Agency Profiles*, provides an overview of key information from each state and insular area health agency that completed the survey.

**FIGURE 7.4**

PROGRAM AREAS FOR INSULAR AREA HEALTH AGENCY ELECTRONIC DATA COLLECTION, 2016 (N=6-7)





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# ALABAMA



## Agency Mission

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

## Top Five Priorities

- 1 Funding to maintain public health services
- 2 Substance abuse (e.g., tobacco, prescription drugs, illicit drugs)
- 3 Infant mortality
- 4 Obesity
- 5 Chronic disease prevention

### Structure and Relationship with Local Health Departments

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

- 2** Independent local health agencies (led by staff employed by local government)
- 65** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

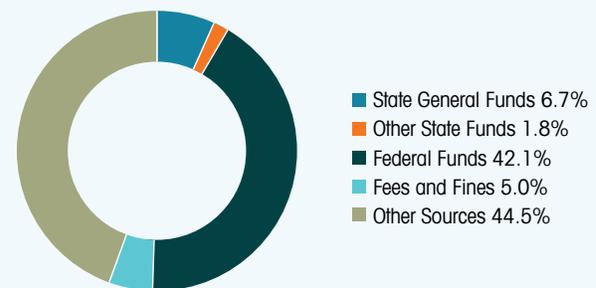
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

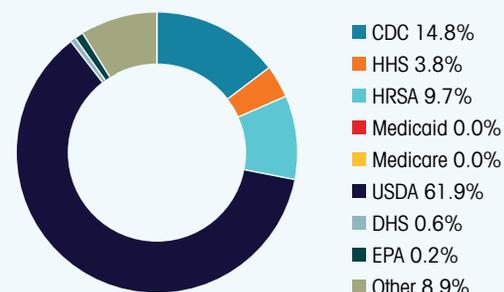
The state/territorial health agency has 2,576 FTEs, including 1,962 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$472,893,914**  
**Total Federal Revenue FY15: \$198,922,578**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# ALASKA

## Agency Mission

To protect and promote the health of Alaskans.

## Top Five Priorities

- 1 Tobacco and nicotine use
- 2 Colorectal and cervical cancer
- 3 Poisoning and overdose
- 4 Infectious disease
- 5 Child and adolescent health

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 2** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 0** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

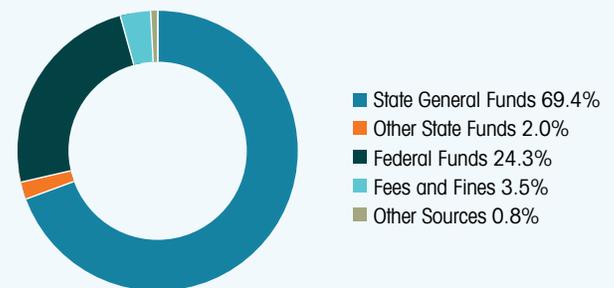
**The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.**

### Agency Workforce

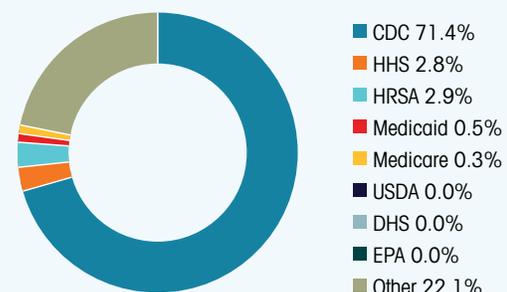
The state/territorial health agency has 469 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$108,784,200**  
**Total Federal Revenue FY15: \$25,244,900**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# ARIZONA



## Agency Mission

To promote, protect, and improve the health and wellness of individuals and communities in Arizona.

## Top Four Priorities

- 1 Aligning agency resources to achieve targeted health outcomes
- 2 Promoting and supporting public health and safety
- 3 Making focused improvements in public health infrastructure
- 4 Maximizing agency effectiveness

### Structure and Relationship with Local Health Departments

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

- 15** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

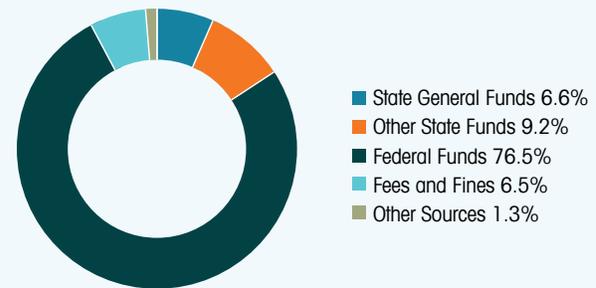
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

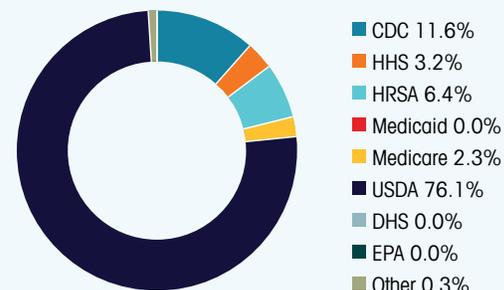
The state/territorial health agency has 1,376 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$277,435,900**  
**Total Federal Revenue FY15: \$211,828,200**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# ARKANSAS

## Agency Mission

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

## Top Five Priorities

- 1 Immunizations
- 2 Childhood obesity
- 3 Hypertension
- 4 Tobacco
- 5 Teen pregnancy

### Structure and Relationship with Local Health Departments

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

- 0** Independent local health agencies (led by staff employed by local government)
- 94** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 5** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

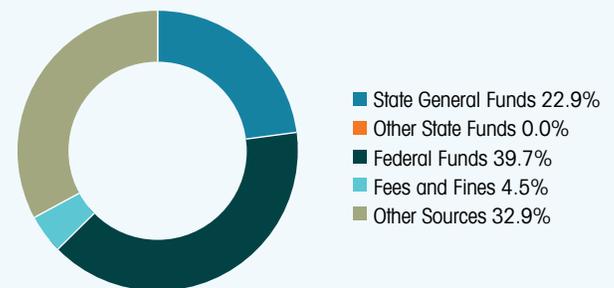
The state/territorial agency has achieved accreditation.

### Agency Workforce

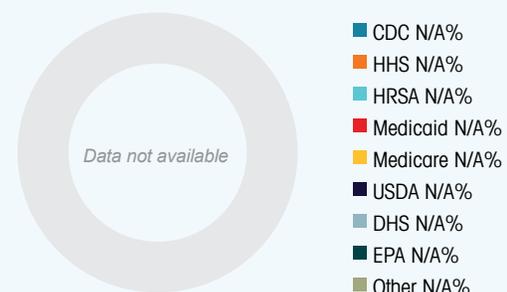
The state/territorial health agency has 2,275 FTEs, including 1,420 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$372,463,274**  
**Total Federal Revenue FY15: Data not available**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# CALIFORNIA



## Agency Mission

To optimize the health and well-being of the people in California.

## Top Five Priorities

- 1 Leveraging opportunities to build foundational public health
- 2 Public Health 2035 initiative
- 3 Strengthening internal operations
- 4 Supporting "Let's Get Healthy California" initiative
- 5 Workforce development/succession planning

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a "superagency" or "umbrella agency"—and has a decentralized relationship with local health departments.

- 61** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✗ Strategic Plan

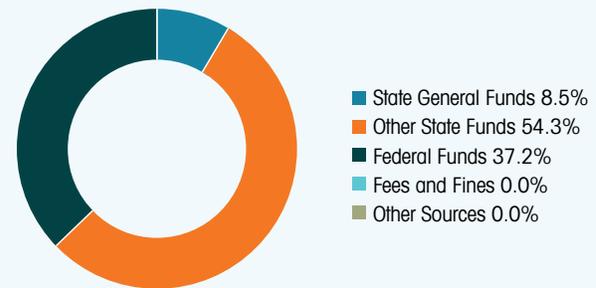
The state/territorial agency has achieved accreditation.

### Agency Workforce

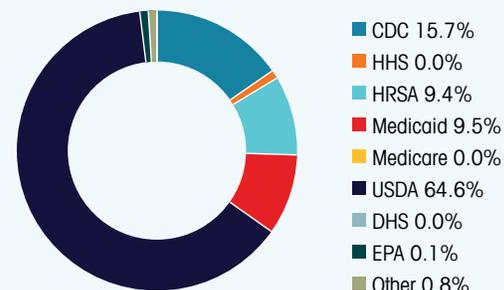
The state/territorial health agency has 3,441 FTEs, including 1,467 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$1,418,726,042**  
**Total Federal Revenue FY15: \$1,663,021,499**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# COLORADO

## Agency Mission

To protect and improve the health of Colorado’s people and the quality of the state’s environment.

## Top Five Priorities

- 1 Implementing plans supporting the health and environment priorities (e.g., substance use, mental health, obesity, immunizations, air, and water)
- 2 Increasing CDPHE’s efficiency, effectiveness, and elegance
- 3 Improving CDPHE’s employee engagement
- 4 Promoting health equity and environmental justice
- 5 Preparing for and responding to all emerging issues

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a decentralized relationship with local health departments.

- 54** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

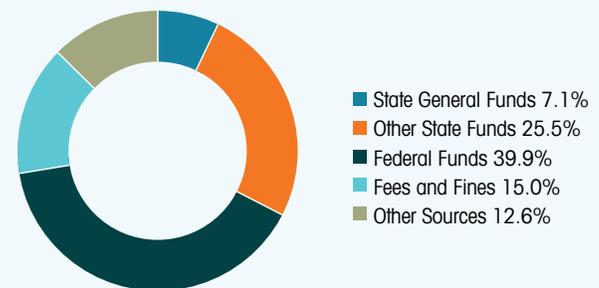
The state/territorial agency has achieved accreditation.

### Agency Workforce

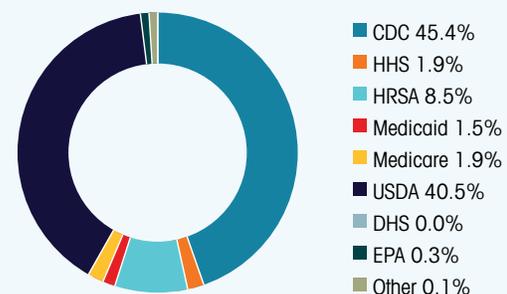
The state/territorial health agency has 1,328 FTEs, including 25 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$220,302,319**  
**Total Federal Revenue FY15: \$215,417,900**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS



## Agency Mission

To improve the health and well-being of the Commonwealth of the Northern Mariana Islands (CNMI) through excellence and innovation in service.

## Top Five Priorities

- 1 Reorganizational plan with clear reporting and authority lines
- 2 Recruitment and retention plan
- 3 A service plan code of ethics
- 4 Facility plan
- 5 Full implementation of electronic health records

### *Structure and Relationship with Local Health Departments*

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency.”

### *Organizational Structure*

The health official reports directly to the governor. The state/territory has the Commonwealth Healthcare Corporation Advisory Board.

### *Planning and Accreditation*

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

**The state/territorial health agency plans to apply for accreditation, but has not yet registered in e-PHAB.**

### *Agency Workforce*

The state/territorial health agency has 50 FTEs.





# CONNECTICUT

## 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; preventing disease, injury, and disability; and promoting the equal enjoyment of the highest attainable standard of health, which is a human right and a priority of the state.

## Top Five Priorities

- 1 Disease prevention, management, and surveillance
- 2 Public health preparedness and emergency response
- 3 Healthcare industry regulation
- 4 Public health code enforcement
- 5 Health data management and registry

### 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.

- 53** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 20** Independent regional or district offices  
(led by non-state employees)
- 0** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

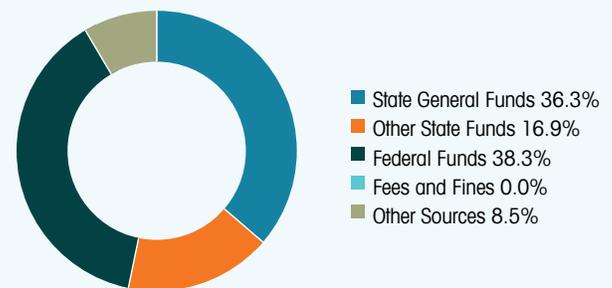
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

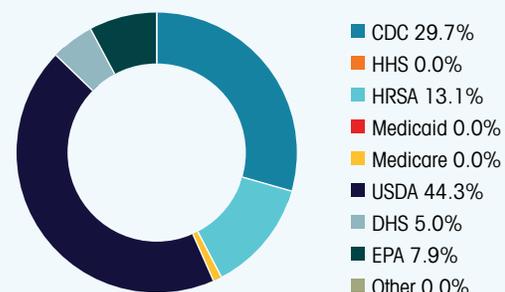
The state/territorial health agency has 702 FTEs, including four state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$305,555,567**  
**Total Federal Revenue FY15: \$116,884,996**

\*FY15 was defined as 7/1/2014-6/30/2015.



# DELAWARE

## Agency Mission

To protect and promote the health of all people in Delaware.

## Top Five Priorities

- 1 Active living and healthy eating
- 2 Health equity
- 3 Opioid and heroin addiction
- 4 Health reform
- 5 Performance improvement

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 0 **Independent local health agencies**  
(led by staff employed by local government)
- 0 **State-run local health agencies**  
(led by staff employed by state government)
- 0 **Independent regional or district offices**  
(led by non-state employees)
- 0 **State-run regional or district offices**  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

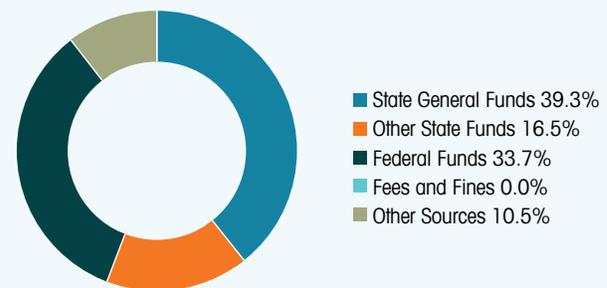
The state/territorial agency has achieved accreditation.

### Agency Workforce

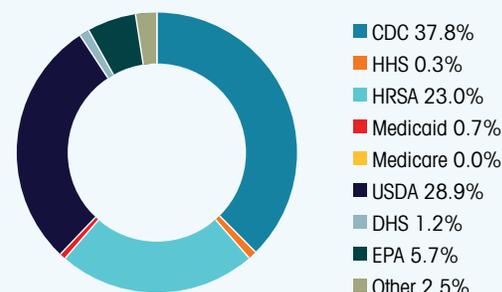
The state/territorial health agency has 713 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$130,587,377**  
**Total Federal Revenue FY15: \$43,957,604**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# DISTRICT OF COLUMBIA



## Agency Mission

To promote and protect the health, safety, and quality of life of residents, visitors, and those doing business in the District of Columbia, including: 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 Five Priorities

- 1 Promoting communitywide culture of health and wellness
- 2 Strengthening public-private partnerships
- 3 Closing the chasm between clinical medicine and public health
- 4 Promoting data-driven and outcome-oriented approaches
- 5 Applying health equity and social determinants of health to all that the agency does

## Structure and Relationship with Local Health Departments

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

- 0 **Independent local health agencies**  
(led by staff employed by local government)
- 1 **State-run local health agencies**  
(led by staff employed by state government)
- 0 **Independent regional or district offices**  
(led by non-state employees)
- 0 **State-run regional or district offices**  
(led by state employees)

## Organizational Structure

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

## Planning and Accreditation

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

- ✓ Health Assessment
- ✗ Health Improvement Plan
- ✓ Strategic Plan

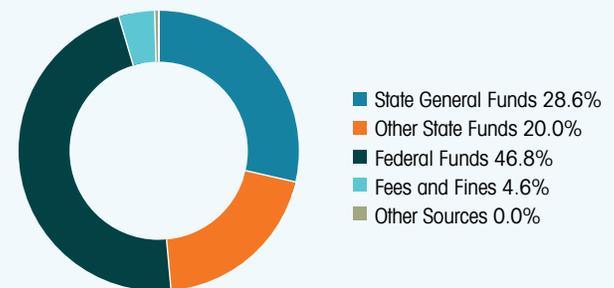
The state/territorial agency has achieved accreditation.

## Agency Workforce

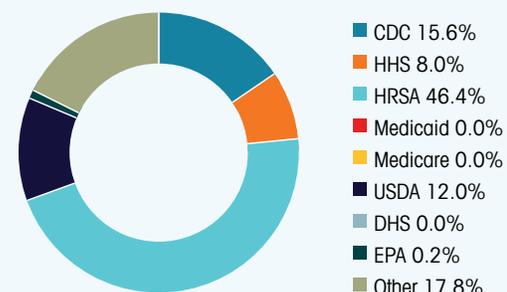
The state/territorial health agency has 548 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

## Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$245,915,548**  
**Total Federal Revenue FY15: \$115,118,218**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# FEDERATED STATES OF MICRONESIA



## Agency Mission

To promote and protect health and well-being of island communities in the Federated States of Micronesia (FSM).

## Top Five Priorities

- 1 Decreasing funding in Compact of Free Association
- 2 Chronic diseases
- 3 Aging health workforce
- 4 Putting qualified students in health/medical fields
- 5 Upgrading quality of medical care in the country

### *Structure and Relationship with Local Health Departments*

The state/territorial health agency is a freestanding/independent agency.

### *Organizational Structure*

The health official reports directly to the president of the Federated States of Micronesia.

The state/territory does not have a board of health.

### *Planning and Accreditation*

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

**The state/territorial health agency has not decided whether to apply for accreditation.**

### *Agency Workforce*

The state/territorial health agency has 83 FTEs.



# FLORIDA



## Agency Mission

To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

## Top Five Priorities

- 1 Eliminating infant mortality
- 2 Increasing healthy life expectancy
- 3 Demonstrating readiness for emerging health threats
- 4 Establishing a sustainable infrastructure, which includes a competent workforce, standardized business practices, and effective use of technology
- 5 Establishing a regulatory structure that supports the state's strategic priorities related to global competitiveness and economic growth

### Structure and Relationship with Local Health Departments

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

- 0 Independent local health agencies (led by staff employed by local government)
- 67 State-run local health agencies (led by staff employed by state government)
- 0 Independent regional or district offices (led by non-state employees)
- 0 State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

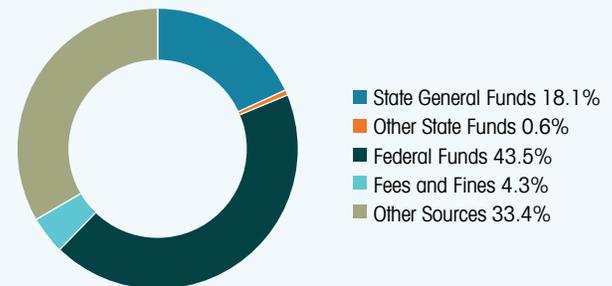
The state/territorial agency has achieved accreditation.

### Agency Workforce

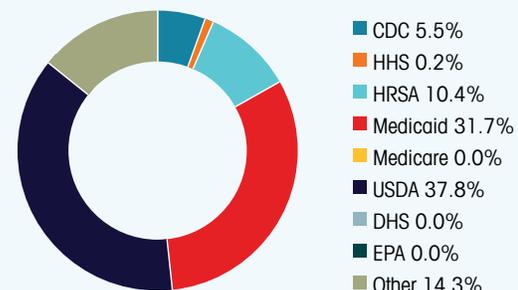
The state/territorial health agency has 13,768 FTEs, including 10,213 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$2,683,295,879**  
**Total Federal Revenue FY15: \$1,286,193,482**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# GEORGIA



## Agency Mission

To prevent disease, injury, and disability; promote health and well-being; and prepare for and respond to disasters.

## Top Five Priorities

- 1 Childhood obesity
- 2 Early brain development and language acquisition
- 3 Infant mortality
- 4 Access to healthcare/primary care
- 5 Technological infrastructure

### Structure and Relationship with Local Health Departments

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

- 159** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 18** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

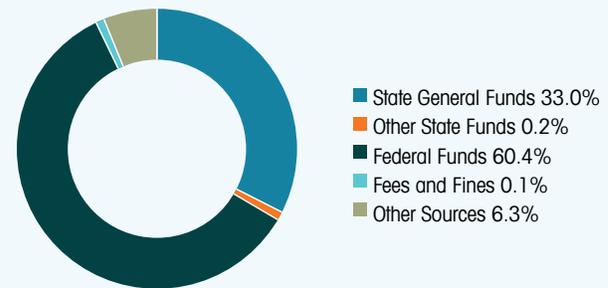
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

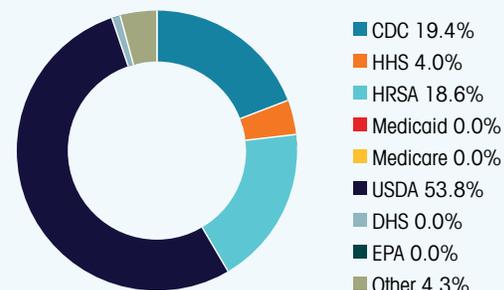
The state/territorial health agency has 974 FTEs, including 180 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$603,744,049**  
**Total Federal Revenue FY15: \$363,753,469**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# GUAM



## Agency Mission

To assist the people of Guam in achieving and maintaining their highest levels of independence and self-sufficiency in health and social services.

## Top Five Priorities

- 1 Prevention and control of Zika and communicable diseases
- 2 Promote elimination of non-communicable diseases
- 3 Outreach to uninsured, underinsured, indigent, and high-risk groups for nursing services
- 4 Continue education programs for family planning, childhood mental health, and abstinence
- 5 Continue to search and apply for funding sources to assist nurses and prevention programs

### *Structure and Relationship with Local Health Departments*

The state/territorial health agency is a freestanding/independent agency.

### *Organizational Structure*

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

### *Planning and Accreditation*

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

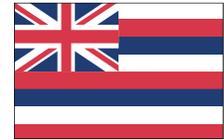
**The state/territorial health agency has not decided whether to apply for accreditation.**

### *Agency Workforce*

The state/territorial health agency has 422 FTEs.



# HAWAII



## Agency Mission

To protect and improve the health and environment for all people in Hawaii.

## Top Three Priorities

- 1 Maternal and child health
- 2 Mental health
- 3 Telehealth

### Structure and Relationship with Local Health Departments

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

- 0 Independent local health agencies (led by staff employed by local government)
- 0 State-run local health agencies (led by staff employed by state government)
- 0 Independent regional or district offices (led by non-state employees)
- 3 State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✗ Health Improvement Plan
- ✓ Strategic Plan

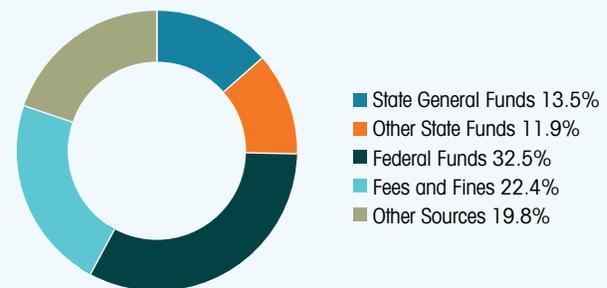
The state/territorial agency has decided not to apply for accreditation.

### Agency Workforce

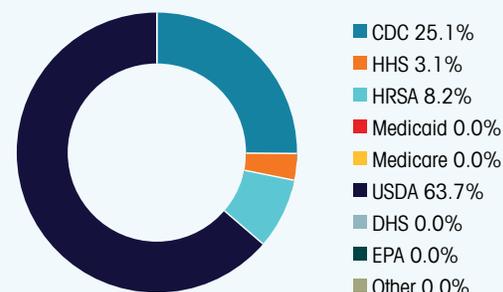
The state/territorial health agency has 2,631 FTEs. There are no state/territorial agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



Total Revenue FY15: \$278,956,338  
Total Federal Revenue FY15: \$46,720,791

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# IDAHO



## Agency Mission

To promote and protect the health and safety of Idahoans.

## Top Five Priorities

- 1 Public health accreditation
- 2 Development of an Office of Suicide Prevention
- 3 Population health as part of healthcare reform
- 4 Workforce development
- 5 Quality improvement/data analytics

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 0 **Independent local health agencies**  
(led by staff employed by local government)
- 0 **State-run local health agencies**  
(led by staff employed by state government)
- 7 **Independent regional or district offices**  
(led by non-state employees)
- 0 **State-run regional or district offices**  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

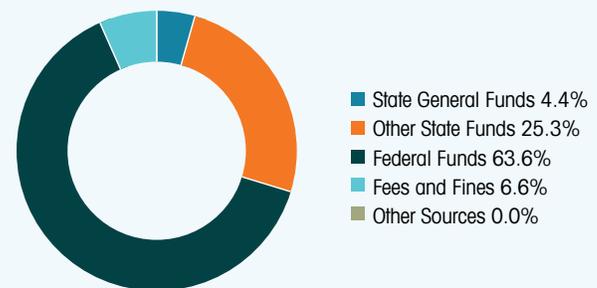
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

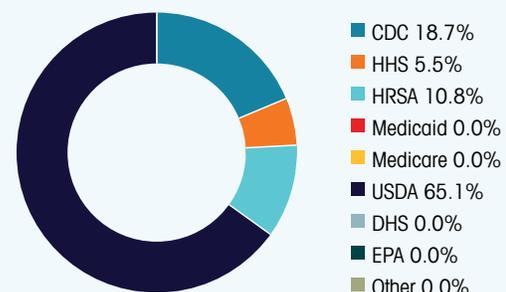
The state/territorial health agency has 228 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$85,224,196**  
**Total Federal Revenue FY15: \$51,247,019**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# ILLINOIS



## Agency Mission

To promote the health of the people of Illinois through the prevention and control of disease and injury.

## Top Five Priorities

- 1 Enhance stakeholder engagement (partnerships)
- 2 Improve data quality and dissemination
- 3 Broaden understanding of agency role and function
- 4 Improve regulatory compliance
- 5 Reduce health disparities

### Structure and Relationship with Local Health Departments

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

- 96** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 7** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

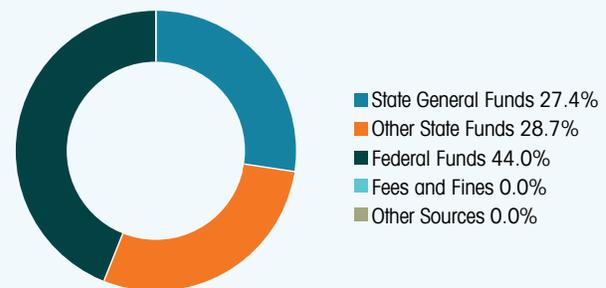
The state/territorial agency has achieved accreditation.

### Agency Workforce

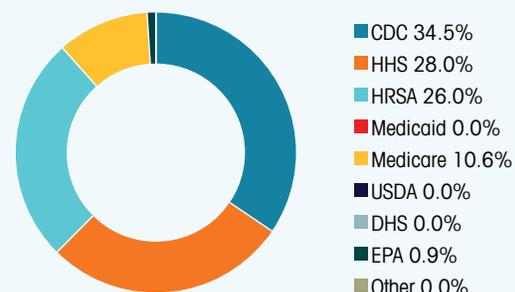
The state/territorial health agency has 1,124 FTEs, including 550 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$354,074,236**  
**Total Federal Revenue FY15: \$146,947,400**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# INDIANA



## Agency Mission

To promote and provide essential public health services.

## Top Five Priorities

- 1 Decrease disease incidence and burden
- 2 Improve response and preparedness networks and capabilities
- 3 Reduce administrative costs by improving efficiencies
- 4 Recruit, evaluate, and retain public health workforce
- 5 Use information and electronic data to develop outcome driven programs

### Structure and Relationship with Local Health Departments

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

- 93** **Independent local health agencies**  
(led by staff employed by local government)
- 0** **State-run local health agencies**  
(led by staff employed by state government)
- 0** **Independent regional or district offices**  
(led by non-state employees)
- 0** **State-run regional or district offices**  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

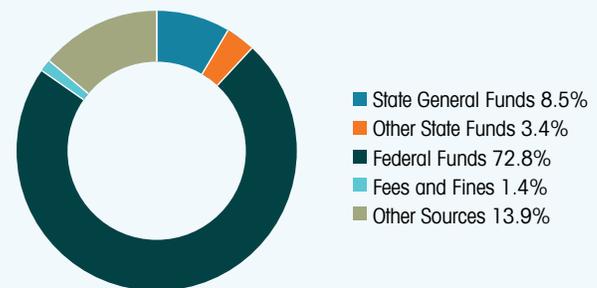
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

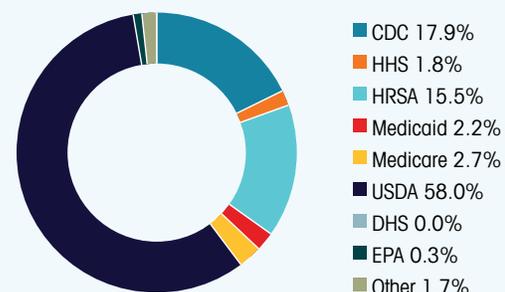
The state/territorial health agency has 741 FTEs, including 200 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$341,242,237**  
**Total Federal Revenue FY15: \$248,767,286**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# IOWA



## Agency Mission

To promote and protect the health of Iowans.

## Top Five Priorities

- 1 Public health quality improvement
- 2 State Innovation Model and Healthiest State population health objectives, specifically focusing on tobacco prevention, obesity reduction, and diabetes
- 3 Funding flexibility for state and local public health agencies
- 4 Infectious disease control, including healthcare associated infections
- 5 Improved data and informatics capabilities

### Structure and Relationship with Local Health Departments

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

- 101** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

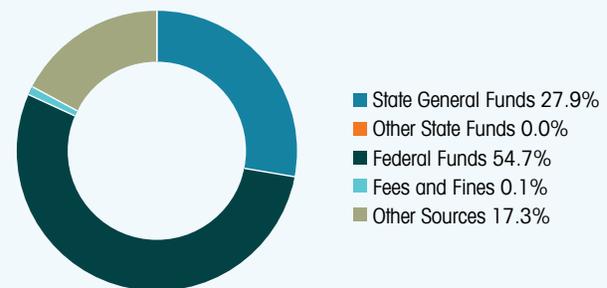
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

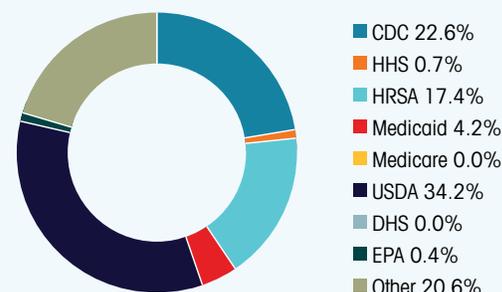
The state/territorial health agency has 469 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$448,303,334**  
**Total Federal Revenue FY15: \$126,222,998**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# KANSAS



## Agency Mission

To protect and improve the health and environment of all Kansans.

## Top Five Priorities

*\*Information not available*

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 100** **Independent local health agencies**  
(led by staff employed by local government)
- 0** **State-run local health agencies**  
(led by staff employed by state government)
- 0** **Independent regional or district offices**  
(led by non-state employees)
- 6** **State-run regional or district offices**  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

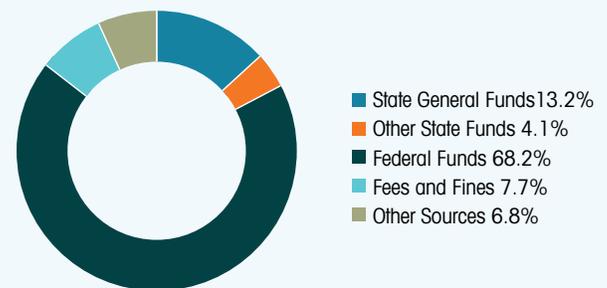
**The state/territorial agency has submitted an application for accreditation.**

### Agency Workforce

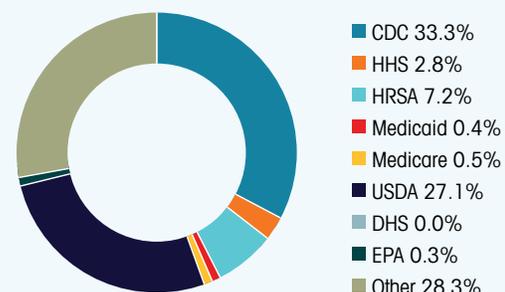
No data available on the number of workers for the state/territorial health agency.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$174,349,114**  
**Total Federal Revenue FY15: \$223,849,113**

*\*FY15 was defined as 7/1/2014 – 6/30/2015.*



# KENTUCKY

## Agency Mission

To improve the health and safety of people in Kentucky through prevention, promotion, and protection.

## Top Five Priorities

- 1 Opioid dependencies and related issues (e.g., neonatal abstinence syndrome, harm reduction syringe exchange programs, naloxone rescue)
- 2 Obesity/diabetes prevention
- 3 Cancer prevention and detection
- 4 Tobacco-Free Kentucky
- 5 Preparing for emerging diseases (e.g., Ebola, Zika virus)

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 61** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✗ Health Improvement Plan
- ✗ Strategic Plan

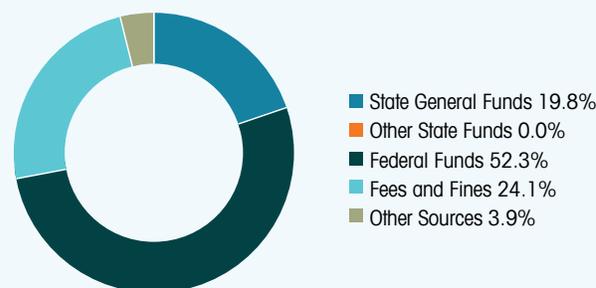
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

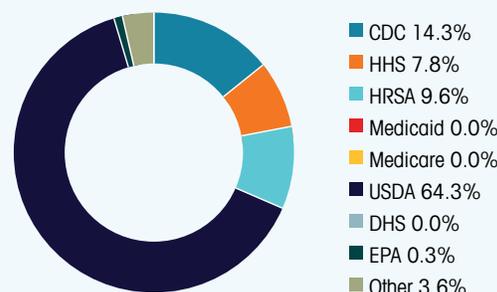
The state/territorial health agency has 510 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$344,341,595**  
**Total Federal Revenue FY15: \$180,007,145**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# LOUISIANA

## Agency Mission

To protect and promote the health and wellness of all individuals and communities in Louisiana.

## Top Five Priorities

- 1 Increase financial stability
- 2 Foster meaningful internal and external collaborations
- 3 Improve workforce development
- 4 Health information technology exchange and infrastructure, utilization, and integration
- 5 Reduce health disparities

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 2** Independent local health agencies  
(led by staff employed by local government)
- 63** State-run local health agencies  
(led by staff employed by state government)
- 5** Independent regional or district offices  
(led by non-state employees)
- 9** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

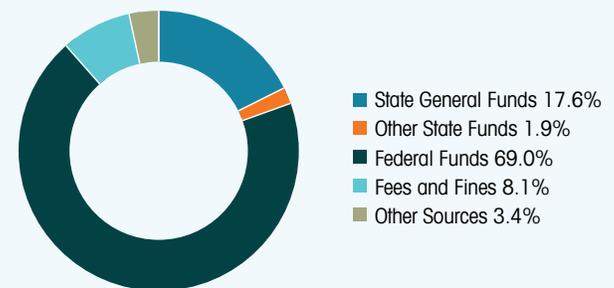
The state/territorial agency has registered in e-PHAB in order to pursue accreditation.

### Agency Workforce

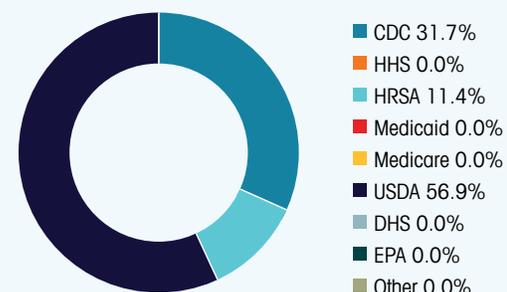
The state/territorial health agency has 1,218 FTEs, including 574 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$329,424,464**  
**Total Federal Revenue FY15: \$214,460,785**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# MAINE

## Agency Mission

\*Information not available

## Top Five Priorities

\*Information not available

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 2** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 9** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

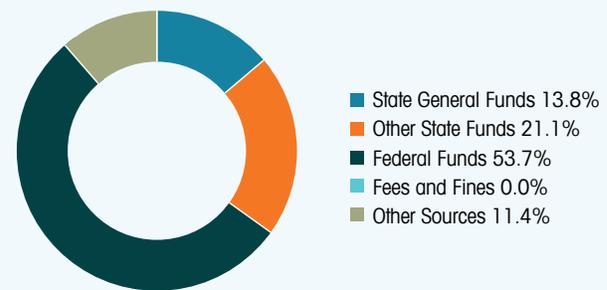
**The state/territorial agency has achieved accreditation.**

### Agency Workforce

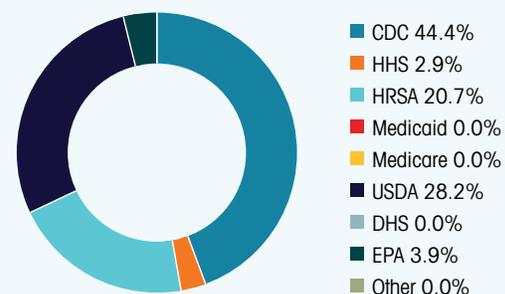
The state/territorial health agency has 492 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$112,045,316**  
**Total Federal Revenue FY15: \$60,152,901**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# MARYLAND

## Agency Mission

To promote and improve the health and safety of all Marylanders through disease prevention, access to care, quality management, and community engagement.

## Top Five Priorities

- 1 Overdose/opioids
- 2 Zika
- 3 Healthcare reform
- 4 Workforce development
- 5 Budget

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 1** Independent local health agencies  
(led by staff employed by local government)
- 23** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 0** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

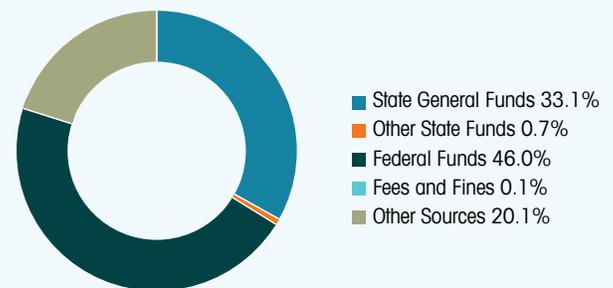
The state/territorial agency has achieved accreditation.

### Agency Workforce

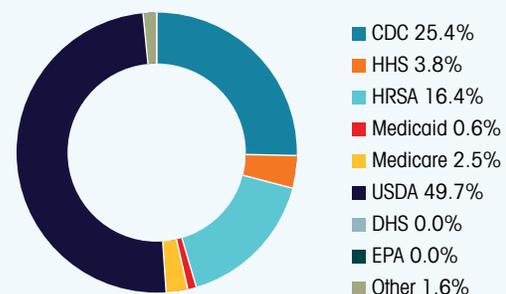
The state/territorial health agency has 9,069 FTEs, including 6,904 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$466,395,328**  
**Total Federal Revenue FY15: \$214,349,087**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# MASSACHUSETTS

## Agency Mission

To prevent illness, injury, and premature death; to ensure access to high-quality public health and healthcare services; and to promote wellness and health equity for all people in the commonwealth.

## Top Five Priorities

- 1 Reduce health disparities and achieve health equity for all
- 2 Utilize and link data in innovative ways to advance precision public health and improve population health
- 3 Identify, prevent, and reduce the risk factors associated with opioid overuse, misuse, and overdose
- 4 Strengthen core public health infrastructure
- 5 Strive to exceed our customers' expectations

### Structure and Relationship with Local Health Departments

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

- 351** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 16** Independent regional or district offices (led by non-state employees)
- 4** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✕ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

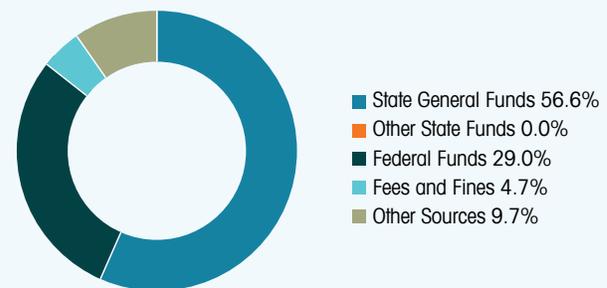
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

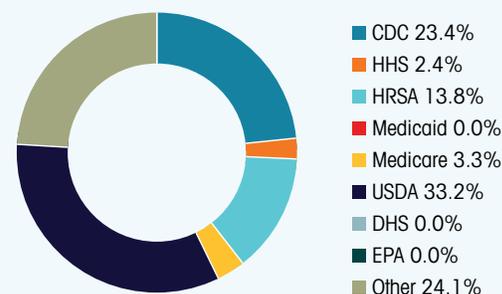
The state/territorial health agency has 2,864 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$961,945,215**  
**Total Federal Revenue FY15: \$247,884,174**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# MICHIGAN

## Agency Mission

To promote a healthy, safe, and stable environment for residents to be self-sufficient.

## Top Five Priorities

- 1 Emergency response and recovery for Flint water crisis
- 2 Increasing environmental and policy support for healthy behavior, including the areas of physical activity, nutrition, etc.
- 3 Ensuring public health capacity to address emerging threats
- 4 Promoting practices and policies that support all people in attaining their optimal level of health
- 5 Promoting the development and use of interoperable information systems for public health functions

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a decentralized relationship with local health departments.

- 45** **Independent local health agencies**  
(led by staff employed by local government)
- 0** **State-run local health agencies**  
(led by staff employed by state government)
- 0** **Independent regional or district offices**  
(led by non-state employees)
- 0** **State-run regional or district offices**  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

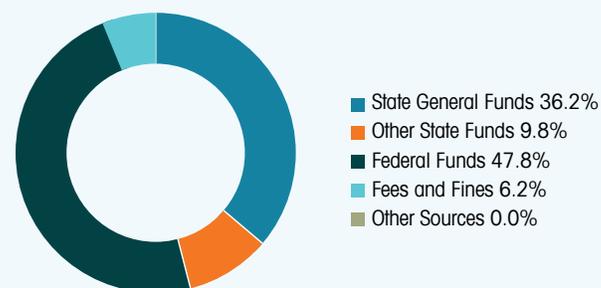
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

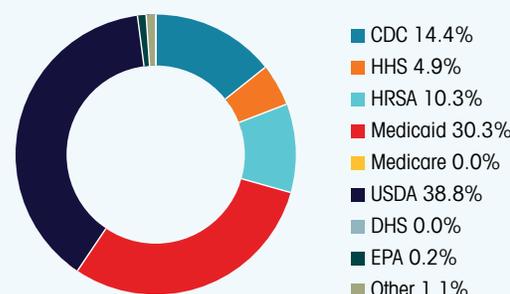
The state/territorial health agency has 474 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$556,486,400**  
**Total Federal Revenue FY15: \$462,978,503**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# MINNESOTA

## Agency Mission

To protect, maintain, and improve the health of all Minnesotans.

## Top Five Priorities

- 1 Health equity
- 2 Data
- 3 Mental well-being
- 4 Public health capacity
- 5 Informatics and communications

### Structure and Relationship with Local Health Departments

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

- 49** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 8** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

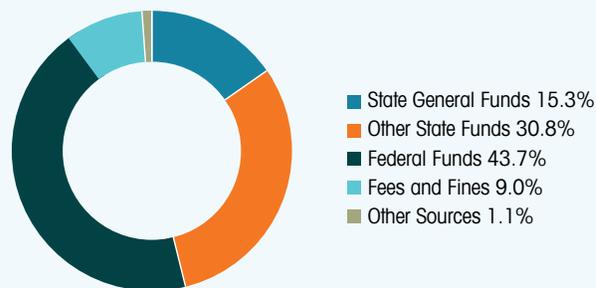
The state/territorial agency has achieved accreditation.

### Agency Workforce

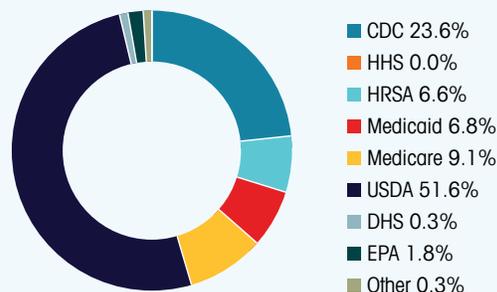
The state/territorial health agency has 1,445 FTEs, including 163 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding

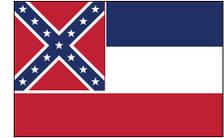


### Federal Funding Sources



**Total Revenue FY15: \$533,182,812**  
**Total Federal Revenue FY15: \$238,088,535**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# MISSISSIPPI

## Agency Mission

To promote and protect the health of the citizens of Mississippi.

## Top Five Priorities

- 1 Ensure effective implementation of state health improvement plan priorities
- 2 Cultivate community-based health initiatives
- 3 Align partners statewide to support health improvement
- 4 Align funding in support of health improvement priorities
- 5 Strengthen organizational effectiveness and adaptability

### Structure and Relationship with Local Health Departments

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

- 0** Independent local health agencies  
(led by staff employed by local government)
- 80** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 9** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

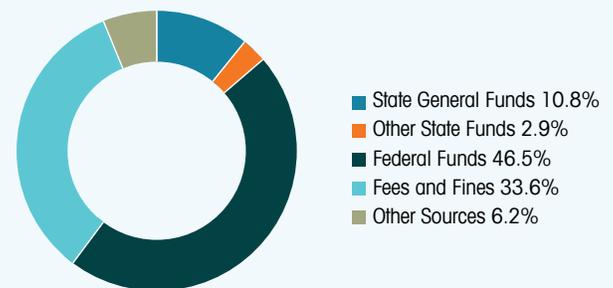
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

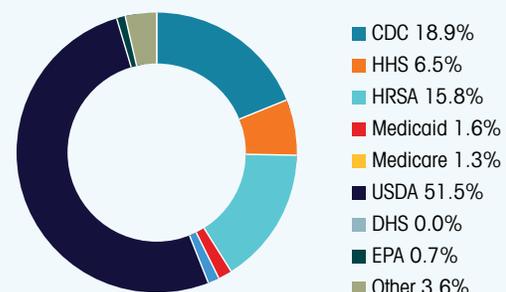
The state/territorial health agency has 2,015 FTEs, including 1,092 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue: \$318,806,862**  
**Total Federal Revenue: \$148,254,404**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# MISSOURI

## Agency Mission

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

## Top Five Priorities

- 1 Reduce infant mortality and prematurity
- 2 Reduce prescription drug abuse
- 3 Reduce childhood obesity
- 4 Increase chronic disease prevention and management activities among seniors
- 5 Increase access to care in underserved populations

### Structure and Relationship with Local Health Departments

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

- 115** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 9** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

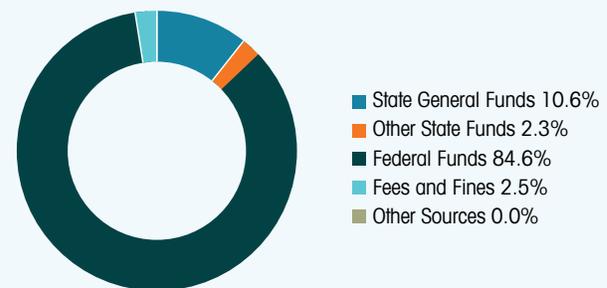
The state/territorial agency has achieved accreditation.

### Agency Workforce

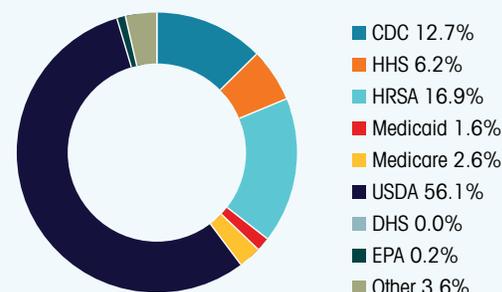
The state/territorial health agency has 1,879 FTEs, including 840 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$407,506,438**  
**Total Federal Revenue FY15: \$344,837,731**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# MONTANA

## Agency Mission

To improve and protect the health of Montanans by creating conditions for healthy living.

## Top Five Priorities

- 1 Tobacco prevention and cessation
- 2 Childhood and adolescent immunizations
- 3 Colorectal cancer screening
- 4 Injury prevention
- 5 Access to chronic disease prevention programs

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a decentralized relationship with local health departments.

- 58** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 0** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

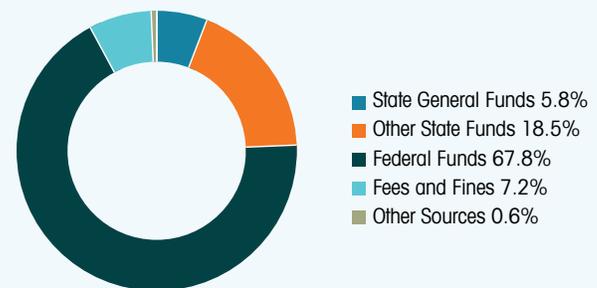
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

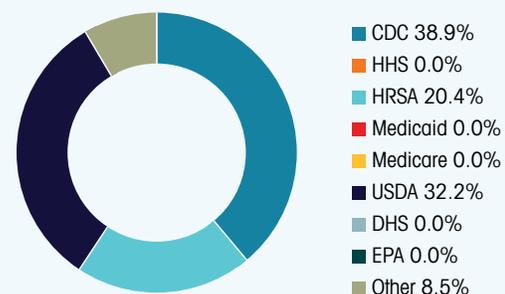
The state/territorial health agency has 195 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$118,304,962**  
**Total Federal Revenue FY15: \$45,558,168**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# NEBRASKA

## Agency Mission

To help people live better lives.

## Top Five Priorities

- 1 Prescription Drug Monitoring Program
- 2 Health disparities and health equity
- 3 Process improvement
- 4 Accreditation
- 5 System of care

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 2** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 19** Independent regional or district offices  
(led by non-state employees)
- 0** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

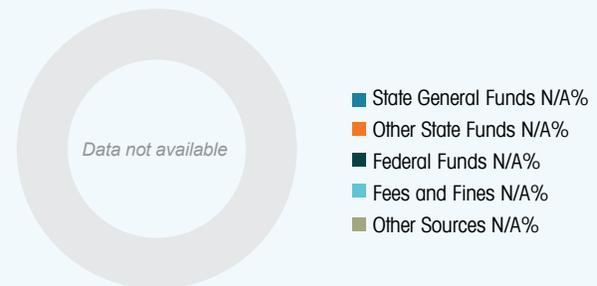
The state/territorial agency has achieved accreditation..

### Agency Workforce

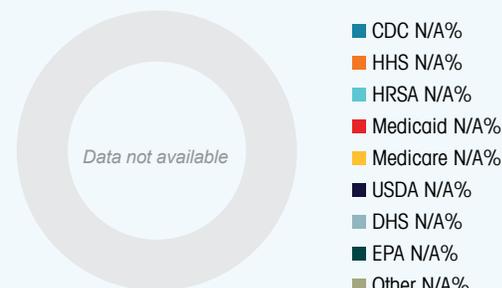
The state/territorial health agency has 454 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: Data not available**  
**Total Federal Revenue FY15: Data not available**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# NEW HAMPSHIRE

## Agency Mission

To assure the health and well-being of people in New Hampshire by protecting and promoting physical, mental, and environmental health and preventing disease, injury, and disability.

## Top Five Priorities

- 1 Misuse of alcohol and drugs
- 2 Healthy mothers and babies
- 3 Injury prevention
- 4 Infectious disease prevention
- 5 Heart disease and stroke

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 2** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 0** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

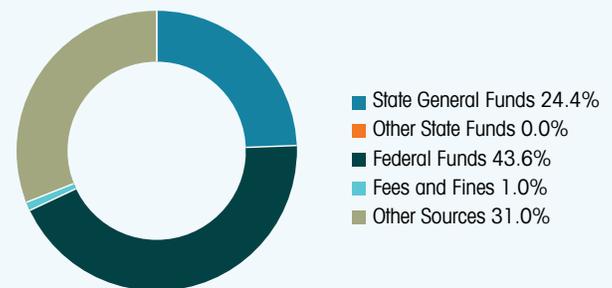
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

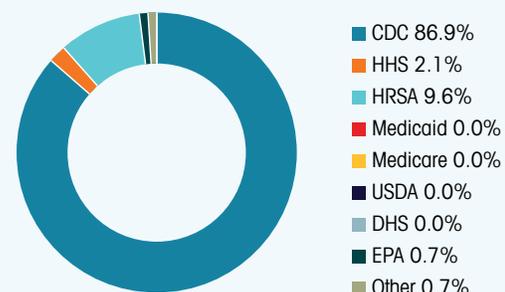
The state/territorial health agency has 227 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$86,940,665**  
**Total Federal Revenue FY15: \$33,603,990**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# NEW JERSEY



## Agency Mission

To improve health through leadership and innovation.

## Top Five Priorities

- 1 Population health
- 2 Chronic disease
- 3 Birth outcomes
- 4 Workplace wellness
- 5 Performance management

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 90** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 1** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

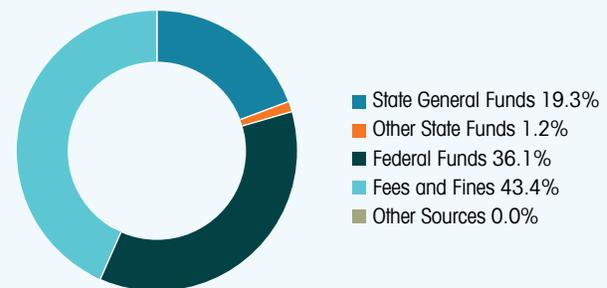
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

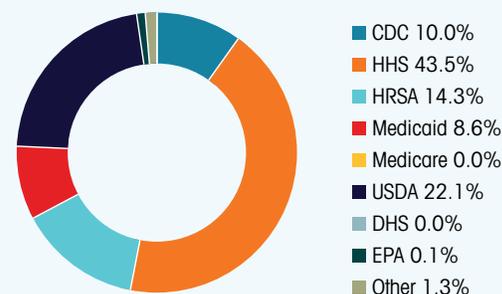
The state/territorial health agency has 1,067 FTEs, including 31 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$1,726,993,809**  
**Total Federal Revenue FY15: \$618,683,033**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# NEW MEXICO



## Agency Mission

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 Five Priorities

- 1 Obesity reduction
- 2 Smoking cessation
- 3 Control of vaccine-preventable diseases
- 4 Teen pregnancy reduction
- 5 Prevention and control of diabetes

### Structure and Relationship with Local Health Departments

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

- 0 Independent local health agencies  
(led by staff employed by local government)
- 0 State-run local health agencies  
(led by staff employed by state government)
- 0 Independent regional or district offices  
(led by non-state employees)
- 4 State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

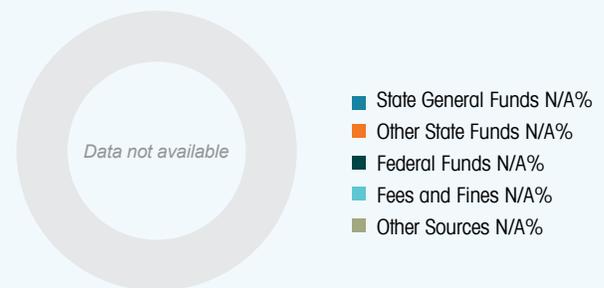
The state/territorial agency has achieved accreditation.

### Agency Workforce

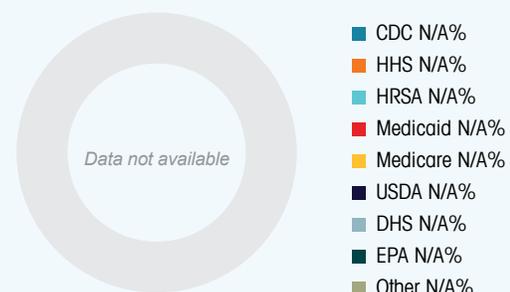
The state/territorial health agency has 3,775 FTEs, including 800 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: Data not available**  
**Total Federal Revenue FY15: Data not available**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# NEW YORK

## Agency Mission

To protect, improve, and promote the health, productivity, and wellbeing of all New Yorkers by promoting public health and patient safety; by reducing health disparities; and by assuring access to affordable, high-quality health services.

## Top Five Priorities

- 1 Prevent chronic disease
- 2 Promote healthy women, infants, and children
- 3 Promote healthy and safe environments
- 4 Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases, and healthcare-associated infections
- 5 Promote mental health and prevent substance abuse

### Structure and Relationship with Local Health Departments

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

- 58** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 12** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

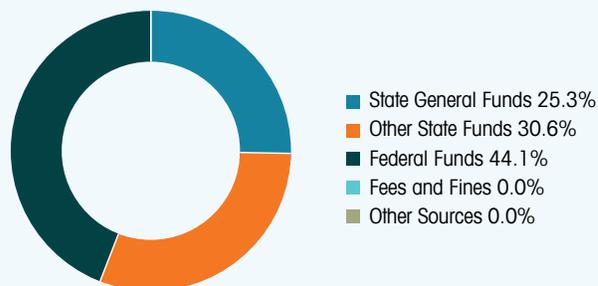
The state/territorial agency has achieved accreditation.

### Agency Workforce

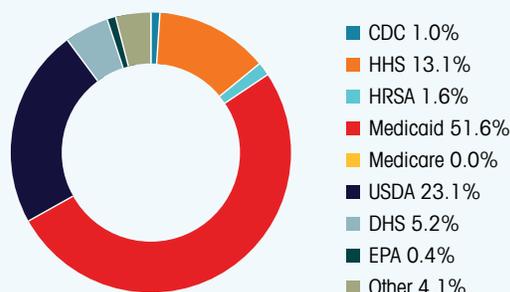
The state/territorial health agency has 3,151 FTEs, including 722 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



Total Revenue FY15: \$4,128,673,660  
Total Federal Revenue FY15: \$1,822,273,610

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# NORTH CAROLINA

## Agency Mission

To promote and contribute to the highest level of health possible for the people of North Carolina.

## Top Five Priorities

- 1 Improve internal business functions
- 2 Prevent hepatitis C infections
- 3 Reduce infant mortality rate
- 4 Reduce prescription opioid misuse, abuse, morbidity, and mortality
- 5 Improve the medical examiner system

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 85** **Independent local health agencies**  
(led by staff employed by local government)
- 0** **State-run local health agencies**  
(led by staff employed by state government)
- 6** **Independent regional or district offices**  
(led by non-state employees)
- 0** **State-run regional or district offices**  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

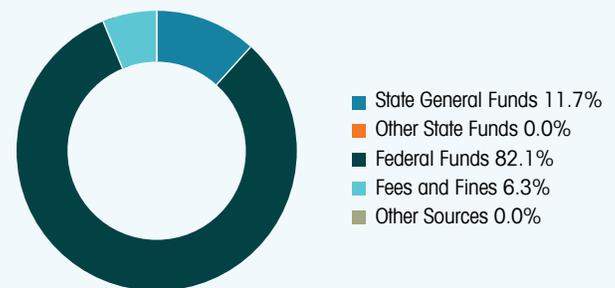
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

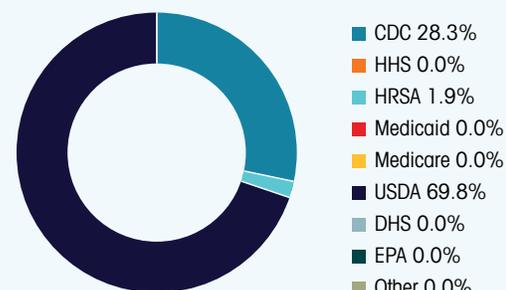
The state/territorial health agency has 1,924 FTEs, including 714 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$454,773,148**  
**Total Federal Revenue FY15: \$364,118,743**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# NORTH DAKOTA

## Agency Mission

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

## Top Five Priorities

- 1 Environmental oil/energy impact
- 2 Information technology security and health data
- 3 Integration of public health and private sector/primary care
- 4 Cardiovascular disease and associated risk factors
- 5 Accreditation and quality improvement

### Structure and Relationship with Local Health Departments

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

- 28** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 8** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

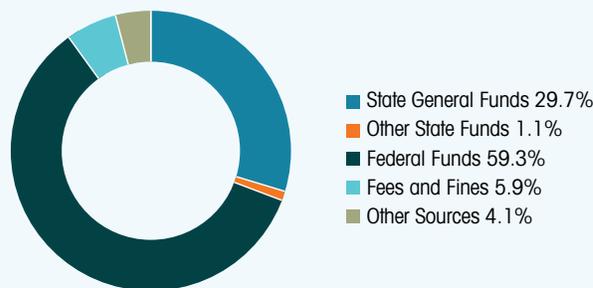
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

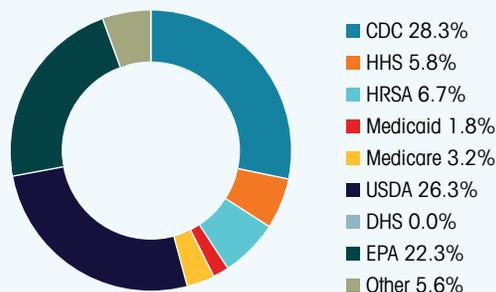
This state/territorial health agency has 355 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$82,371,244**  
**Total Federal Revenue FY15: \$48,823,828**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# OHIO



## Agency Mission

To protect and improve the health of all Ohioans by preventing disease, promoting good health, and assuring access to quality care.

## Top Five Priorities

- 1 One mission, one voice
- 2 System alignment
- 3 Data-driven performance
- 4 Workforce development
- 5 Access to core public health services

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 120** **Independent local health agencies**  
(led by staff employed by local government)
- 0** **State-run local health agencies**  
(led by staff employed by state government)
- 0** **Independent regional or district offices**  
(led by non-state employees)
- 2** **State-run regional or district offices**  
(led by state employees)

### Organizational Structure

The health official does not report directly to the governor. The state has an advisory board that fulfills an advisory role, but does not have authority.

### Planning and Accreditation

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

- ✗ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

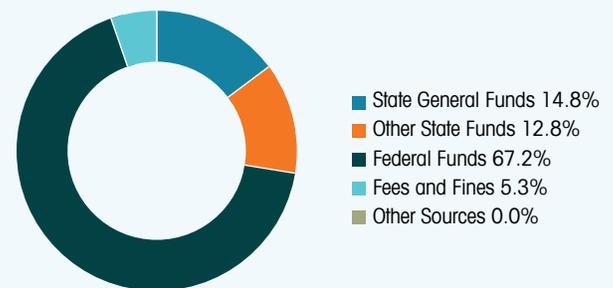
The state/territorial agency has achieved accreditation.

### Agency Workforce

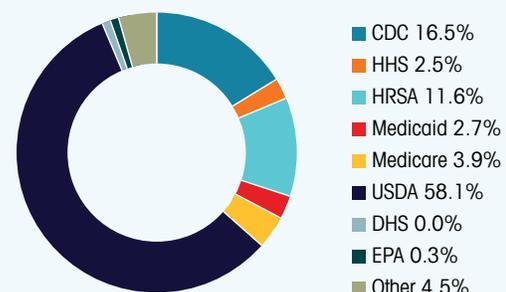
The state/territorial health agency has 1,075 FTEs, including 106 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$581,819,877**  
**Total Federal Revenue FY15: \$390,693,300**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# OKLAHOMA



## Agency Mission

To protect and promote health, to prevent disease and injury, and to cultivate conditions by which Oklahomans can be healthy.

## Top Five Priorities

- 1 Infectious disease control, regulatory functions, preparedness, and response services
- 2 Tobacco use prevention
- 3 Obesity
- 4 Children’s health
- 5 Behavioral health

### Structure and Relationship with Local Health Departments

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

- 2 Independent local health agencies (led by staff employed by local government)
- 1 State-run local health agencies (led by staff employed by state government)
- 0 Independent regional or district offices (led by non-state employees)
- 68 State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

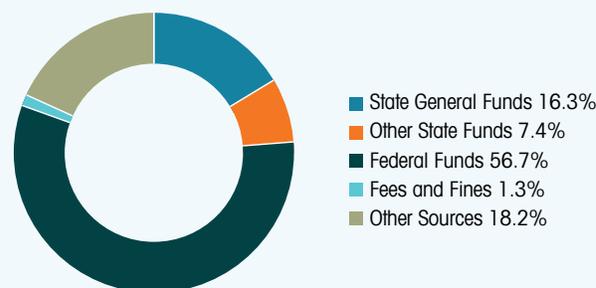
The state/territorial agency has achieved accreditation.

### Agency Workforce

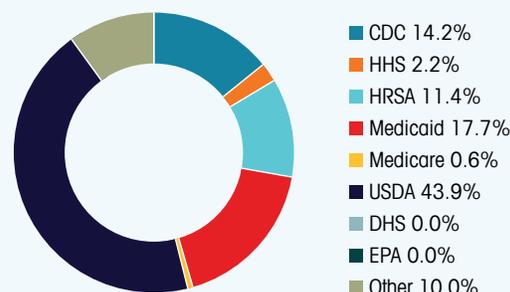
The state/territorial health agency has 2,206 FTEs, including 1,406 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$349,740,633**  
**Total Federal Revenue FY15: \$198,395,992**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# OREGON

## Agency Mission

To promote health and prevent the leading causes of death, disease, and injury in Oregon.

## Top Five Priorities

- 1 Prevent tobacco use, harms of substance abuse, and deaths by suicide
- 2 Slow the increase of obesity
- 3 Improve oral health and immunization rates
- 4 Protect from communicable diseases
- 5 Implement public health modernization

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 34** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 0** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

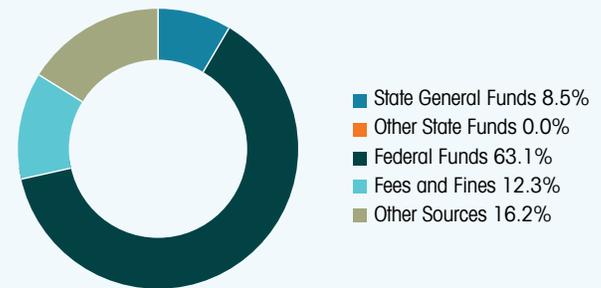
The state/territorial agency has achieved accreditation.

### Agency Workforce

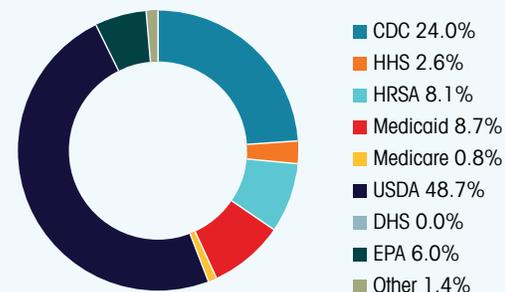
The state/territorial health agency has 674 FTEs, including 61 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



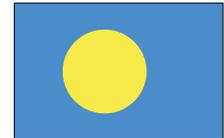
Federal Funding Sources



**Total Revenue FY15: \$234,501,887**  
**Total Federal Revenue FY15: \$147,904,287**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# PALAU



## Agency Mission

To ensure that all members of the community have access to the resources, education, knowledge, and services needed to achieve the highest possible level of health.

## Top Five Priorities

- 1 Strategic planning
- 2 Workforce development
- 3 Health promotion
- 4 Surveillance and data capacity building
- 5 Research and policy development

### *Structure and Relationship with Local Health Departments*

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency.”

### *Organizational Structure*

The health official reports directly to the U.S. Secretary of Health and Human Services.

The state/territory does not have a board of health.

### *Planning and Accreditation*

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

- ✓ Health Assessment
- ✗ Health Improvement Plan
- ✓ Strategic Plan

**The state/territorial health agency plans to apply for accreditation, but has not yet registered in e-PHAB.**

### *Agency Workforce*

The state/territorial health agency has 145 FTEs.



# PENNSYLVANIA



## Agency Mission

To promote healthy lifestyles, prevent injury and disease, and to assure the safe delivery of quality health care for all Commonwealth citizens.

## Top Five Priorities

- 1 Develop a culture of data-driven quality improvement
- 2 Continue to work toward public health accreditation
- 3 Publish four-year Health Innovation in Pennsylvania Implementation Plan
- 4 Implement Prescription Drug Monitoring Program
- 5 Publish four-year strategic plan

### Structure and Relationship with Local Health Departments

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

- 10** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 6** State-run regional or district offices  
(led by state employees)

### Organizational Structure

The health official does not report directly to the governor. The state has a health policy board, which is similar to a board of health.

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

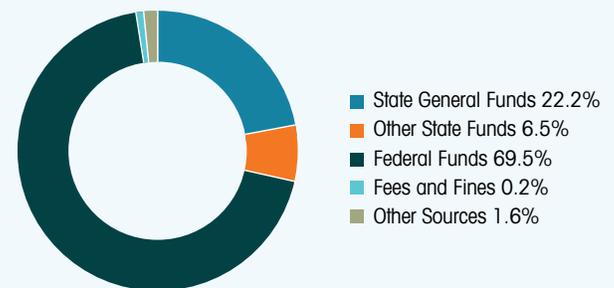
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

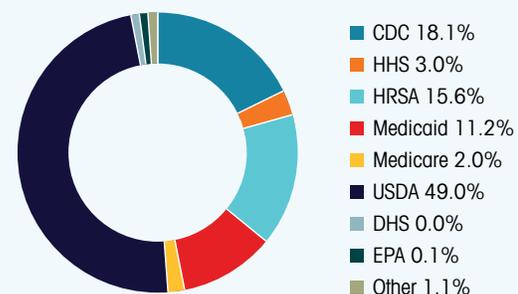
The state/territorial health agency has 1,105 FTEs, including 472 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$1,774,568,000**  
**Total Federal Revenue FY15: \$616,500,000**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# PUERTO RICO

## Agency Mission

To prevent diseases, promote and maintain health so that each human being reaches physical, emotional, and social well-being that allows for the full enjoyment of life and contribution to the productive efforts of human society.

## Top Five Priorities

- 1 Institutionalize the use of health information technology
- 2 Improve resource acquisition and management to optimize health impact
- 3 Strengthen the department of health using accreditation
- 4 Strengthen the infrastructure to support sustainable collaboration
- 5 Medicare and Medicare parity of funds

### *Structure and Relationship with Local Health Departments*

The state/territorial health agency is a freestanding/independent agency.

### *Organizational Structure*

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

### *Planning and Accreditation*

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

- ✓ Health Assessment
- ✗ Health Improvement Plan
- ✓ Strategic Plan

**The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.**

### *Agency Workforce*

The state/territorial health agency has 4,894 FTEs.



# REPUBLIC OF THE MARSHALL ISLANDS



## Agency Mission

To strengthen the commitment to the Healthy Islands concept by implementing health promotion to protect and promote healthy lifestyles; to improve the lives of the people through primary health; and to build the capacity of the Ministry of Health, communities, families, and partners to actively participate in and coordinate preventive services programs and activities as the core resources in primary health care services.

## Top Five Priorities

- 1 Address tuberculosis (TB), including multi-drug resistant TB
- 2 Eradicate leprosy
- 3 Reduce non-communicable diseases and their major risk factors
- 4 Protect against vaccine-preventable diseases
- 5 Fight childhood malnutrition

### *Structure and Relationship with Local Health Departments*

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency.”

### *Organizational Structure*

The health official does not report directly to the president of the Republic of the Marshall Islands. The state/territory has a board of health.

### *Planning and Accreditation*

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

- ✗ Health Assessment
- ✗ Health Improvement Plan
- ✓ Strategic Plan

**The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.**

### *Agency Workforce*

The state/territorial health agency has 570 FTEs.



# RHODE ISLAND



## Agency Mission

To positively demonstrate for Rhode Islanders the purpose and importance of public health.

## Top Five Priorities

- 1 Promote healthy living for all through all stages of life
- 2 Ensure access to safe food, water, and healthy environments in all communities
- 3 Promote a comprehensive health system that a person can navigate, access, and afford
- 4 Prevent, investigate, control, and eliminate health hazards and emerging threats
- 5 Analyze and communicate data to improve the public's health

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 0 **Independent local health agencies**  
(led by staff employed by local government)
- 0 **State-run local health agencies**  
(led by staff employed by state government)
- 0 **Independent regional or district offices**  
(led by non-state employees)
- 0 **State-run regional or district offices**  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

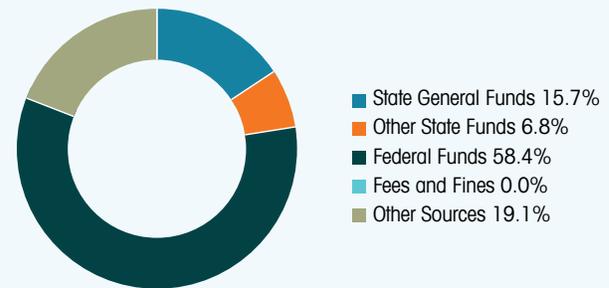
The state/territorial agency has achieved accreditation.

### Agency Workforce

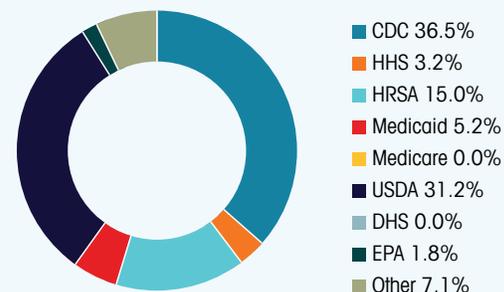
The state/territorial health agency has 444 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$124,790,005**  
**Total Federal Revenue FY15: \$72,886,752**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# SOUTH CAROLINA

## Agency Mission

To improve the quality of life for all South Carolinians by protecting and promoting the health of the public and the environment.

## Top Five Priorities

- 1 Securing and aligning financial resources with strategic initiatives
- 2 Reducing obesity rates
- 3 Achieving national public health accreditation
- 4 Promoting health equity and environmental justice
- 5 Recruiting and retaining the public health workforce

### Structure and Relationship with Local Health Departments

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

- 0 Independent local health agencies  
(led by staff employed by local government)
- 63 State-run local health agencies  
(led by staff employed by state government)
- 0 Independent regional or district offices  
(led by non-state employees)
- 4 State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✗ Health Assessment
- ✗ Health Improvement Plan
- ✓ Strategic Plan

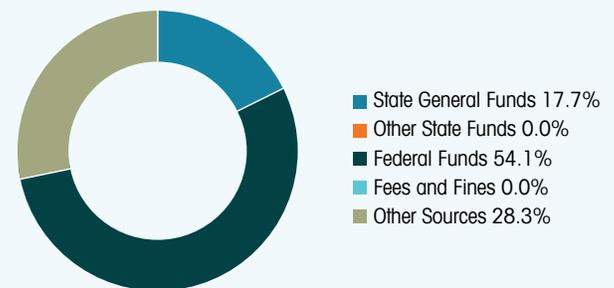
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

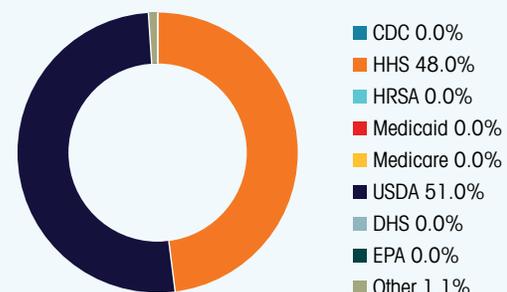
The state/territorial health agency has 2,991 FTEs, including 1,538 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$376,996,654**  
**Total Federal Revenue FY15: \$196,163,626**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# SOUTH DAKOTA

## Agency Mission

To promote, protect, and improve the health of every South Dakotan.

## Top Five Priorities

- 1 Improve the quality, accessibility, and effective use of healthcare
- 2 Support lifelong health for South Dakotans
- 3 Prepare for, respond to, and prevent public health threats
- 4 Develop and strengthen strategic partnerships to improve public health
- 5 Maximize the effectiveness and strengthen infrastructure of the department of health

### Structure and Relationship with Local Health Departments

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

- 1** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 7** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✗ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

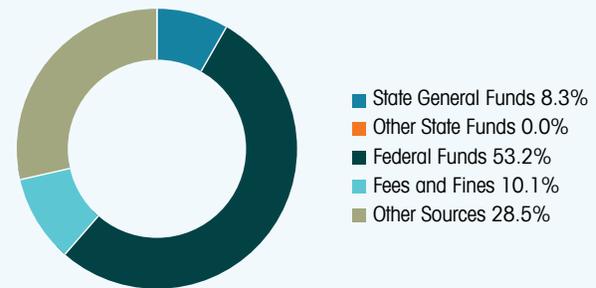
The state/territorial agency has not decided whether to apply for accreditation.

### Agency Workforce

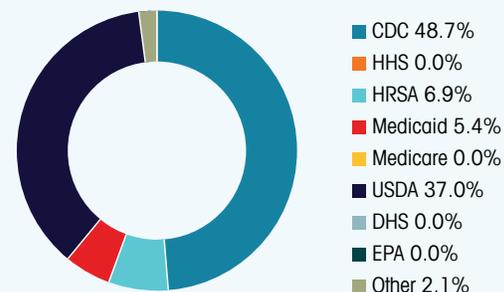
The state/territorial health agency has 430 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$99,623,583**  
**Total Federal Revenue FY15: \$95,846,372**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# TENNESSEE



## Agency Mission

To protect, promote, and improve the health and prosperity of people in Tennessee.

## Top Five Priorities

- 1 Reduce tobacco use
- 2 Reduce obesity
- 3 Increase physical activity
- 4 Decrease substance abuse, especially opioids
- 5 Improve organizational functioning using the Baldrige Model

### Structure and Relationship with Local Health Departments

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

- 0 Independent local health agencies  
(led by staff employed by local government)
- 89 State-run local health agencies  
(led by staff employed by state government)
- 6 Independent regional or district offices  
(led by non-state employees)
- 7 State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

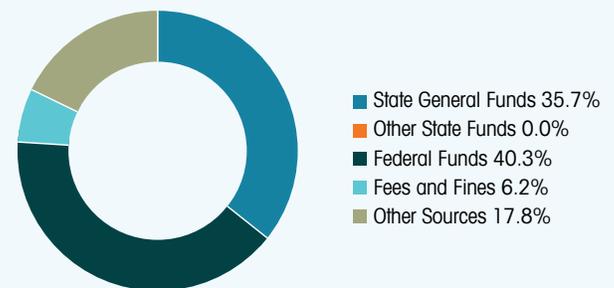
The state/territorial agency has not decided whether to apply for accreditation.

### Agency Workforce

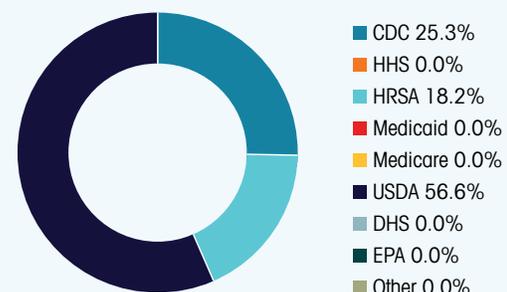
The state/territorial health agency has 2,913 FTEs, including 1,799 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$527,722,832**  
**Total Federal Revenue FY15: \$209,648,883**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# TEXAS



## Agency Mission

To improve health and well-being in Texas.

## Top Five Priorities

- 1 Improve health through prevention
- 2 Improve health through safety net services
- 3 Enhance public health response to disasters and disease outbreaks
- 4 Address emerging changes in the health delivery system
- 5 Protect consumers through regulation

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 59** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 8** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

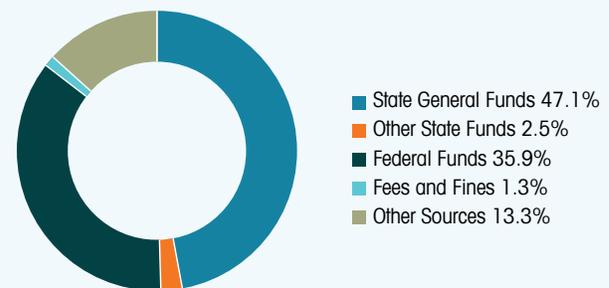
The state/territorial agency has decided not to apply for accreditation.

### Agency Workforce

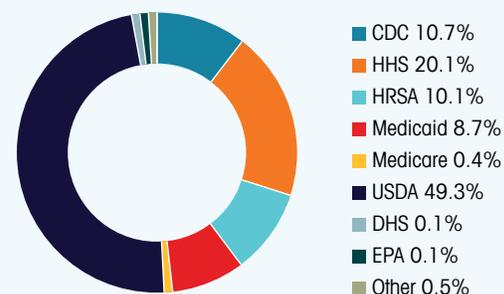
The state/territorial health agency has 11,181 FTEs, including 9,397 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$3,198,763,971**  
**Total Federal Revenue FY15: \$1,147,960,636**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# U.S. VIRGIN ISLANDS



## Agency Mission

To achieve health equity through public health transformation.

## Top Five Priorities

- 1 Staff recruitment for current vacancies
- 2 Staff training and development
- 3 Agency reorganization and stabilization
- 4 Implementing activities to address health equity
- 5 Zika response

### *Structure and Relationship with Local Health Departments*

The state/territorial health agency is a freestanding/independent agency.

### *Organizational Structure*

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

### *Planning and Accreditation*

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

- × Health Assessment
- × Health Improvement Plan
- × Strategic Plan

**The state/territorial agency has not decided whether to apply for accreditation.**

### *Agency Workforce*

The state/territorial health agency has 359 FTEs.



# UTAH



## Agency Mission

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

## Top Five Priorities

- 1 Utahans will be the healthiest people
- 2 Medicaid expansion under the Affordable Care Act
- 3 Opioid overdose prevention
- 4 Medical examiner caseload
- 5 Early intervention caseload growth

### Structure and Relationship with Local Health Departments

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

- 13** Independent local health agencies (led by staff employed by local government)
- 0** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

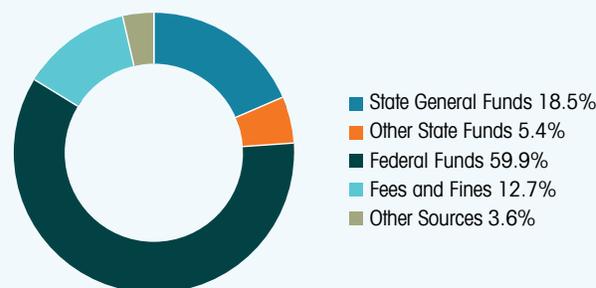
The state/territorial agency has submitted an application for accreditation.

### Agency Workforce

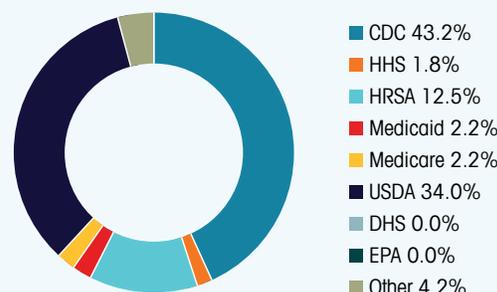
The state/territorial health agency has 1,012 FTEs. There are no state/territorial health agency workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$227,951,260**  
**Total Federal Revenue FY15: \$136,442,615**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# VERMONT



## Agency Mission

To protect and promote the best health for all Vermonters.

## Top Five Priorities

- 1 Improve childhood immunization rates
- 2 Reduce prevalence of mental illness
- 3 Reduce prevalence of substance abuse
- 4 Reduce tobacco use
- 5 Increase good nutrition and physical activity

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 0 **Independent local health agencies**  
(led by staff employed by local government)
- 0 **State-run local health agencies**  
(led by staff employed by state government)
- 0 **Independent regional or district offices**  
(led by non-state employees)
- 12 **State-run regional or district offices**  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

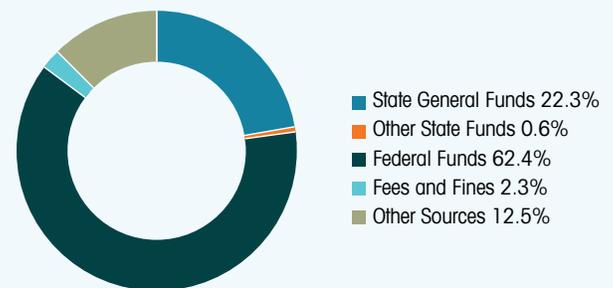
The state/territorial agency has achieved accreditation.

### Agency Workforce

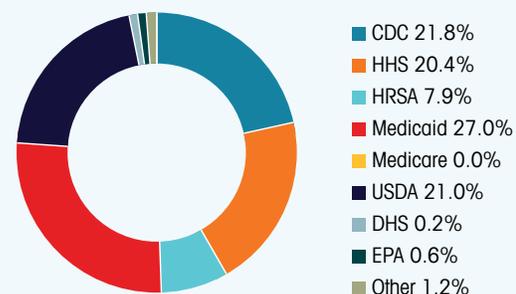
The state/territorial health agency has 532 FTEs, including 147 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$118,226,771**  
**Total Federal Revenue FY15: \$73,698,737**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# VIRGINIA



## Agency Mission

To promote and protect the health of all Virginians.

## Top Five Priorities

- 1 Improve the health of Virginians and decrease healthcare costs by controlling communicable disease
- 2 Improve the health and well-being of families by improving family planning and decreasing unintended pregnancies
- 3 Improve food security and nutrition for at-risk Virginians
- 4 Prevent foodborne disease outbreaks in both public and private settings
- 5 Assure the provision of clean, safe drinking water to all Virginians.

### Structure and Relationship with Local Health Departments

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

- 2** Independent local health agencies (led by staff employed by local government)
- 128** State-run local health agencies (led by staff employed by state government)
- 0** Independent regional or district offices (led by non-state employees)
- 0** State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✗ Strategic Plan

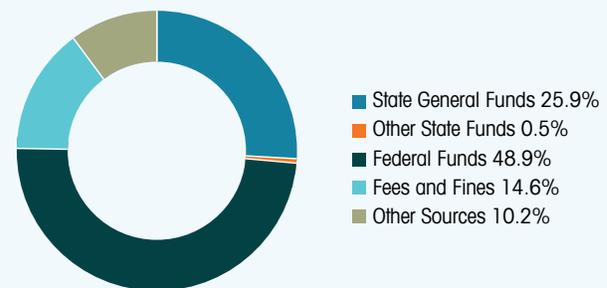
The state/territorial agency has registered in e-PHAB in order to pursue accreditation.

### Agency Workforce

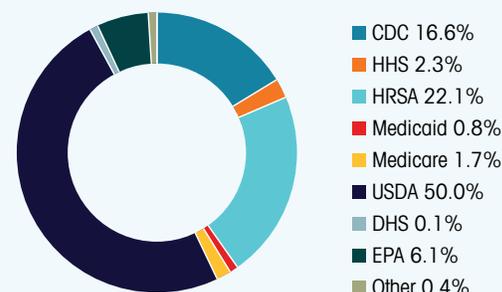
The state/territorial health agency has 3,682 FTEs, including 2,591 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$633,778,537**  
**Total Federal Revenue FY15: \$309,239,289**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# WASHINGTON



## Agency Mission

To protect and improve the health of all people in Washington state.

## Top Five Priorities

- 1 Implement plans to achieve End AIDS Washington goals
- 2 Describe, plan for, track, and begin mitigating and adapting for the public health impacts of climate change
- 3 Secure sustainable funding for Foundational Public Health Services
- 4 Reduce the use of tobacco, e-cigarettes/vaping devices, and marijuana in persons under 21 years old
- 5 Ensure health equity and improve population health

### Structure and Relationship with Local Health Departments

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

- 35** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 4** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

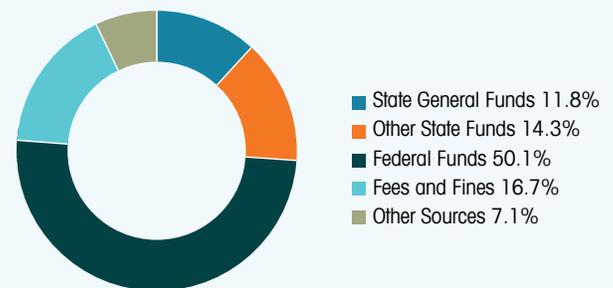
The state/territorial agency has achieved accreditation.

### Agency Workforce

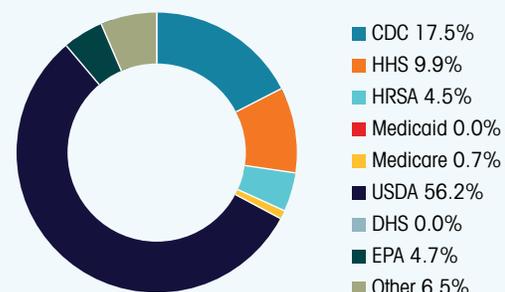
The state/territorial health agency has 1,576 FTEs, including 273 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$510,767,432**  
**Total Federal Revenue FY15: \$255,963,855**

\*FY15 was defined as 7/1/2014 – 6/30/2015.



# WEST VIRGINIA

## Agency Mission

To have healthy people and communities and to help shape the environments within which people and communities can be safe and healthy.

## Top Five Priorities

- 1 Decrease prevalence of obesity and associated factors
- 2 Reduce tobacco use and associated conditions
- 3 Focus on improving mental health and reducing substance abuse
- 4 Focus on preventable care and avoidable costs
- 5 Strengthen evidence-based healthcare, data, and outcomes

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 49** Independent local health agencies  
(led by staff employed by local government)
- 0** State-run local health agencies  
(led by staff employed by state government)
- 2** Independent regional or district offices  
(led by non-state employees)
- 0** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✓ Health Assessment
- ✓ Health Improvement Plan
- ✓ Strategic Plan

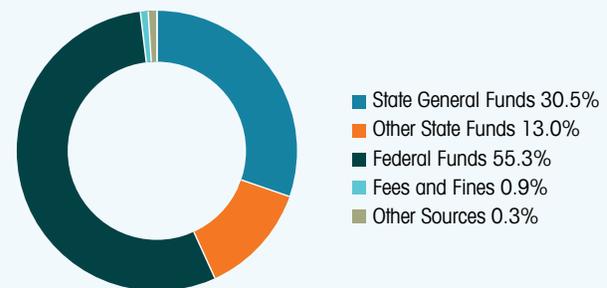
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

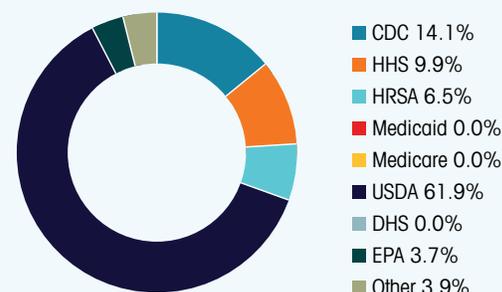
The state/territorial health agency has 684 FTEs, including 76 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$225,264,361**  
**Total Federal Revenue FY15: \$124,161,700**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# WISCONSIN



## Agency Mission

To protect and promote the health and safety of people of Wisconsin.

## Top Three Priorities

- 1 State public health accreditation
- 2 Timely completion of the Wisconsin Health Improvement Plan
- 3 Develop emergency preparedness, response, and recovery procedures that promote a continuum of care in regulated health and residential care facilities

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 0 Independent local health agencies (led by staff employed by local government)
- 0 State-run local health agencies (led by staff employed by state government)
- 0 Independent regional or district offices (led by non-state employees)
- 5 State-run regional or district offices (led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- × Health Assessment
- × Health Improvement Plan
- × Strategic Plan

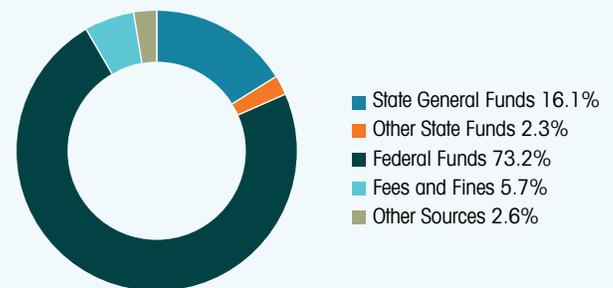
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

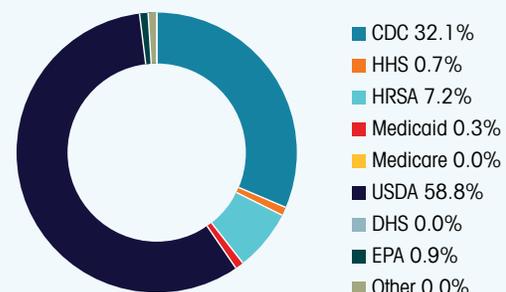
The state/territorial health agency has 470 FTEs, including 46 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



Federal Funding Sources



**Total Revenue FY15: \$236,803,750**  
**Total Federal Revenue FY15: \$173,403,175**

\*FY15 was defined as 7/1/2014 – 6/30/2015.

# WYOMING



## Agency Mission

To promote, protect, and improve health and prevent disease and injury in Wyoming.

## Top Five Priorities

- 1 Fostering programmatic excellence
- 2 Developing efficiencies in program operations
- 3 Focusing on population-based services versus direct care services
- 4 Providing cost-effective professional development for staff
- 5 Promoting value/relevance of public health

### Structure and Relationship with Local Health Departments

The state/territorial health agency is under a larger agency—sometimes referred to as a “superagency” or “umbrella agency”—and has a mixed relationship with local health departments.

- 5** Independent local health agencies  
(led by staff employed by local government)
- 18** State-run local health agencies  
(led by staff employed by state government)
- 0** Independent regional or district offices  
(led by non-state employees)
- 0** State-run regional or district offices  
(led by state employees)

### Organizational Structure

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

### Planning and Accreditation

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

- ✗ Health Assessment
- ✗ Health Improvement Plan
- ✓ Strategic Plan

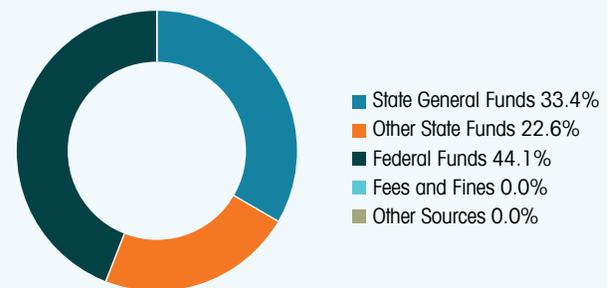
The state/territorial agency plans to apply for accreditation, but has not yet registered in e-PHAB.

### Agency Workforce

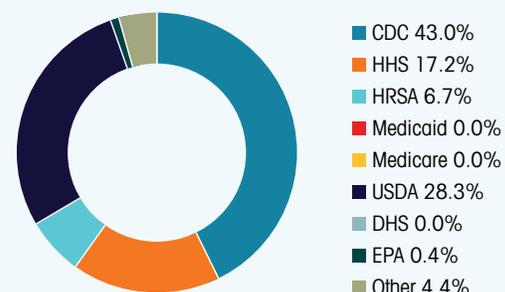
The state/territorial health agency has 1,457 FTEs, including 91 state/territorial workers assigned to local/regional offices.

### Agency Finance (FY15\*)

Source of Funding



### Federal Funding Sources



**Total Revenue FY15: \$64,144,454**  
**Total Federal Revenue FY15: \$28,265,957**

\*FY15 was defined as 7/1/2014 – 6/30/2015.





*The ASTHO Profile of State and Territorial Public Health, Volume Four* 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.

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**ASTHO Profile of State and Territorial Public Health**  
Volume Four

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