Attachment F

# ASTHO Profile of State Public Health

## Volume Three

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# Contents


Acknowledgments . . . . . 4

A Letter from the Executive Director . . . . . 5

A Letter from CDC . . . . . 6

A Letter from RWJF . . . . . 7

Executive Summary . . . . . 9

Top 20 . . . . . 10

Introduction . . . . . 12

Part I–State Public Health: Who We Are . . . . . 16

Chapter 1: State Health Agency Structure, Governance, and Priorities . . . . . 17

Chapter 2: State Health Agency Workforce . . . . . 28

Part II–State Public Health: What We Do . . . . . 40

Chapter 3: State Health Agency Activities . . . . . 41

Part III–State Public Health: How We Do It . . . . . 58

Chapter 4: Planning and Quality Improvement . . . . . 59

Chapter 5: Health Information Management . . . . . 68

Chapter 6: State Health Agency Finance . . . . . 78

State Profiles . . . . . 91

# Acknowledgments

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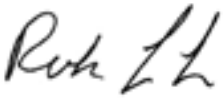
We are thankful to Jim Pearsol for his leadership, guidance, and dedication to state public health. The members of the ASTHO Survey Advisory Workgroup and Data Harmonization Workgroup provided thoughtful recommendations and useful suggestions for further improvement of the survey throughout the process.

Kyle Bogaert assisted in followup with state health agencies, cleaned and analyzed the data, and generated the tables and figures that appear in this report. Kunthea Nhim verified all of the data in the report and created a master codebook, available online at **www.astho.org/profile**, which allows researchers to compare the 2007, 2010, and 2012 questionnaires item by item.

Lisa Junker and ASTHO's Communications team provided editorial support. PCE Systems developed and hosted the web-based survey. Belmont, Inc. designed the publication and Linemark printed it.

Most importantly, we would like to thank the staff of the 49 state health agencies that responded to the survey. They put a substantial amount of effort into answering the lengthy questionnaire that forms the basis of this dataset. We appreciate their commitment to their work and their willingness to make time for this important effort.

Katie Sellers, DrPH, CPH
Chief Science & Strategy Officer
ASTHO



Rivka Liss-Levinson, PhD
Director, Survey Research
ASTHO

# A Letter from the Executive Director

I am honored to share the ***ASTHO Profile of State Public Health, Volume Three***, with results from our third survey of state and territorial health agencies. Since 2007, the profile report has served as an essential guide to understanding the current activities of state health agencies and new developments on issues such as governance, quality improvement and accreditation, workforce, finance, and health information technology. I hope you enjoy this comprehensive look at state public health.

Volume three of the ***ASTHO Profile of State Public Health*** details some exciting developments and continued challenges for state health agencies. The survey found that they are making substantial strides forward to complete the prerequisites for national voluntary accreditation through the Public Health Accreditation Board. The percentage of state health agencies that have completed a state health assessment plan, state health improvement plan, and agency-wide strategic plan has increased from 2010 to 2012.

Many health agencies have also made significant progress in their use of health information exchanges and health information technology. States are increasingly engaging in bidirectional information sharing and using health information exchanges to monitor and communicate about a variety of health topics.

Both of these accomplishments speak to the resilience of state health departments in the face of budget cuts. Despite limited funding and an estimated decrease in the size of the state health agency workforce from 2010 to 2012 of nearly 6,000 full-time equivalents, agencies continue to provide a broad array of services and are taking on new projects and initiatives to further improve health and well-being in their jurisdictions.

We remain continuously grateful to ASTHO's members for devoting time and effort to completing this exhaustive 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 and 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 your support for state public health.

Paul E. Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials

# A Letter from CDC

Dear Colleague:


The Centers for Disease Control and Prevention (CDC) is pleased to have supported the Association of State and Territorial Health Officials (ASTHO) in its work to develop the ***ASTHO Profile of State Public Health, Volume Three***. CDC congratulates ASTHO for the release of this report, which will help state and local health departments, policymakers, federal agencies, governing bodies, researchers, and others better understand the foundational public health capabilities of our nation's states.

The ***ASTHO Profile of State Public Health, Volume Three*** provides comprehensive data about state health department responsibilities, organization and structure, workforce, planning, and quality improvement activities. I would like to commend ASTHO and the state health departments that provided these data for their dedication and contribution to public health. We anticipate that the data presented in this report will provide many opportunities to inform policy, practice, and research, as well as advance our mutual goal of improving population health outcomes.

Sincerely,

Thomas R. Frieden, MD, MPH
Director, CDC

Judith A. Monroe, MD
Director, Office for State, Tribal, Local, and Territorial Support, and
Deputy Director, CDC

# A Letter from RWJF

Dear Colleague:

We are pleased to support the ***ASTHO Profile of State Public Health, Volume Three***. This report provides a comprehensive look at state public health that enables public officials and policymakers to make critical, well-informed decisions working with partners across the public and private sectors to strengthen America's public health system.

This profile is part of a collaborative effort between ASTHO and the National Association of City and County Health Officials (NACCHO)—with leadership from the National Coordinating Center for Public Health Services and Systems Research (PHSSR) at the University of Kentucky—to develop a complete picture of governmental public health in the United States. This partnership assists in identifying best practices to organize, manage, finance, and structure public health systems and services and to answer questions relevant to public health practice and policymaking, including those emerging in our work with CDC to develop a national agenda for PHSSR. In addition, information in the profile on key trends such as state health agencies' intent to pursue accreditation and use of health information technology to communicate about a variety of health topics informs the system-level changes that are needed to improve the nation's health.

We applaud the 49 agencies that so generously devoted time and effort to respond to the questionnaire. It is a testament to your dedication and to the leadership of ASTHO to ensure the success of this effort. I would like to express our gratitude and commend all who have contributed to this invaluable resource, and I look forward to continuing our work together building a national Culture of Health.

Risa Lavizzo-Mourey, MD, MBA
President and CEO
Robert Wood Johnson Foundation

# Executive Summary

The ASTHO Profile of State Public Health, Volume Three highlights findings from the 2012 ASTHO Profile Survey. ASTHO is the national nonprofit organization representing public health agencies in the United States, its territories and freely-associated states, and the District of Columbia and the more than 100,000 public health professionals that these agencies employ. ASTHO members, the chief health officials of these jurisdictions, develop and influence public health policy and ensure excellence in state-based public health practice. ASTHO's primary function is to track, evaluate, and advise its members on the impact and formation of public or private health policy that may affect them and provide them with guidance and technical assistance on improving the nation's health.

The ASTHO Profile of State Public Health is the only comprehensive source of information about state 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 public health services, identify variations in practice among state public health agencies, and contribute to the development of best practices in governmental public health.

This report describes the structure, functions, and resources of state health agencies and indicates what data are available for public use from the 2012 ASTHO Profile Survey. Comparisons by state governance classification, geographic region, and state population size are discussed when appropriate. Also, when applicable, the 2012 findings are compared with data from the 2010 and 2007 ASTHO Profile Surveys.

**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 101,000 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 conducted by state health agencies. Activities documented include prevention; screening and treatment services; laboratory services; data, epidemiology, and surveillance activities; maternal and child health services; environmental health activities; and research activities, among others. 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.

**State Profiles** provide a snapshot of the health agencies in each of the 48 responding states and the District of Columbia, including information about their governance, finances, local health departments, and top priorities.

To view or download the complete Profile report, or request access to Profile data, visit 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 20

The top 20 consists of the most significant, timely, and relevant findings from the 2012 ASTHO Profile Survey. They include the following:

1. Nearly 30 percent of states (n=14) have a centralized or largely centralized governance structure where local health units are primarily led by state employees, with a mean number of 28 state-run local health departments in each state.
2. State health agencies do not generally share resources with each other. When they do, it is typically for all-hazards preparedness and response (58%) and epidemiology or surveillance (36%).
3. State health agencies serve as leaders in the integration of the public health and healthcare sectors by being highly collaborative with hospitals, physicians, and other entities in the healthcare sector.
4. The state health agency workforce was comprised of approximately 101,000 full-time equivalents (FTEs) in 2012. From 2010 to 2012, both the number of FTEs and the number of staff members have shown a decrease of more than 5,000.
5. The 2012 Profile Survey represents the first time ASTHO has collected demographic data on the state health agency workforce. The majority of the state health agency workforce is white, non-Hispanic/Latino, and female. Overall, the state health agency workforce has a greater proportion of women than the U.S. population, is more racially diverse than the U.S. population, and has a smaller proportion of Hispanics/Latinos than the overall U.S. population.
6. In 2012, 12 percent of state health agency positions were vacant on average, but only 24 percent of those positions were being actively recruited for.
7. From FY 2012 to FY 2016, the percentage of state health agency employees who are eligible to retire is expected to increase from 18 to 25 percent.
8. State health agencies frequently have programmatic and fiscal responsibility for federal initiatives. When they do not have sole responsibility, they typically share it with a local governmental agency or nonprofit organization. Nearly all state health agencies have responsibility for CDC's Public Health Emergency Preparedness cooperative agreement, Title V Maternal and Child Health funding, vital statistics, the Preventive Health and Health Services Block Grant, and the ASPR Hospital Preparedness Program cooperative agreement.
9. State health agencies provide technical assistance and training to a variety of partners, including emergency medical services, healthcare providers, hospitals, and laboratories. The most common topic area for which technical assistance and training are provided is quality improvement, accreditation, and performance. States most commonly provide training for local health departments. The most common training topics are disease prevention and control, tobacco prevention and control services, and preparedness.
10. State health agencies serve a critical role in promoting and protecting the health of their citizens, and access to healthcare services is a key element of that effort. The majority of state health agencies engage in health disparities, minority health, and rural health initiatives; 71% of state health agencies provide financial support to primary care providers.

11. State health agencies provide a wide range of population-based primary prevention services. The greatest numbers of states provide tobacco prevention and control services, HIV prevention programs, and sexually transmitted disease counseling and partner notification.

12. Research plays an important role at state health agencies, with 90 percent reporting both collecting, exchanging, or reporting on data and results and disseminating research findings to stakeholders. The mean number of studies conducted by state health agencies in the two-year timeframe was 46 and the median number was 15.

13. State health agencies have been engaged in accomplishing the prerequisites for the Public Health Accreditation Board's (PHAB) voluntary national accreditation program, with 69 percent having completed a state health assessment, 57 percent a state health improvement plan, and 75 percent a strategic plan. From 2010 to 2012, the percentage of state health agencies that have completed each prerequisite has increased.

14. In 2012, 80 percent of state health agencies indicated that they had decided to seek accreditation through the voluntary national accreditation program. Of the 26 states that indicated that they planned to pursue accreditation but had not yet submitted a letter of intent, 85 percent intended to do so in 2013 or 2014.

15. Quality improvement continues to play a significant role in state health agencies, with state health agencies frequently using the Plan-Do-Check-Act or Plan-Do-Study-Act framework, and 96 percent of agencies having implemented some kind of formal quality improvement activities.

16. The capacity for electronic data exchange is significant at state health agencies, with the majority of electronic data collected through systems implemented on the state level.

17. State health agencies have made progress toward the Meaningful Use public health objectives, with the majority of state health agencies having the systems in place to meet those objectives. Additionally, the majority of state health agencies have the capacity to send and receive data with federal agencies.

18. For FY 2010 and FY 2011, the two largest spending categories in state health agency budgets were improving consumer health, which includes clinical services, and WIC.

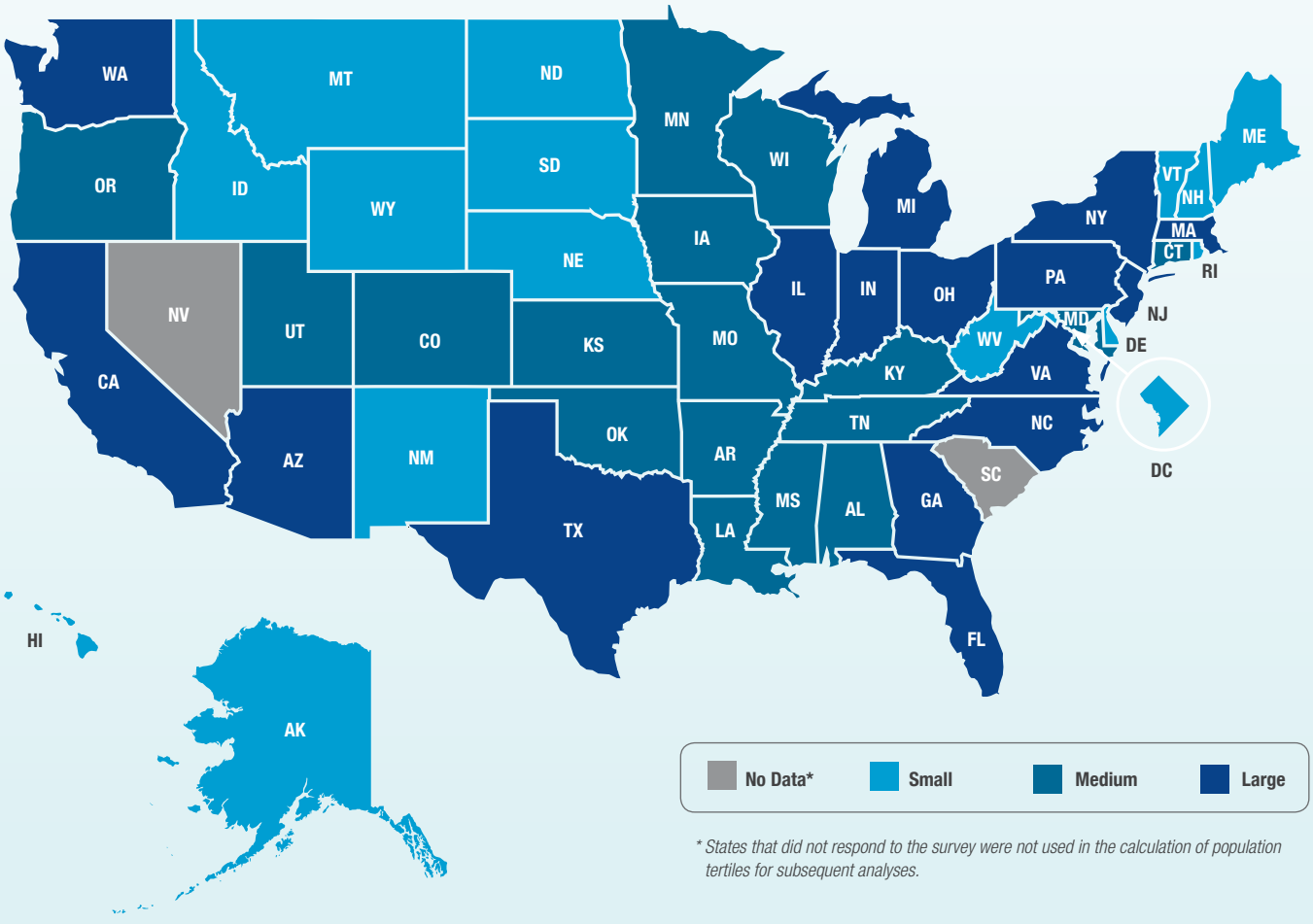
19. More than half of state health agency revenue (53%) was sourced from federal funds in FY 2011, with the U.S. Department of Agriculture and CDC providing the greatest percentage of those funds.

20. State health agencies partner with a number of other entities, distributing funding to local health departments, nonprofit organizations, other governmental entities, and other recipients. Forty-four percent of state health agency contracts, grants, and awards were awarded to local health departments.

# Introduction

This report marks the 2014 release of the Association of State and Territorial Health Officials (ASTHO) Profile Survey of State Public Health. The ASTHO Profile Survey 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 public health services, identify variations in practice among state public health agencies, and contribute to the development of best practices in governmental public health. The Profile drives improvement at state health agencies, educates policymakers, enables the sharing of best practices among state health agencies, and is a resource to the field of public health systems and services research (PHSSR). This is the third survey in a series; prior surveys were completed by state and territorial health agencies in 2007 and 2010. In October 2012, ASTHO launched the third version, sending a link to the web-based survey to senior deputies from the 50 states, DC, and eight territories and freely associated states. The 121-question instrument covers the following topic areas:

**Figure 0.1: State Population Size**

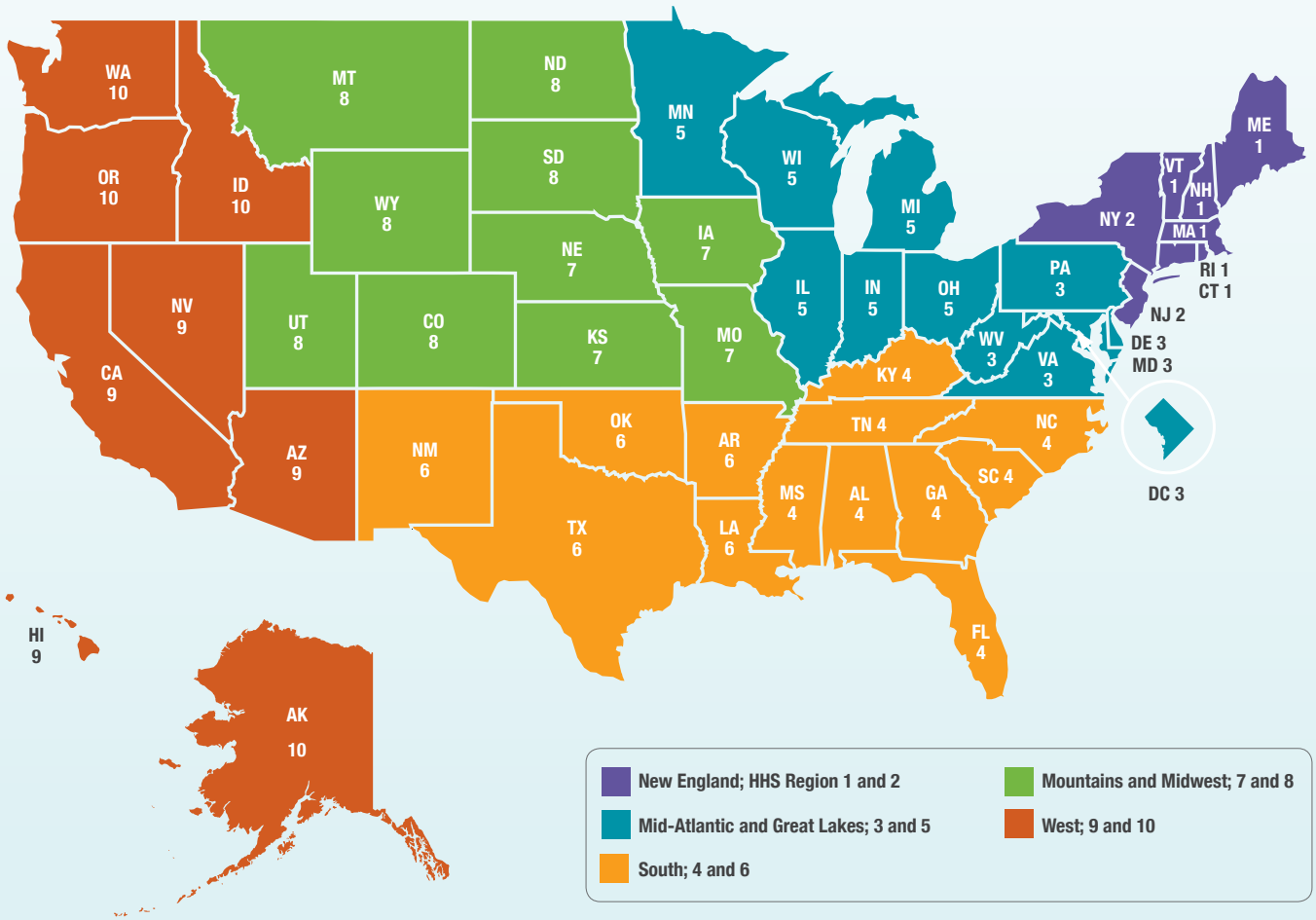



** States that did not respond to the survey were not used in the calculation of population tertiles for subsequent analyses.*

1. Structure, governance, and priorities
2. Workforce
3. State health agency activities
4. Planning and quality improvement
5. Health information management
6. Finance

Along with general instructions, senior deputies received recommendations on the most appropriate staff/departments to fill out each section of the survey. Surveys could be filled out by multiple personnel in multiple sittings. A question-and-answer webinar was held midway through the survey administration period to clarify instructions, resolve technical issues, and respond to item-specific questions. Senior deputies were asked to complete the survey by Dec. 1, 2012. However, the survey administration system was held open until May 2013 to allow as many states and territories to complete the survey as possible. At the close of survey administration, the Profile Survey response rate was 96 percent among the 50 states and DC, and 92 percent among all states, territories, and freely associated states. Results from the five territories and freely associated states that responded to the survey will be published in a separate report. Extensive followup was conducted with the states throughout 2013 to verify responses. When response errors were identified, ASTHO's Survey Research team worked with the state to correct these responses. In instances where the state did not respond to multiple follow-up attempts, the Survey Research team used their expertise to determine whether or not to retain the data.

**Figure 0.2: Combined Health and Human Services Regional Classification**

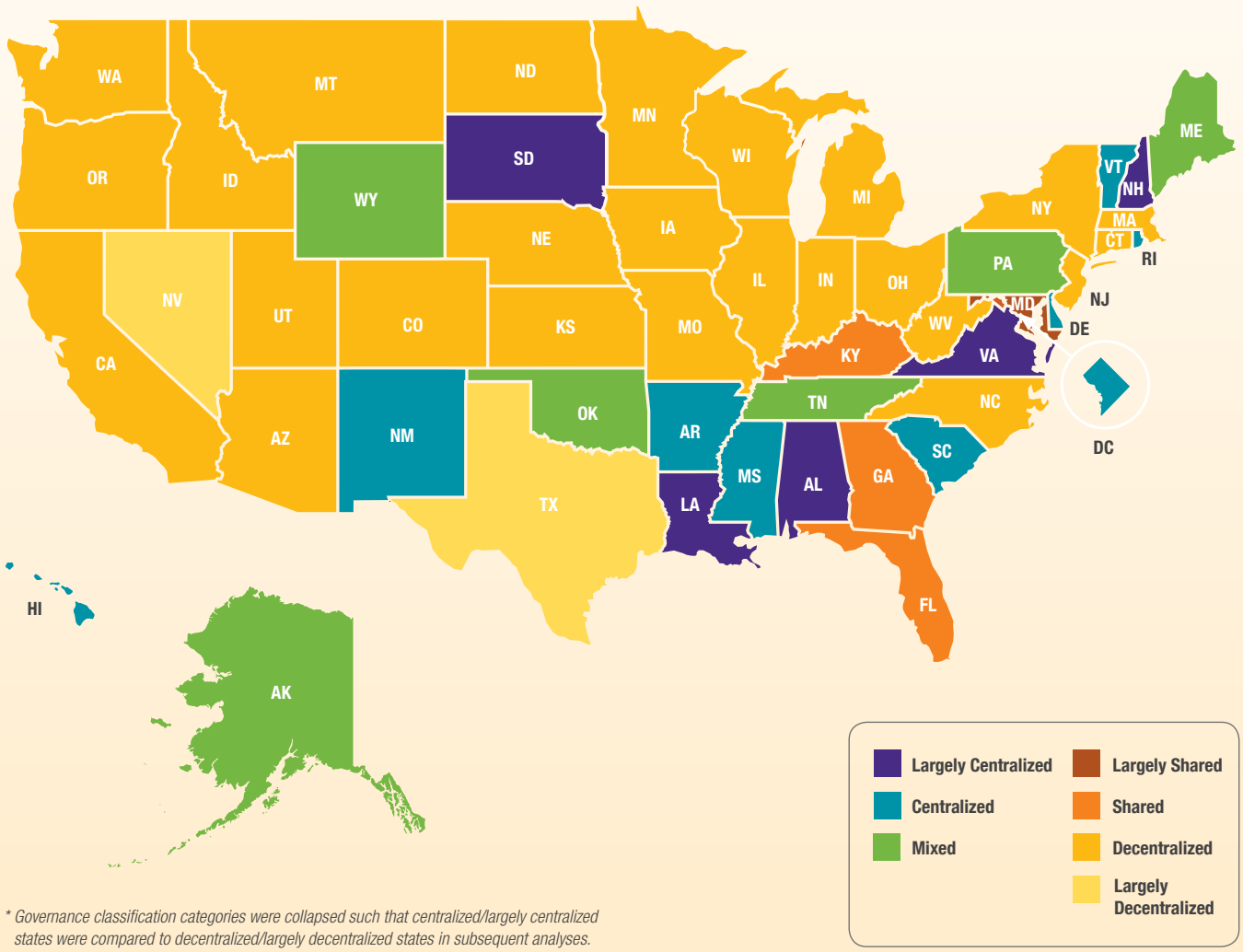


## Differences Between Surveys

In an effort to continuously improve the Profile Survey and the quality of our data, several notable changes were made to the survey from the 2010 version. ASTHO convened a Survey Advisory Workgroup consisting of state health agency senior staff, researchers, ASTHO staff and alumni, and representatives from national public health partner organizations to review initial drafts of the survey instrument, make recommendations on content, formatting, survey administration, and analyses, and pilot test the survey. Staff also leveraged the expertise of two of ASTHO's peer networks, the Human Resources (HR) 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 2010 Profile Survey evaluation report were used to make revisions to the 2012 survey instrument, including the following:

1. The number of questions in the Structure, Governance, and Priorities sections of the survey was significantly reduced between 2010 and 2012.
2. Questions about state health official authority, qualifications, and salary were moved to the Workforce section. ASTHO recommended that HR directors fill out these questions instead of state health officials. In addition, text boxes for additional comments and clarifications were included in the Workforce section based on the feedback of the HR Directors Peer Network.

**Figure 0.3: Governance Classifications***




** Governance classification categories were collapsed such that centralized/largely centralized states were compared to decentralized/largely decentralized states in subsequent analyses.*

3. Response options for the Activities section questions were modified between 2010 and 2012 to ease response burden and clarify instructions.
4. The Planning and Quality Improvement section was modified to ask additional questions about accreditation status and preparations.
5. The Health Information Management section was redesigned to collect the most useful information on health information exchanges and to include questions on Meaningful Use public health objectives.
6. In the Finance section, respondents were asked to report actual expenditures for a list of expenditure categories (e.g., chronic disease, all-hazards preparedness and response) by source of funding (e.g., state general funds, fees and fines). In addition, respondents were asked to further break down federal spending by source of funding (e.g., CDC, HRSA, Medicare) for each expenditure category.

## Structure of Report

The report is structured to provide a narrative of state 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. The third section of the report, 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 the following: Chapter 4: Planning and Quality Improvement, Chapter 5: Health Information Management, and Chapter 6: State Health Agency Finance. Finally, Part IV—State Profiles contains a one-page summary of key information about each state from the report.

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

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

1. **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, 2012 population estimates from the U.S. Census Bureau[1] were used. **Figure 0.1** displays a map of states by population size.
2. **Region of the United States**. Regional classifications are based on the U.S. Department of Health and Human Services regions,[2] which were paired to increase the number of state health agencies for comparison in each region. **Figure 0.2** displays a map of states by HHS region.
3. **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 Public Health, Volume Three is available online as a downloadable PDF on ASTHO's website at http://www.astho.org/Profile. Also available on this page is additional information about the Profile Survey, including a downloadable questionnaire, codebook, slides of all tables and figures that appear in this report, and several issue briefs and infographics. 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 surveyresearch@astho.org.

1 U.S. Census Bureau. "State & County QuickFacts." Available at http://quickfacts.census.gov/qfd/index.html. Accessed 3-5-2014.
2 U.S. Department of Health and Human Services. "HHS Region Map." Available at http://www.hhs.gov/about/regionmap.html. Accessed 3-5-2014.

Part I–State Public Health:

# Who We Are

# Chapter 1: 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 can vary; 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 appointment of the state health official, 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 2012 data with 2010 and 2007 data, when possible, and will note differences in structure by agency characteristics when applicable.

## Key Findings:

- In 2012, 28 state public health agencies (58%) are freestanding/independent agencies, while 20 (42%) are a unit of a larger umbrella agency.
- In 2012, 48 state public health agencies reported having a total of 2,744 local health departments and 298 regional or district offices.
- Twenty-two state health agencies (45%) report having a state board of health. An additional four states (8%) report having an entity that performs similar functions.
- States health agencies do not generally share resources with each other. When they do, it is typically for all-hazards preparedness and response (58%) and epidemiology or surveillance (36%).
- State health agencies report being highly collaborative with local public health agencies, hospitals, and many other entities in the healthcare field.
- In three-quarters of state health agencies (76%), the state health official is appointed by the governor of the state.

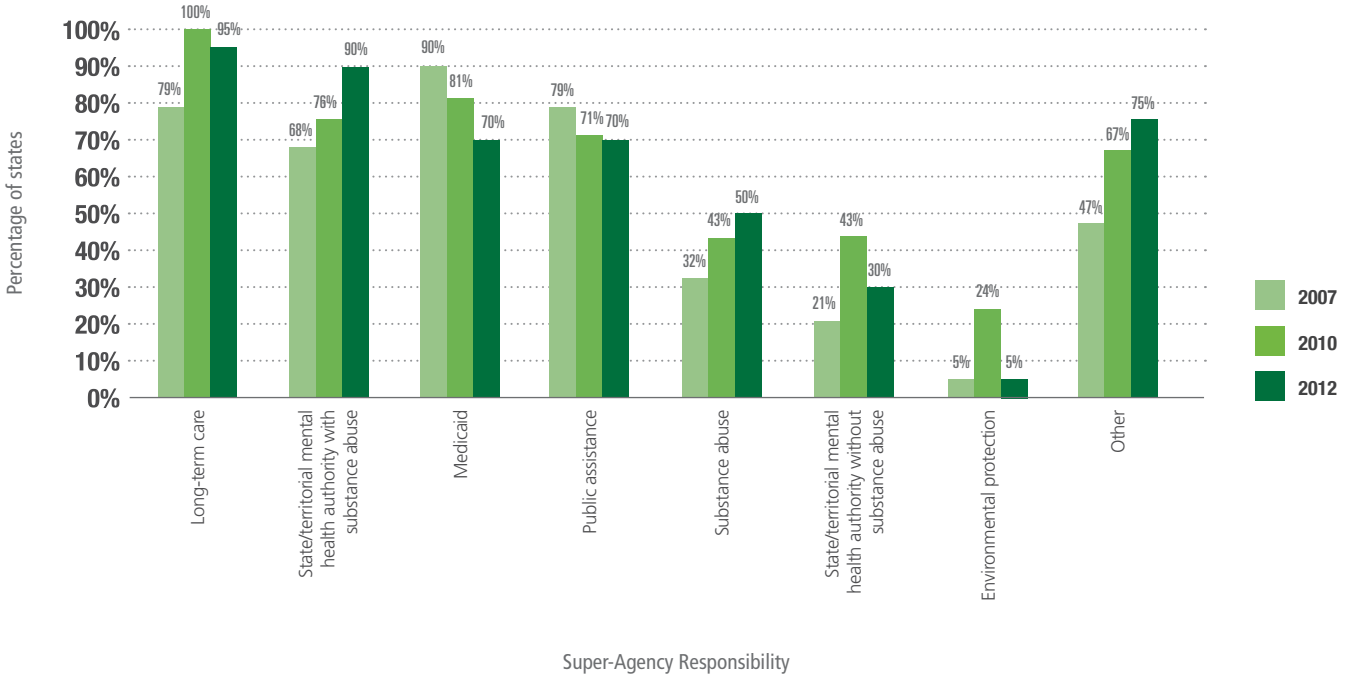
## Agency Structure

The structure of a state public health agency refers to the placement of the state public health agency within the larger departmental/organizational structure for the state. State public health agencies can either be freestanding/independent agencies or a unit of a larger agency, 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/or mental health services.

In 2012, 28 state public health agencies (58%) were freestanding/independent agencies, while 20 (42%) were a unit of a larger umbrella agency.[3] These proportions have remained almost identical to the percentages for 2007 and 2010 (in both years, 56% were freestanding/independent agencies and 44% were under a larger agency). While these numbers show that a net total of one state moved from being under a larger agency to being a freestanding/independent agency, it is worth noting that seven states actually changed structures from 2010 to 2012. A similar percentage of centralized/largely centralized[4] and decentralized/largely decentralized[5] states are freestanding/independent agencies (62% and 60%, respectively). Twice as many state health agencies in the South are freestanding/independent agencies (n=8) than are under a larger agency (n=4). States with medium and large populations are more likely to be freestanding/independent agencies (65% of medium-sized states and 80% of large states) than are states with small populations (31%).

States that reported being under a larger agency (n=19-21) were asked the major areas of responsibility of the larger agency that are separate from the statutory responsibility of the state/territorial public health agency. **Figure 1.1** shows the other major areas of responsibility of the larger agency that reported data in 2007, 2010, and 2012. In 2012, the top three areas of responsibility were long-term care (95%), state mental health authority with substance abuse (90%), and Medicaid and public assistance (both 70%). While responsibility for mental health and substance abuse has continued to rise among the larger umbrella agencies over time (68% in 2007, 76% in 2010, and 90% in 2012), responsibility for Medicaid has demonstrated the reverse trend (90% in 2007, 81% in 2010, and 70% in 2012). In the New England region, 75 percent of states report larger agency responsibility for mental health without substance abuse in 2012. In contrast, this service is provided by 0 to 33 percent of states in the other four regions. State health agencies in states with medium-sized populations are less likely to provide public assistance (33%) than are state health agencies in large states (67%) and small

**Figure 1.1: Responsibilities of Larger Umbrella Agencies, 2007-2012 (n=19-21)**



states (91%). None of the larger umbrella agencies in large states provide substance abuse services, while 64 percent of umbrella agencies in small states and 50 percent of those in medium states do. Only in small states (55%) do the larger umbrella agencies provide mental health without substance abuse services. No umbrella agencies in medium or large states do so.

## Numbers and Types of Local Health Departments

In 2012, 48 state public health agencies reported having a total of 2,744 local health departments and 298 regional or district offices.[6] **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 from 2010 to 2012.

The number of local and regional health departments shows an expected relationship with governance classification, such that 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 the South having a greater average number of state-run local health departments (48.92) than all

3 One state did not respond to this survey item.

4 "Centralized/largely centralized" refers to a governance structure in which local health units are primarily led by employees of the state and the state retains authority over most decisions related to the budget, issuing public health orders, and the selection of the local health official. See pages 20 and 21 for more detailed information about governance classifications.

5 "Decentralized/largely decentralized" refers to a governance structure in which local health units are primarily led by employees of local governments and the local governments retain authority over most key decisions. See pages 16 and 17 for more detailed information about governance classifications.

6 One state did not respond to this survey item.

**Table 1.1: Number of Local and Regional Health Departments, 2010-2012 (n=48)**

| | 2010 | | | | 2012 | | | |
|---|---|---|---|---|---|---|---|---|
| | Mean | Median | Min | Max | Mean | Median | Min | Max |
| Independent local health departments | 44.40 | 20.00 | 0 | 351.00 | 43.79 | 19.50 | 0 | 351.00 |
| State-run local health departments | 11.25 | 0 | 0 | 94.00 | 13.38 | 0 | 0 | 94.00 |
| Independent regional or district offices | 0.92 | 0 | 0 | 20.00 | 1.60 | 0 | 0 | 21.00 |
| State-run regional or district offices | 4.29 | 0 | 0 | 33.00 | 4.60 | 1.50 | 0 | 33.00 |

**Table 1.2: Average Number of Types of Local and Regional Health Departments by State Health Agency Characteristics**

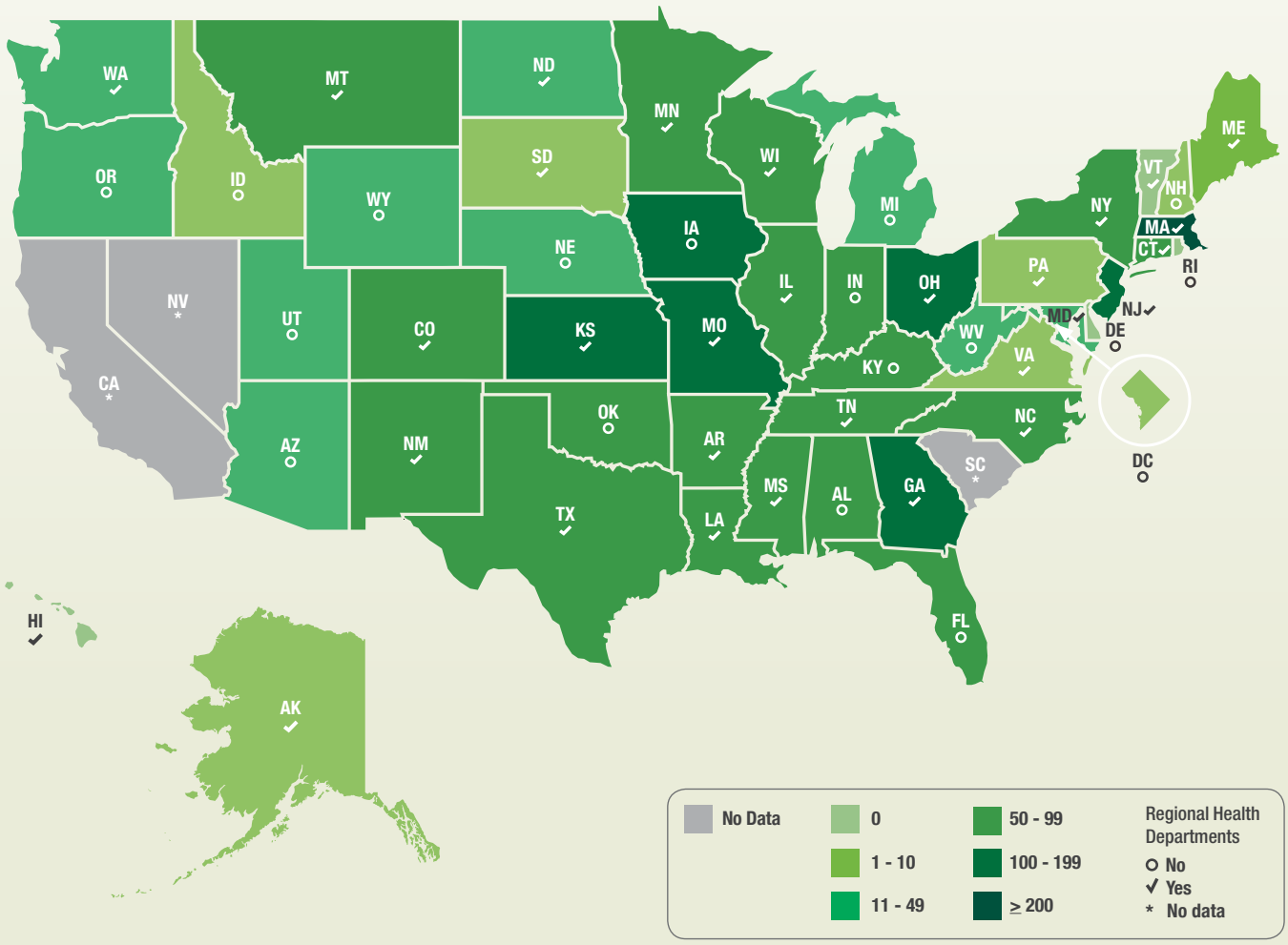
| SHA Characteristic | Mean Number of Health Departments | | | |
|---|---|---|---|---|
| | Local Health Departments | | Regional Health Departments | |
| **Governance (n=38)** | **Independent Local** | **State-Run Local** | **Independent Regional** | **State-Run Regional** |
| Centralized/largely centralized | 1.00 | 28.00 | 0.38 | 6.23 |
| Decentralized/largely decentralized | 73.72 | 0 | 2.88 | 2.92 |
| **Region (n=48)** | | | | |
| New England | 72.88 | 0 | 7.13 | 5.00 |
| South | 30.83 | 48.92 | 0.92 | 5.08 |
| Mid-Atlantic and Great Lakes | 46.58 | 2.00 | 0 | 5.50 |
| Mountains/Midwest | 49.70 | 3.10 | 0.90 | 2.40 |
| West | 15.50 | 0 | 0 | 5.00 |
| **Population Size (n=48)** | | | | |
| Small | 11.31 | 5.38 | 0.56 | 3.63 |
| Medium | 39.94 | 28.76 | 1.53 | 3.71 |
| Large | 82.80 | 4.47 | 2.80 | 6.67 |

other regions (averages for other four regions range from 0-3.10), and large states having significantly more independent local health departments on average (82.80) as compared with small (mean = 11.31) and medium (mean = 39.94) states. The number of local health departments by state is displayed in **Figure 1.2.**

## Governance Structure

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

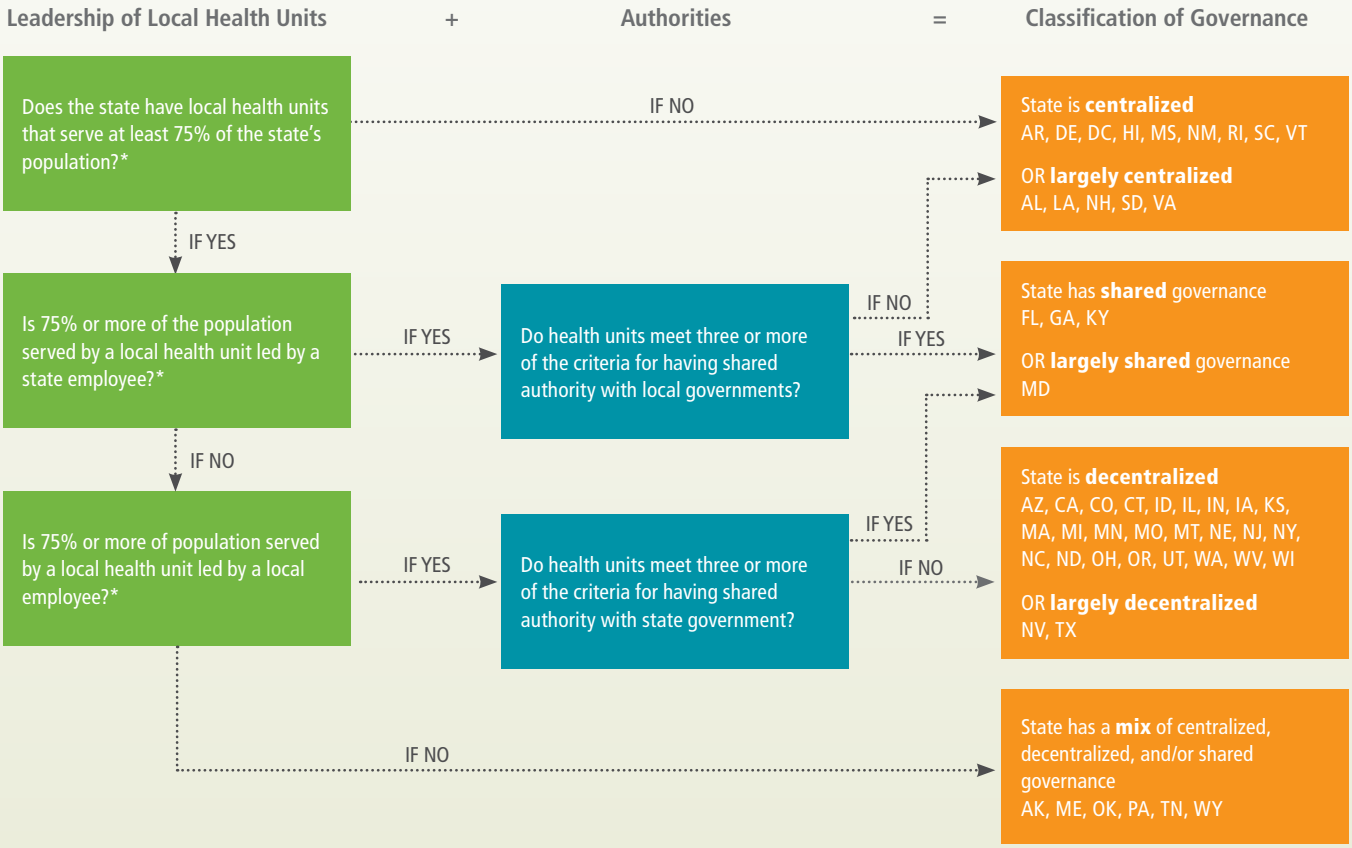
**Figure 1.2: Number of Local Health Departments**



within the community. ASTHO developed a uniform and 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 (**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 local health units are primarily led by employees of the state and the state retains authority over most decisions related to the budget, issuing public health orders, and the selection of the local health official. Four states (10%) have a shared governance system, in which local

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

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

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

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

health units may be led by employees of the state or employees of local government. If they are led by state employees, the local government has the authority to make key decisions. In states with a shared governance system, local health departments are led by local employees 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 health units are primarily led by employees of local governments and the local governments retain authority over most key decisions. Twelve percent of states (n=6) have a mixed governance structure, in which some local health units are led by employees of the state and some are led by employees of local government. In states with a mixed governance structure, no one arrangement predominates in the state.

## Board of Health

Twenty-two state health agencies (45%) report having a state board of health. In addition, four states (8%) report having an entity that, while not called a board of health, performs similar functions. Decentralized/largely decentralized states are more likely to have a board of health or equivalent entity than are centralized/largely centralized states (62% and 54%, respectively). There are no notable differences in board of health status by geographic region. Large states are more likely to have a board of health (56%) than are medium (41%) or small states (38%).

## Resource Sharing

A topic in public health that is receiving increased attention is states' engagement in the sharing of 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 46 responding states in 2012, only four (9%) report sharing resources with other states on a continuous, recurring (non-emergency) basis. Three of those four are states with small populations.

While less than 10 percent of state health agencies report sharing resources with other states, two-thirds (n=31) report facilitating the sharing of resources among local health departments on a continuous, recurring basis.

States that are decentralized/largely decentralized report facilitating local sharing more frequently as compared with centralized/largely centralized states (79% and 58%, respectively). The majority of states in the South (83%) and in the Mountains and Midwest (80%) facilitate local health department resource sharing, while states in New England, the Mid-Atlantic and Great Lakes, and West are more evenly split as to whether or not they facilitate local health department resource sharing.

With regard to population size, medium (75%) and large (80%) states are more likely to facilitate local sharing than are small states (47%). While many states (41%) do not have any laws or regulations related to the sharing of resources between local health departments on a continuous, recurring basis, one state has laws or regulations that prohibit such sharing, one state has laws or regulations requiring sharing, and 41 percent have laws and regulations that facilitate the sharing of resources. Of the 18 states that have laws facilitating resource sharing, 78 percent are decentralized/largely decentralized states. In addition, larger states are more likely to have laws facilitating sharing of resources (67%) than are medium (40%) and small (14%) states.

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 (58%) and epidemiology or surveillance (36%). Among states that share resources with other states, 62 percent report having some sort of agreement in place. Of the 28 states reporting agreements, 57 percent report formal, written agreements, 36 percent report some formal and some informal agreements, and only one state reports having only an informal agreement. Decentralized/largely decentralized states take part in formal, written agreements more than centralized/largely centralized states do (64% and 38%, respectively).

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 (43%) and epidemiology and surveillance (28%). 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 is the case with resource sharing among states, when states share resources with tribes (n=21), they are most likely to engage in formal, written agreements (52%) followed

**Figure 1.4: Shared Services and Functions Between State Health Agencies, 2012 (n=45)**

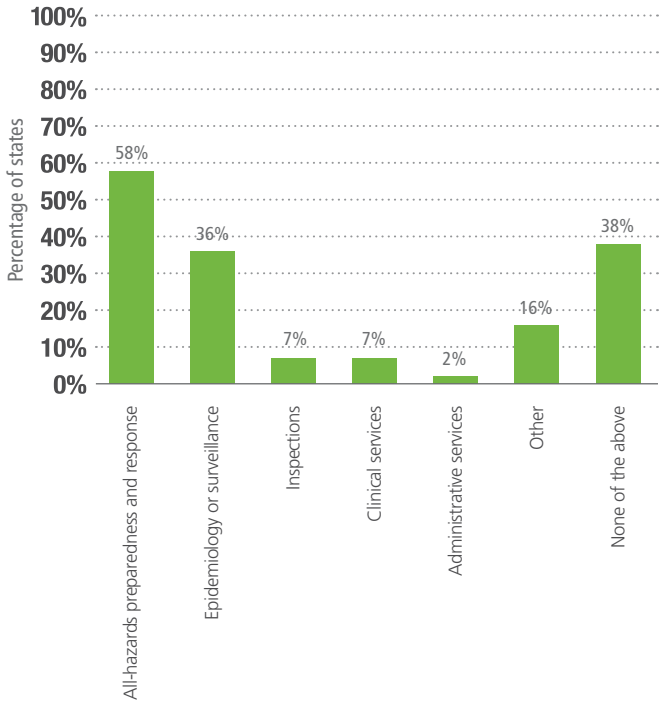



**Figure 1.5: Shared Services and Functions Between State Health Agencies and Tribes, 2012 (n=46)**

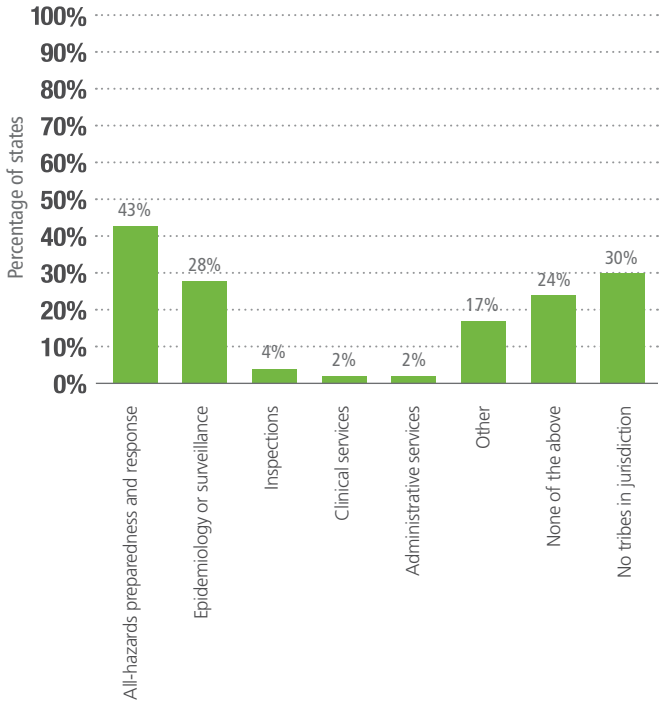


**Table 1.3: Activities in Collaboration with Other Agencies/Organizations (n=39-49)**

| | Exchange Information | | Work Together on Projects | | State Health Agency Provides Financial Resources | | State Health Agency Has Leadership Role Within the Partnership | | No Relationship Yet | | Organization Does Not Exist In Jurisdiction | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n | % |
| Local public health agencies | 44 | 90% | 44 | 90% | 43 | 88% | 39 | 80% | 0 | 0% | 5 | 10% |
| Hospitals | 48 | 98% | 48 | 98% | 41 | 84% | 29 | 59% | 0 | 0% | 0 | 0% |
| Physician practices/medical groups | 44 | 94% | 43 | 91% | 23 | 49% | 18 | 38% | 1 | 2% | 0 | 0% |
| Community health centers | 44 | 92% | 47 | 98% | 36 | 75% | 24 | 50% | 1 | 2% | 0 | 0% |
| Other healthcare providers | 43 | 90% | 39 | 81% | 25 | 52% | 20 | 42% | 1 | 2% | 3 | 6% |
| Health insurers | 34 | 72% | 38 | 81% | 4 | 9% | 8 | 17% | 5 | 11% | 1 | 2% |
| Regional cancer centers | 44 | 92% | 43 | 90% | 17 | 35% | 12 | 25% | 0 | 0% | 1 | 2% |
| Emergency responders | 48 | 98% | 48 | 98% | 30 | 61% | 33 | 67% | 0 | 0% | 0 | 0% |
| Land use/planning agencies | 28 | 62% | 25 | 56% | 3 | 7% | 4 | 9% | 11 | 24% | 3 | 7% |
| Economic and community development agencies | 29 | 66% | 30 | 68% | 4 | 9% | 5 | 11% | 8 | 18% | 4 | 9% |
| Housing agencies | 32 | 70% | 35 | 76% | 11 | 24% | 5 | 11% | 5 | 11% | 2 | 4% |
| Utility companies/agencies | 20 | 48% | 16 | 38% | 4 | 10% | 3 | 7% | 15 | 36% | 15 | 36% |
| Environmental and conservation agencies | 35 | 81% | 36 | 84% | 5 | 12% | 2 | 5% | 6 | 14% | 1 | 2% |
| Cooperative extensions | 37 | 80% | 39 | 85% | 12 | 26% | 8 | 17% | 5 | 11% | 1 | 2% |
| Schools | 43 | 90% | 47 | 98% | 32 | 67% | 19 | 40% | 1 | 2% | 0 | 0% |
| Parks and recreation | 37 | 80% | 39 | 85% | 7 | 15% | 3 | 7% | 4 | 9% | 1 | 2% |
| Transportation | 35 | 76% | 36 | 78% | 7 | 15% | 5 | 11% | 5 | 11% | 1 | 2% |
| Community-based organizations | 44 | 94% | 45 | 96% | 38 | 81% | 23 | 49% | 1 | 2% | 0 | 0% |
| Faith communities | 44 | 90% | 42 | 86% | 23 | 47% | 11 | 22% | 2 | 4% | 0 | 0% |
| Other voluntary or nonprofit organizations (e.g., libraries) | 37 | 80% | 35 | 76% | 15 | 33% | 8 | 17% | 5 | 11% | 2 | 4% |
| Higher education (e.g., universities, medical schools, community colleges) | 47 | 96% | 47 | 96% | 32 | 65% | 18 | 37% | 1 | 2% | 0 | 0% |
| Business | 37 | 82% | 39 | 87% | 5 | 11% | 5 | 11% | 2 | 4% | 1 | 2% |
| Media | 43 | 90% | 36 | 75% | 13 | 27% | 9 | 19% | 1 | 2% | 0 | 0% |
| Tribal government agencies or other tribal community | 34 | 72% | 32 | 68% | 22 | 47% | 14 | 30% | 3 | 6% | 10 | 21% |
| Continuing education (e.g., pharmacy, medical, nursing) | 42 | 93% | 36 | 80% | 12 | 27% | 9 | 20% | 1 | 2% | 0 | 0% |
| State boards of health | 30 | 65% | 23 | 50% | 12 | 26% | 15 | 33% | 0 | 0% | 18 | 39% |
| Local boards of health | 34 | 77% | 29 | 66% | 19 | 43% | 14 | 32% | 1 | 2% | 8 | 18% |
| Food agencies | 41 | 89% | 37 | 80% | 9 | 20% | 6 | 13% | 2 | 4% | 2 | 4% |
| Energy agencies | 23 | 59% | 20 | 51% | 1 | 3% | 2 | 5% | 12 | 31% | 5 | 13% |
| Law enforcement | 44 | 92% | 44 | 92% | 9 | 19% | 6 | 13% | 2 | 4% | 0 | 0% |
| Justice system | 34 | 79% | 34 | 79% | 4 | 9% | 4 | 9% | 3 | 7% | 2 | 5% |

by some formal and some informal agreements (29%) and then informal agreements (10%). The final 10 percent of states that share resources with tribes report not knowing the nature of their agreements.

## 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, and other health providers. At least 90 percent also report exchanging information with schools, faith communities, the media, and law enforcement. The percentage of state health agencies that report working together on projects with these organizations is also very high. Providing financial resources to these organizations is less common overall, and there is a large variation in whether or not the state health agency has the leadership role within that particular partnership.

## State Health Officials

The resource sharing, collaborations, and partnerships just discussed 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), sometimes referred to as a state health secretary or commissioner of health. As of 2012, 37 of 49 state health agencies (76%) report that the SHO is appointed by the governor of the state. SHOs are also appointed by the state health and human services secretary, boards or commissions, or by the legislature. Of the 47 states that answered this question in 2010 and 2012, the proportion of SHOs appointed by the governor has increased by eight percentage points. A graph showing who appointed the SHO in 2010 and 2012 is displayed in **Figure 1.6.** Only medium-sized states in the South (n=3) have SHOs that are appointed by boards or commissions.

Once the SHO is appointed, 73 percent of state health agencies require confirmation of the appointment by the legislature, governor, board or commission, secretary



**Figure 1.6: Appointment of the State Health Official, 2010-2012 (n=47)**

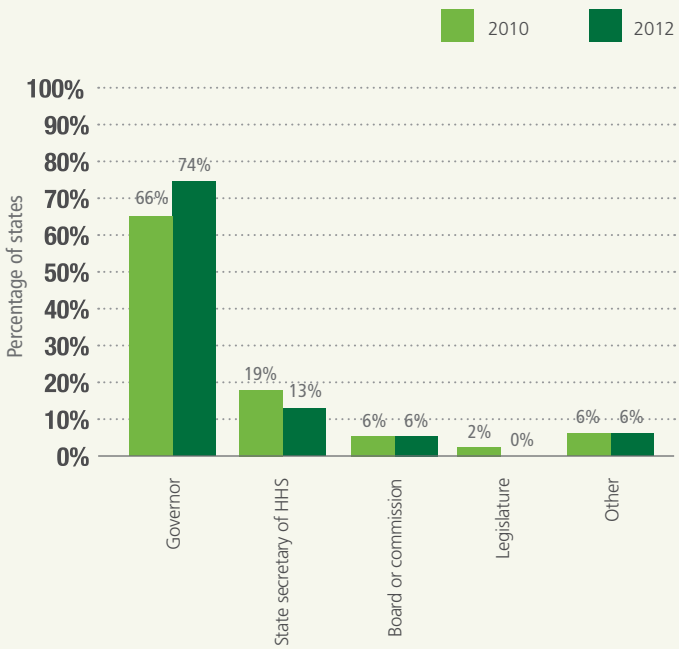
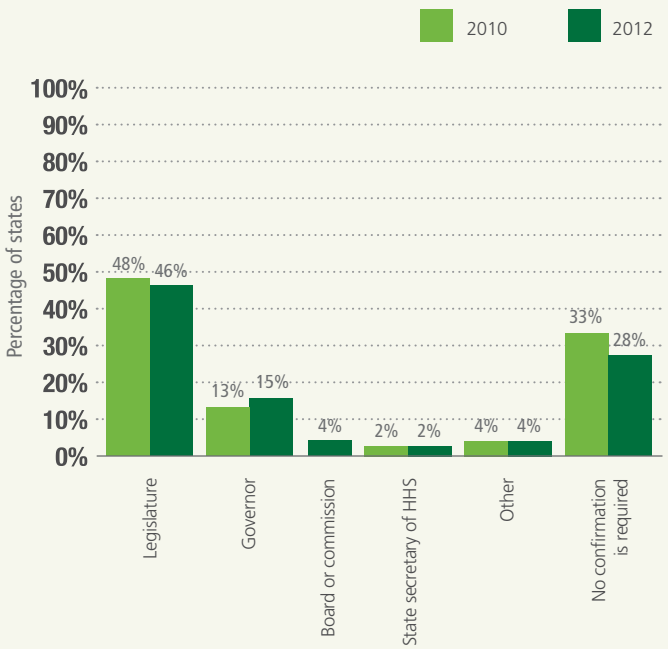



**Figure 1.7: Confirmation of the State Health Official, 2010-2012 (n=46)**




*Note: "Board or commission" was not a response option in 2010.*

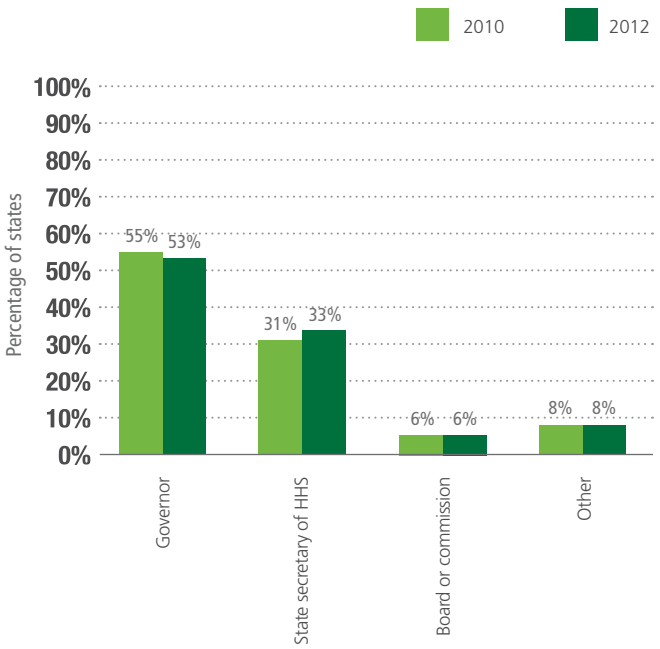
of health and human services, or another entity. The percentage of state health agencies that require confirmation of the SHO by each of these entities among states who responded in 2010 and 2012 is displayed in **Figure 1.7**. Only decentralized/largely decentralized states (24%) report having SHOs confirmed by the governor. While the entity responsible for confirming the SHO generally varies across regions, all nine Mountains and Midwest states that require confirmation of the SHO require it from the legislature. Of the seven states that indicated that the SHO's appointment was confirmed by the governor, six indicated that the SHO was both appointed and confirmed by the governor. Confirmation by the governor is more often required in large states (40%) than in medium (0%) or small (6%) states.

When state health officials are appointed, only 10 states (20%) appoint the SHO to a specific term. This percentage is identical to the percentage appointed to a specific term in 2010. Centralized/largely centralized state health agencies are twice as likely to appoint SHOs to a specific term as are decentralized/largely decentralized state health agencies (38% and 19%, respectively). States in New England are the most likely to appoint SHOs to a specific term (38% of them do), while states in the South are the least likely (only 8% of them do). The appointment of SHOs to a specific term shows some variation by state size (19% of small, 29% of medium, and 13% 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 3.9 years. Centralized/largely centralized states have SHOs with official term lengths slightly longer than those of decentralized/largely decentralized states (an average of 4.2 years and 3.6 years, respectively). The state with the longest set term is in the South (6.0 years), while states in the Mid-Atlantic and Great Lakes have the shortest set term lengths on average (3.3 years). Medium-sized states have longer set terms (average length = 4.4 years) than do small states (average length = 3.7 years) and large states (average length = 3.0 years). When SHOs are appointed to a specific term, the term is set by law, rather than contract, for all states (n=10).

More than half of state health officials (53%) report directly to the governor, while about one-third (33%) report to the state secretary of health and human services (HHS). As shown in **Figure 1.8**, the percentage of SHOs that directly report to various entities has not

**Figure 1.8: State Health Official Direct Report, 2010-2012 (n=49)**




changed substantively from 2010 to 2012. SHOs in decentralized/largely decentralized states are most likely to report directly to the governor (65%), while SHOs from centralized/largely centralized states are most likely to report directly to the state secretary of HHS (46%). Only SHOs in the South (25%) report directly to a board or commission. In the Mountains and Midwest, 80 percent of SHOs report directly to the governor. Small states are twice as likely to have SHOs that report to the state secretary of HHS (50%) than medium (24%) and large (25%) states.

When asked who is involved in the budget approval process, the governor (92%), legislature (90%), and the state budget office (69%) were the top three entities selected. Other entities involved in the budget approval process are the state secretary of HHS (35%), the board of health (4%), and other (6%). This distribution is quite similar to the distribution for 2010. States in New England are more likely to have the state secretary of HHS involved in the budget approval process (63%) than are states in other regions (values range from 20-43%). 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 secretary of HHS, such that large states are less likely than small or medium-sized states to have the state secretary of HHS involved in the budget approval process.

Just as the SHO is most frequently appointed by and reporting directly to the governor, in the majority of states (88%), the state health official can be removed from his or her position at the will of the governor. This is more often the case in decentralized/largely decentralized states (96%) than in centralized/largely centralized states (69%). In some instances, the SHO can be removed by board or commission action (only in the South; 25%) and by legislative action (only in New England; 13%).

## State Health Agency Priorities

The portfolio of the state health official is large and diverse. SHOs must strategize and prioritize the many important topics that come to their attention during their tenure. Senior deputies, who responded on behalf of the state health official, 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 and 2012 (categorized by expenditure category[7]) are displayed in **Table 1.4.** Though responses varied by state, several common themes emerged. As in 2010, the prevention and treatment of chronic disease was mentioned by many states, as was dealing with funding issues. Improvement of internal operations, such as workforce capacity, infrastructure, and quality improvement, was also frequently mentioned. In 2012, many states listed priorities that did not fit neatly into a single health topic (accreditation, reducing health disparities), possibly reflecting a trend toward cross-cutting programs in public health.

**Table 1.4: State Health Agency Top Priorities, 2010-2012**

| Category | 2010: n (%) | 2012: n (%) |
|---|---|---|
| Administration | 77 (30.2%) | 88 (34.5%) |
| Chronic disease | 43 (16.9 %) | 38 (14.9%) |
| Other | 39 (16.3%) | 37 (14.5%) |
| Improving consumer health | 21 (8.2%) | 27 (10.8%) |
| Infectious disease | 17 (6.7%) | 12 (4.7%) |
| All-hazards preparedness and response | 13 (5.1%) | 11 (4.3%) |
| Health data | 13 (5.1%) | 9 (3.5%) |
| Environmental protection | 10 (3.9%) | 2 (0.8%) |
| Quality of health services | 5 (2.0%) | 5 (2.0%) |
| Injury prevention | 4 (1.6%) | 6 (2.4%) |
| Health laboratory | 0 (0.0%) | 1 (0.4%) |
| Vital statistics | 0 (0.0%) | 1 (0.4%) |
| Missing | 13 (5.1%) | 18 (7.1%) |
| Total | 255 (100%) | 255 (100%) |

State health officials 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 success of the state health agency.

7 Definitions for expenditure categories can be found on page 83.

## Key Findings:

- Based on the figures reported in 2012, the total number of FTEs for the 50 states and District of Columbia is estimated to be approximately 101,000. Both the number of FTEs and number of staff have shown a decrease of more than 5,000 from 2010 to 2012.
- The number of staff and FTEs are related to state population size, such that smaller states tend to have the fewest number of staff and FTEs and larger states tend to have the greatest number of staff and FTEs. However, a state's size is inversely related to FTEs per 100,000 population, such that smaller states have the greatest number of FTEs per 100,000 population on average, while larger states have the fewest number of FTEs per 100,000 population on average.
- The occupational classifications with the greatest mean number of staff at state health agencies are administrative and clerical staff, public health nurses, and environmental health workers.
- ASTHO collected the demographics of state health agency employees for the first time in the 2012 Profile Survey. The majority of employees at state health agencies are female (71%), white (73%), and non-Hispanic/Latino (93%). Overall, the state health agency workforce has a greater proportion of women than the U.S. population, is more racially

# Chapter 2: State Health Agency Workforce

This chapter describes the workforce of state public health agencies. It details the size of the state health agency workforce, salaries by occupational categories, and demographics of state health agency employees. It includes information on vacancies and projected retirements. This chapter also describes the appointment, qualifications, tenure, and salaries of state health officials. Throughout the chapter, 2012 data will be compared with 2010 and 2007 data when possible, and differences in state health agency workforce by governance structure, region, and state population size will be noted when applicable.

diverse than the U.S. population, and has a smaller proportion of Hispanics/Latinos than the overall U.S. population. However, there are some differences in the racial composition of state health agency staff, with Southern states having on average the highest proportion of black/African-American employees (25%) and Western states having on average the highest proportion of Asian employees (15%); the racial composition of these regions is relatively representative of the populations that they serve.

- On average, 12 percent of positions at state health agencies are currently vacant. However, only 24 percent of vacant positions are currently being actively recruited for.
- From FY 2012 to FY 2016, the percentage of state health agency employees who are eligible for retirement is expected to increase from 18 to 25 percent on average.
- The length of time that state health officials have held their position is highly variable. As of December 2012, the range in length of time state health officials had been in their position was one month to 20 years. Nearly 75 percent of state health officials hold a medical degree, and nearly 50 percent hold an MPH.
- State health agencies prioritize workforce development. More than half of state health agencies have a workforce development plan in place, and half have a workforce development director.

# Number of State Health Agency Employees

In 2012, the 49 responding state health agencies reported a total of 97,127 FTEs, and 40 responding state health agencies reported a total of 72,794 staff members. Based on the figures reported in 2012, the total number of FTEs for all states and the District of Columbia is estimated to be approximately 101,000.[8] Among responding states from 2010 to 2012, the number of FTEs has decreased by approximately 5,500 and the number of staff has decreased by 5,000 individuals (**Table 2.1**). These results are in alignment with data from ASTHO's Budget Cuts Survey series, which has been tracking the effects of budget cuts on the state health agency workforce since 2008.[9]

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. States in the South 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, number of staff and FTEs are 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. However, a state's size is inversely related to FTEs per 100,000 population, such that smaller states have the highest number of FTEs per 100,000 population on average, while larger states have the lowest number of FTEs per 100,000 population on average. **Table 2.2** displays the average number of FTEs and the mean number of FTEs per 100,000 population for states that serve small, medium, and large populations. As the size of the population increases, the mean number of FTEs per 100,000 population decreases.

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

8 State population and the mean number of FTEs per 100,000 population for states who responded were used to estimate the number of FTEs for states who did not report data in 2012.

9 Visit http://www.astho.org/Research/State-Health-Agency-Budget-Cuts/ for the most recent Budget Cuts Impact Research Brief.

10 Only states that reported values in both 2010 and 2012 are included in Table 2.1.

11 Only states that reported values above 0 were included.

**Table 2.1: Number of State Health Agency Employees, 2010-2012[10]**

| | 2010 | | | 2012 | | |
|---|---|---|---|---|---|---|
| | Mean | Median | Total | Mean | Median | Total |
| Number of FTEs (n=48) | 2,117 | 1,210 | 101,623 | 2,001 | 1,151 | 96,070 |
| Number of staff members (n=38) | 1,994 | 1,212 | 75,778 | 1,862 | 1,158 | 70,768 |

**Table 2.2: Average Number of FTEs and Average Number of FTEs per 100,000 Population by State Size (n=49)**

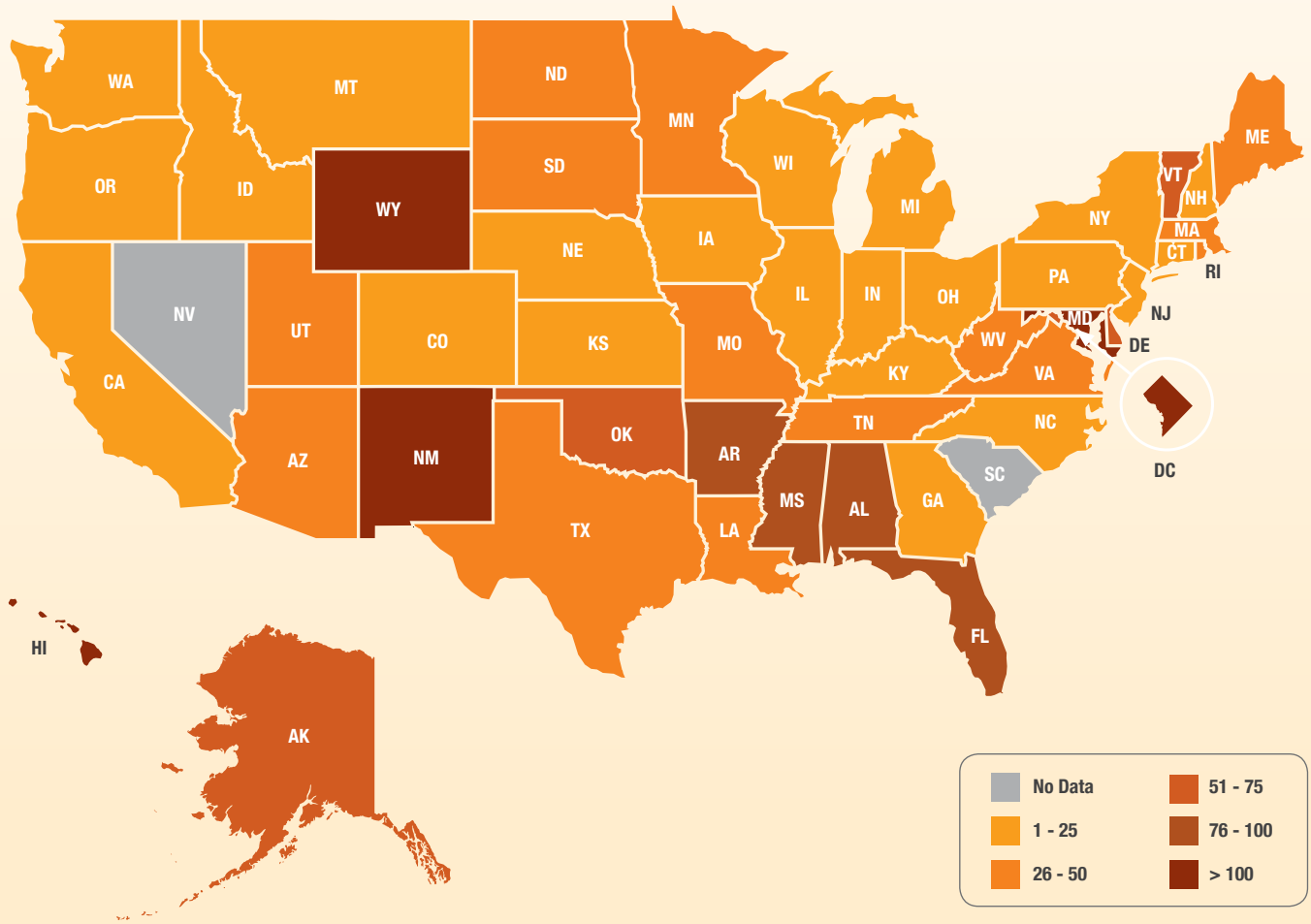
| State Size | Mean Number of FTEs | Mean Number of FTEs per 100,000 population |
|---|---|---|
| Small (n=16) | 803 | 69 |
| Medium (n=17) | 1,894 | 43 |
| Large (n=16) | 3,255 | 24 |

**Table 2.3: Number of State Health Agency Employees by Category and Assignment[11]**

| | n | Mean | Median | Minimum | Maximum |
|---|---|---|---|---|---|
| Hourly/temporary or as-needed | 43 | 146 | 38 | 2 | 2,426 |
| Part-time workers | 46 | 76 | 31 | 1 | 433 |
| Assigned to the central office | 38 | 966 | 735 | 176 | 3,722 |
| Assigned to local health departments | 13 | 1,682 | 1,097 | 11 | 9,720 |
| Assigned to regional or district offices | 28 | 694 | 215 | 22 | 9,343 |

In 2012, union membership in state health agencies ranged from a low of 3 percent to a high of 100 percent. Of the 29 states reporting percentages for collective bargaining, on average, 70 percent of employees are represented by a union. Union membership among agencies that responded in both 2010 and 2012 (n=21) is the same, with an average of 73 percent of employees represented by a union in both 2010 and 2012. A greater percentage of employees in centralized/largely centralized states (72%) are represented by a union than employees in decentralized/largely decentralized states (66%). States in the New England region have the greatest average percentage of employees represented by unions (90%), while states in the Mountains and Midwest have the lowest percentage (50%). There are no trends in union membership by state size.

**Figure 2.1: Full-Time Equivalents per 100,000**



## State Health Agency Employee Occupational Classifications, Salary Ranges, and Fringe Benefits

Employees at state health agencies fulfill a variety of roles that span a number of occupational classifications. **Table 2.4** displays the average number of FTEs for the most common occupational classifications in state public health agencies, the average salary range for each position, and the average employee and fringe benefits as a percentage of salary.

Please see page 39 for descriptions and examples of occupational classifications.

In 2012 (as in 2010), the occupational classifications at state health agencies with the greatest number of employees are administrative/clerical staff, public health nurses, and environmental health workers. In 2012, the highest paid state public health agency professionals are public health managers, physicians, and oral health professionals. As in 2010, these positions also have the widest range in salary in 2012. Average fringe benefits as a percentage of salary are fairly even across occupational classifications, ranging from an average low of 34 percent (for physician assistants) to 41 percent (for public health nurses, lab workers, and epidemiologists/statisticians).

States were also asked to provide salary range and benefits information for leadership staff (other than the state health official). Responses from states are shown in **Table 2.5**. Among all leadership positions, the

**Table 2.4: Average Number of FTEs, Salary Range, and Fringe Benefits by State Health Agency Occupational Classification**

| Occupational Classification | n | Average Number of FTEs | Median Number of FTEs | Average Salary Range | Average Fringe Benefits as a % of Salary |
|---|---|---|---|---|---|
| Administrative/clerical staff | 39 | 395.3 | 140 | $23,602-$71,169 | 40% |
| Public health nurse | 37 | 223.3 | 74 | $42,827-$79,248 | 41% |
| Environmental health worker | 34 | 116.4 | 67 | $33,692-$82,465 | 40% |
| Public health manager | 37 | 97.1 | 59 | $47,916-$131,213 | 39% |
| Lab worker | 34 | 78.3 | 65 | $26,173-$81,552 | 41% |
| Social worker | 26 | 75.9 | 17 | $35,693-$61,892 | 37% |
| Epidemiologist/statistician | 37 | 52.0 | 34 | $38,621-$86,232 | 41% |
| Health educator | 34 | 51.6 | 27 | $37,519-$66,661 | 39% |
| Nurse practitioner | 13 | 42.1 | 29 | $54,009-$86,053 | 35% |
| Nutritionist | 38 | 35.6 | 16.5 | $39,736-$67,770 | 40% |
| Public health informatics specialist | 27 | 32.5 | 9 | $42,580-$85,217 | 40% |
| Preparedness staff | 36 | 27.7 | 20 | $35,086-$94,852 | 39% |
| Public health physician | 34 | 19.1 | 5.2 | $101,941-$171,917 | 39% |
| Oral health professional | 28 | 16.2 | 3.5 | $46,654-$117,391 | 39% |
| Physician assistant | 7 | 7.6 | 6 | $48,511-$83,002 | 34% |
| Public health information specialist | 33 | 5.3 | 3 | $46,683-$80,176 | 38% |
| Primary care director | 20 | 1.6 | 1 | $61,674-$94,563 | 37% |

*Note: For each occupational classification, only states that responded to all elements of the question (number of FTEs, salary range, and fringe benefits) were included in the analysis.*

**Table 2.5: Salary Range and Fringe Benefits of State Health Agency Leadership**

| Occupational Classification | n | Average Salary Range | Average Fringe Benefits as a % of Salary |
|---|---|---|---|
| Senior deputy | 32 | $90,943-$148,263 | 40% |
| Chief medical officer | 25 | $130,788-$195,842 | 39% |
| Chief science officer | 3 | $99,865-$156,169 | 37% |
| Chief financial officer | 35 | $69,925-$116,132 | 40% |
| Chief information officer | 31 | $71,403-$110,616 | 40% |
| State epidemiologist | 28 | $89,706-$137,430 | 41% |
| State lab director | 30 | $75,091-$114,794 | 41% |
| Local health department liaison | 22 | $60,200-$103,946 | 42% |

*Note: For each occupational classification, only states that responded to both elements of the question (salary range and fringe benefits) were included in the analysis.*

chief medical officer is the highest paid staff member on average, while the local health department liaison is the lowest paid staff member on average. Average fringe benefits for leadership staff as a percentage of salary are similar to fringe benefits for other state health agency employees, on average ranging from 37 percent (for chief science officers) to 42 percent (for local health department liaison).

## State Health Agency Employee Demographics

In 2012, on average 71 percent of state health agency employees are female.[12] On average, decentralized/largely decentralized state health agencies have a greater percentage of male employees (32%) than do centralized/largely centralized states (26%). On average, states in the Mid-Atlantic and Great Lakes have the highest percentage of male employees (35%), while states in the South have the lowest percentage of male employees (21%).

Respondents were asked to provide the number of staff working at their state health agency by racial category. Responses are presented in **Table 2.6**. On average, nearly three-quarters of all state health agency employees are white, with the next largest percentage being black/African-American (14.9%). On the whole, the racial composition of a state health agency is relatively similar to that of the racial composition of the United States in 2012. Employees in decentralized/largely decentralized states are more likely to be white than are employees in centralized/largely centralized states (78.6% vs. 59.6%). Employees at centralized/largely centralized states are more likely to be black/African-American (20.1%), another race (12.1%), or two or more races (18.0%) than are employees at decentralized/largely decentralized states (10.8%, 6.4%, and 1%, respectively). On average, the Mountains and Midwest have the greatest percentage of white employees (90%; other regions range from 62-80%), the South has the greatest percentage of black/African-American employees (25%; other regions range from 3-17%), and the West has the greatest percentage of Asian employees (15%; other regions range from 2-4%). The West also has the greatest percentage of employees of two or more races (11%; other regions range from 0-1%). The racial composition of the state health agency workforce by region is, on average, reflective of the

**Table 2.6: Mean Percentage of State Health Agency Staff by Racial Category, 2012**

| Racial Category | n | Average Percentage |
|---|---|---|
| White | 45 | 72.6% |
| Black/African-American | 43 | 14.9% |
| American Indian/Alaska Native | 40 | 1.1% |
| Asian | 43 | 4.5% |
| Native Hawaiian/Other Pacific Islander | 12 | 0.7% |
| Another race | 30 | 6.9% |
| Two or more races | 10 | 2.5% |
| Missing data on race | 10 | 2.5% |

populations each region serves. State size does not show consistent patterns with racial categories of state health agency employees.[13]

State health agencies were also asked about the ethnicity of their employees. Of the responding agencies (n=41), on average 5 percent of state health agency employees in 2012 are Hispanic/Latino. In centralized/largely centralized states, about 8 percent of employees are Hispanic/Latino, while in decentralized/largely decentralized states only about 4 percent are. States in the South (9%) and the West (8%) have the greatest percentage of Hispanic/Latino employees; these two regions also have on average higher proportions of their populations who are Hispanic/Latino. Smaller states have a greater percentage of Hispanic/Latino employees (8%) than do medium (3%) or large (5%) states.

State health agencies report that the average age of employees is 47 and the median age of employees is 48; the state health agency workforce is on average older than the general U.S. workforce, which has a median age of 42 years.[14] The average number of years of service by a state health agency employee is 12. These findings are consistent with results from the 2007 and 2010 ASTHO Profile Surveys. Average age of employees, median age, and average number of years of service does 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

12 N=46, as three states did not respond to this item.

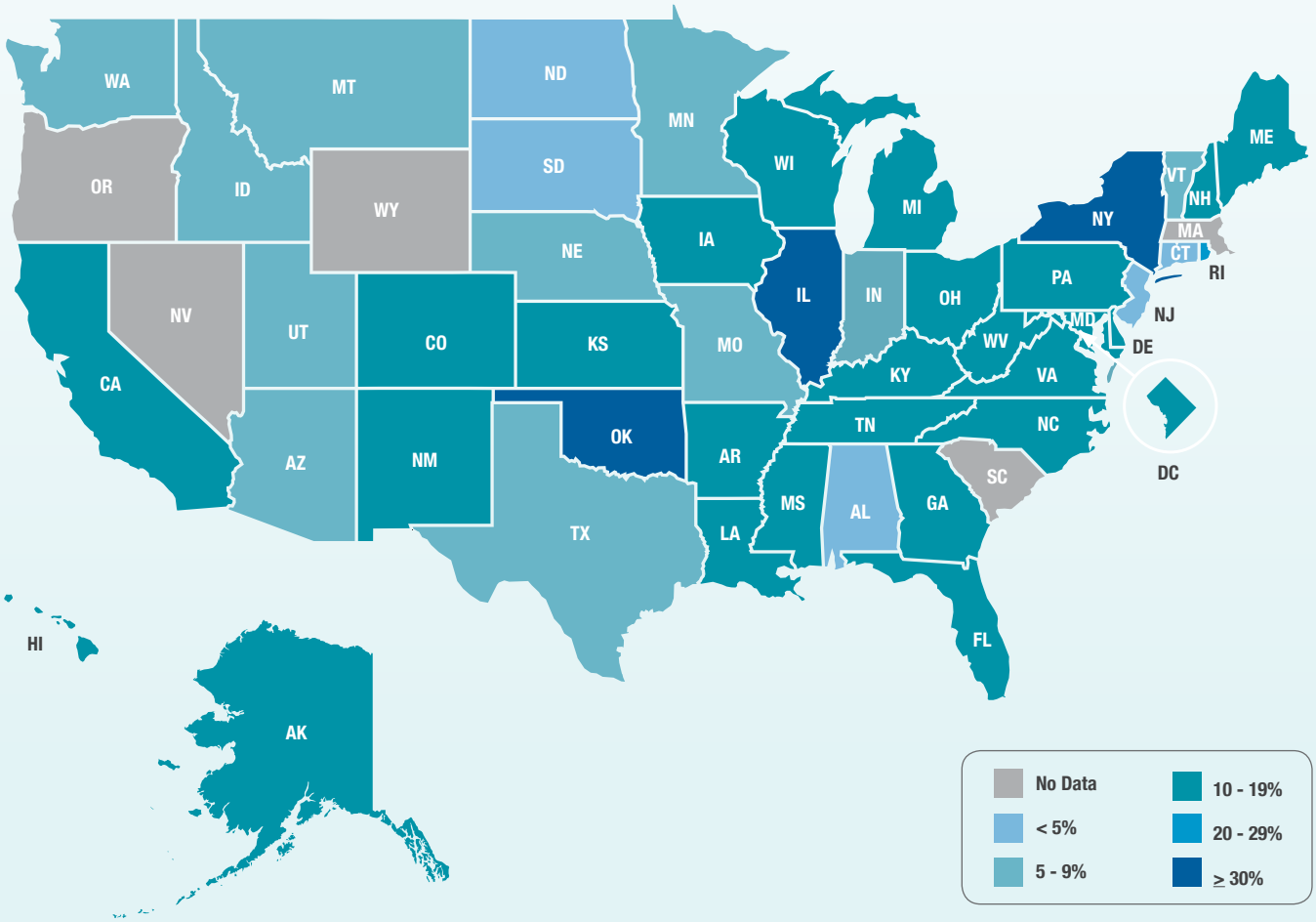
13 To create an average demographic picture of each region, 2012 Census data about the racial and ethnic makeup of each state was compared with the state health agency workforce for each region.

14 U.S. Department of Labor, Bureau of Labor Statistics. "Labor Force Statistics from the Current Population Survey." Available at http://www.bls.gov/cps/industry_age.htm. Accessed 3-6-2014.

employees in New England tend to have the most (average = 14 years). There are also trends in average years of service by state size, such that larger states tend to have employees with more years of service.

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 employees at state health agencies was 40 (FY09), 40 (FY10), and 41 (FY11). The average age of new employees is fairly constant across state health agencies; it does not vary substantively by governance classification, region, or state size.

**Figure 2.2: Percentage of Vacant Positions**



## Vacancies and Retirements

In FY 2011, an average of 274 nontemporary employees separated from state health agencies.[15] On average, states in the South had substantially more employees separate from the state health agency than did other regions (South mean for FY11 = 637; other regions' means range from 86 to 199). The number of separations was associated with state population size, such that more employees separated from states with larger populations. This may be related to states with large populations having a greater average number of employees than states with smaller populations.

In 2012, on average 12 percent of state health agency positions were vacant. This percentage is similar to the percentage of vacant positions in 2010 (11%). States in New England have the greatest percentage of vacancies (15%), while states in the Mountains and Midwest have the lowest percentage of vacancies (8%). Larger states have a greater percentage of vacancies (15%) than do small (11%) and medium (12%) states. **Figure 2.2** shows the percentage of vacant positions by state.

The average number of vacant positions at state health agencies in 2012 is 303. Among the 41 states that responded to this question in both 2010 and 2012, the average number of vacant positions increased from 282 to 304.[16] State health agencies in the Mountains and Midwest have fewer vacant positions on average than do state health agencies in other regions (mean Mountains and Midwest = 67; other regions' means range from 241 to 506 vacancies). Larger states have more vacancies on average (536) than do small (133 vacancies) and medium (256 vacancies) states. Despite the large number of vacancies, on average state health agencies are only actively recruiting for 74 positions, or 24 percent of vacancies. The results of ASTHO's Budget Cuts Survey series suggest that agencies are often unable to fill vacancies due to hiring freezes.[17]

15 This number includes retirements.

16 The change in average number of vacant positions from 2010 to 2012 excludes states that did not respond at both time points.

17 Visit http://www.astho.org/Research/State-Health-Agency-Budget-Cuts/ for the most recent Budget Cuts Impact Research Brief.

From fiscal year 2012 to fiscal year 2016, the percentage of state health agency employees that are eligible for retirement is expected to increase from 18 to 25 percent on average. The projected percentage of employees eligible for retirement among states that answered this item in both 2010 and 2012 is displayed in **Figure 2.3.** Among the 27 states that responded in 2010 and 2012, the percentage of employees eligible for retirement is expected to increase from 19 percent in FY10 to 26 percent in FY16. **Figure 2.4** shows the projected retirement eligibility percentage for each state in FY16.

**Figure 2.3: Mean Percentage of Full-Time Classified Employees Eligible for Retirement, FY10-FY16 (n=27)**

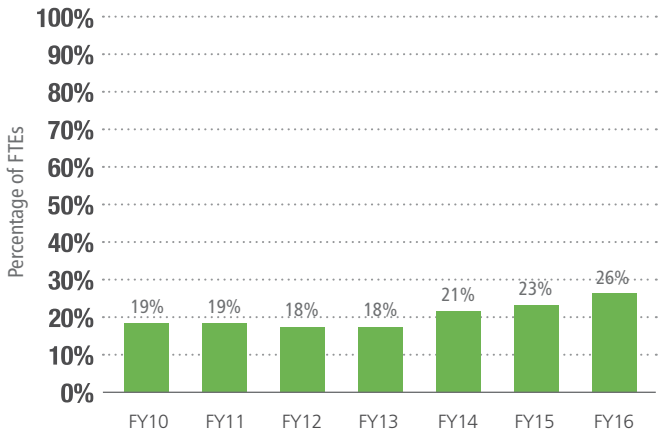



**Figure 2.4: Percentage of Employees Eligible for Retirement in FY 2016**

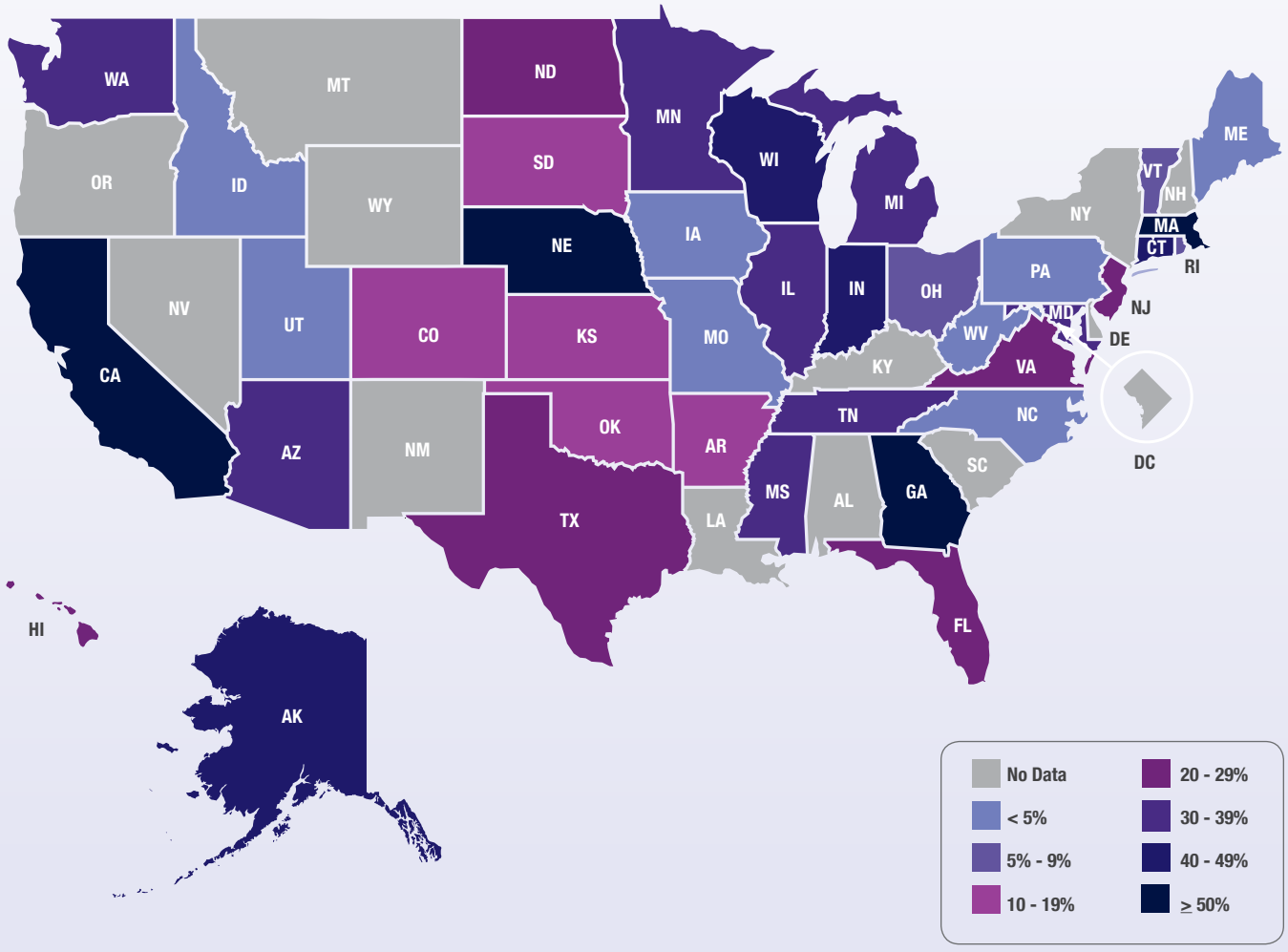
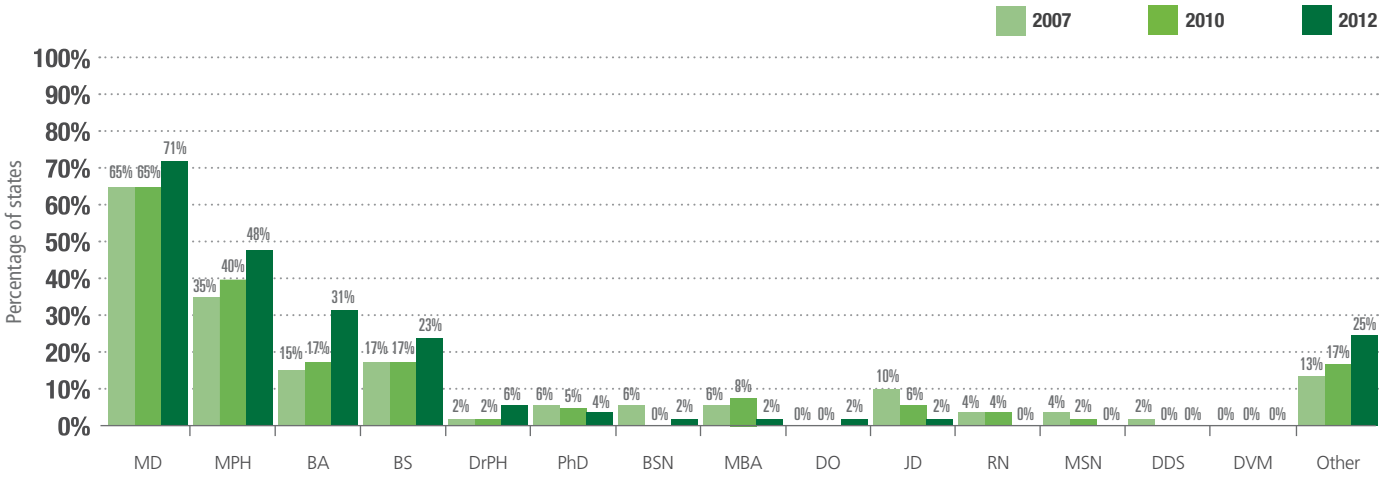


**Figure 2.5: State Health Official Educational Qualifications, 2007-2012 (n=48)**




## State Health Officials

As of December 2012, the average tenure of a state health official is 3.4 years, the median tenure is 1.8 years, and the range is one month to 20 years.[18] On average, SHOs have been in the public health profession for 19.5 years. The average number of years of experience in public health before becoming a SHO is 16.4 years (n=35). A total of 96 percent of SHOs have had executive management experience before becoming the state health official.

Since 2007, ASTHO has been tracking SHOs' levels of educational attainment. The educational qualifications of the current state health official are displayed in **Figure 2.5**. In 2012, the percentage of SHOs with MDs increased by 6 percent to nearly three-quarters of all SHOs, the percentage of SHOs with MPHs increased by 8 percent to nearly half of all SHOs, the percentage of SHOs with a DrPH increased from 2 to 6 percent, and for the first time one state has a SHO with a DO. Twenty state health officials in 2012, or 42 percent, had dual advanced degrees, with the most common combination being MD and MPH. In contrast, the percentage of SHOs with MBAs decreased from 8 to 2 percent, and the percentage of SHOs with JDs decreased from 6 to 2 percent. Other degrees held by SHOs include master's degrees in social work, education, and public administration. More than half of states (53%) have the official statutory requirement that the SHO possess an MD or DO. In the West, only one state requires this. Nearly one-third of states (29%) report no statutory requirements for the education level of the SHO.

On average, state health officials in 2012 were paid a salary of $160,162 (median salary = $153,960). SHO salaries range from a minimum of $94,640 to a maximum of $268,996. While the average salary has increased by about $3,600 since 2010, the range of salaries has become narrower at both the high and low end, such that the lowest-paid SHO is being paid approximately $12,000 more than in 2010, while the highest-paid SHO receives a salary that is nearly $19,000 less than the maximum salary in 2010. On average, SHOs are paid more if they work in a centralized/largely centralized state (mean salary = $163,820) than if they work in a decentralized/largely decentralized state (mean salary = $157,453). SHOs in the South receive higher salaries on average than do SHOs in other regions, as can be seen in **Table 2.7.** SHOs from medium-sized states tend to receive a higher average salary than do SHOs from small or large states. For SHOs that have an MD, 17 percent of states provide a salary differential.

**Table 2.7: Average and Median SHO Salary by U.S. Region (n=48)**

| Region | Average SHO Salary | Median SHO Salary |
|---|---|---|
| New England | $148,436 | $138,768 |
| South | $187,814 | $184,622 |
| Mid-Atlantic and Great Lakes | $159,087 | $158,155 |
| Mountains and Midwest | $149,057 | $134,600 |
| West | $142,284 | $137,304 |

The salaries for state health officials are determined through one of several methods: governor's discretion (55%), state legislature's discretion (29%), state pay scale (25%), board or commission (8%), or another method

18 Since Jan. 1, 2013, 26 new state health officials have been appointed. Currently there are no vacancies.

(12%). A greater percentage of decentralized/largely decentralized states' SHO salaries are determined by the governor, while a greater percentage of centralized/largely centralized states' SHO salaries are determined by the state legislature. Governors in the Mountains and Midwest states are more likely to determine SHO salaries than those in other regions (Mountains and Midwest mean = 80%; other regions range from 42-57%).

## Workforce Development

State health agencies are committed to workforce development. The Core Competencies for Public Health Professionals,[19] determined through a consensus process by the Council on Linkages Between Academia and Public Health Practice, reflect the desirable skills and characteristics of public health workers to effectively deliver the essential public health services. The competencies 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 to manage their career development and learning. More than half (59%) of state health agencies have created a health department workforce development plan that addresses staff training needs and core competency development. Thirty percent of state health agencies have not developed such a plan, while 11 percent of respondents did not have access to information about a workforce development plan. Medium-sized states and states in the South are most likely to have developed a plan. Half of state health agencies also report having a designated workforce development director. Decentralized/largely decentralized states and states in the South and West are most likely to have a designated workforce development director, while small states are least likely to have one.

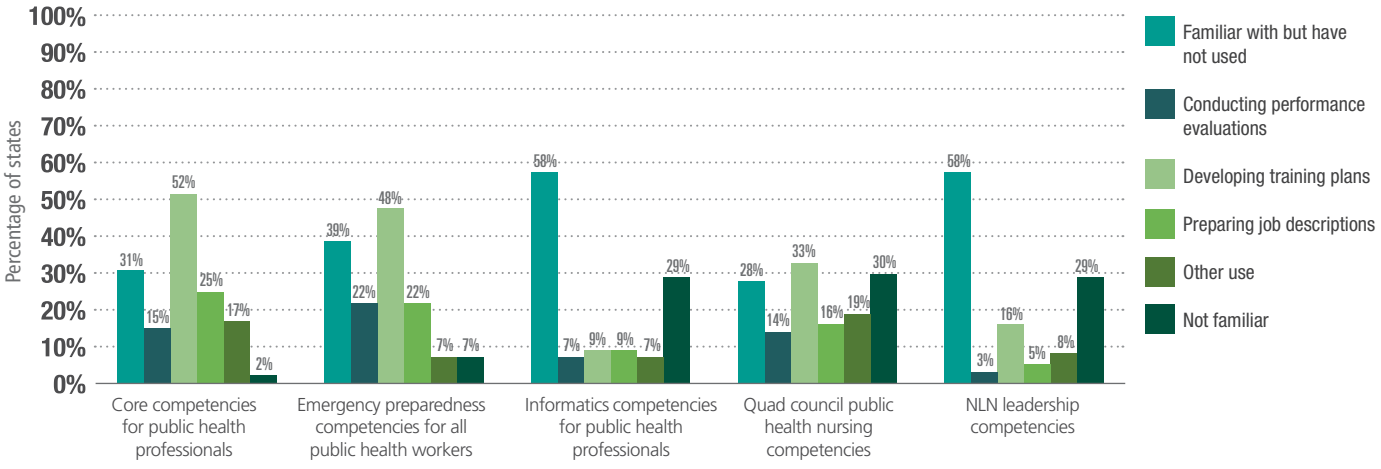
Respondents were also asked to indicate their familiarity with and use of various public health core competencies in the course of managing agency personnel. Results are displayed in **Figure 2.6**. More than half of state health agencies were familiar with but had not used informatics competencies for public health professionals and National League for Nursing (NLN) leadership competencies. When states used any of the core competencies, it was most frequently for the purpose of developing training plans. Nearly one-third of state health agencies were unfamiliar with informatics competencies, Quad Council of Public Health Nursing competencies, and NLN leadership competencies.

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 Public Health: What We Do, focus moves to the myriad services and activities that state health agencies provide throughout the country.

19 Public Health Foundation. "About the Core Competencies for Public Health Professionals." Available at http://www.phf.org/programs/corecompetencies/Pages/About_the_Core_Competencies_for_Public_Health_Professionals.aspx. Accessed 3-6-2014.

20 For more information on Core Competencies for Public Health Professionals, see 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 http://nwcphp.org/docs/phi/comps/phic_web.pdf. For information on NLN leadership competencies, see http://www.nln.org/faculty-programs/Competencies/index.htm.

**Figure 2.6: Familiarity with and Use of Public Health Core Competencies[20]**



# Descriptions and Examples of 2012 Occupational Classifications

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

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

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

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

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

Nurse practitioners.

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

Oral health professional. Includes public health dentists and dental hygienists.

Other.

Physician assistants.

Preparedness and response staff. Includes planners, responders, preparedness directors, preparedness policy staff, SNS [Strategic National Stockpile] coordinator, preparedness volunteer coordinator.

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

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

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

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

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

Public information specialist. Also known as public information officer.

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

Part II–State Public Health:

# What We Do

# Chapter 3: State Health Agency Activities

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



## Key Findings:

- State health agencies often have primary programmatic and fiscal responsibility for a variety of federal initiatives. When state health agencies do not have sole responsibility for an initiative, they typically share it with another state health agency, a local governmental agency, or a nonprofit organization.
- With the high level of collaboration between state health agencies, local health departments, the healthcare sector, and others, state health agencies often provide technical assistance and training to a variety of partners on different topics, most commonly on quality improvement, performance, and accreditation. Nearly all state health agencies provide training to local health agencies on disease prevention and control (94%), tobacco (92%), and preparedness (90%).
- The majority of state health agencies engage in activities to promote access to healthcare, particularly health disparities and minority health initiatives (94%) and rural health (72%). Additionally, the majority of state health agencies report providing financial support to primary care providers.
- State health agencies provide a number of services related to population-based primary prevention, screening, and treatment of diseases and conditions. The services provided by the greatest number of agencies are tobacco, HIV, and sexually transmitted disease counseling and partner notification.
- State health agencies perform a variety of functions related to surveillance, data collection, and laboratory functions. The three laboratory services provided by the greatest number of state health agencies are bioterror agent testing, foodborne illness testing, and influenza typing. Additionally, the majority of state health agencies perform the majority of data collection, epidemiology, and surveillance activities listed in the survey, with 100 percent of state health agencies directly performing reportable disease data collection, epidemiology, and surveillance activities, and 98 percent performing communicable/infectious disease, foodborne illness, and vital statistics activities in 2012.
- Fifty-nine percent of responding states indicated that their state would be establishing a health insurance exchange as part of the implementation of the Affordable Care Act. Among the 28 states that are establishing exchanges, the state health agency was engaged in that process in 20 of those states.

As in previous chapters, 2012 data will be compared with 2010 and 2007 data when possible, and differences in state health agency workforce by governance structure, region, and state population size will be noted when applicable. However, rather than note differences by agency characteristic for each of 248 public health activities, an index was created for each public health activity category by summing the number of activities performed by each state and the percentage of activities performed in a given category was compared by agency characteristic. For example, the 2012 Profile Survey had 15 items about screenings for diseases and conditions; the screening index was calculated by summing the number of those 15 types of screenings performed by each state.

## 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, a local governmental agency (e.g., a local health department), or a nonprofit organization. The 10 federal initiatives for which state health agencies most frequently report having responsibility are displayed in **Table 3.1**.

## Technical Assistance and Training

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 overall to local public health departments, most often for the topic of quality improvement/performance and accreditation.

In addition to providing technical assistance, state health agencies provide training to local health department personnel. As shown in **Figure 3.1**, the three topics for which the greatest percentage of state health agencies provide training to local health department personnel are disease prevention and control, tobacco, and preparedness. These were also the top three topics in 2010. On average, states in the South were more likely to provide technical assistance on a greater percentage of topics (90% performed in South; 71-77% performed in other regions). On average, small states provided technical assistance on fewer topics (mean = 5.81) than did medium and large states (mean = 8.88 for both).

## 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. State health agencies were asked to indicate the services they provide related

**Table 3.1: State Health Agency Responsibility for Federal Initiatives**

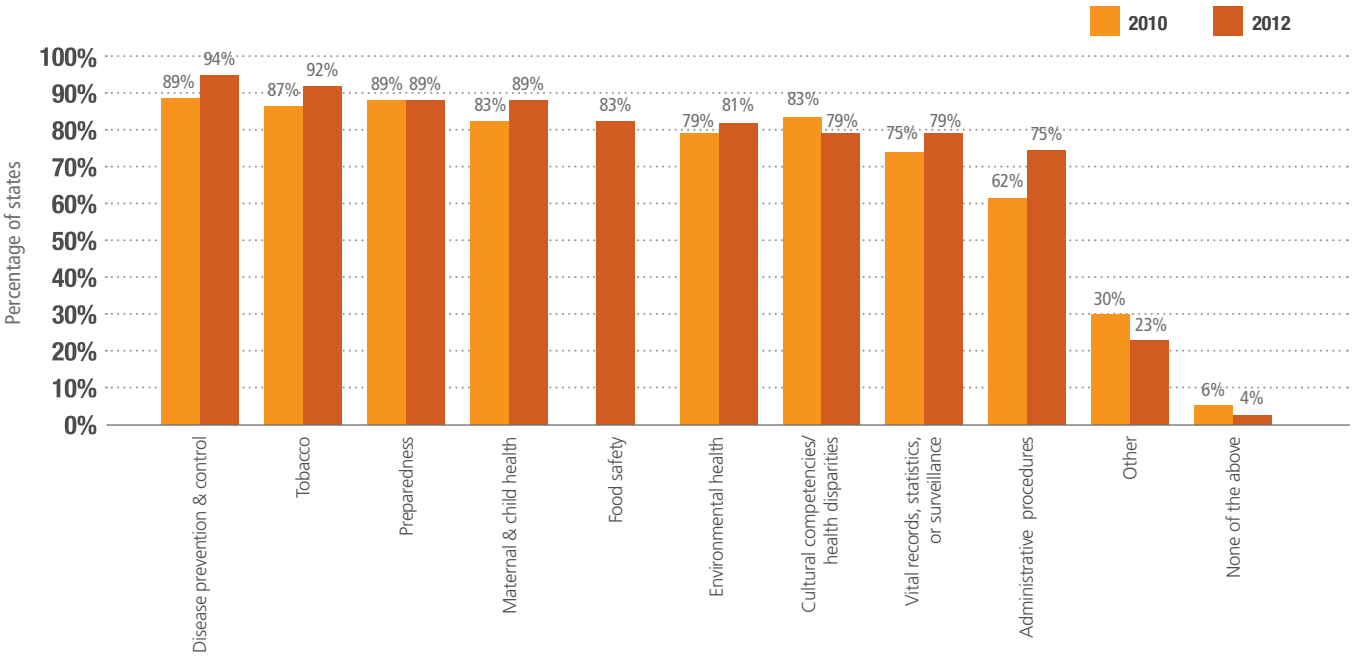
| Federal Initiative | n | % |
|---|---|---|
| Public Health Emergency Preparedness cooperative agreement (CDC) | 48 | 100% |
| Maternal and Child Health/Title V | 47 | 98% |
| Vital statistics (National Center for Health Statistics) | 47 | 98% |
| Preventive Health and Health Services Block Grant (CDC) | 46 | 96% |
| ASPR Hospital Preparedness Program cooperative agreement | 46 | 96% |
| National Cancer Prevention and Control Program Grant (CDC) | 45 | 94% |
| Immunization Funding, Section 317 | 44 | 92% |
| Women, Infants, and Children program (U.S. Department of Agriculture) | 44 | 92% |
| Healthy People | 43 | 90% |
| Injury Prevention (CDC) | 39 | 81% |

**Table 3.2: Technical Assistance Provided by State Health Agencies to Partners**

| 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 | 83% | 75% | 63% | 63% | 63% | 0% |
| Providers | 47 | 87% | 68% | 55% | 60% | 62% | 4% |
| Hospitals | 48 | 90% | 69% | 58% | 60% | 46% | 2% |
| Laboratories | 48 | 88% | 54% | 44% | 38% | 40% | 2% |
| Local public health agencies | 49 | 84% | 74% | 76% | 84% | 74% | 10% |
| Nonprofits/community-based organizations | 45 | 56% | 44% | 53% | 71% | 42% | 16% |

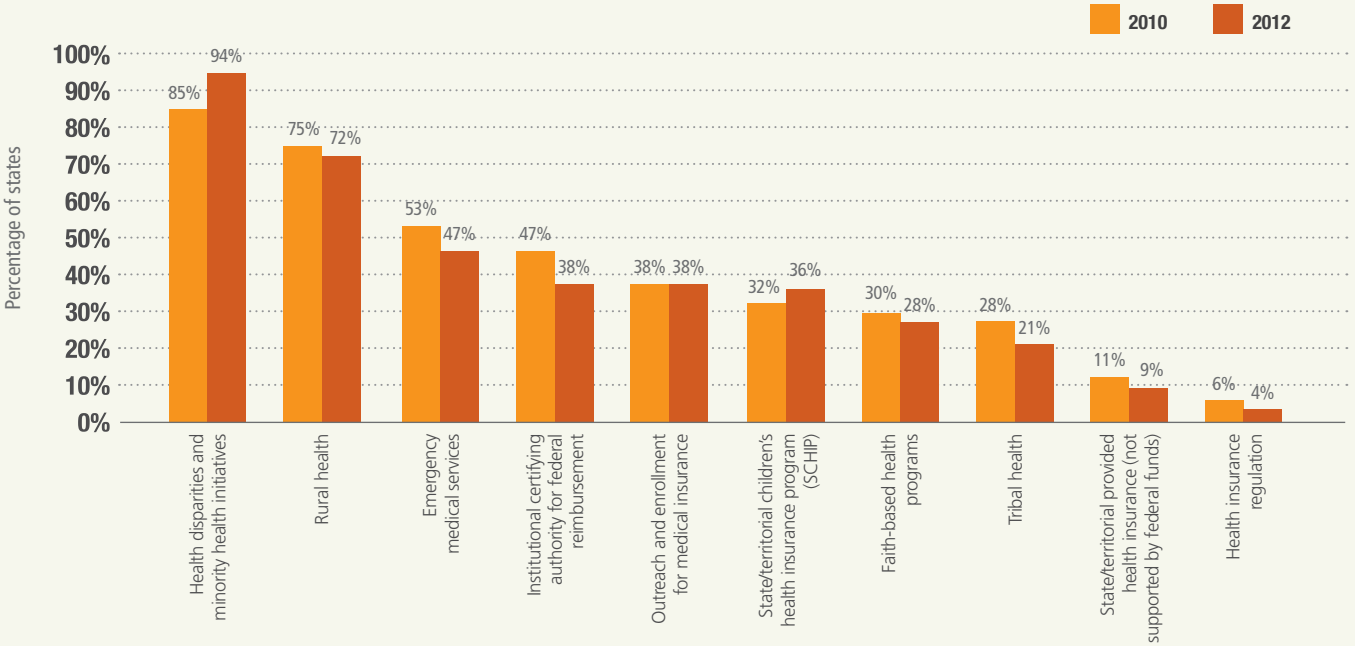
to healthcare. **Figure 3.2** shows the percentage of state health agencies that engage in activities to ensure access to healthcare services. The three activities performed by the greatest percentage of state health agencies to ensure access were health disparities and minority health initiatives, rural health initiatives, and emergency medical services. Health disparities/minority health initiatives showed the greatest increase from 2010 (85%) to 2012 (94%), while acting as the institutional certifying authority for federal reimbursement showed the greatest decrease from 2010 (47%) to 2012 (38%). In 2012, 71 percent of state health agencies report providing financial support to primary care providers.

**Figure 3.1: State Health Agency Training Provided to Local Health Department Personnel, 2010-2012 (n=47)**




*Note: Food safety only appeared on the 2012 Profile Survey.*

**Figure 3.2: State Health Agency Access to Healthcare Services, 2010-2012 (n=47)**



Many states do have state-sponsored loan repayment programs in place to increase the supply of select positions in the community. As shown in **Figure 3.3**, 85 percent of states have loan repayment programs to increase the supply of physicians and more than two-thirds have programs to increase the supply of dentists. The percentage of states with loan repayment programs for nurses has seen a decrease from 54 percent of states in 2010 to 42 percent in 2012. In contrast, the percentage of states with loan repayment programs for other primary care providers has increased from 23 percent in 2010 to 39 percent in 2012.

**Figure 3.3: State-Sponsored Loan Repayment Programs to Increase the Supply of Providers, 2010-2012 (n=26)**

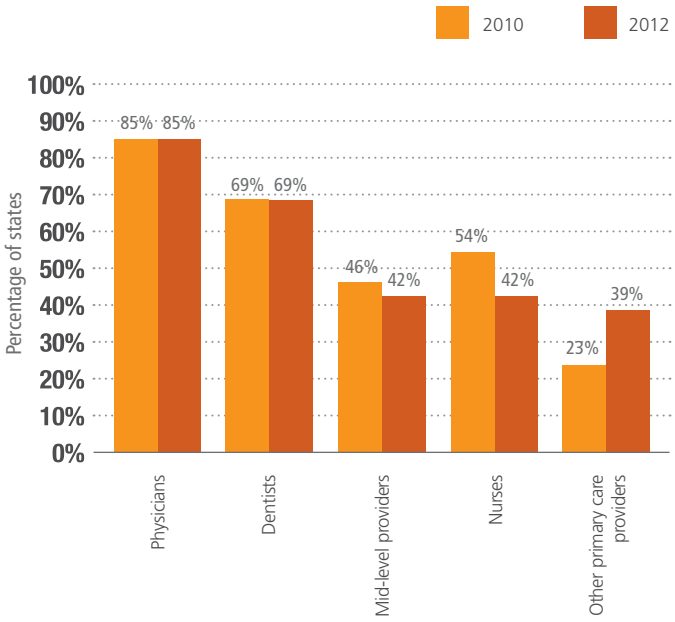
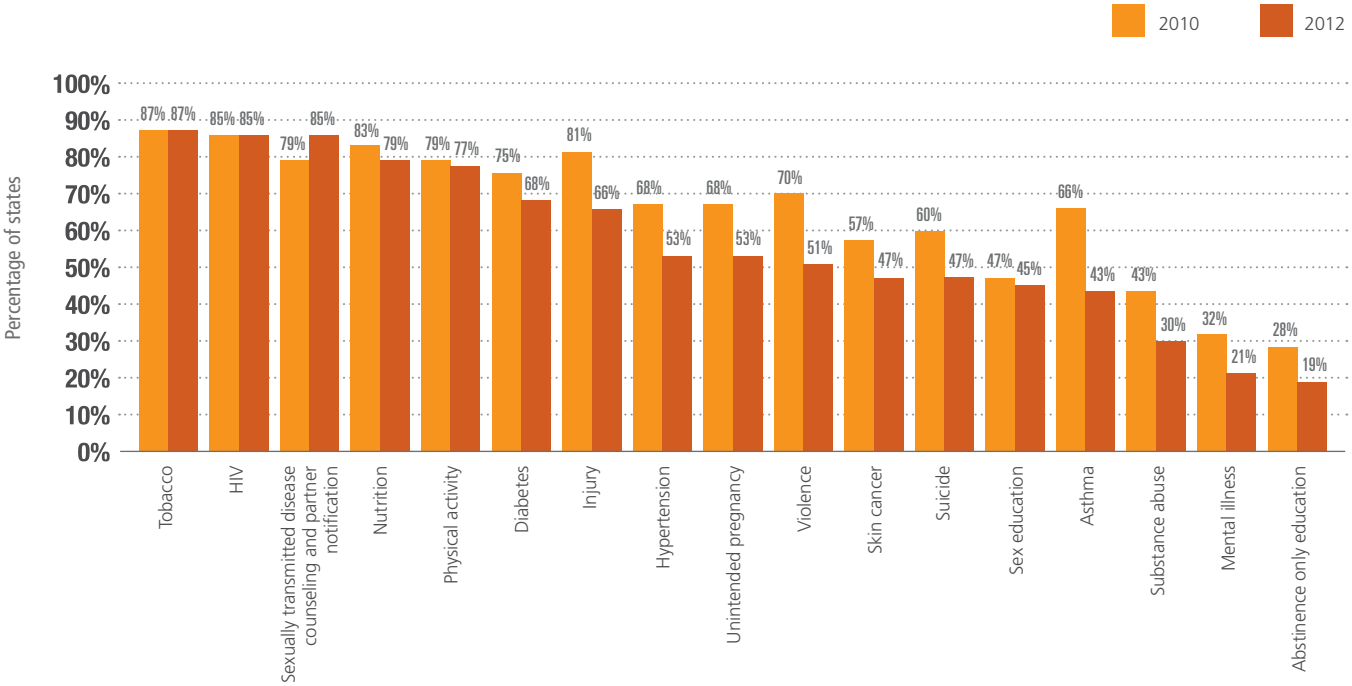



**Figure 3.4: Population-Based Primary Prevention Services Performed Directly by State Health Agencies, 2010-2012 (n=47)**



## Population-Based Primary Prevention Services

State health agencies provide a variety of population-based primary prevention services. **Figure 3.4** displays the percentage of state health agencies that directly performed population-based primary prevention services in 2010 and 2012. While provision of STD counseling and partner notification increased from 2010 (79%) to 2012 (85%), the percentage of state health agencies directly performing all other services remained the same or decreased from 2010 to 2012, with the overall trend decreasing.

Looking at population-based primary prevention activities overall, centralized/largely centralized states on average perform a greater percentage of population-based primary prevention services (67% of 17 activities) than do decentralized/largely decentralized states (50% of 17 activities). On average, states in the West perform the most population-based primary prevention services (72%) while states in the Mid-Atlantic and Great Lakes perform the fewest on average (44%). Performance of population-based primary prevention services is inversely related to population size, such that small states directly perform the greatest percentage of population-based primary prevention services on average (64%), followed by medium (57%) and large states (46%). Only the number of the prevention services provided was measured, and no information was collected about the quality or intensity of each service provided.

## Immunization Services

More than 90 percent of state health agencies are responsible for vaccine order management and inventory distribution for childhood immunizations, and more than 80 percent are responsible for vaccine order management and inventory distribution for adult immunizations. In contrast, approximately one-quarter perform order management for international travel immunizations directly (see **Figure 3.5**). 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 3.6**).

**Figure 3.5: Vaccine Order Management Performed Directly by State Health Agencies, 2010-2012 (n=48)**

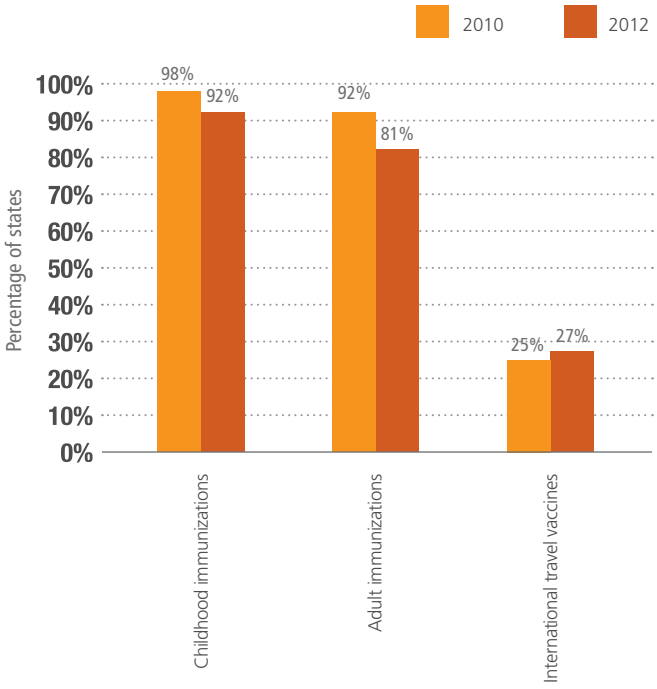
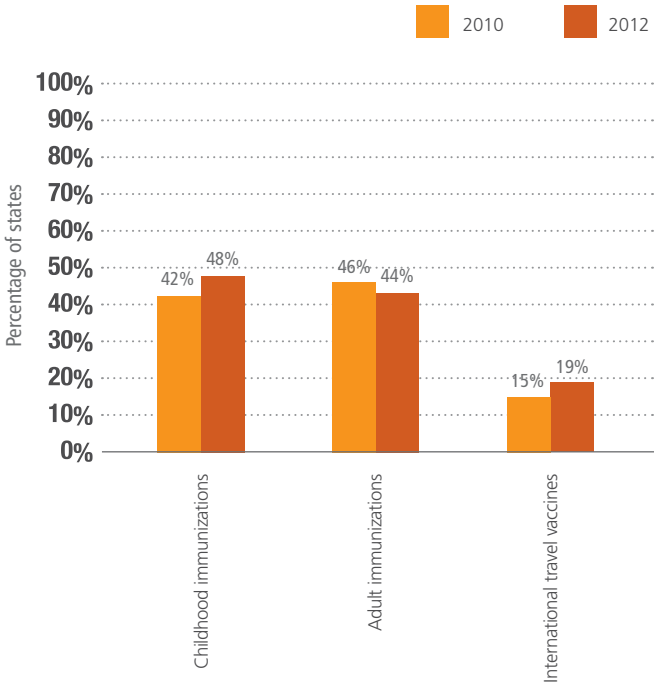



**Figure 3.6: Vaccine Administration to Population Performed Directly by State Health Agency, 2010-2012 (n=48)**



## Screening for Diseases and Conditions

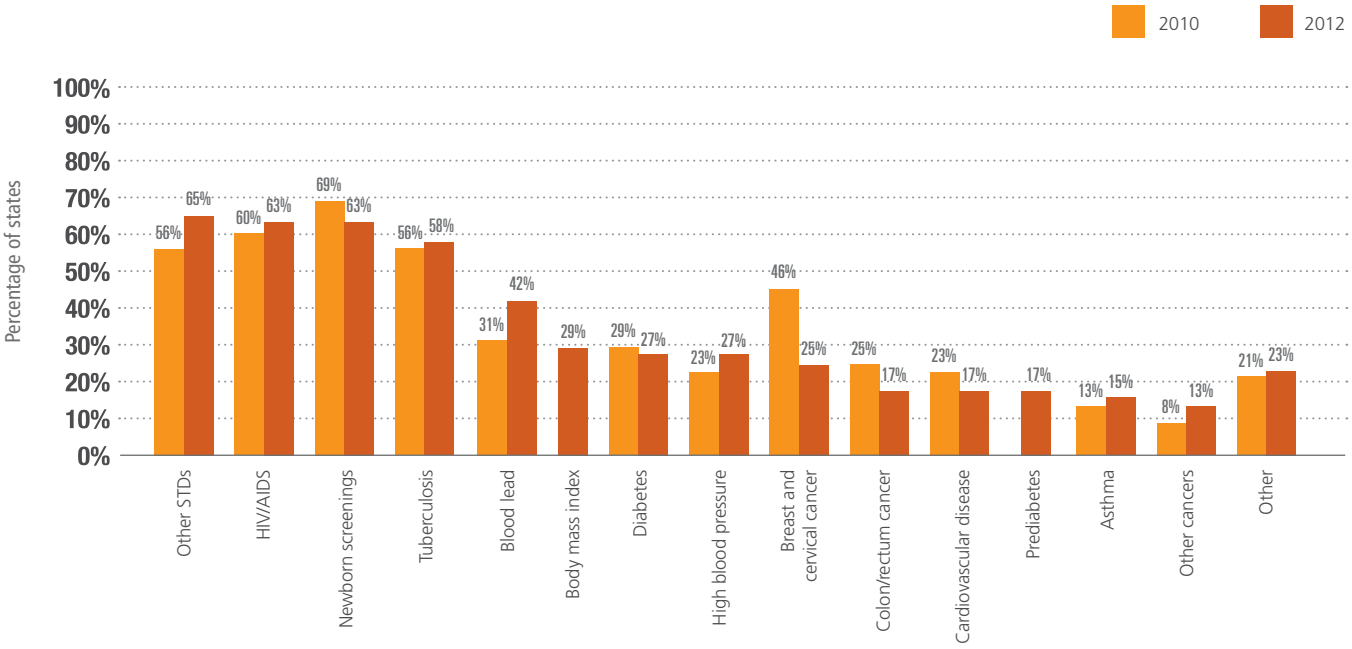
**Figure 3.7** displays the percentage of state health agencies that directly perform screenings for diseases and conditions. The three diseases and conditions screened for directly by the most state health agencies are HIV/AIDS, other STDs, and newborn screenings. From 2010 to 2012, blood lead screenings showed the greatest increase in frequency (31% in 2010 to 42% in 2012), while breast and cervical cancer screenings showed the greatest decrease in frequency of performance, dropping from 46 percent of state health agencies performing this service directly in 2010 to 25 percent in 2012.

Overall, centralized/largely centralized states performed a greater percentage of the 15 screening activities (45% performed on average) than did decentralized/largely decentralized states (24% performed on average). These data do not account for screenings that may be done at the local level by local health departments. States in the South performed substantially more screening activities (62% on average) than did states in other regions (percentages ranged from 20-28%).

## Other Clinical Services Provided to Individuals

State health agencies provide a variety of clinical services directly to individuals. As shown in **Figure 3.8**, oral health, pharmacy, and substance abuse education/prevention services were the three clinical services performed directly by the greatest percentage of state health agencies in 2012. All clinical services showed a decrease in direct performance by state health agencies from 2010 to 2012, with the exception of home healthcare, which remained stable at 15 percent. The performance of both domestic violence victim services and sexual assault victim services showed large drops from 2010 to 2012 (decreases of 17% and 23%, respectively). Performance of rural health clinical services also dropped 17 percentage points from 2010 to 2012. On average, centralized/largely centralized states performed a greater percentage of all clinical services listed (24%) than did decentralized/largely decentralized states (14%).

**Figure 3.7: Screening for Diseases and Conditions Performed Directly by State Health Agencies, 2010-2012 (n=48)**




*Note: Body mass index and prediabetes only appeared on the 2012 Profile Survey.*

## Treatment for Diseases

In addition to screening for diseases, state health agencies provide a variety of treatment services for diseases and conditions. **Figure 3.9** displays the percentage of state health agencies that directly provided treatment for select diseases and conditions from 2010 to 2012. In both 2010 and 2012, the greatest percentage of state health agencies provided treatment services for tuberculosis, HIV/AIDS, and other STDs.

On average, centralized/largely centralized states directly perform 20 percent of 13 treatment services for diseases, while decentralized/largely decentralized states perform 10 percent. On average, states in the South perform a greater percentage of disease treatment services directly than do states from other regions (35% for the South; range of 9-15% for other regions).

**Figure 3.8: Other Clinical Services Performed Directly by State Health Agencies, 2010-2012 (n=48)**

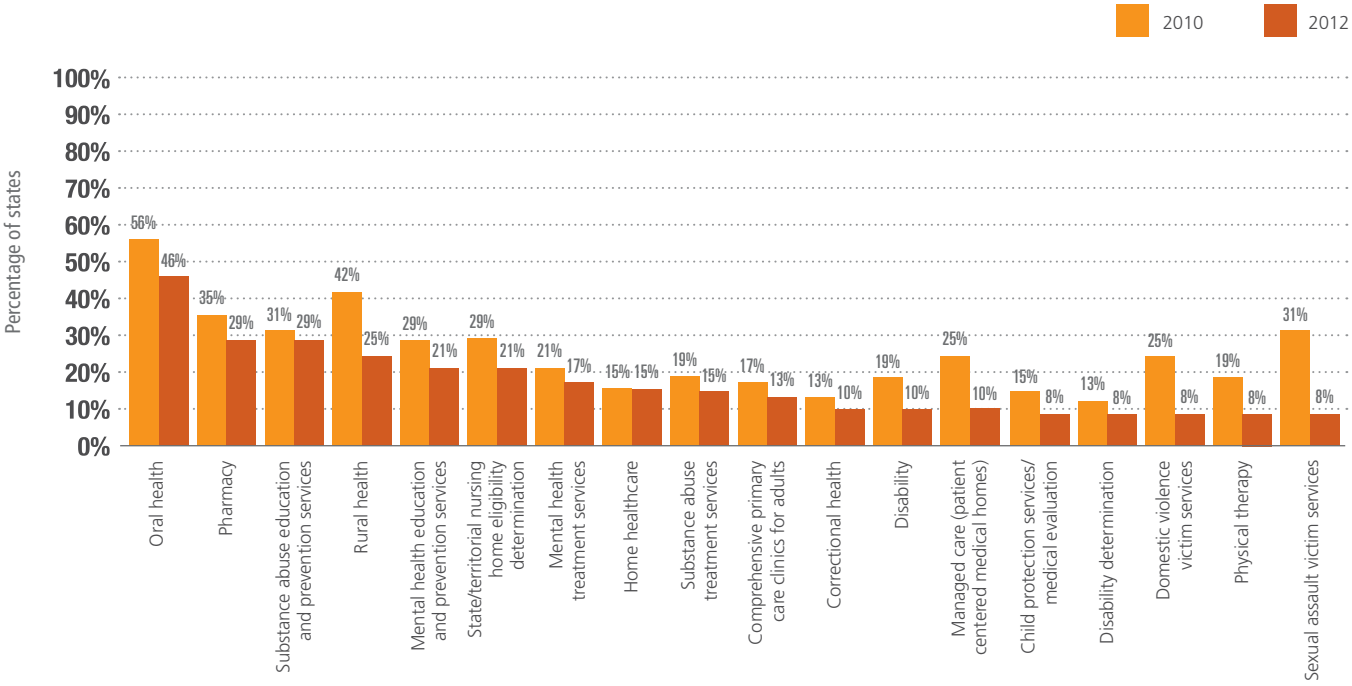
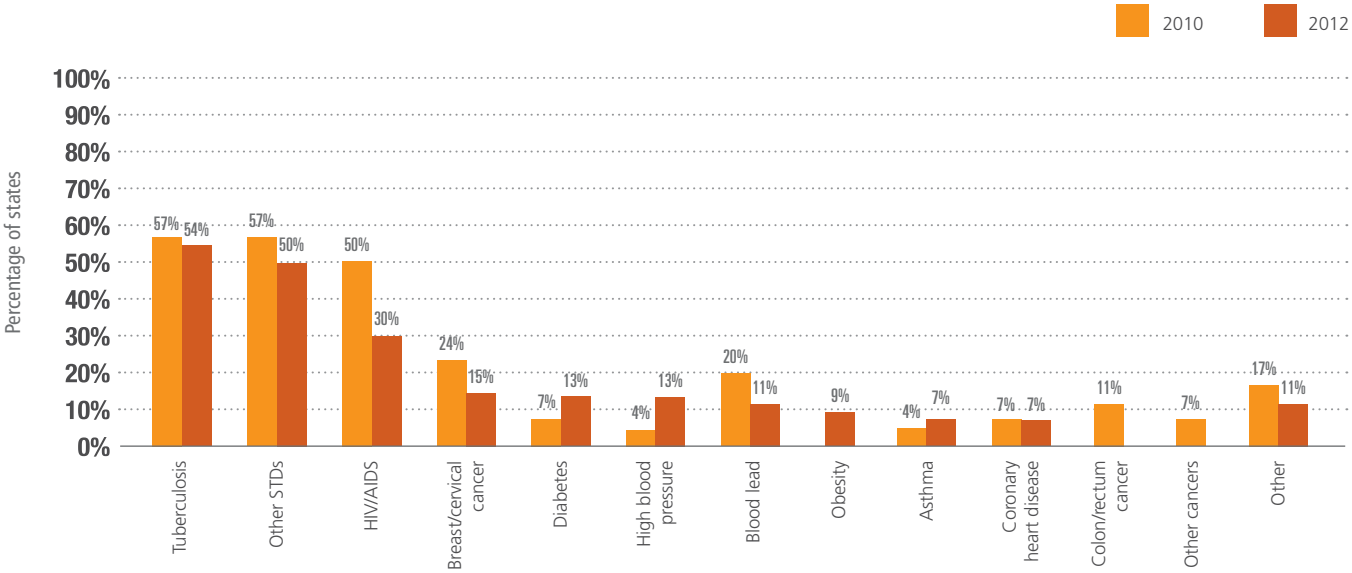



**Figure 3.9: Treatment for Diseases and Conditions Performed Directly by State Health Agencies, 2010-2012 (n=46)**




*Note: Obesity only appeared on the 2012 Profile Survey, while colon/rectum cancer and other cancers only appeared on the 2010 Profile Survey.*

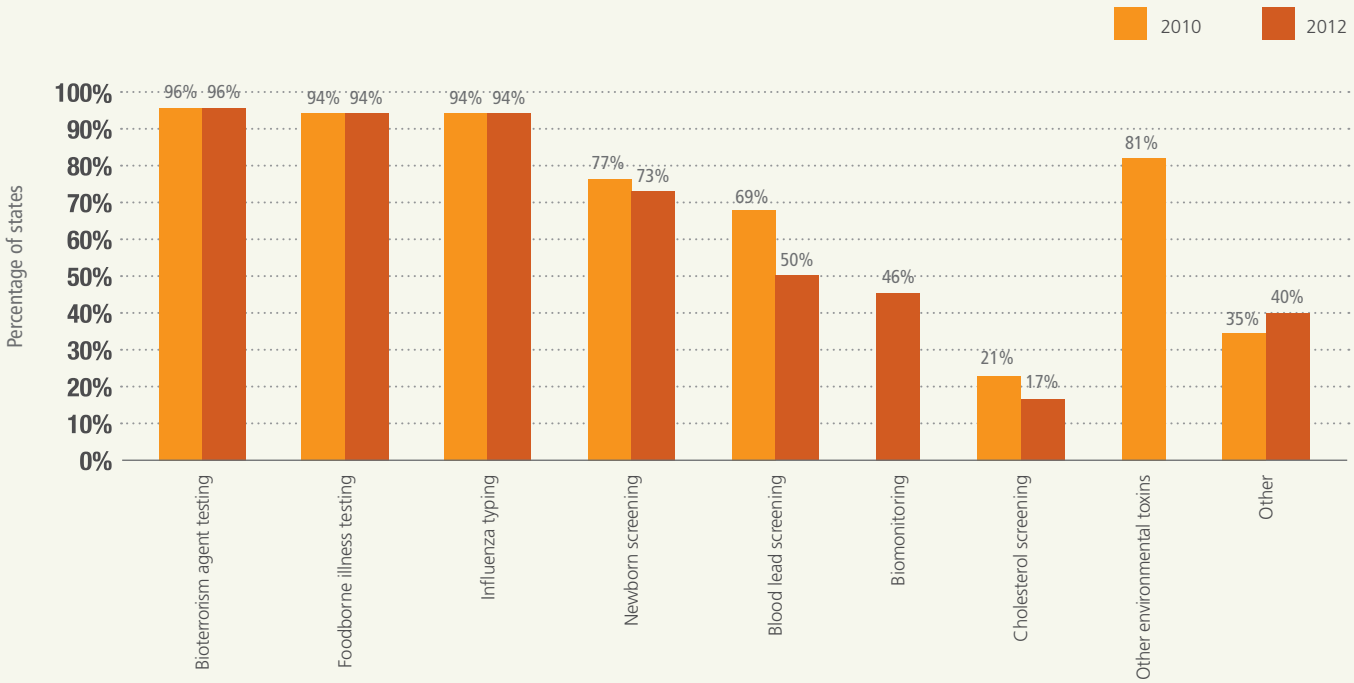
## State Laboratory Services

The laboratory services performed directly by state health agencies in 2010 and 2012 are displayed in **Figure 3.10**. In both 2010 and 2012, the three lab services performed by the most state health agencies directly 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 2012. Blood lead screening showed a notable decrease from 69 percent of state health agencies performing this service directly in 2010 to 50 percent in 2012. On average, medium and larger states performed a greater percentage of lab services (67% and 70% of lab services, respectively) than did small states (53%).

## Registry Maintenance

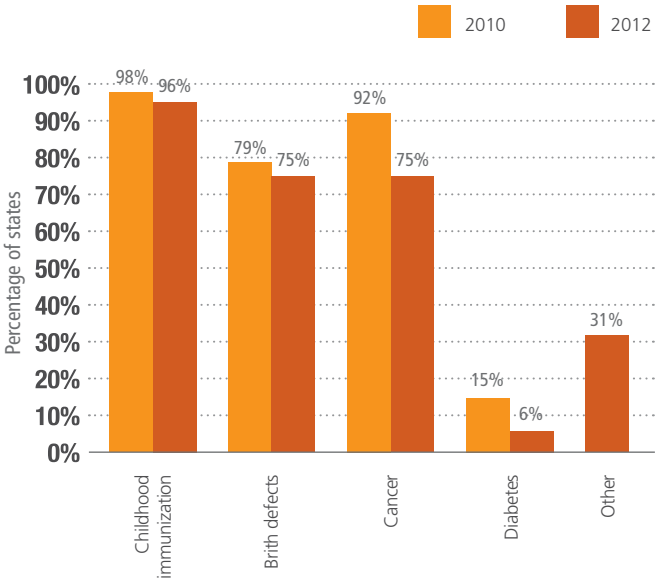
State health agencies maintain registries in response to state and federal mandates and to promote the health and well-being of their residents. The percentage of state health agencies that performed these activities directly in 2010 and 2012 is displayed in **Figure 3.11**. The three registries maintained by the greatest percentage of state health agencies in 2010 and 2012 were childhood immunization, birth defects, and cancer. All have shown some decrease in the percentage of state health agencies performing these activities from 2010 to 2012. Other registries maintained by state health agencies include autism, asthma, HIV/AIDS, and blood lead level registries, among others.

**Figure 3.10: Laboratory Activities Performed Directly by State Health Agencies, 2010-2012 (n=48)**




*Note: Other environmental toxins only appeared on the 2010 Profile Survey; biomonitoring only appeared on the 2012 Profile Survey.*

**Figure 3.11: Registry Maintenance Activities Performed Directly by State Health Agencies, 2010-2012 (n=48)**




*Note: Other only appeared on the 2012 Profile Survey.*

## Maternal and Child Health Services

The maternal and child health (MCH) services performed by state health agencies are displayed in **Figure 3.12**. Services for children with special healthcare needs, the U.S. Department of Agriculture's Women, Infants, and Children (WIC) program, and home visits were the three maternal and child health services provided directly by the greatest percentage of state health agencies in 2010 and 2012. While WIC and home visits remained fairly stable over time, a notable drop 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 60 percent in 2012.

On average, centralized/largely centralized states offered a greater percentage of maternal and child health services (47%) directly than did decentralized/largely decentralized states (19% of services provided on average). States in the South provided more of 14 MCH services on average than did states in other regions (55% of MCH activities offered in South on average; 21-28% of MCH activities offered in other regions on average).

**Figure 3.12: Maternal and Child Health Activities Performed Directly by State Health Agencies, 2010-2012 (n=48)**

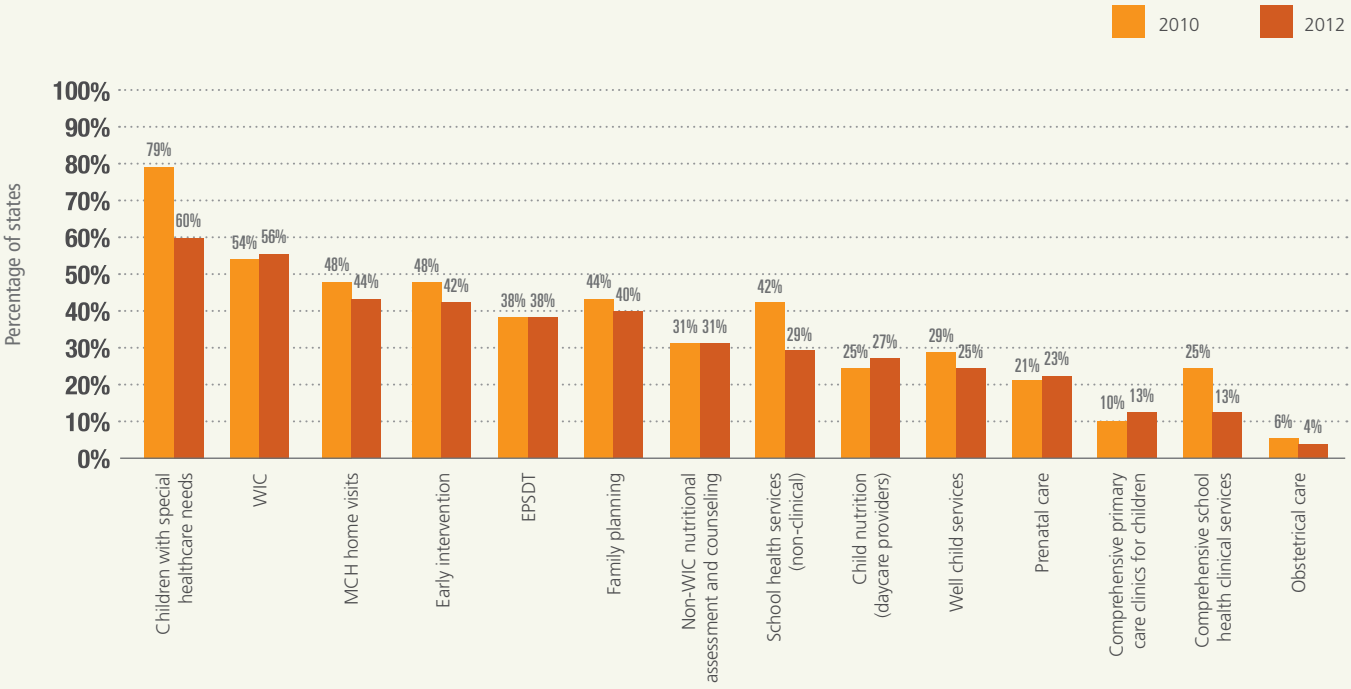
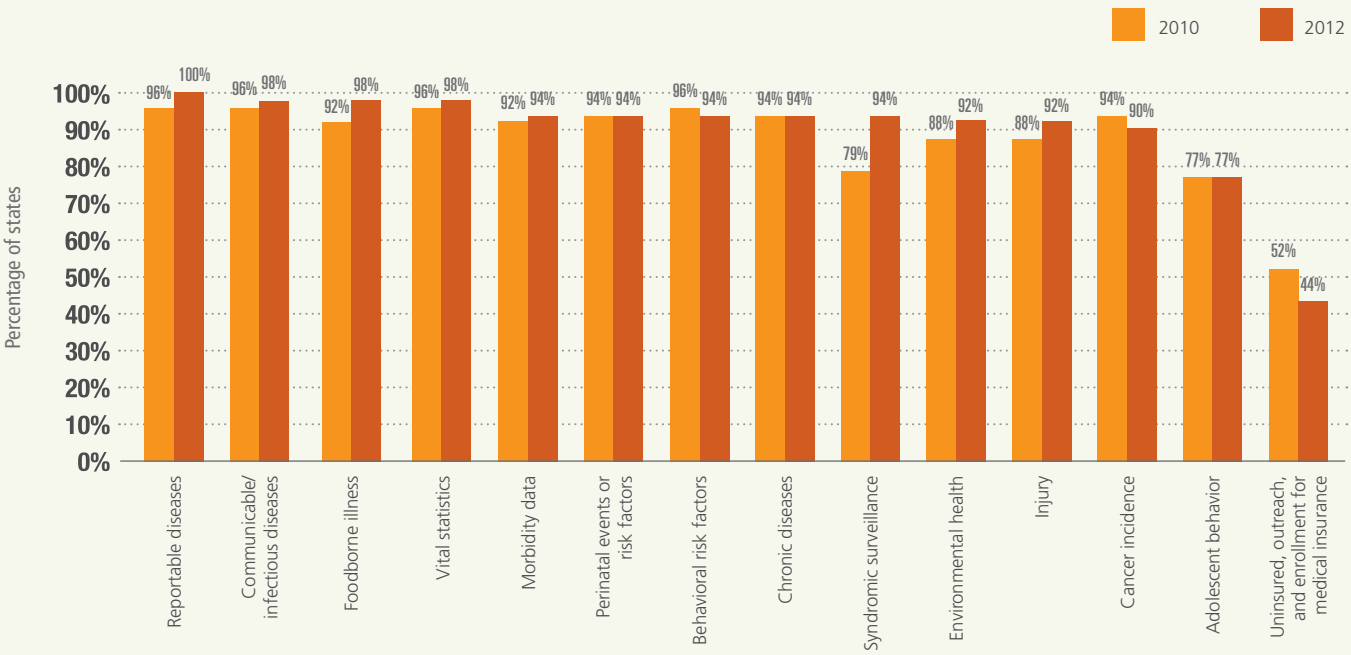


**Figure 3.13: Data Collection, Epidemiology, and Surveillance Activities Performed Directly by State Health Agencies, 2010-2012 (n=48)**




## Data Collection, Epidemiology, and Surveillance Activities

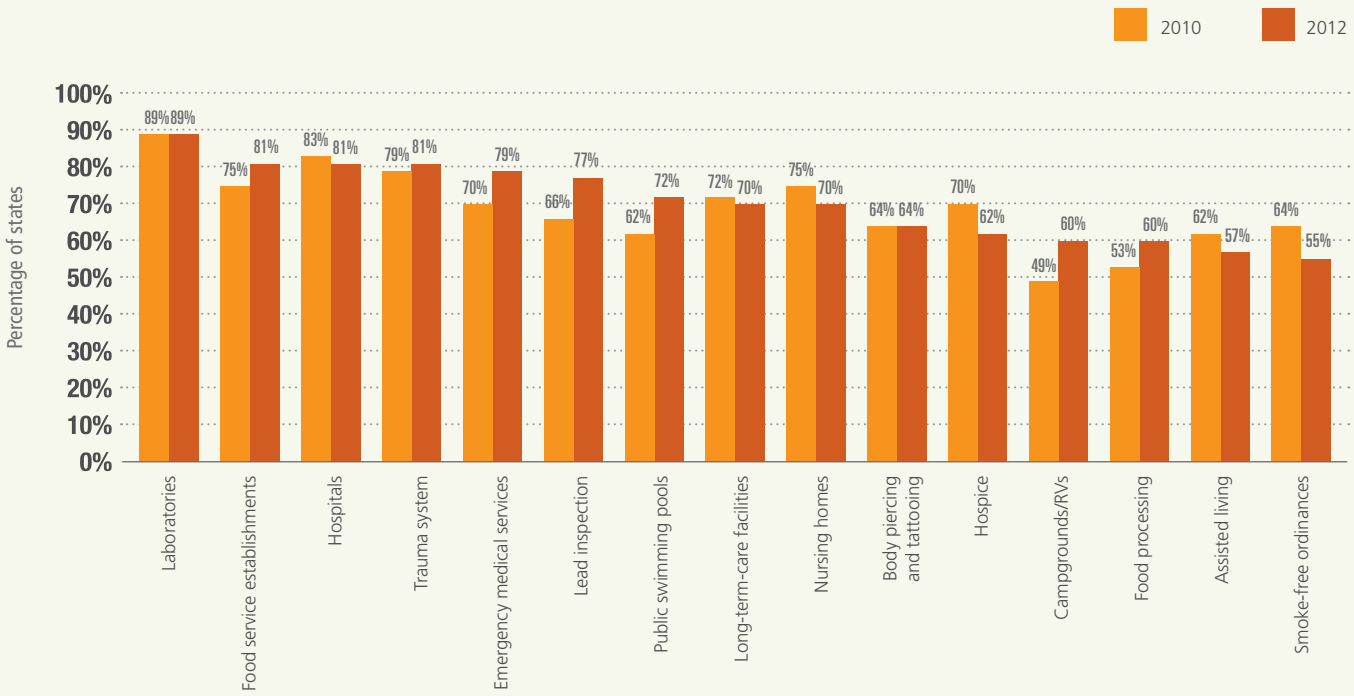
State health agencies often serve as the front lines for data collection, epidemiology, and surveillance activities (**Figure 3.13**). The majority of state health agencies perform the majority of data collection, epidemiology, and surveillance activities, and a number of activities showed increases in percentage of state health agencies performing them from 2010 to 2012. All state health agencies reported directly performing reportable diseases activities in 2012, and 98 percent of state health agencies reported performing communicable/ infectious disease, foodborne illness, and vital statistics activities in 2012. Syndromic surveillance activities showed the greatest increase over time, with 79 percent of state health agencies directly performing this activity in 2010 and 94 percent performing it directly in 2012.

## Regulation, Inspection, and Licensing

State health agencies enforce the laws and regulations that protect health and ensure safety. **Figure 3.14** shows the 15 most commonly performed regulation, inspection, and licensing activities. The four regulatory activities performed by the greatest percentage of state health agencies in 2012 were regulation, inspection, and licensing of laboratories, food service establishments, hospitals, and trauma systems. While regulation of labs remained constant from 2010 to 2012, regulation of hospitals showed a small decrease over time (2%), regulation of food service showed an increase from 75 percent in 2010 to 81 percent in 2012, and regulation of trauma systems showed an increase of 2 percent from 2010 to 2012.

Looking at all the regulation, inspection, and licensing activities together, states in New England performed a greater percentage of these activities on average

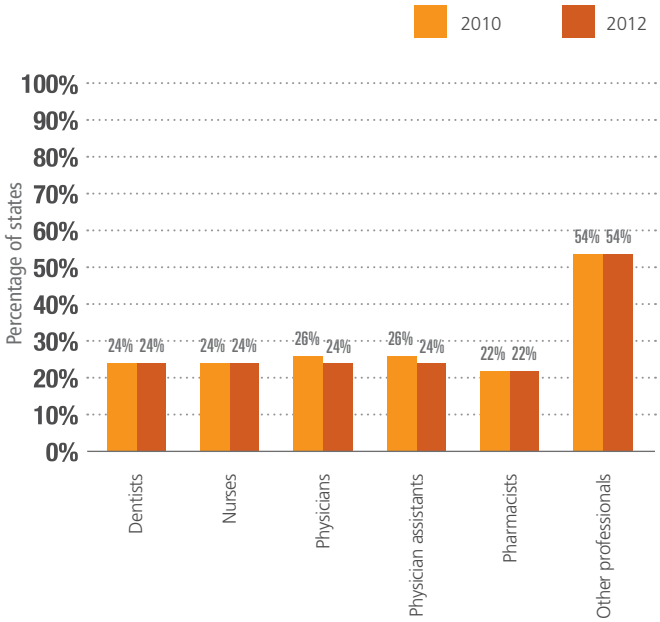
**Figure 3.14: Top 15 Regulation, Inspection, and Licensing Activities Performed Directly by State Health Agencies, 2010-2012 (n=47)**




than did other regions (57% New England; 40-47% for other regions). Medium and large states on average also performed a greater percentage of regulation, inspection, and licensing activities (49% and 50%, respectively) than did small states (42%).

State health agencies are also involved in oversight of professional licensure activities. **Figure 3.15** displays the percentage of state health agencies that directly performed professional licensure activities in 2010 and 2012. Overall, the percentage of state health agencies performing the various professional licensure activities remained stable from 2010 to 2012, with about one-quarter of state health agencies directly performing professional licensure activities. States in New England tended to perform more professional licensure activities than did states in other regions (40% performed on average in New England; range of 21-33% performed by other regions). The category "other professionals" included emergency medical technicians, midwives, and nurse aides, among many others.

**Figure 3.15: Professional Licensure Activities Performed Directly by State Health Agencies, 2010-2012 (n=46)**



## Environmental Health Activities

Human health is inextricably linked to the environments in which we live, so state health agencies are key players in environmental health. **Table 3.3** shows the percentage of state health agencies that performed select environmental health activities in 2010 and 2012. In 2012, 94 percent of state health agencies were involved in environmental epidemiology (a slight increase from 2010) and 83 percent were involved in food safety training and education (a 7% decrease from 2010). Outdoor air quality showed the greatest increase over time, from 10 percent in 2010 to 25 percent in 2012, while performance of poison control activities showed the greatest decrease over time, from 33 percent of state health agencies performing this directly in 2010 to only 13 percent in 2012.

**Table 3.3: Environmental Health Activities Performed Directly by State Health Agencies, 2010-2012 (n=48)**

| | 2010 | 2012 |
|---|---|---|
| | Percentage of State Health Agencies | Percentage of State Health Agencies |
| Environmental epidemiology | 92% | 94% |
| Food safety training/education | 90% | 83% |
| Radiation control | 69% | 69% |
| Toxicology | 75% | 69% |
| Indoor air quality | 71% | 65% |
| Radon control | 58% | 63% |
| Vector control | 63% | 56% |
| Groundwater protection | 46% | 48% |
| Public water supply safety | 52% | 48% |
| Private water supply safety | 52% | 46% |
| Hazmat response | 35% | 35% |
| Surface water protection | 35% | 29% |
| Outdoor air quality | 10% | 25% |
| Animal control | 19% | 17% |
| Hazardous waste disposal | 21% | 17% |
| Collection of unused pharmaceuticals | 19% | 13% |
| Land use planning | 15% | 13% |
| Poison control | 33% | 13% |
| Noise pollution | 8% | 8% |
| Coastal zone management | NA | 2% |
| Other pollution prevention | 6% | 10% |
| Air pollution | 21% | NA |
| Mosquito control | 40% | NA |

*Note: Coastal zone management only appeared on the 2012 Profile Survey; air pollution and mosquito control only appeared on the 2010 Profile Survey.*

**Table 3.4: Other Public Health Activities Performed Directly by State Health Agencies, 2010-2012 (n=48)**

| | 2010 | 2012 |
|---|---|---|
| | Percentage of State Health Agencies | Percentage of State Health Agencies |
| Trauma system coordination | 81% | 88% |
| Veterinarian public health activities | 71% | 81% |
| State/territorial health planning and development | 77% | 77% |
| Health consultations for childcare environments | NA | 69% |
| Institutional review board | 67% | 63% |
| Nonclinical services in correctional facilities | 60% | 63% |
| Occupational safety and health services | 35% | 27% |
| State/territorial mental health institutions/hospitals | 23% | 27% |
| Medical examiner | 23% | 25% |
| Support for military personnel, veterans, and their families | NA | 23% |
| Forensics laboratory | 31% | 21% |
| State/territorial mental health authority with substance abuse | 19% | 21% |
| Eldercare services | 15% | 17% |
| Needle exchange | 27% | 13% |
| State/territorial tuberculosis hospitals | 15% | 13% |
| State/territorial mental health authority without substance abuse | 8% | 10% |
| Substance abuse facilities | 17% | 8% |
| Agriculture regulation | 4% | 6% |

*Note: Health consultations for childcare environments and support for veterans and military personnel and their families only appeared on the 2012 Profile Survey.*

Looking at the environmental health activities overall, small states on average performed a lower percentage of environmental health activities (33%) than did medium and large states (43% and 41%, respectively).

## Other Public Health Activities

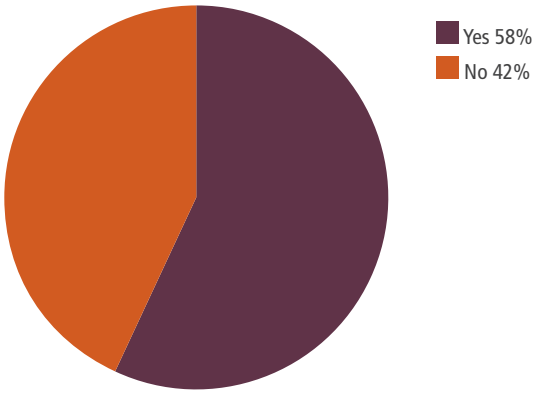
Other public health activities frequently provided directly by state health agencies in 2010 and 2012 are displayed in **Table 3.4**. In both 2010 and 2012, the three other public health activities performed directly by the greatest percentage of state health agencies are trauma system coordination, veterinarian public health activities, and state health planning and development services. The percentage of state health agencies performing veterinary public health activities directly increased from 71 percent in 2010 to 81 percent in 2012. The largest decrease over time in the percentage of state health agencies performing an activity was seen for needle exchange, with 27 percent providing this service directly in 2010 and only 13 percent providing it directly in 2012.



## Health Insurance Exchanges

State health agencies were asked whether or not their state was currently establishing a health insurance exchange. Of the 48 states that responded to this question, more than half are establishing health insurance exchanges (see **Figure 3.16**). On average, decentralized/largely decentralized states are slightly more likely to be establishing health insurance exchanges than are centralized/largely centralized states (68% vs. 62%). States in the Mid-Atlantic and Great Lakes are most likely to be establishing health insurance exchanges on average (83%), while states in the South are least likely to be doing so on average (33%). A greater percentage of medium (65%) and large (67%) states are establishing health insurance exchanges than are small states (44%). Among the 28 states that are establishing health insurance exchanges, the state health agency is engaged in the process of establishing the health insurance exchange in 20 of these states (71%).

**Figure 3.16: Establishment of Health Insurance Exchanges by States in 2012 (n=48)**



## Worksite Wellness

Worksite wellness programs can help state health agencies support the physical and emotional well-being of their employees and serve as a model for other agencies and businesses in their communities. Components of worksite wellness programs offered at state health agencies in 2010 and 2012 are shown in **Figure 3.17**. A greater percentage of state health agencies engaged in almost every worksite wellness activity in 2012 compared with 2010, except for three: weight loss or physical activity challenges or incentives, smoke-free venues for offsite meetings, and menu labeling in the office building cafeteria. The greatest increase was observed for healthy maternity policies (80% in 2010 to 96% in 2012) and insurance coverage for tobacco cessation programs (62% in 2010 to 81% in 2012). On average, smaller states tended to offer fewer worksite wellness program components than did medium and large states.

## Research Activities

State health agencies promote research and disseminate research findings in various ways. **Figure 3.18** shows the types of research activities state health agencies participated in over the past two years. A substantially greater percentage of decentralized/largely decentralized states (72%) reported participating in activities to help other organizations apply research findings to practice than did centralized/largely centralized states (23%). States in the Mid-Atlantic and Great Lakes and the Mountains and Midwest were less likely to apply research findings to practices within the organization (33% and 50%, respectively) than were states in the other three regions (percentages for other regions ranged from 83%-100%).

**Figure 3.17: Components of Worksite Wellness Programs Implemented at State Health Agencies, 2010-2012 (n=47)**

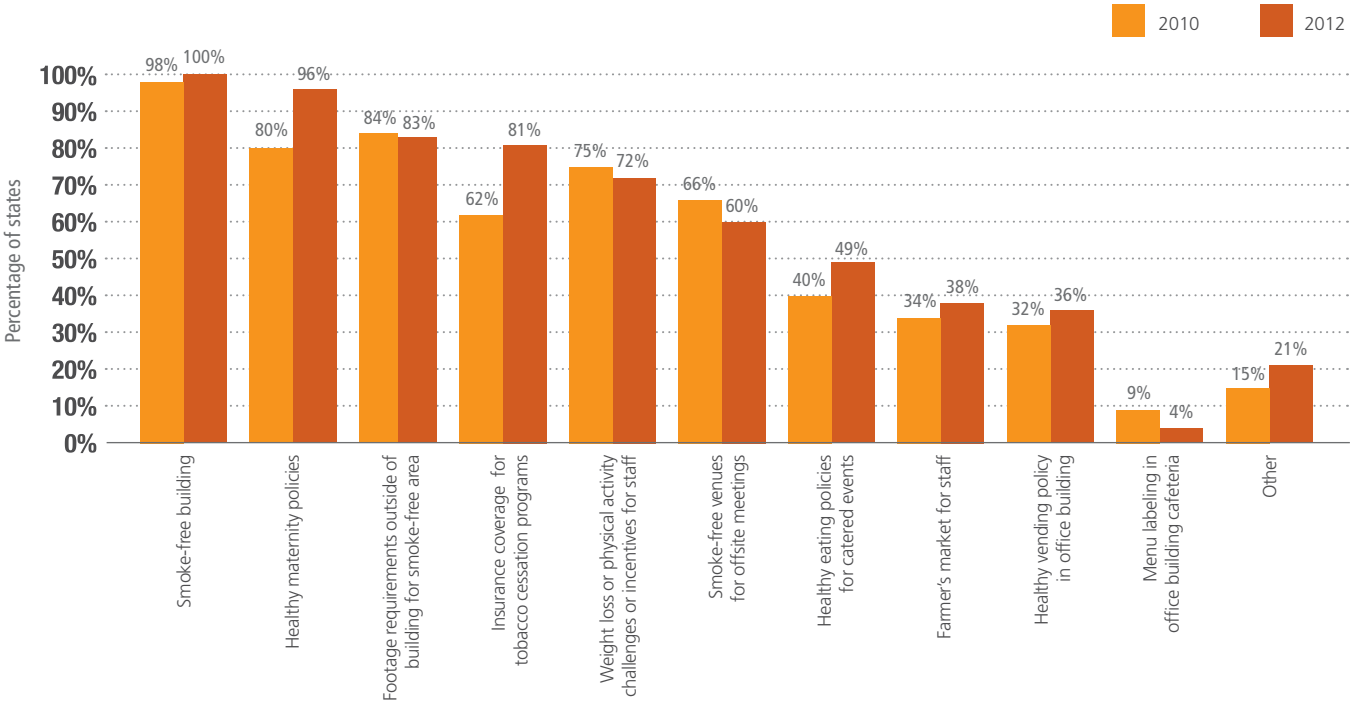
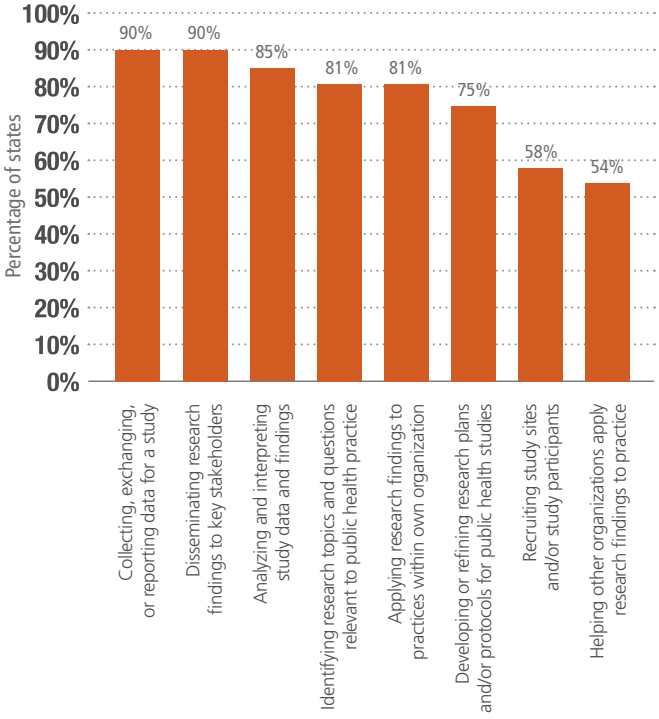


**Figure 3.18: Participation in Research Studies in Past Two Years by State Health Agencies (n=48)**




The number of research studies that state health agencies have engaged in over the past two years ranges from a minimum of one to a maximum of 427 (mean number of studies = 46; median = 15). On average, 41 percent of these studies are led by the state health agency. On average, states in New England have participated in the greatest number of studies (mean = 99; median = 35) while states in the Mountains and Midwest have participated in the lowest number of studies (mean = 16; median = 6). On average, large states have participated in more research studies in the past two years than have medium and small states.

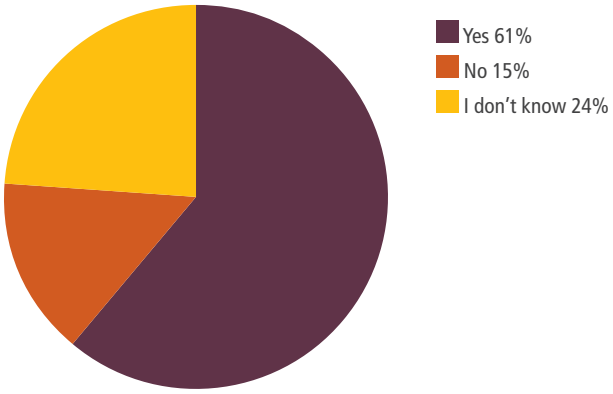
When states do participate in research studies, an average of 27 studies are conducted with researchers based at a university or research institute. When state health agencies do collaborate with researchers, about 30 percent of the studies involve a formal research agreement between the agency and the university or research institute to conduct joint studies on a reoccurring basis.

## Health Impact Assessments

Health impact assessments are the process by which the potential health effects of a project or policy are systematically evaluated. State health agencies were asked if anyone in the agency had attended a health impact assessment (HIA) training in the past two years. More than half of state health agencies reported that someone in the agency attended a HIA training in the past two years (see **Figure 3.19**). Nearly one-quarter (24%) of states were unsure whether or not anyone in the state health agency had attended an HIA training in the past two years. Individuals from states in the West were most likely to have participated in an HIA training (80%), while individuals from states in the Mountains and Midwest were least likely to have done so (44%).

States were also asked if their state health agency had participated in an HIA in the past two years; less than half had (45%). Of those states that reported participating in a health impact assessment, state health agencies had conducted or been part of two to three HIAs in the past two years on average.

**Figure 3.19: Participation in HIA Training in Past Two Years by Anyone in State Health Agency (n=46)**

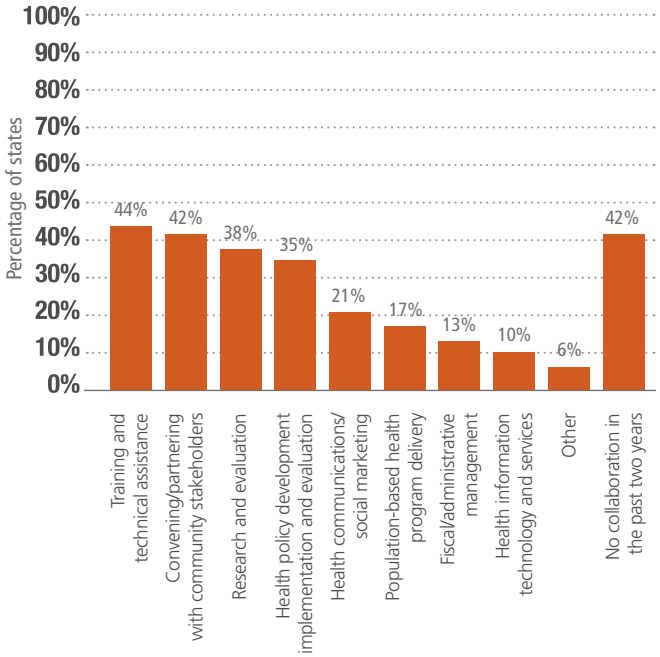



## Public Health Institute Collaboration

Public health institutes are nonprofit organizations that leverage resources and build partnerships across sectors in different geographic areas. In some instances, state health agencies report some form of collaboration with public health institutes over the past two years (see **Figure 3.20**). Collaboration with public health institutes most frequently occurs for training and technical assistance, convening/partnering with community stakeholders, and research and evaluation. The larger the state, the more likely they are on average to collaborate with public health institutes on the following: training and technical assistance; convening/partnering with community stakeholders; research and evaluation; health policy development, implementation, and evaluation; health communications/social marketing; and population-based health program delivery.

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

**Figure 3.20: Collaboration Between Public Health Institutes and State Health Agencies (n=48)**



Part III–State Public Health:

# How We Do It

# Chapter 4: Planning and Quality Improvement



This chapter describes state health agencies' completion of accreditation prerequisites and intentions to apply for accreditation, state health agency performance management systems and quality improvement (QI) efforts, staff involvement in quality improvement, and use of U.S. Preventive Services Task Force's Community Guide to Preventive Services. Where available, 2012 data will be compared with 2010 and 2007 data, and differences in state health agency planning and quality improvement efforts by governance structure, region, and state population size will be described.

## Key Findings:

- In 2012, 69 percent of state health agencies reported completing a state health assessment, with 85 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 increased from 23 percent in 2007 to 38 percent in 2010 to 43 percent in 2012.
- As of 2012, 75 percent of state health agencies have developed an agency-wide strategic plan. From 2010 to 2012, the percentage of state health agencies that planned to develop an agency-wide strategic plan in the next year increased from 7 percent to 23 percent.
- Four-fifths of state health agencies reported that they plan to seek accreditation through the Public Health Accreditation Board's voluntary national accreditation program. Of the 26 states that plan to pursue accreditation but have not yet submitted a letter of intent, 85 percent intend to do so in 2013 or 2014.
- The three most common frameworks/approaches used for quality improvement in state health agencies are Plan-Do-Check-Act or Plan-Do-Study-Act (used by 88% of state health agencies), Lean (used by 43%), and Six Sigma (used by 20%).
- When asked about their use of specific quality improvement techniques, all state health agencies reported obtaining baseline data, 96 percent reported setting measurable objectives, and 88 percent reported mapping a process.
- The most common ways that state health agencies support or encourage staff involvement in quality improvement efforts is through staff training on QI methods (85%), a QI committee to coordinate QI efforts (48%), and job descriptions that include QI-related responsibilities (44%).

## Accreditation Prerequisites

The Public Health Accreditation Board (PHAB) established a voluntary national accreditation program for state, local, and tribal health agencies in 2011. Accreditation through PHAB provides agencies with the opportunity to measure their performance and demonstrate accountability. There are three prerequisites for accreditation, all of which relate to planning and quality improvement: 1) conducting a state health assessment, 2) creation of a state health improvement plan, and 3) development of an agency-wide strategic plan.

## State Health Assessments

As of 2012, 69 percent of state health agencies have developed a state health assessment; 85 percent of those have done so within the last three years. From 2010 to 2012, the percentage of state health agencies that developed a state health assessment in the last three years increased from 49 percent to 57 percent. Additionally, from 2010 to 2012 the percentage of state health agencies that plan to develop a health assessment in the next year increased from 11 to 28 percent (see **Figure 4.1**).

Centralized/largely centralized states are twice as likely as decentralized/largely decentralized states to be planning to develop a health assessment in the next year (31% of centralized/largely centralized vs. 15% decentralized/largely decentralized). The Mid-Atlantic and Great Lakes had the highest proportion of states (75%) that had developed a health assessment in the last three years, while the lowest proportion was in the West (29%). Larger states (69%) are more likely to have completed a health assessment in the last three years than small (56%) and medium (53%) states. Conversely, small (31%) and medium (29%) states are more likely to be planning to develop a health assessment in the next year than are large states (19%). The three-year timeframe is tied to PHAB's prerequisites for voluntary accreditation.

**Figure 4.1: Development of State Health Assessment Plans by State Health Agencies, 2010-2012 (n=47)**

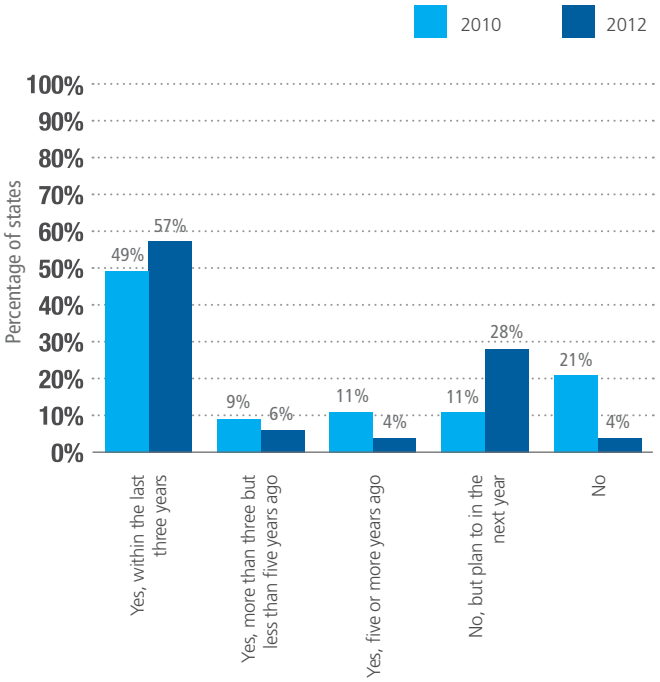
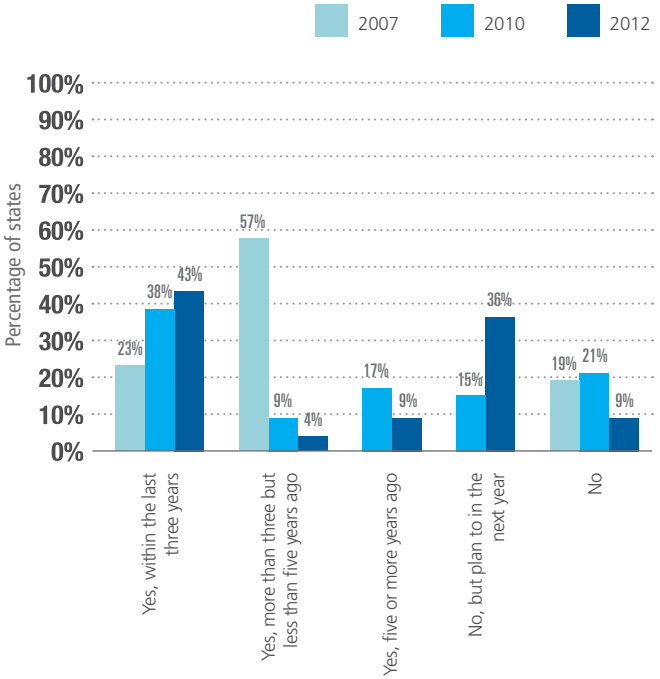



**Figure 4.2: Development or Participation in Development of a State Health Improvement Plan, 2007-2012 (n=47)**




*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.*

## State Health Improvement Plans

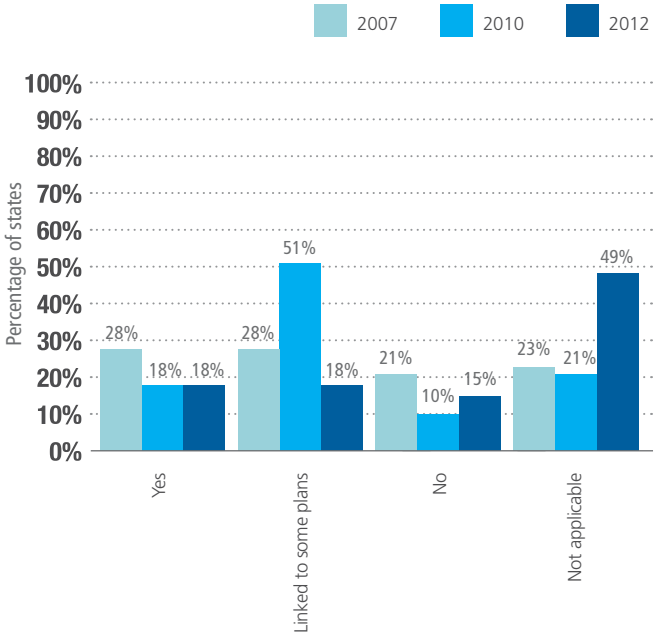
As of 2012, 57 percent of the 49 responding state health agencies developed or participated in developing a state health improvement plan. Of those that had developed or participated in developing a state health improvement plan, 75 percent had done so within the last three years. From 2007 to 2012, the percentage of state health agencies that developed or participated in developing a state health improvement plan in the last three years increased from 23 percent in 2007 to 38 percent in 2010 to 43 percent in 2012. Additionally, from 2010 to 2012, the percentage of state health agencies that plan to develop or participate in developing a state health improvement plan in the next year more than doubled, from 15 percent to 36 percent (see **Figure 4.2**).

Decentralized/largely decentralized states are more than four times as likely as centralized/largely centralized states to have developed or participated in developing a state health improvement plan in the last three years (62% of decentralized/largely decentralized vs. 15% centralized/largely centralized). A greater percentage of states in New England plan to develop or participate in developing a state health improvement plan in the next year (63%) than states in the other four regions (percentages range from 25-33%). A greater percentage of medium (47%) and large (56%) states have developed or participated in developing a state health improvement plan in the last three years than small (25%) states.

Of the 27 states reporting a state health improvement plan in 2012, 23 (85%) intend to update the plan within the next three years. Seventy-four percent of state health agencies with a health improvement plan have one that was developed using the results of a state health assessment. Decentralized/largely decentralized states are substantially more likely to have developed their state health improvement plan using the results of a state health assessment than are centralized/largely centralized states (94% of decentralized/largely decentralized states vs. 17% of centralized/largely centralized states). Additionally, the larger the state, the more likely they are to have developed their state health improvement plan using the results of a state health assessment (44% of small states, 78% 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 2012, 37 percent of state health agencies with state health improvement plans had plans that were linked to local health improvement plans. The percentage of state health agencies with state health improvement plans linked to local health improvement plans from 2007 to 2012 is displayed in **Figure 4.3**. From 2007 to 2012, the percentage of all state health agencies with state health improvement plans linked to local health improvement plans decreased from 28 percent in 2007 to 18 percent in 2010 and 2012; the percentage linked to some plans decreased from 51 percent in 2010 to 18 percent in 2012. Decentralized/largely decentralized states are more likely to have state health improvement plans linked to local health improvement plans than are centralized/largely centralized states (47% vs. 0%).

**Figure 4.3: Linking of State Health Improvement Plans to Local Health Improvement Plans, 2007-2012 (n=39)**



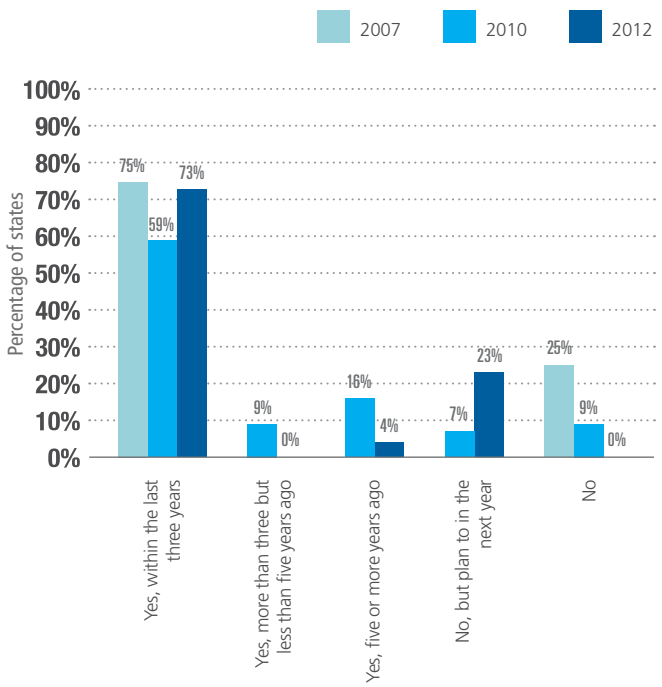
## Agency-Wide Strategic Plans

As of 2012, 75 percent of state health agencies have developed an agency-wide strategic plan; 95 percent of those have done so within the last three years. A greater percentage of decentralized/largely decentralized states (81%) have developed a strategic plan in the last three years than centralized/largely centralized states (54%). The percentage of state health agencies with strategic plans from 2007 to 2012 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 75 percent to 59 percent. This number was near 2007 levels in 2012, with 73 percent having developed an agency-wide strategic plan in the last three years. Additionally, from 2010 to 2012, the percentage of state health agencies that plan to develop an agency-wide strategic plan in the next year increased from 7 percent to 23 percent.

State health agencies were also asked about the status of the implementation of their strategic plan. In 2012, 31 percent of state health agencies had implemented their agency-wide strategic plan in the past year and another 17 percent had implemented the plan more than one year ago with an annual written evaluation on progress not yet conducted. Implementation status for state health agencies from 2010 to 2012 is displayed in **Figure 4.5**. From 2010 to 2012, the percentage of state health agencies that had implemented agency-wide strategic plans in the past year increased substantially from 7 percent to 30 percent.

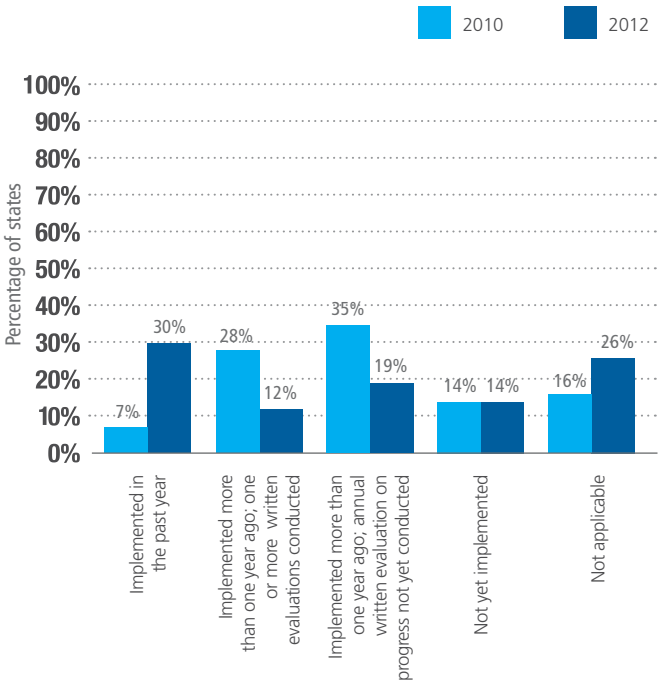
A greater percentage of decentralized/largely decentralized states (62%) implemented the strategic plan within the past year than centralized/largely centralized states (0%). A smaller percentage of states in the West (17%) implemented plans in the past year than states in other regions (percentages range from 43-57% for the other four regions), and a greater percentage of medium (50%) and large states (69%) implemented plans within the past year than did small states (0%).

**Figure 4.4: State Health Agency Development of Agency-Wide Strategic Plan, 2007-2012 (n=44)**




*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.*

**Figure 4.5: State Health Agency Implementation of Agency-Wide Strategic Plan, 2010-2012 (n=43)**



## Intention to Apply for Accreditation

As states begin to earn PHAB accreditation, state health agencies are at different stages in the process. As shown in **Figure 4.6**, the greatest percentage of state health agencies (53%) plan to apply for accreditation but have not yet submitted a letter of intent. A greater percentage of centralized/largely centralized state health agencies have submitted a statement of intent to pursue accreditation (31% vs. 15%), while a greater percentage of decentralized/largely decentralized states have submitted an application for accreditation (12% vs. 0%). States in the West are more likely to have submitted an application for accreditation (29% in West vs. 0-8% in the other four regions).

Of the 26 states that plan to pursue accreditation but have not yet submitted a letter of intent, 85 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 citing the reason as the fees being too high.

**Figure 4.6: State Health Agency Participation in PHAB Accreditation Program, 2012 (n=49)**

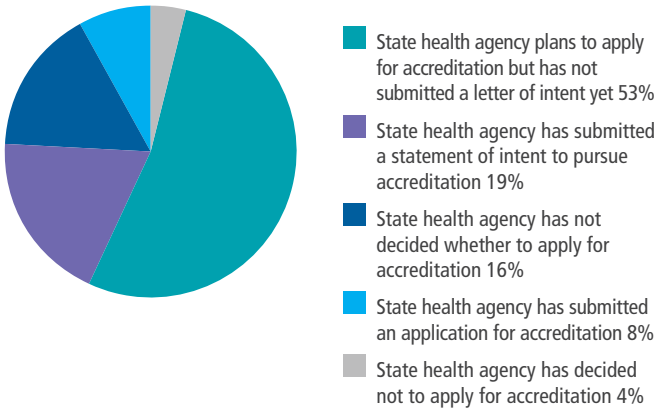
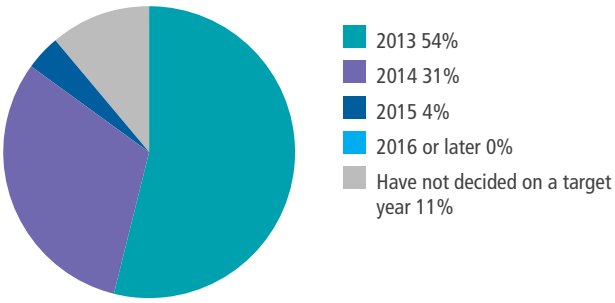



**Figure 4.7: Anticipated Year of Letter of Intent Submission for Accreditation, 2012 (n=26)**




## Performance Management Systems

A performance management system is made up of four components: performance standards, performance measures, reporting of progress, and quality improvement. 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:[21]

*Performance standards* are generally accepted, objective forms of measurement that serve as a rule or guideline against which an organization's level of performance can be compared. Standards may be set by benchmarking against similar organizations, or they may be based on national, state/territory, or scientific guidelines such as Healthy People 2010 and 2020.[22]

21 PHAB. "Acronyms and Glossary of Terms, Version 1.0." 2011. Available at http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf. Accessed 3-7-2014.

22 Healthy People. "2020 Topics and Objectives—Objectives A-Z." Available at http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx. Accessed 3-7-2014.

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

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

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

For state health agencies reporting data in 2010 and 2012, the percentage of state health agencies with a formal performance management plan increased from 68 percent in 2010 to 74 percent in 2012 (see **Figure 4.8**). State health agencies were slightly more likely to have fully implemented a performance management plan department-wide in 2012 than they were in 2010 (13% vs. 9%), and they also were more likely to have fully implemented a performance management plan for specific programs in 2012 than in 2010 (19% vs. 15%). 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 (42% do not have a plan in the Mid-Atlantic and Great Lakes vs. 13%-29% for other regions).

## State Health Agency Quality Improvement Efforts

State health agencies engage in a variety of frameworks or approaches to quality improvement. In 2012, the three most common frameworks/approaches used were Plan-Do-Check-Act or Plan-Do-Study-Act (used by 88% of state health agencies), Lean (used by 43%), and Six Sigma (used by 20%). **Figure 4.9** shows the quality improvement frameworks/approaches used by state health agencies in 2010 and in 2012. From 2010 to 2012, use of all frameworks increased, except for Balanced Scorecard (which decreased). In addition, the percentage of state health agencies reporting no specific framework or approach used decreased from 28 percent in 2010 to 4 percent in 2012.

State health agencies indicated that they had used a number of techniques in their quality improvement efforts in the past year. The most frequently used techniques are obtaining baseline data (100%), setting measurable objectives (96%), and mapping a process (88%). The percentage of state health agencies using these techniques in 2010 and 2012 is displayed in **Figure 4.10**. There was an increase in the use of all techniques from 2010 to 2012, with the greatest increases for obtaining baseline data, mapping a process, and identifying root causes.

When asked about the nature of their agency's current quality improvement activities, more than two-thirds of all state health agencies reported formal quality improvement activities implemented in specific programmatic/functional areas but not agency-wide (see **Figure 4.11**). A greater percentage of centralized/largely centralized states (85%) reported formal quality improvement activities than decentralized/largely decentralized states (65%).

**Figure 4.8: Formal Performance Management Program in Place at State Health Agencies, 2010-2012 (n=47)**

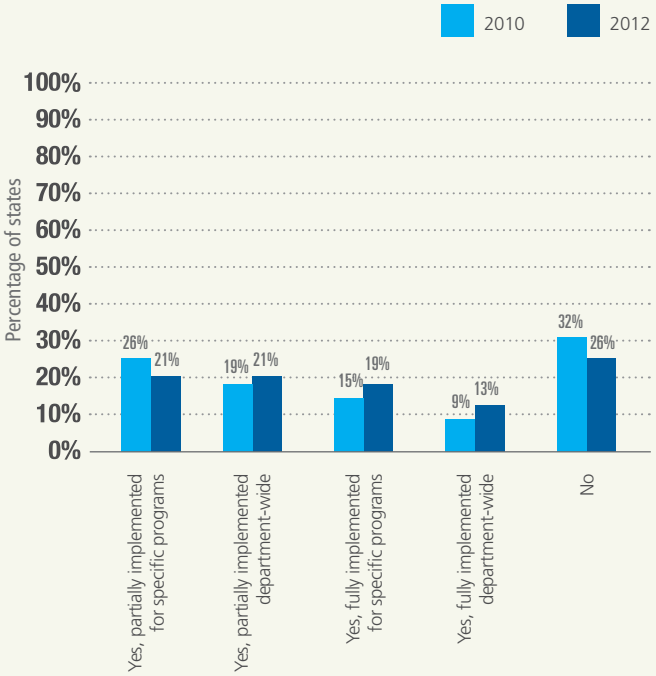



**Figure 4.9: Quality Improvement Frameworks/Approaches Used at State Health Agencies, 2010-2012 (n=46)**

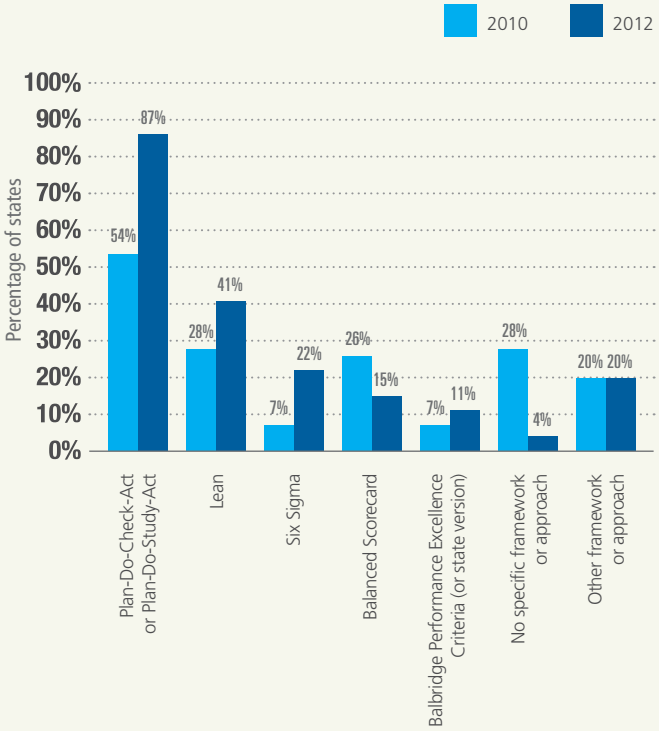



**Figure 4.10: Elements of State Health Agency Quality Improvement Efforts, 2010-2012 (n=47)**

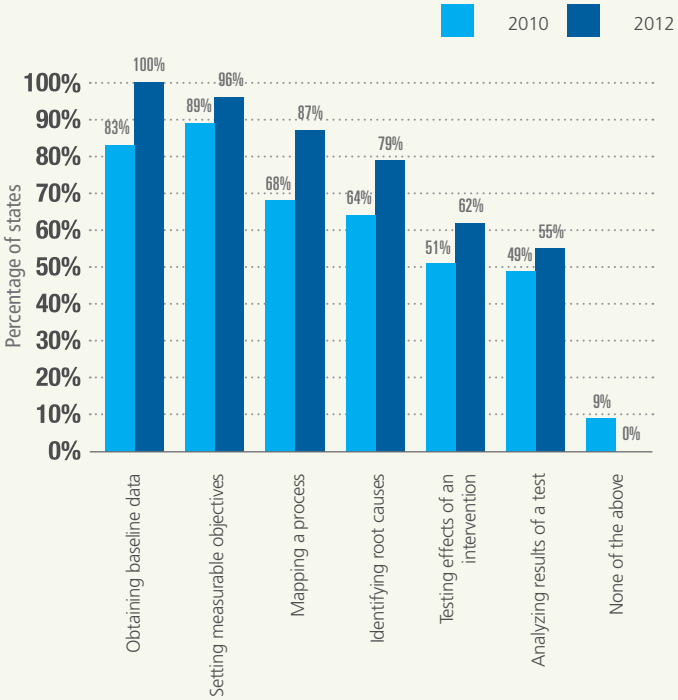



**Figure 4.11: Nature of State Health Agency's Current Quality Improvement Activities, 2012 (n=49)**

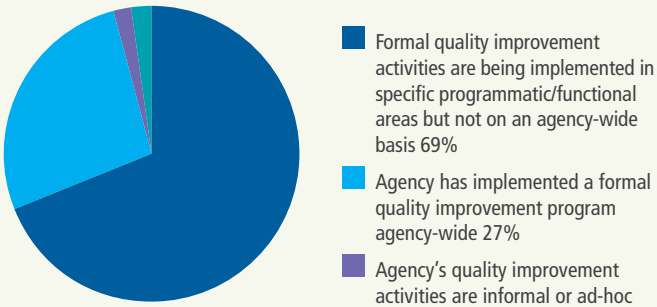


**Figure 4.12: Elements of Formal, Agency-Wide Quality Improvement Programs in Place at State Health Agencies, 2012 (n=47)**

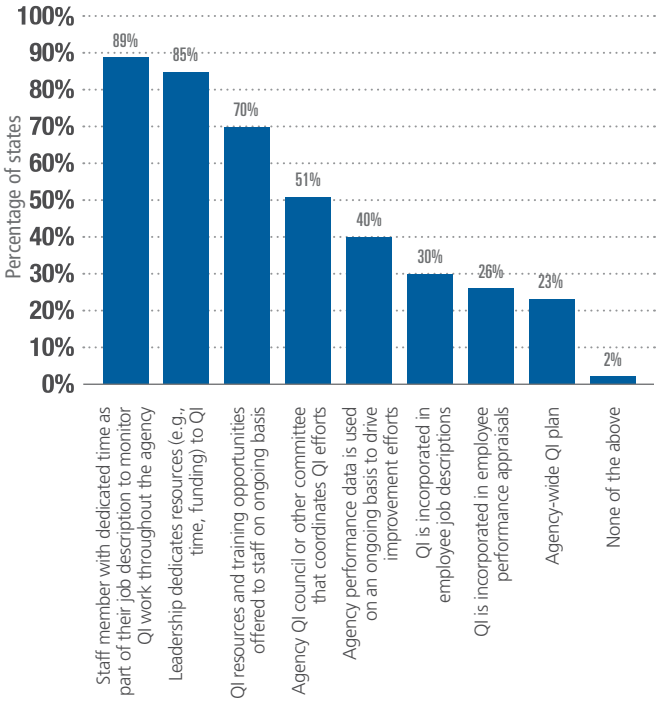
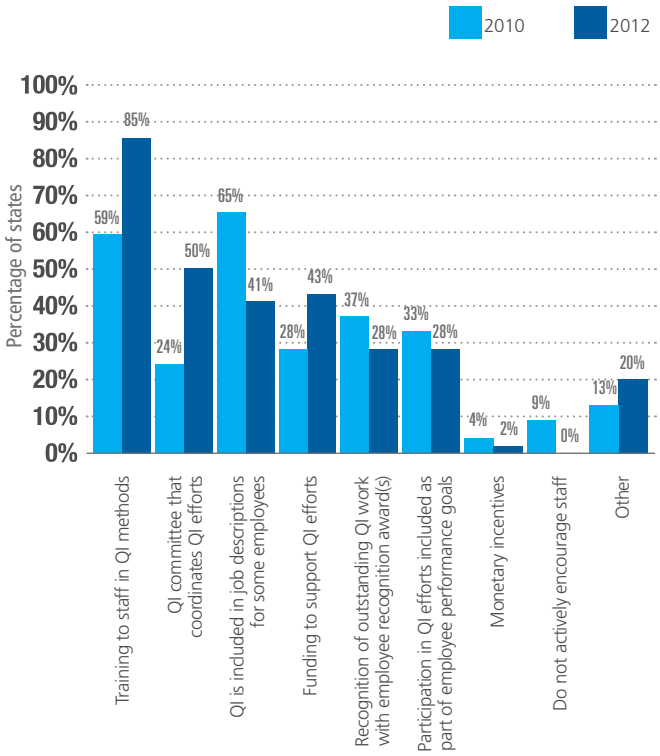



**Figure 4.13: Staff Involvement in Quality Improvement Efforts at State Health Agencies, 2010-2012 (n=46)**




State health agencies range in terms of which elements of a formal agency-wide quality improvement program they have in place. As shown in **Figure 4.12**, the most common elements in place are a staff member with dedicated time as part of his or her job description to monitor QI work throughout the agency (89%), leadership that dedicates resources (e.g., time, funding) to QI (85%), and QI resources and training opportunities that are offered to staff on an ongoing basis (70%). Less than one-quarter of state health agencies (23%) report having an agency-wide QI plan.

A greater percentage of decentralized/largely decentralized states (81%) offer QI resources and training opportunities to staff on an ongoing basis than do centralized/largely centralized states (58%). Decentralized/largely decentralized states are also more likely to have QI incorporated in employee job descriptions (35% of decentralized/largely decentralized states vs. 8% of centralized/largely centralized states). A smaller percentage of state health agencies in New England (13%) have an agency QI council or other committee that coordinates QI efforts (percentages for other four regions range from 56-67%). Small states are less likely to have an agency-wide QI program than are medium and large states (7% of small states vs. 31% of medium and large states).

## Staff Involvement in Quality Improvement

In 2012, the most common ways that state health agencies supported or encouraged staff involvement in quality improvement efforts was through training to staff in QI methods (85%), a QI committee that coordinates QI efforts (48%), and job descriptions that include QI (44%). Decentralized/largely decentralized states were equally or more likely to support or encourage staff involvement in QI efforts in all ways than were centralized/largely centralized states. A greater percentage of large state health agencies (56%) had recognition awards for staff QI excellence than small (7%) or medium (18%) states.

Change in staff involvement in QI efforts at state health agencies from 2010 to 2012 is shown in **Figure 4.13**. Staff training in QI methods, having a QI committee that coordinates QI efforts, and funding to support QI efforts all increased from 2010 to 2012. In contrast, job descriptions including QI, recognition awards for staff QI excellence, and participation in QI efforts included as part of employee performance goals all decreased from 2010 to 2012.

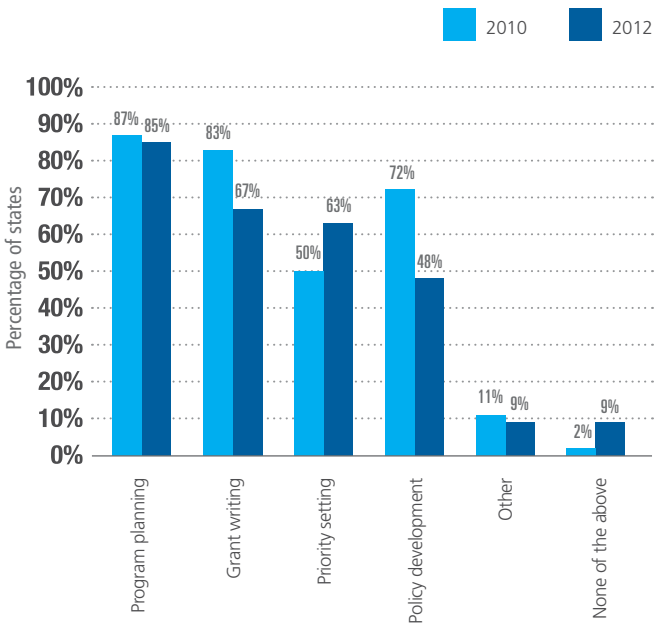
## Use of The Community Guide

In 2012, state health agencies had most commonly used the U.S. Preventive Services Task Force's Guide to Community Preventive Services ("The Community Guide") in the past two years for program planning (86%), grant writing (67%), and priority setting (61%). Decentralized/largely decentralized states were more likely to use the guide for program planning, grant writing, priority setting, and priority development than were centralized/largely centralized states. A smaller percentage of states in the West (29%) used the guide for grant writing than did states in other regions (percentages ranged from 58% to 88%). Similarly, a smaller percentage of states in the West (29%) and Mid-Atlantic and Great Lakes (17%) used the guide for policy development (percentages for other regions ranged from 58% to 75%).

Changes in state health agencies' use of The Community Guide from 2010 to 2012 are displayed in **Figure 4.14**. Use of the guide for priority setting increased from 50 percent in 2010 to 63 percent in 2012. Use for all other purposes decreased from 2010 to 2012.

This chapter has described state health agencies' accreditation readiness and engagement in quality improvement efforts. In the next chapter, focus will shift to the increased use of health information systems and technology in state public health agencies.

**Figure 4.14: Use of the Guide to Community Preventive Services at State Health Agencies, 2010-2012 (n=46)**




## Key Findings

- Chief information officers or chief medical information officers (or equivalents) most frequently have primary responsibility for decisions around health information exchange and overall decisionmaking authority for public health information management systems at state health agencies.
- More than half (59%) of informatics offices for state health agencies are located within the agency itself. Only 4 percent of informatics offices serving state health agencies are centralized at the state level.
- While just more than half (51%) of state health agencies use health information exchanges to monitor health topics, this is more than in 2010, when 42 percent reported using health information exchanges to monitor health topics. The most common topics monitored using health information exchanges are emerging infectious diseases (33%), environmental exposures (21%), and chronic disease indicators and risk factors (both 13%).

# 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 includes the use of electronic health records.[23] Health information exchange (HIE) is the electronic movement of health-related information among organizations according to nationally recognized standards.[24] As more healthcare providers adopt health information technologies, public health agencies will be more likely to exchange data directly with them.

- Among state health agencies that responded in 2010 and 2012, 39 percent used health information exchanges to communicate about a variety of health topics in 2012, which represents a slight decrease from 2010. In 2012, state health agencies most commonly used health information exchanges to communicate about the notification of communicable disease outbreaks, drug warnings, or environmental risks (31%); vaccination guidelines and requirements (24%); and disease case definitions and diagnostic guidelines or criteria (18%).
- Electronic data exchange is common at the majority of state health agencies, though less so in the areas of water wells, electronic health records, and onsite waste water treatment. Bidirectional data exchange is most common for electronic health records (71%), Medicaid billing (56%), and lab results (53%). Data are most commonly collected using a state system rather than local for all topic areas.
- The majority of state health agencies have all of the systems in place to meet Meaningful Use public health objectives, and while bidirectional data reporting and exchange varies among systems, most state health agencies send and receive data from federal agencies.

23 For more information, visit http://www.healthit.gov/.

24 HHS and the National Alliance for Health Information Technology. "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." April 28, 2008.

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 individuals within state health agency leadership who have responsibility for HIE/HIT issues; entities with which SHAs exchange data and how those data are exchanged; and how state health agencies use HIE for specific programs. There is also a discussion of program areas for which state health agencies collect data electronically and systems in place to address the Meaningful Use public health objectives.

## Primary Responsibility for Health Information Exchange

As of 2012, in 41 percent of state health agencies, the chief information officer/chief medical information officer or the equivalent for the state health agency has primary responsibility for decisions regarding HIE or HIT issues; in another 16 percent of state health agencies, the chief information officer or equivalent for multiple agencies has primary responsibility. From 2010 to 2012, the percentage of state health agencies with a chief information officer/ chief medical information officer or equivalent for the state health agency or another entity with primary responsibility has shown increases, while the percentage of chief information officer or equivalent for multiple agencies, boards or committees for multiple agencies within the state government, and informatics directors with primary responsibility has decreased. The percentage with a board or committee for the state health agency with primary responsibility for decisions regarding HIE or HIT issues has remained constant (see **Figure 5.1**).

Centralized/largely centralized states are nearly twice as likely as decentralized/largely decentralized states (69% vs. 35%) to have the chief information officer/ chief medical information officer or equivalent for the state health agency having primary responsibility for HIE or HIT issues. A greater percentage of medium and large states (47% and 44%, respectively) have the chief information officer/chief medical information officer or equivalent for the state health agency having primary responsibility than do small states (31%). Conversely, a greater percentage of small states (31%) have the chief information officer or equivalent for multiple agencies with primary responsibility for these decisions than do medium (12%) and large (6%) states.

## Decisionmaking Authority for Public Health Information Management Systems

In more than half of state health agencies, the chief information officer or chief medical information officer (or equivalent) for the state health agency has overall decisionmaking authority for state public health information management systems. In 29 percent of state health agencies, another entity has the overall decisionmaking authority; in the remainder of state health agencies, overall decisionmaking authority resides with the chief information officer (or equivalent) for multiple agencies in state government (8%) or the informatics director (8%). From 2010 to 2012, the percentage of state health agencies with the chief information officer or chief medical information officer (or equivalent) for the state health agency having overall decisionmaking authority for public health information management systems increased from 47 percent to 53 percent. The percentage with chief information officer (or equivalent) for multiple agencies in state government and informatics directors having overall decisionmaking authority decreased, while the percentage with another entity remained stable over time (see **Figure 5.2**).

A greater percentage of centralized/largely centralized states reported that the chief information officer or chief medical information officer (or equivalent) for the state health agency had overall decisionmaking authority than decentralized/largely decentralized states (77% vs. 46%). Decentralized/largely decentralized states were more likely to have another entity with overall decisionmaking authority than were centralized/largely centralized states (38% vs. 15%). States in the Mid-Atlantic and Great Lakes and the West were most likely to have the chief information officer or chief medical information officer (or equivalent) for the state health agency having overall decision-making authority (75% and 71%, respectively), while states in New England and the Mountains and Midwest were least likely (38% and 30%, respectively). Only small states (25%) reported that the chief information officer (or equivalent) for multiple agencies in state government had overall decisionmaking authority for state public health management systems.

**Figure 5.1: Primary Decisionmaking Authority for Health Information Exchange or Health Information Technology Issues at State Health Agencies, 2010-2012 (n=47)**

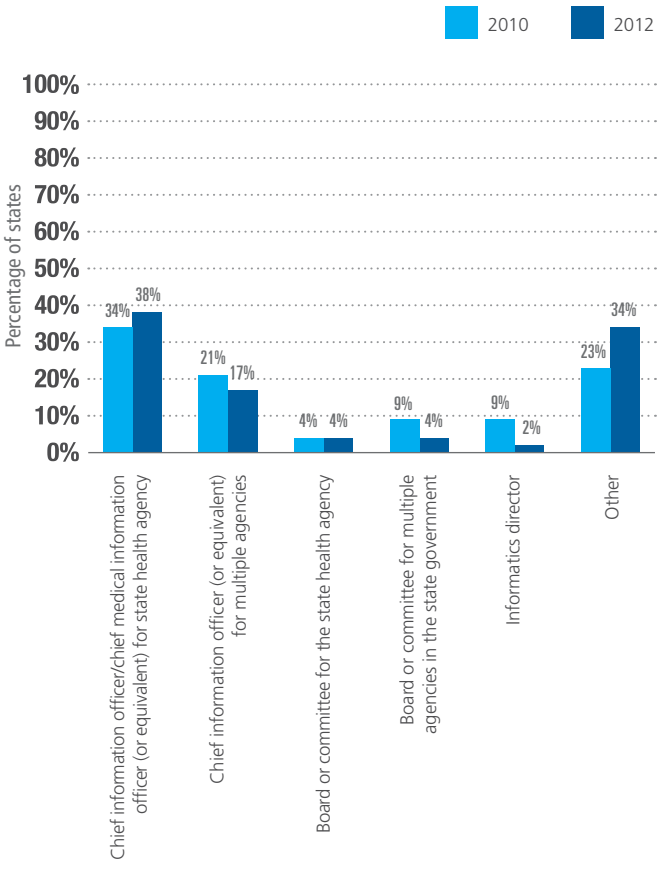
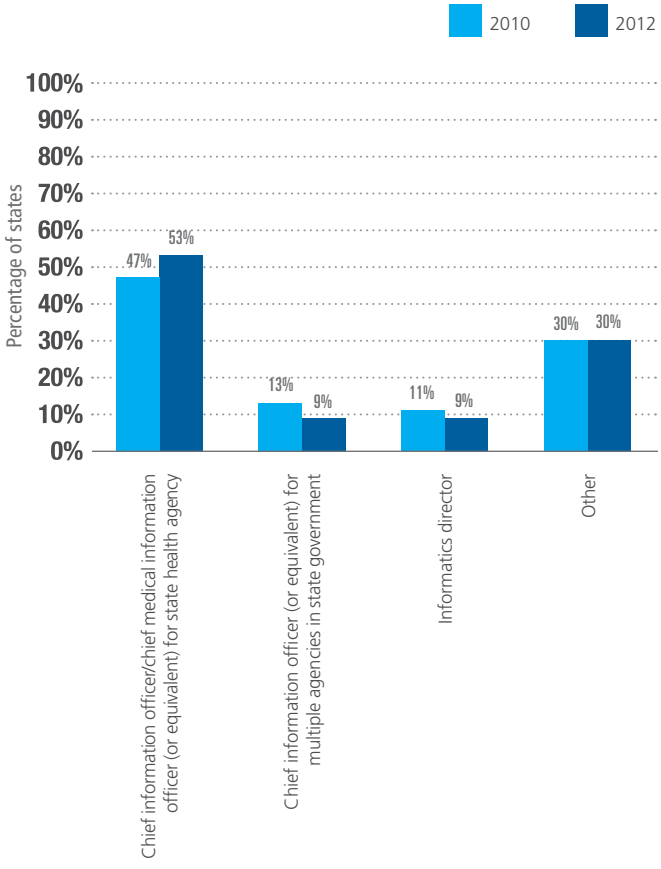


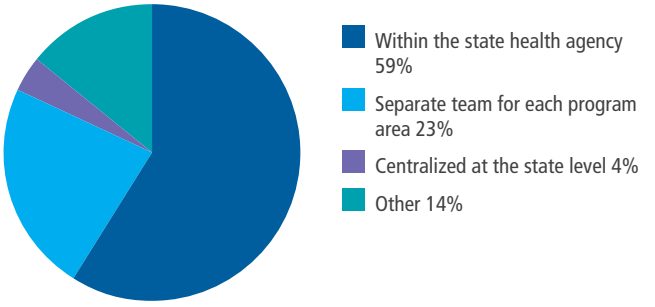

**Figure 5.2: Overall Decisionmaking Authority for State Public Health Information Management Systems, 2010-2012 (n=47)**



## Location of Informatics Office

In more than half of state health agencies, the informatics office is located within the state health agency. For nearly one-quarter of state health agencies, the informatics office is located in separate teams for each program area. For the remaining state health agencies, the office is centralized at the state level or at another location (see **Figure 5.3**). A greater percentage of state health agencies in New England (75%) and the Mid-Atlantic and Great Lakes (83%) have informatics offices located within the state health agency than states in the South (33%) or West (43%). A greater percentage of small (31%) and large (25%) states have informatics offices located in separate teams for each program area than do medium-sized states (12%).

**Figure 5.3: Location of Informatics Office at State Health Agencies, 2012 (n=49)**

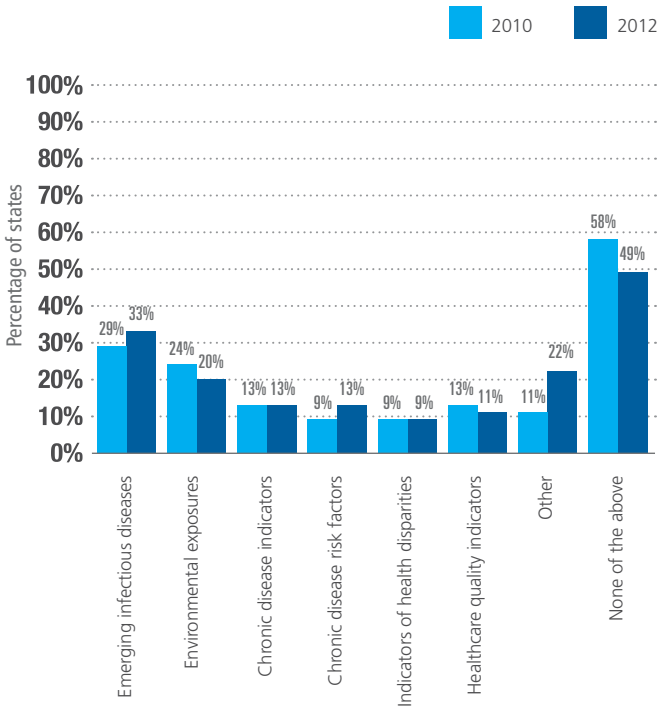



## Health Information Exchange: Monitoring

State health agencies use health information exchanges to monitor a variety of public health topics. In 2012, health information exchanges were most frequently used to monitor emerging infectious diseases (33%), environmental exposures (21%), and chronic disease indicators and risk factors (both 13%). Nearly half of state health agencies (48%) did not use health information exchanges to monitor any topics. From 2010 to 2012, the percentage of state health agencies using health information exchanges for monitoring emerging infectious diseases, chronic disease risk factors, and other health topics increased. In contrast, the percentage of state health agencies using health information exchanges for monitoring environmental exposures, healthcare quality indicators, and for no health topics decreased. The percentage of state health agencies using health information exchanges for monitoring chronic disease indicators and indicators of health disparities remained constant over time (see **Figure 5.4**).

Centralized/largely centralized states were slightly more likely to use health information exchanges for monitoring emerging infectious diseases and environmental exposures than were decentralized/largely decentralized states. States in the West were most likely to use health information exchanges for monitoring other topics (50% of states in West as compared with

**Figure 5.4: Use of Electronic Health Information Exchanges for Monitoring, 2010-2012 (n=45)**



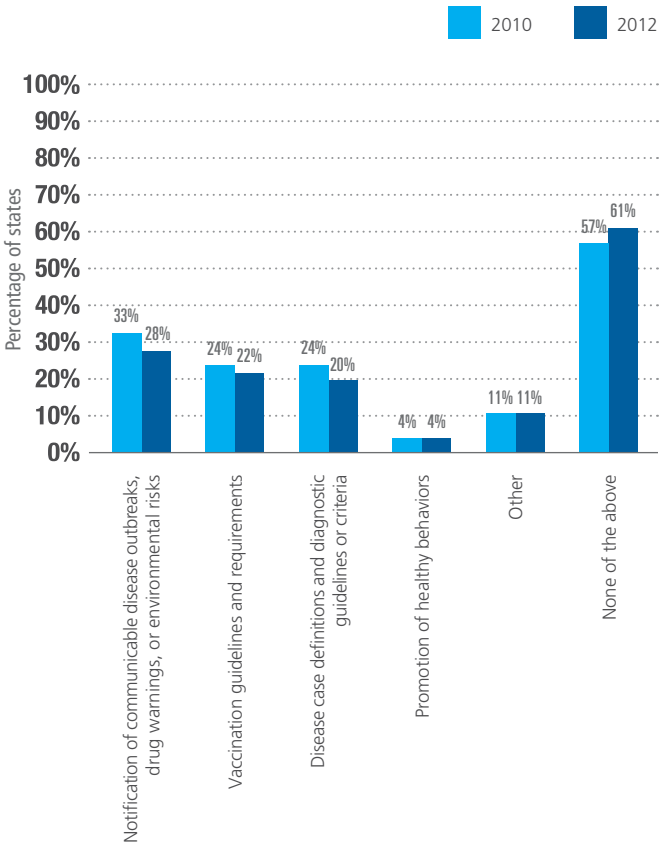
8-33% of states in other four regions). Medium-sized states (53%) were more likely to use health information exchanges to monitor emerging infectious diseases than were small (19%) or large (27%) states. Medium-sized states (24%) were also more likely to use health information exchanges for monitoring chronic disease indicators and risk factors than were small (0%) or large (13%) states.

## Health Information Exchange: Communication

State health agencies also use health information exchanges for communication purposes. In 2012, state health agencies most frequently used health information exchanges for notification of communicable disease outbreaks, drug warnings, or environmental risks (31%); vaccination guidelines and requirements (24%); and disease case definitions and diagnostic guidelines or criteria (18%). More than half (59%) of state health agencies did not use health information exchanges for communication. From 2010 to 2012, there was little change in the percentage of state health agencies that used health information exchanges for communication of specific topics—no increase or decrease was greater than 5 percent, or two state health agencies (see **Figure 5.5**).

Centralized/largely centralized states were twice as likely to use health information exchanges for notification of communicable disease outbreaks, drug warnings, or environmental risks as were decentralized/largely decentralized states (38% vs. 19%). In contrast, decentralized/largely decentralized states were approximately twice as likely to use health information exchanges for disease case definitions and diagnostic guidelines or criteria as were centralized/largely centralized states (15% vs. 8%). States in the South (42%), Mid-Atlantic and Great Lakes (50%), and West (43%) were more likely to use health information exchanges for notification of communicable disease outbreaks, drug warnings, or environmental risks than were states in New England (13%) and the Mountains and Midwest (0%). Small states (19%) were more likely to use health information exchanges to communicate other health topics than were medium and large states (both 6%).

**Figure 5.5: Use of Electronic Health Information Exchanges for Communication, 2010-2012 (n=46)**




## Electronic Data Exchange

State health agencies collect, receive, and exchange program specific information electronically. **Table 5.1** shows the program areas for which state health agencies collect data electronically. More than half of state health agencies collect information electronically for all areas except water wells, electronic health records, and onsite waste water treatment systems. It is notably less common for agencies to receive data about these program areas through a health information exchange entity (percentages of state health agencies doing so range from 0-35%). Bidirectional data reporting and exchange is greatest for electronic health records (71%), Medicaid billing (56%), and lab results (53%). For all topic areas, data are collected primarily with the state system for more than 80 percent of state health agencies. It is much less common for data to be collected primarily with local systems.

Decentralized/largely decentralized states are substantially more likely to collect geocoded data for mapping than are centralized/largely centralized states (95% vs. 50%) and to collect healthcare systems data (80% vs. 58%). In contrast, centralized/largely centralized states are more likely to collect Medicaid billing data, WIC data, food inspection data, water wells data, electronic health records, and onsite waste water treatment data than are decentralized/largely decentralized states. States in New England are less likely to collect healthcare systems data than are states in other regions (25% for New England vs. 57-91% for other four regions). States in the South are more likely to collect onsite waste water treatment data than are states in other regions (63% for South vs. 0-36% for other regions). Small states (43%) are less likely to collect geocoded data for mapping than are medium (86%) and large states (100%). Similarly, small states (43%) are less likely to collect healthcare systems data than are medium (79%) and large (83%) states.

**Table 5.1: Program Areas for Which State Health Agencies Collect Data Electronically, 2012**

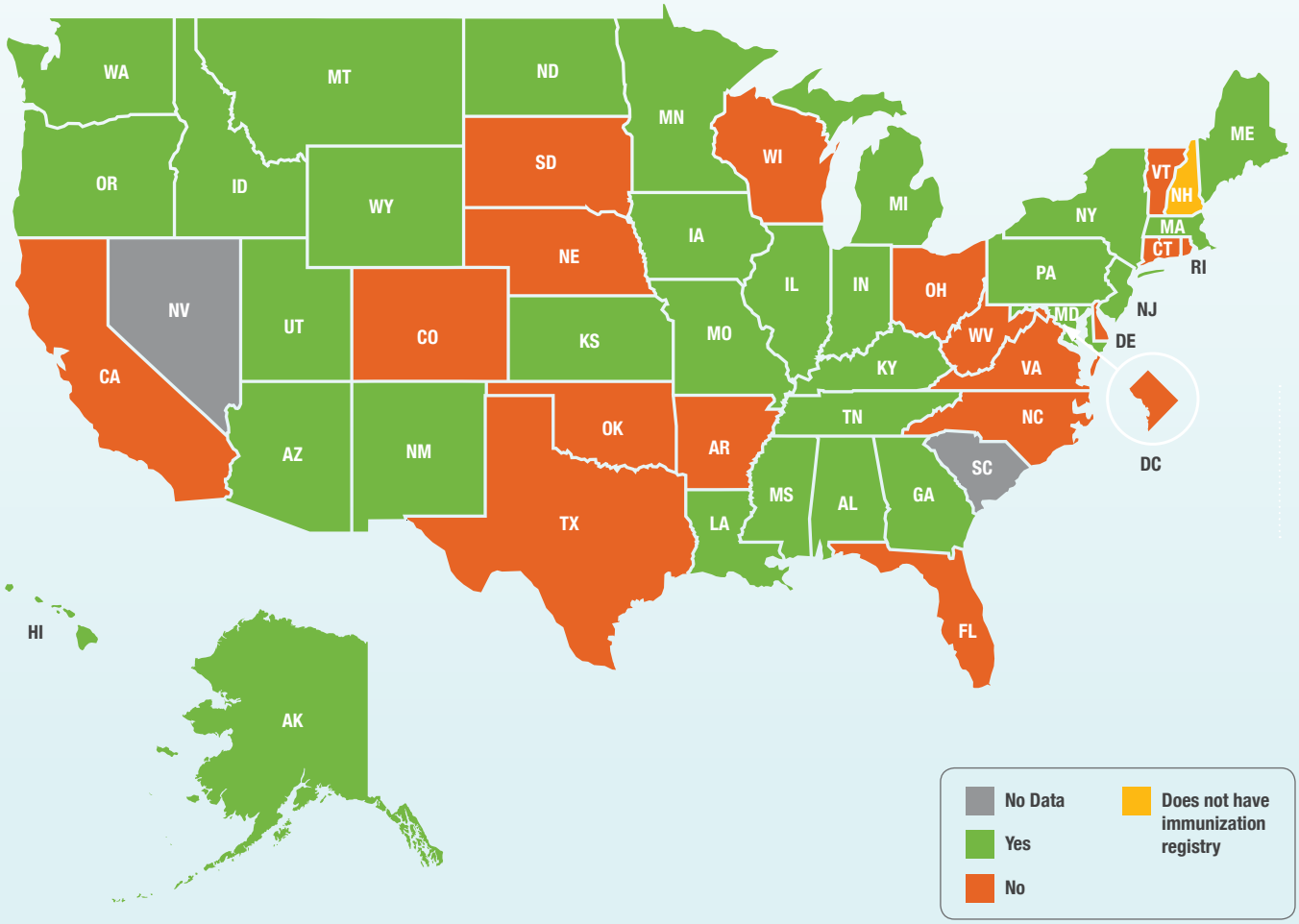
| | | Agency Collects Information Electronically | | Data Received Through HIE Entity | | Bidirectional Data Reporting and Exchange Capacity | | Data Collected Primarily with State System | | Data Collected Primarily with Local System | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total n | n | % | n | % | n | % | n | % | n | % |
| Lab results | 48 | 47 | 98% | 13 | 28% | 25 | 53% | 44 | 94% | 3 | 6% |
| Reportable diseases | 49 | 48 | 98% | 9 | 19% | 24 | 50% | 45 | 94% | 3 | 6% |
| Vital records | 47 | 44 | 94% | 4 | 9% | 21 | 48% | 41 | 93% | 3 | 7% |
| WIC | 47 | 40 | 85% | 2 | 5% | 17 | 43% | 34 | 85% | 6 | 15% |
| Outbreak management | 48 | 38 | 79% | 7 | 18% | 15 | 39% | 33 | 89% | 4 | 11% |
| MCH reporting | 44 | 34 | 77% | 3 | 9% | 8 | 24% | 30 | 88% | 4 | 12% |
| Geocoded data for mapping | 46 | 35 | 76% | 4 | 11% | 13 | 37% | 33 | 94% | 2 | 6% |
| Healthcare systems data | 47 | 33 | 70% | 1 | 3% | 13 | 39% | 31 | 94% | 2 | 6% |
| Case management | 48 | 33 | 69% | 3 | 9% | 17 | 52% | 29 | 88% | 4 | 12% |
| Medicaid billing | 46 | 27 | 59% | 6 | 22% | 15 | 56% | 25 | 93% | 2 | 7% |
| Food service inspections | 45 | 23 | 51% | 1 | 4% | 8 | 35% | 19 | 83% | 4 | 17% |
| Water wells | 42 | 16 | 38% | 0 | 0% | 4 | 25% | 15 | 94% | 1 | 6% |
| Electronic health records | 46 | 17 | 37% | 6 | 35% | 12 | 71% | 15 | 88% | 2 | 12% |
| Onsite waste water treatment systems | 43 | 11 | 26% | 0 | 0% | 2 | 18% | 11 | 100% | 0 | 0% |

## Meaningful Use

The Health Information Technology for Economic and Clinical Health (HITECH) Act promotes the use of electronic health records and health information exchanges to promote high quality care, reduce costs, facilitate coordination of care among providers, and improve population health. Implementing Meaningful Use of electronic health records by providers will require a public health infrastructure that can support the receipt and exchange of data with the provider community.

State health agencies have systems in place to address the Meaningful Use public health objectives, and as shown in **Table 5.2**, the majority of state health agencies have all the systems in place. Bidirectional data reporting and exchange are currently performed most frequently with immunization registry systems, electronic communicable disease reporting systems, and electronic laboratory communicable disease reports. Bidirectional reporting with immunization registries by state is displayed in **Figure 5.6**. State health agencies also frequently send and receive data to and from federal agencies. This most frequently

**Figure 5.6: Capable of Bidirectional Reporting with Immunization Registries**



occurs with electronic communicable disease reporting systems, cancer registries, and electronic laboratory communicable disease reports. For all registries and systems, data are collected primarily with the state system rather than primarily with the local system.

Decentralized/largely decentralized states were slightly more likely to have systems for Meaningful Use related to immunization registries, cancer registries, and electronic lab communicable disease reports than centralized/largely centralized states. States in the Mid-Atlantic and Great Lakes were more likely than other regions to have all of the Meaningful Use systems they were surveyed about. Additionally, large states were slightly more likely than small and medium states to have systems in place for communicable disease reporting, cancer registries, and electronic lab communicable disease reports. Medium-sized states (60%) were less likely to have syndromic surveillance systems than were small (94%) or large (92%) states.

This chapter has 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.



**Table 5.2: Meaningful Use Objectives, 2012**

| | | Agency Has System | | System Currently Performs Bidirectional Data Reporting & Exchange | | Agency Sends/ Receives Data to/from Federal Agencies | | Data Collected Primarily with State System | | Data Collected Primarily with Local System | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total n | n | % | n | % | n | % | n | % | n | % |
| Immunization registry | 48 | 47 | 98% | 29 | 62% | 29 | 62% | 44 | 94% | 3 | 6% |
| Cancer registry | 48 | 46 | 96% | 11 | 24% | 38 | 83% | 44 | 96% | 2 | 4% |
| Electronic laboratory communicable disease reports | 43 | 41 | 95% | 18 | 44% | 32 | 78% | 38 | 93% | 3 | 7% |
| Electronic communicable disease reporting system | 48 | 45 | 94% | 21 | 47% | 41 | 91% | 41 | 91% | 4 | 9% |
| Electronic syndromic surveillance system | 46 | 37 | 80% | 9 | 24% | 23 | 62% | 33 | 89% | 4 | 11% |
| Other registry | 21 | 12 | 57% | 2 | 17% | 6 | 50% | 11 | 92% | 1 | 8% |

## Key Findings

- Between FY10 and FY11, there were increases in total revenue for federal funds, state/territory general funds, fees and fines, and other sources.
- Federal funds were the largest source of state health agency revenue for FY10 and FY11.
- State health agency total federal revenue for FY10 was approximately $14.3 billion and exceeded $14.9 billion for FY11. More than half of state health agency total federal revenue in FY11 was from the U.S. Department of Agriculture.

# Chapter 6: State Health Agency Finance

In 2012, state health agencies were asked to report on revenues, expenditures, and dollars distributed to local and regional health agencies and nonprofit organizations. This chapter describes state health agency funding sources, expenditures, and dollars distributed to health agencies and community-based organizations for FY 2010 and FY 2011 and examines differences between those two years. States were also asked to provide more detailed information on sources of federal funding received in FY10 and FY11.

- The average per capita expenditure for the states and DC in FY11 was $98; the median per capita expenditure was $78.
- Between FY10 and FY11, average and total state health agency expenditures increased for most categories. The two largest spending categories were improving consumer health and WIC.
- State health agencies distributed approximately $5.8 billion through contracts, grants, and awards in FY10 and nearly $6.1 billion in FY11. Forty-four percent of state health agency contracts, grants, and awards were awarded to local health departments, and nearly one-third (32%) of state health agency contracts, grants, and awards were distributed to nonprofit organizations.

## State Health Agency Revenue

State health agencies were asked to report revenue for FY10 and FY11 by funding source (see **Figure 6.1** for definitions of funding sources). Results are displayed in **Figure 6.2**. State health agency total revenue for FY10 exceeded $26.5 billion, while state health agency total revenue for FY11 was approximately $28.1 billion. Between FY10 and FY11, there were increases in total revenue for federal funds, state general funds, fees and fines, and other sources. Conversely, from FY10 to FY11, there were decreases in total revenue for state/territory other funds. More than half (53%) of state health agency revenue in FY11 was from federal funds, while just under one-quarter (24%) was from state/territory general funds (see **Figure 6.3**).

**Table 6.1** presents the mean, median, minimum, and maximum revenue for FY10 and FY11 by source of funding. For all sources of funding, the mean exceeds the median, in some cases by a substantial amount, indicating several state health agencies with particularly high revenues from specific sources that skewed (increased) the mean.

**Figure 6.1: Funding Source Descriptions**

**State general funds.** Include revenues received from state general revenue funds to fund state operations. Exclude federal pass-through funds.

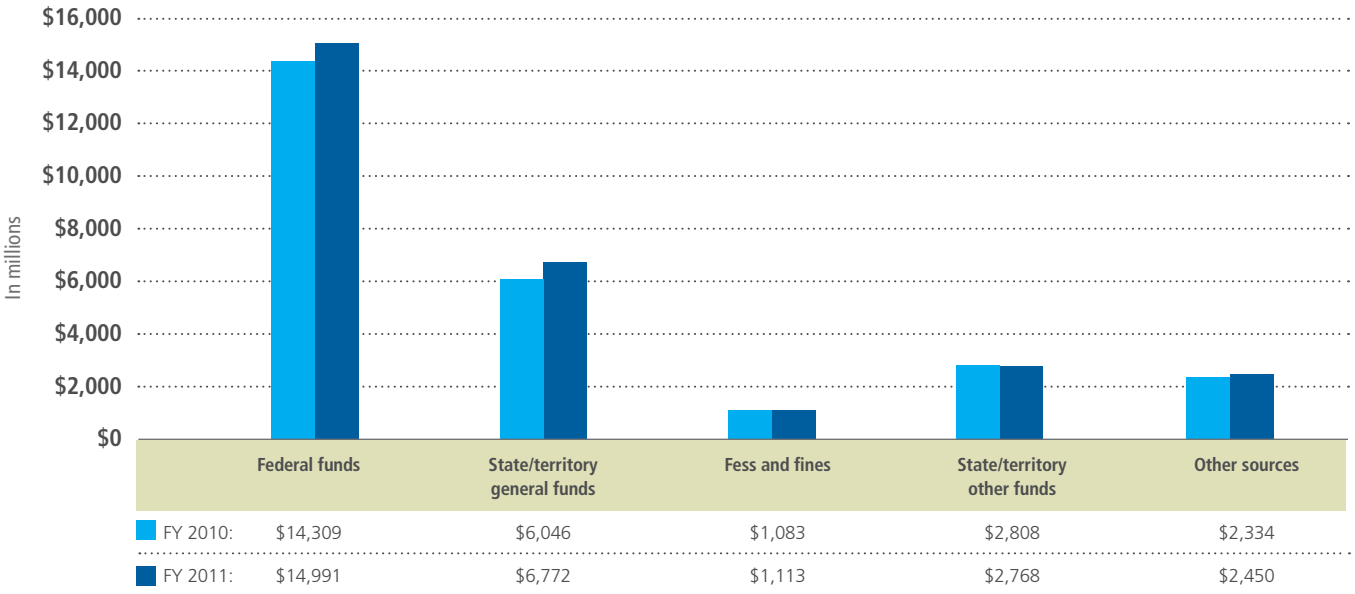
**Federal funds.** Include all federal grants, contracts, and cooperative agreements.

**Fees and fines.** Include fines, regulatory fees, and laboratory fees.

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

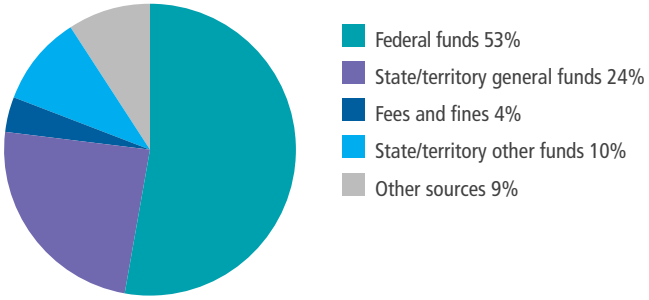
**Other state/territory funds.** Include revenues received from the state/territory that are not from the state general fund.

**Figure 6.2: Total State Health Agency Revenue for FY10 and FY11 by Source of Funding (n=49*)**




**Note: Not all states provided values for all revenue sources and expenditure categories. Ns range from 35 to 49.*

**Figure 6.3: Percentage of State Health Agency Revenue by Funding Source for FY11 (n=49*)**




**Note: Not all states provided values for all revenue sources or expenditure categories. Ns range from 35 to 49.*

## Federal Revenue

In 2012, state health agencies were also asked to further break down federal revenue by source/agency for FY10 and FY11. Results are displayed in **Figure 6.4**. State health agency federal revenue for FY10 was approximately $11.9 billion, while state health agency federal revenue for FY11 exceeded $12.9 billion.[25] Between FY10 and FY11, there were increases in total federal revenue from U.S.

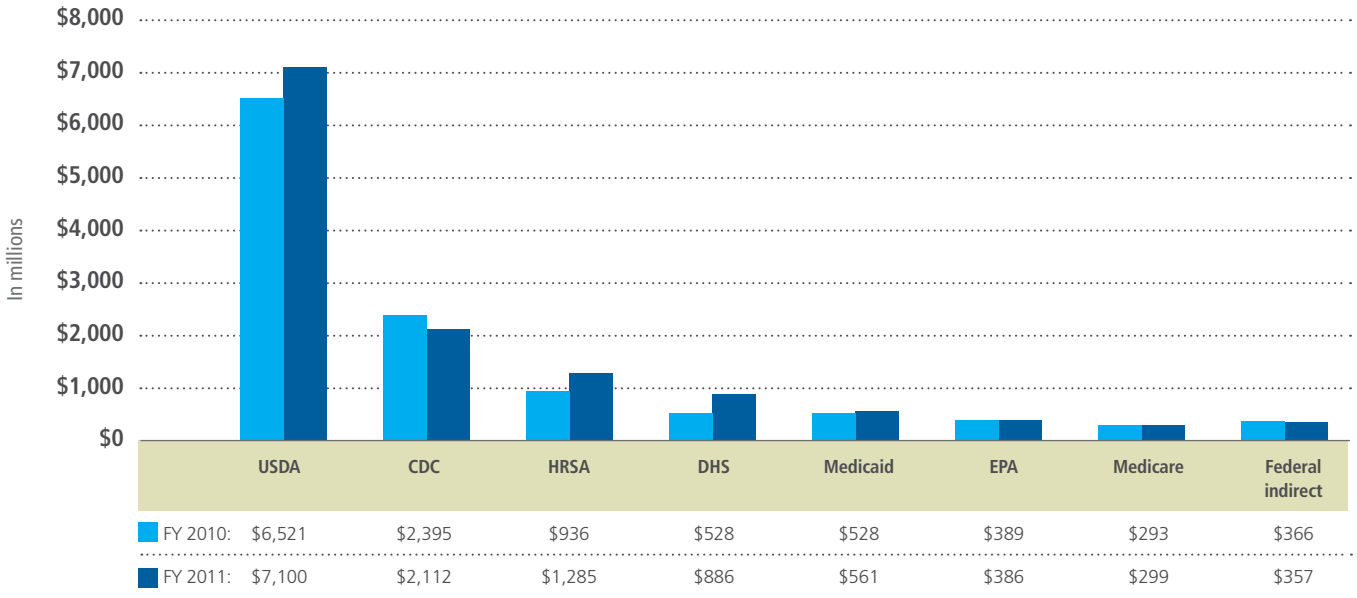
25 For both total federal funds as well as the breakdown by agency, there were increases from FY10 to FY11. However, the total federal funds we report is larger than the total broken down by agency, due to some states including federal funds in their total that they received from agencies not specified.

**Table 6.1: Average State Health Agency Revenue by Source of Funding for FY10 and FY11, in Millions (n=49*)**

| | FY10 (in millions) | | | | FY11 (in millions) | | | |
|---|---|---|---|---|---|---|---|---|
| | Mean | Median | Min | Max | Mean | Median | Min | Max |
| State/territory general funds | $128 | $58 | $4 | $1,320 | $138 | $53 | $4 | $1,306 |
| State/territory other funds | $70 | $24 | $0.02 | $927 | $71 | $23 | $0.02 | $958 |
| Federal funds | $298 | $177 | $24 | $1,954 | $306 | $185 | $20 | $1,880 |
| Fees and fines | $33 | $19 | $1 | $131 | $34 | $21 | $1 | $118 |
| Other sources | $60 | $18 | $0.2 | $887 | $64 | $16 | $0.01 | $871 |

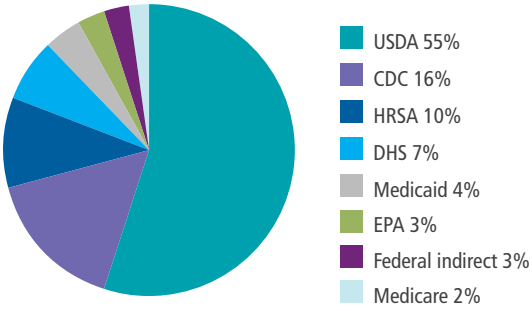
**Note: Not all states provided values for all revenue sources or expenditure categories. Ns range from 35 to 49.*

**Figure 6.4: State Health Agency Federal Revenue by Source for FY10 and FY11 (n=46*)**




**Note: Not all states provided values for all federal revenue sources or expenditure categories. Ns range from 29 to 46.*

**Figure 6.5: Percentage of State Health Agency Federal Revenue by Funding Source for FY11 (n=46*)**




**Note: Not all states provided values for all revenue sources or expenditure categories. Ns range from 29 to 46.*

Department of Agriculture (USDA), Health Resources and Services Administration (HRSA), Medicaid, Medicare, and the Department of Homeland Security (DHS). Conversely, there were decreases in total federal revenue between FY10 and FY11 from CDC, EPA, and federal indirect funds. As shown in **Figure 6.5**, more than half (55%) of state health agency total federal revenue in FY11 was from USDA; the next highest percentage came from CDC (16%).

**Table 6.2** presents the mean, median, minimum, and maximum federal revenue for FY10 and FY11 by source of funding. As with all sources of funding, the means for all federal sources of funding exceed the medians, in some cases by substantial amounts, indicating several state health agencies with particularly high federal revenues from specific sources that skewed (increased) the mean.

**Table 6.2: Average State Health Agency Federal Revenue by Source of Funding for FY10 and FY11 (n=46*)**

| | FY10 (in millions) | | | | FY11 (in millions) | | | |
|---|---|---|---|---|---|---|---|---|
| | Mean | Median | Min | Max | Mean | Median | Min | Max |
| CDC | $53 | $38 | $4 | $263 | $46 | $37 | $5 | $182 |
| HRSA | $21 | $9 | $0.1 | $186 | $28 | $11 | $0.2 | $353 |
| Medicaid | $13 | $5 | $0.001 | $99 | $14 | $5 | $0.02 | $119 |
| Medicare | $10 | $3 | $0.01 | $166 | $6 | $1 | $0.01 | $158 |
| USDA | $145 | $101 | $4 | $1,136 | $154 | $94 | $5 | $1,215 |
| DHS | $14 | $8 | $0.003 | $104 | $23 | $9 | $0.05 | $366 |
| EPA | $10 | $1 | $0.003 | $174 | $10 | $1 | $0.1 | $164 |
| Federal indirect | $12 | $3 | $0.1 | $148 | $12 | $5 | $0.1 | $126 |

**Note: Not all states provided values for all federal revenue sources or expenditure categories. Ns range from 29 to 46.*

**Figure 6.6: Expenditure Category Descriptions**

**Chronic disease.** Include chronic disease prevention such as heart disease, cancer, and tobacco prevention control programs, as well as substance abuse prevention. Include programs such as disease investigation, screening, outreach, and health education. Also include Safe and Drug-Free Schools, health education related to chronic disease, and nutrition education (excluding WIC).

**Infectious disease.** Include TB prevention, family planning education and abstinence programs, and AIDS and STD prevention and control. Include 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.** Include 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.** Include all expenditures related to the WIC program, including nutrition education and voucher dollars.

**Environmental health.** Include 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, mine and cave safety, pesticide regulation and disposal, and nuclear power safety. Also include food service inspections and lodging inspections.

**Improving consumer health.** Include 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, chronic renal disease, breast and cervical cancer treatment, TB treatment, emergency health services, genetic services, state/territory assistance to local health clinics (prenatal, child health, primary care, family planning direct services), refugee preventive health programs, student preventive health services, and early childhood programs.

**All-hazards preparedness and response.** Include 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/pods).

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

**Health data.** Include 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.** Include costs related to administration of the state/territorial health laboratory including chemistry lab, microbiology lab, laboratory administration, building related costs, supplies.

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

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

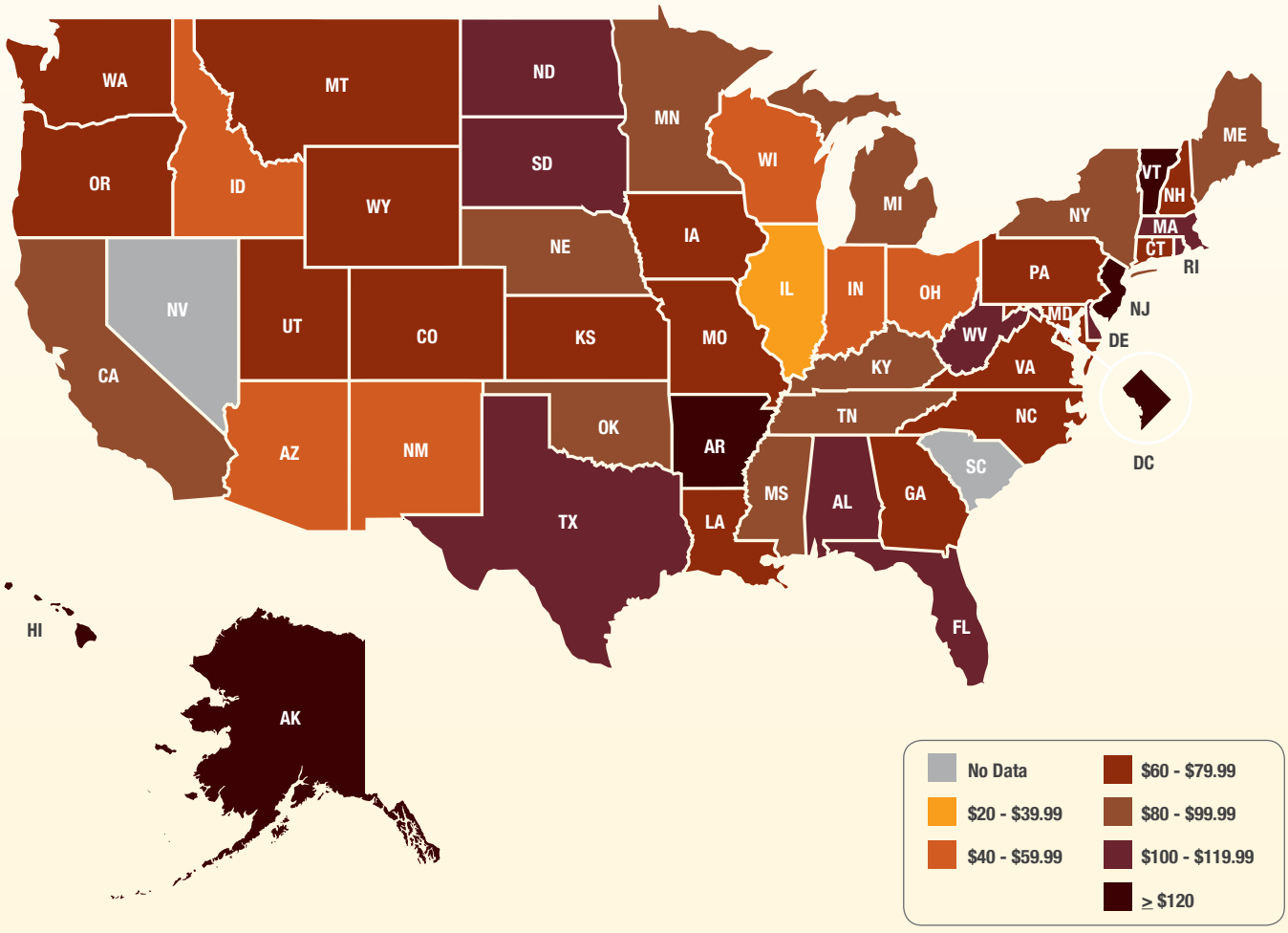
**Other.** Include forensic examination and infrastructure funds to local public health agencies.

## State Health Agency Expenditures

State health agencies were asked to report expenditures for FY10 and FY11 by expense category (see **Figure 6.6** for definitions of expenditure categories). In FY10, state health agency total expenditures were approximately $26.5 billion; in FY11, state health agency total expenditures were just over $28 billion. For all respondents, average per capita expenditures were $99 for FY10 and $98 for FY11. Median per capita expenditures were somewhat lower at $80 for FY10 and $78 for FY11. FY11 per capita expenditures, categorized based on spending range, are displayed in **Figure 6.7** for all responding states and DC.

The mean and median per capita expenditures for all states and DC, as well as based on structure and governance classification, are displayed in **Table 6.3**.

**Figure 6.7: FY 2011 Per Capita Expenditures**

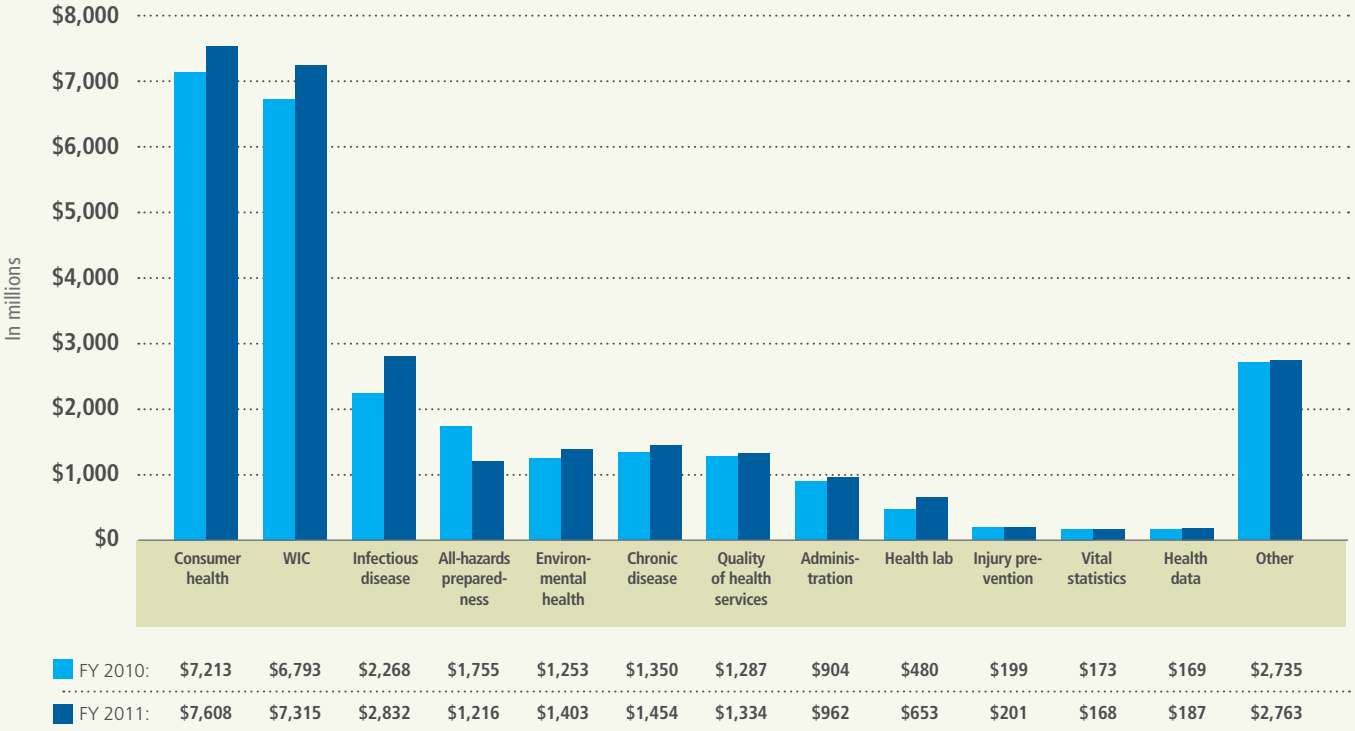


Centralized and largely centralized states have higher average per capita expenditures than do decentralized and largely decentralized states. This is due to local health department expenditures that are included in centralized and largely centralized states, whereas in decentralized and largely decentralized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

**Table 6.3: Per Capita Expenditures by Governance Classification and Structure for FY10 and FY11 (n=49)**

| | FY10 | | FY11 | |
|---|---|---|---|---|
| | Mean | Median | Mean | Median |
| States and DC | $99 | $80 | $98 | $78 |
| Centralized | $130 | $115 | $131 | $107 |
| Decentralized | $88 | $71 | $88 | $76 |
| Freestanding | $107 | $73 | $108 | $80 |
| Under a larger agency | $88 | $81 | $86 | $80 |

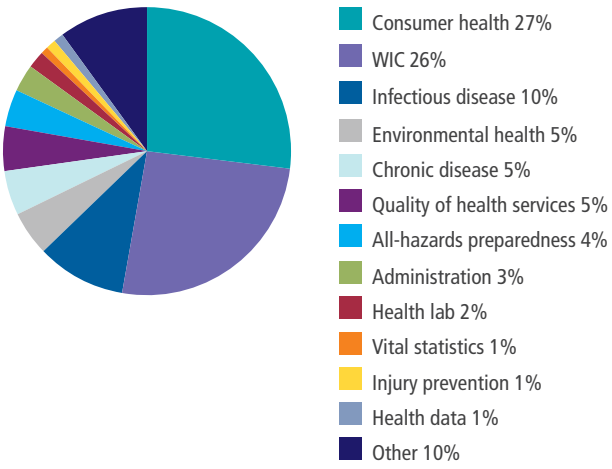
**Figure 6.8: State Health Agency Expenditures by Expense Category for FY10 and FY11 (n=49*)**




**Note: Not all states provided values for all revenue sources and expenditure categories. Ns range from 40 to 49.*

**Figure 6.8** shows total state health agency expenditures for FY10 and FY11 by expense category. Between FY10 and FY11, there were increases in total expenditures for WIC, consumer health (which includes clinical services), infectious disease, environmental health, chronic disease, quality of health services, administrative services, health laboratory, injury prevention, health data, and other services. Conversely, there were decreases in total expenditures between FY10 and FY11 for all-hazards preparedness and vital statistics. In FY11, the greatest percentage of expenditures was accounted for by consumer health and WIC (each accounting for approximately one-quarter of all state health agency expenditures). Vital statistics, injury prevention, and health data accounted for the lowest amount of expenditures, with only 1 percent of total expenditures spent on each of the three categories (see **Figure 6.9**).

**Figure 6.9: Percentage of State Health Agency Expenditures by Expense Category for FY11 (n=49*)**




**Note: Not all states reported values for all expenditure categories or sources of revenue. Ns ranged from 40 to 49.*

**Table 6.4: Average State Health Agency Expenditures by Expense Category for FY10 and FY11 (n=49*)**

| | FY10 (in millions) | | | | FY11 (in millions) | | | |
|---|---|---|---|---|---|---|---|---|
| | Mean | Median | Min | Max | Mean | Median | Min | Max |
| Consumer health | $176 | $53 | $0.1 | $2,946 | $181 | $57 | $0.1 | $2,899 |
| WIC | $148 | $91 | $11 | $1,371 | $156 | $94 | $7 | $1,438 |
| Infectious disease | $47 | $25 | $3 | $295 | $58 | $31 | $3 | $522 |
| Environmental health | $26 | $9 | $0.1 | $287 | $29 | $8 | $0.1 | $375 |
| Chronic disease | $29 | $17 | $2 | $189 | $30 | $16 | $2 | $187 |
| Quality of health services | $32 | $19 | $0.4 | $163 | $32 | $17 | $0.04 | $204 |
| All-hazards preparedness | $37 | $24 | $0.3 | $219 | $25 | $16 | $0.1 | $131 |
| Administrative | $20 | $17 | $0.1 | $76 | $20 | $18 | $0.004 | $78 |
| Health lab | $11 | $8 | $1 | $45 | $15 | $8 | $1 | $150 |
| Vital statistics | $4 | $3 | $0.4 | $20 | $4 | $3 | $0.5 | $15 |
| Injury prevention | $5 | $1 | $0.1 | $47 | $5 | $1 | $0.04 | $45 |
| Health data | $4 | $2 | $0.2 | $22 | $4 | $2 | $0.01 | $19 |
| Other | $83 | $21 | $0.04 | $1,005 | $84 | $20 | $0.3 | $1,022 |

** Note: Not all states provided values for all revenue sources and expenditure categories. Ns range from 40 to 49.*

**Table 6.4** presents the mean, median, minimum, and maximum expenditures for FY10 and FY11 by expense category. Once again, the means for all expenditure categories exceeded the medians, in some cases by substantial amounts, indicating several state health agencies with particularly high expenditures from specific categories that skewed (increased) the mean.

## State Agency Contracts, Grants, and Awards to Local Health Departments and Community-Based Organizations

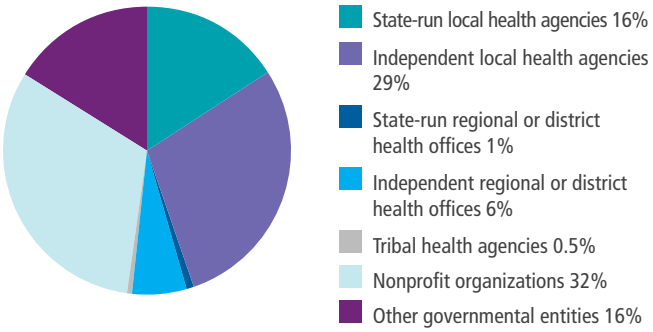
State health agencies were asked to report dollars distributed via contracts, grants, and awards to local health departments and community-based organizations. In FY10, state health agencies distributed approximately $5.8 billion; in FY11, state health agencies

distributed nearly $6.1 billion through contracts, grants, and awards. Between FY10 and FY11, there were slight increases in dollars distributed to all entities, except for other government entities, which showed a slight decrease from FY10 to FY11 (see **Figure 6.10**). As shown in **Figure 6.11**, nearly one-third (32%) of state health agency contracts, grants, and awards were distributed to nonprofit organizations; the next highest percentage was distributed to independent local health departments (28%). The combined category of local health departments, including both state-run local health departments and independent local health departments, receives the greatest proportion (44%) of state health agency contracts, grants, and awards. (See **Figure 6.12** for definitions of organization types.)

**Table 6.5** presents the mean, median, minimum, and maximum dollars distributed by state health agencies through contracts, grants, and awards to local health departments and community-based organizations for FY10 and FY11. Once again, the means for all organizations exceeded the medians, in some cases by substantial amounts, indicating several state health agencies with particularly high expenditures to various entities that skewed (increased) the mean. Spending was fairly constant from FY10 to FY11.

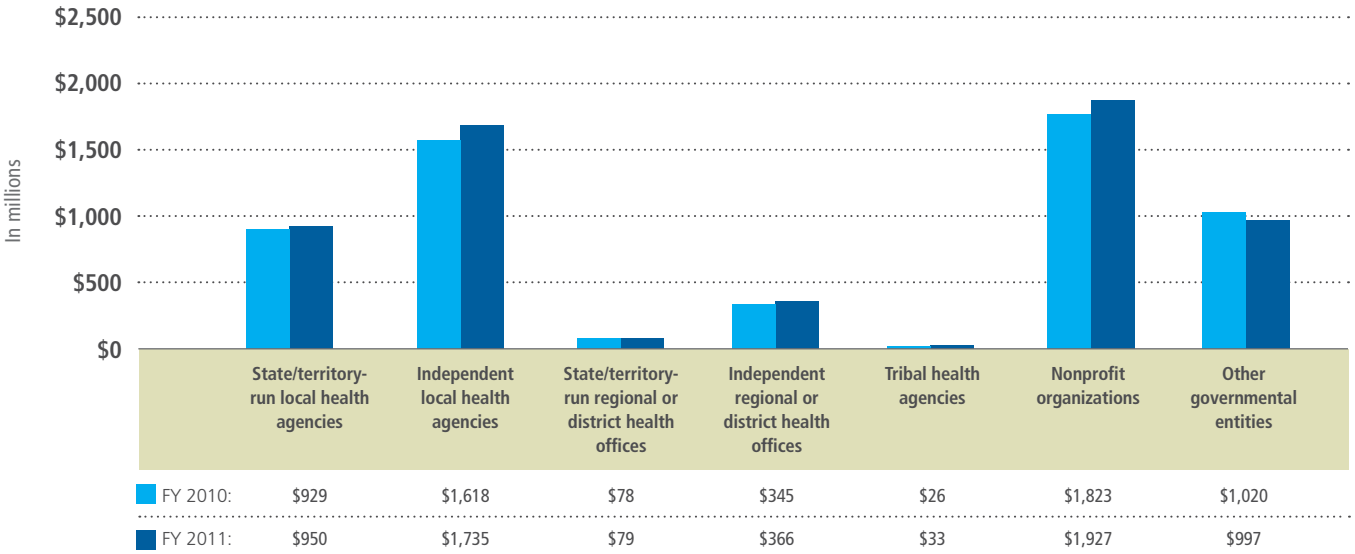
The first three sections of the ASTHO Profile of State Public Health have focused on the structure of state health agencies, the individuals that comprise state health agencies, the activities and services that state health agencies perform, and the tools, processes, and resources utilized by state health agencies to perform these functions. In the final section of the report, State Profiles, a snapshot will be provided of each state health agency and the District of Columbia that responded to the survey.

**Figure 6.11: Percentage of State Health Agency Contracts, Grants, and Awards Distributed to Local Health Departments and Community-Based Organizations for FY11 (n=41*)**




**Note: Not all states provided values for all organizations. Ns range from 7 to 41.*

**Figure 6.10: State Health Agency Contracts, Grants, and Awards Distributed to Local Health Departments and Community-Based Organizations for FY11 (n=41*)**




**Note: Not all states provided values for all organizations. Ns range from 7 to 41.*

**Figure 6.12 Contracts, Grants, and Awards Recipient Type Descriptions**

**State/territory-run local health agencies.** Include expenditures passed through the state/territory health agency onto local public health agencies that are led by staff employed by state/territory government.

**Independent local health agencies.** Include expenditures passed through the state/territory health agency onto local public health agencies that are led by staff employed by local government.

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

**Independent regional or district health offices.** Include expenditures passed through the state/territory health agency onto regional or district public health offices that are led by non-state/territory employees.

**Tribal health agencies.** Include expenditures passed through the state/territory health agency onto tribal public health agencies.

**Nonprofit organizations.** Include expenditures passed through the state/territory health agency onto nonprofit organizations such as community-based organizations.

**Other governmental entities.** Include expenditures passed through the state/territory health agency to other governmental entities such as public schools, parks and recreation, public safety, etc.

**Table 6.5: Average Dollars Distributed by State Health Agencies Through Contracts, Grants, and Awards Distributed to Local Health Departments and Community-Based Organizations for FY10 and FY11 (n=41*)**

| | FY10 (in millions) | | | | FY11 (in millions) | | | |
|---|---|---|---|---|---|---|---|---|
| | Mean | Median | Min | Max | Mean | Median | Min | Max |
| State/territory-run local health agencies | $84 | $20 | $2 | $475 | $86 | $21 | $2 | $438 |
| Independent local health agencies | $52 | $24 | $0.3 | $216 | $54 | $25 | $0.4 | $242 |
| State/territory-run regional or district health offices | $11 | $4 | $1 | $45 | $11 | $4 | $0.5 | $49 |
| Independent regional or district health offices | $43 | $18 | $0.2 | $191 | $46 | $20 | $0.1 | $203 |
| Tribal health agencies | $2 | $1 | $0.001 | $11 | $2 | $1 | $0.001 | $15 |
| Nonprofit organizations | $57 | $17 | $0.1 | $311 | $60 | $17 | $0.1 | $364 |
| Other governmental entities | $35 | $10 | $0.01 | $374 | $34 | $10 | $0.01 | $354 |

**Note: Not all states provided values for all organizations. Ns range from 7 to 41.*

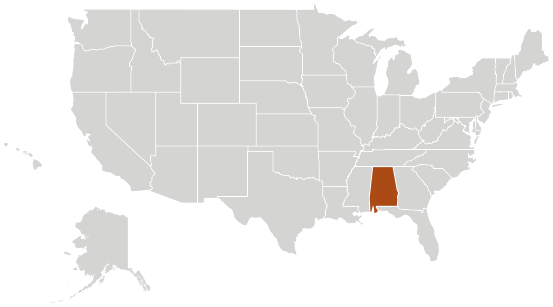
# State Profiles

## Index (Alphabetically by State)


Alabama ..... 92
Alaska ..... 93
Arizona ..... 94
Arkansas ..... 95
California ..... 96
Colorado ..... 97
Connecticut ..... 98
Delaware ..... 99
District of Columbia ..... 100
Florida ..... 101
Georgia ..... 102
Hawaii ..... 103
Idaho ..... 104
Illinois ..... 105
Indiana ..... 106
Iowa ..... 107
Kansas ..... 108
Kentucky ..... 109
Louisiana ..... 110
Maine ..... 111
Maryland ..... 112
Massachusetts ..... 113
Michigan ..... 114
Minnesota ..... 115
Mississippi ..... 116
Missouri ..... 117
Montana ..... 118
Nebraska ..... 119
New Hampshire ..... 120
New Jersey ..... 121
New Mexico ..... 122
New York ..... 123
North Carolina ..... 124
North Dakota ..... 125
Ohio ..... 126
Oklahoma ..... 127
Oregon ..... 128
Pennsylvania ..... 129
Rhode Island ..... 130
South Dakota ..... 131
Tennessee ..... 132
Texas ..... 133
Utah ..... 134
Vermont ..... 135
Virginia ..... 136
Washington ..... 137
West Virginia ..... 138
Wisconsin ..... 139
Wyoming ..... 140

# Alabama

Alabama Department of Public Health



## Agency Mission

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

## Top 5 Priorities for State Health Agency

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

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 2

## Number of state-run local health agencies

(led by state government staff): 65

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

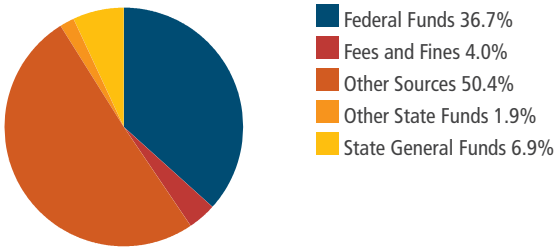
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

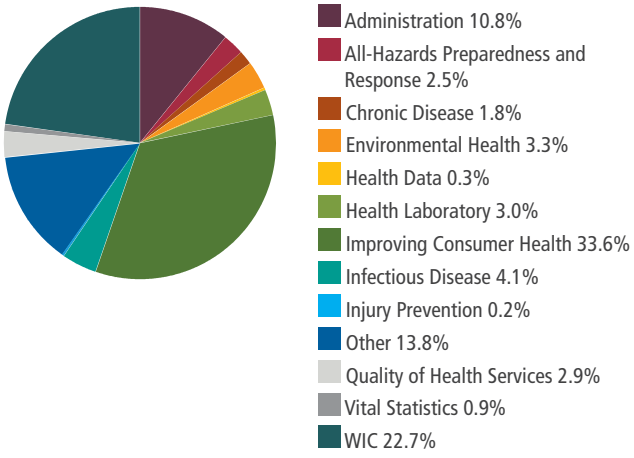
The state health agency has 4,129 FTEs, including 2,071 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

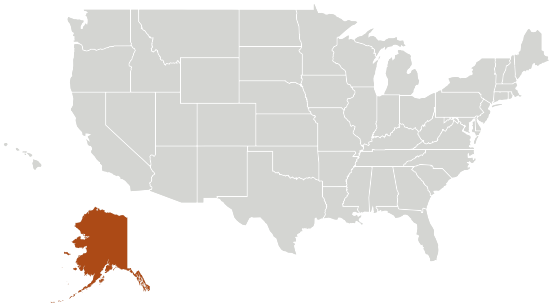



Total Expenditures FY10: $552,647,855
Total Expenditures FY11: $563,582,818

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Alaska

Alaska Department of Health and Social Services,
Alaska Division of Public Health





## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Obesity prevention and control
2. Tobacco prevention and control
3. Infectious disease and childhood immunizations
4. Oral health and community water fluoridation
5. Injury prevention

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 2

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 25

## State Organizational Structure

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

## State Health Planning

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

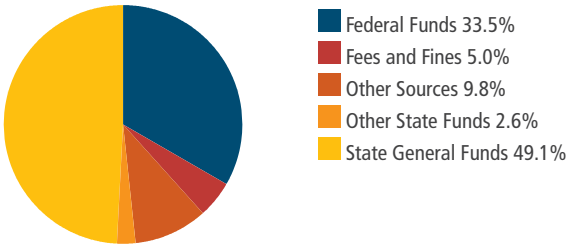
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

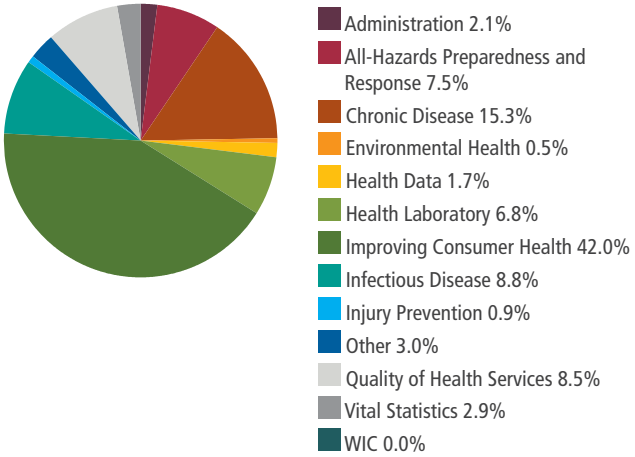
The state health agency has 441 FTEs, including 164 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

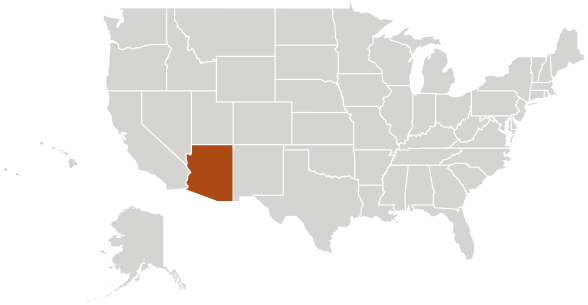



Total Expenditures FY10: $85,474,700
Total Expenditures FY11: $87,724,840

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Arizona

Arizona Department of Health Services



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Impact Arizona's Winnable Battles
2. Integrate behavioral and physical health services
3. Promote public health and safety
4. Strengthen statewide public health system
5. Maximize Arizona Department of Health Services' effectiveness through policy, continuous quality improvement, technology, and workforce development

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 15

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

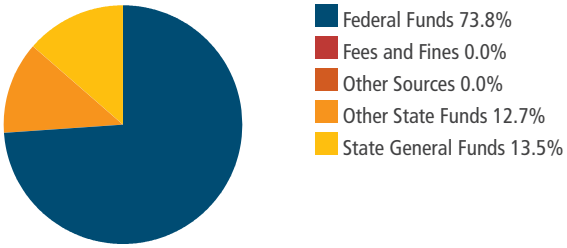
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

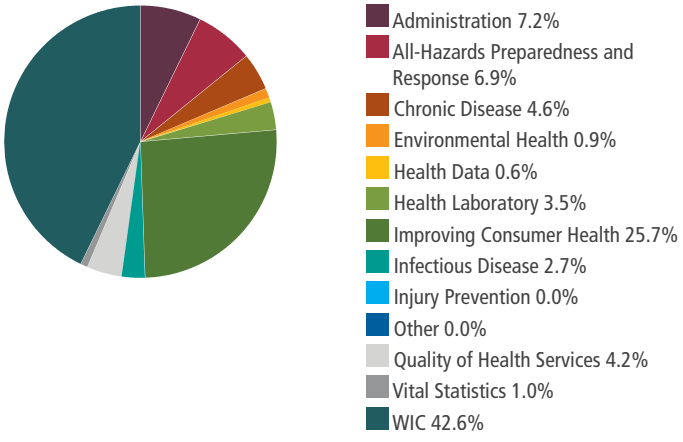
The state health agency has 1,647 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)




Total Expenditures FY10: $406,885,400
Total Expenditures FY11: $378,542,600

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Arkansas

Arkansas Department of Health




## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Strengthen and expand statewide clinical and other services
2. Focus on high burden health issues
3. Strengthen the statewide public health system
4. Strengthen organizational effectiveness and infrastructure
5. Strengthen resource acquisition and utilization

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 0

## Number of state-run local health agencies

(led by state government staff): 94

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 5

## State Organizational Structure

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

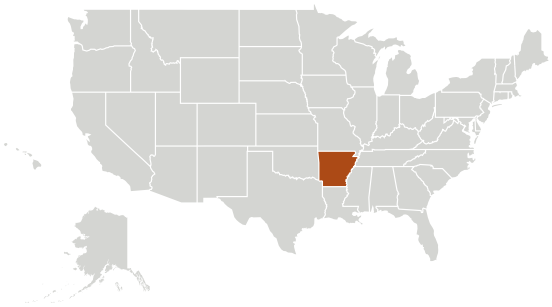
## State Health Planning

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

| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

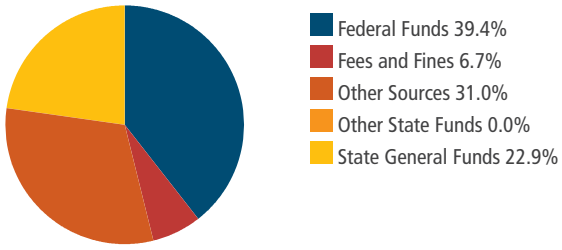
## State Health Agency Workforce

The state health agency has 2,636 FTEs, including 1,887 state workers assigned to local/regional offices.

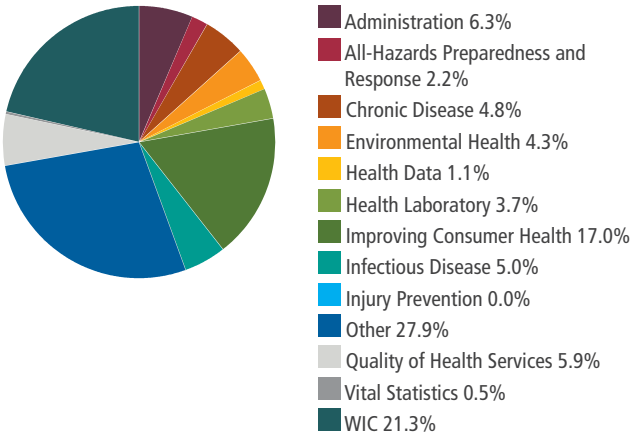


## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)




Total Expenditures FY10: $342,159,340
Total Expenditures FY11: $362,005,147

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# California

California Department of Public Health


## Agency Mission

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

## Top Priorities for State Health Agency

1. Achieve health equity through public health programs
2. Prepare for and respond to public health threats
3. Strengthen the department as an innovative, high-performing organization by retaining and recruiting a skilled workforce, optimizing the department's organizational structure and processes, and making continuous quality improvement a way of life in the department
4. Achieve national public health accreditation

## Structure and Relationship with Local Health Departments

Data are not available about the structure of the agency. The state health agency has a decentralized relationship with local health departments.

Data are not available about the number of local health agencies and regional/district health offices.

## State Organizational Structure

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

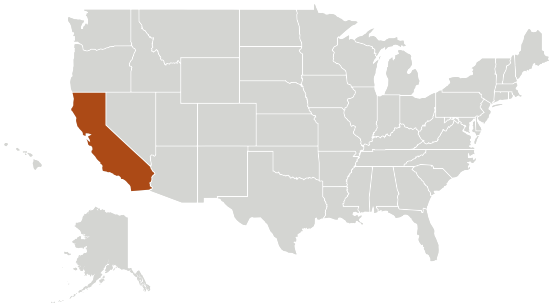
## State Health Planning

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

| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

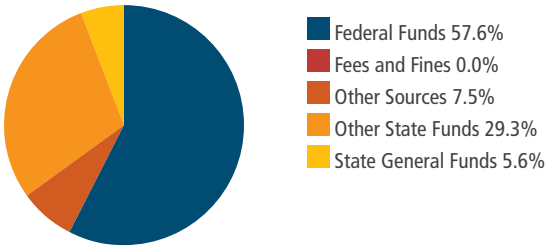
## State Health Agency Workforce

The state health agency has 3,313 FTEs, including 1,817 state workers assigned to local/regional offices.

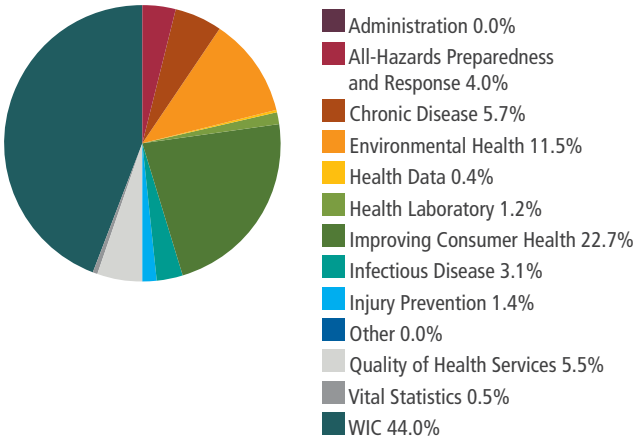


## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

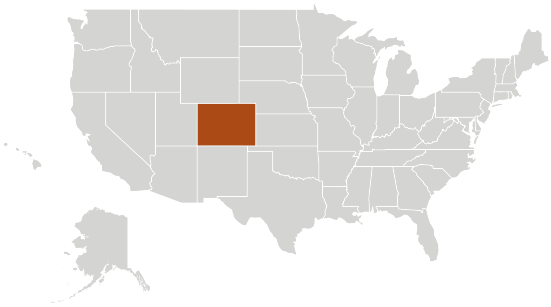



Total Expenditures FY10: $3,182,410,054
Total Expenditures FY11: $3,266,005,147

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Colorado

Colorado Department of Public Health and Environment





## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Colorado Winnable Battles
2. Public health improvement planning
3. Health equity and environmental justice
4. Lean quality improvement
5. Strengthen public health system

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 54

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 2

## State Organizational Structure

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

## State Health Planning

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

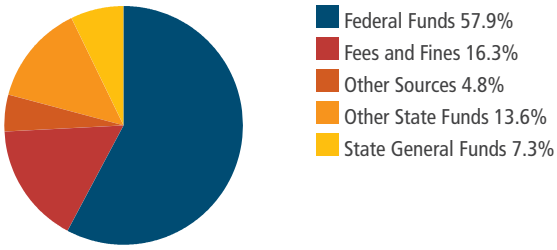
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

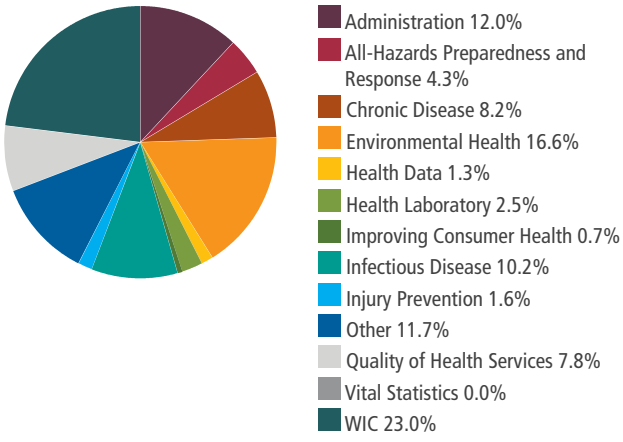
The state health agency has 1,272 FTEs, including 25 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)




Total Expenditures FY10: $425,645,086
Total Expenditures FY11: $406,825,422

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Connecticut

Connecticut Department of Public Health



## Agency Mission

To protect and improve the health and safety of the people of Connecticut by:

- Assuring the conditions in which people can be healthy.
- Preventing disease, injury, and disability.
- Promoting the equal enjoyment of the highest attainable standard of health, which is a human right and a priority of the state.

## Top 5 Priorities for State Health Agency

1. Addressing health disparities and inequities with a particular focus on infant mortality and low birth weight
2. Building a comprehensive, coordinated chronic disease program that includes injury prevention
3. Integrating public health and primary care
4. Remaining focused and strategically realigning programs in order to provide the core public health functions with the same or potentially less funding
5. Implementing a federally compliant vital records birth registry system

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 53

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 21

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

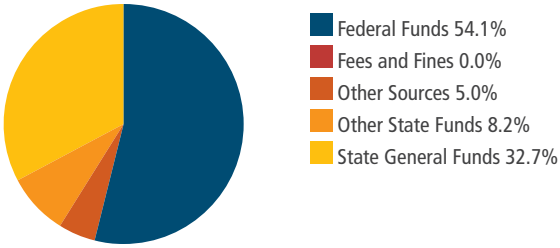
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

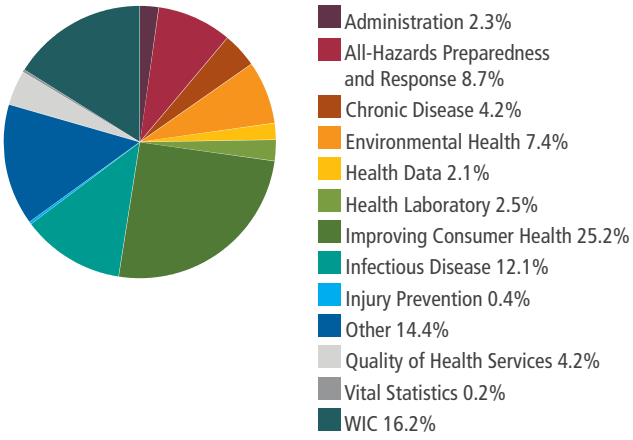
The state health agency has 798 FTEs, including 11 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)




Total Expenditures FY10: $255,118,639
Total Expenditures FY11: $253,810,899

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Delaware

Delaware Department Health & Social Services, Division of Public Health



## Agency Mission

The Division of Public Health's mission is to protect and enhance the health of the people of Delaware by: working together with others; addressing issues that affect the health of Delawareans; keeping track of the state's health; promoting positive lifestyles; responding to critical health issues and disasters; and promoting the availability of health services.

## Top Priorities for State Health Agency

1. Obesity
2. Health reform
3. Health equity
4. Performance improvement

## Structure and Relationship with Local Health Departments

The state health agency is under a larger agency and is classified as centralized governance because it does not have local health departments.

## Number of independent local health agencies

(led by local government staff): 0

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

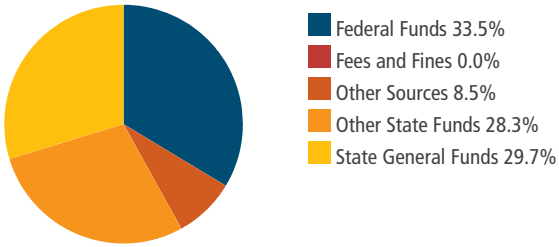
## State Health Agency Workforce

The state health agency has 630 FTEs.

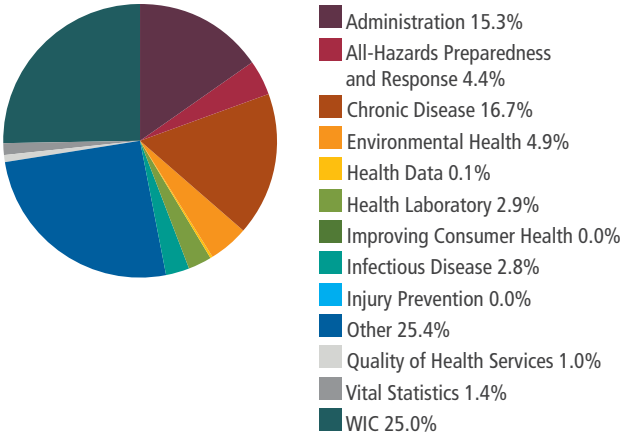


## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

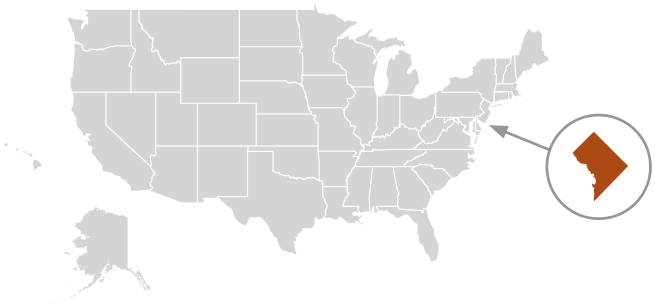



Total Expenditures FY10: $106,069,920
Total Expenditures FY11: $93,253,009

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# District of Columbia

District of Columbia Department of Health



## Agency Mission

The mission of the Department of Health is to promote and protect the health, safety, and quality of life of residents, visitors, and those doing business in the District of Columbia.

## Top Priorities for State Health Agency

1. School health
2. Home visiting

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 0

## Number of state-run local health agencies

(led by state government staff): 1

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

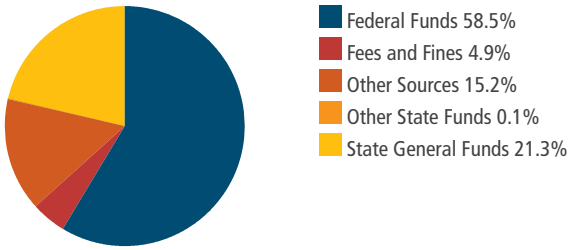
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

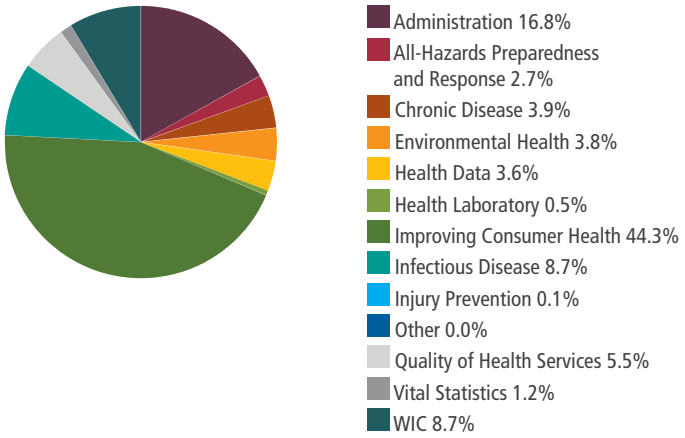
The state health agency has 798 FTEs.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

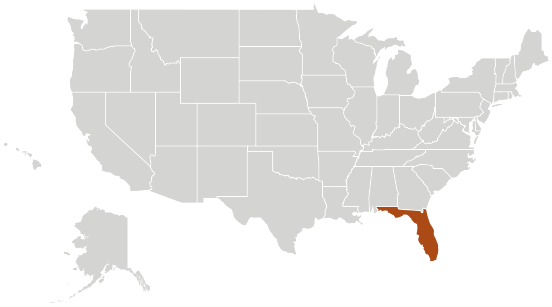



Total Expenditures FY10: $175,659,936
Total Expenditures FY11: $204,320,692

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Florida

Florida Department of Health





## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Health protection
2. Chronic disease prevention
3. Community redevelopment and partnerships
4. Access to care
5. Health finance and infrastructure

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 0

## Number of state-run local health agencies

(led by state government staff): 67

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

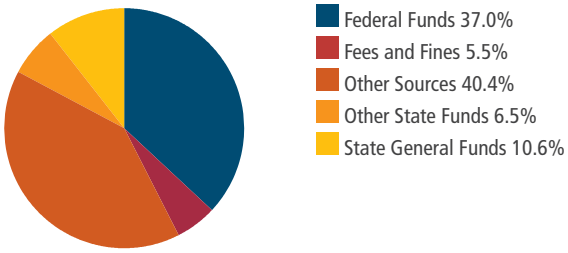
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

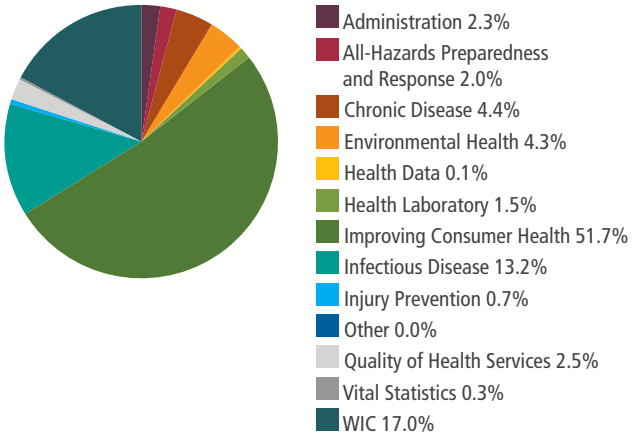
The state health agency has 15,026 FTEs, including 9,720 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

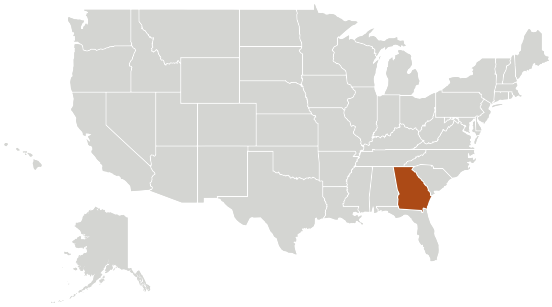



Total Expenditures FY10: $2,193,575,221
Total Expenditures FY11: $2,157,422,882

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Georgia

Georgia Department of Public Health



## Agency Mission

The mission of the Georgia Department of Public Health is to prevent disease, injury, and disability; promote health and well-being; and prepare for and respond to disasters.

## Top 5 Priorities for State Health Agency

1. Childhood obesity
2. Infant mortality
3. Immunizations
4. Tobacco cessation
5. Workforce development

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 159

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 18

## State Organizational Structure

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

## State Health Planning

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

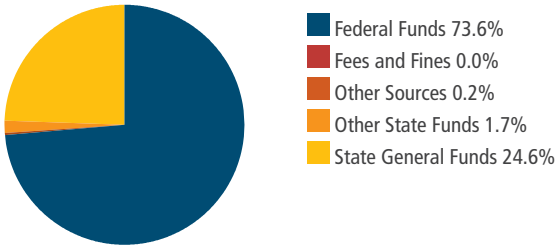
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

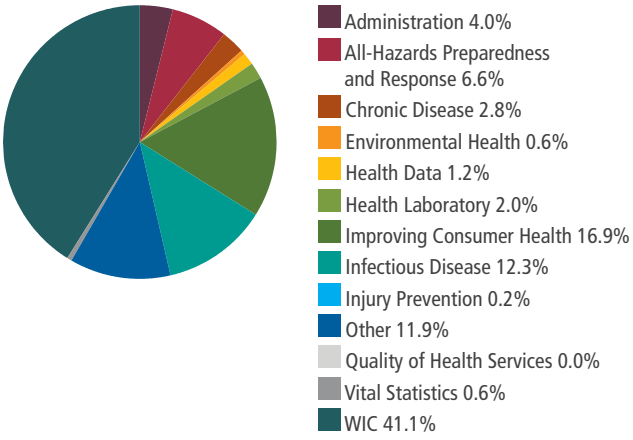
The state health agency has 1,001 FTEs, including 182 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

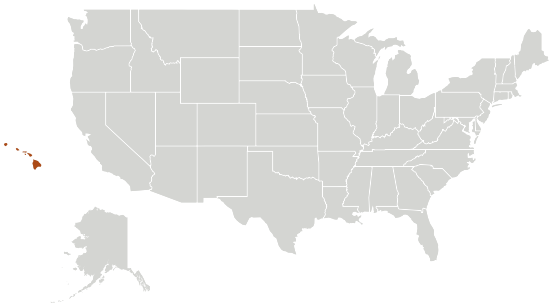



Total Expenditures FY10: $615,462,654
Total Expenditures FY11: $690,032,912

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Hawaii

Hawaii State Department of Health





## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Health equity
2. Disease prevention
3. Emergency preparedness
4. Clean and sustainable environment
5. Quality and service excellence

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 0

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 1

## State Organizational Structure

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

## State Health Planning

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

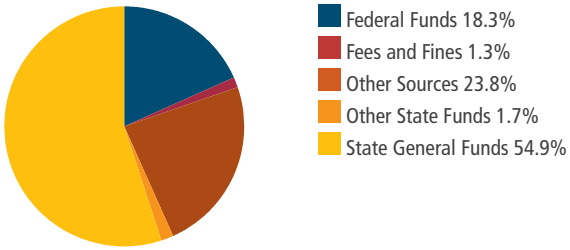
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

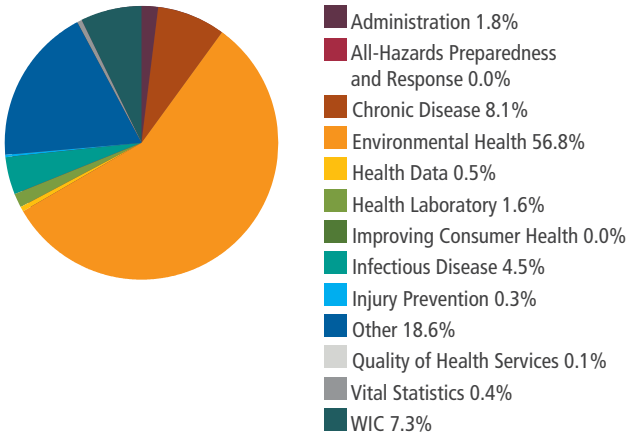
The state health agency has 2,593 FTEs. Data are not available on the number of state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

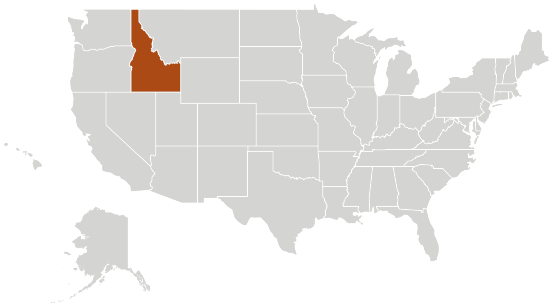



Total Expenditures FY10: $459,480,968
Total Expenditures FY11: $442,480,464

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Idaho

Idaho Department of Health and Welfare



## Agency Mission

Our mission is to promote and protect the health and safety of Idahoans.

## Top 5 Priorities for State Health Agency

1. Prevent communicable disease and other health threats
2. Support and encourage healthy communities and environments
3. Implement models of healthcare and public health integration
4. Implement business practices that address workforce quality
5. Build sustainability in public health through targeted efforts

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 7

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

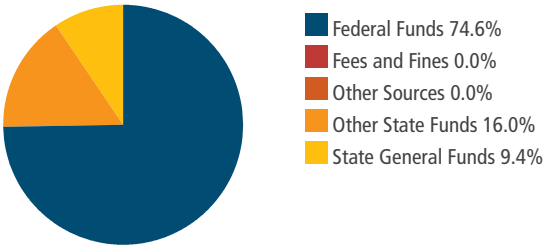
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

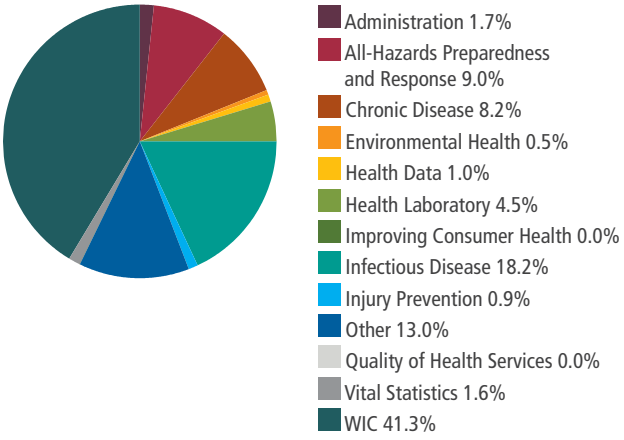
The state health agency has 214 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

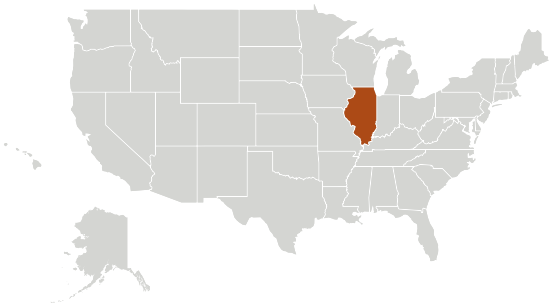



Total Expenditures FY10: $86,342,346
Total Expenditures FY11: $87,032,365

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Illinois

Illinois Department of Public Health





## Agency Mission

The mission of the Illinois Department of Public Health is to promote the health of the people of Illinois through the prevention and control of disease and injury.

## Top 5 Priorities for State Health Agency

1. Enhanced stakeholder engagement (partnerships)
2. Improve data quality and dissemination
3. Broaden agency marketing, communication, and branding
4. Improve regulatory compliance
5. Reduce health disparities

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 96

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 7

## State Organizational Structure

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

## State Health Planning

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

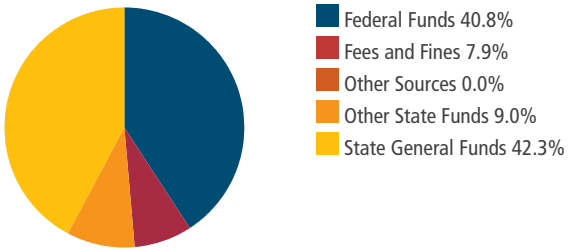
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

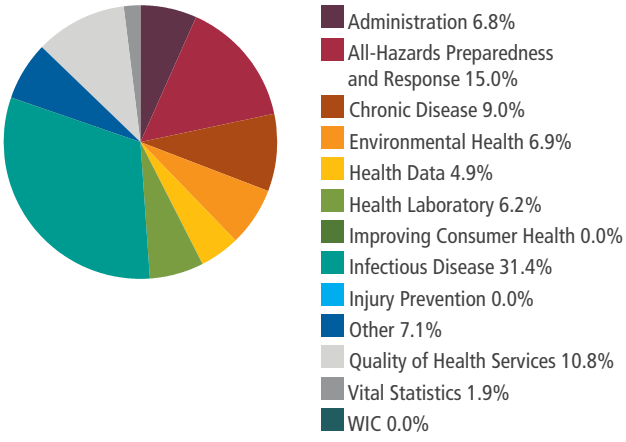
The state health agency has 1,057 FTEs, including 520 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

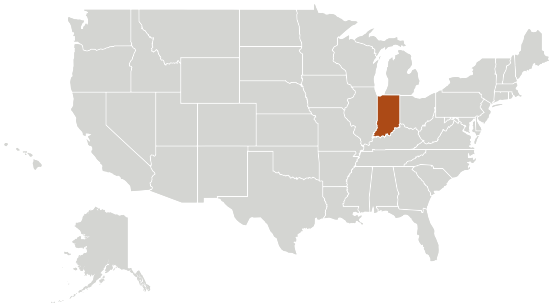



Total Expenditures FY10: $368,982,775
Total Expenditures FY11: $316,133,550

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Indiana

Indiana State Department of Health



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Decrease disease incidence and burden
2. Improve response and preparedness networks and capabilities
3. Reduce administrative costs by improving efficiencies
4. Recruitment, evaluation, and retention of public health workforce
5. Information and electronic data use to develop outcome-driven programs

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 93

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

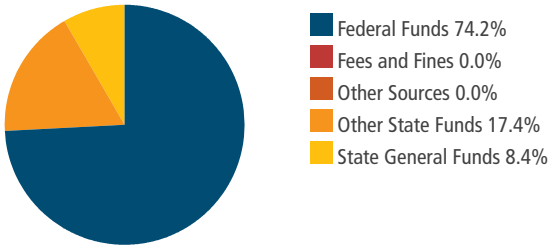
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

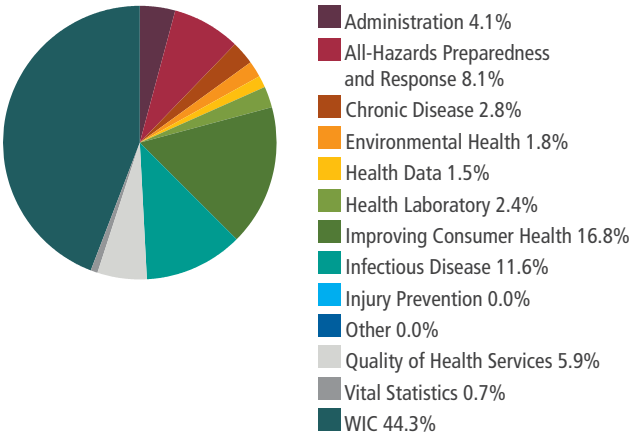
The state health agency has 792 FTEs, including 216 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

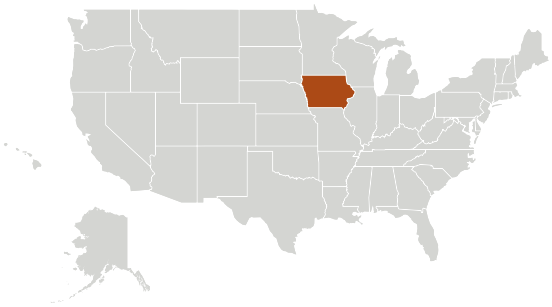



Total Expenditures FY10: $353,322,522
Total Expenditures FY11: $330,033,623

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Iowa

Iowa Department of Public Health





## Agency Mission

Promoting and protecting the health of Iowans.

## Top 5 Priorities for State Health Agency

1. Continue to work with Preparedness Advisory Committee
2. Guidance and support to local public health and hospitals to build healthcare coalitions
3. Support local public health and hospitals in implementing preparedness capabilities
4. Program management, fiscal oversight, and accountability of preparedness programs
5. Sustain response capabilities in Iowa Department of Public Health and with partners

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 101

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

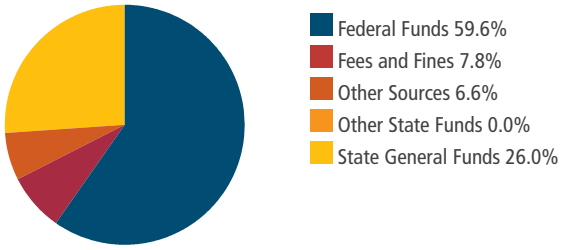
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

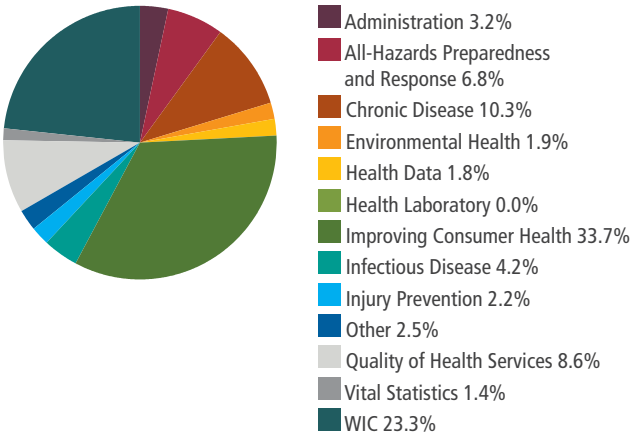
The state health agency has 410 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)




Total Expenditures FY10: $223,425,133
Total Expenditures FY11: $205,661,795

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Kansas

Kansas Department of Health and Environment, Division of Health


## Agency Mission

The mission of the Division of Health is to promote and protect health and prevent disease and injury among the people of Kansas.

## Top 5 Priorities for State Health Agency

1. Public health accreditation
2. Quality improvement/performance management
3. Tribal health
4. Reducing infant mortality
5. Obesity

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 100

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 6

## State Organizational Structure

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

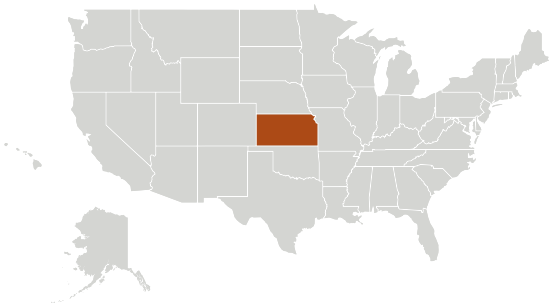
## State Health Planning

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

| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

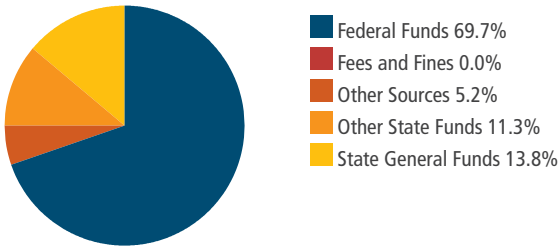
## State Health Agency Workforce

The state health agency has 386 FTEs, including 66 state workers assigned to local/regional offices.

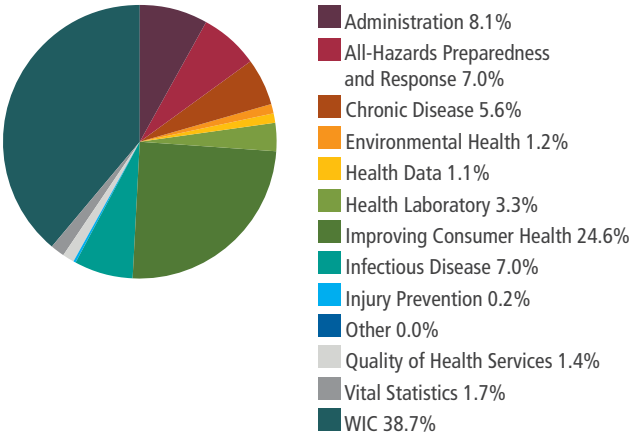


## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

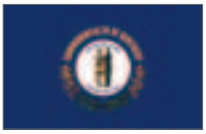


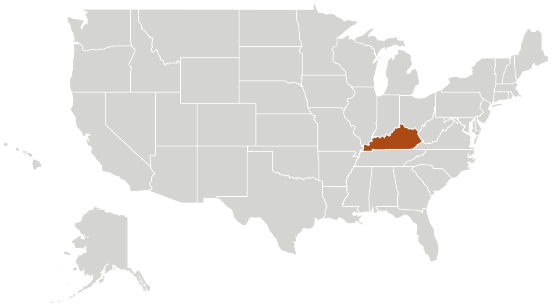

Total Expenditures FY10: $189,260,493
Total Expenditures FY11: $192,070,034

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Kentucky

Kentucky Department for Public Health







## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. HPV vaccination
2. Smoke-free legislation
3. Obesity
4. Neonatal abstinence syndrome
5. Expansion of home visiting program, HANDS

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 59

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

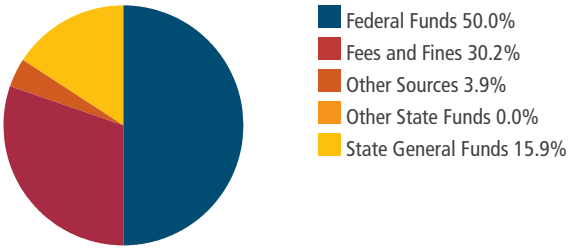
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

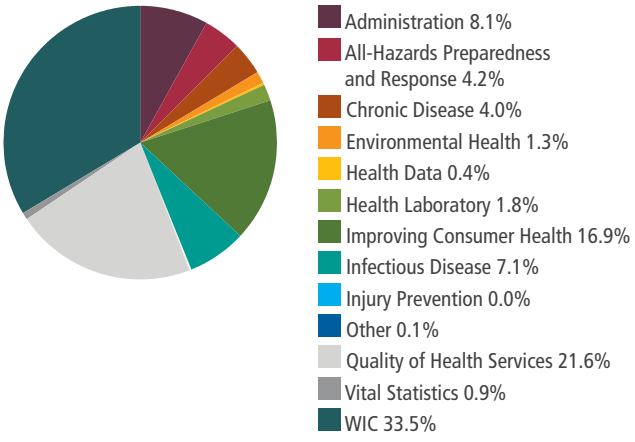
The state health agency has 470 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

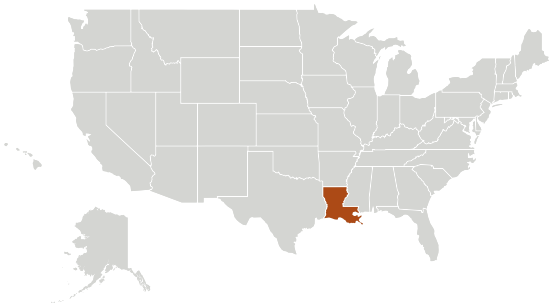



Total Expenditures FY10: $389,724,405
Total Expenditures FY11: $386,479,989

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Louisiana

Louisiana Department of Health & Hospitals,
Office of Public Health



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Clinic operations improvement project/environmental health overhaul
2. Integrating public health and primary care
3. Statewide state health improvement plan for better health outcomes
4. Strategic planning
5. Improving outdated and inefficient processes

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 2

## Number of state-run local health agencies

(led by state government staff): 69

## Number of independent regional or district offices

(led by non-state employees): 5

## Number of state-run regional or district offices

(led by state employees): 9

## State Organizational Structure

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

## State Health Planning

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

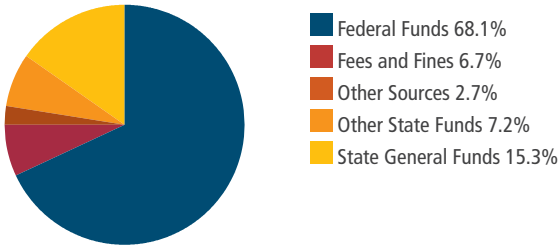
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

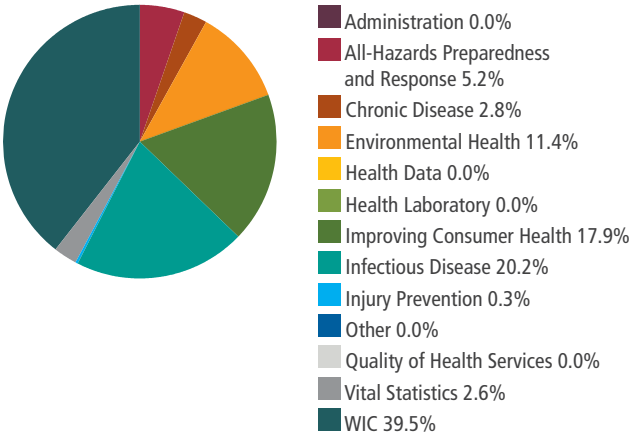
The state health agency has 1,157 FTEs.
Data are not available on the number of state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

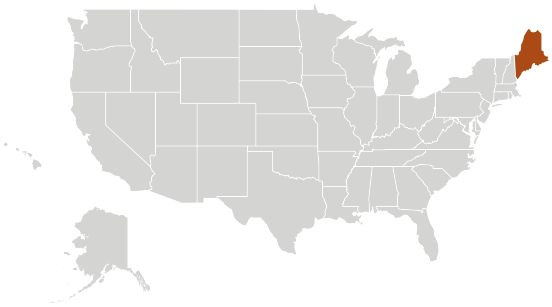



Total Expenditures FY10: $325,278,239
Total Expenditures FY11: $317,836,888

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Maine

Maine Department of Health and Human Services,
Center for Disease Control and Prevention





## Agency Mission

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

## Top Priorities for State Health Agency

1. Ensure programmatic excellence
2. Promote the value and contributions of public health
3. Secure sustainable funding
4. Support and maintain a competent, empowered workforce

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 2

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 8

## State Organizational Structure

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

## State Health Planning

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

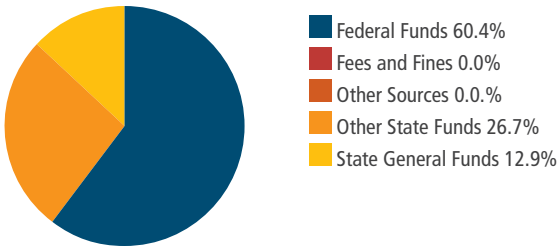
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

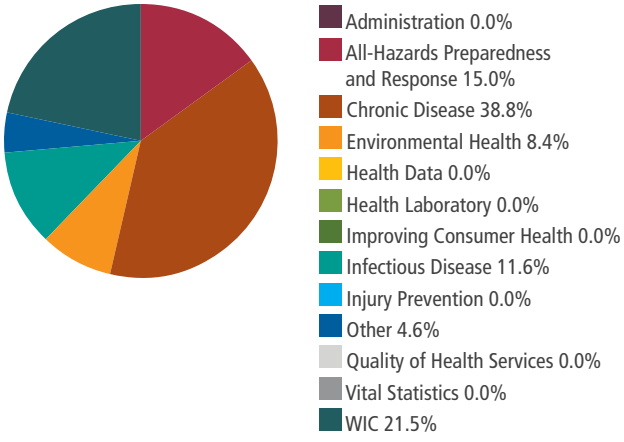
## State Health Agency Workforce

The state health agency has 387 FTEs.
Data are not available on the number of state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)



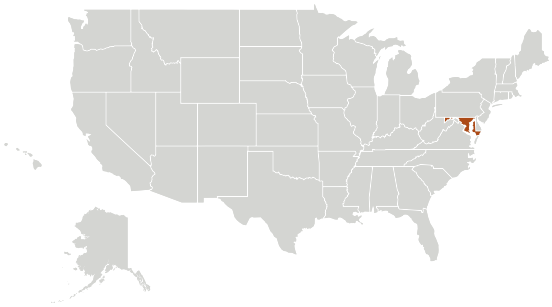




Total Expenditures FY10: $107,751,511
Total Expenditures FY11: $108,077,254

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Maryland

Maryland Department of Health and Mental Hygiene



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Access
2. Quality
3. Disparities
4. Data
5. Local engagement

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 1

## Number of state-run local health agencies

(led by state government staff): 23

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 3

## State Organizational Structure

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

## State Health Planning

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

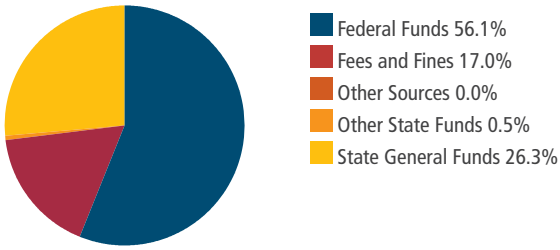
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

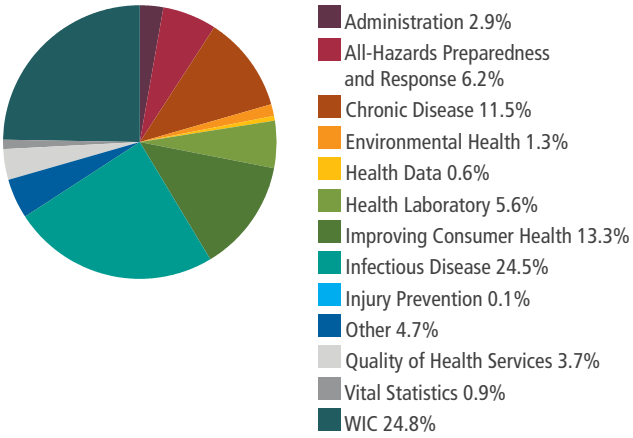
The state health agency has 8,246 FTEs, including 2,466 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

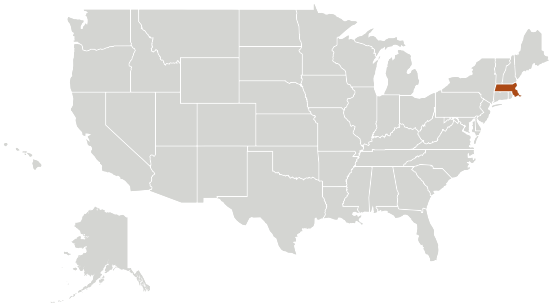



Total Expenditures FY10: $427,487,221
Total Expenditures FY11: $423,845,330

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Massachusetts

Massachusetts Department of Public Health





## Agency Mission

The mission of the Massachusetts Department of Public Health is to prevent illness, injury, and premature death; to assure access to high quality public health and healthcare services; and to promote wellness and health equity for all people in the Commonwealth.

## Top 5 Priorities for State Health Agency

1. Supporting implementation of health reform
2. Achieving health equity/eliminating health disparities
3. Preventing youth violence
4. Strengthening public health infrastructure
5. Promoting wellness/managing chronic disease

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 351

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 16

## Number of state-run regional or district offices

(led by state employees): 5

## State 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.

## State Health Planning

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

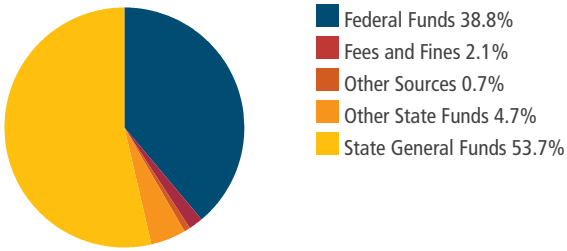
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

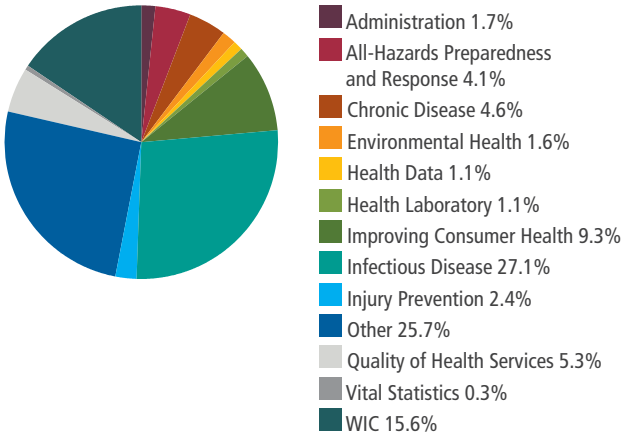
The state health agency has 2,933 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

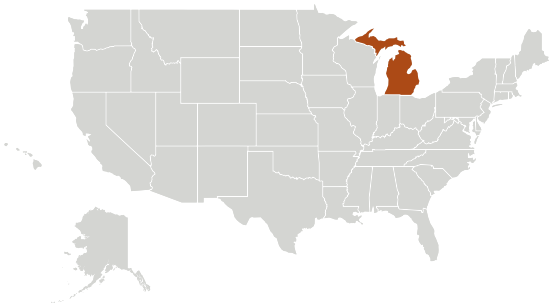



Total Expenditures FY10: $766,247,024
Total Expenditures FY11: $762,569,729

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Michigan

Michigan Department of Community Health



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Reduce obesity and improve wellness
2. Reduce infant mortality
3. Reduce health disparities/promote health equity
4. Promote integration of public health within the primary care system
5. Enhance the safety planning and response to all hazards, public health, and healthcare emergencies

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 45

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

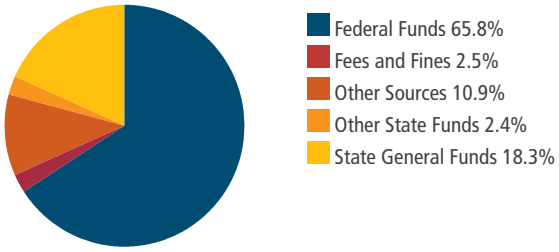
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

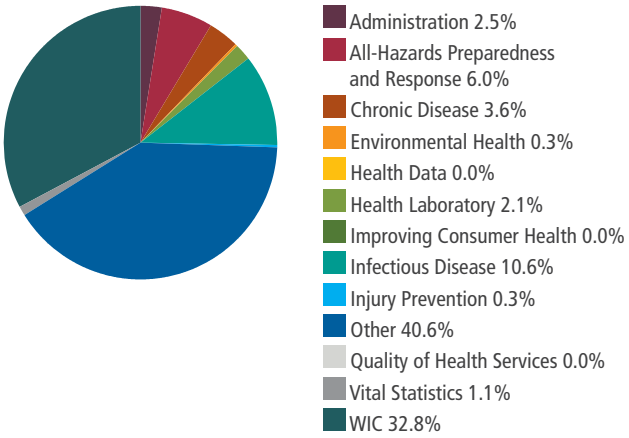
The state health agency has 487 FTEs, including 21 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

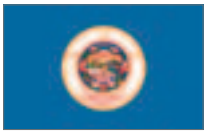


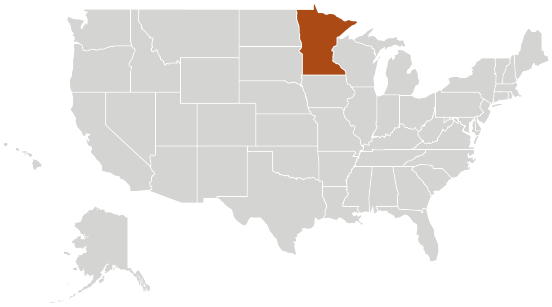

Total Expenditures FY10: $769,041,300
Total Expenditures FY11: $814,665,900

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Minnesota

Minnesota Department of Health







## Agency Mission

Protecting, maintaining, and improving the health of all Minnesotans.

## Top 5 Priorities for State Health Agency

1. State health improvement program—stable funding, statewide
2. Access to healthcare with strong emphasis on prevention
3. Health careers—workforce to meet primary and preventive needs
4. Maintain strong public health infrastructure at Minnesota Department of Health and local public health
5. Maintain a quality workforce through continuous quality improvement

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 50

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 8

## State Organizational Structure

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

## State Health Planning

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

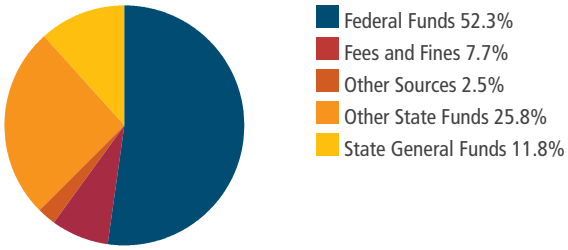
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

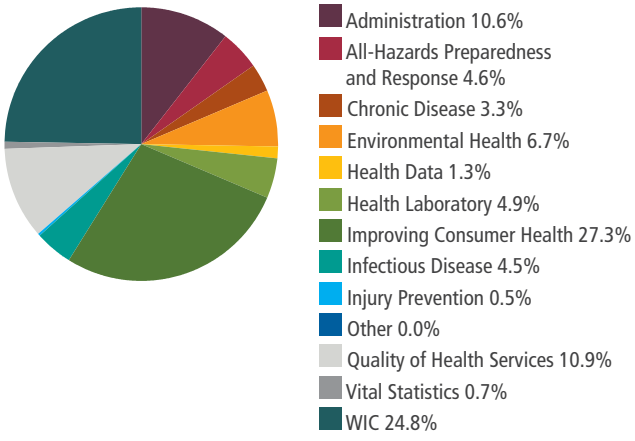
The state health agency has 1,440 FTEs, including 207 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

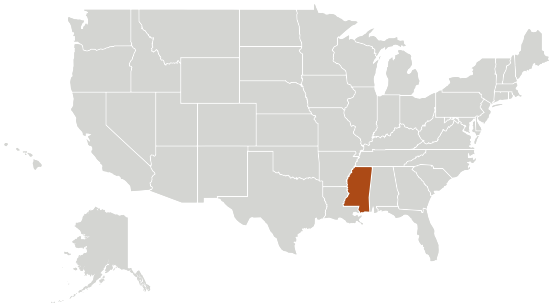



Total Expenditures FY10: $500,432,252
Total Expenditures FY11: $505,192,264

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Mississippi

Mississippi State Department of Health



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Infant mortality
2. Chronic disease implemented locally
3. HIV/STDs
4. Immunizations
5. Electronic laboratory reporting/billing

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 0

## Number of state-run local health agencies

(led by state government staff): 81

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 9

## State Organizational Structure

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

## State Health Planning

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

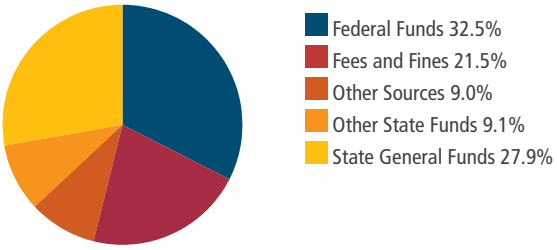
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

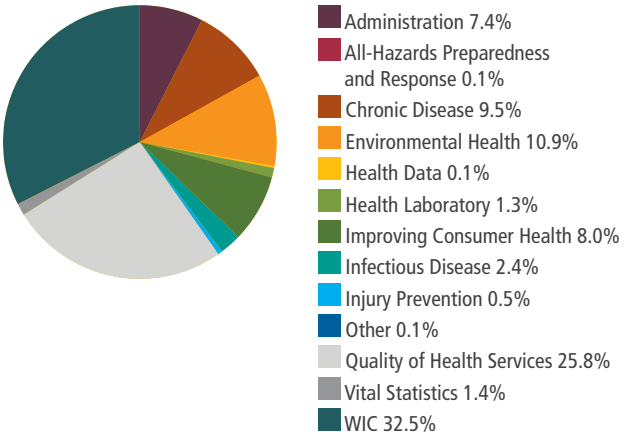
The state health agency has 2,338 FTEs, including 1,399 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

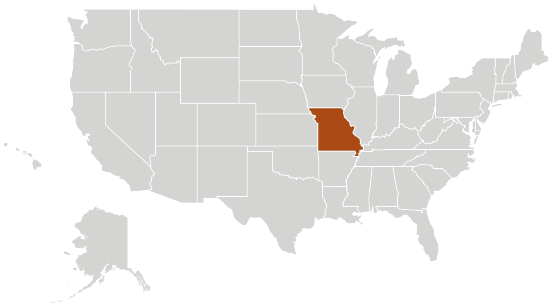



Total Expenditures FY10: $253,898,742
Total Expenditures FY11: $248,925,981

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Missouri

Missouri Department of Health & Senior Services





## Agency Mission

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

## Top Priorities for State Health Agency

1. Ensure Missourians are healthy, safe, and informed
2. Maximize health and safety outcomes
3. Engage and invest in our staff
4. Position resources to ensure maximum returns
5. Increase health equity

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 115

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 9

## State Organizational Structure

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

## State Health Planning

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

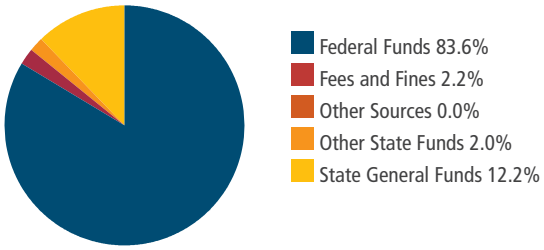
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

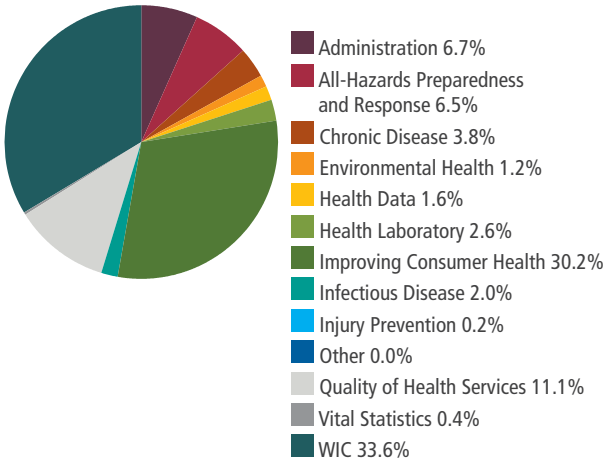
The state health agency has 1,816 FTEs, including 819 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)




Total Expenditures FY10: $393,529,045
Total Expenditures FY11: $377,768,078

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Montana

Montana Department of Public Health and Human Services


## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Prepare for PHAB accreditation
2. Implement our state health improvement plan
3. Enhance and develop the workforce
4. Achieve operational efficiencies
5. Enhance health information technology

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 57

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 1

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

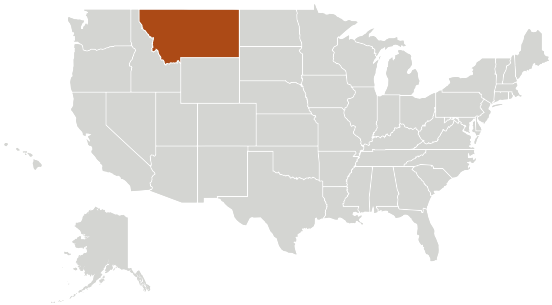
## State Health Planning

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

| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

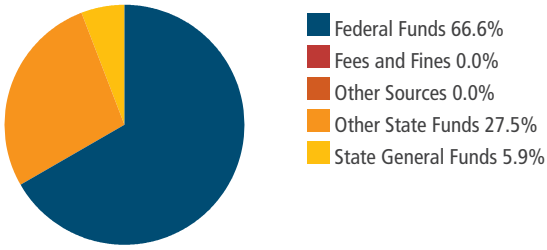
## State Health Agency Workforce

The state health agency has 192 FTEs. There are no state health agency workers assigned to local/regional offices.

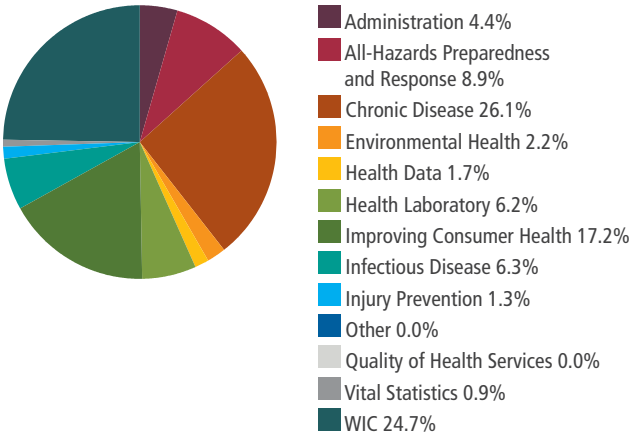


## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

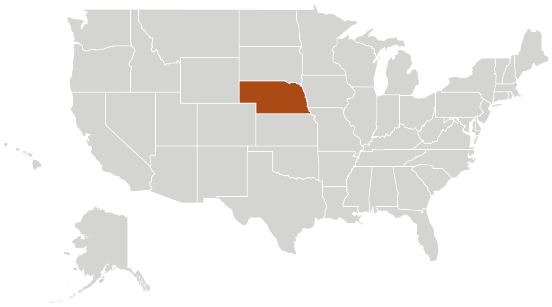



Total Expenditures FY10: $68,801,137
Total Expenditures FY11: $62,740,185

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Nebraska

Nebraska Department of Health & Human Services





## Agency Mission

We help Nebraskans live better lives.

## Top 5 Priorities for State Health Agency

1. Trusted source of state health data
2. Addressing health disparities
3. Media and education plan
4. Create a culture of wellness
5. Budget transparency

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 24

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

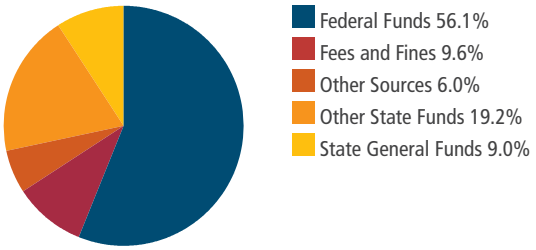
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

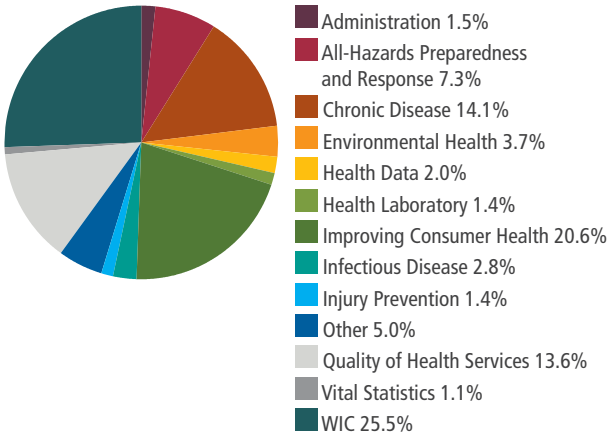
The state health agency has 463 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

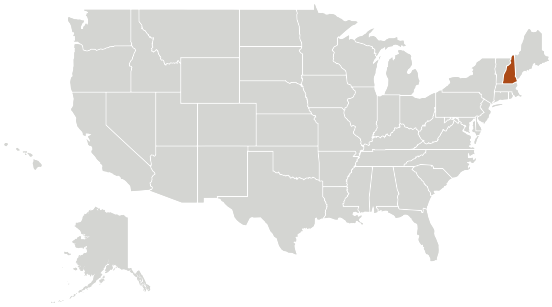



Total Expenditures FY10: $159,369,227
Total Expenditures FY11: $156,736,377

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# New Hampshire

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



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Develop, implement, and maintain approaches to integrate population health
2. Fully implement a systematic quality and performance improvement system
3. Improve effectiveness and resource allocation
4. Develop and implement a public health management system
5. Develop and implement a strategy for social media

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 5

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

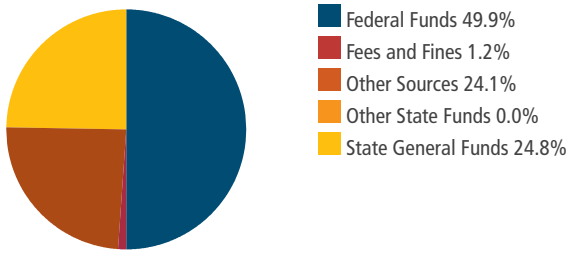
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

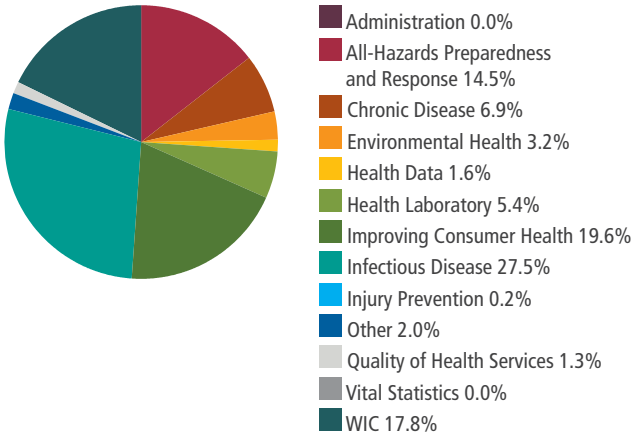
The state health agency has 244 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

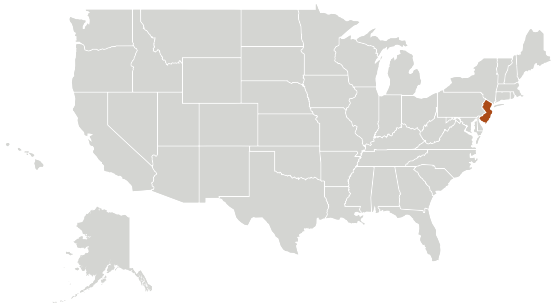



Total Expenditures FY10: $87,410,665
Total Expenditures FY11: $84,841,539

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# New Jersey

New Jersey Department of Health





## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Funding for mandated services
2. Staff resources
3. Public health infrastructure
4. Data based public health policy
5. State and federal grant availability

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 114

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 20

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

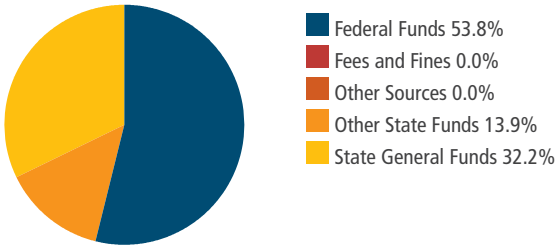
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

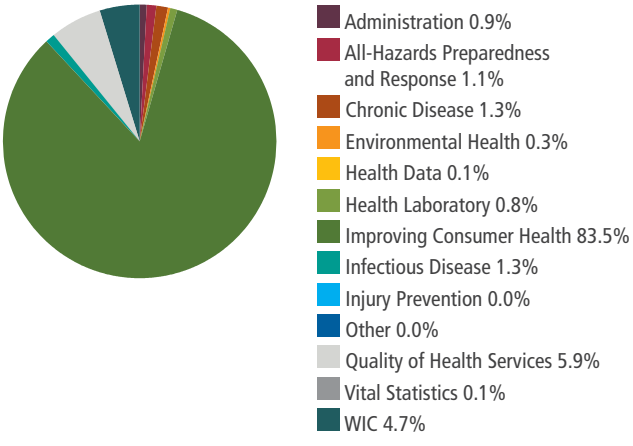
The state health agency has 1,208 FTEs, including 59 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

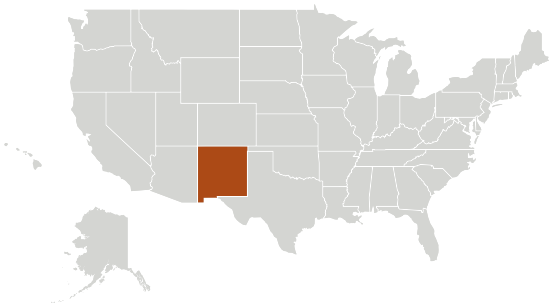



Total Expenditures FY10: $3,514,717,482
Total Expenditures FY11: $3,472,819,064

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# New Mexico

New Mexico Department of Health



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Public health accreditation
2. Filling staff vacancies
3. Employee engagement
4. Reducing prescription drug overdose death
5. Reducing pertussis morbidity

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 1

## Number of state-run local health agencies

(led by state government staff): 54

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 5

## State Organizational Structure

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

## State Health Planning

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

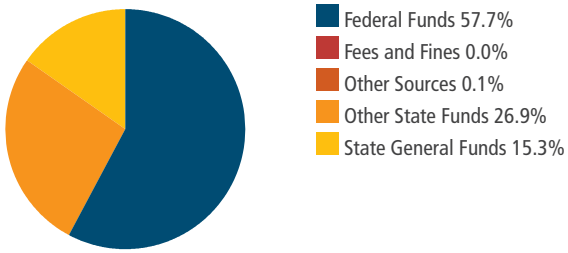
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

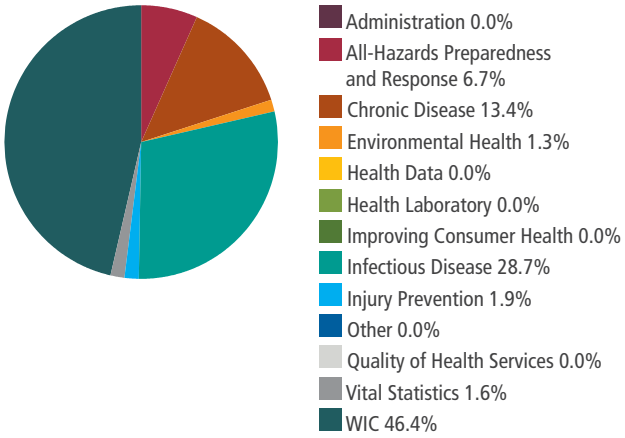
The state health agency has 3,246 FTEs, including 766 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

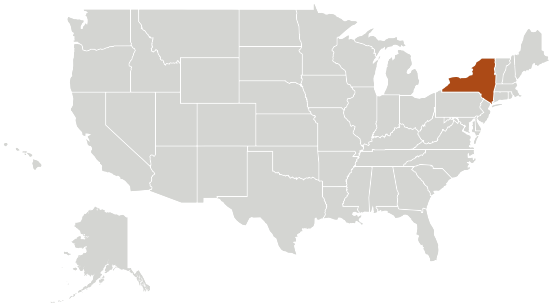



Total Expenditures FY10: $122,268,795
Total Expenditures FY11: $113,323,670

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# New York

New York State Department of Health





## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Implement New York State Prevention Agenda 2013-17
2. Obtain public health agency accreditation
3. Implement Medicaid reform
4. Implement Affordable Care Act
5. Achieve certificate of need reform

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 58

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 15

## State Organizational Structure

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

## State Health Planning

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

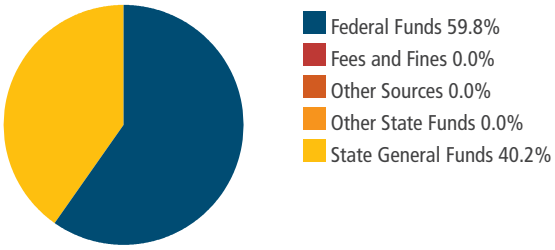
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

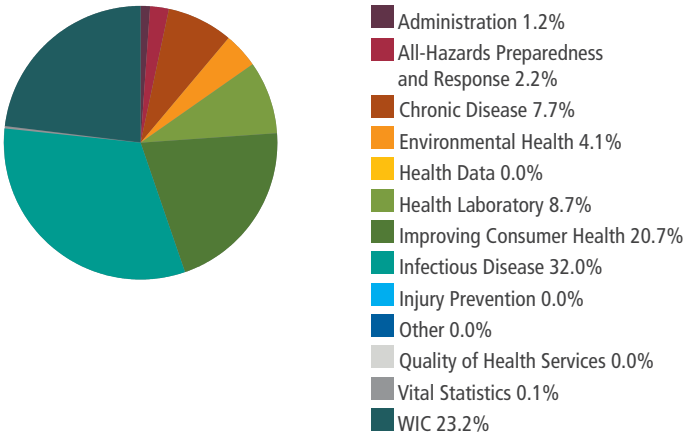
The state health agency has 3,127 FTEs, including 849 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

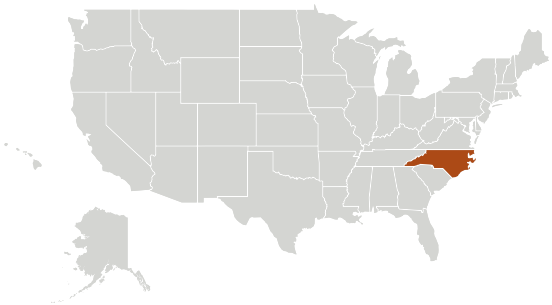



Data not available for total expenditures for FY10.
Total Expenditures FY11: $1,721,808,483

*FY11 was defined as 4/1/10 - 3/31/11.

# North Carolina

North Carolina Division of Public Health



## Agency Mission

The mission of the public health system is to promote and contribute to the highest level of health possible for the people of North Carolina.

## Top 5 Priorities for State Health Agency

1. Maintain public health infrastructure
2. Reduce health disparities
3. Build healthy communities through community transformation
4. Reform the health system to value prevention and improve health
5. Create a nimble, quality-driven organization

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 80

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 6

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

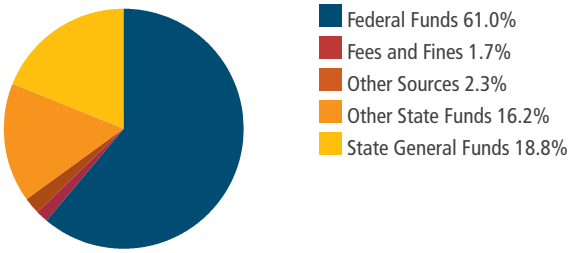
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

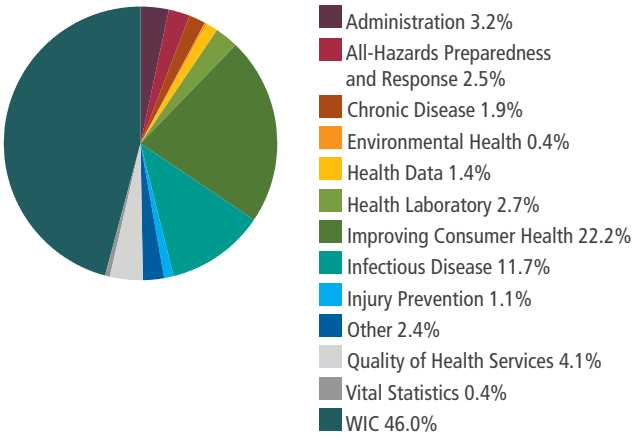
The state health agency has 1,828 FTEs, including 791 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

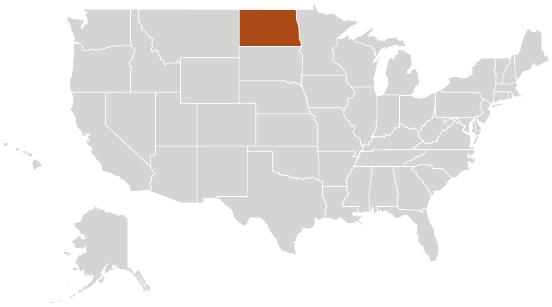



Total Expenditures FY10: $788,957,975
Total Expenditures FY11: $739,133,562

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# North Dakota

North Dakota Department of Health





## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Environmental oil/energy impact
2. Integration of public health and private sector/primary care
3. Obesity
4. Aging IT infrastructure, health information, and interoperability
5. Accreditation and quality improvement

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 28

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 8

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

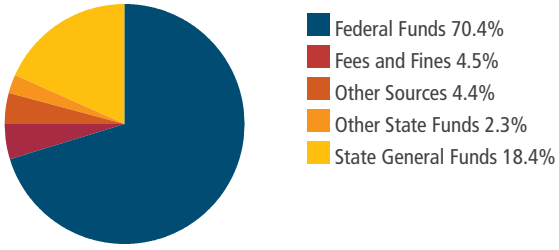
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

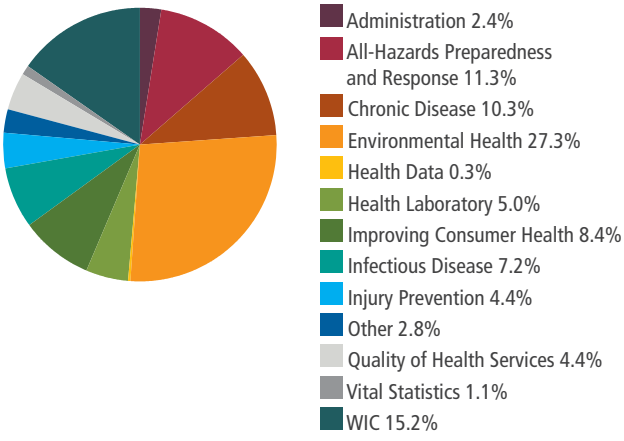
The state health agency has 331 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

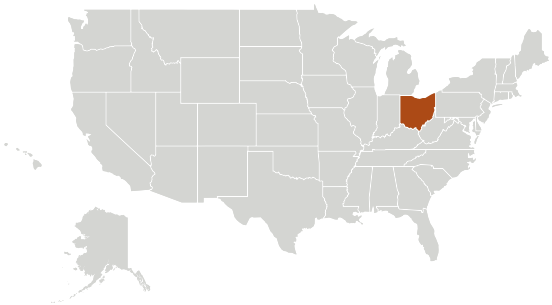



Total Expenditures FY10: $78,083,351
Total Expenditures FY11: $80,965,605

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Ohio

Ohio Department of Health



## Agency Mission

To protect and improve the health of all Ohioans.

## Top Priorities for State Health Agency

1. Reduce tobacco use
2. Reduce infant mortality
3. Expand patient centered medical home model across the state
4. Reduce obesity

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 125

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 4

## State Organizational Structure

The health official reports directly to the governor. The state has an advisory board that provides recommendations on new rules.

## State Health Planning

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

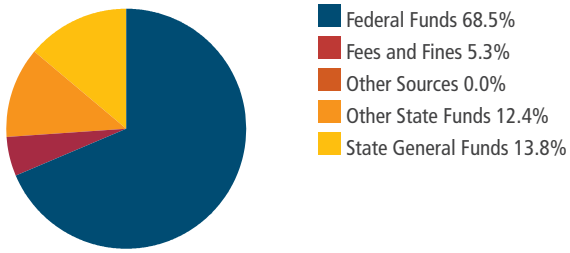
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

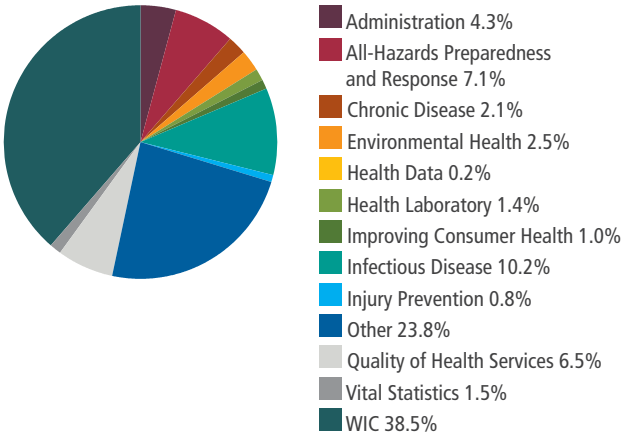
The state health agency has 1,146 FTEs, including 223 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

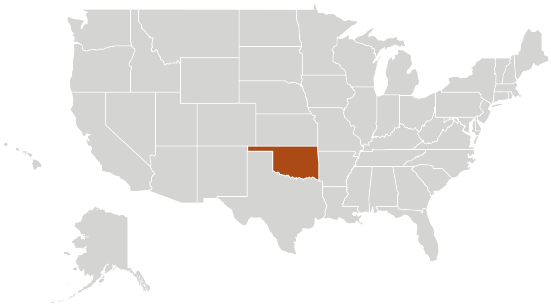



Total Expenditures FY10: $653,445,283
Total Expenditures FY11: $622,994,267

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Oklahoma

Oklahoma State Department of Health



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Mandates (licensing, consumer protection, medical facilities, long-term care)
2. Infectious disease control
3. Emergency preparedness and response
4. Wellness (tobacco, physical activity, obesity)
5. Children's health programs

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 2

## Number of state-run local health agencies

(led by state government staff): 68

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

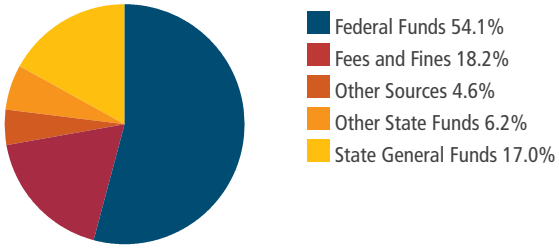
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

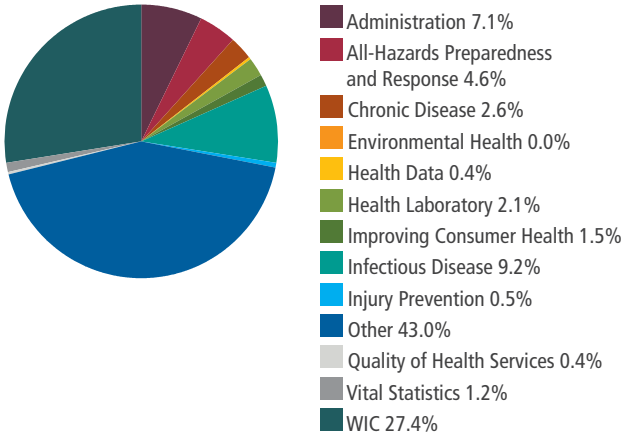
The state health agency has 2,030 FTEs, including 1,074 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)




Total Expenditures FY10: $353,653,469
Total Expenditures FY11: $337,939,571

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Oregon

Oregon Department of Human Services, Public Health Division


## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Tobacco
2. Obesity
3. Suicide
4. Heart disease and stroke
5. Health reform

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 34

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

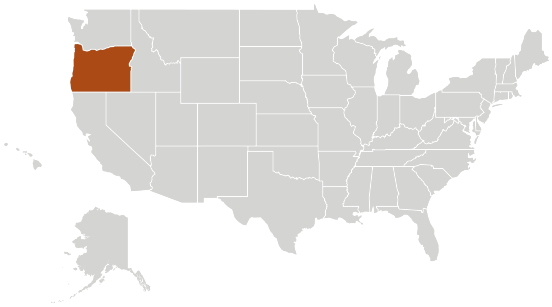
## State Health Planning

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

| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

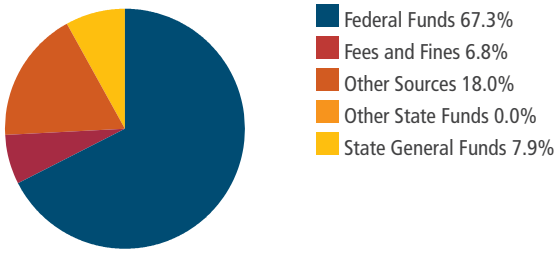
## State Health Agency Workforce

The state health agency has 634 FTEs, including 61 state workers assigned to local/regional offices.

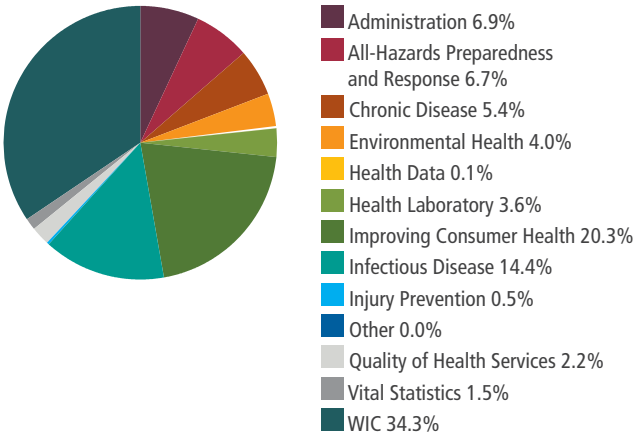


## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

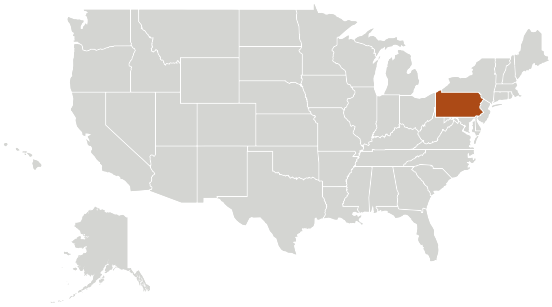



Total Expenditures FY10: $235,349,681
Total Expenditures FY11: $275,054,858

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Pennsylvania

Pennsylvania Department of Health





## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Streamlining administration of programs
2. Passing updated regulations for infectious disease
3. Preparedness planning at regional level
4. Chronic care
5. Reprioritizing based on federal and state funding

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 10

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 6

## State Organizational Structure

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

## State Health Planning

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

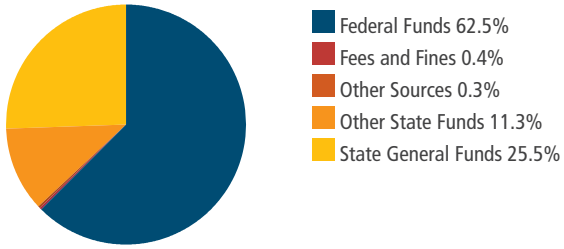
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

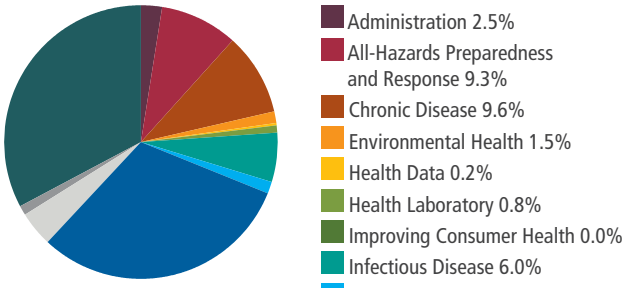
The state health agency has 1,255 FTEs, including 712 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)




Total Expenditures FY10: $900,064,000
Total Expenditures FY11: $888,579,000

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Rhode Island

Rhode Island Department of Health



## Agency Mission

The primary mission of the Rhode Island Department of Health is to prevent disease and to protect and promote the health and safety of the people of Rhode Island.

## Top 5 Priorities for State Health Agency

1. Shape the healthcare delivery system for best outcomes at affordable cost
2. Build a population based primary care system
3. Promote the value and contributions of public health
4. Optimize department resources in strategic direction
5. Secure and align financial resources with strategic requirements

## Structure and Relationship with Local Health Departments

The state health agency is under a larger agency and is considered centralized because it does not have local health departments.

## Number of independent local health agencies

(led by local government staff): 0

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

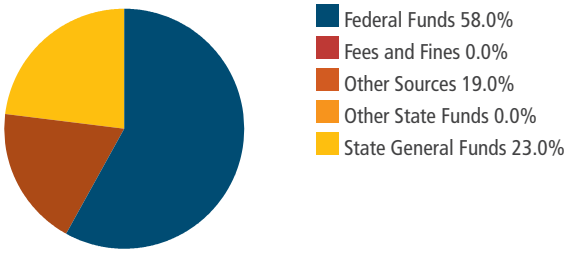
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

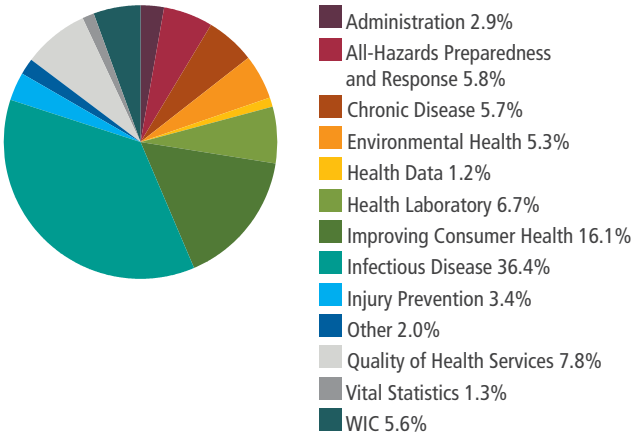
The state health agency has 390 FTEs.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

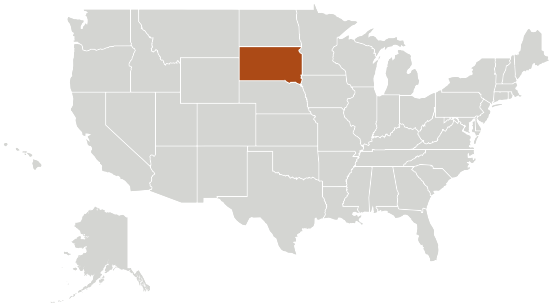



Total Expenditures FY10: $131,649,235
Total Expenditures FY11: $119,439,169

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# South Dakota

South Dakota Department of Health





## Agency Mission

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

## Top Priorities for State Health Agency

1. Improve the birth outcomes and health of 0- to 18-year-olds in South Dakota
2. Improve the health behaviors of South Dakotans to reduce chronic diseases
3. Strengthen healthcare delivery system in South Dakota
4. Strengthen responses to current and emerging public health threats

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 1

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 7

## State Organizational Structure

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

## State Health Planning

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

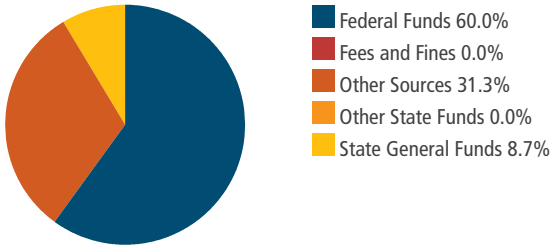
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

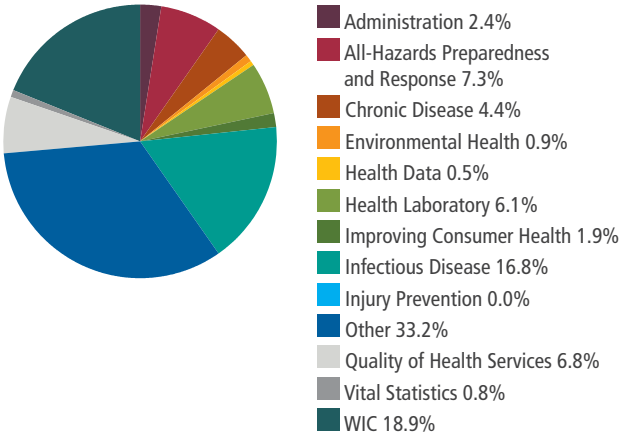
The state health agency has 412 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

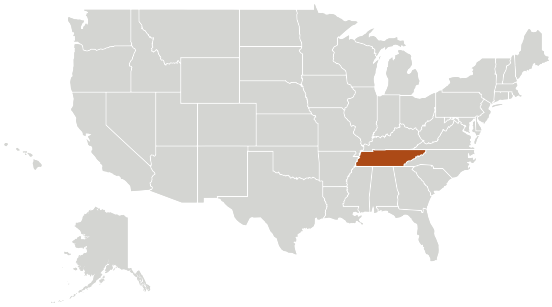



Total Expenditures FY10: $90,174,839
Total Expenditures FY11: $89,464,874

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Tennessee

Tennessee Department of Health



## Agency Mission

Protect, promote, and improve the health and prosperity of people in Tennessee.

## Top 5 Priorities for State Health Agency

1. Primary prevention (including overall health ranking)
2. Performance excellence (including electronic knowledge management)
3. Infant mortality
4. Childhood obesity
5. Substance abuse (including tobacco)

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 6

## Number of state-run local health agencies

(led by state government staff): 89

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 7

## State Organizational Structure

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

## State Health Planning

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

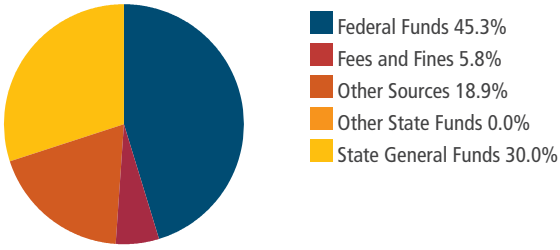
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

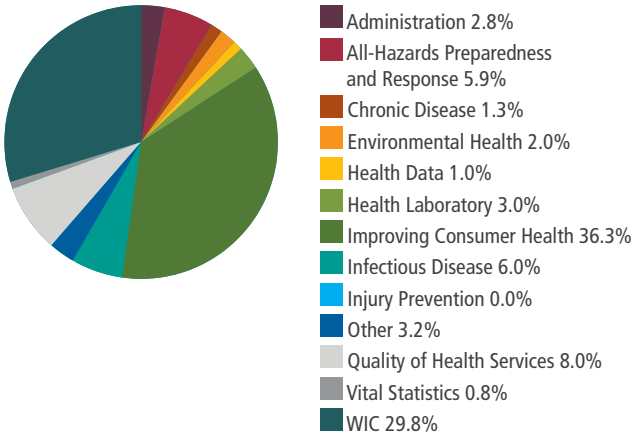
The state health agency has 3,046 FTEs, including 1,835 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

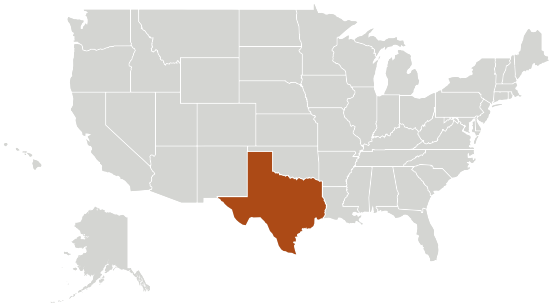



Total Expenditures FY10: $507,258,978
Total Expenditures FY11: $526,580,019

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Texas

Texas Department of State Health Services





## Agency Mission

To improve health and well-being in Texas.

## Top 5 Priorities for State Health Agency

1. Enhancing public health response to disasters and disease outbreaks
2. Preventing chronic diseases and infectious diseases
3. Improving the health of infants and women
4. Meeting increased regulatory demands due to business growth
5. Increasing emphasis on healthcare quality

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 59

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 8

## State Organizational Structure

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

## State Health Planning

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

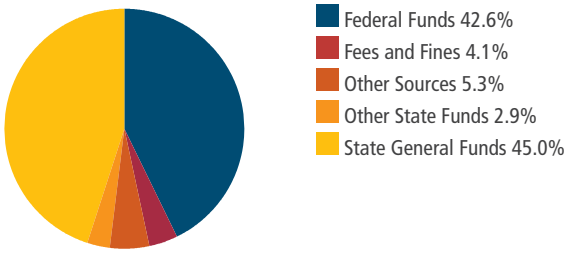
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

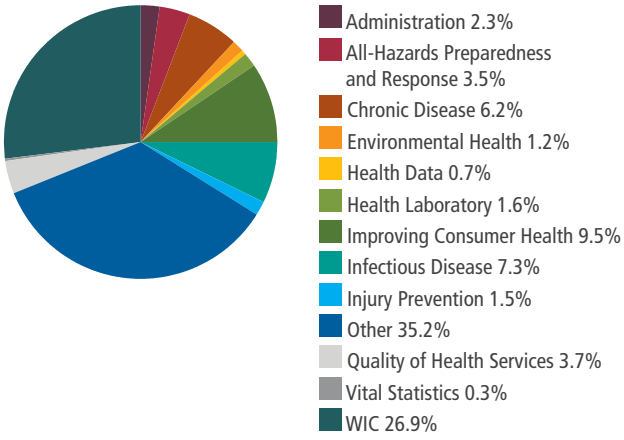
The state health agency has 11,862 FTEs, including 9,343 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

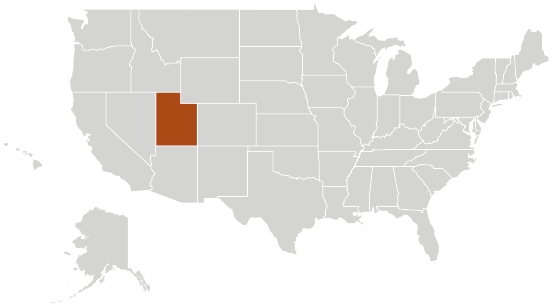



Total Expenditures FY10: $3,126,006,174
Total Expenditures FY11: $2,900,850,300

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Utah

Utah Department of Health



## Agency Mission

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

## Top 5 Priorities for State Health Agency

1. Implement Medicaid accountable care organization
2. Develop plan to make Utahans the healthiest people in the United States
3. Obtain funding via budget request for obesity program
4. Complete and implement statewide health improvement plan
5. Complete reporting deliverables from All Payer Claims Database

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 12

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

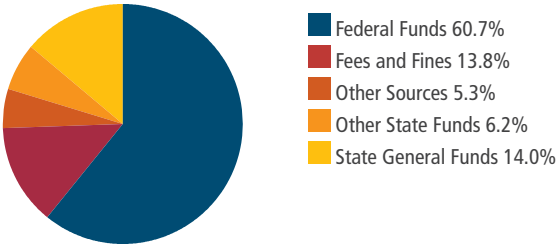
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

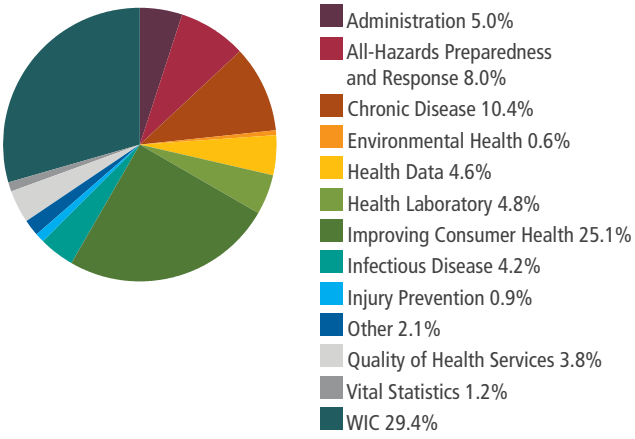
The state health agency has 1,000 FTEs. There are no state health agency workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

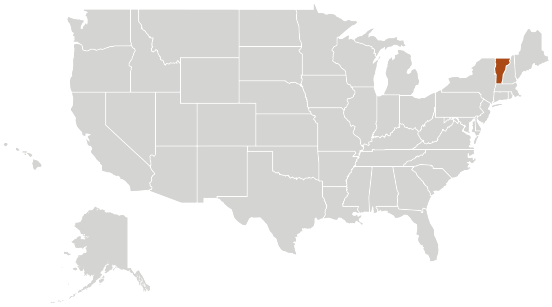



Total Expenditures FY10: $186,384,346
Total Expenditures FY11: $204,861,700

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Vermont

Vermont Department of Health





## Agency Mission

To protect and promote optimal health for all Vermonters.

## Top 5 Priorities for State Health Agency

1. Tobacco
2. Obesity
3. Drug/alcohol use
4. Immunization
5. Injury

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 0

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 12

## State Organizational Structure

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

## State Health Planning

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

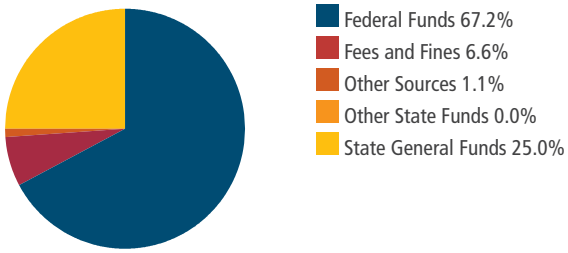
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

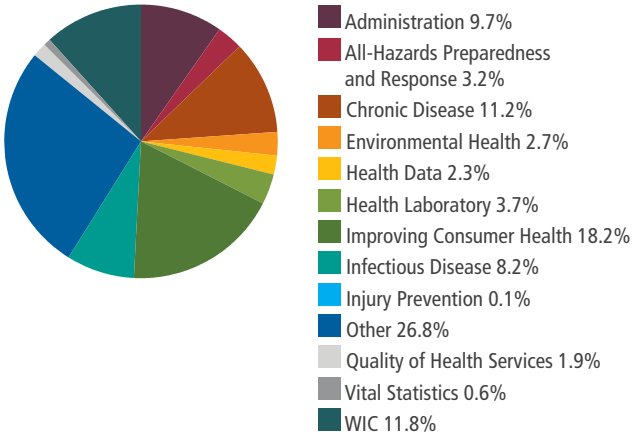
The state health agency has 445 FTEs, including 184 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

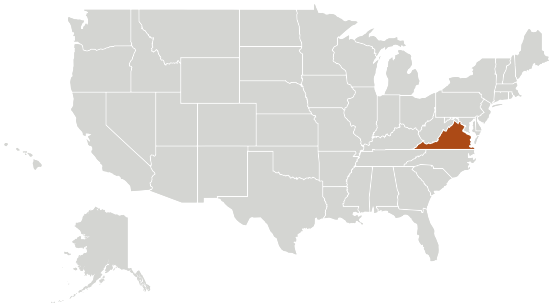



Total Expenditures FY10: $100,595,513
Total Expenditures FY11: $101,937,807

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Virginia

Virginia Department of Health



## Agency Mission

The mission of the Virginia Department of Health is to promote and protect the health of all Virginians.

## Top 5 Priorities for State Health Agency

1. Preserve funding for core public health services
2. Foster a culture of continuous quality improvement
3. Reduce infant mortality rate
4. Increase immunization rate
5. Reduce obesity rate

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 2

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 33

## State Organizational Structure

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

## State Health Planning

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

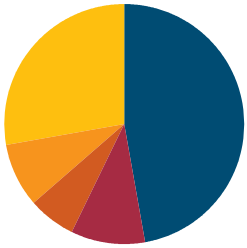
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

The state health agency has 3,751 FTEs, including 2,977 state workers assigned to local/regional offices.

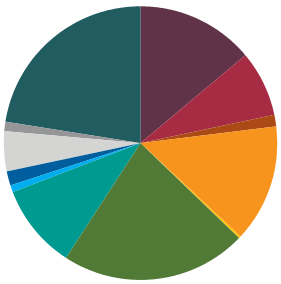
## State Public Health Agency Finance*

### Sources of Funding (FY11)



- Federal Funds 47.2%
- Fees and Fines 10.0%
- Other Sources 6.4%
- Other State Funds 8.7%
- State General Funds 27.7%

### Expenditures (FY11)



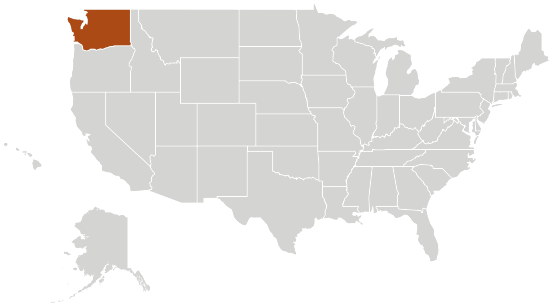
- Administration 13.9%
- All-Hazards Preparedness and Response 7.7%
- Chronic Disease 1.5%
- Environmental Health 13.9%
- Health Data 0.2%
- Health Laboratory 0.0%
- Improving Consumer Health 22.0%
- Infectious Disease 9.8%
- Injury Prevention 0.8%
- Other 1.7%
- Quality of Health Services 4.8%
- Vital Statistics 1.0%
- WIC 22.6%

Total Expenditures FY10: $528,826,887
Total Expenditures FY11: $561,734,353

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Washington

Washington State Department of Health





## Agency Mission

The department of health works to protect and improve the health of people in Washington state.

## Top 5 Priorities for State Health Agency

1. Preventing communicable disease and other health threats
2. Fostering healthy communities and environments
3. Partnering with the healthcare system
4. Promoting a framework for foundational public health services
5. Enhancing the use of performance management tools

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 35

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 4

## State Organizational Structure

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

## State Health Planning

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

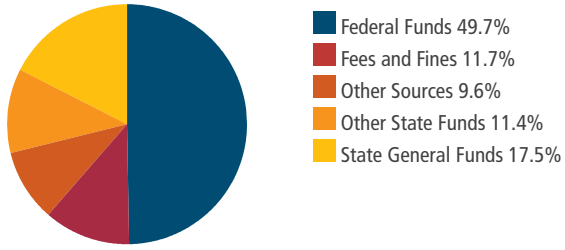
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

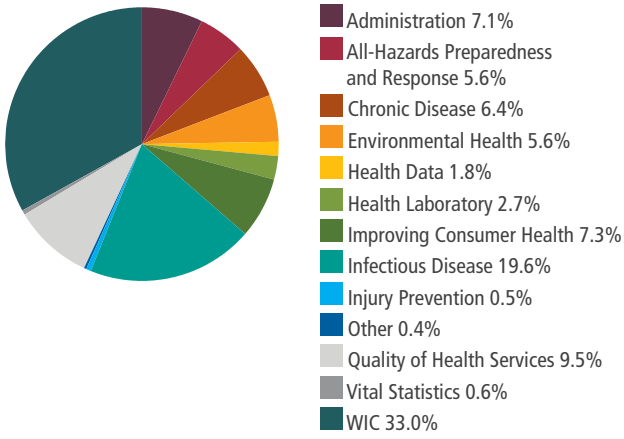
The state health agency has 1,650 FTEs, including 285 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

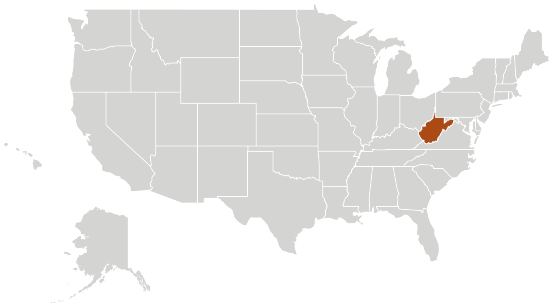



Total Expenditures FY10: $484,411,369
Total Expenditures FY11: $537,213,509

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# West Virginia

West Virginia Department of Health & Human Resources



## Agency Mission

To help shape the environments within which people and communities can be safe and healthy.

## Top 5 Priorities for State Health Agency

1. Reduce the prevalence of chronic disease in West Virginia's population
2. Maintain a competent public health workforce in a changing environment
3. Maximize use of all human and fiscal resources
4. Assure infrastructure is in place to meet statutory requirements
5. Reduce mortality in West Virginia from selected conditions

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 49

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

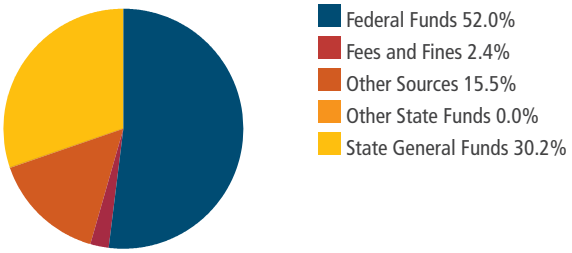
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

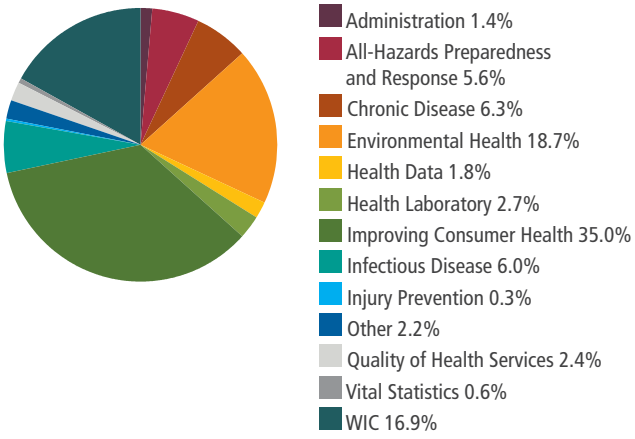
The state health agency has 651 FTEs, including 95 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

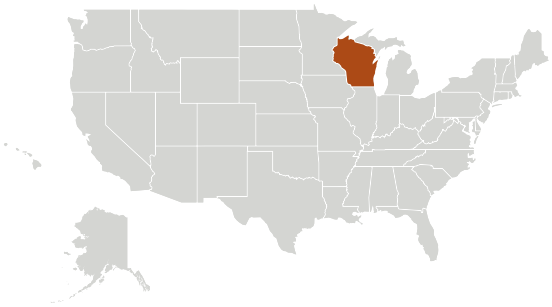



Total Expenditures FY10: $207,829,417
Total Expenditures FY11: $218,083,952

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Wisconsin

Wisconsin Department of Health Services



## Agency Mission

Protecting and promoting the health and safety of the people of Wisconsin.

## Top Priorities for State Health Agency

1. Reduce preterm births and infant mortality
2. Chronic disease prevention and management
3. Integration and partner collaboration in emergency preparedness
4. Improve data exchange to enhance health
5. Support creating innovative care models for special populations

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 88

## Number of state-run local health agencies

(led by state government staff): 0

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 5

## State Organizational Structure

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

## State Health Planning

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

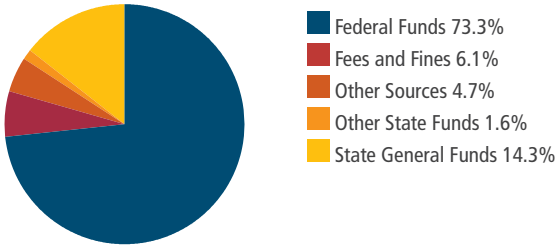
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

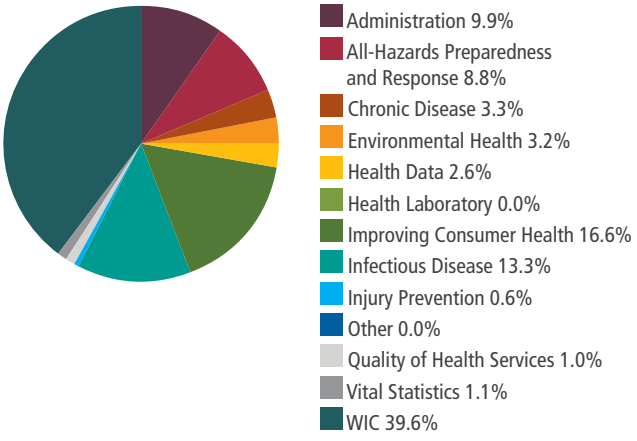
The state health agency has 395 FTEs, including 22 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)

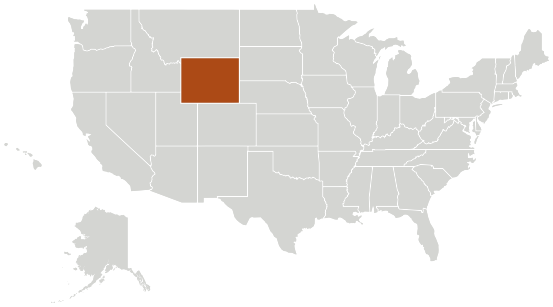



Total Expenditures FY10: $259,283,072
Total Expenditures FY11: $258,546,185

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

# Wyoming

Wyoming Department of Health



## Agency Mission

Our mission is to promote, protect, and enhance the health of all Wyoming citizens.

## Top 5 Priorities for State Health Agency

1. Preserving services with respect to budget cuts
2. Changing focus to population based (vs. direct care) services
3. Fostering programmatic excellence
4. Workforce development/recruitment
5. Promoting value/relevance of public health

## Structure and Relationship with Local Health Departments

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

## Number of independent local health agencies

(led by local government staff): 5

## Number of state-run local health agencies

(led by state government staff): 31

## Number of independent regional or district offices

(led by non-state employees): 0

## Number of state-run regional or district offices

(led by state employees): 0

## State Organizational Structure

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

## State Health Planning

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

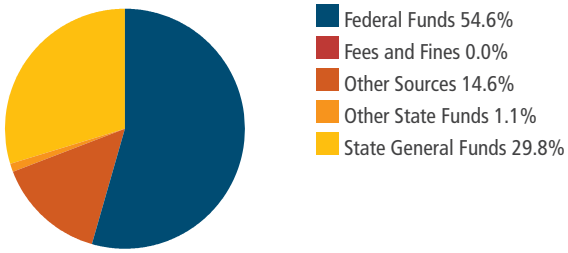
| | | |
|---|---|---|
| Y | N | State Health Assessment |
| Y | N | State Health Improvement Plan |
| Y | N | Strategic Plan |

## State Health Agency Workforce

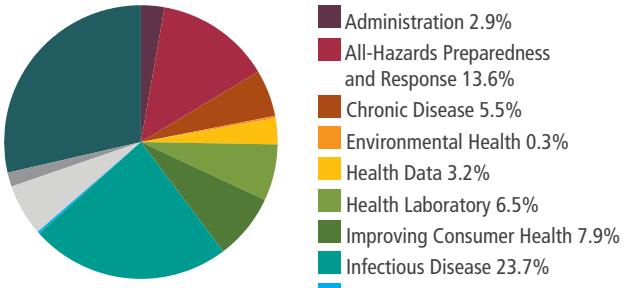
The state health agency has 1,411 FTEs, including 241 state workers assigned to local/regional offices.

## State Public Health Agency Finance*

### Sources of Funding (FY11)




### Expenditures (FY11)




Total Expenditures FY10: $41,126,850
Total Expenditures FY11: $37,022,012

*FY11 was defined as 7/1/10 - 6/30/11. FY10 was defined as 7/1/09 - 6/30/10.

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

To view this publication online, visit ASTHO's website at **www.astho.org/profile**.

# Vision

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

# Mission

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

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