Promoting Improved Oral Health

Legislator Policy Brief

The Healthy States Initiative

A partnership to promote public health

The Healthy States Initiative provides information state policymakers need to make decisions on public health issues. The Council of State Governments' partners in the initiative are the National Black Caucus of State Legislators (NBCSL) and the National Hispanic Caucus of State Legislators (NHCSL). The initiative brings state legislators together with public health experts and officials from the Centers for Disease Control and Prevention (CDC) and state health departments to share information and identify innovative policy solutions.

Healthy States Resources for State Policymakers

- **Healthy States Web site.** This unique Web site offers information and resources on many public health issues. Visit *http://www.healthystates.csg.org* to get information, sign up for publications and view the calendar and other information about the initiative.
- **Healthy States e-monthly.** This free monthly electronic newsletter brings the latest public health news, resources, reports and upcoming events to your inbox.
- **Healthy States Quarterly.** This free quarterly newsletter covers public health policy initiatives, innovative best practices, emerging disease prevention issues and information on Healthy States activities.
- **Healthy States Forums.** These forums, which bring together state legislators from across the country, feature educational sessions on public health issues, new legislator training and roundtable discussions with public health experts.
- **Healthy States Policy Briefs and Talking Points.** These resources, designed specifically for state legislators, address public health issues such as prevention of cancer and chronic diseases, HIV/AIDS and sexually transmitted diseases, use of vaccines, efforts to address health disparities and efforts to achieve wellness through community and school programs.

For More Information

Visit *http://www.healthystates.csg.org*

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Overview

Oral diseases are among the most widespread of all chronic illnesses. In fact, among school-age children (5 to 17), tooth decay is the most common chronic disease, five times more prevalent than asthma and seven times more prevalent than hay fever. However, oral diseases aren't just kid stuff. Tooth decay is often a bigger problem in adults than children, and gum disease and oral cancers afflict adults.

Emerging research suggests that oral diseases are linked with diabetes, heart disease, preterm, low birth weight deliveries and, in rare instances can be life-threatening. A 12-year-old Maryland boy died in 2007 after bacteria from an untreated abscessed tooth spread to his brain.

Oral diseases can be painful, costly and disfiguring. They often result in lost productivity at work. Yet unlike many other chronic illnesses, oral diseases almost always can be prevented.

What Do State Legislators Need to Know About Oral Health?

- **Oral diseases result in lost productivity.** Dental problems cause adults to lose 164 million work hours each year. Children miss 50 million school hours a year due to dental illnesses.[2]

  ≠**Racial, geographic and socioeconomic inequities exist in oral diseases.**

  ≠African-Americans and Hispanics are more likely than whites to have untreated tooth decay, and African-Americans are disproportionately affected by oral cancer.

  ≠People in rural areas are less likely to receive regular dental care and more apt to lose all their teeth than those in other regions. Poor oral health was found in one study to be the greatest obstacle in going from welfare to work in rural areas.[3]

  ≠Low-income children lose 12 times more school days due to dental illness than children from higher income families.[2]

- **Oral diseases bring on associated social, psychological and physical issues.** Untreated cavities can lead to chronic pain and tooth loss in adults. Children with untreated cavities may have difficulty eating, speaking or paying attention in school.
- **Fortunately, tooth decay is declining among most age groups.** Increased community water fluoridation, dental sealants for children and improved oral care have resulted in less tooth decay. Despite such improvements, 25 percent of Americans ages 20 to 64 years had some untreated tooth decay from 1999 to 2004.[4]
- **Oral and pharyngeal cancers are usually linked with smoking or smokeless tobacco.** These cancers affect more than 30,000 people per year.[5] Only half of those with oral cancer survive five years after their diagnosis.[6]

What Can State Legislators Do to Improve Oral Health?

- Support policies to focus state prevention programs on people at high risk for oral diseases and to make oral health care more accessible;
- Support programs known to reduce decay, such as community water fluoridation and dental sealant programs in schools;
- Mandate an ongoing state oral health program, develop a state oral health plan, and implement use of use of a surveillance system.

Actions for State Legislators

Demonstrate Leadership on Oral Health Issues

- Communicate with your state dental director and dental providers to learn about the effects of oral health diseases in your state.
- Become a champion for better oral health. Develop coalitions with state dental health providers to identify oral health care issues and implement effective strategies to address them.

Make Oral Health Care More Accessible

- Provide Medicaid reimbursement rates that encourage dentists to provide services for eligible participants.
  - ≠Provide coverage for fluoride varnish, a thin coating applied to tooth surfaces to prevent decay, and expand the types of providers able to offer it to young children.
  - ≠Consider policy changes that allow for adult dental care to be reimbursed through Medicaid, especially for mothers of young children.
  - ≠Include dental care benefits in State Children's Health Insurance Programs. Consider spending uncommitted State Children's Health Insurance Program funds for oral public health measures targeted at high-risk children.
- Provide dental benefits to state employees and support workplace and employer initiatives.
  - ≠Encourage employers to provide insurance coverage for oral health screenings and dental care.
  - ≠Promote oral disease prevention programs in worksites.
- Encourage school-based oral health programs.
  - ≠Support funding for dental education in schools that teach children the importance of brushing daily with fluoride toothpaste.
  - ≠Promote use of portable dental units to provide dental sealants efficiently in schools.
  - ≠Mandate oral health screenings in schools.
  - ≠If no private dental services are available, add a dental component to school-based health clinics.
- Work with local health departments, federal Head Start programs for low-income children and other agencies to provide oral health services to at-risk populations.

Support Science-Based Programs Known to Prevent Oral Diseases

- Support community water fluoridation to prevent tooth decay.
  - ≠Improve knowledge about the benefits and safety of water fluoridation.
  - ≠Consider legislation to mandate fluoridation of public water supplies.
  - ≠Support local referenda for water fluoridation.
- Support school-based and school-linked dental sealant programs to prevent tooth decay.
- Support smoking cessation programs to reduce oral and pharyngeal cancers and encourage educational programs about the health effects of tobacco, including smokeless (chewing) tobacco.

Create a Strong State Oral Health Program

- Support a mandate for a state oral health program.
  - ≠A state oral health program reinforces the importance of oral health.
  - ≠Healthy People 2010 calls on all state health agencies serving jurisdictions of at least 250,000 people to have a state oral health program.
- Work with the state department of health to develop a comprehensive state oral health plan.
  - ≠A strategic state oral health plan describes and addresses the burden of oral diseases and sets goals and objectives aimed at enhancing the oral health of its residents.
  - ≠A state plan addresses coordination of preventive interventions, increased access to dental care and efficient use of available resources.
- Support a state-based oral health surveillance system to collect, analyze and disseminate oral health data.

Work to Reduce Inequities and Focus on High-Risk Populations

- Provide loan repayment programs or other incentives for dentists who locate their practices in underserved areas or who treat underserved populations, such as Medicaid-eligible children.
- Support cultural competency training for dental practitioners.
- Encourage community water fluoridation, dental sealant programs in schools and strategies to increase access to dental care for underserved populations.

Want to Know More?

We'll help you find experts to talk to about this topic.

If you would like to explore this topic in greater depth, contact us at the Healthy States Initiative and we'll help you connect with:

≠an expert on this issue from the CDC;
≠fellow state legislators who have worked on this issue; or
≠other public health champions or officials who are respected authorities on this issue.

Send your inquiry to *healthpolicy@csg.org* or call the health policy group at (859) 244-8000 and let us help you find the advice and resources you need.

State Policy Examples

Mandate for Arkansas Oral Health Program

A good state oral health program incorporates all policies and strategies designed to reduce cavities and improve oral health. Without a legislative mandate, oral health programs sometimes face reduced funding during budget cuts. With a legislative mandate, legislators and state health officials have a greater incentive to maintain a state's oral health program and to give it the support needed to be successful, according to Arkansas Director of Oral Health Dr. Lynn Mouden.

Arkansas legislators passed House Bill 785 in 2001, mandating a state oral health program. Since enactment of the legislation, numerous state agencies in Arkansas have encountered budget cuts. However, Mouden credits the mandate with sparing the state's oral health program from cutbacks.

"When there are budget decisions to be made, sometimes the state oral health program gets the ax first," Mouden explained. "The legislative mandate for our oral health program ensures stability, allowing us to develop long-term programs that attract partners and sustain these programs for maximum effectiveness." Mouden said state oral health programs typically include prevention programs such as water fluoridation and school-based dental sealants, as well as strategies to expand access to dental care.

Arkansas is one of at least 23 states with a statutory mandate for an oral health program, according to a survey by the Association of State and Territorial Dental Directors. The others are Arizona, California, Florida, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maryland, Mississippi, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas and Wyoming.[7] (see map on page 8)

See ASTDD policy summary: *http://www.astdd.org/docs/BPAStatutoryMandate.pdf*

Loan Repayment Program puts Colorado Dentists in Underserved Areas

The vast majority of Colorado's 64 counties are classified as either rural or frontier (with six or fewer people per square mile). Nearly one-third of Colorado counties lack access to dental services for low-income and at-risk populations covered through Medicaid, Child Health Plan Plus and Medicare. Ten Colorado counties have no licensed dentists. An additional 12 counties have no oral health providers who accept Medicaid patients, according to Colorado Dental Director Diane Brunson.

The Dental Loan Repayment program was authorized by the Colorado General Assembly in the 2001 legislative session. The program pays all or part of the principal, interest and related expenses of the educational loan of eligible dentists and dental hygienists who agree to provide treatment to underserved populations.

During the 2006–2007 fiscal year, Colorado appropriated nearly $200,000 from tobacco settlement funding for this program. This money supported nine new dental providers in addition to 12 providers from the previous year. Since the program's inception, 46 providers have located their practices in 13 counties designated as Dental Health Provider Shortage Areas and in five counties with extensive underserved populations. These providers have served more than 120,000 patients. Of that number, about half were Medicaid-eligible children, and another 15,000 represented uninsured adults and children.

Brunson believes it is important that loan repayment programs include not only dental providers in underserved areas, but also those who practice in urban areas with large underserved populations, as Colorado's program does.

See: *http://www.cdphe.state.co.us/pp/oralhealth/DentLoan.html*

Tennessee Community Water Fluoridation Exceeds 2010 Goal

Community water fluoridation is identified as one of 10 great public health achievements of the 20th century by the Centers for Disease Control and Prevention. Tennessee has become a national leader in providing fluoridated drinking water to its communities and exceeding the *Healthy People 2010* target, which calls for at least 75 percent of community water supplies to be fluoridated.

According to 2002 data, approximately 96 percent of people on public water systems in Tennessee have access to optimally fluoridated water, compared to two-thirds nationally. Tennessee ranks fourth for the highest percentage of public water customers receiving optimally fluoridated water, trailing only Kentucky, Illinois and Minnesota.[8]

The Tennessee Division of Oral Health Services provides financial assistance to communities to initiate fluoridation and purchase or replace fluoridation equipment. Since 2004, Tennessee has helped 25 community water systems purchase equipment to start or continue water fluoridation. Along with the Division of Water Supply, the Tennessee Division of Oral Health also provides technical expertise and monitoring to ensure that the fluoride concentration of the water supply is maintained at the recommended level.

Tennessee Dental Director Suzanne Hayes said adding fluoride to drinking water supplies makes good economic sense. "Uninsured individuals with untreated decay and infections often use emergency rooms for dental care," she said. "That is not a cost-effective method of treating dental disease."

See: *http://health.state.tn.us/oralhealth/CWF.html*

Ohio Dental Sealant Programs in Schools

Dental sealants, plastic coatings applied to the chewing surfaces of teeth, are one of the best ways to reduce cavities and are an effective means to reduce disparities in tooth decay, according to Mark Siegal, chief of the Ohio Department of Health's Bureau of Oral Health Services. For more than 20 years, Ohio has provided dental sealants to children from low-income families through targeted school-based programs.

The Ohio Department of Health provides grants to 16 local health departments and nonprofit agencies with school-based sealant programs that serve 40 counties. Those local agencies use the funding to provide targeted dental sealants to second and sixth grade students in schools meeting income eligibility requirements. Three other sealant programs in Cleveland, Columbus and Cincinnati operate with local funds.

Ohio's targeted school-based sealant program provides sealants to children unlikely to receive them otherwise, especially low-income children on the free and reduced lunch program. While nationally, children of racial and ethnic minority groups receive about half as many dental sealants as white children, Siegal said in Ohio the gap is much more narrow.[9] About 44 percent of white children have sealants in Ohio compared to 41 percent of African-Americans children, according to Siegal.

One study in Ohio demonstrated that students in schools with sealant programs were much more likely to have at least one sealant as those in schools without sealant programs. In schools with sealant programs, Siegal said approximately 62 percent of students received at least one sealant, compared to 37 percent of students in schools without similar programs.

See: *http://www.odh.ohio.gov/odhprograms/ohs/oral/fluoride/dentsealants.aspx*

Advice from a State Legislator

Getting Sugary Snacks Out of Schools

Ron Stollings

West Virginia Senate

Ron Stollings, a physician from Boone County, W.Va., was first elected to the West Virginia Senate in 2006. He served as co-chairman of the 2007 Interim Subcommittee on Oral Health, which made numerous recommendations to improve access to oral health care and reduce the incidence of tooth decay in the state.

West Virginia leads the nation in the percentage of adults older than 65 who have had all their teeth extracted (43 percent), and has the fourth lowest percentage of adults who have visited a dentist in the previous year (61 percent).[10,11]

Stollings introduced two bills in the 2008 legislature incorporating the subcommittee's recommendations. Senate Bill 222 would have banned soft drinks and sugary snacks from school vending machines to improve oral health and reduce obesity. Senate Bill 235 would have created a new state Office of Oral Health, required children to have a dental screening to enter elementary school, expanded the role of dental hygienists, and increased Medicaid reimbursement rates for dentists. Neither bill was successful.

His Advice to State Legislators:

- **Encourage parents to get dental exams for children at a young age.** "Kids need to have an oral health exam by the time they're 2 or 3 years old. We learned that if you wait until these kids are 5 or 6 years, upon entering school, it's too late. They already have rotten teeth."
- **Remove sugary snacks from school vending machines.** "The health of our kids is worth so much more than the lost revenue (from school vending machines). We should all be concerned about having sugary snacks and beverages in schools because this is where future behavior is learned. Essentially, students are getting hooked on these tasty, but harmful, foods."
- **Improve Medicaid reimbursement rates for all dental providers.** "If a dentist is busy seeing a group of good paying patients, why would he or she load up with a bunch of low-pay patients? In West Virginia, there are a number of rural health clinics and some have dental services that help combat some of these issues since they get cost-based reimbursements." Stollings believes increasing reimbursement rates would result in more dentists accepting Medicaid patients.
- **Emphasize preventive oral health programs.** "The cost of treatment of poor oral health is much higher than the cost of prevention. We need to frontload the system where spending money early has a great return on investment. There is a cost to society as people with poor (oral health) have less chance of obtaining a good job. There are self-esteem issues. We need to level the playing field so poor children can have a chance to grow up, get a job and pay taxes."

Advice From a Public Health Official

How Legislators Can Improve Oral Health Care

Dr. Lynn Mouden

Arkansas Dental Director

Dr. Lynn Mouden was appointed director of the Arkansas Office of Oral Health in 1999, after 16 years as a private practice dentist and eight years at the Missouri Department of Health. He serves as the American Dental Association's national spokesperson on family violence prevention. Dr. Mouden is a founder of the Prevent Abuse and Neglect through Dental Awareness (PANDA) program, which trains dental professionals to recognize signs of abuse and neglect in their patients. For his efforts in family violence prevention and oral health advocacy, Dr. Mouden has received the dental association's Dentist of the Year and Distinguished Service awards and is the immediate past president of the Association of State and Territorial Dental Directors (ASTDD). He recently received the Outstanding Service Award from ASTDD.

His Advice to State Legislators:

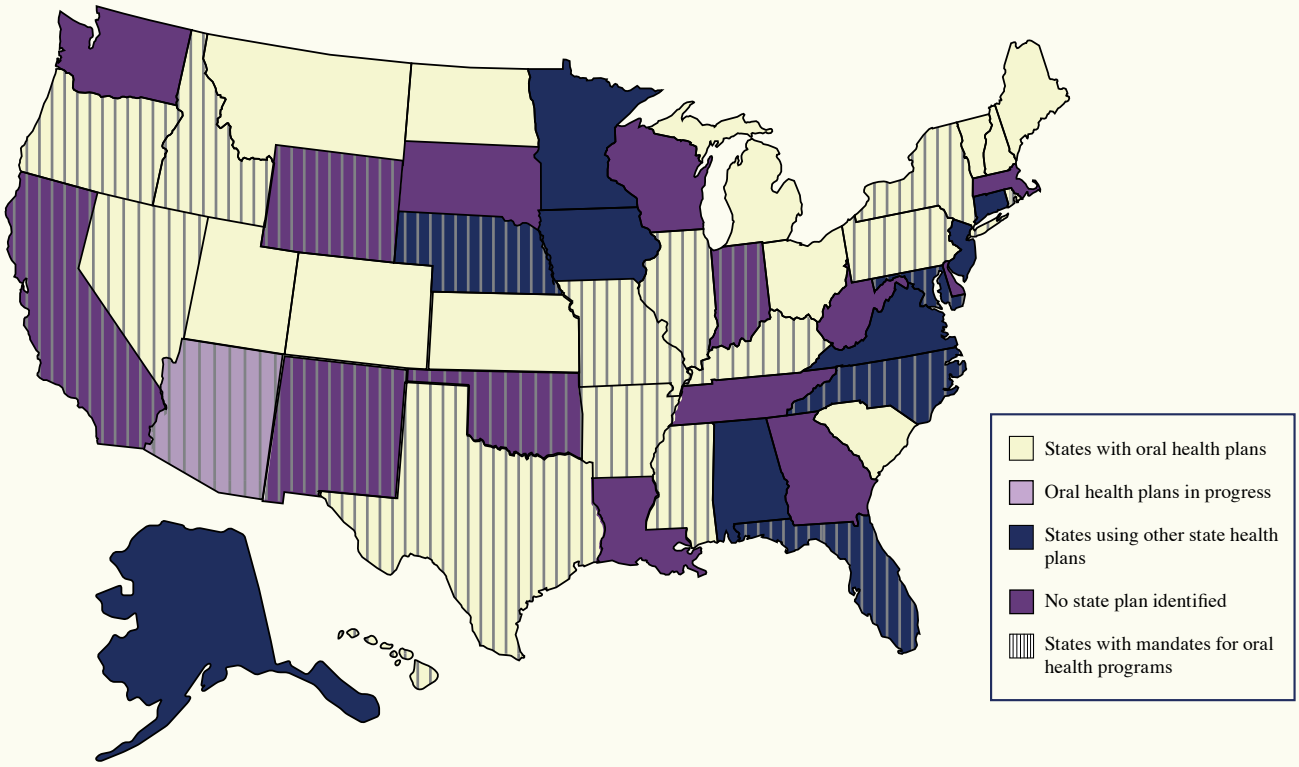
- **Treat oral health as a part of general health.** "Health care, for some people, ends at the neck. So dental health, mental health (and) hearing are all something different. Why is it important to have a mandate (for a state oral health program)? Because often people don't remember that oral health is part of general health."
- **Consider an oral health mandate as important for the continuity of oral health programs.** "Stops and starts don't work, because when we talk about primary prevention programs it has to be ongoing or you backslide. Funders want to know that the people who support the program are going to be there next year."
- **Make fluoridation of water supplies the backbone of a state oral health program.** "We can prevent up to 65 percent of tooth decay. Fluoridation is a program that doesn't require any action on the individual's part. It's a perfect public health program and also one that costs an average of less than $1 per person per year. A lifetime of fluoridation costs less than one dental filling."
- **Become educated on oral health issues.** "Go to the ASTDD Web site and look at best practices. One of the best practices that is studied in detail on that Web site is a state mandate. So it not only provides examples, but also lists the states that have provided examples and their experiences."
- **Remind people about the importance of oral health for building the economy.** "There's an old line out there that somebody is more willing to hire somebody missing a leg than missing a front tooth."

Key Facts and Terms

What Are the Health Implications of Oral Disease?

- **Tooth decay:** More than half of children ages 5 to 9 have at least one cavity or filling; 78 percent of 17-year-olds have experienced tooth decay.[12] Nearly 25 percent of American adults ages 20 to 64 have untreated cavities.[4] Tooth pain can limit what a person eats, resulting in malnourishment and weight loss.
- **Lost teeth:** By age 17, 7 percent of children have lost at least one permanent tooth to decay.[13] Nearly half of adults 65 and older have lost at least six teeth to tooth decay or gum disease, and approximately 1 in 5 have lost all their natural teeth.[14]
- **Links with other diseases:** Severe gum disease is associated with diabetes, heart disease and preterm, and low birth weight deliveries. Poor eating due to tooth pain can cause malnourishment and weight loss.
- **Oral Cancer:** Approximately 34,000 people in the U.S. are diagnosed each year with oral and pharyngeal cancers. Only half survive five years after their diagnosis,[6] and unlike other cancers, the overall U.S. survival rate has not improved in recent years.[28] About 75 percent of these cancers are caused by smoking and other uses of tobacco.[15]

States with Oral Health Plans and Mandated Oral Health Programs



Source for oral health plans: Centers for Disease Control and Prevention. Accessed from http://www.cdc.gov/OralHealth/state_programs/OH_plans/ on May 19, 2008.
Source for mandates for oral health programs: Association of State and Territorial Dental Directors. Accessed from http://www.astdd.org/docs/BPAStatutoryMandate.pdf on May 19, 2008.
(Note: The Republic of Palau has an oral health plan. Data not reported for other territories.)

What Are the Financial Impacts of Oral Diseases and Oral Health Care?

- **Lost productivity:** Children lose approximately 50 million school hours each year to dental-related illnesses and low income children lose 12 times as much. Adults lose 164 million hours of work each year because of preventable dental problems.[2]
- **Cost of dental services:** In 2007, Americans made about 500 million visits to dentists and spent approximately $100 billion on dental services. That figure is expected to increase to nearly $170 billion by 2017.[16]

What Oral Health Inequities Exist?

- **Racial and Ethnic Minorities**
  - ≠Nearly two-thirds of African-Americans 65 and older have lost at least six teeth because of tooth decay, compared to 44 percent of whites and 47 percent of Hispanics.[17]
  - ≠Compared to whites, the incidence of oral cancer is almost one-third higher among African-Americans and the mortality rate is almost twice as high.[18,28]
- **Rural and Geographic Inequities**
  - ≠Adults ages 18 to 64 are nearly twice as likely to lose their natural teeth if they reside in rural communities and are more likely to have untreated tooth decay.[19]
  - ≠Rural residents are less likely to have dental insurance or to have visited a dentist during the previous 12 months.[20]
  - ≠Several states in the South and Southwest have a disproportionately high percentage of people who have lost all their natural teeth.[21]
- **Low-Income and Uninsured Children**
  - ≠Low-income children have twice as many cavities as their more affluent peers and their disease is more likely to go untreated. Less than 20 percent of Medicaid-covered children receive any preventive dental services in a year.[2]
  - ≠Uninsured children receive dental care less than half as often as insured children.[2]

What Scientific Research Says

Fluoridated Water Reduces Cavities

- People who receive fluoridated water have 15 percent to 40 percent fewer cavities than people living in communities that don't add fluoride to their water supplies.[22]
- The per capita lifetime cost of fluoridation is less than the cost of one dental filling.[23]
- In communities with at least 20,000 residents, every $1 invested in community water fluoridation yields about $38 in savings from fewer cavities treated.[22]
- Approximately one-third of people in the U.S. do not have access to fluoridated water.[24]

School-Based Dental Sealant Programs Save Money

- Sealants, which are thin plastic coatings applied to the chewing surfaces of the molar (back) teeth, are clinically effective in preventing tooth decay as long as the sealant remains in place. Studies have shown a median decrease of 60 percent in cavities on the chewing surfaces of these teeth.[25] Sealants are considered 100 percent effective in fighting cavities if the sealant is fully retained on the tooth.[28]
- *Healthy People 2010* calls for at least 50 percent of 8- and 14-year-old children to have sealants on permanent molar teeth.[26] Currently, only about one-third of children ages 6 to 19 have them.[27]
- While the cost of dental sealants varies, a sealant usually costs less than filling a tooth that has a cavity.
- The use of dental sealants varies. Whites are more likely than Hispanics or African-Americans to have sealants. Those with higher incomes and education levels also are more likely to have sealants.[28]

Fluoride Varnish Prevents Cavities

- Fluoride varnish, a thin resin coating brushed on tooth surfaces, results in an 18 percent to 25 percent reduction in cavities.[29]
- Infants, toddlers and preschool children who had no tooth decay benefited most from fluoride varnish.
- Trained paraprofessionals can apply the varnish since no special equipment or tools are required.

Smoking Prevention and Cessation Programs Reduce Oral Cancer

- Increasing the price of tobacco products has been shown to decrease tobacco use. Young people, African-Americans and low-income adults are particularly sensitive to price increases.
- Sustained public education campaigns in combination with culturally appropriate community services, quit lines and other interventions are effective in reducing smoking.
- Smoking bans in workplaces lead to an average reduction in secondhand smoke exposure of 72 percent.[30]

Resources

Centers for Disease Control and Prevention

- Oral Health Web Page
  http://www.cdc.gov/OralHealth/
- National Oral Health Surveillance System Web Page
  http://www.cdc.gov/nohss/
- Oral Health: Preventing Cavities, Gum Disease, and Tooth Loss (2008)
  http://www.cdc.gov/nccdphp/publications/aag/pdf/oh.pdf
- The Guide to Community Preventive Services: Oral Health Chapter
  http://www.thecommunityguide.org/oral/default.htm
- Oral Health in America: A Report of the Surgeon General
  http://www.surgeongeneral.gov/library/oralhealth/

Healthy States

- Oral Health Web Page
  http://www.healthystates.csg.org/Public+Health+Issues/Oral+Health/
- Protecting Precious Smiles, Issue Brief, Web Conference Transcript and Archive
  http://www.healthystates.csg.org/EVENTS+and+Conferences/Web+Conferences/Oral+Health+Web+Conference.htm
- Preventing Tooth Decay Talking Points
  http://www.healthystates.org/Publications

Association of State and Territorial Dental Directors http://www.astdd.org

- Proven and Promising Best Practices for State and Community Oral Health Programs
  http://www.astdd.org/index.php?template=bestpractices.html
- Synopses of State and Territorial Dental Public Health Programs
  http://apps.nccd.cdc.gov/synopses/

Center for Healthier Children, Families & Communities National Oral Health Policy Center

http://www.healthychild.ucla.edu/nohpc/Default.asp

American Dental Association

http://www.ada.org/

American Cancer Society Web Page

http://www.cancer.org/docroot/home/index.asp

Oral Cancer Foundation Web Page

http://www.oralcancerfoundation.org/

Oral Health America: Campaign for Oral Health Parity

http://www.oralhealthamerica.org/OralHealthParity.html

The Oral Health America National Grading Project: 2003

http://www.oralhealthamerica.org/pdf/2003ReportCard.pdf

Children's Dental Health Project

www.cdph.org

The Center for Health and Health Care in Schools: School-based Dental Health

http://www.healthinschools.org/Health-in-Schools/Health-Services/School-Based-Dental- Health.aspx

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What the CDC Does for States

The Centers for Disease Control and Prevention (CDC) is part of the United States Department of Health and Human Services, which is the main federal agency for protecting the health and safety of all Americans. Since it was founded in 1946 to help control malaria, CDC has remained at the forefront of public health efforts to prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities and environmental health threats.

Helping state governments enhance their own public health efforts is a key part of CDC's mission. Every year, CDC provides millions in grants to state and local health departments. Some funds are in the form of categorical grants directed at specific statutorily–determined health concerns or activities. Other funds are distributed as general purpose block grants, which the CDC has more flexibility in deciding how to direct and distribute.

The CDC does not regulate public health in the states. Rather, it provides states with scientific advice in fields ranging from disease prevention to emergency management. It also monitors state and local health experiences in solving public health problems, studies what works, provides scientific assistance with investigations and reports the best practices back to public agencies and health care practitioners.

For state legislators who are interested in improving their state's public health, the CDC offers a wealth of resources, including:

- Recommendations for proven prevention strategies;
- Examples of effective state programs;
- Access to top public health experts at the CDC;
- Meetings specifically aimed at state legislative audiences;
- Fact sheets on policies that prevent diseases; and
- State–specific statistics on the incidence and costs of disease.

This publication from the Healthy States Initiative is also an example of CDC's efforts to help states. The Healthy States Initiative is funded by a cooperative agreement with the CDC.

The CDC has developed partnerships with numerous public and private entities—among them medical professionals, schools, nonprofit organizations, business groups and international health organizations—but its cooperative work with state and local health departments and the legislative and executive branches of state government remains central to its mission.

The Council of State Governments' (CSG) Healthy States Initiative is designed to help state leaders make informed decisions on public health issues. The enterprise brings together state legislators, officials from the Centers for Disease Control and Prevention, state health department officials, and public health experts to share information, analyze trends, identify innovative responses, and provide expert advice on public health issues. CSG's partners in the initiative are the National Black Caucus of State Legislators and the National Hispanic Caucus of State Legislators.

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