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KANSAS FOUNDATIONAL PUBLIC HEALTH SERVICES CAPACITY ASSESSMENT

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AUGUST 2017

Author

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Executive Summary

Background

This report describes the results of a capacity assessment of the Foundational Public Health Services (FPHS) conducted in Kansas to describe the current ability in the state to implement the Kansas FPHS model and to inform strategies for implementation. 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 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 Are*a, 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.

FPHS Development and Assessment Process

As part of the work toward the FPHS and KALHD's vision, a capacity assessment of the FPHS in Kansas was conducted to describe the current ability in the state to implement the Kansas FPHS model and to inform strategies for implementation.

The FPHS capacity assessment, described in this report, is the third phase of a three-part effort to define the FPHS for Kansas and assess the extent to which the public health system was equipped to deliver the defined FPHS services. The three phases 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; and 3) a capacity assessment involving all 100 local health department administrators in the state. The purpose of the capacity assessment was to examine the Kansas public health system's current capacity and capability to deliver the FPHS services defined for Kansas and to identify areas of strength and areas in need of improvement.

The FPHS capacity assessment was completed by administering an online survey to local health department administrators collecting information on how they rate their LHD's capacity (defined as *staff, time and funding*) and capability (defined as *skills, knowledge and expertise*) to deliver each of the 109 components of Kansas' FPHS model, and to describe barriers to full implementation. Capacity and capability were rated on a five-point scale that ranged from 0 (no capacity or capability) to 4 (full capacity or capability). The survey was completed by 81 of 100 (81 percent) of Kansas' local health department administrators in March 2017. These 81 health departments represent 86 of the 105 Kansas counties.

Key Findings

In general, local 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 (activities critical to prepare for and respond to public health emergencies);
- FC: Organizational Competencies (activities to support the business, management and leadership functions within the public health system);
- FA: Communicable Disease Control (programs and activities to prevent and control the spread of communicable disease); and
- FA: Access to Clinical Care (programs and activities for assuring access to specific preventive and primary care clinical services).

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 (activities to inform, develop and implement public health policy);
- FC: Assessment (activities for the collection and analysis of public health data); and
- FA: Environmental Health (programs and activities to prevent and reduce exposure to environmental hazards).

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 local public health 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.

Implications and Next Steps

The results of this capacity assessment illustrate that there are variations in the ability to implement the FPHS components. 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.

Introduction

Note: A glossary of key terms can be found in *Appendix A*, page 39.

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 been spurred on by both chronic underfunding and unstable budgeting for public health activities.[i] 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 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 a concept for a new public health services framework.[ii] 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.[iii] 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 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 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 FCs 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 FAs. FAs are the substantive areas of expertise or program-specific activities. Within each FC and FA, there is a list of components that are subordinate to each FC and FA which specify distinct abilities or activities for the delivery of 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 for local communities and may be delivered by some health departments in addition to the FPHS.

Developing a Model for Foundational Public Health Services in Kansas

Work towards the FPHS in Kansas began in September 2015, when 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.*" Following this, 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—aligned its efforts to support the development and implementation of the FPHS in Kansas. For this purpose, four subcommittees were developed: 1) Policy; 2) Assessment and Performance Management; 3) Legal; and 4) Fiscal. KALHD, as chair of the PHSG, partnered with the Kansas Health Institute (KHI) to lead the Assessment and Performance Management Subcommittee to undertake a project to assess local capabilities and capacities to deliver the FPHS. The aim of this project was to: 1) Define the FPHS for Kansas; and 2) Assess the system's capacity for implementation of the FPHS. The subcommittee's efforts consisted of three parts: a literature review, the identification of the foundational services for Kansas, and a capacity assessment.

First, a literature review of other states' FPHS models was completed to identify the extent to which each state model differed from the RESOLVE model, and to compile a list of possible components from which Kansas could build its own FPHS model.

Second, the team conducted a series of key-informant interviews with local and state health department personnel to investigate what they considered truly "foundational" for all health departments to provide in Kansas. When identifying what should be provided by state or local public health agencies in the FPHS for the Kansas model, the following criteria were used to select "foundational" components:

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);

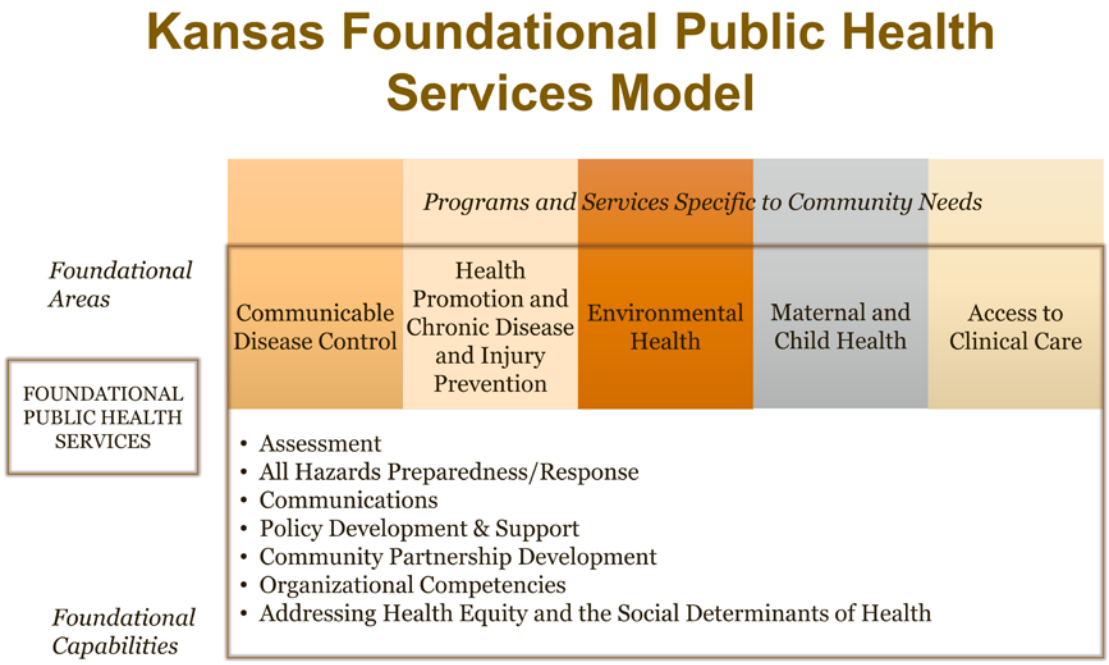
2) ***Governmental public health*** is the only or best potential provider of service (e.g., disease surveillance and epidemiology); and

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

Using the results of the key-informant interviews, a list of components was compiled and shared with KALHD board members, local health department (LHD) administrators, and other public health system partners for feedback. After all feedback was incorporated, the KALHD board voted in October 2016 to approve the FPHS list for Kansas, and the entire KALHD membership followed suit in November 2016. The final FPHS list for Kansas included seven FCs and five FAs with a combined total of 109 components. A full list of the Kansas FPHS model components can be found in *Appendix B*, page 41. See *Figure 1*, page 9, for a visualization of the Kansas FPHS model's FCs and FAs.

Finally, the team designed a survey to examine the Kansas public health system's current capacity (staff, time and funding) and capability (skills, knowledge and expertise) to deliver the services that were identified in Kansas' FPHS model. This FPHS Capacity Assessment was implemented alongside a separate assessment conducted by BERK Consulting, Inc., to estimate the projected costs of financing the full implementation of the Kansas FPHS model.

Figure 1. **Kansas Foundational Public Health Services Model**



Source: Kansas Public Health Systems Group, 2016.

Assessment Process

The capacity assessment survey was developed in late 2016 and early 2017 based on similar assessments in other states and on input from the Public Health Systems Group and other partners. The purpose of the FPHS Capacity Assessment was to identify Kansas health departments' current ability to deliver each of Kansas' FPHS model components as well as identify gaps and areas for future capacity building and support. To accomplish this, the survey was designed to measure local health department administrators' self-rated levels of capability and capacity to deliver the FPHS in Kansas.

Capability and capacity were defined as follows:

> ***Capability*** *is a measure of whether or how well something can be done. In other words, are the skills, knowledge and expertise in place that are needed to perform the task?*

> ***Capacity*** *is a measure of how much of something can be done. In other words, does the health department have the appropriate amount of staff, time and funding to fulfill the level of need for this service in the community?*

The survey consisted of 47 total questions and was organized into three parts: *Part 1—Foundational Capabilities; Part 2—Foundational Areas;* and *Part 3—Budgetary Considerations*. The first two parts were divided into sub-sections for each of the seven *Foundational Capabilities* and five *Foundational Areas*. All 109 Kansas FPHS components were assessed within the survey. Local health department administrators were asked to rate their capacity and capability for each of the FPHS components on a 5-point scale as follows:

0 — None

1— Minimal

2 — Some

3 — Sufficient

4 — Full

Additional questions at the end of each of the FC and FA sections asked respondents to rate their level of agreement with the statement *"My health department is currently able to perform the components within this Foundational Capability/Area."* Respondents were also asked to list barriers —other than funding—that contribute to a gap in capability or capacity for that FC or FA.

Part 3 of the survey included budgetary questions by BERK Consulting, Inc. to inform the separate fiscal assessment being conducted at the same time to estimate the costs of delivering the FPHS for Kansas. Questions included: the total operating budget for the health department, total full-time equivalents (FTEs), and budgets for specific items such as overhead costs, and number of staff by job title.

The project team piloted the survey with a group of four local health department administrators prior to its launch. The final survey instrument can be found in *Appendix C*, page 55.

The survey was distributed to local health department administrators on March 3, 2017, via an email with a link generated by Qualtrics survey software. Local health department administrators were given three weeks to complete the survey. Throughout the three-week period, local health department administrators were provided technical assistance in completing the survey, and

reminders were sent periodically. As of the survey's closing date, 51 of the 100 local health department administrators had completed the survey. Project staff contacted non-respondents via individual emails and phone calls to encourage them to complete the survey. Through this process, an additional 30 survey responses were received. Among those local health department administrators who were individually contacted but did not complete the survey, most indicated that they would not complete the survey because their schedule did not allow the time to do so.

Analysis

Survey results are summarized by FC, FA and components using tabulations of the percent of respondents indicating "full" or "sufficient" capability and capacity for each. The average responses of "full" and "sufficient" capability and capacity are also summarized across all model components, by Kansas region, and population-density peer groups.

Components for which the percent of respondents indicating "full" or "sufficient" capacity or capability is greater than 78.0 percent for capability, and 52.5 percent for capacity, were defined as "high-rated components." These thresholds represent the 90th percentile of respondents indicating "full" or "sufficient" capacity or capability among all components. Similarly, components for which the percent of respondents indicating "full" or "sufficient" capability is lower than 29.7 percent for capability, and 16.1 percent for capacity, (their respective 10th percentile) were defined as "low- rated components."

Additionally, the project team utilized linear regression models to examine the relationship between the percent of respondents indicating "full" or "sufficient" capability and capacity and the health departments' total budgets, number of staff FTEs, and population served. To examine possible relationships with geography (region) and population density, the team used Kruskal-Wallis and Tukey and Kramer (Nemenyi) post-hoc tests to determine whether capability and capacity ratings differed significantly between region and population density groups. Statistical significance was tested at a level of $p<0.05$.

Limitations

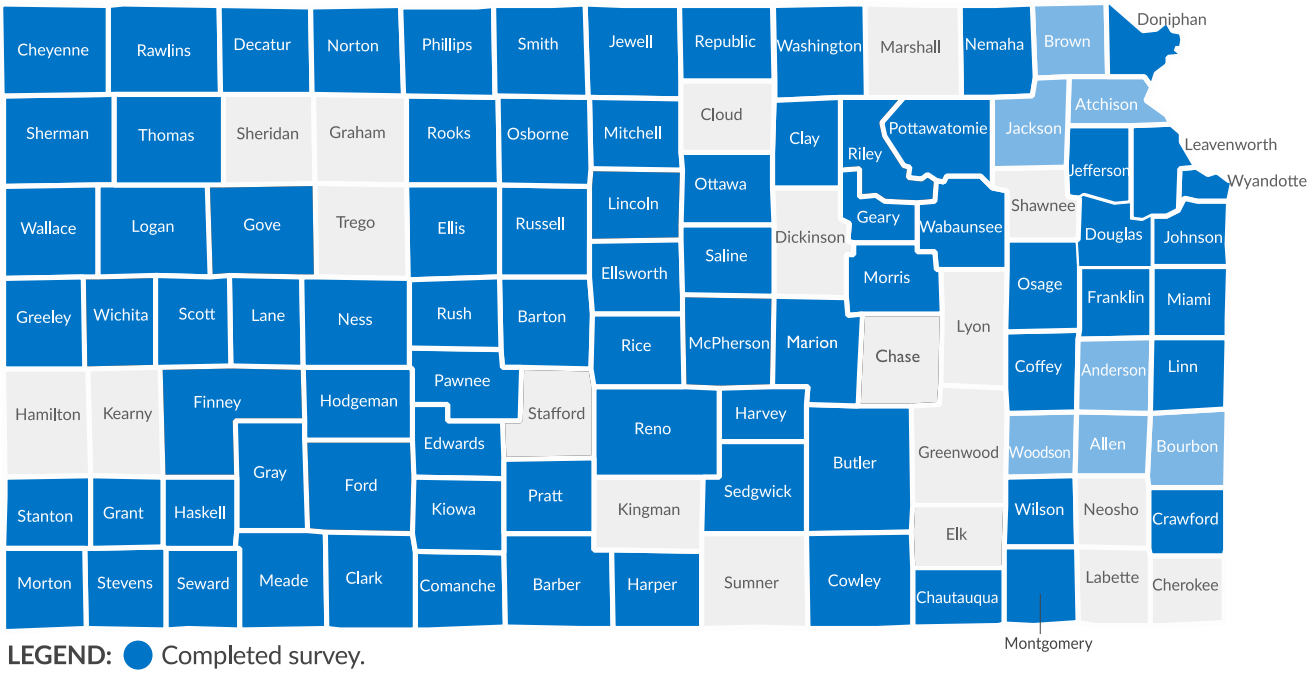
The limitations of this capacity assessment include the fact that it relies on self-reported levels of capacity and capability. As a self-report survey, it is subject to differing interpretations of the scale points used, which may impact reliability. It is also subject to response bias, in which respondents may change their answer depending on what they perceive the "correct" response to be. This may impact the validity of the survey. Additionally, since only 81 of 100 local health departments responded to the survey, this report details only the responses from those local health department administrators who were willing and inclined to take the survey. Therefore, it may not be representative of the perspectives of all 100 local health department administrators.

Summary of Respondent Characteristics

Overall, 81 of the 100 health departments completed the survey, for an 81 percent response rate. These health departments represented 86 of the 105 Kansas counties. Because there are two multi-county health departments which serve multiple counties—Northeast Kansas (NEK) Multi-County Health Department serves three counties in northeast Kansas, and Southeast Kansas (SEK) Multi-county Health Department serves four counties in southeast Kansas—the total number of health departments is less than the total number of counties in Kansas.

On average, health departments that completed the survey served a population of 31,358, while those who did not complete the survey served an average population of 19,329. However, it should be noted that the health departments with the nine smallest service areas did complete the survey. *Figure 2, page 13,* shows the locations of the counties that completed the Capacity Assessment.

Figure 2. **Map of Completed FPHS Capacity Assessment Surveys**



Note: Southeast Kansas (SEK) and Northeast Kansas (NEK) Multi-County Health Departments are indicated in light blue.

Source: Diymaps.net

Response Summary by Population Density Peer Group

Responses were also summarized by a population density peer group. The densely settled rural peer group had the lowest percent completion (66.7 percent), while the semi-urban population density peer group had 100.0 percent survey completion. See *Figure 3*. (See *Appendix E*, page 84 for population density classification criteria for Kansas counties.)

Figure 3. **Capacity Assessment Survey Completion by Population Density Peer Group**

Population Density	Number in Group	Number Completed	Percent Completed
Frontier	36	27	75.0%
Rural	30	27	90.0%
Densely Settled Rural	18	12	66.7%
Semi-Urban	10	10	100.0%
Urban	6	5	83.3%
Total	100	81	81.0%

Note: Southeast Kansas (SEK) and Northeast Kansas (NEK) Multi-County Health Departments were assigned to a population density group based on the combined population density for the included counties. SEK is considered "rural," and NEK is considered "densely settled rural."

Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Response Summary by Kansas Regions

Responses were summarized by each of the six Kansas regions where KDHE's district offices are held and which are used for district meetings for local health department administrators. (See *Appendix G,* page 88, for a map of the regions used for this analysis.) The southeast region had the lowest percent completion (54.5 percent), while the southwest region had the highest, at 89.5 percent survey completion (*Figure 4).*

Figure 4. **Capacity Assessment Survey Completion by Kansas Regions**

Kansas Region	Number in Region	Number Completed	Percent Completed
Northwest	15	12	80.0%
North Central	14	12	85.7%
Northeast	21	17	81.0%
Southwest	19	17	89.5%
South Central	20	17	85.0%
Southeast	11	6	54.5%
Total	100	81	81.0%

Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Results

The following analysis of the FPHS Capacity Assessment is organized from broad (overall ratings of capability and capacity) to specific (capability and capacity ratings by individual components). For ease of display, the percent of respondents who indicated "full" or "sufficient" capacity or capability for each area is the metric displayed for all breakdowns beyond the overall capacity and capability ratings. However, a table with the full results (including each response category for every component, FA/FC and overall) can be found in *Appendix D*, page 65. Unless otherwise noted, all figures are based on the 81 survey responses received.

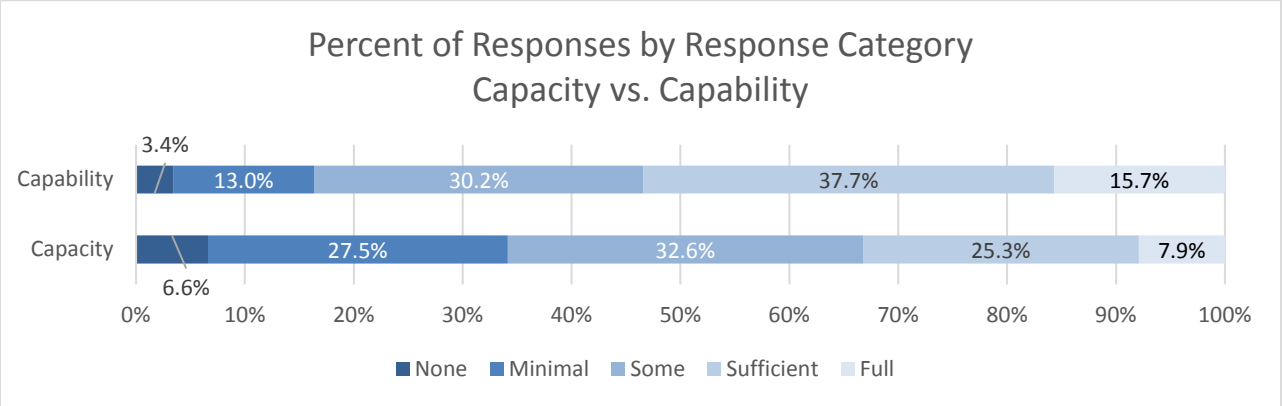
Overall Capability and Capacity

In general, capability was more frequently rated as "full" or "sufficient" than capacity. For all components, on average, 15.7 percent rated the FPHS model components as "full" capability, and 37.7 percent rated "sufficient" capability (53.4 percent "full" or "sufficient").

For capacity, an average of 7.9 percent of respondents rated the FPHS model components "full" capacity, and 25.3 percent rated "sufficient" capacity (33.2 percent "full" or "sufficient") (*Figure 5).*

On average, a higher percent of respondents reported "full" or "sufficient" for capability than capacity for all model components. This is also the case for every subdivision of the model. For FCs, FAs, and each individual component, respondents more frequently rated capability as "full" or "sufficient" than capacity. In other words, respondents indicated a greater confidence in skills, expertise and knowledge, and a lower confidence in the available resources to do the job.

Figure 5. **Percent of Respondents Selecting Each Response Category for Capability and Capacity**



Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

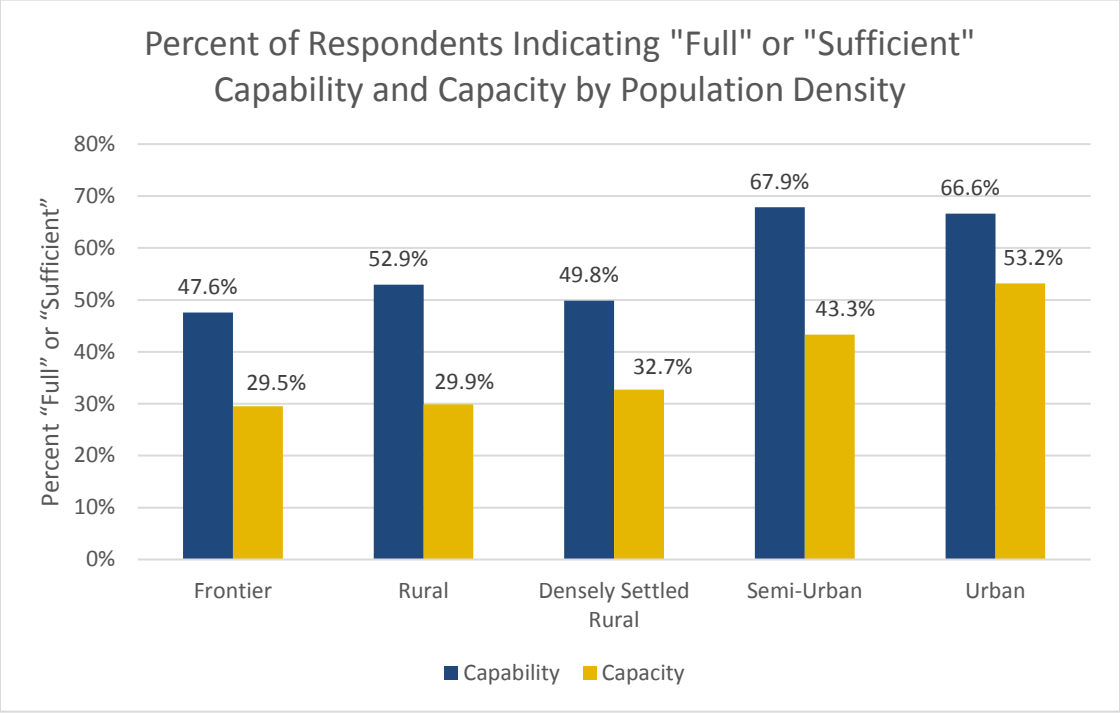
Capability and Capacity by Population Density and Population Served

Capability and capacity results are summarized for each population density peer group. In general, there was a gradient from low to high capacity between population density groups, with rural and frontier counties generally reporting lowest capacity and urban counties generally reporting highest capacity (*Figure 6,* page 16). For capability, the counties in the frontier, rural, and densely settled rural groupings generally reported lower capability than urban and semi-urban population groupings, though the gradient was not as consistent for capacity.

Additional analysis indicates that there is a significant but weak association between the size of the population served and a rating of "full" or "sufficient" capacity, with larger jurisdictions reporting higher capacity (p=0.03, correlation coefficient of 0.24). However, the association

between population served and capability is not significant. See *Appendix E*, page 84 for a table detailing the results of the statistical tests.

Figure 6. **Percent of Respondents Indicating "Full" or "Sufficient" Capability and Capacity by Population Density**

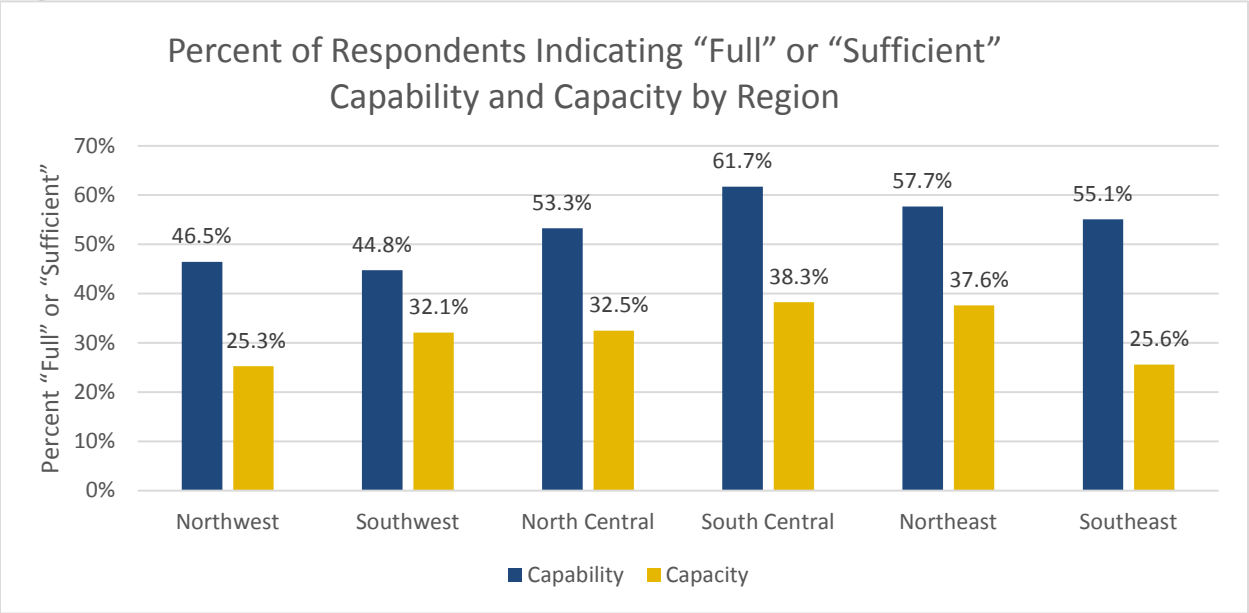


Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Capability and Capacity by Kansas Region

Capability and capacity results are summarized for each region of Kansas. Local health department administrators in south central Kansas reported the highest rates for both capability (61.7 percent) and capacity (38.3 percent). Northwest and southwest Kansas local health department administrators reported the lowest rates for capability (46.5 and 44.8 percent, respectively), while local health department administrators in northwest and southeast Kansas reported the lowest rates for capacity (25.3 and 25.6 percent, respectively). (*Figure 7*, page 17*)*

Figure 7. **Percent of Respondents indicating "Full" or "Sufficient" Capability and Capacity, by Region**



Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

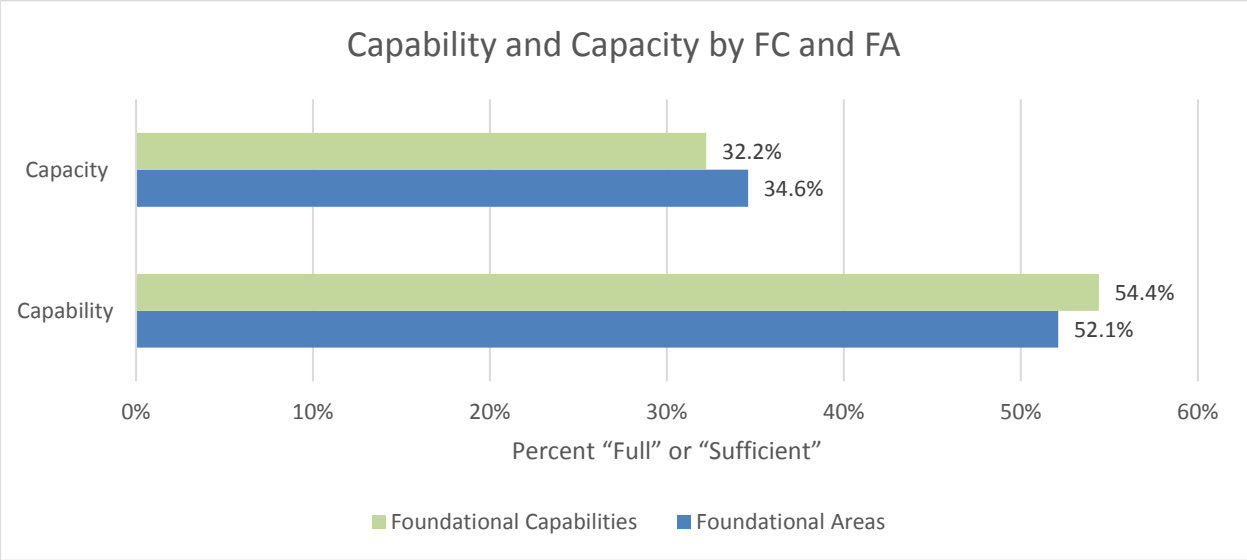
Analysis by Foundational Capabilities and Foundational Areas

On average, a slightly higher percent of respondents reported "full" or "sufficient" capability for the components within the FCs (54.4 percent) than for the components within the FAs (52.1 percent).

In contrast, a slightly lower percent of respondents indicated "full" or "sufficient" for capacity on the FCs (32.2 percent) than for the components within the FAs (34.6 percent). (*Figure 8,* page 18)

This may be a reflection of the way public health is currently structured: programs such as those that are mentioned in the FAs are funded through programmatic grants. Therefore, it is logical that these would have a higher rating for capacity, which includes the components of staff, time and funding. The FCs—with the exception of *All Hazards Preparedness and Response*—do not have dedicated funding streams, but are the skills necessary to deliver the programs of the health department.

Figure 8. **Percent of Respondents Indicating "Full" or "Sufficient" Capability and Capacity by Foundational Capability and Foundational Area**

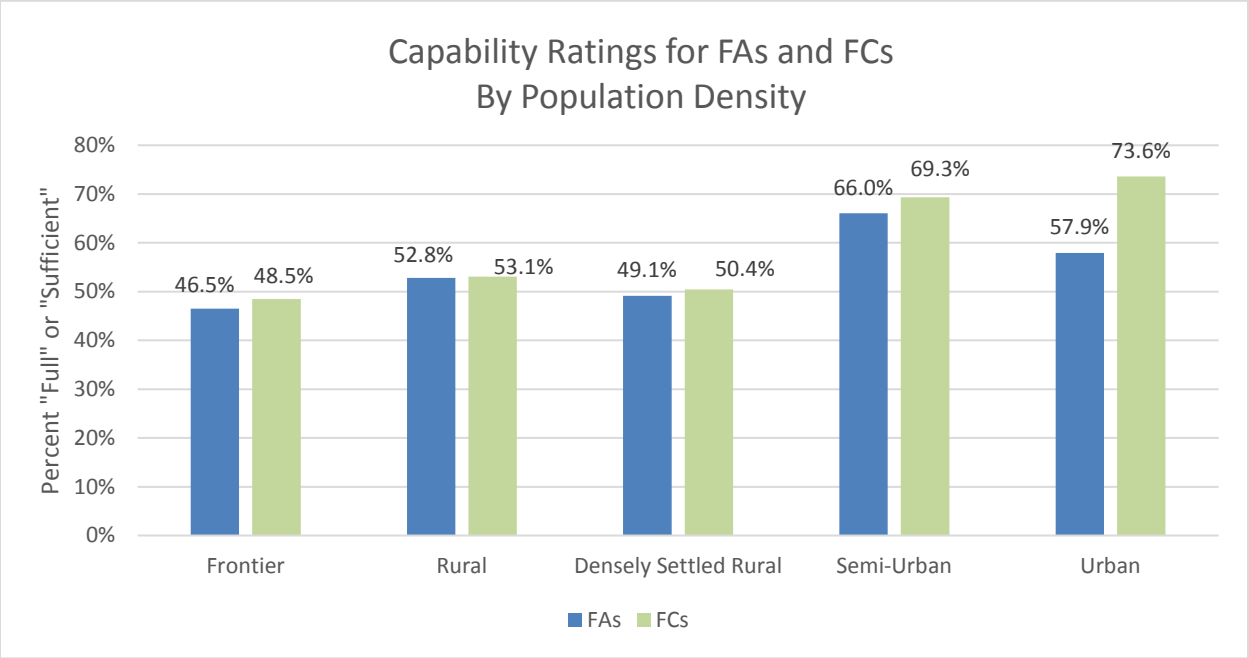


Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Capability and Capacity of Foundational Capabilities and Foundational Areas by Population Density

Capability was rated "full" or "sufficient" more frequently for the FCs than for the FAs, across all population density groups (*Figure 9,* page 19).

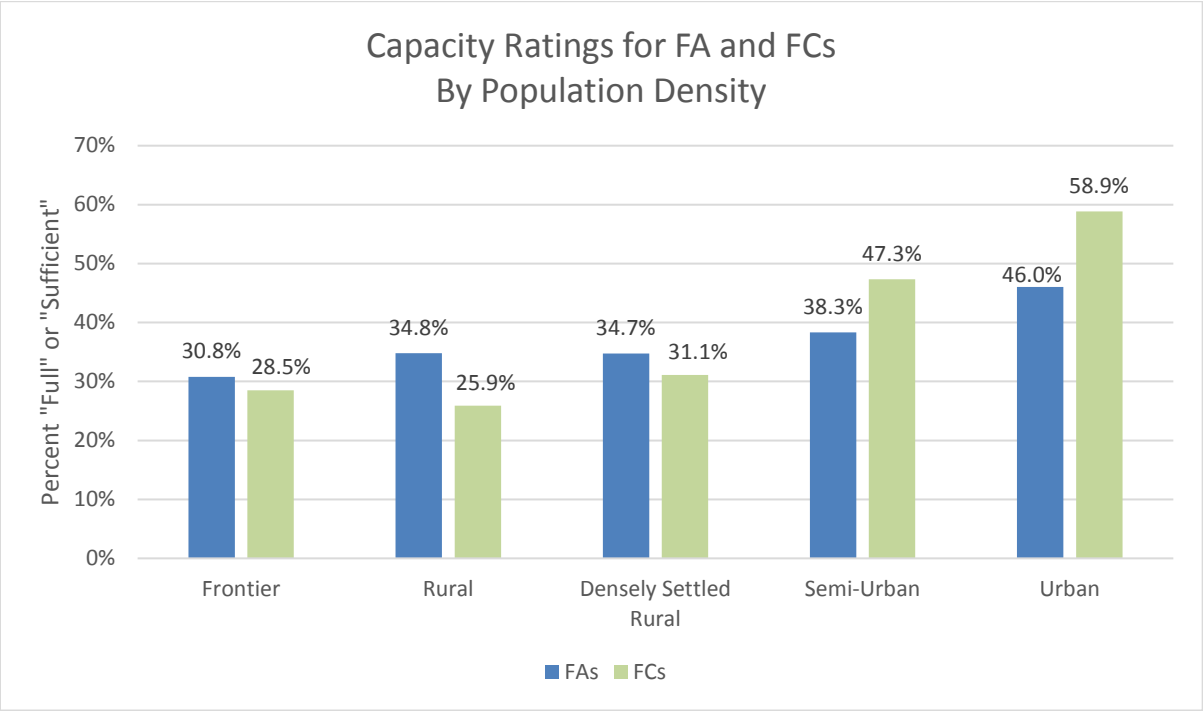
Figure 9. **Capability Ratings for FAs and FCs by Population Density**



Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

In contrast, capacity was rated "full" or "sufficient" more frequently for the FAs than for FCs in less densely-populated areas of the state (frontier, rural, and densely settled rural areas), while in urban and semi-urban areas, respondents more often indicated "full" or "sufficient" capacity for FCs than FAs (*Figure 10*, page 20*).*

Figure 10. **Capacity Ratings for FAs and FCs by Population Density**

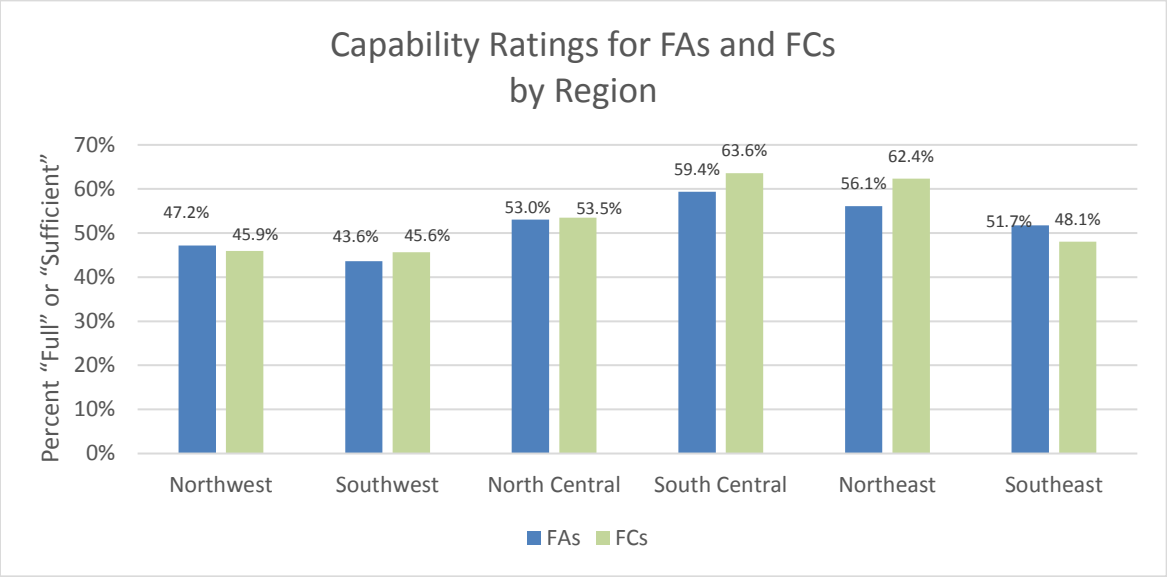


Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Capability and Capacity of Foundational Capabilities and Foundational Areas by Region

Capability for the FCs was generally rated "full" or "sufficient" slightly more frequently than the FAs, except in northwest and southeast Kansas, where a slightly higher percentage of respondents indicated "full" or "sufficient" capability for the FAs than the FCs (*Figure 11*, page 21).

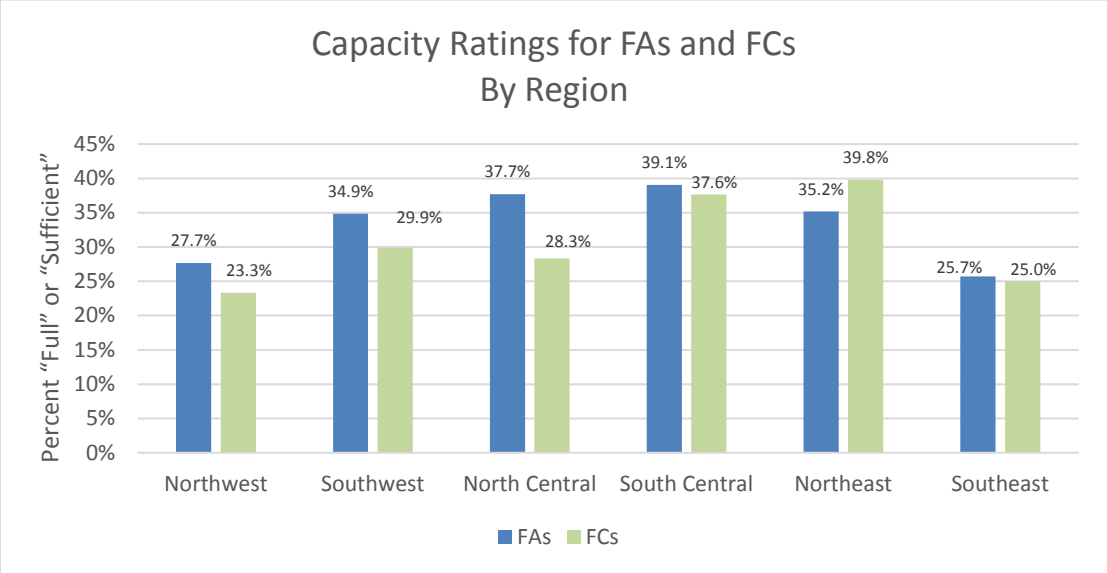
Figure 11. **Capability Ratings for Foundational Areas and Foundational Capabilities by Region**



Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

In general, capacity was more frequently rated "full" or "sufficient" for FAs than FCs, except in northeast Kansas, where a higher percentage of respondents indicated "full" or "sufficient" capacity for FCs than FAs (*Figure 12).*

Figure 12. **Capacity Ratings for Foundational Areas and Foundational Capabilities by Region**



Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Assessment Results for Foundational Capabilities

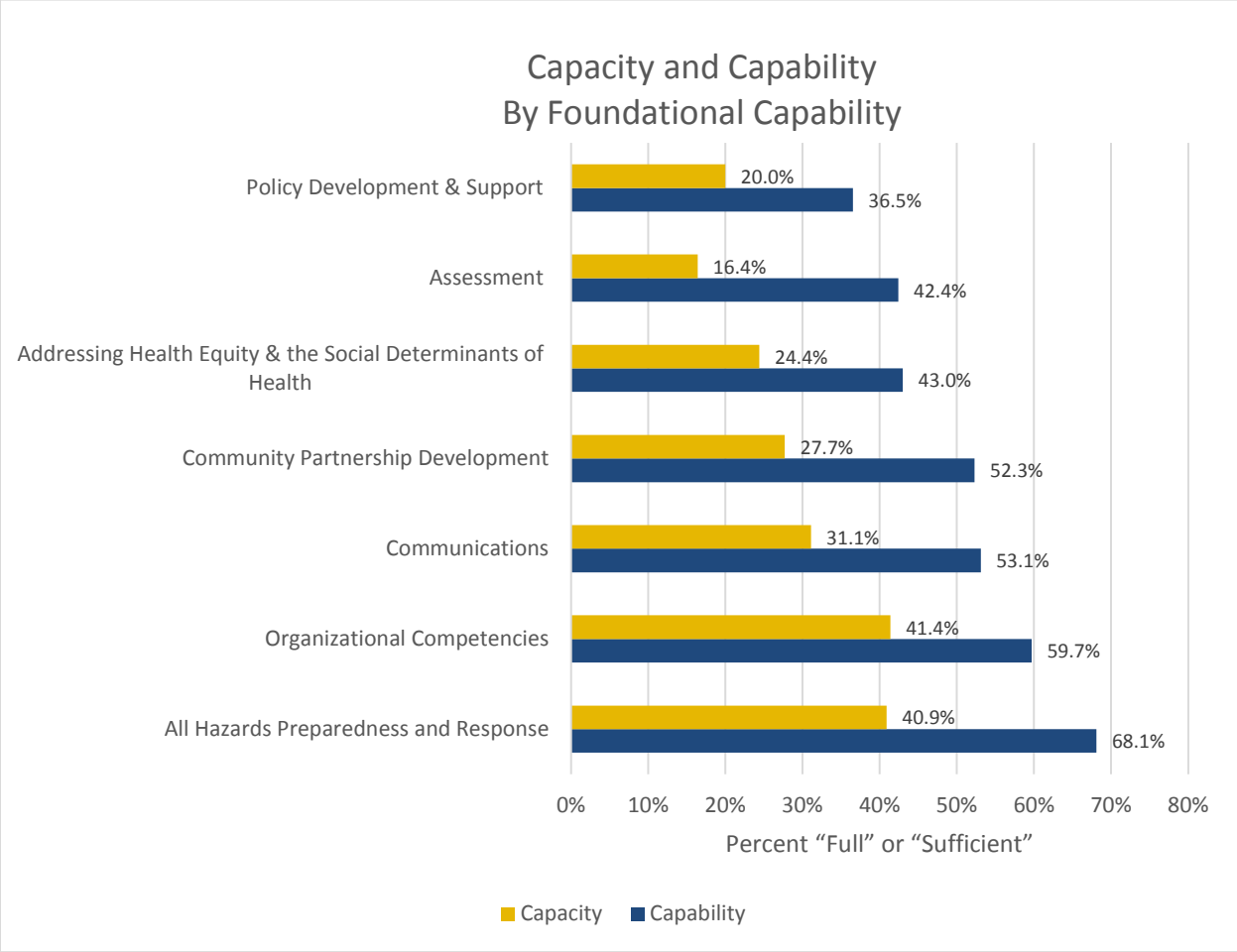
The FC with the highest percent of respondents reporting "full" or "sufficient" capability was *All Hazards Preparedness and Response* (68.1 percent), while the lowest-rated was *Policy Development and Support* (36.5 percent).

The FC with the highest percent of respondents reporting "full" or "sufficient" capacity was *Organizational Competencies* (41.4 percent), while the lowest was *Assessment* at just 16.4 percent (*Figure 13, page 23*).

The FCs that rated higher are those which have received reliable funding streams or statewide attention in recent years. *All Hazards Preparedness and Response* has been funded for specific emergency preparedness functions, and many of the components of *Organizational Competencies*, such as quality improvement, performance management and strategic planning, have received attention following the creation of a national accreditation program.

Those that rated lower, such as *Policy Development and Support, Assessment*, and *Addressing Health Equity* and the *Social Determinants of Health*, may be considered more population-based or specialized, and may reflect newer or less traditional public health roles.

Figure 13. **Percent of Respondents Indicating "Full" or "Sufficient" Capacity and Capability by Foundational Capability**



Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

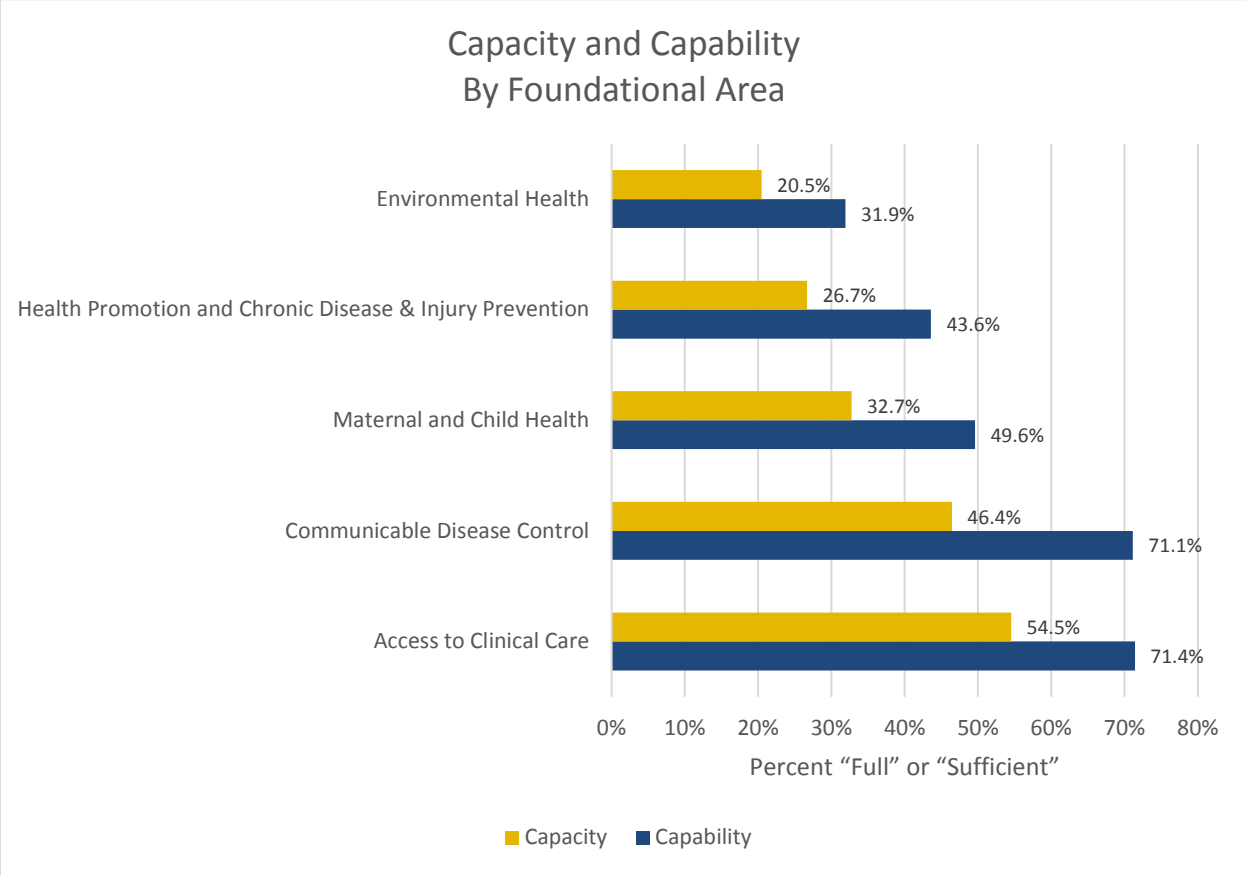
Assessment Results for Foundational Areas

The highest-rated FA for both capability and capacity was *Access to Clinical Care,* at 71.4 percent indicating "full" or "sufficient" capability, and 54.5 percent indicating "full" or "sufficient" capacity. The FAs that rated higher may reflect more traditional or clinical public health roles, such as ensuring *Access to Clinical Care* through the family planning program and others.

The lowest-rated FA for both capability and capacity was *Environmental Health*, with just 31.9 percent indicating "full" or "sufficient" capability and only 20.5 percent indicating' full' or "sufficient" capacity (*Figure 14,* page 24). The FAs that rated lower, such as *Environmental Health*, may be less familiar to local health department administrators. In Kansas, the local

Environmental Health Protection Program (LEPP) funding has been significantly decreased, and local environmental health activities have diminished. Furthermore, many environmental health roles are carried out by other county departments or contracted to private providers. Therefore, this is an area with which local health department administrators are less familiar.

Figure 14. **Percent of Respondents Indicating "Full" or "Sufficient" Capacity and Capability by Foundational Area**



Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Analysis by Components

One of the goals of this assessment was to identify specific areas of strength and areas for improvement in implementation of the FPHS. Components that were rated high (90th percentile or above among all components for capability and capacity, separately) are noted in *Figure 15,* page 26. Components that rated low (10th percentile or below for capability and capacity, separately) are noted in *Figure 16*, page 28. Component ratings are highlighted in the corresponding column if they meet the high and low criteria for capability or capacity.

Note: The determination of a component as one that was rated "high" or "low" does not necessarily indicate whether the system's capability or capacity for that component is acceptable or unacceptable, simply that these components were at the extreme ends compared to others in the model, and are worth highlighting as strategies for FPHS implementation are considered.

High-Rated Components

All Hazards Preparedness and Response, Organizational Competencies and *Communicable Disease Control* all had several components that rated highly for capability. *Organizational Competencies, Communicable Disease Control, and Access to Clinical Care* all had several components that rated highly for capacity.

The highest-rated component was *Assure availability of childhood, adolescent and adult immunization services*—with nearly 92.6 percent indicating full or sufficient capability and 72.8 percent indicating full or sufficient capacity. This and other high-rated components, such as *Assure access to maternal and infant services* and *Assure proper diagnosis and treatment for individuals with latent or active tuberculosis,* reflect more traditional public health roles.

Figure 15. **Percent of Respondents Indicating "Full" or "Sufficient" Capability and Capacity for Each Component That Scored at or Above the 90th Percentile Among All Components**

High-Rated Components			
Foundational Area/Foundational Capability	Component	Capability	Capacity
FA: Communicable Disease Control	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).	92.6%	72.8%
FA: Access to and Linkages With Clinical Care	Assure access to maternal and infant services (e.g., maternity support, WIC).	87.7%	69.1%
FA: Communicable Disease Control	Assure proper diagnosis and treatment for individuals with latent or active tuberculosis in accordance with national, state, and local mandates and guidelines.	84.0%	69.1%
FC: All Hazards Preparedness and Response	Ability to be notified of public health emergencies on a 24/7 basis.	90.1%	59.3%
FC: Organizational Competencies	Ability to uphold business practices in accordance with local, state, and federal laws, and professional standards.	80.2%	56.8%
FC: Organizational Competencies	Ability to have proper systems in place to keep protected health information (PHI) and confidential organizational data restricted.	80.2%	55.6%
FC: Organizational Competencies	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.	79.0%	55.6%
FA: Communicable Disease Control	Provide timely, accurate and locally relevant information on communicable diseases and their control, including strategies to increase local immunization rates.	85.2%	46.9%
FC: All Hazards Preparedness and Response	Ability to package and ship clinical specimens to the state reference laboratory (Kansas Health and Environmental Laboratory, or KHEL) for identification of threats.	79.0%	51.9%
FC: Organizational Competencies	Ability to procure, maintain and manage safe facilities to support agency operations.	76.5%	54.3%
FA: Access to and Linkages with Clinical Care	Assure access to family planning services.	70.4%	58.0%

FA: Communicable Disease Control	Conduct disease investigations, including contact tracing and notification, in accordance with national, state and local mandates and guidelines.	80.2%	48.1%
FA: Access to and Linkages with Clinical Care	Assure access to STD and HIV testing and treatment.	71.6%	55.6%
FC: Organizational Competencies	Ability to comply with federal, state and local standards and policies for contracting.	69.1%	54.3%
FC: All Hazards Preparedness and Response	Ability to respond to public health emergencies on a 24/7 basis.	79.0%	40.7%

Source: KHI Analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Low-Rated Components

The *Environmental Health* FA had the most low-rated components for capability. The *Assessment* FC and the *Environmental Health* FA both had several low-rated components for capacity. Many of these low-rated components are either new ideas and concepts within public health (such as Health in All Policies, or HiAP), or may reflect roles that the health departments have traditionally not held in the community, such as the several within *Environmental Health* that appear on this list. Several components within the *Assessment* FC were rated low, which may indicate a lack of specialized training and support for those capabilities.

Two environmental health components rated the lowest for capability: *"Advocate and seek funding for environmental public health policies and initiatives,"* and, *"Develop and implement an environmental public health plan to prevent and reduce exposures to health hazards in the environment."* For both of these components, just 13.6 percent of respondents indicated "full" or "sufficient" capability.

The two lowest-rated components for capacity were the "*Ability to utilize Health in All Policies (HiAP) approaches for all policy development,"* (9.9 percent indicated "full" or "sufficient" capacity), and the *Environmental Health* component, "*Participate in land use planning and sustainable development,"* (6.3 percent indicated full or sufficient capacity).

Figure 16. **Percent of Respondents Indicating "Full" or "Sufficient" Capability and Capacity for Each Component that Scored at or Below the 10th Percentile Among All Components**

Low-Rated Components			
Foundational Area/Foundational Capability	Component	Capability	Capacity
FA: Environmental Health	Participate in land use planning and sustainable development (e.g., consideration of housing, urban development, recreational facilities and transportation).	16.0%	6.3%
FA: Environmental Health	Advocate and seek funding for environmental public health policies and initiatives.	13.6%	11.3%
FA: Environmental Health	Develop and implement an environmental public health plan to prevent and reduce exposures to health hazards in the environment.	13.6%	12.3%
FC: Policy Development and Support	Ability to utilize Health in All Policies (HiAP) approaches for all policy development.	17.3%	9.9%
FA: Environmental Health	Prevent or reduce environmental public health hazards and assure abatement of nuisances.	23.5%	11.1%
FA: Environmental Health	Identify assets for environmental public health.	22.2%	16.0%
FC: Assessment	Ability to respond to data requests with meaningful reports (valid, statistically accurate and readable by intended audiences).	30.9%	11.1%
FA: Environmental Health	Provide the community with information on reducing unnecessary radiation exposure (e.g., radon in the home).	29.6%	13.6%
FA: Environmental Health	Provide timely, accurate and locally relevant information on environmental public health issues and health impacts from both common and toxic exposure sources.	25.9%	17.3%
FA: Communicable Disease Control	Advocate and seek funding for communicable disease control policies and initiatives.	29.6%	18.5%
FA: Environmental Health	Assure availability of public health laboratory services for reference and confirmatory testing related to environmental public health threats.	29.6%	18.5%
FC: Organizational Competencies	Ability to continuously evaluate and improve organizational processes, including using planning tools such as Plan-Do-Study-Act (PDSA) cycles.	29.6%	19.8%
FC: Assessment	Ability to evaluate efficiency and effectiveness of public health programs.	37.0%	13.6%
FC: Assessment	Ability to interpret, display and communicate public health data and its analysis.	37.0%	14.8%

FA: Health Promotion and Chronic Disease and Injury Prevention	Work to reduce rates of substance abuse in the community.	29.6%	22.2%
FC: Organizational Competencies	Ability to define and communicate strategic direction for public health initiatives through agency strategic planning processes.	29.6%	25.9%
FC: Assessment	Ability to identify patterns, causes, and effects of chronic and communicable diseases (epidemiology).	39.5%	16.0%
FC: Assessment	Ability to participate in the collection of primary public health data.	54.3%	13.6%

Source: KHI Analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Identified Barriers to Capability and Capacity

At the end of each FC or FA section, respondents were asked the question, *"Other than funding, what contributes to a gap in capacity or capability for this Foundational Capability/Area?"* The top responses for barriers to capability and capacity are considered to be those mentioned in 10 percent or more of responses. Across the FCs and FAs, there were several responses that were consistently included as barriers to many or all sections. These are summarized in *Figure 17,* page 31. Additionally, unique responses for each of the FCs and FAs are listed.

These commonly identified barriers may represent areas for which overarching strategies may be undertaken to improve overall capacity and capability to deliver the FPHS.

- The ***number of staff*** was the most commonly cited barrier, and was included as one of the top responses for all 12 of the FCs and FAs.
- ***Training*** was included as one of the top responses for 10 of the 12 FCs and FAs.
- ***Time*** was included as one of the top responses for 10 of the 12 FCs and FAs.

Even though the question asked, *"Other than funding, what are some barriers that contribute to a gap in capacity or capability,"* ***funding*** was the fourth most common response, and was a top response in four of the 12 FCs and FAs: *Communicable Disease Control, Health Promotion* and *Chronic Disease and Injury Prevention, Environmental Health,* and *Organizational Competencies*.

The number of staff is closely tied to the common theme of available time. Theoretically, hiring additional staff would increase the number of man-hours available to do the work of the FPHS. The number of staff is also closely related to the noted lack of funding.

Workforce development strategies could also aid in increasing the availability of qualified individuals for the FPHS roles, and could fill the stated need for training in many of the FCs and FAs.

Figure 17. **Listed Barriers That Were Unique to Each FC and FA**

Foundational Capability/ Foundational Area	Unique Responses
FC: Assessment	Type of staff (e.g., trained epidemiologists) Technology
FC: All Hazards Preparedness and Response	Partner participation Communication with the community Program requirements Ability to understand the needs of vulnerable populations
FC: Communications	Confidence to engage in communication strategies Lack of a strategic communications plan
FC: Policy Development and Support	Board of Health support Partner relationships Difficulty of policymaking
FC: Community Partnership Development	Trust Disadvantaged populations are difficult to engage
FC: Organizational Competencies	Board of Health support Turnover Staff interest
FC: Addressing Health Equity and the Social Determinants of Health	Difficulty of identifying and reaching vulnerable populations Data availability Small population sizes Understanding concepts related to health equity
FA: Communicable Disease Control	Small numbers of events, contributing to a lack of experience Increasing requirements for disease investigations Staff turnover
FA: Health Promotion and Chronic Disease and Injury Prevention	Community interest Partnerships Data management Increasing mental health needs in the community
FA: Environmental Health	Another entity provides the service
FA: Maternal and Child Health	Health department does not offer the program Reporting demands Small population sizes Challenges reaching certain populations
FA: Access to Clinical Care	Lack of providers in the community Inadequacy of the safety net Partnerships with providers

Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Summary of Budgetary Considerations

In Part 3 of the survey, respondents were asked to list their total annual operating budget as well as number of FTEs employed by the health department. Budgets ranged from $73,550 to $15,556,177 with a median of $434,772. Per capita spending ranged from $6.78 to $212.08 per capita, with a median of $52.52. The number of FTEs ranged from one to 140 with a median of 5. (*Figure 18*)

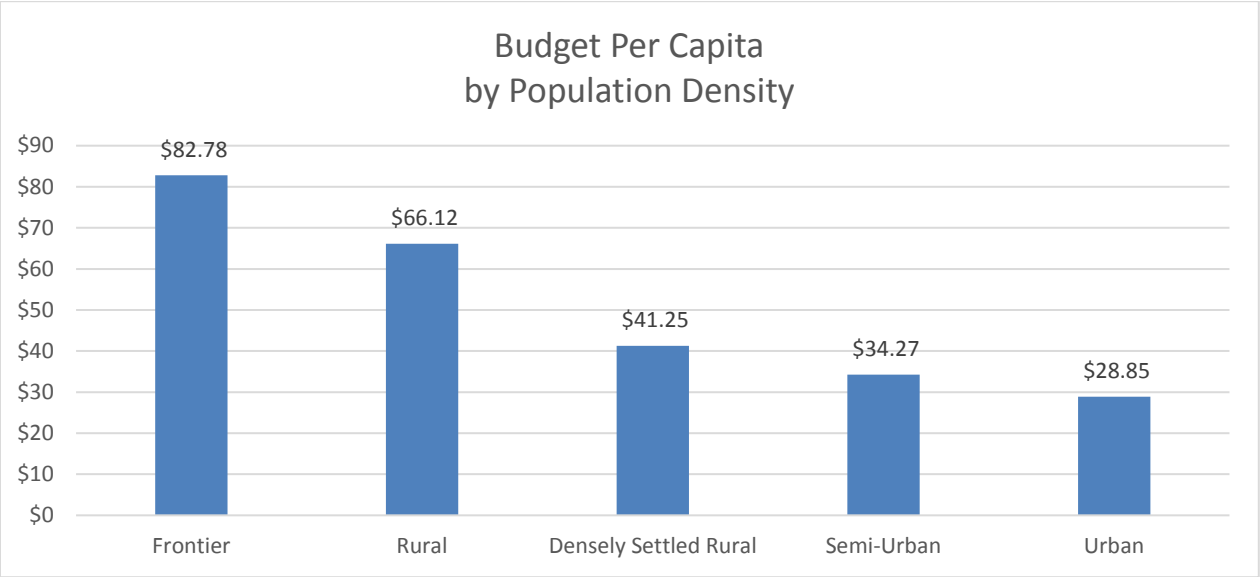
Figure 18. **Total and Per Capita Budget and Total FTEs**

	Minimum	Maximum	Median	Average
Total Operating Budget *(n=76)*	**$73,550**	**$15,556,177**	**$434,772**	**$1,101,293**
Budget Per Capita *(n=76)*	**$6.78**	**$212.08**	**$52.52**	**$61.23**
Total FTEs *(n=79)*	**1.0**	**140.0**	**5.0**	**12.8**

Note: Not all respondents completed Part 3 of the survey. Number of responses is noted for each variable.
Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

The per capita budgets were summarized by region and population density peer group. Health departments serving more population-dense communities spent less per capita than those serving communities with lower population density. The differences between frontier communities and densely settled rural, semi-urban, and urban communities were all significant using Kruskal-Wallis and post-hoc tests (*Appendix E*, page 84). Further, health departments in communities classified as urban spend less than half per capita than those in frontier and rural communities. This may be due to a variety of factors, including economies of scale and the mix of direct and population-based services provided (*Figure 19,* page 33).

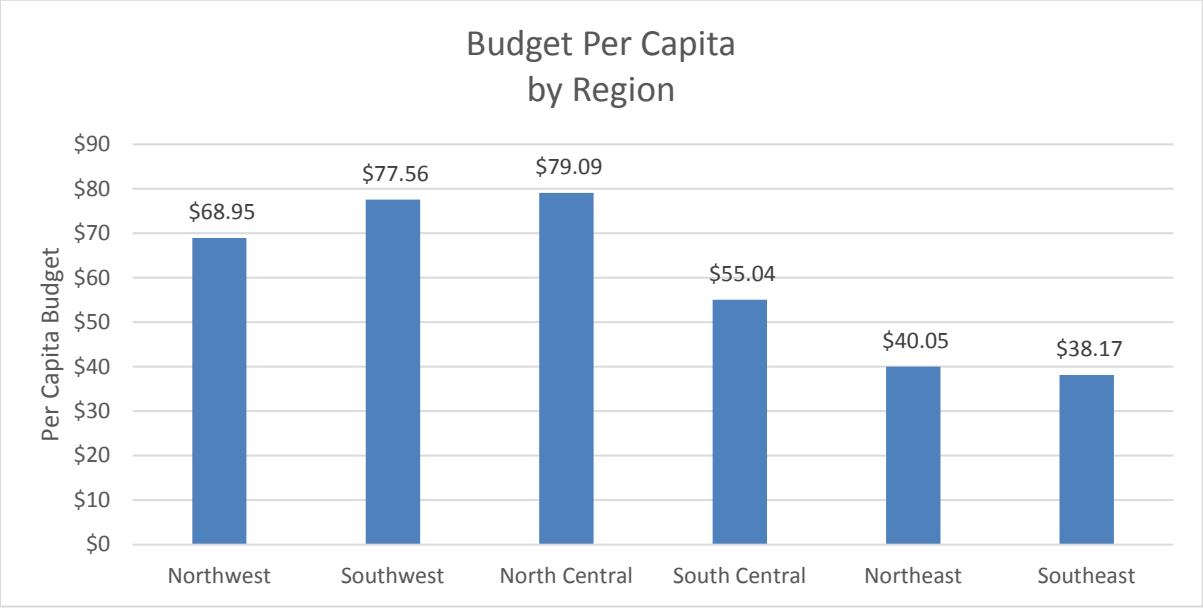
Figure 19. **Budget Per Capita by Population Density**



Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Health departments in northeast and southeast Kansas generally spend fewer dollars per capita than those in northwest, southwest, and north central Kansas. (*Figure 20*) The differences between northeast and north central, and northeast and southwest regions were significant using Kruskal-Wallis and post-hoc tests (*Appendix E*, page 84).

Figure 20. **Budget Per Capita by Region**



Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Using regression analysis, higher overall capacity was significantly—although weakly—correlated with a larger number of FTEs and a larger total operating budget. This finding is in alignment with the definition of capacity, which includes staff, time and funding. However, given the weak correlation, other factors not covered by this survey may be driving differences in capacity between health departments. In contrast, overall capability was not significantly associated with either FTEs or total operating budget. Neither capability nor capacity was associated with the budget per capita (*Appendix E*, page 84).

The project team also examined these associations by *Foundational Areas* and *Foundational Capabilities.* Higher capacity and capability for the FCs were each significantly but weakly associated with a greater total operating budget and a larger number of FTEs. This may indicate that larger health departments with more resources tend to invest in the components that fall within the FCs. Neither capacity nor capability was associated with either budget or FTEs for the FAs. Neither capacity nor capability was associated with the budget per capita for FAs or FCs (*Appendix E*, page 84).

Discussion

The results of this assessment illustrate that there are important variations in the current ability to implement the FPHS model in Kansas.

In general, local health department administrators rated their capability to deliver the FPHS higher than the capacity to do so. This may indicate a greater confidence in skills, expertise and knowledge, and a lower confidence in the available resources to do the job.

Respondents rated their capability to deliver the *Foundational Capabilities* slightly higher than their capability to deliver the *Foundational Areas*, whereas they rated the capacity to deliver the FAs slightly higher than their capacity to deliver the FCs. This may reflect the way public health is currently structured. Programs such as those that are mentioned in the FAs are primarily funded through programmatic grants. Therefore, it is logical that these would have a higher rating for capacity, which includes the components of staff, time and funding. The FCs, except for *All Hazards Preparedness and Response*, do not have dedicated funding streams.

Overall, the survey results indicate that there is currently capacity and capability for implementation of some parts of the FPHS model. FCs and FAs of the model that were most highly rated include *All Hazards Preparedness and Response, Organizational Competencies, Communicable Disease Control* and *Access to Clinical Care*. Several of these highly rated areas either have dedicated funding streams (*All Hazards Preparedness and Response*, and some of the items within *Access to Clinical Care*) or are explicitly noted in Kansas statute as health department responsibilities (*Communicable Disease Control*). Ongoing efforts by the PHSG members aim to estimate needed funding and develop a legal framework to support implementation of all the Kansas FPHS components in all counties.

There are also parts of the FPHS for which the system does not yet have the capacity and capability for implementation. The areas with the biggest opportunities for improvement are *Policy Development and Support, Assessment*, and *Environmental Health*. These three areas may be considered more population-oriented than others, and their status as the lower-rated areas reflects the ongoing challenges to shift from direct clinical services to population-based public health services. In order to fully support this paradigm shift, continued efforts to increase capacity and capability in these areas are needed.

There were also wide differences between the rated 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 that have not yet been widely adopted, such as the ability to engage in Health in All Policies (HiAP) and participation in land use and development planning. A strategy to increase capability and capacity for these lower-rated components should be a part of further implementation efforts. However, it should also be noted that a higher rating does not necessarily mean that performance is “acceptable” or “unacceptable.” Performance standards should be developed which outline clear expectations for the delivery of the FPHS model components.

There were regional and demographic differences in the rated capacity and capability to deliver FPHS. Administrators of local public health agencies that serve more population-dense counties generally rated their agencies higher for capacity and capability than those that serve more sparsely populated areas. In northeast Kansas, and in more densely populated areas, the capacity for FCs was higher than for FAs. Furthermore, capacity for the FCs was correlated with FTEs and

total operating budgets. One explanation for this could be that in more densely populated areas, such as northeast Kansas, additional local or discretionary funding is applied toward FCs components, such as assessment, policy development, and health equity, which are less likely to have dedicated funding streams. Access to additional local or discretionary funding is more limited in rural areas. Additional budgetary details are necessary to further explore this connection.

The survey found that the total operating budgets and number of staff FTEs varied greatly among health departments. The smallest budget was just over $73,000, while the largest budget was more than $15.5 million. Per capita, budgets ranged from just under $7.00 per person to more than $210 per person. In general, smaller health departments spend more per capita on public health than larger health departments. This may be due to a variety of factors, including economies of scale and the mix of current services provided. More than half of the respondents had five FTEs or fewer, a level likely inadequate to cover all the components of the FCs and FAs even in small health departments. The wide range of FTEs (from 1 to 140) also poses important challenges in the movement towards achieving a more uniform level of foundational public health services in the state.

Furthermore, an analysis of the relationship between workforce, resources and capacity and capability showed that the number of FTEs and total operating budget were positively correlated with capacity ratings, but not with capability ratings. This finding is in alignment with the definition of capacity, which includes staff time and funding. However, given the weak correlation, it should be noted that funding and staffing are not the only factors that contribute to increased capacity. Other factors not covered by this survey may be driving differences in capacity between health departments.

Some of the most commonly noted barriers to implementation of the FPHS—other than funding—were available staff, adequate time, and sufficient training on the FPHS components. The number of staff is closely tied to the common theme of available time. Theoretically, additional staff would increase the number of man-hours available to do the work of the FPHS. The number of staff is also closely related to the noted lack of funding. Workforce development strategies could aid in increasing capability through the availability of qualified individuals for the FPHS roles, and could fill the stated need for training in many of the FCs and FAs.

Future Work

As the PHSG partners begin work to address these barriers and increase the capacity and capability for implementation of the FPHS in Kansas, there are several existing subcommittees which can play a role. Specifically, there are fiscal, policy and legal subcommittees exploring various topics and strategies to support the development of an FPHS implementation plan. The ongoing activities of these workgroups are critical, and can be informed by the results of this capacity assessment.

- A fiscal assessment of the current and needed resources to deliver the FPHS is currently underway. Based on the findings of the capacity and fiscal assessments, there is an opportunity for investing sufficient and targeted funds into the public health system that may help to address the identified gaps.

- The policy subcommittee is focused on governance strategies that may facilitate FPHS implementation. For example, cross-jurisdictional sharing may be one strategy to deliver services for which there is low capacity but high capability.

- The legal subcommittee is exploring the statutory and regulatory requirements for local health departments in Kansas as well as legal frameworks from other states engaged in FPHS work. The capacity assessment found that services with existing statutory for public health, such as the FA *Communicable Disease Control*, generally have higher capacity and capability. The proposal of a legal framework for the FPHS in Kansas could strengthen the basis for funding and supporting capacity and capability for implementing the FPHS model.

- Finally, the assessment subcommittee is currently working on developing a list of performance measures and standards to be included in a performance management system upon implementation of the FPHS. These performance measures would be used to inform continuous quality improvement and capacity building activities during and after FPHS implementation. The selection of the performance measures may be informed by the results of the capacity assessment and could focus on improvement in areas where there are gaps in current capacity and capability to implement specific FPHS components.

Conclusion

The current capacity and capability for implementation of FPHS services varies greatly between components of the model. There are also differences in the capacity and capability for implementation of FPHS by region and population density. In general, local health department administrators rated capacity lower than capability to implement the FPHS, showing the perceived need for additional resources to support local public health. As Kansas public health stakeholders continue their work to ensure a high-functioning public health system for all Kansans, the results of this assessment can inform focused activities and plans for capacity and capability improvements.

APPENDIX A: GLOSSARY OF KEY TERMS

Term	Definition	Page of First Reference
Foundational Public Health Services (FPHS)	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.	Page 3
Foundational Capability (FC)	Cross-cutting skills and abilities that need to be present everywhere to ensure high-quality and equitable public health services.	Page 3
Foundational Area (FA)	Substantive areas of expertise or program-specific activities.	Page 3
Component	Refers to the items subordinate to a Foundational Capability or Foundational Area.	Page 3
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. This group was originally convened by the Kansas Health Foundation (KHF) in 2001 and has been meeting regularly since then.	Page 3
Capacity	How much of something can be done. In other words, does the health department have the appropriate amount of staff, time and funding to fulfill the level of need for this service in the community?	Page 4
Capability	Whether or how well something can be done. In other words, are the skills, knowledge and expertise in place that are needed to perform the task?	Page 4
RESOLVE FPHS Model	RESOLVE is an independent, nonprofit organization that was contracted by the Public Health Leadership Forum to explore a new public health services framework. By 2014, RESOLVE had drafted a national model, often called the Foundational Public Health Services (FPHS) model or the RESOLVE model. Since 2014, this model has been adapted in several states.	Page 6
BERK Consulting, Inc.	BERK is an interdisciplinary consultancy integrating strategy, planning, and policy development; financial and economic analysis; and facilitation, design and communications. The Kansas PHSG has contracted with BERK to conduct a fiscal analysis of the projected costs to fully implement the FPHS model.	Page 8
FC: Assessment	The Assessment capability includes activities for the collection and analysis of public health data.	Page 22
FC: All Hazards Preparedness and Response	The All Hazards Preparedness/Response capability includes activities critical to prepare for and respond to public health emergencies.	Page 22
FC: Communications	The Communications capability includes activities that ensure a comprehensive communications strategy is developed and implemented.	Page 22
FC: Policy Development and Support	The Policy Development/Support capability includes activities to inform, develop and implement public health policy.	Page 22

FC: Organizational Competencies	The Organizational Competencies include activities to support the business, management and leadership functions within the public health system.	Page 22
FC: Addressing Health Equity and the Social Determinants of Health	Health Equity and Social Determinants of Health includes activities to identify and respond to health disparities and the needs of vulnerable populations.	Page 22
FA: Access to and Linkages with Clinical Care	The Access to Clinical Care area includes programs and activities for assuring access to specific preventive and primary care clinical services.	Page 23
FA: Environmental Health	The Environmental Health area includes programs and activities to prevent and reduce exposure to environmental hazards.	Page 23
FA: Communicable Disease Control	The Communicable Disease Control area includes programs and activities to prevent and control the spread of communicable disease.	Page 24
FA: 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)	Page 24
FA: 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.	Page 24

APPENDIX B: FPHS FOR KANSAS 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)."

The KALHD board adopted this vision statement 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 Foundational Public Health Services (FPHS). As part of these efforts, the Kansas Health Institute (KHI), in partnership with KALHD and the PHSG started to conduct an assessment of 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 compared them to the RESOLVE model.[1] 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 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 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*, there 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 the Kansas model, the components were evaluated against the following criteria:

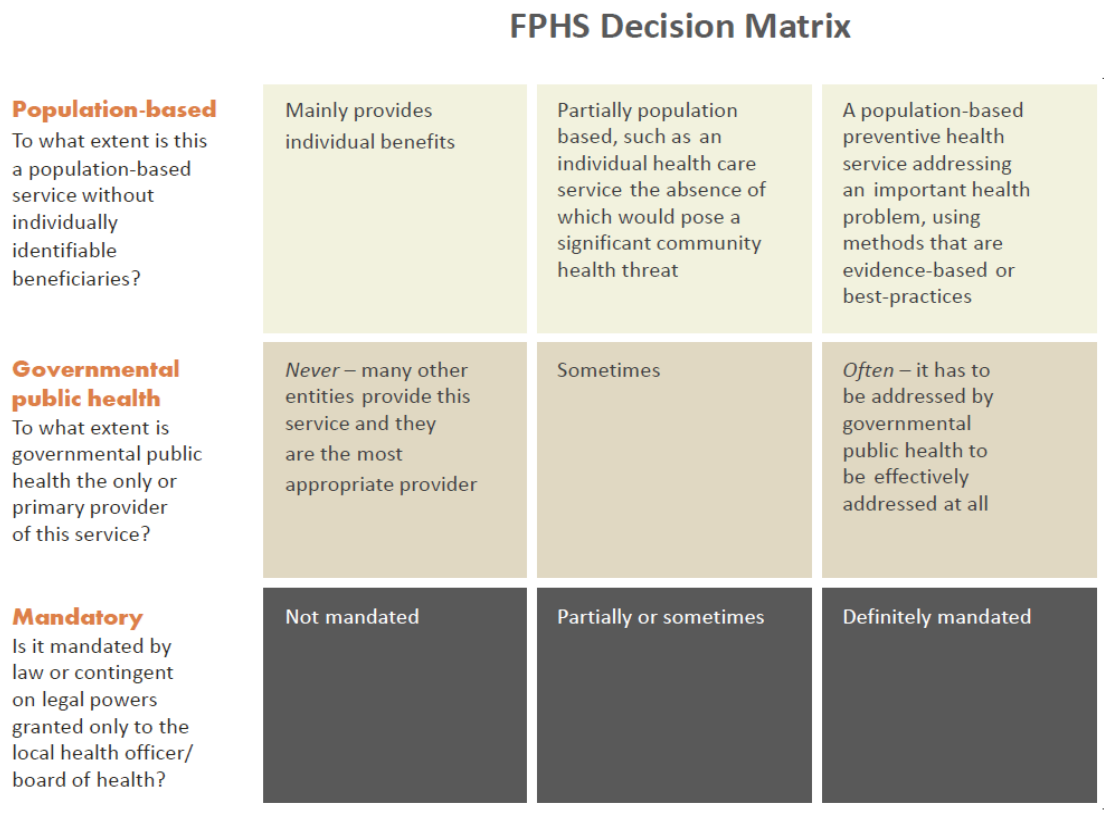
1) ***Population-based*** preventive health services that target specific communities defined by geography, race, ethnicity, gender, illness or other health conditions (e.g., water fluoridation, creation of walkable communities);

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

3) ***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 (*Figure B-1*, page 43). Priority is given to the services that fall in the far right column.

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



Source: Washington State Department of Health, 2015.

When becoming 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.

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 (e.g., 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 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

Health Equity and Social Determinants of Health 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 (e.g., 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 Chronic Disease and Injury 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, 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 C: FPHS CAPACITY ASSESSMENT SURVEY QUESTIONNAIRE

FPHS Capacity Assessment

March 3, 2017

Dear Health Department Administrator,

The Kansas Health Institute, in partnership with the Kansas Public Health Systems Group (PHSG), is conducting an assessment of the Foundational Public Health Services (FPHS) in Kansas. The purpose of this assessment is to determine an FPHS model for Kansas and to examine the system's current capacity for future implementation of the model.

This self-assessment allows LHDs to assess their current capacity and expertise to deliver the proposed FPHS model for Kansas. This is not a performance assessment and this information will not be used in any way to penalize you or your agency. The results of the survey will be used to identify gaps and strategies for improvement at a state level and will inform the future implementation of the FPHS in Kansas. Your responses will be compiled with other responses and reports will never identify your individual response. You can choose to skip questions that you don't feel comfortable answering and you can stop at any time. There have been no identified personal risks or benefits to participating in this survey.

The survey should take approximately one hour of your time. If you are unable to complete it all at once, you may save by simply closing the survey and returning to it by clicking on the provided link from the same computer you started it on. We ask that you complete the survey no later than March 24, 2017. Please contact Sarah Hartsig at shartsig@khi.org with any questions. Thank you for your participation!

By clicking "next," you are verifying that you have read the explanation of the study and that you agree to participate.

Background

In September 2015, a group of KALHD members met to set a vision for local public health in the state. The vision is:

"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 conducting an assessment of 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.

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. 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 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 further define what it means to fully implement that capability or area. It may be helpful to review the list of *Foundational Capabilities, Foundational Areas*, and components within each prior to responding to this survey. The document containing these can be found at the following link: http://www.kalhd.org/wp-content/uploads/2012/10/FPHS-in-Kansas.pdf

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 services are not included in the FPHS model because they are not provided at all health departments. However, they are still important and essential for local communities.

Instructions

This survey is a self-assessment of how well you believe that your organization is currently able to provide these capabilities and areas and the quality with which you are able to provide them. Please be as honest as possible: there is no reward for a "high" answer, nor penalty for a "low" one, and the more accurate the responses are, the better we will be able to respond to identified needs. It is perfectly okay if your answer is "none" for some or many of the items on this survey, as it provides us a way to plan for future capacity-building efforts. This is not a performance assessment and the results from individual agencies will not be published. This information will not be used in any way to penalize you or your agency. Each set of components is assessed twice using two scales: a capability scale and a capacity scale. Capability is a measure of whether or how well something can be done. Are the skills, knowledge, and expertise in place that are needed to perform the task?

Capacity is a measure of how much of something can be done. Does the health department have the appropriate amount of staff, time and funding to fulfill the level of need for this service in the community? In this document, capability and capacity are both assessed using the following scale:

0 – None

1– Minimal

2 – Some

3 – Sufficient

4 – Full

We realize that some of these responses involve a level of subjectivity. This is inherent to an assessment like this that does not involve objective measurements of the quality and intensity of each activity. We encourage you to answer each question to the best of your knowledge.

Please note: In some cases, the component that we are asking about contains the term "assure." To "assure" means that 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. For the components that begin with "'assure,"'

please indicate your capability/capacity to ensure that the service is available in the community, whether or not it is provided by the health department.

For all other components (when "assure" is not present), please indicate the current capability/capacity of the health department to provide the service. A service can be provided directly or through a contract with another health department or a private entity. In a contract, the health department retains primary responsibility for the service, or shares that responsibility with another health department (for example, through a cross-jurisdictional agreement).

You may save and return to the survey using the provided link if you are unable to complete it all at once. If you have any questions or would like assistance as you complete this survey, please contact Sarah Hartsig at shartsig@khi.org.

Please select your agency from the following list: (Drop-down list)

Part 1: Foundational Capabilities:

The Foundational Capabilities are the cross-cutting skills that need to be present everywhere for the system to work anywhere.

Assessment

The *Assessment* capability includes activities for the collection and analysis of public health data. To what degree does your department currently have the capability (i.e., skills, knowledge and expertise) and capacity (i.e., the appropriate amounts of staff, time and funding) for the following components that are part of the *Assessment* capability?

	Capability (skills, knowledge, and expertise)					Capacity (staff, time, and funding)				
	4 Full	3 Sufficient	2 Some	1 Minimal	0 None	4 Full	3 Sufficient	2 Some	1 Minimal	0 None
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 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.	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Please indicate your level of agreement with the following statement: "My health department is currently able to perform the components within the Assessment capability."

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree

What are some barriers—other than financial constraints—that contribute to a current gap in capability or capacity for the Assessment capability?

[Repeated for each of the Foundational Capabilities]

Part 2: Foundational Areas

Foundational Areas are the substantive areas of expertise or program-specific activities.

Please note: 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. For the components that begin with "assure," please indicate your capability/capacity to ensure that the service is available in the community, whether or not it is provided by the health department. For all other components (when "assure" is not present), please indicate the capability/capacity of the health department to provide the service or to contract with another entity to do so.

Communicable Disease Control

The *Communicable Disease Control* Foundational Area includes activities to prevent and control the spread of communicable disease. To what degree does your department currently have the capability (i.e., skills, knowledge and expertise) and capacity (i.e., the appropriate amounts of staff, time and funding) for the following components that are part of *Communicable Disease Control*?

	Capability (skills, knowledge, and expertise)					Capacity (staff, time, and funding)				
	4 Full	3 Sufficient	2 Some	1 Minimal	0 None	4 Full	3 Sufficient	2 Some	1 Minimal	0 None
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.	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Please indicate your level of agreement with the following statement: "My health department is currently able to perform the components within Communicable Disease Control."

- o Strongly agree
- o Somewhat agree
- o Neither agree nor disagree
- o Somewhat disagree
- o Strongly disagree

What are some barriers—other than financial constraints—that contribute to a current gap in capability or capacity for *Communicable Disease Control*?

[Repeated for each of the Foundational Areas]

Part 3: Budgetary Considerations

The following questions have been added to assist in the development of a financial model for the implementation of FPHS.

What is your total operating budget for 2017? (Please provide a value without a dollar sign)

If your local health department operating budget does not include environmental public health services—like inspections—please provide your county's operating budget for 2017. (Please provide a value without a dollar sign)

How many total full-time equivalents (FTE; equal to approximately 2,080 hours per year) are included in your operating budget for 2017? (Please provide a numerical value)

If possible, please provide the number of FTE you have on staff by job title.

Approximately what percentage of your total 2017 operating costs/expenditures went to overhead costs (i.e., facility costs such as rent, maintenance, utilities, or other overhead costs like a car fleet)? Please provide this percentage as a whole number without a percentage sign)

Does your local health department have access to general county support services (i.e., finance, HR, communications, IT) that are not included in these numbers? If so, please describe.

Are your budgeted expenditures in 2017 representative of your normal annual costs? In other words, are your 2017 costs in line with your costs in previous years? If not, why?

Thank you for completing this assessment. We appreciate your time and effort. If you have any questions about the FPHS or the survey and how the results will be used, please contact Sarah Hartsig at shartsig@khi.org. Thank you!

APPENDIX D: FULL SURVEY RESULTS

Figure D-1. Results for each Component, by Capacity and Capability (percent of respondents indicating each response option)

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Foundational Capabilities	1.9%	11.8%	31.9%	40.0%	14.4%	54.4%	3.5%	28.1%	36.1%	25.2%	7.0%	32.2%
Assessment	3.7%	18.2%	35.6%	34.7%	7.7%	42.4%	8.0%	35.6%	40.0%	14.8%	1.5%	16.4%
Ability to participate in the collection of primary public health data.	1.2%	8.6%	35.8%	46.9%	7.4%	54.3%	3.7%	32.1%	50.6%	13.6%	0.0%	13.6%
Ability to access and utilize secondary data from key sources, including U.S. Census data, vital statistics, Behavioral Risk Factor Surveillance Survey (BRFSS), etc.	1.2%	9.9%	33.3%	43.2%	12.3%	55.6%	7.4%	28.4%	42.0%	18.5%	3.7%	22.2%
Ability to interpret, display, and communicate public health data and its analysis.	2.5%	25.9%	34.6%	32.1%	4.9%	37.0%	9.9%	40.7%	34.6%	13.6%	1.2%	14.8%
Ability to identify patterns, causes, and effects of chronic and communicable diseases (epidemiology).	6.2%	18.5%	35.8%	33.3%	6.2%	39.5%	7.4%	37.0%	39.5%	14.8%	1.2%	16.0%
Ability to lead or participate in a community health assessment, including health disparity analysis and identification of health priorities.	1.2%	14.8%	40.7%	30.9%	12.3%	43.2%	4.9%	40.7%	33.3%	17.3%	3.7%	21.0%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Abilitto respond to data requests with meaningful reports (valid, statistically accurate, and readable by intended audiences).	3.7%	29.6%	35.8%	27.2%	3.7%	30.9%	9.9%	38.3%	40.7%	11.1%	0.0%	11.1%
Ability to evaluate efficiency and effectiveness of public health programs.	3.7%	18.5%	40.7%	30.9%	6.2%	37.0%	6.2%	38.3%	42.0%	11.1%	2.5%	13.6%
Ability to access and utilize electronic health information systems.	9.9%	19.8%	28.4%	33.3%	8.6%	42.0%	14.8%	29.6%	37.0%	18.5%	0.0%	18.5%
All Hazards Preparedness and Response	0.4%	6.8%	24.7%	47.5%	20.6%	68.1%	0.6%	24.7%	33.8%	29.7%	11.2%	40.9%
Ability to develop and rehearse emergency response strategies and plans.	0.0%	4.9%	28.4%	54.3%	12.3%	66.7%	0.0%	18.5%	44.4%	29.6%	7.4%	37.0%
Ability to coordinate with emergency response partners from both private and governmental sectors.	0.0%	3.7%	21.0%	50.6%	24.7%	75.3%	0.0%	21.0%	32.1%	39.5%	7.4%	46.9%
Ability to serve as the local primary or coordinating agency for Emergency Support Function 8 - Public Health and Medical.	1.2%	4.9%	23.5%	54.3%	16.0%	70.4%	1.2%	27.2%	34.6%	29.6%	7.4%	37.0%
Ability to operate within the National Incident Management System as well as within any local emergency response processes.	2.5%	3.7%	32.1%	49.4%	12.3%	61.7%	1.2%	22.2%	38.3%	29.6%	8.6%	38.3%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
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.	0.0%	8.6%	23.5%	50.6%	17.3%	67.9%	0.0%	28.4%	30.9%	35.8%	4.9%	40.7%
Ability to maintain a continuity of operations plan (COOP) that includes access to financial resources to execute emergency responses.	0.0%	7.4%	28.4%	53.1%	11.1%	64.2%	0.0%	30.9%	33.3%	30.9%	4.9%	35.8%
Ability to conduct investigations of threats to public health.	1.2%	11.1%	32.1%	42.0%	13.6%	55.6%	1.2%	35.8%	34.6%	22.2%	6.2%	28.4%
Ability to issue emergency health orders via statutory authority (community disease containment, mandated treatment, boil water orders, etc.).	0.0%	17.3%	27.2%	42.0%	13.6%	55.6%	1.2%	28.4%	29.6%	34.6%	6.2%	40.7%
Ability to identify, prioritize, and address the needs of vulnerable populations in advance of a public health emergency.	0.0%	9.9%	43.2%	43.2%	3.7%	46.9%	1.2%	30.9%	42.0%	23.5%	2.5%	25.9%
Ability to be notified of public health emergencies on a 24/7 basis.	0.0%	1.2%	8.6%	38.3%	51.9%	90.1%	0.0%	13.6%	27.2%	28.4%	30.9%	59.3%
Ability to respond to public health emergencies on a	0.0%	4.9%	16.0%	45.7%	33.3%	79.0%	0.0%	25.9%	33.3%	21.0%	19.8%	40.7%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
24/7 basis.												
Ability to notify the public of a public health emergency on a 24/7 basis	0.0%	4.9%	22.2%	43.2%	29.6%	72.8%	0.0%	18.5%	32.1%	28.4%	21.0%	49.4%
Ability to package and ship clinical specimens to the state reference laboratory (Kansas Health and Environmental Laboratory, or KHEL) for identification of threats.	0.0%	6.2%	14.8%	50.6%	28.4%	79.0%	1.2%	19.8%	27.2%	33.3%	18.5%	51.9%
Communications	1.9%	11.4%	33.6%	39.6%	13.6%	53.1%	2.8%	24.4%	41.7%	23.9%	7.1%	31.1%
Ability to maintain ongoing relationships with local media outlets.	2.5%	4.9%	21.0%	48.1%	23.5%	71.6%	2.5%	18.5%	35.8%	28.4%	14.8%	43.2%
Ability to develop and implement a strategic communications plan to articulate the agency's mission, vision, values, roles, and responsibilities to the community.	1.2%	17.3%	40.7%	32.1%	8.6%	40.7%	7.4%	23.5%	44.4%	21.0%	3.7%	24.7%
Ability to communicate the role of public health to the public and to policymakers.	0.0%	6.2%	34.6%	44.4%	14.8%	59.3%	0.0%	22.2%	44.4%	27.2%	6.2%	33.3%
Ability to communicate specific health or public health issues through written and verbal communication tools.	0.0%	2.5%	34.6%	43.2%	19.8%	63.0%	0.0%	22.2%	39.5%	30.9%	7.4%	38.3%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
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.)	0.0%	14.8%	32.1%	42.0%	11.1%	53.1%	1.2%	24.7%	40.7%	25.9%	7.4%	33.3%
Ability to communicate in culturally and linguistically appropriate and accessible formats for various communities served, in accordance with state and federal guidelines.	4.9%	18.5%	38.3%	30.9%	7.4%	38.3%	4.9%	27.2%	46.9%	17.3%	3.7%	21.0%
Ability to facilitate two-way communications (transmit and receive) with the public via social media and other tools.	3.7%	11.1%	25.9%	44.4%	14.8%	59.3%	1.2%	27.2%	39.5%	23.5%	8.6%	32.1%
Ability to develop and implement a proactive health education strategy to support good population health.	2.5%	16.3%	41.3%	31.3%	8.8%	40.0%	5.0%	30.0%	42.5%	17.5%	5.0%	22.5%
Policy Development & Support	1.9%	11.4%	33.6%	39.6%	13.6%	53.1%	6.9%	37.5%	35.6%	18.0%	2.0%	20.0%
Ability to identify evidence-based public health policy recommendations.	1.2%	19.8%	38.3%	35.8%	4.9%	40.7%	6.2%	37.0%	37.0%	18.5%	1.2%	19.8%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Ability to work with partners and policymakers to develop and enact public health policies.	2.5%	19.8%	34.6%	35.8%	7.4%	43.2%	3.7%	38.3%	35.8%	18.5%	3.7%	22.2%
Ability to work with partners and policymakers to support the development of public health administrative rules, regulations and ordinances.	3.7%	16.0%	39.5%	34.6%	6.2%	40.7%	7.4%	34.6%	33.3%	22.2%	2.5%	24.7%
Ability to utilize Health in All Policies (HiAP) approaches for all policy development.	13.6%	32.1%	37.0%	16.0%	1.2%	17.3%	12.3%	42.0%	35.8%	8.6%	1.2%	9.9%
Ability to enforce public health mandates (e.g., policies, statutes, regulations, ordinances.)	1.2%	18.5%	39.5%	33.3%	7.4%	40.7%	4.9%	35.8%	35.8%	22.2%	1.2%	23.5%
Community Partnership Development	0.5%	10.9%	36.3%	40.7%	11.6%	52.3%	3.5%	26.2%	42.7%	22.7%	4.9%	27.7%
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.	0.0%	2.5%	28.4%	50.6%	18.5%	69.1%	3.7%	21.0%	37.0%	32.1%	6.2%	38.3%
Ability to strategically select and articulate governmental public health roles in programmatic and policy activities.	1.2%	14.8%	43.2%	35.8%	4.9%	40.7%	4.9%	30.9%	44.4%	17.3%	2.5%	19.8%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Ability to work with community members and organizational partners to identify community assets and resources.	0.0%	4.9%	24.7%	49.4%	21.0%	70.4%	2.5%	22.2%	42.0%	24.7%	8.6%	33.3%
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.	1.2%	19.8%	45.7%	27.2%	6.2%	33.3%	2.5%	33.3%	45.7%	14.8%	3.7%	18.5%
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.	0.0%	12.3%	39.5%	40.7%	7.4%	48.1%	3.7%	23.5%	44.4%	24.7%	3.7%	28.4%
Organizational Competencies	1.8%	8.7%	29.8%	40.6%	19.1%	59.7%	2.8%	24.6%	31.3%	31.0%	10.3%	41.4%
Ability to serve as the public face of governmental public health in the community.	0.0%	2.5%	24.7%	51.9%	21.0%	72.8%	0.0%	17.3%	34.6%	37.0%	11.1%	48.1%
Ability to define and communicate strategic direction for public health initiatives through agency strategic planning processes.	1.2%	18.5%	50.6%	21.0%	8.6%	29.6%	1.2%	39.5%	33.3%	22.2%	3.7%	25.9%
Ability to uphold business practices in accordance with local, state and federal laws,	0.0%	3.7%	16.0%	55.6%	24.7%	80.2%	0.0%	17.3%	25.9%	43.2%	13.6%	56.8%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
and professional standards.												
Ability to develop and maintain a performance management system to monitor achievement of organizational and programmatic objectives.	3.7%	17.3%	45.7%	22.2%	11.1%	33.3%	6.2%	33.3%	39.5%	16.0%	4.9%	21.0%
Ability to continuously evaluate and improve organizational processes, including using planning tools such as Plan-Do-Study-Act (PDSA) cycles.	8.6%	25.9%	35.8%	22.2%	7.4%	29.6%	8.6%	39.5%	32.1%	18.5%	1.2%	19.8%
Ability to systematically apply computer literacy skills and information technology to public health practice and learning.	2.5%	22.2%	33.3%	29.6%	12.3%	42.0%	3.7%	37.0%	27.2%	28.4%	3.7%	32.1%
Ability to have proper systems in place to keep protected health information (PHI) and confidential organizational data restricted.	0.0%	3.7%	16.0%	51.9%	28.4%	80.2%	2.5%	16.0%	25.9%	42.0%	13.6%	55.6%
Ability to recruit and retain a competent public health workforce with considerations for succession planning.	3.7%	13.6%	38.3%	37.0%	7.4%	44.4%	9.9%	30.9%	28.4%	27.2%	3.7%	30.9%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Ability to develop and maintain a competent public health workforce through workforce development and training, performance review, and staff accountability.	2.5%	4.9%	37.0%	43.2%	12.3%	55.6%	2.5%	28.4%	37.0%	25.9%	6.2%	32.1%
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.	0.0%	0.0%	21.0%	45.7%	33.3%	79.0%	0.0%	14.8%	29.6%	37.0%	18.5%	55.6%
Ability to comply with federal, state and local standards, and policies for contracting.	0.0%	2.5%	28.4%	42.0%	27.2%	69.1%	1.2%	19.8%	24.7%	37.0%	17.3%	54.3%
Ability to procure, maintain and manage resources to support agency operations (e.g., funding, assets, supplies and hardware/software).	1.2%	6.2%	23.5%	50.6%	18.5%	69.1%	2.5%	21.0%	30.9%	37.0%	8.6%	45.7%
Ability to procure, maintain and manage safe facilities to support agency operations.	0.0%	3.7%	19.8%	45.7%	30.9%	76.5%	2.5%	16.0%	27.2%	37.0%	17.3%	54.3%
Ability to access appropriate governmental legal services to support agency operations.	2.5%	3.7%	27.2%	42.0%	24.7%	66.7%	1.2%	22.2%	25.9%	34.6%	16.0%	50.6%
Ability to engage with the public health governing entity to advocate for public health funding and	1.2%	7.4%	35.8%	35.8%	19.8%	55.6%	2.5%	23.5%	32.1%	28.4%	13.6%	42.0%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
initiatives.												
Ability to coordinate and integrate categorically funded programs and services.	1.2%	3.7%	23.5%	53.1%	18.5%	71.6%	0.0%	17.3%	45.7%	24.7%	12.3%	37.0%
Addressing Health Equity & the Social Determinants of Health	2.0%	16.0%	39.0%	36.0%	6.9%	43.0%	4.2%	34.6%	36.8%	23.5%	1.0%	24.4%
Ability to recognize and understand the determinants of health disparities within the community.	1.2%	6.2%	38.3%	44.4%	9.9%	54.3%	2.5%	24.7%	44.4%	27.2%	1.2%	28.4%
Ability to coordinate programming to improve health disparities within the community.	1.2%	14.8%	46.9%	34.6%	2.5%	37.0%	3.7%	38.3%	37.0%	21.0%	0.0%	21.0%
Ability to develop and advocate for policies that will promote health for all, particularly the most vulnerable.	1.2%	19.8%	40.7%	30.9%	7.4%	38.3%	4.9%	38.3%	38.3%	16.0%	2.5%	18.5%
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.	2.5%	16.0%	35.8%	37.0%	8.6%	45.7%	2.5%	34.6%	30.9%	32.1%	0.0%	32.1%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Ability to provide public health information for the community that is stratified by demographic characteristics.	3.7%	23.5%	33.3%	33.3%	6.2%	39.5%	7.4%	37.0%	33.3%	21.0%	1.2%	22.2%
Foundational Areas	5.2%	14.6%	28.1%	34.8%	17.3%	52.1%	10.5%	26.6%	28.3%	25.4%	9.1%	34.6%
Communicable Disease Control	1.2%	5.5%	22.1%	45.8%	25.4%	71.1%	2.3%	22.4%	28.9%	34.6%	11.9%	46.4%
Provide timely, accurate and locally relevant information on communicable diseases and their control, including strategies to increase local immunization rates.	0.0%	2.5%	12.3%	65.4%	19.8%	85.2%	1.2%	17.3%	34.6%	37.0%	9.9%	46.9%
Identify assets for communicable disease control.	1.2%	4.9%	17.3%	59.3%	17.3%	76.5%	0.0%	22.2%	33.3%	40.7%	3.7%	44.4%
Develop and implement a communicable disease control plan prioritizing important communicable diseases.	1.2%	8.6%	30.9%	40.7%	18.5%	59.3%	2.5%	28.4%	33.3%	30.9%	4.9%	35.8%
Advocate and seek funding for communicable disease control policies and initiatives.	3.7%	23.5%	43.2%	21.0%	8.6%	29.6%	9.9%	35.8%	35.8%	16.0%	2.5%	18.5%
Assure availability of public health laboratory services for reference and confirmatory testing related to communicable diseases.	8.6%	6.2%	28.4%	38.3%	18.5%	56.8%	8.6%	28.4%	24.7%	30.9%	7.4%	38.3%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Receive and promptly process laboratory and clinical reports of communicable diseases.	0.0%	4.9%	21.0%	46.9%	27.2%	74.1%	0.0%	23.5%	29.6%	34.6%	12.3%	46.9%
Conduct disease investigations, including contact tracing and notification, in accordance with national, state, and local mandates and guidelines.	0.0%	1.2%	18.5%	48.1%	32.1%	80.2%	1.2%	19.8%	30.9%	35.8%	12.3%	48.1%
Identify and respond to communicable disease outbreaks in accordance with national, state, and local mandates and guidelines.	0.0%	2.5%	19.8%	49.4%	28.4%	77.8%	0.0%	23.5%	30.9%	34.6%	11.1%	45.7%
Support local screening/testing of reportable diseases, based on national and state recommendations and guidelines.	0.0%	4.9%	22.2%	49.4%	23.5%	72.8%	3.7%	18.5%	30.9%	35.8%	11.1%	46.9%
In conjunction with appropriate partners, enforce emergency health orders via statutory authority (e.g., community disease containment, mandated treatment, boil water orders, etc.).	1.2%	9.9%	22.2%	45.7%	21.0%	66.7%	1.2%	24.7%	28.4%	38.3%	7.4%	45.7%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
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).	0.0%	0.0%	7.4%	29.6%	63.0%	92.6%	0.0%	11.1%	16.0%	30.9%	42.0%	72.8%
Assure proper diagnosis and treatment for individuals with latent or active tuberculosis in accordance with national, state, and local mandates and guidelines.	0.0%	0.0%	16.0%	48.1%	35.8%	84.0%	1.2%	13.6%	16.0%	46.9%	22.2%	69.1%
Educate providers in national, state, and local communicable disease control mandates and guidelines.	0.0%	2.5%	28.4%	53.1%	16.0%	69.1%	0.0%	24.7%	30.9%	37.0%	7.4%	44.4%
Health Promotion and Chronic Disease & Injury Prevention	3.3%	15.7%	37.4%	32.5%	11.1%	43.6%	10.9%	32.6%	29.9%	22.1%	4.6%	26.7%
Provide timely, accurate, and locally relevant information on health promotion and chronic disease and injury prevention.	0.0%	11.1%	32.1%	40.7%	16.0%	56.8%	6.2%	33.3%	32.1%	22.2%	6.2%	28.4%
Identify assets for health promotion and chronic disease and injury prevention.	0.0%	12.3%	37.0%	40.7%	9.9%	50.6%	4.9%	35.8%	27.2%	28.4%	3.7%	32.1%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Develop and implement a health promotion and chronic disease and injury prevention plan.	2.5%	23.5%	32.1%	32.1%	9.9%	42.0%	11.1%	34.6%	30.9%	18.5%	4.9%	23.5%
Advocate and seek funding for health promotion and chronic disease and injury prevention policies and initiatives.	3.7%	18.5%	40.7%	24.7%	12.3%	37.0%	12.3%	38.3%	23.5%	21.0%	4.9%	25.9%
Work with partners to identify evidence-based, population-based interventions that utilize valid evaluation studies.	3.7%	17.3%	37.0%	29.6%	12.3%	42.0%	9.9%	30.9%	32.1%	23.5%	3.7%	27.2%
Work to reduce rates of tobacco use through policies and programs that conform with local, state, and federal laws and recommendations.	2.5%	9.9%	34.6%	43.2%	9.9%	53.1%	11.1%	28.4%	29.6%	25.9%	4.9%	30.9%
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.	1.2%	13.6%	37.0%	37.0%	11.1%	48.1%	4.9%	33.3%	33.3%	22.2%	6.2%	28.4%
Develop and implement comprehensive community-based health promotion strategies to address common risk factors and chronic diseases.	4.9%	17.3%	39.5%	29.6%	8.6%	38.3%	12.3%	30.9%	32.1%	19.8%	4.9%	24.7%
Promote community mental health and well-being.	3.7%	21.0%	37.0%	25.9%	12.3%	38.3%	16.0%	29.6%	30.9%	19.8%	3.7%	23.5%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Work to reduce rates of substance abuse in the community.	11.1%	12.3%	46.9%	21.0%	8.6%	29.6%	19.8%	30.9%	27.2%	19.8%	2.5%	22.2%
Environmental Health	12.7%	26.3%	29.1%	23.0%	8.9%	31.9%	23.4%	29.5%	26.6%	16.1%	4.4%	20.5%
Provide timely, accurate and locally relevant information on environmental public health issues and health impacts from both common and toxic exposure sources.	12.3%	27.2%	34.6%	19.8%	6.2%	25.9%	21.0%	33.3%	28.4%	14.8%	2.5%	17.3%
Identify assets for environmental public health.	9.9%	30.9%	37.0%	18.5%	3.7%	22.2%	24.7%	29.6%	29.6%	13.6%	2.5%	16.0%
Advocate and seek funding for environmental public health policies and initiatives.	21.0%	30.9%	34.6%	9.9%	3.7%	13.6%	35.0%	27.5%	26.3%	8.8%	2.5%	11.3%
Develop and implement an environmental public health plan to prevent and reduce exposures to health hazards in the environment.	22.2%	30.9%	33.3%	9.9%	3.7%	13.6%	38.3%	24.7%	24.7%	9.9%	2.5%	12.3%
Assure availability of public health laboratory services for reference and confirmatory testing related to environmental public health threats.	9.9%	30.9%	29.6%	21.0%	8.6%	29.6%	23.5%	29.6%	28.4%	13.6%	4.9%	18.5%
Assure implementation of environmental public health inspections (e.g., inspection of child care facilities) in accordance with federal, state, and local laws and regulations.	6.2%	21.0%	22.2%	35.8%	14.8%	50.6%	17.3%	24.7%	25.9%	27.2%	4.9%	32.1%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
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).	8.6%	27.2%	25.9%	27.2%	11.1%	38.3%	19.8%	28.4%	27.2%	19.8%	4.9%	24.7%
Identify and address notifiable conditions and environmental hazards.	7.4%	25.9%	34.6%	25.9%	6.2%	32.1%	13.6%	42.0%	22.2%	19.8%	2.5%	22.2%
Assure access to elevated blood lead screenings.	1.2%	8.6%	21.0%	38.3%	30.9%	69.1%	6.2%	19.8%	24.7%	33.3%	16.0%	49.4%
Support adult and child blood lead case management.	4.9%	17.3%	27.2%	37.0%	13.6%	50.6%	13.8%	32.5%	22.5%	27.5%	3.8%	31.3%
Prevent or reduce environmental public health hazards and assure abatement of nuisances.	9.9%	30.9%	35.8%	18.5%	4.9%	23.5%	25.9%	33.3%	29.6%	7.4%	3.7%	11.1%
Participate in land use planning and sustainable development (e.g., consideration of housing, urban development, recreational facilities and transportation).	37.0%	29.6%	17.3%	11.1%	4.9%	16.0%	41.3%	30.0%	22.5%	3.8%	2.5%	6.3%
Provide the community with information on reducing unnecessary radiation exposure (e.g., radon in the home).	14.8%	30.9%	24.7%	25.9%	3.7%	29.6%	24.7%	28.4%	33.3%	9.9%	3.7%	13.6%
Maternal and Child Health	3.7%	15.2%	31.5%	36.4%	13.2%	49.6%	5.6%	29.2%	32.5%	24.3%	8.4%	32.7%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
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.	3.7%	14.8%	33.3%	37.0%	11.1%	48.1%	4.9%	32.1%	28.4%	27.2%	7.4%	34.6%
Identify assets for maternal and child health.	2.5%	7.4%	28.4%	45.7%	16.0%	61.7%	2.5%	24.7%	32.1%	30.9%	9.9%	40.7%
Develop and implement a prioritized maternal and child health prevention plan using life course approaches and an understanding of health priorities.	3.7%	18.5%	34.6%	30.9%	12.3%	43.2%	4.9%	33.3%	32.1%	22.2%	7.4%	29.6%
Advocate and seek funding for maternal and child health policies and initiatives.	4.9%	23.5%	33.3%	27.2%	11.1%	38.3%	7.4%	33.3%	30.9%	19.8%	8.6%	28.4%
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.	4.9%	11.1%	27.2%	43.2%	13.6%	56.8%	7.4%	25.9%	34.6%	23.5%	8.6%	32.1%
Identify, disseminate and promote evidence-based information about early interventions in the prenatal period to lower infant mortality and pre-term birth outcomes.	2.5%	16.0%	32.1%	34.6%	14.8%	49.4%	6.2%	25.9%	37.0%	22.2%	8.6%	30.9%

	Capability						Capacity					
	None	Minimal	Some	Sufficient	Full	Full or Sufficient	None	Minimal	Some	Sufficient	Full	Full or Sufficient
Access to Clinical Care	2.3%	6.6%	19.8%	38.9%	32.5%	71.4%	4.7%	17.1%	23.7%	32.7%	21.8%	54.5%
Provide timely, accurate, and locally relevant information on how to access and navigate the health care system.	2.5%	7.4%	33.3%	39.5%	17.3%	56.8%	6.2%	22.2%	28.4%	29.6%	13.6%	43.2%
Assure access to family planning services.	7.4%	3.7%	18.5%	37.0%	33.3%	70.4%	7.4%	14.8%	19.8%	38.3%	19.8%	58.0%
Assure access to maternal and infant services (e.g., maternity support, WIC)	0.0%	1.2%	11.1%	40.7%	46.9%	87.7%	0.0%	12.3%	18.5%	35.8%	33.3%	69.1%
Assure access to STD and HIV testing and treatment.	3.7%	6.2%	18.5%	33.3%	38.3%	71.6%	6.2%	14.8%	23.5%	34.6%	21.0%	55.6%
Link community members to existing clinical services (including oral health services) and health insurance resources in the community.	0.0%	8.6%	19.8%	42.0%	29.6%	71.6%	3.7%	18.5%	27.2%	30.9%	19.8%	50.6%
Link community members to existing behavioral health services in the community.	0.0%	12.3%	17.3%	40.7%	29.6%	70.4%	4.9%	19.8%	24.7%	27.2%	23.5%	50.6%

Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

APPENDIX E: RESULTS OF STATISTICAL TESTS

Figure E-1. **Correlation Coefficients and Significant Associations Between Total and Per Capita Budget, FTEs, and Population and Capability and Capacity—Overall and for FCs and FAs**

	Capacity (Overall)	Capability (Overall)	FCs		FAs	
			Capacity	Capability	Capacity	Capability
Population	0.24*	0.20	0.27*	0.23*	0.19	0.14
Total operating budget	0.24*	0.22	0.26*	0.25*	0.18	0.16
Per capita budget	-0.05	-0.03	-0.09	-0.02	0.01	-0.05
Number of FTEs	0.23*	0.20	0.25*	0.23*	0.17	0.15

*Denotes significance at the p<0.05 level.

Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Figure E-2. **Kruskal-Wallis Results: P-Value of Global Models**

	Budget Per Capita	Capacity (Overall)	Capability (Overall)	FCs		FAs	
				Capacity	Capability	Capacity	Capability
Population Density	<0.01*	0.2	0.2	0.04^	0.13	0.71	0.37
Region	0.01*	0.6	0.4	0.37	0.32	0.75	0.51

*Denotes significance at the p<0.05 level. See post-hoc results for significant associations in Figures E-3 and E-4.

^Denotes significance at the p>0.05 level, however, no significant associations between individual groups were found during post-hoc tests. *Figure E-5*.

Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Figure E-3. **Budget Per Capita: Differences Between Population Density Groups, P-Values Using a Tukey and Kramer (Nemenyi) Post-Hoc Test**

	Frontier	Rural	Densely-Settled Rural	Semi-Urban	Urban
Frontier	--				
Rural	0.71	--			
Densely Settled Rural	<0.01*	0.09	--		
Semi-Urban	<0.01*	0.06	0.99	--	
Urban	<0.01*	0.06	0.93	0.99	--

Note: *Denotes significance at the p<0.05 level.

Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Figure E-4. **Budget Per Capita: Differences Between Regions, P-Values Using a Tukey and Kramer (Nemenyi) Post-Hoc Test**

	Northwest	Southwest	North Central	South Central	Northeast	Southeast
Northwest	--					
Southwest	1.00	--				
North Central	0.97	0.99	--			
South Central	0.88	0.66	0.36	--		
Northeast	0.17	0.05*	0.02*	0.69	--	
Southeast	0.73	0.59	0.36	0.98	1.00	--

Note: *Denotes significance at the p<0.05 level.

Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

Figure E-5. **Capacity for FCs: Differences Between Population Density Groups, P-Values Using a Tukey and Kramer (Nemenyi) Post-Hoc Test**

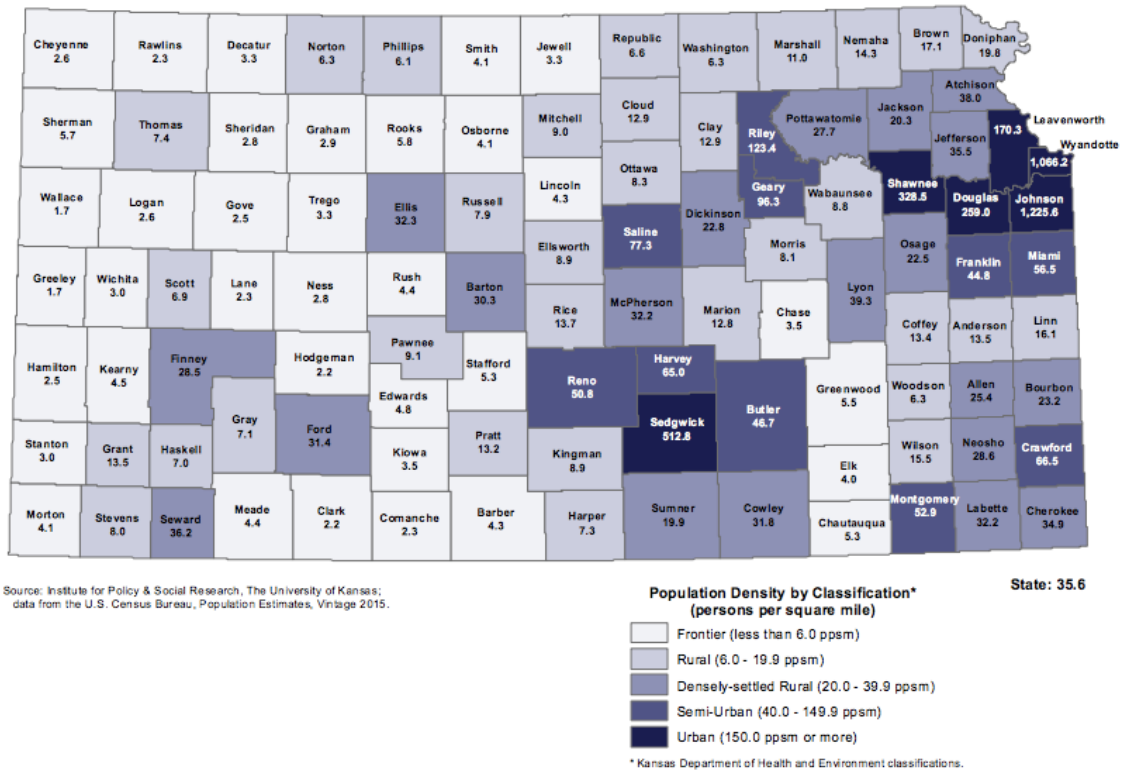
	Frontier	Rural	Densely Settled Rural	Semi-Urban	Urban
Frontier	--				
Rural	0.99	--			
Densely Settled Rural	0.99	0.94	--		
Semi-Urban	0.20	0.10	0.56	--	
Urban	0.23	0.14	0.48	0.99	--

Note: *Denotes significance at the p<0.05 level.

Source: KHI analysis of the Foundational Public Health Services Capacity Assessment, 2017.

APPENDIX F: POPULATION-DENSITY GROUPINGS USED FOR ANALYSIS

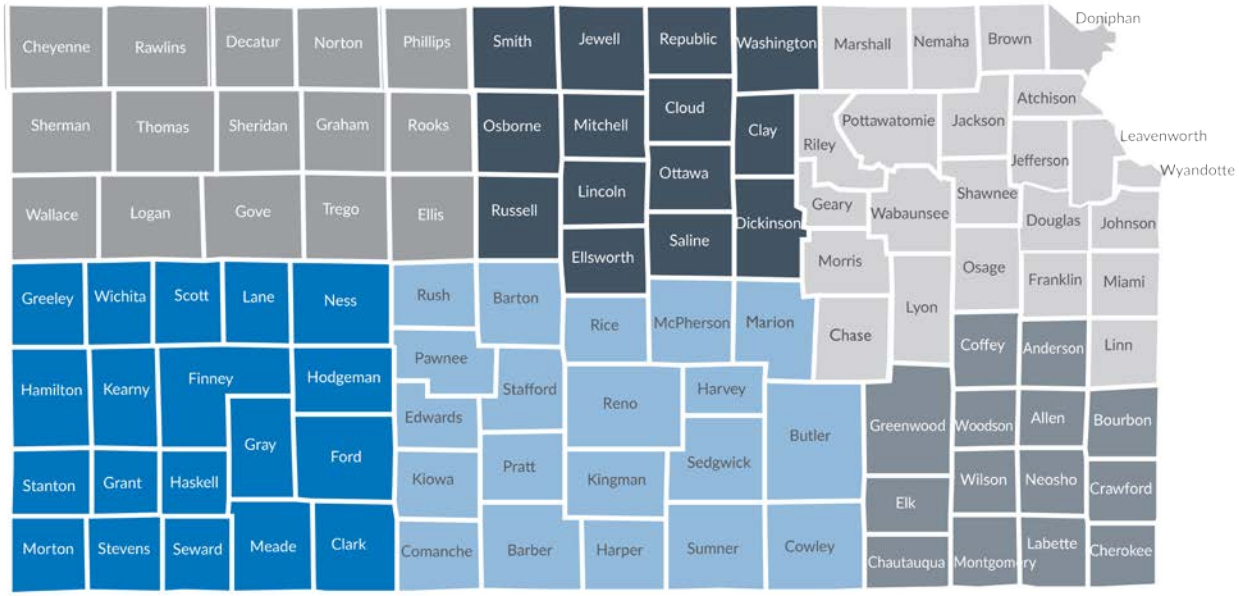
Figure F-1. Population Density Classifications in Kansas by County, 2015



Source: University of Kansas Institute for Policy and Social Research, 2015.

APPENDIX G: REGIONS USED FOR ANALYSIS

Figure G-1. Local Public Health Regional Attendance Map, 2017



Source: Kansas Department of Health and Environment, 2017.

ENDNOTES

[i] Institute of Medicine. (2012). *For the Public's Health: Investing in a Healthier Future*. Washington, DC: The National Academies Press.

[ii] ibid.

[iii] RESOLVE. (2014). *Defining and Constituting Foundational Capabilities and Areas — Version 1.* Available at: http://www.resolv.org/site-foundational-ph-services/files/2014/04/V-1-Foundational-Capabilities-and-Areas-and-Addendum.pdf

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