Kansas Association of Local Health Departments
Voluntary Minimum Standards Assessment Project

FINAL REPORT

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KANSAS
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Executive Summary[1]

Study Purpose

Local health departments are central to sustaining public health in Kansas. In an effort to assure the quality of services provided by local health departments, the Kansas Association of Local Health Departments (KALHD) initiated the development of minimum standards for core functions of public health.

The Kansas Health Institute (KHI), in collaboration with KALHD and the Kansas Department of Health and Environment (KDHE), conducted an assessment of the capacities of local health departments to meet standards in five areas: communicable disease; immunization; sexually transmitted disease (STD); tuberculosis (TB); and, human immunodeficiency virus / acquired immune deficiency syndrome (HIV/AIDS).

While the standards assessment process in Kansas was initiated before the recent escalation in concern about bioterrorism, the findings and implications of this study now have even greater relevance to protecting and promoting the health of Kansans. This report summarizes findings from this 2001/2002 assessment.

• **Local health departments are doing well in some standards areas.** Approximately one-third of the standards under consideration were fully met by all or nearly all health departments in this assessment.

• **Written policies, procedures, and protocols are a challenge for many local health departments.** Written policies and protocols are important requirements of the KALHD standards. Most local health departments conduct daily business without written documentation by relying on the knowledge and experience of their staff.

• **Childhood immunization rates are lower than the standards require.** Local health departments in less populated counties tended to report relatively higher immunization rates. According to those interviewed, immunization rates in more urban counties were lower due to the mobility of the population served and the inability to track and report immunizations given by the private health providers available in those communities.

• **Local health department promotion and oversight of immunizations provided by the private sector does not occur as required by the standards.** There is poor compliance with this requirement because the concept is not supported by many local health department staff.

• **Most local health departments are not actively involved in HIV/AIDS prevention activities.** Some health departments provide HIV/AIDS services that meet the criteria for providing counseling, testing, and basic educational material. However, compliance with standards on community-based prevention efforts and collaboration was generally low.

• **Most rural health departments have neither the staffing nor the training to deal with serious communicable disease outbreaks.** Smaller local health departments were more likely than larger ones to lack the capacity required by the KALHD standards to deal with communicable disease crises.

Assessment Process

To conduct this assessment, a tool was developed to measure the health departments' status of compliance with the KALHD standards. Twelve representative sites were chosen for assessment to provide a cross section of Kansas local health departments based on population density and geographic location.

A team of at least two but typically three or more evaluators consisting of representatives of KHI, KALHD and KDHE visited each site. At each site, the standards were assessed independently to determine whether or not the health department was in full compliance with the standard, and if not, what changes would be necessary to achieve full compliance.

Implications

The patterns of compliance and non-compliance in these five standards areas across the twelve local health departments included in the study were generally consistent. This suggests that the findings are likely to be representative of local health departments in Kansas that were not included in the study as well.

The assessment identified a number of areas in which local health departments are not in compliance with existing standards. Careful consideration of options to best resolve compliance issues is necessary to address these complex challenges and insure that local health departments in Kansas are prepared to play their crucial role in safeguarding the health of people in our state.

[1] This Executive Summary has also been published as a KHI Research Brief entitled "Capacity of Local Health Departments: Assessing Their Ability to Respond to Communicable Disease Threats." The publication number is KHI/RB 02-1.

Chapter One: Background

Background and Rationale

The mission of the public health system is to fulfill society s interest in assuring conditions in which persons can be healthy.[1] In Kansas, many organizations and individuals address this mission, but the governmental public health agencies assume a unique role: to assure that vital elements are in place and that the mission is adequately addressed.[2] The pillars of the public health system in Kansas are the local health department and the public health nurse. Today, public health services are available in all 105 counties in the state.

The importance of having well functioning local health departments was recognized nationally in the Public Health Service s Healthy People 2000 report[3] issued in 1991. This report emphasized the need for the U.S. population to be served by local health departments that have the ability to effectively perform the core public health functions by the year 2000. However, amid conflicting resource and funding streams, changing community public health needs, and multiple state and local requirements, achieving these core functions continues to be a challenge for many local health departments.

In Kansas, local health departments have the responsibility for ensuring that health problems are monitored and that services to correct those problems are available. They have a responsibility to lead their communities in an examination of local health issues and in the development of plans to overcome existing inadequacies. As such, assuring that local health departments in Kansas are able to perform essential public health functions is critical.

KALHD Standards Process

As one mechanism for ensuring the ability of local health departments in Kansas to perform essential public health functions, the Kansas Association of Local Health Departments (KALHD) began considering the development of performance standards for local health departments in 1994, a topic that also was being discussed at the national level. After considering many options, KALHD decided to use local health department standards developed by the Michigan Public Health Institute (MPHI) as a model in creating standards for Kansas local health departments. In 1999, with funding provided by the Kansas Health Foundation, KALHD created a committee of KALHD members and Kansas Department of Health and Environment (KDHE) representatives to adapt the standards created by MPHI to the needs of Kansas. Feedback was sought from other local health departments and public health personnel as part of an ongoing quality improvement

process. This initial process resulted in the development of what was referred to as the KALHD Voluntary Minimum Standards (See Appendix A). These standards covered the provision and administration of public health services by local health departments in six areas: administration, general communicable disease control, immunizations, sexually transmitted diseases (STDs), tuberculosis (TB), and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS).

The KALHD standards address administrative and service delivery issues of local health departments. Each standard area addresses the broad issues of policies, self-evaluation, and relationships with other community service providers, as well as the more specific aspects of health department service delivery. These delivery features include: clinic protocols, job responsibilities, resource materials and staff training.

Part of the original project design was an assessment of the capacity of local health departments to meet the standards. This assessment was intended to develop, test and refine an instrument and methodology for assessing local health department capacity as well as provide a sense of statewide capacity, based on a sample of local health departments. It also was planned that the contractor evaluate the feasibility of a methodology for projecting statewide costs of all local health departments to achieve compliance with the standards, based on a sample of local health department assessments. KALHD contracted with the Kansas Health Institute (with funding from the Kansas Health Foundation) to undertake this assessment.

Assessment Process

KHI collaborated with KALHD and KDHE on the assessment. Matthew D. Shepherd, Ph.D., researcher for KHI, was the principal investigator for the project. Mary V. Ransom, Ph.D., was co-investigator and project consultant. Lily Akings, Director of the Barton County Health Department, represented KALHD and assisted in the assessment. In addition, several representatives of KDHE who work closely with local health departments (Shirley Orr, Connie Scheffer, and Vada Winger) provided assistance.

Five of the six standard areas that had the most impact on population health were assessed: general communicable disease control, immunizations, STDs, TB and HIV/AIDS. At the request of KALHD, standards for administration were not assessed.

To determine the capacity of health departments across the state to meet the performance standards developed by KALHD, the project team undertook a qualitative and quantitative assessment at 12 local health departments across the state. These health departments were selected to provide a broad cross section of Kansas local health departments based on geographic location, administrative format, and county population.

The primary data collection process consisted of in-depth site visits at each local health department. These site visits were conducted by small teams of site visitors consisting of at least one representative of KHI and one representative of KALHD and/or KDHE. To facilitate the assessment, a questionnaire was developed and piloted at two sites. Site visitors collected detailed information on the compliance of health department practices with each standard and, if appropriate, information concerning how and why each standard was not fully met. In addition, information was collected on staffing capacity and staff experience in each standard area.

Organization of this Report

The remainder of this report consists of five chapters. Chapter Two will provide a detailed description of the methodology used in the assessment. In Chapter Three, findings of the assessment will be discussed, as well as the policy implications of those findings. Chapter Four will look at the findings by standard area, and Chapter Five will examine findings with common themes. Chapter Six will conclude the report.

Chapter Two: Methodology

This assessment process involved the development of a survey questionnaire, the selection of counties to be sampled, testing of the questionnaire, full fielding of the questionnaire, and analysis of the data. The fielding of the questionnaire took place during site visits conducted over a 12-week period from February 2001 to April 2001.

Survey Instrument

A survey instrument was developed that was a combination of quantitative and qualitative (closed and open-ended) questions regarding the health departments status with respect to compliance with the KALHD standards. (The KALHD standards may be found at Appendix A, and the survey instrument may be found at Appendix B.) It allowed information to be collected on whether the standards were fully met, and if applicable, the reason standards were not fully met, along with any action plan by the local health department for meeting the standards. In addition, questionnaire space was provided that allowed the site visitors to note unique or innovative practices, their own recommendations for the health department to fully meet each standard, what material and information had been provided, and any additional comments. For each standard area, the questionnaire also allowed the collection of information regarding the training of staff, numbers of staff, and the number of service encounters provided during the previous year.

Sample Selection

Concurrent with the development of the survey questionnaire, 12 assessment sites were chosen for the survey. It was anticipated that there could be important differences in how health departments of various sizes (serving different population sizes) provide services and comply with the KALHD standards. It also was considered important that the sample represent different regions of the state, as western and southeastern regions of Kansas are sometimes under-represented. Sites were selected to provide a cross section of Kansas local health departments based on population density (Table 1), and geographic location (based on KDHE regional districts) (Table 2). Twelve initial sites were selected and asked to participate. One county declined and was replaced in the sample by another county with a similar profile. The final 12 project counties included Barton, Barber, Elk, Ellis, Finney, Jackson, Marshall, Rice, Riley, Shawnee, Sumner, and Woodson.

Table 1. Population Density for Counties in Sample

Category	Frontier < 6 p/sm*	Rural 6-19.9 p/sm	Densely-Settled Rural 20-49.9 p/sm	Semi-Urban 50-149.9 p/sm	Urban ≥ 150 p/sm
Total number and percent of counties in each category	31 counties 29.6%	39 counties 37.1%	22 counties 21.0%	8 counties 7.6%	5 counties 4.7%
Counties in study and percent of sample in each category	Barber Elk 17%	Jackson** Marshall Rice Woodson 33%	Barton** Ellis Finney Sumner 33%	Riley 8%	Shawnee 8%

* p/sm = persons per square mile
** pilot sites

Table 2. KDHE Regional Representation for Counties in Sample

KDHE Region	North East	North Central	North West	South East	South Central	South West
County	Jackson** Marshall Shawnee	Rice Riley	Barton** Ellis	Elk Woodson	Sumner	Barber Finney

** pilot sites

Survey Instrument Validation Procedure

In order to test and refine the survey instrument and process, two sites (Barton and Jackson) were selected for pilot site visits prior to the full fielding of the questionnaire. These sites were selected because their administrators had a good knowledge of the standards process, which aided in the refinement of the assessment process. During and after each site visit, input was obtained from the site visitors and health department participants about how to improve the process of data collection, what additional information to collect, and what documentation was necessary to establish compliance. During these visits, reviewers discussed the evaluation process and established consistent criterion for assessing compliance with each standard. Because of the

consistency of data collection instruments and processes between the two initial sites and remaining sites, data from the initial sites were included in the final analysis.

Site Visits

After some minor refinement of the questionnaire, consisting primarily of the additional collection of standard-wide information (staffing and encounters), the full fielding of the questionnaire began. In mid-February 2001 the remaining ten sites were scheduled for individual site visits and mailed a packet of information that included: 1) the standards to be examined; 2) the questionnaire; and 3) a list of material to have available for documenting compliance with the standards. Sites were asked not to change anything they were doing in preparation for the site visit, as the goal was to understand compliance across the state and not the performance of any one site in particular. Sites also were assured that all information provided would be confidential and that no individual person or site would be identified in any report.

During the first site visit, all site visitors participated. Criterion established during the survey validation process regarding the consistent assessment of the standards was reviewed and refined. Inter-rater reliability for each standard was reviewed and areas of inconsistency were addressed to ensure a consistent data collection process. After the initial visit, a site visit team of at least two but typically three or more evaluators visited each site to interview health department staff and observe compliance with KALHD standards. The site visit teams were composed of at least one representative of KHI; in addition, at least one representative of KALHD and/or KDHE made up the balance of the team. Site visits took between two and five hours to conduct and involved representatives from the health department management and nursing staff. Each site visitor assessed each standard independently of other site visitors, indicating if each was fully met or not. Assessments were based on staff interviews, the examination of health department policies and protocols, patient encounter records, reference materials, required reports, and direct observation. After each site visit, team members were given the opportunity to review their questionnaire and notes and make any clarifications or revisions necessary. Questionnaires were then given or mailed to the principal investigator.

In order to obtain complete and consistent information among all sites, follow-up calls were placed to the principal contact person at each local health department when necessary to answer questions and obtain additional information. This included calls to the two test sites that were asked to provide the small amount of additional information not collected during their site visits.

Analysis

Once the site visits were completed, data from the surveys was entered into a spreadsheet and analyzed using Microsoft Excel and Statistical Package for the Social Sciences (SPSS 10.1) software. Although an attempt was made to use a scaled approach to determine the degree of compliance for each standard, this information was excluded from the final analysis for reasons of meaningfulness and clarity. The information from each reviewer was combined to create a single, final local health department assessment for each standard. There were a few cases where one or more reviewers disagreed on whether a standard was fully met. In these cases, the questionnaire from each site visitor was carefully examined for areas of disagreement. In all cases, the majority opinion among the site reviewers was selected as the final assessment.

Chapter Three: Study Findings

Despite differences across the local health departments in this sample, there emerged a consistent pattern of compliance and non-compliance with the standards assessed. Overall, the health departments in this sample were similar in regard to which standards were in compliance. However, there were some standards that clearly indicated different patterns of compliance between local health departments in more urban counties and those in more rural counties.

It is these consistent areas of strength and weakness in complying with the KALHD standards that this report attempts to address. It should be noted that while some standards relate to specific and discreet issues (i.e., having a plug cover on each refrigerator), other standards cover much broader issues regarding the operation of the health department and its relationship to external organizations (i.e., collaboration with other community providers for disease prevention activities). In cases where problems with compliance relate to specific and discreet issues or behaviors, the method for increasing compliance is straightforward. In the cases where standards cover broad issues, and multiple standards address the same set of interrelated issues, compliance with the KALHD standards becomes much more complex.

Based on the methodology used and the representativeness of the sample, it is our expectation that the common issues found within this sample would be, in general, the same as the issues for other local health departments across the state. This should not imply that these findings are representative of every local health department in Kansas. It is likely that there are individual health departments in the state that would have a different pattern of compliance with the KALHD standards assessed (possibly having better overall compliance, worse compliance, or a different pattern of compliance). As such, this assessment should not be used to imply the compliance of any one local health department (beyond those in the sample), but is intended to be a representation of Kansas local health departments overall.

Finding #1 - Local health departments are doing well in many areas

Many of the standards assessed document the strengths of local health departments. Approximately one-third of the standards assessed had high compliance rates among the sites in this sample. A particularly high level of compliance was found with those standards that dealt with the administration and provision of immunizations to children. These standards covered issues such as the reporting of immunization information, client education, vaccine storage, and vaccine transportation. In addition, most health departments did well in tracking communicable

disease cases in their counties. (It is worth noting that some counties had relatively few communicable disease occurrences to track.) Overall, health departments did well in the actual provision of clinical services and education of their clients. Problems with compliance most often were associated with standards that cover issues related to the infrastructure that supports these clinical services, such as the documentation of activities, relationships with external organizations, and preparedness.

Finding #2 – Many compliance problems have simple solutions

Although the local health departments do well in many areas, there were system-wide deficiencies in their ability to meet the minimum level of quality established by KALHD in several areas. Because local health department staffs were asked not to make any changes in preparation for the site visit, and many were not familiar with the KALHD standards, the assessment found several specific issues that appeared to be system-wide concerns, yet would likely require simple actions to achieve compliance. Each of these standards was not fully met by one-half or more of the sample local health departments. All health departments surveyed were willing to make the necessary changes, and most were unaware they were noncompliant. This would suggest that, for these issues, most local health departments could make the appropriate changes as needed to improve compliance.

Job Descriptions

Many standards call for staff responsibilities to be assigned in written job descriptions. The assessment found that this requirement was achieved in approximately one-half of local health departments. To come into compliance, many health departments need to revise job descriptions to more accurately and specifically represent the duties and responsibilities of staff in each standard area.

Plug Covers

Standard 2.3.2 requires that all refrigerators/freezers used for the storage of vaccines have plug covers. Plug covers were found in place less than one-half of the time. Local health departments without plug covers need to purchase and install them for compliance.

CDC Standards

Standard 2.3.5 requires that local health departments prominently post vaccine storage and handling standards published by the CDC. The CDC standards[4] were posted in about half of the

health departments assessed. Local health departments need to obtain and post the CDC standards.

Immunization Registry

Standard 2.6.1 indicates that health departments should document their willingness to participate in a state immunization registry by maintaining on file a letter stating their willingness. Few sites had any documentation of this willingness to participate. To fully meet the standard, those health departments that are willing to participate need to place a statement on file indicating such.

Procedures for Addressing Legal Issues

Standard 3.4.1 requires local health departments to perform activities that control the spread of STDs, which includes having procedures for addressing legal issues in this area. Few local health departments had any procedures in place to deal with legal issues should they arise. It was recommended by members of the site visit team that legal counsel services to local health departments be considered in this regard. In addition, many health department staff members were unclear what kind of legal issues could occur involving STD control.

Finding #3 – Some compliance problems require more complex solutions

While some of the system-wide problems found during this assessment could be resolved with relatively simple solutions, other problem areas emerged that are more complex. Unlike the problems discussed above, these problems tended not to relate to specific standards but more often highlighted system-wide problems in the performance and capacity of local health departments in Kansas.

Protocols, Policies, and Procedures

Documentation of the policies and practices of the local health department is a substantial requirement of each standard area. What is asked for and how it is described varies across the standards topical areas, but each section explicitly or implicitly requires this documentation. The kind of written materials required fall into two categories. First, there are standards that ask for a description of the overall (high level) functioning of the health department in dealing with the particular standard area. For example, Standard 1.3 states, The local health department maintains on file written policies and procedures based on widely accepted public health reference material for performing education, treatment, immunization, and isolation around individual communicable disease reports. Second, there are standards that ask for specific clinical or

procedural information (low level) on how to treat or deal with a specific disease or situation. For example, Standard 2.4.6 states, The local health department maintains on file written VAERS policies, procedures and reports complying with program elements.

While there were some exceptions, typically these protocols, policies, and procedures did not exist at the local health departments. The lower level standards were more likely to be in place (but still not commonly), while the higher level policies were absent sample-wide. This was true regardless of the size of the health department. Local health departments were able to conduct daily business without written documentation by relying on the knowledge and experience of their staffs. It was common to find key staff at each agency who had worked with the local health department for 20 or 30 years. These individuals knew what needed to be done and how, although that knowledge was not captured in written form. If a local health department were to suddenly find itself without these key staff and with no written protocols, policies, or procedures, conducting the essential public health services of the health department in a timely manner would likely be more difficult. For example, late reporting of disease cases or inappropriate follow-up on disease cases could result in additional transmission of the disease.

Due to the consistency of this finding, it is likely that a similar lack of written protocols, policies, and procedures exists statewide. Furthermore, site visits indicated that given the day-to-day demands placed upon their staffs, most local health departments have neither the time nor the technical expertise to draft the overarching policies for individual standard areas.

Providing Immunizations

Immunizations are a keystone of public health. It is also the area assessed that had the greatest activity and best overall compliance with the KALHD standards. However, while the standards involving the administration and provision of immunizations do not have a problem with compliance, the overall goal of immunizing children is often not being met. Standard 2.2.1 requires that 90 percent of the 0-35 months-old children served in agency clinics are immunized as required by KDHE. Less than half of the sites in this study were able to meet that criterion (based on KDHE data). This trend exists statewide, with just over one-fourth of the counties in Kansas having greater than 90 percent of their clients (0-35 months old) immunized with the standard childhood immunizations. This finding is important because vaccines are among the greatest public health achievements of the 20th century. Yearly, thousands of cases of disease that

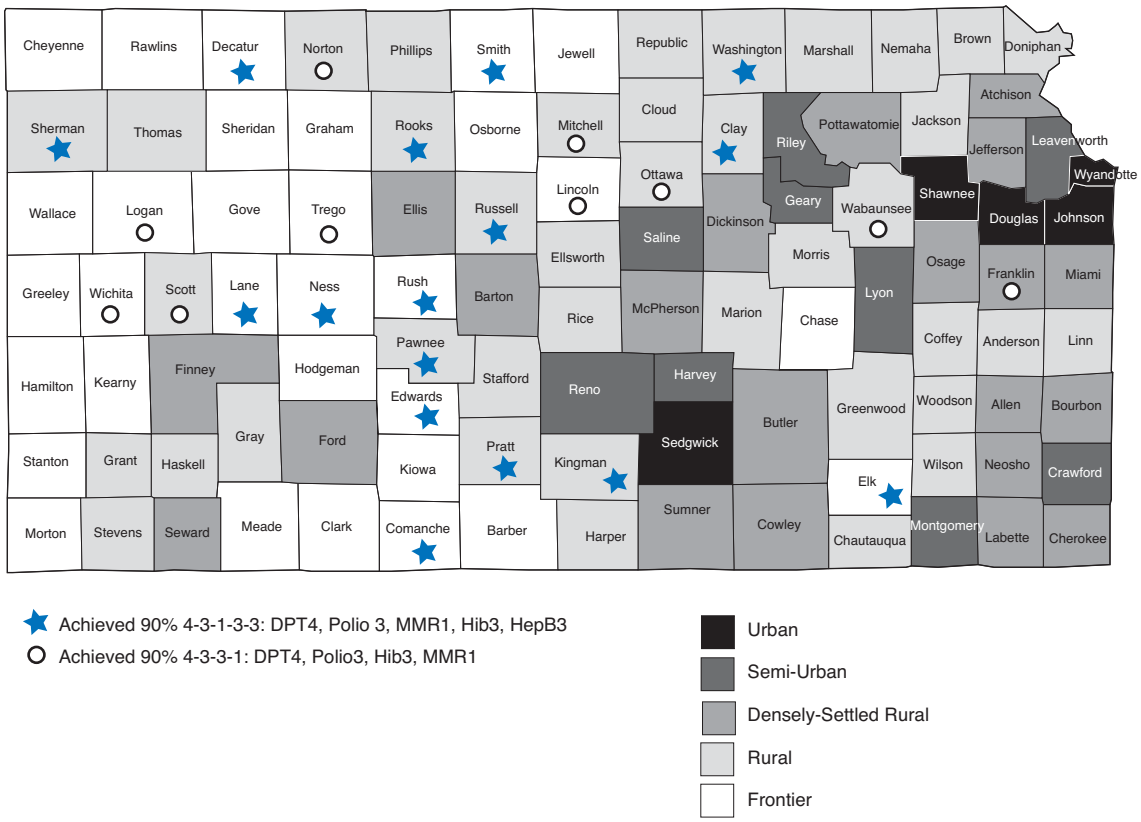
previously resulted in death and serious illness are prevented with immunization, and the spread of disease is minimized.

A strong relationship appears to exist between the size of the population covered and the percent of children receiving the required immunizations. As the population base becomes larger, it is more difficult to obtain a high percentage. There is also a converse relationship that indicates as the population covered becomes smaller, the immunization program becomes a larger proportion of the overall function of the health department. In addition, the smaller the population covered, the higher the proportion of total immunizations given in the county by the local health department. In many of the counties with smaller populations, the local health department is the only provider of immunizations, and the immunization program was the only one of the five areas investigated that had any significant programmatic activity.

These trends appeared to hold true for the entire state as indicated by KDHE Clinic Assessment Software Application (CASA) data (See Figure 1). Those health departments that did the best at keeping their clients properly immunized tended to be in the least populated counties. Those interviewed suggested these differences were due to the increased mobility of clients and numerous alternative providers found in more urbanized areas.

The immunization rate (weighted by county population) for the health departments in the study sample was 75 percent, the same average as for all Kansas health departments. This suggests that the study sample is roughly representative of Kansas local health departments overall. The primary mechanisms for improving immunization rates of young children in order to comply with KAHLD standards of 90 percent, as suggested by staffs of health departments in this sample, were better tracking of existing clients and more aggressive outreach to noncompliant or non-responsive families.

Figure 1. County Health Departments Achieving 90% Coverage for Two-Year Old Cohort in 1998



Promotion and Oversight of Immunizations Provided by the Private Sector

In addition to addressing the importance of the administration and provision of immunizations to children by the health department, three of the immunization standards included a recurring theme of promoting immunizations given by private providers. Standard 2.1.1 indicates that local health departments should have a plan that includes methods for promoting vaccination by private sector health care providers. Standard 2.4.1 requires that the local health department sends KDHE a provider certification form for the agency and a copy of the provider certification form for each participating health care provider. Standard 2.4.7 requires that the local health department ensures that participating health care providers are adhering to all relevant vaccine program requirements, as stipulated in the provider certification form. Together these standards hold health departments responsible for all the immunizations within their county by requiring them to promote and monitor immunizations administered by the private sector.

Promotion of vaccinations and monitoring of private providers by local health departments was not something that was being done by any health department included in this assessment. This was an activity that most of the local health department staff members interviewed did not feel comfortable performing. Furthermore, many questioned the appropriateness of it for their health department. They had several concerns. First, they did not feel that local providers (physicians) would be receptive to having local health department staff members telling them what to do, nor did they feel that they currently had the authority to do so. Many respondents suggested that some kind of state mandate or legislative authority would be needed to give local health departments the necessary authority to undertake this activity. Some of the strongest reactions came from the staffs of small county health departments that performed most, if not all, of the immunizations in their communities. They suggested that the local health department was the most appropriate organization to provide these immunizations, because local health department staffs are experienced, and because there are few alternative providers in these small communities. Alternative providers that do exist in their communities have neither the time nor the financial resources to serve as a primary source of immunizations.

The similarity of the immunization indicators of this sample compared with Kansas as a whole and the consistency of these findings make it likely that a similar lack of compliance with these standards would be found statewide. Furthermore, this assessment indicates that the health department staffs in less populated counties have concerns about the changes required by these standards. Given that two-thirds of the counties in Kansas are rural or frontier, increasing compliance with these standards may be a difficult task.

HIV/AIDS Prevention

Many of the standards in the HIV/AIDS section state the need for local health departments to be actively involved in prevention efforts in their communities. Standard 5.2.1 requires that the local HIV prevention plan must highlight communities HIV prevention priorities and that it should be designed with community input. Standard 5.2.2 states that the local health departments must collaborate with the HIV State Prevention Community and that they must use KDHE analysis in (the) HIV prevention plan. Standard 5.2.3 indicates that the local health departments must have evidence of activities initiated in response to the State Prevention Plan. Finally, Standard 5.2.4 requires that the local health department evaluate prevention activities and staff.

These standards require a local health department to be an important player, or leader if necessary, in local HIV/AIDS prevention efforts that are tied closely to statewide efforts. It must be noted that the five health departments in this sample serving the smallest county populations did not provide HIV/AIDS services and could not be evaluated on these criteria. The seven local health departments that did provide HIV/AIDS services met the criteria for providing HIV/AIDS counseling, testing, and basic educational material to the public. However, compliance with prevention efforts as described in the KALHD standards was relatively low. In general, most local communities did not have a local prevention plan, and the local health department did not have a local community plan of its own. Not having a local prevention plan made achieving most of the other HIV/AIDS standards impossible (i.e., getting community input on plan, using state analysis in plan, responding to statewide plan, etc.). The county that complied most closely with these standards had a state Disease Intervention Specialist (DIS) on staff who performed the majority of the work and led their HIV/AIDS program.

As stated above, only seven of the 12 local health departments in this assessment provided any HIV/AIDS services. Furthermore, there are only 14 local county health departments in Kansas that have HIV/AIDS prevention contracts with the state, four of which were included in the sample. Those local health departments with state contracts are the primary agencies responsible for HIV/AIDS prevention activities at the local level. The type and intensity of HIV/AIDS services provided varies across the sample and statewide, particularly among those agencies that provide some HIV/AIDS services without a state contract. As such, it would be inappropriate to infer the findings from this assessment beyond the 14 local health departments that have such contracts. For those counties with a contract, the primary barrier to compliance with the standards appeared to be a lack of involvement in and awareness of local and statewide prevention efforts.

Staffing Numbers and Training

Four of the five standard areas examined dealt with the treatment and control of existing communicable diseases (i.e., general communicable disease control, TB, STD, HIV/AIDS). The majority of counties examined in this assessment had relatively low rates of these diseases. As such, this assessment not only tried to assess how well each local health department was currently dealing with these diseases, but also how well prepared they were to deal with either routine or critical occurrences. The latter question was more difficult to answer as it deals to some extent with the unknown. This assessment was complicated further by the fact that not all local health departments had programs or provided services in all areas.

Regardless of the current rates of disease, local health departments have a role as a primary responder for dealing with communicable diseases in Kansas. Maintaining the capacity to deal with potential outbreaks of disease is an important task. As a way to examine this issue, each local health department was asked about its history with handling outbreaks of communicable diseases. If they had no recent experience with outbreaks, they were asked to describe the impact on their local health department should they discover tomorrow that they had two active cases of TB in their county. They also were asked how they would handle the situation and what kind of strain it would place upon their resources. Issues around sufficient staffing and whether staff members had the skills and experience to deal with such an outbreak were examined.

Not surprisingly, this assessment found direct relationships among the size of the health department, the population covered, and the ability of the local health department to deal with communicable disease crises. The more staff members a local health department employed and the more they dealt with these diseases on a regular basis, the better prepared and able they were to handle new outbreaks. Generally, there was a clear distinction between rural and frontier counties and the more populated counties. Urban and semi-urban counties were able to handle outbreaks with relatively little impact on the other critical health department services, having a greater number of staff who frequently had more recent training. With one exception, densely-settled rural counties also were able to handle outbreaks, although it strained their resources. (The one exception was a county that was already understaffed for daily activities.)

Health departments in rural and frontier counties indicated an inability to handle outbreaks without external assistance. They had neither the necessary number of staff nor experience to be comfortable dealing with outbreaks. These health departments expressed that they would be largely dependent upon assistance from the state and neighboring health departments should an outbreak occur. Multi-county health departments shared staff for many services, allowing some advantage over singular counties in being able to borrow staff easily to respond. Despite staff availability, experience and training still were lacking in multi-county departments. This differed from the large health departments that were more likely to have a specialist or individual devoted specifically to each standard area. The smaller health departments staffs are relied upon to fulfill responsibilities in every standard area. Given that two-thirds of the counties in the state are categorized geographically as rural or frontier, this raises concerns about the ability of the Kansas public health infrastructure to deal with local public health crises.

Based on the representativeness of this sample regarding geographic location and population density, and given the consistency of this finding in the assessment, it is likely that these findings would apply statewide. This assessment found that local health departments in rural and frontier counties consider themselves unprepared to deal with an outbreak of TB or some other communicable disease, both because they have limited staff capacity and because they have very little experience with these diseases due to their low occurrence. Even when the incidence of a disease is high, the overall chance for an outbreak or occurrence in any one rural or frontier county is relatively low because of smaller population size. Given this state of unpreparedness, it should be noted that there is currently no systematic mechanism or policy for providing the needed support to these counties. Limited short-term support is provided on an ad hoc basis to local health departments by KDHE. In addition, some counties may be able to obtain assistance from other local health departments in a time of crisis. However, given that up to two-thirds of the counties in Kansas may be in a similar situation, increasing compliance with these KALHD standards will be a difficult problem requiring creative solutions.

Chapter Four: Findings by Standard Area

There were a total of 43 standards (in the five standard areas) reviewed during this assessment process (see Appendix A). Most of the sites were not rated on some individual standards or entire standard areas because they were not applicable to their operations or they did not provide services in that area. This occurred most frequently with regard to standard 2.1.3 that reads, The local health department uses the reporting form or approved data system and submits complete and accurate school immunization data reported to the state annually. Seven of the local health departments in this sample were not assessed on this standard because reporting of school immunization data was the responsibility of the school nurse and the school system and not the local health department. The five smallest health departments did not provide HIV/AIDS services. Additionally, STD services were not provided by two of those five health departments. Only three health departments received ratings on all 43 standards.

What follow are the detailed results of the assessment. This chapter examines compliance with the KALHD standards in each of the five standard areas. Chapter Five reviews detailed findings organized by common themes.

Standard Area 1: Communicable Disease Control

All local health departments in this sample were responsible for controlling communicable diseases in their counties. Table 3 identifies the number of communicable disease reports per county in 2000. The six smaller counties had six or fewer communicable disease reports in the previous year. Of these six counties, three indicated that the disease reports did not originate within the health department. Physicians or other health organizations reported these cases; therefore they received notification after reporting to the state was completed. For these smaller health departments, the number of cases that they handled averaged less than one per year. Communicable disease reports for the more populated counties ranged from 13 (Sumner) to 1,371 (Shawnee) during 2000.

Table 3. Communicable Disease Reports (Year 2000)

County	Case reports*
Shawnee	1,371
Barton	120
Riley	60
Finney	60
Ellis	18
Sumner	13
Jackson	6
Marshall	5
Rice	3
Barber	3
Woodson	2
Elk	0

*Health department self-reported counts.

In all but the two most populated counties (Shawnee and Riley), the entire staff was responsible for duties related to communicable disease control. Shawnee and Riley counties had dedicated staff members who specifically dealt with these issues. Ten of the 12 health departments reported one or more communicable disease trainings for their staff during the past year. These trainings frequently were KDHE based conference calls or Centers for Disease Control and Prevention (CDC) teleconferences.

The lack of written policies and protocols was the primary reason that all health departments did not fully meet the ten standards within this component (Table 4), particularly the overall guidance policies directing staff to the appropriate written protocol and procedure manuals.

Current and recommended protocol manuals (including the American Academy of Pediatrics Red Book, Beneson s Control of Communicable Disease Manual, and current CDC guidelines) were available, and staff members indicated their use in all but three health departments where a current Beneson s manual was not available.

Table 4. Health Departments Fully Meeting Communicable Disease Standards

Standard No.	Brief Description of Standard	Number of Health Departments (N = 12)	Percent of Health Departments
1.2.3*	Submission of follow-up forms	10	100%
1.3.3	Submission of numbers of people Mantoux skin-tested and started on anti-tuberculosis therapy	11	92%
1.1.2*	Submission of case reports	8	80%
1.3.2*	Submission of outbreak investigation reports	7	70%
1.1.1	Adequate/qualified staff for case reporting activities	7	58%
1.2.2	Adequate/qualified staff for investigation and follow-up activities	7	58%
1.3.1	Adequate/qualified staff for control activities	6	50%
1.2.1	Protocols for communicable disease follow-up activities	3	25%
1.3	Protocols for communicable disease control activities	3	25%
1.1	Protocols for receiving/entering communicable disease data, data analysis, and feedback	2	16%

* Two local health departments that handled no cases of communicable disease in the previous year were unable to be rated on these criteria (N=10)

Standard Area 2: Immunizations

Most local health departments in this assessment serve as a primary provider of immunizations within their county. As with communicable disease, all staff members in the smaller health departments assisted with immunization duties. The number of immunizations administered through the local health department on a county basis is presented in Table 5. Training typically included health department staff attending the state-sponsored annual immunization update meeting.

Table 5: Immunizations (Year 2000)

County	Total number of Immunizations*
Shawnee	38,118
Riley	8,071
Barton	7,642
Ellis	4,500
Sumner	3,593
Finney	3,300
Barber	2,070
Marshall	1,567
Jackson	1,286
Rice	936
Woodson	585
Elk	314

*Health department self-reported number of immunizations given to children during previous year.

Adherence to the immunization standards varied greatly (Table 6). The standards that dealt with vaccine storage, vaccine transportation, reporting forms, vaccine information statements (VIS) and contraindications for immunizations (2.3.1, 2.3.4, 2.4.3, 2.4.4, and 2.4.5) were fully met by all or nearly all health departments. The five health departments responsible for school reporting (as in Standard 2.1.3) fully met this standard; it was not applicable for the other seven health departments.

In contrast, a low level of compliance to the standards was found in five of the nineteen standards. Several of these standards dealt with private provider immunization certification and oversight issues (2.1.1, 2.4.1, 2.4.7). There was a reluctance to provide oversight in this area that was consistent across sites. Other problem areas included: electrical outlet plug covers (2.3.2)

were missing for vaccine storage refrigerators in four departments; six did not have the CDC standards for vaccine storage and handling requirements posted (2.3.5); and the nine health departments not currently using the Kansas Integrated Public Health Information System (KIPHS) did not have verification of willingness to participate in such a program on file (2.6.1). One health department was not willing to participate in the KIPHS computerized database at that time. It should be noted that the six health departments without CDC storage and handling procedures posted had them either in a book located nearby or used another publication.

Table 6. Health Departments Fully Meeting Immunization Standards

Standard Number	Brief Description of Standard	Number of Health Departments (N = 12)	Percent of Health Departments
2.3.4	Vaccine transport	12	100%
2.4.3	Vaccine records and reports	12	100%
2.1.3*	Records and reports for school data	5	100%
2.4.5	Adherence to contraindications guidelines	11	92%
2.3.1	Vaccine storage	11	92%
2.1.2**	Records and reports for day care centers	9	90%
2.4.4	Up-to-date clinic protocol	10	83%
2.3.2	Refrigerator/freezer security system	8	67%
2.3.3	Refrigerator/freezer temperature verification	8	67%
2.3.5	Vaccine storage and handling standards	6	50%
2.3.6	Vaccine management during power outage	6	50%
2.4.6	Conforms to VAERS	6	50%
2.2.1	Immunization level data and reports	5	42%
2.5.1	State Vaccine Program (SVP) eligibility	5	42%
2.1	Protocols for assessing provision of childhood immunizations	5	42%
2.6.1	Participation in state registry	3	25%
2.1.1	Plan for school, day care, preschool, private sector outreach	0	0%
2.4.1	Provider certification forms	0	0%
2.4.7	Oversight of private providers	0	0%

*Data for the five local health departments responsible for the activities listed in this standard

**Data for the ten local health departments responsible for the activities listed in this standard

State audits revealed that five local health departments met or exceeded the 90 percent level of immunization for their clients aged 35 months and under, as part of standard 2.2.1. There appears to be a relationship between the size of the population covered and the percentage of children immunized as required. The larger the population covered, the more difficult obtaining a high percentage becomes. There is also a converse relationship indicating that as the covered population becomes smaller, the immunization program becomes a larger proportion of the overall function of the health department relative to the other public health functions. In addition, the smaller the population covered, the higher the proportion of total countywide immunizations administered by the local health department. In many of these counties with smaller populations, the local health department is the sole provider of immunizations and the immunization program is the only one of the five standard areas investigated that has substantial programmatic activity.

Standard Area 3: Sexually Transmitted Diseases

Sexually Transmitted Disease (STD) services were provided in all but two of the counties. As in the standard areas previously discussed, effort dedicated to these activities was minimal in the smaller counties with more dedicated staff time in the larger counties. The smaller counties typically referred clients to neighboring county health departments, rural clinics or local private providers. Only half of the counties received one or more trainings during the year on the subject of STDs.

Nine counties, including those not providing services, had five or fewer STD cases reported during the previous year. The three larger counties (Finney, Riley, and Shawnee) had 159, 11 and 655 STD cases, respectively.

As seen in other standard areas, the general policies guiding the health departments typically were not in written form. However, disease-specific protocols and procedures were available in written form. Other than the problems with written policies, only standard 3.4.1 relating to procedures for dealing with legal issues in the area of STDs had problems with compliance across the sites (Table 7).

Table 7: Health Departments Fully Meeting Sexually Transmitted Disease Standards

Standard Number	Brief Description of Standard	Number of Health Departments* (N = 10)	Percent of Health Departments
3.2.1	Up-to-date clinic protocol and reporting	7	70%
3.3.1	Partner notification protocol	3	30%
3.4.1	Protocols, procedures, and personnel to conduct program	2	20%
3.1.1	Protocol for reporting and follow-up	1	10%

*Data for the ten local health departments responsible for the activities listed in this standard

Standard Area 4: Tuberculosis

All county health departments provided tuberculosis (TB) testing and screening activities. It was not surprising, however, that there was a great deal of regional variability in the number of encounters (client contacts) regarding TB (Table 8). Finney County had the highest number of encounters for TB with 3,650, but only one active case during 2000. Riley County had the most active cases under current management (3 cases), while all other counties had two or fewer. Five counties had no active cases during the previous year. Staffs in the five less populated counties received no TB trainings in the past year, and staffs in five other counties received one training.

Table 8. Tuberculosis Cases and Encounters (Year 2000)

County	Number of Client Contacts	Number of Active Cases
Finney	3,650	1
Ellis	1,000	1
Shawnee	833	2
Riley	610	3
Sumner	313	1
Barton	174	1
Marshall	112	2
Jackson	100	0
Rice	100	0
Barber	63	0
Woodson	36	0
Elk	20	0

In general, the adherence to standards was limited by the lack of written, overriding policies (Table 9). In many ways, the Tuberculosis Manual, published by KDHE and adopted by many of the sites, served to provide written policies. Some sites had low adherence to standard 4.5.1 reflecting limited efforts in educating the community about TB. Staffs further reported community apathy about the possibility that TB could occur in the county, which affected their educational efforts.

Table 9: Health Departments Fully Meeting Tuberculosis Standards

Standard Number	Brief Description of Standard	Number of Health Departments (N = 12)	Percent of Health Departments
4.1	Protocol for skin testing procedures	7	58%
4.2	Protocol for diagnosis and treatment	6	50%
4.3	Protocol for client contacts	5	42%
4.4	Protocols for collecting and reporting data	4	33%
4.5	Protocols and personnel for education	2	16%

Standard Area 5: HIV/AIDS Prevention and Intervention

The programmatic activity in the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) standard area was low for most of the counties. Only the health departments in the four most populated counties administered more than 25 HIV/AIDS tests in the previous year. Two of these health departments covered multi-county areas. Nine of the 12 counties had no identified HIV/AIDS cases in their area. Not surprisingly, the number of trainings attended by local health department staff was low.

Services covered by the HIV/AIDS standards were provided by seven of the 12 health departments. These services were provided in the counties with the largest populations and primarily consisted of testing and follow-up. The standards in this area had the lowest compliance rates among the five standard areas assessed. Standard 5.1.1, which dealt with testing and providing basic educational materials, had the highest compliance within this section. Six of the seven health departments fully met this standard.

Less than half of the seven counties fully met any of the other four standards in this area (Table 10). Standard 5.2.1 dealt primarily with testing and counseling procedures. Standards 5.2.2, 5.2.3, and 5.2.4 generally referred to prevention activities. Only one health department came close to fully meeting standard 5.2.4 by having an evaluation plan for their prevention efforts. The lower ratings reflect a lack of prevention planning and evaluation activity within the department and the community. The health departments in the four most populated counties demonstrated some efforts in community prevention planning and evaluation along with use of the state plan and data. The two health departments that are members of multi-county offices were involved in these efforts to a greater extent than the small counties that functioned independently. It was noted that prevention and evaluation activities were not well supported by the state, as many health departments did not know what data and community prevention plans were available.

Table 10. Health Departments Fully Meeting HIV/AIDS Standards

Standard Number	Brief Description of Standard	Number of Health Departments (N = 7)	Percent of Health Departments
5.1.1	Counseling, testing, educational materials	6	86%
5.2.2	HIV surveillance activities	3	43%
5.2.3	State prevention plan and personnel	3	43%
5.2.1	Quality assurance standards and prevention plan	1	14%
5.2.4	Evaluation of prevention activities	0	0%

Chapter Five: Common Themes

This chapter presents results organized by themes that cut across multiple standard areas. These results demonstrate that despite some gaps, a consistent pattern of compliance and non-compliance across local health departments emerged. Except in two specific areas, this pattern was independent of health department size or administrative format.

Standards Fully Met Consistently

Several of the standards documented strengths of the local health departments. Of the 43 standards, 13 were met consistently among the health departments reviewed. Two standards (2.4.3, and 2.4.4) were fully met by all 12 health departments, while an additional 10 standards were fully met by most of the health departments in the sample conducting the program component (Table 11).

Written Protocols and Job Descriptions

Written documentation is an important requirement of the KALHD standards. Twenty of the forty-three standards made some reference to written policies, procedures, protocols, or other written documentation. In addition, five standards require specific information about staff responsibilities to be included in written job descriptions.

Predominately, the policies and procedures required by the standards did not exist in written form (Table 12) in this sample. Frequently, policies and procedures could be verbalized by the staff but did not exist in written form sufficient to meet the standards. Of the twenty standards described above, only two of the standards existed in written form in more than half of the health departments. Standards 3.2.1 and 4.1.1 were found in written form in seven of the 12 counties. Six health departments had written policies for three other standards (2.3.6, 2.4.6, and 4.2.1). All other standards calling for written protocols had compliance in five or fewer counties.

Table 11. Standards Met by All or Most Health Departments Conducting the Program Component

Standard Number	Brief Description of Standard	Number of Health Departments (N = 12)	Percent of Health Departments
2.3.4	Health department has coolers and cold packs for vaccine transport.	12	100%
2.4.3	Local health department completes the KDHE vaccine reporting forms and sends summarized data to KDHE monthly, keeping a copy of forms sent.	12	100%
1.2.3	Submission of timely, complete, and accurate communicable disease case follow-up forms	10	100%
2.1.3[a]	Health department uses reporting form or approved data system and submits complete school immunization data to the state annually.	5	100%
1.3.3	Submission of number of persons started on anti-tuberculosis preventive therapy and number of persons Mantoux skin-tested for tuberculosis in follow-up of active cases when requested by KDHE	11	92%
2.3.1	The health department has adequate refrigerators/freezers for at least a one-month supply of vaccines.	11	92%
2.4.5	Health department adheres to guides to contraindications for childhood and adult vaccination, standards for pediatric and adult immunization practices, and Advisory Committee on Immunization Practices (ACIP) statements published in the Morbidity and Mortality Weekly Report (MMWR).	11	92%
2.1.2[c]	Health department maintains on file a copy of the reporting form or holds records in an approved data system and reports accurate day care center immunization data annually.	9	90%
5.1[b]	The local health department will have HIV counseling, testing, educational materials available to the public.	6	86%
2.4.4	Health department provides the appropriate Vaccine Information Statements to every client or parent prior to administering vaccines	10	83%
1.1.2[c]	Submission of communicable disease case reports	8	80%
3.2.1[c]	There is evidence of use of a clinical protocol based on guidelines distributed or approved by KDHE.	7	70%
1.3.2[c]	Submission of timely, complete and accurate communicable disease outbreak investigation reports	7	70%

[a]Data for the five local health departments responsible for the activities listed in this standard

[b]Data for the seven local health departments responsible for the activities listed in this standard

[c]Data for the ten local health departments responsible for the activities listed in this standard

Table 12. Health Departments with Written Standards

Standard Number	Brief Description of Protocol/Policy	Number of Health Departments (N = 12)	Percent of Health Departments
3.2.1[c]	Clinic/referral protocol for STDs	7	70%
4.1	TB screening and referral	7	58%
2.3.6	Management of vaccines during power outage	6	50%
2.4.6	Conforming to VAERS requirements	6	50%
4.2	Diagnosis, medication, monitoring TB	6	50%
5.2.3[a]	Medical intervention/referral of HIV clients	3	43%
2.5.1	Child eligibility for State Vaccine Program	5	42%
4.3	Tracing, treatment, monitoring of TB client contacts	5	42%
2.1	Assessment of childhood immunizations	5	42%
4.4	Collection, protection, reporting of TB client data	4	33%
3.3.1[c]	Partner notification for STDs	3	30%
1.2.1	Communicable disease follow-up activities	3	25%
1.3	Communicable disease control activities	3	25%
3.4.1[c]	Control activities for STDs	2	20%
1.1	Receiving/entering communicable disease data, data analysis, and feedback	2	16%
4.5	TB community education	2	16%
5.2.1[a,b]	HIV counseling, testing, referral	1	14%
3.1.1[c]	Reporting and follow-up of STDs	1	10%
2.1.1	Immunization follow-up and outreach to schools, daycare, preschool, private sector	0	0%
5.2.4[a,b]	Evaluation of HIV staff	0	0%

[a]Data for the seven local health departments participating in this component

[b]Assumed written requirement in contract

[c]Data for the ten local health departments participating in this component

A review of job descriptions (Table 13) showed that half of the local health departments had job descriptions that described employee duties as specified in the standards, while the other half used job descriptions that listed general nursing and employee duties.

Table 13. Health Departments with Job Duties Specified in Job Description

Standard Number	Brief Description of Standard	Number of Health Departments (N = 12)	Percent of Health Departments
4.5	TB community education	8	67%
1.2.2	Communicable disease investigation and follow-up	7	58%
1.3.1	Communicable disease control activities	6	50%
5.2.3*	HIV test clients who do not return	3	43%
1.1.1	Communicable disease case reporting	5	42%
3.4.1	Control of STDs	5	42%

*Data for the seven local health departments participating in this component

Staff Numbers

Both the total number of public health nurses and the associated number of nursing Full Time Equivalents (FTEs) for each health department were obtained. The total number of public health nurse FTEs in each county varied from 0.65 in Woodson County to 48 in Shawnee County. Table 14 compares the public health nursing staff to total county population. Understaffing may have a significant impact on the ability of the health department to meet the standards under review.

Table 14. Comparison of County Population to Public Health Nursing Staff

County	Population	Number of nurse FTEs	Ratio of population to nurse FTE
Shawnee	169,871	48.0	3,539
Riley	62,843	12.0	5,236
Finney	40,523	7.5	5,403
Barton	28,205	6.0	4,700
Ellis	27,507	3.0	9,169
Sumner	25,946	4.0	6,486
Jackson	12,657	2.5	5,062
Marshall	10,965	1.4	7,832
Rice	10,761	3.1	3,471
Barber	5,307	2.5	2,122
Woodson	3,788	.65	5,827
Elk	3,261	2.0	1,630
SAMPLE AVERAGE	33,469	7.68	4,357

Staff Training

The frequency of training in each of the standard areas by local health departments was directly related to the frequency with which that health department dealt with those particular health issues. Trainings were most common and frequent for immunization issues, with most health departments having staff attend two or three trainings a year. Conversely, training was least common in the HIV and TB standard areas, with most sites having no trainings on these issues in the last year. KDHE conference calls, annual statewide meetings, and in some cases, video conferences were the primary source for staff training, although some self-study was reported as well.

Collaboration with Other Organizations

As a group, health departments assessed had problems complying with standards that encouraged or required collaboration with the state or other organizations involved in ensuring the health of their community. Standard 4.5, which requires the local health department to collaborate with other entities in the community to assess the need for community education regarding tuberculosis, was met by only two health departments in this assessment.

Several of the immunization standards (2.1.1, 2.4.1, and 2.4.7) that require local health departments to work with local providers in their communities were not fully met by any of the sites in this assessment. These standards are aimed at promoting the provision of childhood immunizations by private health care providers and require a long-term, collaborative relationship between the health department and these local providers.

Most of the standards in the HIV/AIDS Prevention and Intervention section (5.2.1, 5.2.2, and 5.2.3) require the health department to collaborate with local and statewide prevention efforts. Less than half of the sample assessed on these standards was able to meet any of these standards in regard to their collaborative efforts.

Chapter Six: Conclusions

The preceding assessment examined the ability of local health departments in Kansas to meet the standards developed by KALHD in the areas of general communicable disease control, immunizations, STDs, TB, and HIV/AIDS. While local health departments in Kansas are doing well in many areas, they are unable to fully meet up to two-thirds of the performance standards developed by KALHD. In some cases, this lack of compliance is related to specific policies or behaviors that can be easily resolved. In other cases, this lack of compliance reflects complex and interrelated problems. Most often these problems involve: 1) a lack of written policies, procedures and protocols; 2) staffing issues, including understaffing and appropriate training of existing staff; and/or 3) the way and extent to which local health departments interact and collaborate with other community resources and agencies.

Of particular concern is the likelihood that many of Kansas 70 rural and frontier counties may be unprepared to deal with communicable disease outbreaks. Low disease prevalence, inadequate staffing numbers and training appear to contribute to this situation. According to our findings:

- The health departments in the six smallest counties in this sample handled few, if any, communicable disease cases in 2000.
- The health departments in the smaller counties had very few cases of STDs and no cases of HIV/AIDS.
- The health departments in the five least populated counties had no TB cases in 2000.
- Staff training for communicable disease is less common in areas of low incidence.
- Health departments in less populated counties have fewer staff members and less staffing flexibility in dealing with communicable disease cases than health departments in more populated counties.

Local health departments are an important component of the public health infrastructure in Kansas. Among other things, they provide cost-saving health care and act to control the spread of communicable diseases. Identifying the areas where local health departments are not in compliance with the KALHD standards and finding ways to enable local health departments to resolve issues related to compliance will help ensure that quality public health services continue to be available to all Kansans.

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