

# **Federal Funding of Public Health Activities in Kansas**

**November 2009**

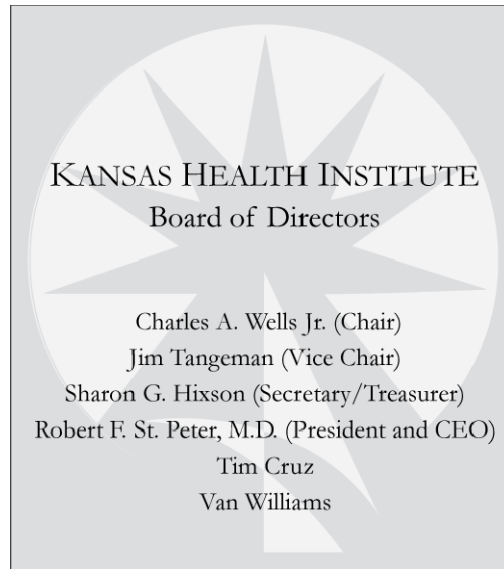
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## EXECUTIVE SUMMARY

Compared with other states, Kansas receives less federal public health funding per capita from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). The *Shortchanging America's Health* reports, published in 2008 and 2009 by the Trust for America's Health (TFAH), have ranked states by the levels of public health funding that they receive, but have not provided additional details that would enable Kansas policymakers and public health leaders to better understand the reasons for the state's low funding levels.

The Kansas Health Institute conducted a comprehensive review of available funding awards data to identify potential areas of opportunity for increasing Kansas funding levels. KHI used three sources of information to complete this assessment: 1) funding awards data from the U.S. Department of Health and Human Services Tracking Accountability in Government Grants (TAGGS) database, 2) funding program descriptions from the U.S. Catalog of Federal Domestic Assistance (CFDA), and 3) key informant interviews with representatives of Kansas organizations that have had direct experience seeking and obtaining federal public health funding. Although funding programs that support public health initiatives are administered by many federal agencies, we restricted the scope of this study to programs administered by either CDC or HRSA, because they represent a large share of the total federal funding for public health activities.

Our analysis confirms that per capita levels of public health funding allocated to Kansas entities from CDC and HRSA are significantly less than levels in the majority of other states. Kansas ranked 32<sup>nd</sup> among states (including Washington, D.C.) for per capita funding received from CDC in federal fiscal year 2008, and ranked last among states for funds awarded by HRSA. A breakdown of funding by grantee organizational type indicates that CDC funding awarded to state governmental entities in Kansas is on par with other states, but HRSA funding for these entities is somewhat lower than that of other states. Per capita funding levels awarded to Kansas county and local governmental entities and nonprofit organizations lag significantly behind those of other states for both CDC and HRSA funding. Summarization by funding area reveals that programs related to HIV/AIDS account for significant portions of the Kansas per capita funding

deficits (81.5 percent of the CDC funding deficit and 69.5 percent of the HRSA funding deficit), with funding deficit defined as the difference between per capita funding levels in Kansas and the national average. Several of these funding programs are either formula-based, with funding allocation based on existing disease burden, or eligibility-restricted to specific geographic regions with high prevalence of HIV/AIDS. Kansas has the good fortune of having relatively low rates of HIV/AIDS, so federal funding allocations for these programs are lower in Kansas.

As long as the funding emphasis remains on programs related to HIV/AIDS, it is unlikely that Kansas will rank high among states for public health funding awards from CDC and HRSA. However, the state has the opportunity to increase funding levels through other discretionary grant programs. But, for most of these programs, Kansas applicants face significant barriers to assembling competitive proposals, due to factors including an applicant's small organizational size, the small target populations served, the lack of internal capacity to identify relevant funding opportunities and perform grant writing, the lack of access to current data to support the need for services, and an organization's lack of research expertise in specialized areas such as occupational safety and health.

Success in increasing funding levels will likely require up-front investments in infrastructure and capacity-building to better position Kansas organizations as successful funding candidates. In addition, the program areas of occupational and agricultural health and maternal and child health are potential areas in which Kansas can increase funding.

## INTRODUCTION

Public health services play a vital role in protecting the population's health. While health care services are delivered at the individual level and focus primarily on treating a disease or health condition, public health focuses on disease prevention at the population level. Historically, public health services have been instrumental in the reduction and eradication of infectious diseases such as smallpox and tuberculosis. Although today the historical concerns with infectious diseases have been in part supplanted by those focused on chronic diseases, the role of public health in disease prevention and health promotion continues to be crucial. A robust system of public health services that identifies emerging diseases, develops effective prevention and health promotion strategies, and provides basic preventive services is necessary to protect and improve the population's health. Many public health agencies also play a vital role in the health care safety net, offering primary health care services to individuals who would otherwise lack access to the health care system.

Because public health is primarily concerned with protecting the health of populations, it has traditionally been viewed as a responsibility of government. As a result, financial support for public health services has come primarily from government sources. Public health funding at the local level is usually a mix of dollars from federal, state, and local governments, supplemented by reimbursement for fee-based health care services and, sometimes, grant funding from private sources. In recent years, there has been a renewed interest in strengthening the capacity of our public health systems, with a focus on emergency preparedness. With this interest in capacity-building has come a recognition that public health funding levels have been largely insufficient over recent decades. As a result, more attention has been given to understanding how public funding in support of public health services is allocated and applied.

In 2008 and 2009, TFAH published reports comparing the distribution of federal public health dollars to states. Both reports found per capita levels of public health funding awarded to Kansas agencies and organizations were substantially less than the per capita federal funding to other states; Kansas ranked 41<sup>st</sup> for CDC funding and 51<sup>st</sup> for HRSA funding in federal fiscal year 2008. The possible explanations for the apparent funding gap in Kansas are many, and the summary data included in the TFAH reports left many questions unanswered.

This study, initiated by KHI, attempted to investigate more deeply the levels of federal public health funding awarded to Kansas compared with other states to help public health leaders in Kansas better understand the funding process. The study included two phases of information gathering: 1) analysis of public health funding award data, and 2) interviews with key informants to elicit their experiences and perspectives. The goals of the study were to develop an enhanced understanding of why Kansas received low levels of federal public health funding, and to identify existing opportunities for the state to receive additional federal funds in support of public health.

Although numerous federal agencies award funding for purposes that relate to public health services, the focus of this study has been limited to two primary sources of public health support: CDC and HRSA. This method was applied for two reasons: to gain a more complete understanding of the findings presented in the TFAH reports (which limited analyses to funding awarded by these two agencies plus funding from the Office of the Assistant Secretary of Preparedness and Response), and to keep the scope of this study manageable. CDC and HRSA alone administer more than 150 funding programs, each with a unique set of eligibility and funding requirements. Nevertheless, when considering the results of this study it is important to remember that there are many other federal funding streams supporting public health programs that are outside of the scope of those administered by CDC and HRSA. Examples include: the Women, Infants and Children Nutrition Program administered by the U.S. Department of Agriculture; senior nutrition programs administered by the U.S. Administration on Aging; abstinence education programs funded by the Administration for Children and Families; and many more.

## **BACKGROUND**

At the national level, CDC serves as the primary federal agency for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States. To accomplish its mission, CDC actively monitors disease levels through surveillance and data collection; conducts research in developing and testing effective disease prevention, control and health promotion approaches; administers a national program to assure safe and healthful workplace conditions;



conducts workforce training in disease control and prevention; and administers a national program for improving the performance of clinical laboratories.

The mission of HRSA is to provide national leadership, program resources and services needed to improve access to culturally competent, quality health care. As the federal agency primarily responsible for assuring access to health care, HRSA's goals and activities focus on uninsured, underserved, and special needs populations and are designed to increase access to care, improve the quality of health care, and protect the health and well-being of vulnerable populations. HRSA funding awards support primary health care and prevention clinics for low-income clients, primary care and support services for HIV/AIDS patients, maternal and child health services, health professions training and workforce development, and the availability of accessible health care in rural areas. The agency also oversees the nation's organ and bone marrow transplantation system, administers a drug discount program for safety net providers, and supports both the nation's poison control centers and the vaccine injury compensation program.

Both CDC and HRSA provide substantial grant funding to support state and local government entities, universities and institutes of higher education, and nonprofit and for-profit organizations in endeavors relating to public health. In federal fiscal year 2008, grants awarded by CDC totaled \$4.4 billion; those awarded by HRSA totaled \$5.8 billion.

Two types of grants are awarded through CDC and HRSA: mandatory and discretionary. Mandatory grants are those that the agencies are required by statute to award if the grant recipient (usually a state governmental entity) submits an acceptable plan or application and meets the defined eligibility and compliance requirements. Mandatory grants are either entitlement funds such as those to support Medicaid programs, or block or formula grants. A block grant represents a consolidation of related programs into one legislative package. Authorizing legislation determines the purpose, eligibility, and scope of the block grant program, and the grant recipient, usually a state, has substantial authority over the use of grant funds and the types of activities they support. Formula grants typically are prescribed by law or regulation, and funding awards are based upon such factors as the community's population, poverty level, disease burden and other relevant factors. Discretionary grants permit the granting agency to

exercise judgment in selection of applicant/recipient organizations, through a competitive process. The majority of awards through CDC and HRSA are discretionary: in FFY 2008, mandatory awards accounted for only 2.1 percent of the dollars awarded by CDC and 9.3 percent of those awarded by HRSA.

There are a number of possible explanations for the lower funding levels Kansas receives compared with other states. These explanations include the possibility that Kansans enjoy more favorable health than residents in other states and, therefore, have less need for some public health programs, or the possibility that Kansas-based organizations do not have the capacity to manage large grants, or that they have been less competitive in applying for federal grant funds. This study attempted to investigate these possible explanations, as well as others, through a combination of in-depth analysis of funding awards data and firsthand interviews with key stakeholders in Kansas who have experience seeking federal grant funding for public health endeavors.

## **METHODS**

CDC and HRSA funding awards data were obtained by querying the U.S. Department of Health and Human Services (HHS) Tracking Accountability in Government Grants System (TAGGS) database, available at <http://taggs.hhs.gov>. TAGGS is the department's central repository for all HHS grant award data, and tracks obligated grant funds of both mandatory and discretionary grant programs at the transaction level. Each transaction record includes information about the recipient organization, the program under which the funding was awarded, timeframe, and dollar amount of the transaction. Records of all CDC and HRSA awards to U.S. entities during federal fiscal years 2004 to 2008 were downloaded and analyzed for this study. In review of the data, it was noted that a number of grants to foreign-based entities contained erroneous entries in the location fields that resulted in their being included in the query results as paid to a U.S. entity. All award records in the downloaded dataset used for this study were scrutinized and those where recipient information indicated that the award was to a foreign entity were removed. As a result, total awards amounts reported in this study are somewhat less than those reported in the TFAH reports and elsewhere (this is particularly applicable to CDC awards). The summary figures presented in this report represent only awards to entities whose

primary business location lies within the 50 U.S. states or the District of Columbia. Population counts utilized to calculate per capita funding levels were also restricted to the 50 states plus Washington, D.C.

Funding awards data were summarized by various descriptive groupings, including the year of award, grantee classification type, award type, program office, and program name. Per capita funding levels, calculated by dividing the total grant dollars awarded to each state by the state's population, were used to rank the states and compare state funding to the national average. Per capita funding levels were used to identify "funding gaps" for Kansas, represented by the amount of underfunding for the state compared to the national average per capita figures.

In addition to the grant awards data downloaded from the TAGGS database, background information on the numerous funding programs administered by CDC and HRSA was obtained from the Catalog of Federal Domestic Assistance (CFDA) website, [www.cfda.gov](http://www.cfda.gov). CFDA summaries provide information about each funding program's objectives, uses and restrictions on awarded funding, applicant eligibility, funding formula and match requirements and other program-specific details. Programmatic information was used in conjunction with funding awards data to analyze and identify possible opportunities for increasing funding for Kansas entities.

While grant awards data are useful in revealing patterns in the types of funding awarded and the characteristics of recipient organizations, the data alone cannot identify possible barriers to the submission of successful grant applications, or reasons why eligible organizations may choose not to submit applications for funding. For these questions, key informant interviews were conducted with a small number of individuals whose organizations had been awarded grant funding through CDC or HRSA. Informants were asked about their organization's internal processes and capacity for identifying and responding to grant funding announcements, the apparent barriers to obtaining federal grant funding, and suggestions for actions that might be taken to increase funding awards to Kansas organizations. Information from these interviews was summarized and analyzed for recurrent themes.

## **FINDINGS**

### **ANALYSIS OF FUNDING AWARDS DATA**

Looking at overall funding awarded by CDC and HRSA, our findings are similar to those reported by TFAH. Using per capita funding allocation as a measure, in federal fiscal year 2008 Kansas agencies received \$9.49 per person from CDC and \$9.85 per person from HRSA, compared to a national average of \$11.58 from CDC and \$18.84 from HRSA. Kansas ranked 32<sup>nd</sup> among states for CDC funding, and last at 51<sup>st</sup> for HRSA funding awards (Table 1).

The funding awards data extracted from the TAGGS database were summarized by a number of categorical descriptors, including the type of organization receiving the funds, the federal program office through which the funds were disbursed, the name of the specific program through which funds were awarded, fiscal year in which the grants were made, and the type of the funding award (block, cooperative agreement or discretionary). At each level, the total number of grants awarded, total dollars awarded, and dollars awarded per capita population were calculated. Comparisons were made between per capita funding levels for the entire U.S. and Kansas. Summary level data are presented in Tables 2 and 3.

### **Funding by Grantee Organizational Type**

The TAGGS database includes a categorical description of the organizational type of each grantee. Categories include governmental entities (federal, state, city, county, towns, villages, tribal), nonprofit organizations (public or private), private for-profit organizations (large business or small), individuals, and others. These categories merit some explanation. Grantee organizations such as universities and other institutions of higher education may be grouped in either a governmental category or as a nonprofit organization, depending on their ownership. Similarly, local health departments were most often categorized as a unit of county or local government. Health clinics were sometimes governmental entities, but were more often categorized as nonprofit organizations.

When CDC funding awards data were summarized by organizational type, levels of per capita funding to state governmental entities in Kansas were found to be similar to the national average of per capita funding for state governmental entities. The largest gaps in Kansas funding

awards were observed among nonprofit organizations (\$1.44 per capita in Kansas versus \$10.88 per capita nationally), and the combined grouping of county, city, local and tribal governments (\$0.09 in Kansas versus \$4.81 per capita nationally). Kansas for-profit organizations received funding at levels slightly higher than the national average (\$0.87 per capita in Kansas versus \$0.69 nationally).

Similar to Kansas' CDC funding figures, HRSA funding awards to local government and nonprofit agencies were significantly less than national funding levels, but funding to state governmental entities in Kansas also lagged behind federal funding levels (\$28.44 per capita in Kansas versus \$40.12 nationally). Kansas for-profit organizations received more per capita HRSA funding than the national average (\$6.09 per capita in Kansas versus \$2.00 nationally).

## **Funding by Program**

Within both CDC and HRSA there are numerous program offices, with distinct programmatic missions. The program offices administer multiple funding programs, each with a unique combination of purpose, eligibility requirements, and funding mechanisms. Examination of funding awards levels by funding program name was also helpful in identifying specific areas in which Kansas funding differed from national levels (selected results are shown in Tables 2 & 3).

The level of funding for each program was compared to the program eligibility criteria in order to identify opportunities that may exist to increase funding awards to Kansas entities. Details are displayed in Tables 4 and 5. Within the funding programs administered by CDC, two areas of programmatic focus accounted for more than 90 percent of the gap in per capita funding to Kansas versus the national rate. Programs relating to HIV/AIDS accounted for the largest per capita funding deficit of \$9.72 (\$2.98 in Kansas versus \$12.70 nationally), and made up 79.0 percent of the overall gap. Programs relating to Occupational Safety and Health, including Agricultural Safety and Health, accounted for another \$1.49 per capita deficit, or 12.1 percent of the funding gap. In several areas, including Childhood Lead Poisoning Prevention, Injury Control and Prevention, Emergency Preparedness, and State Health Planning and Development, Kansas per capita funding levels were higher than national rates.

Of the CDC grant programs related to HIV/AIDS, two discretionary funding programs may represent untapped opportunities for Kansas funding. The first is the HIV Prevention Activities — Health Department Based program. The purpose of this funding stream is to assist states and political subdivisions of states in meeting the costs of establishing and maintaining HIV prevention programs. State and local governmental entities are eligible to apply. Data from the TAGGS database show that Kansas received only \$0.54 per capita under this program, compared to a national rate of \$4.67. Representatives of the Kansas Department of Health and Environment have indicated, however, that they believe the TAGGS data to be incomplete, and that Kansas has actually received more funding through this program than indicated. The second HIV-related program presenting possible public health funding opportunities is the HIV Demonstration, Research, Public and Professional Education Projects. Open to state and local governments, and other public and nonprofit entities, the purpose of this program is to fund research to develop, test and disseminate improved HIV prevention strategies. Between federal fiscal years 2004 to 2008, Kansas received \$0.08 per capita in funding, compared to the national rate of \$2.80.

The third CDC funding area that stands out as a potentially untapped opportunity for public health funding in Kansas is a group of three programs related to Occupational and Agricultural Safety and Health. The largest of the three, the Occupational Safety and Health Program, funds the monitoring and surveillance of workplace hazards and injuries, evaluation of the effectiveness of workplace interventions, and expansion and development of occupational medicine and related training programs. Between 2004 and 2008, Kansas received only three grants under this program, totaling approximately \$557,000. The per capita funding level for Kansas was \$0.20, compared to \$1.63 nationally. These grants are available to state and local governments, specialized professional groups, and private nonprofit organizations. Bringing the Kansas funding level up to the national funding rate would result in an additional \$4,007,000 of federal funding reaching Kansas each year. Because this program is focused heavily toward research and professional training, universities would be the likely applicants.

Among the programs administered by HRSA, two program areas made up more than (103 percent) the overall gap in funding between Kansas and the national average. Programs related to HIV/AIDS accounted for \$26.83 (69.5 percent) of the overall state per capita funding deficit of

\$38.59. Consolidated Health Centers grants accounted for another \$12.93 (33.5 percent) of the funding gap. Kansas per capita funding exceeded national levels in several areas, including Bioterrorism Preparedness, Rural Medicine, and Health Professionals Training grants, but higher funding levels in these programs were insufficient to balance out the deficits in other areas.

Several HRSA-sponsored HIV/AIDS funding programs in which Kansas funding levels are less than national rates either restrict grantee eligibility or have funding formulas that prevent Kansas from gaining additional funding. The largest of these, HIV Care Formula Grants, are allocated to states by a federally defined formula based on the prevalence of HIV/AIDS among state populations. The population of Kansas has lower rates of HIV/AIDS than those of many other states, and consequently, receives less funding under this program. Other programs, such as the HIV Emergency Relief Project Grants and the Rapid Expansion of Antiretroviral Therapy programs, are open only to entities within designated geographic areas with high rates of HIV/AIDS, and Kansas is not included in the defined eligibility regions. Together, these three programs account for \$22.96 (86 percent) of the \$26.83 deficit in funding levels for HIV/AIDS — related programs in Kansas.

Funding for the Consolidated Health Centers (CHC) program is the second major area of Kansas funding deficits from HRSA sources. The objective of these grants is to assure access to primary health care services in designated underserved areas. As such, eligibility is restricted to health care providers in HRSA-designated Medically Underserved Areas or Medically Underserved Populations. The CHC grants are highly competitive, and for the most part have been limited to the continuation of service provision in previously funded areas, rather than expansion of services or establishment of new service areas. Funding levels are negotiated based upon service delivery costs. Because of the narrowly targeted eligibility for these grants, it is somewhat unclear how much, if any, potential exists for increasing the level of funding awarded to Kansas entities.

## **INFORMANT COMMENTS**

Key informants identified a number of barriers to bringing federal grant dollars to Kansas, and frequently cited characteristics of the Kansas population as impediments to obtaining federal

public health grants, particularly at the county and local government levels. Kansas has 100 local public health departments, many of which serve small populations in rural counties. Funding programs that focus on a subgroup of the overall population, such as individuals with diabetes or HIV/AIDS, restrict the potential grant target population even further, making it difficult to construct a compelling case for federal funding to serve a small number of individuals. In addition to the challenges of serving rural areas, Kansas has the good fortune of having a population that is in many respects healthier than populations of other states. Kansas ranks among the one-third of states with the lowest rates of HIV/AIDS, asthma, diabetes, hypertension, and sexually transmitted diseases among adult populations. Because nearly 40 percent of HRSA funding awarded in federal fiscal year 2008 was directed to prevention and treatment programs for HIV/AIDS, and a significant portion of that funding is formula-based or directed to designated geographic areas of high need, the lower rates of HIV/AIDS among Kansans has a significant impact on the low HRSA funding levels in Kansas.

The federal funding programs that fall within the scope of this study include several that support research endeavors, and others directed toward support of educational and training programs for health professionals. Kansas has not cultivated a strong concentration of public health research programs, and does not offer some types of health professions training programs, such as a dental school. Additionally, few national or international public health or health professional associations or organizations have selected Kansas as their home base and these organizations also are eligible for some funding programs administered by CDC and HRSA. States with higher concentrations of corporate offices for such organizations, such as New York and Washington, D.C., have a significant number of grant awards contribute to the overall state funding levels.

Informants representing local health departments and nonprofit organizations often identified a lack of access to current, population-based data as a barrier to constructing successful funding proposals. Commonly used data sources for public health proposals — such as vital statistics and Behavioral Risk Factor Surveillance data — are typically more than a year old when released for public use. The most current available data from the U.S. Decennial Census, frequently used for description of population demographics, may be several years old and may not reflect current



population characteristics. For geographic areas with small populations, summary-level data may not be available at all due to restrictions placed on the public-use data to protect individual privacy. Public health practitioners also expressed frustration with the current lack of studies evaluating the effectiveness of public health programs and interventions. They felt that a stronger evidence base would enable them to assemble more compelling funding proposals, as well as serve their target population more effectively.

Informants also noted that, in some cases, an up-front investment in infrastructure and capacity-building is needed so that the applicant organization meets the minimum requirements for funding eligibility. The successful applicant organization must be able to convince the funder that it has the skills, experience, and infrastructure to be able to successfully execute the proposed project. Informants frequently identified their organization's need for staff with enhanced technical skills and expertise in disciplines such as epidemiology and program evaluation.

Informants commented that time intervals between funding announcements and proposal submission deadlines are often short, and application requirements are complex. One informant commented that it is not uncommon for an applicant organization to pay a grant writing professional thousands of dollars for assistance in preparing an application. Another commented that success in winning federal grant funding is often an iterative process requiring refinement and resubmission of proposals across several funding cycles, and that it is probably unrealistic to expect to be successful with the first application. For the inexperienced, the application process can be intimidating.

The complexities do not end with an award of grant funding. Excessive burden of grant administration was also cited more than once as a disincentive to seeking federal funds. For a small organization, the administrative burden imposed by financial accounting and reporting requirements may result in a grant award being perceived as more trouble than gain.

Concerns about sustainability were also frequently mentioned as a disincentive to application for federal public health funding. Many funding programs are project-based and support the

development and implementation of new programs; they cannot be used to sustain ongoing operation of existing programs. It is frustrating to both public health practitioners and stakeholders when a successful program must be discontinued due to a lack of sustainable funding.

## **DISCUSSION**

The results of our analysis suggest that a combination of two factors — a strong funding emphasis by the federal government on HIV/AIDS-related programming, and a relatively low incidence of HIV/AIDS in Kansas — is the primary explanation for why Kansas organizations receive low levels of public health funding.

Nevertheless, some opportunity for improvement may exist. Iowa, which has an even lower prevalence of HIV/AIDS than Kansas, fares better in the funding rankings (Table 6). Areas where Iowa funding levels exceed those in Kansas include the CDC Intervention and Technical Assistance grants and the Occupational Safety and Health grants (including Agricultural Health & Safety). From the HRSA programs, Iowa per capita funding levels surpass those in Kansas in the Consolidated Health Centers program, the Renovation/Construction of Health Facilities program, the Maternal and Child Health Block Grants, and the Maternal and Child Health Federal Consolidated Programs. With the exception of the Maternal and Child Health Block Grants, these are discretionary funding programs, and therefore opportunities may exist for Kansas to increase its discretionary funding awards. Additionally, review of transaction-level detail of federal funding in Iowa suggests that universities there have been more successful in obtaining funding for research initiatives than have Kansas universities. This point is particularly true for CDC grant awards.

## **STEPS THAT MIGHT BE UNDERTAKEN TO INCREASE FEDERAL PUBLIC HEALTH FUNDING**

Close examination of the details of CDC and HRSA funding programs suggests that the low funding levels in Kansas are due in large part to funding criteria and the characteristics of the Kansas population. Some opportunities for increased funding may exist; however, in order to be

considered as competitive applicants, Kansas entities will need to make some investments in infrastructure development and capacity-building.

Small local health departments in Kansas have rarely been the recipients of direct funding from either CDC or HRSA. The challenges of small organizations serving small target populations could be remedied by focusing project proposals and interventions at regional levels. Similarly, efficiencies in grant administration could be achieved through regional cooperation and collaboration. In the last eight years, local health departments in Kansas have formed alliances and shared resources through regional agreements. Although regional groups of local health departments in Kansas have not yet submitted funding proposals to either CDC or HRSA, there have been some promising efforts toward submission of proposals to private funders. Collaboration between public health organizations and universities or other institutions of higher education could be mutually beneficial: public health organizations would gain access to technical expertise in research and evaluation, and academic institutions would gain opportunities to conduct applied research with public health partners.

The first step involved in the grant funding process is to identify relevant funding opportunities for which the potential applicant organization is eligible. Monitoring and screening grant announcements can be a time-consuming process, and small organizations with limited staff and heavy client caseloads rarely have time to dedicate to the process. Networking and collaborating with other entities in monitoring relevant funding opportunities could increase the number of potential funding applications from Kansas organizations.

Additionally, improved access to data would enhance the ability of funding applicants to assemble strong proposals with well-documented justifications of need for the services being proposed. Although local health departments in Kansas submit key public health service data (information about immunization, infectious diseases, and data from the Women, Infants and Children Nutrition Program) to state systems on an ongoing basis, the local health departments have only limited ability to query the system and generate reports with real-time data. Efforts are currently underway to address some of the existing limitations to data access, and new data access options should benefit both the development of funding proposals and the evaluation of

funded programs. The availability of current local and state community health assessments could also provide potential funding applicants with a readily available source of data to support proposals.

Occupational Safety and Health is identified as a program area in which Kansas has an opportunity to expand its level of federal funding. Kansas universities do not currently offer a graduate-level concentration in Occupational Health or Industrial Hygiene, and other states that offer these academic programs have been awarded funds for multiple projects. If current efforts to establish an accredited graduate-level School of Public Health in Kansas are successful, perhaps the newly expanded school will include a concentration of expertise in these disciplines, and could help to position Kansas as a more competitive applicant for research funding.

## **CONCLUSIONS**

Our analysis confirms that per capita levels of public health funding allocated to Kansas entities from CDC and HRSA are substantially lower than funding levels in the majority of other states. Closer scrutiny of the programs that account for the largest funding gaps indicates that it is unlikely that Kansas will ever rank among the states receiving the most per capita federal funding for public health programs. A heavy emphasis of federal funding on programs related to HIV/AIDS services, coupled with a relatively low rate of HIV/AIDS among the Kansas population, limits the eligibility of Kansas organizations for several sizable funding streams.

As demonstrated by the funding levels of states similar to Kansas (like Iowa), Kansas may have the opportunity to expand its federal funding stream for public health programs. Successful pursuit of that opportunity, however, may require that state organizations first make capacity-building investments in order to position themselves as stronger grant competitors.

**Table 1. CDC and HRSA Funding, by State, FFY 2008**

State	CDC Funding			HRSA Funding		
	Total	Per Capita	Rank	Total	Per Capita	Rank
U.S.	\$3,520,000,000	\$11.58		\$5,730,000,000	\$18.84	
Alabama	\$43,500,000	\$9.33	35	\$111,000,000	\$23.81	15
Alaska	\$25,200,000	\$36.72	3	\$48,400,000	\$70.52	2
Arizona	\$42,800,000	\$6.58	48	\$81,700,000	\$12.57	45
Arkansas	\$25,500,000	\$8.93	38	\$48,800,000	\$17.09	28
California	\$307,000,000	\$8.35	41	\$567,000,000	\$15.43	37
Colorado	\$55,000,000	\$11.13	25	\$105,000,000	\$21.26	19
Connecticut	\$42,300,000	\$12.08	21	\$66,400,000	\$18.96	25
Delaware	\$16,100,000	\$18.44	10	\$17,500,000	\$20.04	22
DC	\$241,000,000	\$407.21	1	\$116,000,000	\$196.00	1
Florida	\$119,000,000	\$6.49	49	\$356,000,000	\$19.42	24
Georgia	\$121,000,000	\$12.49	20	\$154,000,000	\$15.90	35
Hawaii	\$23,600,000	\$18.32	11	\$41,300,000	\$32.06	9
Idaho	\$15,500,000	\$10.17	27	\$29,600,000	\$19.42	23
Illinois	\$116,000,000	\$8.99	37	\$224,000,000	\$17.36	27
Indiana	\$35,700,000	\$5.60	51	\$66,000,000	\$10.35	50
Iowa	\$34,400,000	\$11.46	24	\$49,100,000	\$16.35	33
Kansas	\$26,600,000	\$9.49	32	\$27,600,000	\$9.85	51
Kentucky	\$30,000,000	\$7.03	46	\$70,100,000	\$16.42	32
Louisiana	\$64,300,000	\$14.58	16	\$104,000,000	\$23.58	16
Maine	\$21,600,000	\$16.41	14	\$26,500,000	\$20.13	20
Maryland	\$210,000,000	\$37.28	2	\$271,000,000	\$48.10	3
Massachusetts	\$122,000,000	\$18.78	9	\$233,000,000	\$35.86	6
Michigan	\$88,500,000	\$8.85	39	\$122,000,000	\$12.20	46
Minnesota	\$60,300,000	\$11.55	23	\$57,500,000	\$11.01	49
Mississippi	\$29,800,000	\$10.14	29	\$116,000,000	\$39.47	4
Missouri	\$47,600,000	\$8.05	43	\$101,000,000	\$17.09	29
Montana	\$17,200,000	\$17.78	12	\$35,300,000	\$36.49	5
Nebraska	\$23,400,000	\$13.12	19	\$27,300,000	\$15.31	38
Nevada	\$24,000,000	\$9.23	36	\$35,300,000	\$13.58	41
New Hampshire	\$19,700,000	\$14.97	15	\$20,800,000	\$15.81	36
New Jersey	\$81,500,000	\$9.39	34	\$148,000,000	\$17.05	30
New Mexico	\$27,600,000	\$13.91	18	\$65,800,000	\$33.16	8
New York	\$460,000,000	\$23.60	5	\$547,000,000	\$28.07	10
North Carolina	\$92,300,000	\$10.01	31	\$139,000,000	\$15.07	39
North Dakota	\$13,200,000	\$20.58	7	\$15,900,000	\$24.79	13

*Table 1 (cont'd). CDC and HRSA Funding, by State, FFY 2008*

State	CDC Funding			HRSA Funding		
	Total	Per Capita	Rank	Total	Per Capita	Rank
Ohio	\$76,200,000	\$6.63	47	\$127,000,000	\$11.06	48
Oklahoma	\$34,400,000	\$9.44	33	\$47,200,000	\$12.96	44
Oregon	\$40,500,000	\$10.69	26	\$68,700,000	\$18.13	26
Pennsylvania	\$95,800,000	\$7.70	44	\$199,000,000	\$15.99	34
Rhode Island	\$20,900,000	\$19.89	8	\$26,100,000	\$24.84	12
South Carolina	\$45,500,000	\$10.16	28	\$105,000,000	\$23.44	17
South Dakota	\$13,200,000	\$16.41	13	\$21,400,000	\$26.61	11
Tennessee	\$52,100,000	\$8.38	40	\$105,000,000	\$16.89	31
Texas	\$155,000,000	\$6.37	50	\$342,000,000	\$14.06	40
Utah	\$27,500,000	\$10.05	30	\$37,000,000	\$13.52	42
Vermont	\$15,100,000	\$24.31	4	\$14,000,000	\$22.53	18
Virginia	\$55,600,000	\$7.16	45	\$103,000,000	\$13.26	43
Washington	\$76,700,000	\$11.71	22	\$156,000,000	\$23.82	14
West Virginia	\$25,900,000	\$14.27	17	\$61,600,000	\$33.95	7
Wisconsin	\$46,700,000	\$8.30	42	\$63,200,000	\$11.23	47
Wyoming	\$12,200,000	\$22.90	6	\$10,700,000	\$20.09	21

**Table 2. CDC Funding, FFY 2004–2008**

Federal Fiscal Year	U.S.			KANSAS		
	Awards	\$ Awarded	\$/Capita	Awards	\$ Awarded	\$/Capita
2004	3,981	\$4,300,000,000	\$14.14	40	\$31,000,000	\$11.06
2005	3,744	\$3,670,000,000	\$12.07	40	\$25,500,000	\$9.10
2006	3,367	\$2,460,000,000	\$8.09	35	\$16,900,000	\$6.03
2007	2,742	\$3,390,000,000	\$11.15	24	\$25,500,000	\$9.10
2008	3,154	\$3,520,000,000	\$11.58	30	\$26,600,000	\$9.49
<b>Total</b>	<b>16,988</b>	<b>\$17,300,000,000</b>	<b>\$56.90</b>	<b>169</b>	<b>\$125,000,000</b>	<b>\$44.61</b>
<b>Grantee Class</b>						
Federal Government	11	\$3,567,556	\$0.01	0	\$0	\$0.00
State Government	10,466	\$12,300,000,000	\$40.45	127	\$119,000,000	\$42.47
County, City, Local, Tribal	1,318	\$1,462,300,000	\$4.81	12	\$253,856	\$0.09
Nonprofit Organizations	4,657	\$3,307,000,000	\$10.88	14	\$4,040,567	\$1.44
Private For-Profit Organizations	490	\$210,600,000	\$0.69	16	\$2,446,876	\$0.87
<b>Program</b>						
Assistance Programs for Chronic Disease Prevention & Control	443	\$253,000,000	\$0.83	3	\$1,285,361	\$0.46
CDC Investigations & Technical Assistance	4,362	\$4,210,000,000	\$13.85	28	\$33,900,000	\$12.10
Childhood Lead Poisoning Prevention	208	\$142,000,000	\$0.47	5	\$1,986,147	\$0.71
Epidemiologic Research Studies of AIDS/HIV in Selected Population Groups	473	\$591,000,000	\$1.94	7	\$6,288,890	\$2.24
HIV Demonstration, Research, Public and Professional Education Projects	474	\$851,000,000	\$2.80	1	\$215,562	\$0.08
HIV Prevention Activities—Health Department Based	616	\$1,420,000,000	\$4.67	3	\$1,509,605	\$0.54
Immunization Grants	792	\$3,480,000,000	\$11.45	13	\$29,700,000	\$10.60
Injury Prevention and Control Research and State and Community-Based Programs	1,438	\$508,000,000	\$1.67	33	\$6,081,479	\$2.17
Occupational Safety and Health Program	1,127	\$495,000,000	\$1.63	3	\$557,813	\$0.20
Public Health Emergency Preparedness	144	\$1,580,000,000	\$5.20	2	\$17,100,000	\$6.10

**Table 3. HRSA Funding, FFY 2004–2008**

Federal Fiscal Year	U.S.			KANSAS		
	Awards	\$ Awarded	\$/Capita	Awards	\$ Awarded	\$/Capita
2004	8,751	\$5,770,000,000	\$18.98	93	\$36,700,000	\$13.10
2005	9,067	\$5,980,000,000	\$19.67	89	\$33,800,000	\$12.06
2006	7,389	\$5,280,000,000	\$17.37	133	\$26,700,000	\$9.53
2007	9,089	\$5,150,000,000	\$16.94	90	\$24,200,000	\$8.64
2008	7,984	\$5,730,000,000	\$18.84	81	\$27,600,000	\$9.85
<b>Total</b>	<b>42,280</b>	<b>\$27,900,000,000</b>	<b>\$91.76</b>	<b>486</b>	<b>\$149,000,000</b>	<b>\$53.17</b>
<b>Grantee Class</b>						
Federal Government	3	\$254,966	\$0.00	0	\$0	\$0.00
State Government	15,777	\$12,200,000,000	\$40.12	254	\$79,700,000	\$28.44
County, City, Local, Tribal	3,757	\$3,982,000,000	\$13.10	18	\$10,380,944	\$3.70
Nonprofit Organizations	21,443	\$11,010,000,000	\$36.21	119	\$41,900,000	\$14.95
Private For-Profit Organizations	1,118	\$608,000,000	\$2.00	95	\$17,075,000	\$6.09
<b>Program</b>						
Bioterrorism Training and Curriculum Development Program	126	\$70,600,000	\$0.23	7	\$3,337,225	\$1.19
Consolidated Health Centers	10,241	\$7,970,000,000	\$26.21	86	\$37,200,000	\$13.28
Grants for Training in Primary Care Medicine & Dentistry	1,606	\$266,000,000	\$0.87	39	\$5,066,330	\$1.81
National Bioterrorism Hospital Preparedness	195	\$924,000,000	\$3.04	3	\$9,112,919	\$3.25
Project Grants for Renovation or Construction — Health Care & Other Facilities	2,090	\$974,000,000	\$3.20	14	\$5,997,879	\$2.14
Public Health and Social Services Emergency	131	\$492,000,000	\$1.62	2	\$5,288,830	\$1.89
Rural Health Care Services Outreach and Rural Health Network Development	1,114	\$168,000,000	\$0.55	12	\$1,599,712	\$0.57
Rural Telemedicine Grants	140	\$26,400,000	\$0.09	10	\$1,257,122	\$0.45
Small Rural Hospital Improvement Grants	300	\$72,600,000	\$0.24	6	\$4,303,536	\$1.54
State Rural Hospital Flexibility Program	389	\$186,000,000	\$0.61	6	\$2,987,041	\$1.07



**Table 4. Major Funding Programs Administered by CDC, FFY 2004–2008**

<b>Program Title</b>	<b>Objective</b>	<b>Type of Funding</b>	<b>Eligible Applicants</b>	<b>U.S. \$ Total \$ Per Capita</b>	<b>Kansas \$ Total \$ Per Capita</b>
CDC Investigations & Technical Assistance	To assist in controlling communicable & chronic diseases and other preventable health conditions	Cooperative Agreements (Discretionary)	State & local government, public or private nonprofits, for-profit organizations	\$4,210,000,000 \$13.85	\$33,900,000 \$12.10
Immunization Grants	To assist in establishing and maintaining immunization programs	Project Grants (Discretionary)	State & local government, public nonprofit organizations	\$3,480,000,000 \$11.45	\$29,700,000 \$10.60
Public Health Emergency Preparedness	To develop emergency-ready public health departments	Cooperative Agreements (Discretionary)	State, local government	\$1,580,000,000 \$5.20	\$17,100,000 \$6.10
HIV Prevention Activities — Health Department Based	To assist in meeting the costs of establishing and maintaining HIV prevention programs	Project Grants (Discretionary)	State, local government	\$1,420,000,000 \$4.67	\$1,509,605 \$0.54
HIV Demonstration, Research, Public & Professionals Education Projects	To assist with research on the prevention of HIV infection at the community level	Project Grants (Discretionary)	State & local government, public or private nonprofit organizations	\$851,000,000 \$2.80	\$215,562 \$0.08

**Table 4 (cont'd). Major Funding Programs Administered by CDC, FFY 2004–2008**

<b>Program Title</b>	<b>Objective</b>	<b>Type of Funding</b>	<b>Eligible Applicants</b>	<b>U.S. \$ Total \$ Per Capita</b>	<b>Kansas \$ Total \$ Per Capita</b>
Epidemiologic Research Studies AIDS and HIV Infection in Selected Population Groups	To support research on important HIV-related epidemiologic issues. Special interest in minority populations	Project Grants (Discretionary)	State & local government, public or private nonprofit organizations	\$591,000,000 \$1.94	\$6,288,890 \$2.24
Injury Prevention & Control Research and State & Community Based Programs	To support research on priority injury prevention & control issues, and to develop & evaluate methods of injury surveillance	Project Grants, Cooperative Agreements (Discretionary)	State & local government, public or private organizations (for-profit or nonprofit)	\$508,000,000 \$1.67	\$6,081,479 \$2.17
Preventive Health & Health Services Block Grant	To provide states and Native American Tribes with resources to improve the health status of their populations	Formula Grants (Mandatory)	State & Tribal governments	\$509,000,000 \$1.67	\$5,195,537 \$1.85
Occupational Safety & Health Program	To recognize and monitor workplace hazards, to evaluate effectiveness of prevention efforts	Project Grants, Cooperative Agreements, Training (Discretionary)	State & local government, specialized groups, private nonprofit organizations	\$495,000,000 \$1.63	\$557,813 \$0.20

**Table 5. Major Funding Programs Administered by HRSA, FFY 2004–2008**

<b>Program Title</b>	<b>Objective</b>	<b>Type of Funding</b>	<b>Eligible Applicants</b>	<b>U.S. \$ Total \$ Per Capita</b>	<b>Kansas \$ Total \$ Per Capita</b>
Consolidated Health Centers	To improve health of underserved communities and vulnerable populations by insuring access to health care services	Project Grants (Discretionary)	Public & private nonprofits in designated underserved areas	\$7,970,000,000 \$26.21	\$37,200,000 \$13.28
HIV Care Formula Grants	To enable states to improve quality, availability, and organization of health care and support services for individuals and families with HIV disease	Formula Grants (Mandatory)	State government	\$5,270,000,000 \$17.33	\$16,200,000 \$5.78
HIV Emergency Relief Project Grants	To support HIV services in designated geographic areas severely affected by HIV/AIDS	Project Grants (Discretionary)	State & local governments in designated geographic areas	\$2,850,000,000 \$9.37	\$0 \$0.00
Maternal & Child Health Block Grants	To support states in planning, promoting, coordinating, & evaluating health care for pregnant women, mothers, infants, children, and children with special health care needs	Formula Grants (Mandatory)	State government	\$2,740,000,000 \$9.01	\$24,100,000 \$8.60
Project Grants Renovation/ Construction	To construct, renovate, expand, equip or modernize health care and related facilities	Project Grants (Discretionary)	State & local government, public nonprofits, quasi-public nonprofits	\$974,000,000 \$3.20	\$5,997,879 \$2.14

**Table 5 (cont'd). Major Funding Programs Administered by HRSA, FFY 2004–2008**

<b>Program Title</b>	<b>Objective</b>	<b>Type of Funding</b>	<b>Eligible Applicants</b>	<b>U.S. \$ Total \$ Per Capita</b>	<b>Kansas \$ Total \$ Per Capita</b>
National Bioterrorism Hospital Preparedness	To ready hospitals and health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies	Project Grants (Discretionary)	State & local government	\$924,000,000 \$3.04	\$9,112,919 \$3.25
Maternal & Child Health Federal Consolidated Programs	To carry out special MCH projects of regional & national significance (training & research, genetic testing & counseling, information dissemination, grants relating to hemophilia, newborn screening)	Project Grants (Discretionary)	Public nonprofits, other public institutions	\$653,000,000 \$2.15	\$5,159,097 \$1.84
Rapid Expansion Antiretroviral Therapy Programs	To rapidly expand antiretroviral therapy to low- income HIV-infected persons in 15 targeted countries in Africa and the Caribbean	Cooperative Agreements (Discretionary)	Specialized group of health professionals	\$619,000,000 \$2.04	\$0 \$0.00
Public Health & Social Services Emergency	To provide supplemental funding for public health and social services emergencies. Funds are awarded for use in disaster areas.	Project Grants/ Cooperative Agreements (Discretionary)	Federal agencies, state and local governments, other service providers in areas impacted by disaster	\$492,000,000 \$1.62	\$5,288,830 \$1.89

**Table 6. Public Health Funding, Kansas Compared to Iowa, FFY 2004-2008**

	<b>Kansas</b>	<b>Iowa</b>
<b>Demographics and Health Characteristics</b>		
Population (2008 Estimates)	2,802,134	3,002,555
Infant Mortality, 2005, Per 1,000 Live Births	7.4%	5.3%
Low Birthweight Infants, 2006	7.2%	6.9%
AIDS Cases, Cumulative, 2006, Aged 13 and Over	2,781	1,727
<b>Public Health Funding — CDC</b>		
Funding Rank (2008)	32	24
Funding \$ Per Capita (2004–2008 total)	\$44.61	\$61.17
CDC Intervention & Technical Assistance Grants	\$9.33	\$21.43
HIV Prevention Activities — Health Department Based	\$0 .54	\$2.82
Occupational / Agricultural Health & Safety Grants	\$0 .20	\$7.41
<b>Public Health Funding — HRSA</b>		
Funding Rank (2008)	51	33
Funding \$ Per Capita (2004–2008 total)	\$53.17	\$72.79
Consolidated Health Centers Grants	\$13.28	\$24.37
Health Facilities Renovation & Construction Grants	\$2.14	\$7.01
HIV Care Formula Grants	\$5.78	\$4.20
Maternal & Child Health Block Grants	\$8.60	\$11.35
Maternal & Child Health Federal Consolidated Grants	\$1.84	\$2.59