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FOUNDATIONAL PUBLIC HEALTH SERVICES ASSESSMENT AND PERFORMANCE MANAGEMENT SUBCOMMITTEE

Final Report 2016–2017

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Final Report 2016–2017

Prepared for the Public Health Systems Group

NOVEMBER 2017

Author

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TABLE OF CONTENTS

Executive Summary

Background

This is the final report documenting the activities of the Assessment and Performance Management Subcommittee (Assessment Subcommittee). This work is being conducted in partnership with the Kansas Public Health Systems Group (PHSG)—a multi-sector coalition of Kansas state public health partners representing public health practice, academic institutions, government and charitable organizations—to support the Kansas Association of Local Health Departments (KALHD) in achievement of its vision.

Work towards the Foundational Public Health Services (FPHS) in Kansas began in September 2015, when KALHD adopted the following vision statement: "KALHD's vision is a system of local health departments committed to helping all Kansans achieve optimal health by providing Foundational Public Health Services (FPHS).

Since then, the PHSG has been working to support KALHD and its members in progress toward their vision to provide FPHS to all Kansans. The FPHS are a suite of skills, programs and activities that should be available in every community in Kansas through state or local governmental public health agencies as basic elements to keep the public safe and healthy. The model consists of Foundational Capabilities (FC) and Foundational Areas (FA). The Foundational Capabilities are cross-cutting skills and abilities, and Foundational Areas are the substantive areas of expertise or program-specific activities. Within each Foundational Capability and Foundational Area, there is a list of components that are subordinate to each FC and FA, which further define the abilities or activities required to fully implement that capability or area.

Assessment Subcommittee Purpose and Structure

The purpose of the Assessment Subcommittee was to create an inventory of services and identify gaps in the FPHS, identify FPHS performance measures for the public health system, and conduct surveys and focus groups to assess the capacity of the system to implement the FPHS. In order to complete the assessment activities, the Assessment Subcommittee members also conducted a literature review to describe other states' FPHS models and undertook a process to define the FPHS for Kansas.

The Subcommittee was led by staff at the Kansas Health Institute (KHI). The Subcommittee members included representatives from local and state health departments as well as academic and nonprofit institutions.

Key Activities

The primary activities of the Assessment Subcommittee included 1) a literature review of similar models from other states; 2) a stakeholder engagement and vetting process to determine which components would be defined as 'foundational' for Kansas; 3) a capacity assessment survey of all 100 health department administrators in the state; and 4) the development of a list of performance measures for the FPHS.

These activities resulted in a document comparing similar state and national models; a list of the FPHS for Kansas, including seven Foundational Capabilities, five Foundational Areas, and 109 total components; a report of the capacity assessment detailing the strengths and weaknesses of the system's current capacity and capability to implement the FPHS; and a list of candidate performance measures for each of the 109 components of the FPHS model.

Implications and Next Steps

The work of the Assessment Subcommittee was critical to the overall strategy of the PHSG in furthering the development of an FPHS model for Kansas. The results of the Subcommittee's work have been used to inform the estimation of the costs of implementing the FPHS, which is the work of the Fiscal Subcommittee.

Additionally, PHSG members have applied for and received a grant to continue the work of the FPHS exploration through the Public Health National Center for Innovations (PHNCI). This grant will support a pilot project in a Kansas county or group of counties to implement one portion of the FPHS. The capacity assessment may be used to identify which FPHS components will be prioritized for the pilot, and relevant performance measures will be used to measure the success of the pilot.

Introduction

About the Foundational Public Health Services

Throughout the past thirty years, there have been many significant efforts to define and revitalize the United States' public health system. This has this has been spurred on by both chronic underfunding and unstable budgeting for public health activities.[1] At the same time, the role of public health agencies continues to evolve, moving toward providing fewer clinical and individual client services and more health education and population health services. Many national efforts have worked toward developing a means to clearly articulate the public health services in which the local, state and federal governments should invest. States across the nation are working to "modernize" their public health systems, and are considering new models of service delivery.

In April 2012, the Institute of Medicine produced a report which outlined concept for a new public health services framework.[2] The Public Health Leadership Forum obtained funding from the Robert Wood Johnson Foundation and contracted with RESOLVE, an independent, nonprofit organization, to explore recommendations from that report. By 2014, RESOLVE had drafted a national model, often called the Foundational Public Health Services (FPHS) model or the RESOLVE model.[3] The RESOLVE FPHS model included cross-cutting skills for all health departments and defined activities essential for all health departments to protect the health of their communities. Since then, several states have made efforts to adapt this model to fit local resources and needs.

The FPHS are the suite of skills, programs, and activities that should be available in every community through state or local governmental public health agencies as basic components to keep the public safe and healthy. The FPHS are primarily population-based preventive health services that are best addressed by governmental public health. The model consists of Foundational Capabilities (FCs) and Foundational Areas (FAs). The Foundational Capabilities are the cross-cutting skills that need to be present everywhere to ensure high-quality and equitable public health services. They are the essential skills and capacities needed to support the Foundational Areas. Foundational Areas are the substantive areas of expertise or program-specific activities. Within each Foundational Capability and Foundational Area, there is a list of components that specify distinct abilities or activities for the delivery public health services.

There may be additional programs and activities that are of critical significance to a specific health department or that are needed to meet a community's needs. These additional services are not 'foundational' for all health departments and are not included in the FPHS model. However, these additional services are still important and essential for local communities and may be delivered in addition to the FPHS.

Development of the Foundational Public Health Services in Kansas

In September 2015, the Kansas Association of Local Health Departments (KALHD) adopted the following vision statement: *"KALHD's vision is a system of local health departments committed to helping all Kansans achieve optimal health by providing Foundational Public Health Services (FPHS)."* Since then, the Kansas Public Health Systems Group has been working to support KALHD and its members in progress toward their vision to provide FPHS to all Kansans.

Public Health Systems Group Structure

The Public Health Systems Group (PHSG) is a multi-sector coalition of Kansas state public health partners representing public health practice, academic institutions, government and charitable organizations. This group was originally convened by the Kansas Health Foundation (KHF) in 2001 and has been meeting regularly since then.

The PHSG currently includes representatives from the following organizations: Kansas Association of Local Health Departments, Kansas Department of Health and Environment, Kansas Health Institute, Kansas Public Health Association, Kansas Environmental Health Association, Kansas Hospital Association, University of Kansas, Kansas State University, Wichita State University, and the Kansas Health Foundation.

In 2013, KHF announced that its funding for the public health system would be granted through the PHSG. The PHSG members would be tasked with prioritizing projects, allocating funds, and collaboratively managing the activities. This funding and the prioritized activities were titled the Public Health Practice Program (PHPP). The PHPP is a significant investment by KHF to the PHSG to strengthen the Kansas public health system.

The PHPP funding began in 2014, and the funding was organized into five workgroups:

- Academic Health Departments and Practice-Based Research Network (PBRN) Workgroup;

- Informatics Workgroup;
- Cross-Jurisdictional Sharing Workgroup;
- Workforce Development Coordinating Council; and
- Engagement with County Commissioners and Boards of Health.

Following the 2015 development of KALHD's new vision statement, the PHSG reorganized its efforts to support KALHD in the achievement of the vision by exploring the FPHS. For this purpose, four subcommittees were developed:

1) Policy;
2) Assessment and Performance Management;
3) Legal; and
4) Fiscal.

The FPHS Assessment and Performance Management Subcommittee was tasked with creating an inventory of services and identifying the gaps in the FPHS, identifying FPHS performance measures for the public health system, and conducting surveys and focus groups to assess the capacity of the system to implement the FPHS (see list of activities in Appendix B). To complete the assessment activities, the Assessment Subcommittee members undertook two of the activities assigned to the Policy Subcommittee: 1) review and describe how other states developed strategies for the implementation of the FPHS; and 2) to describe in operational terms what the FPHS in Kansas should include and how they can be defined.

Assessment Subcommittee Activities

Between January 2016 and July 2017, the workgroup held a total of four subcommittee meetings. The purpose of these meetings was to provide feedback on the instruments used to conduct each of the four project activities.

Literature Review

Purpose and Process

The first activity of the Assessment Subcommittee was a comprehensive literature review. The primary goal of the literature review was to identify and characterize existing minimum package models for public health services to better understand how the FPHS have been defined in other states and to contribute to the development of model definitions for Kansas. For that purpose, the literature review included one national model (RESOLVE) and other models developed by individual states.

The literature review was conducted by searching for minimum package models in all 50 states. Based on the documents identified, each state's model was compared, using a crosswalk, to the RESOLVE model. The RESOLVE model was a common reference point for the comparison because it was both influenced by existing state minimum package models (Washington, Oregon and Ohio) and later used as a template for many new state models. The team documented which of the RESOLVE Foundational Areas, Foundational Capabilities, and components was present in each state model. As additional FCs, FAs, or components not included in the RESOLVE model were identified, they were added to the full list of model elements and were compared across state models.

This list of FPHS model elements and comparison to the RESOLVE model was used to characterize and compare each of the state models and to identify a full list of candidate components for the Kansas model.

Key Findings

It was found that each model differs by varying degrees from the RESOLVE model and from each other. The differences in each state's model suggest that the ability of a nationwide model to capture what is truly necessary for all states is limited. Given that a nationwide model may not account for local nuances, the development of state-specific models for public health service delivery seems to be appropriate. Fortunately, states such as Kansas wishing to develop their own models can use and adapt the list of services and components already identified by other states.

Other key findings include:

- Eight states were found to have defined minimum package models: Colorado, Kentucky, North Carolina, North Dakota, Ohio, Oregon, Texas and Washington;
- The RESOLVE FCs and FAs were present to varying degrees among state models;
- There were many similarities between the components defined within state models and the national model developed by RESOLVE; and
- State minimum package models often differ, and almost every model included unique elements not included in the RESOLVE framework.

An electronic copy of the full literature review report may be found at: http://www.kalhd.org/wp-content/uploads/2017/02/FPHS-State-by-State-Comparison.pdf.

Key-Informant Interviews

Purpose and Process

After the literature review, the Assessment Subcommittee members undertook a process to develop detailed definitions of the FPHS for Kansas, informed by a series of key-informant surveys and interviews. Following the interviews, a draft list of FPHS was shared with LHD and PHSG partners for vetting. The purpose of the key-informant interviews was to determine which services key stakeholders felt were "truly necessary" to be included in the FPHS list. Additional goals included:

- Identifying any suggested wording changes or confusion about FCs, FAs, and components;
- Gathering suggestions about the organization of the FCs and FAs; and
- Collecting preliminary information on the current capacity to provide FPHS to their community, including perceived availability of staffing, expertise, funding and technical assistance needs.

A survey and a series of phone interviews were conducted nineteen key informants, 13 from local health departments and six from the KDHE. Participants from local health departments

were selected based on geography and population density so that each region and density category were represented in the interview process.

Survey respondents were asked to select all of the services that they felt were "truly necessary" from a list of 162 total components drawn from the literature review of RESOLVE and other states' FPHS models. For this process, "truly necessary" services were defined as those that fit at least one of the following criteria:

1. *Population-based* preventive health services that target specific communities defined by geography, race, ethnicity, gender, illness or other health conditions (e.g., water fluoridation, creation of walkable communities);

2. *Governmental public health* is the only or best potential provider of service (e.g., disease surveillance and epidemiology); and/or

3. *Mandated service* provided by the public health authority (e.g., communicating reportable disease cases to the state health department).

The survey and key-informant interview questionnaire were based on similar assessments conducted in other states with feedback from the PHSG and other partners. Following completion of the survey, participants were invited to participate in key-informant interviews to provide additional context to their survey answers.

In general, components that were selected as foundational by 80 percent or more of respondents were incorporated into the Kansas model, and components that received a rating of 40 percent or less were removed from the list of FPHS for Kansas (exceptions to these cutoffs are noted in the results). The components that received ratings between 40 and 80 percent were discussed among team members. The team members reached consensus on each component for whether to keep, revise or delete each component based on the information collected from the key-informant interviews.

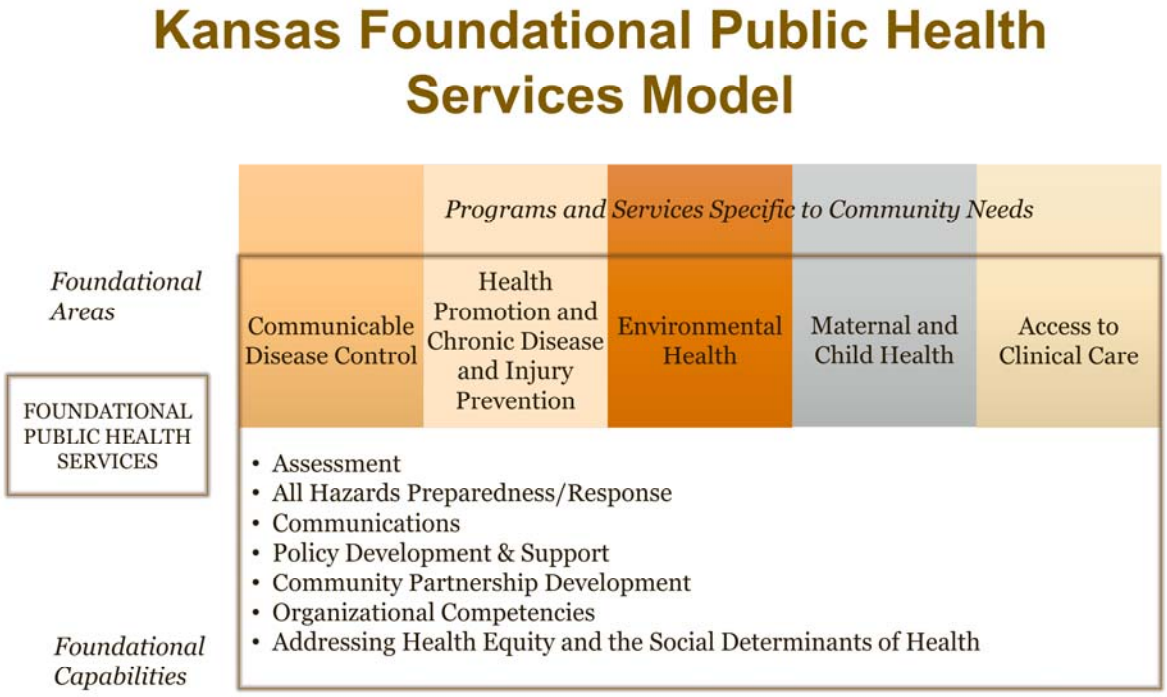
Following the process of identifying the draft list for FPHS in Kansas based on survey and key-informant interview results, team members shared the draft list with the KALHD board, the entire KALHD membership, and other PHSG partners. These groups were given opportunities to provide feedback, suggest changes, or ask questions about the components included in the draft list. Following feedback and additional changes, the final list was adopted by the KALHD board

members at their board meeting on October 18, 2016, and was voted on by the entire KALHD membership at their annual meeting on November 17, 2016.

Key Findings

Using the results of the survey and key-informant interviews, a list of components was compiled. This list was shared with KALHD board members, local health department administrators, and other public health system partners for feedback. The final FPHS list for Kansas included seven FCs and five FAs with a combined total of 109 components (*Figure 1*).

Figure 1: Kansas Foundational Public Health Services Model



A full report of the model development process can be found at: khi.org/policy/article/17-16.

Capacity Assessment

Purpose and Process

As part of the work toward the FPHS and KALHD's vision, a capacity assessment of the FPHS in Kansas was conducted. The purpose of the capacity assessment was to examine the Kansas public health system's current capacity and capability to deliver the FPHS services that were defined for Kansas and to identify areas of strength and areas for improvement.

The FPHS capacity assessment survey asked local health department administrators to rate their capacity (defined as *staff, time and funding*) and capability (defined as *skills, knowledge and expertise*) to deliver each of the components of Kansas' FPHS model, and to describe barriers to full implementation.

Key Findings

The assessment survey was completed by 81 of 100 (81 percent) of Kansas' local health departments in March 2017.

In general, health department administrators rated their capacity to deliver the FPHS lower than the capability to do so. In other words, the level of staff, time and funding is perceived as less sufficient than the skills, knowledge and expertise to deliver these public health services.

Health departments in Kansas already have the capability and capacity to implement some portions of the FPHS model. Foundational Capabilities and Foundational Areas of the model that were most highly rated were:

- FC: All Hazards Preparedness and Response;
- FC: Organizational Competencies;
- FA: Communicable Disease Control; and
- FA: Access to Clinical Care.

However, there are parts of the FPHS for which there is low capability and capacity for implementation. The areas with the biggest opportunities for improvement were:

- FC: Policy Development and Support

- FC: Assessment
- FA: Environmental Health

There were also wide differences between the capacity and capability to deliver the individual model components. Some of the components that were most highly rated reflect traditional public health department roles, such as the ability to assure immunization coverage. Those that rated lowest often reflected newer ideas or concepts in public health, such as the ability to engage in health in all policies (HiAP) and participation in land use and development planning.

There are demographic differences in capacity and capability to deliver FPHS as well. Administrators of agencies that serve more population-dense counties generally reported higher capacity and capability than those that serve more sparsely populated areas. The number of staff employed at local health departments may also impact capacity to implement the FPHS. A higher number of FTEs was associated with higher capacity, and more than half of the respondents had five FTEs or fewer. These small staff numbers may be insufficient to cover all the components of the FCs and FAs.

Some of the commonly noted barriers to implementation of the FPHS, other than funding, were available staff, adequate time, and sufficient training on the FPHS components. Higher numbers of staff FTEs and total operating budget were significantly (although weakly) associated with higher overall capacity ratings. This aligns with the definition of capacity: adequate time, staff and funding. However, the weak correlation indicates that there may be additional drivers of overall capacity in addition to funding and staffing.

A copy of the full Capacity Assessment report can be found at: khi.org/policy/article/17-18.

Performance Measure Development

Purpose and Process

The purpose of the list of performance measures is to provide a comprehensive list from which members of KALHD and the PHSG may select appropriate measures to track progress in implementation of the FPHS in Kansas. The list was developed to be further prioritized by KALHD and PHSG members as the implementation plans of the FPHS become more concrete.

The list was developed so that there is at least one measure for each component of the FPHS in Kansas model, and a standard for each measure where possible. In developing the list, standards were drawn from existing sources of public health standards, such as Healthy People 2020, PHAB Standards and Measures, KDHE guidance, etc. In some cases, no appropriate standard was available. Some of these measures may be of enough value that members may choose to track the measure over several years and develop an appropriate benchmark. Other measures may be prioritized out of the list based on the lack of a meaningful target.

Eventually, the standards and measures in this list will be used in a performance management system to collect data and track progress of the entire system. Health departments will keep record of the agreed-upon measures and performance against the standards will be used to identify opportunities for quality improvement and capacity building.

Results and Next Steps

The list consists of 156 measures that may be used to track the performance of FPHS implementation in Kansas. The list of measures includes each component, the corresponding measure and standard, a timeframe, and data source.

Identifying the final list of measures is the next task for this list. The final list may take one of several forms. It could be a shorter list of a few core measures that all health departments are strongly encouraged to track and report on; it could be a list of core measures plus optional measures; or, it could take on an entirely different form. This should be decided upon by the PHSG partners.

In order to narrow down the list, the partners may want to consider developing criteria for prioritization. Criteria for narrowing down the list may include, but are not limited to availability and ease of collection of data, availability of meaningful standards, value of the measure as an indicator of success of LHD implementation of FPHS, etc. As the PHSG begins the work of the Public Health National Center for Innovations (PHNCI) grant, additional criteria may also be developed.

The full list of performance measures has been shared with members of the Public Health Systems Group for further prioritization as plans continue to develop for FPHS implementation.

Conclusion

Implications and Next Steps

The results of the activities of the FPHS Assessment and Performance Management Subcommittee (the literature review, model development, capacity assessment, and performance measure development) provide a plethora of information for PHSG partners as they work towards the vision of providing Foundational Public Health Services in Kansas. While literature review and model definition process have provided the groundwork for the development of FPHS in Kansas, the results of the capacity assessment and the work done on the performance measures can be acted upon as the partners develop plans for implementation.

The capacity assessment illustrates that there are variations in the ability to implement the FPHS components. The capacity assessment results have been used to inform the estimation of costs of implementation of the FPHS, which is the work of the Fiscal Subcommittee. Other ongoing efforts by the Public Health Systems Group (PHSG) should utilize the results of this assessment to inform future work in the areas of policy, fiscal and legal strategies to implement the FPHS, focusing in particular on the areas of need and the barriers identified by the respondents to this survey.

The performance measures provide a framework by which the partners can define the key measures to track success of the implementation of FPHS and can provide insight to areas where quality improvement efforts are needed.

Finally, PHSG members have applied for and received a grant to continue the work of the FPHS exploration through the Public Health National Center for Innovations (PHNCI). This grant will support a pilot project in several Kansas counties to implement one portion of the FPHS. The capacity assessment may be used to identify which FPHS components will be prioritized for the pilot, and relevant performance measures will be used to measure the success of the pilot.

Appendix A: PHSG Structure

Figure A-1: Structure of the Public Health Systems Group Workgroup and FPHS Subcommittees, February 2016

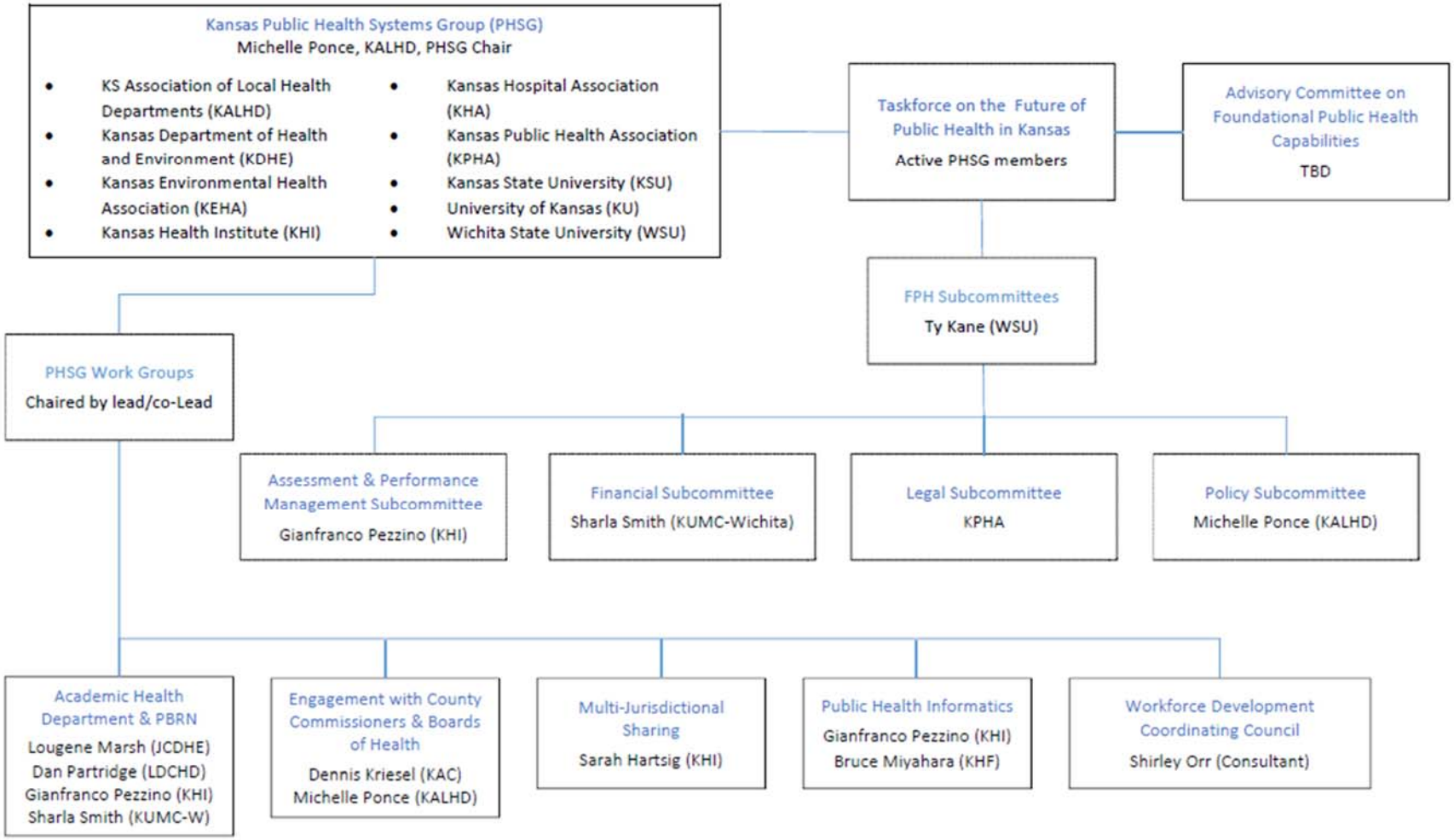


Figure A-2: **FPHS Subcommittee Structure, August 2016**

Appendix B: PHSG, Council and Subcommittee Activities

Figure B-1: PHSG, Council and Subcommittee Activities, November 2015

	Task Force *(All Active PHSG Members)*	Council on the Future of Public Health in Kansas	Assessment/Performance Management Subcommittee	Legal Subcommittee	Policy Subcommittee	Fiscal Subcommittee
Activities						
1	Partner with county commissioner workgroup to develop content for the statewide summit	Hear and discuss results from the work of subcommittees	Create an inventory of services and identify where there are gaps in the FPHS.	Review current statutes and regulations in Kansas that describe the currently required public health services and how they are delivered in the state.	Review and describe how other states have developed strategies for the implementation of the FPHS. Reviews will include at a minimum the states of Washington, Oregon, and Ohio.	Develop cost-estimation models for delivering the FPHS in Kansas. This effort will be informed by the Kansas assessment as well as the review of other states' implementation strategies
2	Development of report describing strategies and options for FPHS implementation in Kansas	Discuss options for FPHS delivery and system organization and governance	Identify FPHS performance measures for the public health system as a whole	Review enacted or proposed statutes in states that have embraced or explored the FPHS model, as well as model public health statutes developed by public health law centers.	Describe in operational terms what the FPHS in Kansas should include and how they can be defined.	Present options for apportioning costs among parties, including federal, state, and local funds.

3			Conduct focus groups of local public health leaders	Develop a possible legislative model suitable for Kansas.	Describe possible governance models, including the respective role of the state and local health departments and the possibility to share some of the FPHS on a multi-jurisdictional base (may coordinate with fiscal workgroup).	Present options on how to track expenses, including the possible adoption of a common chart of accounts.
4			Develop and deploy survey, and analyze results.		Propose possible timelines for the implementation of the strategies discussed.	Present possible options for funding the FPHS over time, including models to share the costs among the different funding sources.
5						Propose one or more possible timelines for the implementation of the strategies discussed.

Appendix C: Kansas FPHS List

Introduction

Background

In September 2015, a group of KALHD members met to set a vision for local public health in the state. Their vision was defined as:

"KALHD's vision is a system of local health departments committed to helping all Kansans achieve optimal health by providing Foundational Public Health Services (FPHS)."

This vision statement was adopted by the KALHD board, and a list of next steps was identified. Shortly after the adoption of this vision statement by KALHD, the Public Health Systems Group (PHSG) organized its work to support the exploration and implementation of the FPHS. As part of these efforts, the Kansas Health Institute (KHI), in partnership with KALHD and the PHSG, is assessing the FPHS in Kansas. The aim of this assessment is to: 1) Define the FPHS for Kansas; and 2) Assess the system's capacity for implementation of the FPHS. The assessment began with a literature review of other states' FPHS models and a comparison to the RESOLVE model[4]. The literature review also examined how other states went about defining the FPHS for their state. Based on the results of that literature review, KHI compiled a list of possible FPHS components, and that list was distributed as a survey to 19 key informants (14 LHD and five KDHE personnel). Interviews were held to discuss the survey responses, and based on the information gathered in the survey and interviews, the list was revised. This list was shared with stakeholders for feedback, and further edits were made.

About the FPHS

The FPHS are the suite of skills, programs and activities that should be available in every community in Kansas through state or local governmental public health agencies as basic components to keep the public safe and healthy. The FPHS are primarily population-based preventive health services that are best addressed by governmental public health and may be mandated by state or federal law. The model consists of Foundational Capabilities and Foundational Areas. The **Foundational Capabilities** are the cross-cutting skills that need to be present everywhere for the system to work anywhere. They are the essential skills and capacities tended to support the Foundational Areas. **Foundational Areas** are the substantive areas of

expertise or program-specific activities. Within each Foundational Capability and Foundational Area is a list of components that further define what it means to fully implement that capability or area.

There may be additional programs and activities that are of critical significance to meet a specific community's needs. These services are not included in the FPHS model because they are not present in all communities. However, they are still important services.

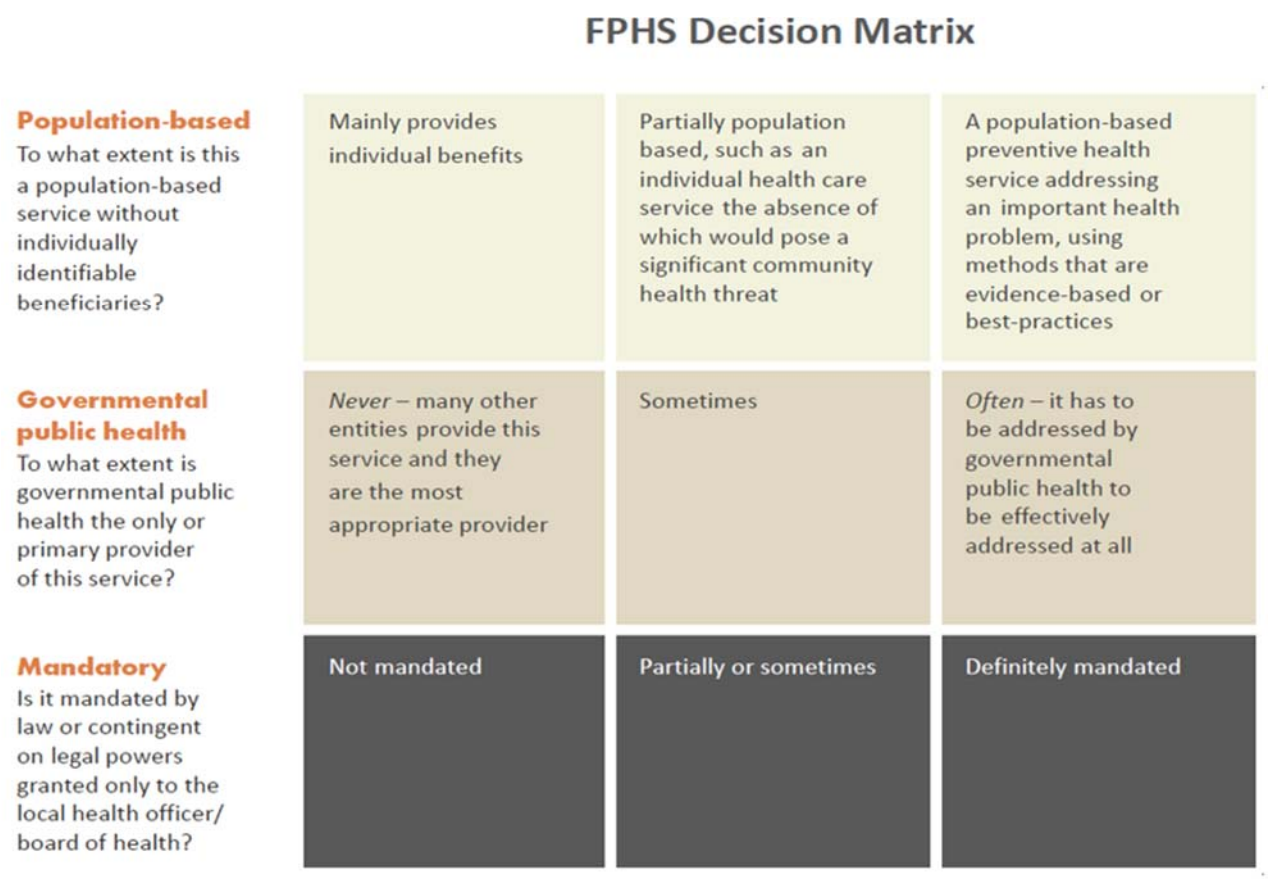
Criteria

When identifying what should be provided by state or local public health agencies in the FPHS for Kansas model, the components were evaluated against the following criteria:

- *Population-based* preventive health services that target specific communities defined by geography, race, ethnicity, gender, illness or other health conditions (e.g., water fluoridation, creation of walkable communities);
- *Governmental public health* is the only or best potential provider of service (e.g., disease surveillance and epidemiology); and
- *Mandated service* provided by the public health authority (e.g., communicating reportable disease cases to the state health department).

The criteria are adapted from a similar process conducted in Washington State (see Figure C-1). Priority is given to the services that fall in the far right column.

Figure C-1. **Washington State FPHS Decision Matrix**



Source: Washington State Department of Health, 2015.

Please Note

As you become familiar with this list, please keep in mind the following:

- The components in this model constitute what SHOULD be provided by state or local public health agencies when KALHD's vision is achieved, not what currently IS provided;
- Only services and capabilities that should be available in EVERY community in Kansas are included in this list;
- To 'assure' means that state or local public health agencies have the primary responsibility to strategically work with community partners to ensure that those who

need the service have access to it, and that there is a plan in place to provide the service. Components that begin with 'assure' should be provided by the state or local public health agencies if no other organizations are willing or able to provide the service in the community. In all other cases (when the term "assure" is not present) the state or local health agencies should be directly responsible for providing the service listed. **This may be achieved through a contract for services, as long as the contract doesn't remove responsibility from the health department;**

- Functions are not always exclusive to an individual health department (i.e., some services may be shared between the state and local public health agencies or between local agencies in multiple jurisdictions); and

- Services and capabilities that are not found on this list may still be important to individual communities (and therefore be provided by some public health departments) based on identified needs for their communities, but may not be available statewide.

Please contact Sarah Hartsig at 785-233-5443 or shartsig@khi.org with any questions.

Foundational Capabilities

The Foundational Capabilities are the cross-cutting skills and capacities needed to support the foundational areas and other programs and activities. Presence of these capabilities is key to protecting the community's health and achieving equitable health outcomes. Each Foundational Capability has components that further define the capability. The following components should be present in state or local public health agencies in Kansas.

Assessment

The Assessment capability includes activities for the collection and analysis of public health data.

- Ability to participate in the collection of primary public health data.

- Ability to access and utilize secondary data from key sources, including U.S. Census Bureau data, vital statistics, Behavioral Risk Factor Surveillance Survey (BRFSS), etc.

- Ability to interpret, display and communicate public health data and its analysis.

- Ability to identify patterns, causes and effects of chronic and communicable diseases (epidemiology).
- Ability to lead or participate in a community health assessment, including health disparity analysis and identification of health priorities.
- Ability to respond to data requests with meaningful reports (valid, statistically accurate, and readable by intended audiences).
- Ability to evaluate efficiency and effectiveness of public health programs.
- Ability to access and utilize electronic health information systems.

All Hazards Preparedness/Response

The All Hazards Preparedness/Response capability includes activities critical to prepare for and respond to public health emergencies.

- Ability to develop and rehearse emergency response strategies and plans.
- Ability to coordinate with emergency response partners from both private and governmental sectors.
- Ability to serve as the local primary or coordinating agency for Emergency Support Function 8 – Public Health and Medical.
- Ability to operate within the National Incident Management System as well as within any local emergency response processes.
- Ability to promote community preparedness and resilience by communicating with the public, in advance of an emergency, preparedness actions that may be taken before, during, or after a public health emergency.
- Ability to maintain a continuity of operations plan (COOP) that includes access to financial resources to execute emergency responses.
- Ability to conduct investigations of threats to public health.

- Ability to issue emergency health orders via statutory authority (community disease containment, mandated treatment, boil water orders, etc.).
- Ability to identify, prioritize, and address the needs of vulnerable populations in advance of a public health emergency.
- Ability to be notified of public health emergencies on a 24/7 basis.
- Ability to respond to public health emergencies on a 24/7 basis.
- Ability to notify the public of a public health emergency on a 24/7 basis.
- Ability to package and ship clinical specimens to the state reference laboratory (Kansas Health and Environmental Laboratory, or KHEL) for identification of threats.

Communications

The Communications capability includes activities that ensure a comprehensive communications strategy is developed and implemented.

- Ability to maintain ongoing relationships with local media outlets.
- Ability to develop and implement a strategic communications plan to articulate the agency's mission, vision, values, roles and responsibilities to the community.
- Ability to communicate the role of public health to the public and to policymakers.
- Ability to communicate specific health or public health issues through written and verbal communication tools.
- Ability to develop a communication strategy to identify a specific public health issue and/or to communicate risk (e.g., providing information on health risks, healthy behaviors, and disease prevention).
- Ability to communicate in culturally and linguistically appropriate and accessible formats for various communities served, in accordance with state and federal guidelines, such as compliance with Section 508 of the Rehabilitation Act of 1973.

- Ability to facilitate two-way communications (transmit and receive) with the public via social media and other tools.
- Ability to develop and implement a proactive health education strategy to support good population health.

Policy Development and Support

The Policy Development/Support capability includes activities to inform, develop and implement public health policy.

- Ability to identify evidence-based public health policy recommendations.
- Ability to work with partners and policymakers to develop and enact public health policies.
- Ability to work with partners and policymakers to support the development of public health administrative rules, regulations, and ordinances.
- Ability to utilize health in all policies (HiAP) approaches for all policy development.
- Ability to enforce public health mandates (e.g., policies, statutes, regulations, ordinances).

Community Partnership Development

The Community Partnership Development capability includes activities to improve collaboration and interdependence within the public health system.

- Ability to create and maintain relationships with key partners, including health care and other health-related organizations, organizations representing populations experiencing health disparities, governmental agencies, and public health champions.
- Ability to strategically select and articulate governmental public health roles in programmatic and policy activities.
- Ability to coordinate with governmental public health partners to support programmatic and policy activities.

- Ability to work with community members and organizational partners to identify community assets and resources.
- Ability to engage community members (including those who experience health disparities) to develop and implement community health improvement plans to address priorities identified in health assessments.
- Ability to convene a broad, multi-sector assembly of public health and medical stakeholders to promote health, prevent disease, and protect residents within the community.

Organizational Competencies

The Organizational Competencies include activities to support the business, management and leadership functions within the public health system.

- Ability to serve as the public face of governmental public health in the community.
- Ability to define and communicate strategic direction for public health initiatives through agency strategic planning processes.
- Ability to uphold business practices in accordance with local, state and federal laws, and professional standards.
- Ability to develop and maintain a performance management system to monitor achievement of organizational and programmatic objectives.
- Ability to continuously evaluate and improve organizational processes, including using planning tools such as Plan-Do-Study-Act (PDSA) cycles.
- Ability to systematically apply computer literacy skills and information technology to public health practice and learning.
- Ability to have proper systems in place to keep protected health information (PHI) and confidential organizational data restricted.
- Ability to recruit and retain a competent public health workforce with considerations for succession planning.

- Ability to develop and maintain a competent public health workforce through workforce development and training, performance review, and staff accountability.
- Ability to comply with federal, state and local standards and policies for fiscal management, including within budgeting, auditing, billing and charts of accounts (revenue and expense) processes.
- Ability to comply with federal, state and local standards and policies for contracting.
- Ability to procure, maintain and manage resources to support agency operations (e.g. funding, assets, supplies, and hardware/software).
- Ability to procure, maintain and manage safe facilities to support agency operations.
- Ability to access appropriate governmental legal services to support agency operations.
- Ability to engage with the public health governing entity to advocate for public health funding and initiatives.
- Ability to coordinate and integrate categorically funded programs and services.

Addressing Health Equity and the Social Determinants of Health

The Health Equity and Social Determinants of Health area includes activities to identify and respond to health disparities and the needs of vulnerable populations.

- Ability to recognize and understand the determinants of health disparities within the community.
- Ability to coordinate programming to improve health disparities within the community.
- Ability to develop and advocate for policies that will promote health for all, particularly the most vulnerable.
- Ability to provide services in culturally and linguistically appropriate and accessible formats for various communities served, in accordance with state and federal guidelines, such as compliance with Section 508 of the Rehabilitation Act of 1973.

- Ability to provide public health information for the community that is stratified by demographic characteristics.

Foundational Areas

The Foundational Areas are the substantive areas of expertise and program-specific activities that are provided by state or local public health agencies. Each Foundational Area has components that further define the activities within that area. The following components should be available in every community in Kansas. In some cases, the role of the public health agencies is to assure that people have reasonable access to certain services.

To 'assure' means that state or local public health agencies have the primary responsibility to strategically work with community partners to ensure that those who need the service have access to it and that there is a plan in place to provide the service. Components that begin with 'assure' should be provided by the state or local public health agencies if no other organizations are willing or able to provide the service in the community. In all other cases (when the term "assure" is not present) the state or local health agencies should be directly responsible for providing the service listed.

Communicable Disease Control

The Communicable Disease Control area includes programs and activities to prevent and control the spread of communicable disease.

- Provide timely, accurate and locally relevant information on communicable diseases and their control, including strategies to increase local immunization rates.
- Identify assets for communicable disease control.
- Develop and implement a communicable disease control plan prioritizing important communicable diseases.
- Advocate and seek funding for communicable disease control policies and initiatives.
- Assure availability of public health laboratory services for reference and confirmatory testing related to communicable diseases.
- Receive and promptly process laboratory and clinical reports of communicable diseases.

- Conduct disease investigations, including contact tracing and notification, in accordance with national, state and local mandates and guidelines.
- Identify and respond to communicable disease outbreaks in accordance with national, state and local mandates and guidelines.
- Support local screening/testing of reportable diseases, based on national and state recommendations and guidelines.
- In conjunction with appropriate partners, enforce emergency health orders via statutory authority (community disease containment, mandated treatment, boil water orders, etc.).
- Assure availability of childhood, adolescent and adult immunization services, including the Vaccines for Children (VFC) program, for all vaccines recommended by the Advisory Council on Immunization Practices (ACIP).
- Assure proper diagnosis and treatment for individuals with latent or active tuberculosis in accordance with national, state and local mandates and guidelines.
- Educate providers in national, state and local communicable disease control mandates and guidelines.

Health Promotion and Chronic Disease and Injury Prevention

The Health Promotion and Disease Prevention area includes programs and activities for health promotion and chronic disease and injury prevention. Special attention should be paid to the leading causes of death in Kansas. (Current Vital Statistics Report from KDHE: http://www.kdheks.gov/hci/annsumm.html)

- Provide timely, accurate, and locally relevant information on health promotion and chronic disease and injury prevention.
- Identify assets for health promotion and chronic disease and injury prevention.
- Develop and implement a health promotion and chronic disease and injury prevention plan.

- Advocate and seek funding for health promotion and chronic disease and injury prevention policies and initiatives.
- Work with partners to identify evidence-based, population-based interventions that utilize valid evaluation studies.
- Work to reduce rates of tobacco use through policies and programs that conform with local, state, and federal laws and recommendations.
- Work to increase statewide and community rates of healthy eating and active living that utilize evidence-based practices that are aligned with local, state and national guidelines.
- Develop and implement comprehensive community-based health promotion strategies to address common risk factors and chronic diseases.
- Promote community mental health and well-being.
- Work to reduce rates of substance abuse in the community.

Environmental Health

The Environmental Health area includes programs and activities to prevent and reduce exposure to environmental hazards.

- Provide timely, accurate and locally relevant information on environmental public health issues and health impacts from both common and toxic exposure sources.
- Identify assets for environmental public health.
- Advocate and seek funding for environmental public health policies and initiatives.
- Develop and implement an environmental public health plan to prevent and reduce exposures to health hazards in the environment.
- Assure availability of public health laboratory services for reference and confirmatory testing related to environmental public health threats.
- Assure implementation of environmental public health inspections (e.g., inspection of child care facilities) in accordance with federal, state and local laws and regulations.

- Coordinate and communicate with agencies that carry out environmental public health functions at the local level (e.g., inspections of food service facilities, drinking water, and liquid and solid waste streams).
- Identify and address notifiable conditions and environmental hazards.
- Assure access to elevated blood lead screenings.
- Support adult and child blood lead case management.
- Prevent or reduce environmental public health hazards and assure abatement of nuisances.
- Participate in land use planning and sustainable development (e.g., consideration of housing, urban development, recreational facilities, and transportation).
- Provide the community with information on reducing unnecessary radiation exposure (e.g. radon in the home).

Maternal and Child Health

The Maternal and Child Health area includes programs and activities for the prevention of developmental impairments and life-threatening illnesses in mothers and children.

- Provide timely, accurate and locally relevant information on emerging and ongoing maternal and child health trends, including the importance of Adverse Childhood Experiences (ACEs) and health disparities.
- Identify assets for maternal and child health.
- Develop and implement a prioritized maternal and child health prevention plan using life course approaches and an understanding of health priorities.
- Advocate and seek funding for maternal and child health policies and initiatives.
- Identify, disseminate and promote evidence-based information about early interventions in the prenatal and early childhood period that optimize lifelong health and social-emotional development.

- Identify, disseminate, and promote evidence-based information about early interventions in the prenatal period to lower infant mortality and pre-term birth outcomes.

Access to Clinical Care

The Access to Clinical Care area includes programs and activities for assuring access to specific preventive and primary care clinical services.

- Provide timely, accurate and locally relevant information on how to access and navigate the health care system.
- Assure access to family planning services.
- Assure access to maternal and infant services (e.g., maternity support, WIC).
- Assure access to STD and HIV testing and treatment.
- Link community members to existing clinical services (including oral health services) and health insurance resources in the community.
- Link community members to existing behavioral health services in the community.

Appendix D: Endnotes

1. Institute of Medicine. (2012). *For the Public's Health: Investing in a healthier future.* Washington, DC: The National Academies Press.

2. Ibid.

3. RESOLVE. (2014). *Defining and Constituting Foundational Capabilities and Areas — Version 1.* Washington, DC: RESOLVE.

4. Public Health Leadership Forum, 2014. *V-1 Foundational Capabilities and Areas with Addendum.* Available at http://www.resolv.org/site-foundational-ph-services/files/2014/04/V-1-Foundational-Capabilities-and-Areas-and-Addendum.pdf

KANSAS HEALTH INSTITUTE

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