FAQs about State Public Health Agencies for CDC's 6|18 Initiative Participants

Q: How are state public health agencies structured within state governments?

A: State public health agencies can be either independent/freestanding agencies or part of a larger umbrella agency, along with other programs such as Medicaid, public assistance and substance abuse. According to ASTHO data from 2016, 29 state public health agencies (58%) are freestanding/ independent agencies, while 21 (42%) operate within a larger umbrella agency. States with freestanding public health agencies may have less experience interacting with Medicaid, so can use participation in the 6|18 Initiative as an opportunity to develop stronger connections with their Medicaid counterparts.

Q: How do state public health agencies interact with local public health agencies?

A: In about 30 percent of states, the state health agency plays a central role in overseeing local public health agencies by staffing local health units with state employees, assuming control over budgeting, and/or issuing public health orders. In over half of states, the state public health agency is not actively engaged in the operation of local health agencies, though may still maintain close relationships with local public health entities. In this type of decentralized system, local government employees staff the local health units and assume decision-making authority. A small number of states have a mixed structure in which some local health agencies are led by state employees and others are led by local government employees. Beyond governance, other mechanisms states can use to partner with local public health agencies include: funding local programs through grants or contracts, leading trainings and technical assistance opportunities, and coordinating planning and quality improvement activities.

6|18 Initiative teams have found connections between state and local public health agencies especially helpful when looking to increase consumer utilization of an existing prevention benefit or program. States can engage local public health officials to: disseminate communications materials like posters and flyers; establish community-based pilot programs and outreach efforts; and better understand conditions "on the ground," such as access barriers and consumer perceptions of prevention programs.

IN BRIEF

This resource addresses questions that Medicaid officials participating in CDC's 6|18 Initiative may have about state public health agencies. The responses to these questions provide high-level information about how public health agencies operate, as well as their role within the 6|18 Initiative. For more detailed information, please see ASTHO's Profile of State and Territorial Public Health, Volume 4.

Q: How are state health officers selected?

A: In most states, the governor appoints the state health official (SHO); this was the case in two-thirds of states in 2016. In states in which the governor does not appoint the SHO, the state Health and Human Services (HHS) secretary or a board/commission may appoint him or her. Most SHOs are appointed without a set term length, though some states (eight in 2016) do specify term lengths (generally from two to six years). About half of SHOs report directly to the governor and about a third report to the HHS Secretary. Additionally, just over half of all states require that a SHO possess a medical degree (MD or DO). In 2016, 64 percent of SHOs had a medical degree and 48 percent had a masters or doctorate in public health.

Q: What types of issues do state health agencies prioritize?

A: State health agencies lead a wide range of activities under the following categories:

- Access to health care for individuals without adequate health services (e.g., health disparities/ minority health initiatives, rural health initiatives, and outreach and enrollment for medical insurance)
- Prevention, screening and treatment of chronic and infectious diseases (e.g., STD counseling, immunization services, TB treatment, and newborn screenings);
- Data collection, epidemiology, and surveillance of infectious and chronic diseases (e.g., collecting and analyzing information about foodborne illness, infectious diseases and perinatal events);
- Regulation, inspection, and licensing of facilities and health care practitioners (e.g., regulating labs, food service, and trauma systems);
- Emergency preparedness and response programs;
- Environmental health activities to reduce exposure to hazards and promote the safety of built and natural environments; and
- Planning and quality improvement to manage and improve organizational performance and efficiency.

Just as 6|18 Initiative teams should consider the state's Medicaid goals and priorities when developing interventions and supporting activities, teams should also work to ensure that their 6|18 Initiative work aligns with or builds on existing public health efforts. Many states use State Health Improvement Plans to identify specific state- and agency-wide priorities, which should be consulted for alignment with 6|18 goals. Further, most 6|18 participants do not develop new prevention programs from scratch, but rather leverage the Initiative's structure and resources to accelerate progress on existing public health programs (e.g., statewide campaigns to improve antibiotic prescribing practices or connect more low-income individuals to tobacco cessation services). Existing public health programs that may be aligned with the 6|18 Initiative include the Preventive Health and Health Services Block Grant and chronic disease funding from CDC. In some cases, 6|18 teams will seek Medicaid reimbursement for public health-led pilot programs, such as asthma home visiting programs.

Q: What kinds of data do public health agencies have access to?

A: State health agencies collect epidemiologic and surveillance data on a variety of public health issues to better understand the scale and severity of health conditions, as well as how these conditions are distributed within or across regions and populations. Data may be collected from population-based surveys, health care provider-based surveillance systems, and health information exchanges/electronic health records. Many state health agencies collect data on the following:

- Communicable and infectious diseases;
- Perinatal events or risk factors;
- Environmental conditions (e.g., air quality, water quality, and radiation levels);
- Behavioral risk factors (e.g., rates of tobacco and alcohol use, immunizations, and health screenings);
- Provider shortage designation areas; and
- Chronic disease and cancer incidence.

State health agencies may also maintain registries to monitor disease trends and patterns over time on topics such as: childhood immunization, birth defects, cancer, HIV/AIDS, tuberculosis, and trauma. 6|18 teams can use public health data during different stages of the Initiative, including: choosing health conditions and interventions; developing metrics to track implementation progress; and evaluating the impact of chosen interventions. Additionally, state health agencies may have access to national datasets in partnership with CDC and universities.

Q: How can 6|18 teams work to promote alignment and collaboration between Medicaid and public health?

A: 6|18 Initiative teams can employ a number of strategies to promote effective cross-agency communication and collaboration, such as:

- **Develop an Action Plan.** Action plans can help team members outline project goals, measures, and timelines, and to ensure all partners agree.

- **Have Frequent Meetings Early On.** Frequent meetings during the launch of the 6|18 Initiative helped teams establish a strong foundation early on.

- **Create Shared Understanding.** Public health and Medicaid staff may not be aware of policies and program structures within their partner agency. Learning each other's language, agency priorities, and decision-making authorities may take time.

- **Designate Lead Staff.** Identifying a lead staff person from both the Medicaid and public health agencies can help to create effective 6|18 Initiative team leadership.

- **Collaborate with Programs that Address 6|18 Conditions.** CDC's 6|18 Initiative and governmental public health programs share similar goals. Collaborations with state and other federal programs can strengthen both initiatives.

- **Create a Medicaid-Public Health Liaison Staff Position.** This position may help you connect strategies between agencies, improve collaboration, and serve as a contact point to improve communication between Medicaid and public health.

ADVANCING IMPLEMENTATION OF THE CDC'S 6|18 INITIATIVE

Through support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies, in collaboration with a number of partners, is coordinating technical assistance to facilitate state Medicaid and public health implementation of the Centers for Disease Control and Prevention's (CDC) 6|18 Initiative. The CDC's 6|18 Initiative promotes the adoption of evidence-based interventions that can improve health and control costs related to six high-burden, high-cost health conditions — tobacco use, high blood pressure, inappropriate antibiotic use, asthma, unintended pregnancies, and type 2 diabetes. For more information and additional resources, visit www.618resources.chcs.org.