Assessment of Foundational Capabilities

Report Summary: The Foundational Public Health Services (FPHS) model serves as the core framework for defining governmental public health responsibilities outlining five foundational program areas and eight cross-cutting capabilities essential for delivering a minimum standard of public health services. This report by the Association of State and Territorial Health Officials (ASTHO) compiles examples and assessments from 25 states to illustrate the implementation and progress of these foundational capabilities, supported by data from 2023 and an additional review in 2024 of Public Health Infrastructure Grant (PHIG) work plans. Highlighting the importance of public health infrastructure, the report also includes a summary chart of state activities, showcases models and strategies for modernization and transformation, and reference tools such as cost assessments, legislation, and funding mechanisms used to strengthen public health systems nationwide.

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Executive Summary

The Foundational Public Health Services (FPHS) model is considered the definitive framework for governmental public health responsibilities. The model is comprised of five foundational areas (programs) and eight foundational capabilities (cross-cutting skills and capacities to support the programs) that describe a minimum package of services that need to be present to support public health. This report contains models of work that demonstrate foundational capabilities and their implementation activities, in addition to a summary chart highlighting state activities to fully implement the foundational capabilities.

Association of State and Territorial Health Officials (ASTHO) members frequently request public health infrastructure guidance specifically to implement the foundational capabilities identified in the FPHS model. To respond to these queries, ASTHO assessed the work of 25 state practices and progress to date at the time of this study (2023) and literature presenting approaches to support foundational public health services and capabilities, modernization, transformation, and public health infrastructure. Additionally, in late 2024, ASTHO reviewed states and territories' Public Health Infrastructure Grant work plans' progress on foundational capabilities. Those summary findings and examples can be found in the Addendum section of this report.

CDC's Public Health Infrastructure Grant (PHIG) is an investment in the public health system that confirms the critical nature of public health infrastructure across the United States. Many states are utilizing PHIG to conduct additional activities to strengthen foundational capabilities that may not be captured in this document. The examples in this report are supported by foundational capabilities frameworks, public health modernization plans and strategies, new service delivery models, legislation, capacity and cost assessments, and information on funding levels and allocation methods.

Approaches to Implementing Foundational Capabilities

Establishing a Minimum Package Framework

1. Adopt the national FPHS model as the framework for foundational capabilities.

Leading the Elements of Effective Public Health System Change

Plans and Strategies:

1. Lead, co-lead, or participate in efforts to implement the foundational capabilities throughout the state. The specific role is not important — being an active participant is what matters.
2. Commit to a multi-year effort, with sufficient time and resources, to develop a comprehensive plan for the full implementation of the foundational capabilities.

3. Include the following components in the plan:
    a. Capacity and cost assessment, to be conducted at the outset of the effort as it will inform subsequent activities.
    b. Plan for allocating new investments among health departments.
    c. Legislative changes to support the effort.
    d. Accountability measures.
4. Take a systems approach:
    a. Include efforts to enhance capabilities of both the state and local health departments.
    b. Engage other important system partners with shared goals, e.g., public health associations, elected officials, academic institutions, public health coalitions, and philanthropic organizations.
    c. Include tribal authorities in early discussions to determine the best role for the state to play in plans to strengthen and improve tribal public health systems.
5. Communicate with the public and system partners about the importance and value of public health.

New Service Delivery Models:

1. Carefully consider the most effective, efficient, and equitable ways to ensure the state is well serviced by foundational capabilities.
2. Codesign all new models with local health departments, even if they only involve changes to the state health department's structure or operations.

State Legislation:

1. Educate and advocate for an examination of how to strengthen and improve the state's public health system.
2. Modify state regulations to adopt the foundational capabilities outlined in the national FPHS model.
3. Identify statutory changes that may be needed to support your efforts, investigate the feasibility of these changes, and pursue them where possible.

Adopting Capacity and Cost Assessments

1. Adapt or adopt the Public Health Accreditation Board (PHAB) Capacity and Cost Assessment tool to estimate current capacity, current costs, and the level of investment needed to achieve full implementation of FPHS.
2. Assess the state health department and local health departments simultaneously.

3. Secure the resources needed for a successful effort, including:
    a. Professionals (staff and/or consultants) with the expertise, experience, and bandwidth to ensure high-quality data collection, analysis, and visualization.
    b. A range of readily available training and technical assistance for assessment participants.

Managing Funding Levels and Cost Allocation

1. Use the results of capacity and cost assessments to inform decisions on how best to distribute funds.
2. Consider data on which communities are most impacted when designing funding formulas.
3. Include plans to demonstrate accountability for FPHS funding in modernization plans and funding requests.

This report is intended to serve as a sample inventory and application guide, presenting strategies to assist with planning, developing, and implementing foundational capabilities to support the FPHS model. ASTHO acknowledges that all states and territories are working toward transformational efforts to support their public health systems, and these examples are a snapshot of the activities occurring across the United States. Due to the dynamic nature of modernization efforts and the continued support from PHIG, each state should be considered the source of the most up-to-date status of this work.

Introduction

The public health practice community recognizes the Foundational Public Health Services (FPHS) as the definitive minimum package of public health programs and capabilities. The model identifies five "foundational areas," or core services, and eight "foundational capabilities" that are the cross-cutting measures supporting the core services. Foundational areas usually, if not always, are funded through programmatic, siloed funding. In sharp contrast, most of the foundational capabilities do not have dedicated funding. This funding can be described as limited, fragmented, and unreliable. As a result, states experience significant gaps between existing capacity and the capacity needed to fully support public health practice.

The foundational capabilities model describes the full complement of functions that, while critical, do not always receive due consideration in budget calculations. ASTHO prepared this assessment to help states and territories learn from practices used by their colleagues across the country to fully implement foundational capabilities across their public health systems.

ASTHO issued a call for information to all states and territories about implementing the foundational capabilities and received information from 25 states. A variety of strategies and initiatives were underway at the time of the study (2023), some of which are captured in comprehensive modernization plans or standalone interdependent strategies. Some states have been engaged in this work for more than a decade, while others began their work post-pandemic. While the trajectory of progress varies in terms of time and scope, all foundational capabilities efforts are driven by dedicated professionals that have made multi-year commitments to this work.

This report presents models based on common themes that emerged from a review of states' initiatives, along with examples of "minimum activities" frameworks, public health modernization plans and strategies, new service delivery models, legislation, capacity and cost assessments, and information on funding levels and allocation methods. The identified models also align with literature supporting recommendations and best practices for state health departments to provide foundational capabilities in the 21st century. The review demonstrated the definitive nature of FPHS as a framework for governmental public health practice. The interrelated concepts described in various sources illustrated overall alignment in support for strengthening the public health system through full implementation of FPHS across the United States.

The models are intended for states and territories interested in taking similar actions and are not intended to be prescriptive. See Appendix C for a summary of activities in 13 states that are working to fully implement the foundational capabilities. Due to the dynamic nature of modernization efforts and the continued support from CDC's Public Health Infrastructure Grant (PHIG), each state should be considered the source of the most up-to-date status of this work.

ASTHO thanks the Public Health Accreditation Board (PHAB) Center for Innovation for their assistance in collecting material and information from the states that participate in the 21st Century Learning Community. ASTHO also gratefully acknowledges the contributions from the following states that responded to the call for information:

Arizona	Illinois	Massachusetts	New Jersey	Oregon
California	Indiana	Michigan	New Mexico	Utah
Colorado	Iowa	Minnesota	North Carolina	Virginia
Connecticut	Kansas	Missouri	Ohio	Washington
Idaho	Kentucky	Nevada	Oklahoma	Wisconsin

Regardless of the degree to which states are currently engaged in modernization efforts or how strongly they adhere to the recommendations included in this report, ASTHO acknowledges and honors the importance and significance of all initiatives to strengthen foundational capabilities.

Methods

The foundational capabilties models and practices were collected through several steps from July through November 2023.

ASTHO conducted a literature review to understand the status of foundational public health services in the practice community, identify common themes related to foundational capabilities, and understand related issues. ASTHO collected materials from the 18 states that comprise the 21st Century Learning Community (21C) facilitated by the Center for Innovation at PHAB. This included information posted on the 21C website, follow-up information PHAB procured from the states, and materials and information found on the states' websites.

ASTHO also issued a call for information to the remainder of its membership, held calls with those who responded, and reviewed all the materials that were submitted. A combination of 21C states and the remaining membership brought the total number of participating states in the work to 25.

The gathered resources provided information, both for general context in addition to specific content related to various foundational capabilities. The following state resources served as the foundation for the models:

- 13 FPHS frameworks.
- 12 modernization/transformation plans or strategies.
- Five capacity and cost assessments.
- One capacity assessment.
- Two communications campaigns.
- 19 pieces of state legislation.
- Nine budget summaries of funding levels and allocations for FPHS.

The resources did not come from a representative group of all health agencies. However, it is noteworthy that all but one of the states have a centralized or largely centralized governance structure. See Appendix A for a summary of activities in 13 states that are working to fully implement the foundational capabilities.

Establishing a Minimum Package Frameworks

Practices and Models

Adopt the national foundational public health services as the framework for the foundational capabilities.

Overview

When working to strengthen a state's public health infrastructure, it is critical to define the capabilities needed to support all programs and services. In 2022, the Center for Innovation at PHAB launched the revised FPHS framework. In addition to listing five service areas, it also lists eight capabilities that must be available in every community. According to PHAB, the foundational capabilities "are the cross-cutting skills and capacities needed to support basic public health protections, programs, and activities key to ensuring community health, well-being, and achieving equitable outcomes." They include the following:

- Assessment and surveillance
- Community partnership development
- Equity
- Organizational competencies
- Policy development and support
- Accountability and performance management
- Emergency preparedness and response
- Communications

ASTHO identified 13 states that are working toward ensuring the full complement of foundational capabilities, all of which have adapted or adopted the national framework. New Jersey, New Mexico, and Virginia, while earlier in their efforts, have cited the national framework as the basis of their work.

With few exceptions, states' adaptations have not resulted in a material difference with respect to the capabilities captured in the original framework. Examples of adaptations include the following:

Not using the term "foundational capabilities" to describe the skills and capacities.

- Using different but clearly analogous terminology for some skills and capacities.
- Organizing the skills and capacities under different titles (most often adding to or subtracting from "organizational competencies").

Therefore, even if different terminology is used or the skills and capacities are organized differently, every state is working to enhance the same broad group of capabilities.

Every state explicitly lists "emergency preparedness" as a capability. And while all other capabilities are addressed one way or another in the states' descriptions of foundational capacities, the most noteworthy differences are found in how equity is embodied in the frameworks. The states that do not list equity as its own capability have clarified that equity is reflected in all their work, and at least one state is actively discussing how to specifically articulate the central role of equity in their FPHS model.

State Implementation Examples

This table summarizes how the foundational capabilities are addressed by each state's model, according to the following key. Black squares reflect adherence to the structure of the national model; gray squares reflect adherence to the concepts in the national model, and no shading reflects that a capability is not specifically embodied in the state's model.

Key:

The capability is listed on its own.	
The capability is included in the state's model as part of another capability.	
The capability is not included in the state's model.	

Foundational Capabilities	CA	CO	IN	KS	KY	MA	MN	MO	NC	OH	OR	WA	WI
Assessment and Surveillance													
Community Partnership Development													
Equity													
Organizational Competencies													
Leadership and Governance													
IT Services													
WFD and HR Workforce Development and Human Resources													
Financial Management, etc.													
Legal Services													
Policy Development and Support													
Accountability and Performance Management													
Emergency Preparedness and Response													
Communications													

Conclusion

Adopting the national FPHS framework provides consistency in understanding and describing state public health agency capacity from a national perspective. Even when states adopt the national FPHS framework, variations in the details of each capability exist due to differences in how the capabilities are organized, funded, and operationalized by each state government. These variations can be captured in detailed definitions that flesh out the capabilities (e.g., for conducting a capacity and cost assessment). However, the same conceptual approach drives important commonalities with respect to assessing current capacity, estimating what is needed to attain full capacity, and calculating the costs associated with closing the gap between current and full capacity. As more states adopt the national model, it is increasingly possible to describe the state of public health across the country in a more accurate and compelling fashion, therefore bolstering efforts to secure support and funding for state public health agencies at the federal level.

Elements of Effective Public Health System Change

Plans and Strategies

Practices and Models

1. Lead, co-lead, or participate in efforts to implement the foundational capabilities throughout the state. The specific role is not important—being an active participant is what matters.
2. Commit to a multi-year effort, with sufficient time and resources, to develop a comprehensive plan for the full implementation of the foundational capabilities.
3. Include the following components in the plan:
    a. Capacity and cost assessment, to be conducted at the outset of the effort as it will inform subsequent activities.
    b. Plan for allocating new investments among health departments.
    c. Legislative changes to support the effort.
    d. Accountability measures.
4. Take a systems approach:
    a. Include efforts to enhance capabilities of both the state and local health departments.
    b. Engage other important system partners with shared goals, e.g., public health associations, elected officials, academic institutions, public health coalitions, and philanthropic organizations.
    c. Include tribal authorities in early discussions to determine the best role for the state to play in plans to strengthen and improve tribal public health systems.
5. Communicate with the public and system partners about the importance and value of public health.

Overview

ASTHO identified 20 states at various stages of strengthening and improving their public health systems – the backdrop for implementing foundational capabilities statewide. State health agency participation in transformation can be described on a continuum. On one end, the state has initiated the work, and at the other end, the state has voiced support for transformation efforts but is not part of a comprehensive and deliberate effort to enact change. Other points along the continuum include the state assuming responsibility for an effort that was generated by local health departments, partnering with local health departments at the outset, joining efforts after they are underway, and formally voicing support.

Maryland and New Mexico recently were directed by legislation to provide recommendations for strengthening public health. In three states—Kansas, New Jersey, and Virginia—public health practitioners have initiated transformation efforts and are working to galvanize formal support and generate momentum and interest throughout the state and at all levels of government. And in Nevada and Nebraska, state health departments are supporting various initiatives to help modernize their public health systems. Another 13 states have identified priorities, developed recommendations, and/or created transformation plans and are in various stages of implementing them.

Several noteworthy commonalities exist in the work that is underway:

- Nine states called for, or have completed, assessments of health departments' current capacity to provide foundational capabilities, the gaps between current capacity and full implementation, and the cost to close the gap.
- Eight states have, or plan to develop, accountability measures.
- Eight states recommend and/or provide incentives for new service delivery models to ensure statewide availability of foundational capabilities.

The trajectory of transformation work varies widely. For example, in Indiana, the Governor's Public Health Commission was established in 2021, their legislatively mandated report was submitted to the governor in 2022, state legislation to support and fund the report's recommendations was passed in 2023 for implementation in 2024. At the other end of the spectrum, the Association of Ohio Health Commissioners published its transformation report in 2012 and has been working since then on a variety of efforts to shore up local governmental public health practice. The Association of Ohio Health Commissioners continues to make important strides with the support of different grants and in partnership with the state health department, despite the absence of a comprehensive plan with dedicated funding. These examples also illustrate the wide variation in funding for developing and implementing transformation plans. States that legislatively mandated recommendations for strengthened public health infrastructures have included support for this work in their budgets, while other states have received grants and in-kind contributions from public health system partners. Still other states have largely relied on local public health leaders to volunteer their time to begin the efforts, for example, by developing concept papers.

Apart from a few states that specify a focus on strengthening governmental public health at the local level, transformation efforts are described as encompassing both state and local public health agencies. Also, three states include tribal health departments in their work. Washington and Minnesota are working with tribal health departments on parallel efforts, beginning with understanding how the state can best support this work. Also, North Carolina specifically includes federally recognized tribes in their recommendations for enhanced funding.

Numerous public health system partners are engaged in transformation work across the country, as illustrated in the Examples section below. Partners assume a variety of roles, e.g., they serve on steering committees, committees, and work groups; review and comment on recommendations; liaise with community members and elected officials; and otherwise provide their perspectives and offer their support. In many states, the range of participation from public health system partners continues to grow as the work progresses.

Finally, some states have included deliberate efforts to better communicate about public health in their work to strengthen and improve their public health system. One state received feedback that their initial transformation efforts were viewed as a funding campaign, prompting them to consider how best to approach their work from the perspective of public health contributions to the community. Several states have referenced *Public Health Reaching Across Sectors* as a valuable resource to guide strategic communications. Indiana, Kansas, Nebraska, and Ohio have plans to develop materials that convey the importance and value of public health. And two states launched communications campaigns to complement their transformation work: Washington's "Public Health is Essential" campaign began in 2017 and North Carolina started "We Are NC Public Health" in 2023.

State Examples

The table below includes links to reports, plans, and websites that describe state transformation efforts.

State	Report or Website	Participants	Date
California	Investments and Capabilities Needed for the Future Public Health System	Future of Public Health Workgroup and other partners: California Department of Public Health, California Health and Human Services Agency, Service Employees International Union, local health departments, California Pan-Ethnic Health Network, Disability Rights California, Vision y Compromiso.	2021
Colorado	Public Health Transformation and Rebuilding website	Colorado Association of Local Public Health Officials, Colorado Department of Public Health and Environment.	2019

Indiana	Governor's Public Health Commission Report	Governor's Public Health Commission: former state senator, former U.S. representative; former health commissioner and President of CDC Foundation, Indiana Department of Health, Indiana University, Indiana University Fairbanks School of Public Health, Indiana Minority Health Coalition, Indiana Rural Health Association, Indiana Public Health Association, county commissioners, mayors, Indiana Hospital Association, local health departments, state public health associations, Public Health Regionalization Working Group.	2022
	Health First Indiana website		
Kansas	Kansas Foundational Public Health Services: An Implementation Roadmap to Modernize the Public Health System	Public Health Systems Group and its Council on the Future of Public Health in Kansas, state and local health departments, state and local elected officials, public administrators, hospitals, medical and behavioral health care providers, health insurance, philanthropy, and higher education.	2018
Kentucky	Public Health Transformation - Cabinet for Health and Family Services	Public Health Transformation project team, comprised of people with state and local health department experience.	2019
Massachusetts	Blueprint for Public Health Excellence	Special Commission on Local and Regional Public Health: Massachusetts Department of Public Health, Massachusetts Department of Environmental Protection, Massachusetts Department of Agricultural Resources, U.S. Department of Veterans Affairs, East Boston Neighborhood Health Center, Brigham Health, state legislators, local health directors.	2019
Minnesota	Transforming the Public Health System in Minnesota website	Joint Leadership Team for Public Health System Transformation in Minnesota: State Community Health Services Advisory Committee, Local Public Health Association of Minnesota, and Minnesota Department of Health.	2019

Missouri	Healthier Missouri	Grassroots initiative with governmental public health professionals and partners.	2020
North Carolina	Foundations of Health and Opportunities: Investing in Local Public Health in North Carolina	North Carolina Institute of Medicine's Task Force on the Future of Local Public Health.	2022
	Workforce and Infrastructure Improvement Plan in Action		2022
Ohio	Ohio Public Health Futures Report	Association of Ohio Health Commissioners' Public Health Futures Committee: local health departments. Partners have grown to include Ohio Department of Health, Ohio Public Health Partnership (Association of Ohio Health Commissioners, Ohio Association of Boards of Health), Ohio Public Health Association, Ohio Environmental Health Association, and Society for Ohio Public Health Educators, Ohio Association of Community Health Centers, health directors, state and regional hospital associations, and physician associations.	2012
	21C - Ohio (phaboard.org)		2020
Oregon	Modernizing Oregon's Public Health System	Task Force on the Future of Public Health in Oregon: state legislators, Oregon Health Authority leaders and staff, local public health administrators, Oregon Public Health Institute, organized labor, Portland State University, Northwest Health Foundation, Trillium Community Health Plan, United Way, and Oregon Department of Human Services.	2014
	Oregon Health Authority: Public Health Modernization Website		

Washington	FPHS – Public Health Modernization Plan	Steering Committee: Washington Department of Health and local health jurisdiction directors.	2016
	Public Health Transformation | Washington State Department of Health Website		
Wisconsin	WALHDAB Public Health Collaborative	University of Wisconsin Population Health Institute, local health departments and boards, WI Department of Health Services/Division of Public Health.	2022

Conclusion

Because state health departments are the mainstay of governmental public health systems, their active participation in statewide public health transformation efforts can generate momentum and funding that facilitates these efforts. Moreover, this post-pandemic era provides a unique opportunity to make much-needed improvements in public health infrastructure, due to a heightened awareness of the vital role of public health and unprecedented levels of federal funds dedicated to improving the public health infrastructure. For this reason, states are well-served by seizing this opportunity to enhance foundational capabilities at both the state and local levels.

Moreover, public health system transformation entails a multi-year, multi-pronged effort comprising interdependent activities. Cost and capacity assessments generate defensible estimates of needed investments. The findings also provide information needed to allocate funds in the most effective and equitable manner and establish a baseline from which to measure improvements and otherwise demonstrate accountability. Legislative changes may be necessary to ensure the delivery of foundational capabilities and institutionalize associated practices. And given historical misconceptions about the role of governmental public health, strategic communications are important when working to generate support for strong public health systems. A comprehensive plan that includes all these issues will help ensure the work is timely and organized.

Finally, statewide implementation of foundational capabilities requires a systems approach to ensure buy-in from key stakeholders, mutually agreeable outcomes, no unintended and negative consequences, and feasible plans and strategies. A systems approach begins with engaging system partners in the initial stages of the work and involves substantive efforts to elicit perspectives, collect feedback, and consider all input.

New Service Delivery Models

Practices and Models

1. Carefully consider the most effective, efficient, and equitable ways to ensure the state is well-served by foundational capabilities.
2. Co-design all new models with local health departments, even if they only involve changes to the state health department's staffing or structure.

Overview

Implementing the full complement of foundational capabilities statewide presents a significant opportunity to rethink the state's governmental public health system. Core public health functions have evolved over time due to changes in federal policy (e.g., American with Disabilities Act), a general trend of decreased federal and state funding, the establishment of a national public health accreditation program, national reckoning with racial injustice, and other factors. Moreover, shifting population density, demographics, disease patterns, and additional pressures have impacted health departments' ability to fulfill their responsibilities. As a result, governmental public health structures that worked well in the past may no longer be the most effective, efficient, and/or equitable way to ensure that all communities are served by the foundational capabilities.

Several states have created new ways of sharing resources and services across health departments that are designed to maximize the resources available for foundational capabilities. These strategies include expanding the availability of expertise through state employees, incentivizing or facilitating multi-jurisdictional health departments, and dedicating funds to support new service delivery models.

State Examples

Dedicated State Staff for Foundational Capabilities

California is establishing five regional health offices with an epidemiologist, public information officer, and a coordinator to provide technical assistance and planning assistance.

Indiana is establishing district offices with staff and resources to support local health departments with epidemiology, data analytics, legal consultation, communications, grant writing, training, and other functions, as necessary.

Ohio has added five regional support positions to its ranks. The essential job functions they will provide are being developed collaboratively with local health departments.

State Support for Innovation

Since 2015, Washington has supported demonstration projects for new service delivery models. Projects have included dedicating one health department as the sole grantee for tuberculosis funds from the state and serving as the statewide support for tuberculosis cases in other jurisdictions; funding one health department to develop websites for other, non-contiguous health departments (upon their request); and embedding epidemiologists in health departments across the state that serve entire regions.

Minnesota awarded 16 grants to local health departments for the period April 2022 – June 2024 to generate and test new ways of sharing services. Awardees chose one of the following areas for sharing: communications, data and epidemiology, community partnerships, and health equity.

Incentives for Multi-Jurisdictional Health Departments

For several years now, Massachusetts has provided grants to health departments interested in developing health districts or other forms of service and resource-sharing arrangements.

In its most recent budget cycle, Ohio allocated $6 million for city health districts serving fewer than 50,000 residents to study whether to merge with county health departments.

Other Support for New Service Delivery Models

The Kansas Public Health Systems Group conducted a pilot program of a seven-county public health coalition. The study found it was feasible to share services and resources comprising foundational public health services.

Nevada supported the development of a new health district in 2022 (the third in the state and the first one serving only rural areas) and a "Rural Health District Toolkit" based on this experience.

Conclusion

The capacity assessments that ASTHO reviewed revealed wide variations in the current ability of local health departments throughout the state to provide all foundational capabilities. Many public health systems have become outdated in that they do not reflect the current realities of the public health practice landscape. Working only to increase funding for existing entities is not likely to be successful — especially in the long run, after the current historically high levels of investment in public health have expired.

A solution to ensuring the provision of foundational capabilities throughout a state depends on precisely the function that the solution is crafted to improve. While the examples provided in this section are intended to enhance knowledge about new service delivery models, most importantly they are intended to inspire creativity. States must understand their capacity gaps, identify existing and needed resources, and use this information to drive their approach to new service delivery models that ensure the provision of foundational public health services throughout the state.

State Legislation

Practices and Models

1. Educate and advocate for an examination of how to strengthen and improve the state's public health system.
2. Modify state regulations to adopt the foundational capabilities outlined in the national Foundational Public Health Services model.
3. Identify statutory changes that may be needed to support your efforts, investigate the feasibility of these changes, and pursue them where possible.

Overview

Legislation is a potential option to ensure that foundational capabilities are available throughout a state's governmental public health system. Many states have pursued the legislative route to mandate the development of recommendations to improve public health infrastructure, institutionalize foundational capabilities as the basis of public health practice, require reports on the impact of new public health funding streams, and otherwise pave the way for public health system transformation.

Transforming a state's public health system to ensure the availability of foundational capabilities requires a multi-year, multi-partner effort to ensure its success. A thorough evaluation of the current infrastructure and recommendations for establishing and sustaining a modern, robust infrastructure form the core of transformation efforts. Because these efforts are systemwide, public health system partners are integral to this work. Public health systems require sufficient resources to support a robust and comprehensive process. In many states, a legislative imperative not only draws key stakeholders to the table, but is also more likely to be financed by the state compared with efforts undertaken separately from the legislative arena. Legislative support also helps bring visibility to the vital role of public health.

Requirements for governmental public health agency capacities are specified in state regulations, and therefore, regulations form the basis for public health activities. Embedding foundational capabilities in state public health regulations ensures they will be institutionalized throughout the state. In addition, work that is required by regulation is more likely to receive institutionalized state funding.

Many states have statutes that narrowly define the structure of local governmental public health agencies (e.g., requiring each municipality to have its own health department and/or board of health, prohibiting or limiting the configuration of multi-municipality health departments, etc.). However, not every sub-state political jurisdiction is large enough to secure staff and contractors with the range of subject-matter expertise embodied by the foundational capabilities. Therefore, state health agencies must understand existing statutes that can impede new service delivery models and identify changes that facilitate effective and efficient approaches to ensuring the availability of foundational capabilities statewide.

The impact and feasibility of legislative changes to support the implementation of foundational capabilities varies according to a number of factors, including the level of support from the public health practice community and system partners, existing statutes, and the political climate. Therefore, state health agencies should consider their unique context when determining whether to pursue legislative action to facilitate uptake of the foundational capabilities.

Successful legislative changes rarely occur in a vacuum and are often accompanied by many contextual activities. For example, state and local health officials can consider the following strategies that have been undertaken by their colleagues pursuing public health transformation:

- Build out a website.
- Host a Public Health Day at the state house.
- Use social media and op-eds to share key messages about public health.
- Discuss the importance and value of public health with key partners.

The state's budget is a critical part of state policy initiatives. Even when states are not operating under statutes that define and support foundational capabilities, they still have been successful in procuring resources that advance and support transformation efforts..

State Examples

Mandate or Provision	Colorado	Indiana	Kentucky	Maryland	Massachusetts	Minnesota	New Mexico	Oregon	Washington	Wisconsin
Develop Recommendations to Strengthen Public Health Infrastructure				X	X		X	X	X	
Provide Foundational Capabilities	X	X	X		X	X		X	X	X
Report on Investments in Foundational Capabilities						X		X	X	
Support New Service Delivery Models										

Statutes That Otherwise Support Aspects of Transformation

Statute	Description
Indiana Senate Bill 4 – Public Health Commission	Requires multi-county health departments to maintain a physical office in each participating county.
Massachusetts Session Law – Acts of 2020 Chapter 72	Establishes a State Action for Public Health Excellence plan to support strengthening the local public health infrastructure.
Washington RCW 43.70.515 – Foundational Public Health Services – Funding	Requires allocation of FPHS funds to be determined by state, local, and tribal public health authorities.

Conclusion

Legislative support to implement the full complement of foundational capabilities throughout a state's public health system can take many forms. The decision to pursue legislation depends on a variety of factors, and the most effective legislation is unique to each state's public health system. State health departments are well-served by carefully considering politically viable legislation to establish and sustain the availability of foundational capabilities.

Public Health System Capacity and Cost Assessments

Practices and Models

1. Adapt or adopt the PHAB Capacity and Cost Assessment tool to estimate current capacity, current costs, and the level of investment needed to achieve full implementation of FPHS.
2. Assess the state health department and local health departments simultaneously.
3. Secure the resources needed for a successful effort, including:
    a. Professionals (staff and/or consultants) with the expertise, experience, and bandwidth to ensure high-quality data collection, analysis, and visualization.
    b. A range of readily available training and technical assistance for assessment participants.

Overview

ASTHO reviewed completed capacity and cost assessments from six states. Three states assessed both local and state health departments; two states assessed only local health departments; and one state, Washington, assessed the state board of health in addition to state and local health departments. All the assessments studied both foundational capabilities and foundational areas, and all states collected data through self-assessments (except for one, which some data collection assistance was provided to several local health departments to increase the response rate). Furthermore, Missouri used its biannual Infrastructure Survey (completion is a requirement for local health department funding) as the vehicle for its capacity assessment. At the time of this study, three additional states (Nebraska, Nevada, and Wisconsin) were either planning to conduct or were conducting assessments.

Five of the six assessments included estimates of current capacity and expenditures and the amount of funding needed to fully provide all foundational public health services. Instead of assessing costs, Missouri assessed the resources needed to fully implement capabilities (e.g., staff, training, and technology) and plans to do a costing assessment soon. Ohio's current cost data collection process is particularly noteworthy, as the Annual Financial Report (a requirement for local health department funding)has evolved such that it mirrors the cost assessment tool; therefore, actual costs of foundational capabilities are now reported each year.

Most of the six assessment tools used a three-tier system when describing FPHS: foundational capability/area; an intermediate tier (often referred to as "functions" or "headline responsibilities"); and discrete activities. The activity level usually captured capacity data, and the intermediate tier usually captured costs. The number of indicators varied among instruments, as seen in the chart in the Example section below.

Capacity scores most often were a composite score based on the level of capacity (staff and other resources)and the level of expertise (knowledge and skills). The scores were estimated percentages of the activity provided or Likert Scale responses related to attainment of capabilities (ranging from a 4- to 6-point scale). In Minnesota, the capacity score reflected the levels of capacity and expertise in the community, while all others focused exclusively on the health departments. See Appendix B for the data visualizations of each capacity assessment's findings.

Although the cost assessments are aligned with, and have many similarities to, the foundational capabilities, the span of time during which data were collected (2016 - 2022), the variation in number and definition of measures, and the differing makeup of assessment participants make it difficult to accurately compare states. Assessment results of per capita spending on FPHS (not just the foundational capabilities) in six states is depicted in Table 1. Of these states, California estimated its costs based on existing investments and benchmarks. Three additional states (not included in the table) estimated the costs for FPHS using other methods: Indiana and North Carolina recommended funding increases to match the national per capita average, and Kentucky calculated a new funding formula based on staffing needed to provide FPHS.

Table 1. Per Capita Costs for FPHS.

Item	California	Colorado	Minnesota	Ohio	Oregon	Washington
Year Data Collected	2021	2018	2022	2019	2016	2018
Per Capita Cost - Current	$71	$48.90	$68.90	$35.99	$51.06	$48.94
Per Capita Cost - Full Implementation	$89 - $92.60	$78.32	$166.45	$43.93	$76.72	$79.14
Includes State Health Departments	x	x	x		x	x
Includes State Boards of Health						x

These assessments entail a great deal of time, effort, and expertise to ensure the data's completion, accuracy, reliability, and validity. Every assessment effort was supported through dedicated funding, and consultants were engaged to assist with survey design, technical assistance for survey completion, analysis, and visualization. Technical assistance for survey respondents was extensive in most states, including some combination of websites with guidance materials (such as operational definition manuals, instruction guides, and Frequently Asked Questions); orientation webinars; office hours; and 1:1 technical assistance by email or phone.

The Center for Innovation at PHAB introduced a Capacity and Cost Assessment tool in August 2023 based on assessment tools and experiences to date. The PHAB tool includes 13 capabilities and areas, 28 headline responsibilities, and 258 activities. The PHAB tool also assesses additional elements including staffing, community capacity for FPHS, and service and resource sharing. Moreover, the tool has instructional guides, operational definitions, and worksheets to assist assessment participants.

State Examples

The table below depicts characteristics of the capacity and cost reports that are publicly available. Links to the reports are embedded in the state abbreviations.

Assessment Characteristics	Colorado	Minnesota	Missouri	Ohio	Oregon	Washington
Entities Assessed						
State Health Departments	x	x			x	x
State Boards of Health						x
Local Health Departments	x	x	x	x	x	x
# of Units in Assessment Tool*						
Foundational Areas and Capabilities	12	13	13	13	11	12
Functions or Headline Responsibilities	53**	52	68		40	45
Activities	346	340	141	111***	302	350
Year Data Collected	2018	2022-2023	2021	2019	2016	2018

**The terms used here are not necessarily the terms used in individual assessments.*

***53 "functions" and 114 "elements." This is a nested system in which every activity aligns with an element, every element aligns with an element, and every element aligns with a function.*

**** includes 60 statewide mandated activities and 58 activities that vary by county.*

Conclusion

Information from a comprehensive capacity and cost assessment offers several benefits, including identifying strengths and areas of need in the public health system, justifiable budget requests, a basis for determining the most equitable ways to allocate funding, and a baseline from which to measure public health system improvements and demonstrate accountability.

The new PHAB assessment tool reflects prior work that yielded useful results, and it can be adopted in full or adapted to reflect a state's unique public health practice environment. The supplementary materials within the tool provide much support for ensuring reliable and valid responses. Moreover, as more states use the PHAB tool it will become increasingly possible to generate meaningful comparisons and analyses of FPHS across the country.

Simultaneous assessments of state and local health departments can be helpful for several reasons. At this point, there are a lot of resources, support, political will, and momentum for this work — factors for success that state health departments cannot control. Moreover, a systems approach to this work highlights the critical interplay between state and local entities and helps practitioners, elected officials, and others understand the entire system.

An effort of this magnitude requires much support to generate meaningful and impactful data. Investment in a sound assessment process is likely to help secure additional investments for public health practice.

Finally, the Uniform Chart of Accounts (UCOA) is worth mentioning — although it currently is dormant, it (or a similar program) may be available in the future. Housed in the Northwest Center for Public Health Practice at the University of Washington, UCOA aligned with the FPHS model and offered a way for state and local health departments to consistently report on spending activities. A recent evaluation by Bekemeier et al (2023) demonstrated that participating local health departments used information from the UCOA reporting tool to inform practice, specifically in demonstrating accountability and making more strategic resource allocation decisions. Moreover, researchers used UCOA data to demonstrate relationships between spending patterns on the foundational capabilities and performance in PHAB accreditation processes, and to track revenue streams and programmatic expenditures from federal sources to states and then to local agencies. Finally, valid comparisons on spending can be made among health departments that used the tool, and if scaled up, UCOA data could yield one-of-a-kind information about public health expenditures across the country.

Funding Levels and Cost Allocations

Practice and Models

1. Use the results of capacity and cost assessments to inform decisions on how best to distribute funds.
2. Consider data on which communities are most impacted when designing funding formulas.
3. Include plans to demonstrate accountability for FPHS funding in modernization plans and funding requests.

Overview

Several state health departments have successfully secured funding to support the implementation of Foundational Public Health Services. The investment amounts vary, as does the context, e.g., the source of funds, purpose of the funding, how funds have been distributed, plans for and methods of demonstrating accountability, and funding formulas that have been developed. In addition to the examples provided below, three additional states (Colorado, Missouri, and North Carolina) are advocating for new investments and/or developing accountability mechanisms.

State Examples

California

The state received $300 million from the state's general fund for FY 2022-2023, with $99.6 million going to the state health department and the remaining $200.4 million directed to local health departments. The funds support implementation of the Future of Public Health Work Group Report, and plans for the funding are described in the Spending Plan for Public Health Infrastructure Investment document. Among other activities, the funds are strengthening the Office of Policy and Planning, with a key initiative to set performance targets for public health and publish results annually.

Indiana

The biennium budget and legislation passed in 2023 provided a recurrent and stable investment in the state's Department of Health and local health departments, one of the recommendations of the Governor's Public Health Commission report. In January 2024, $225 million was made available to counties that opt in for these funds, which include support for core services. The state health department is developing key performance indicators for each core service at the state and local levels. Moreover, the state health department is now required to annually report on these metrics to the state's budget committee and publish this information online.

Kentucky

Legislation passed in 2020 included a statutory amendment that established a new funding formula for local health departments based on estimates of the staffing required to perform core public health services: One full-time equivalent (FTE) staff per 5,000 population, with a minimum population of 15,000 required to receive funding, at a cost of $109,000 per FTE. The state must recalculate the funding formula for every biennium budget. 2023 was the first budget year that local health departments operated under this new allocation formula, after the legislature passed a funding bill that included support for Public Health Transformation in 2022. Efforts to design accountability mechanisms are underway.

Minnesota

The Minnesota Legislature provided a $6 million appropriation in 2021 to strengthen local and tribal health departments. Minnesota's Joint Leadership Team for Transformation (a state-local collaboration) decided to create an Innovation Fund and awarded 16 grants to generate locally driven models of foundational capabilities with the potential to be implemented across the state. Grantees selected communications, community partnerships, data and epidemiology, or health equity as the focus of these models.

In 2023, the Minnesota Legislature allocated local health departments $9,844,000 and tribes $535,000 to fulfill foundational public health responsibilities. This is ongoing, annual funding to strengthen local and tribal public health in Minnesota and is intended for foundational public health responsibilities. Grantees must provide a 75% match for these funds.

The Foundational Public Health Responsibility Funding Work Group developed a funding formula to guide new investments in local health departments to implement FPHS, in addition to reporting and accountability mechanisms. A draft funding formula provides a base to each local health department and allocates 60% of remaining funds based on the social vulnerability index and the other 40% to local health departments serving fewer than 100,000 people. The formula reflects the findings of the capacity and cost assessments and the team's commitment to advancing accessibility of public health services.

Finally, the leadership team's Performance Measurement Workgroup is leading efforts to develop annual system-wide performance measures.

Nevada

In 2022, the state provided a new per capita allocation of $15 million ($5 per capita) to strengthen public health infrastructure. The state health department, as well the existing health districts (that received part of this funding through earmarks), is required to evaluate the public health needs of their jurisdiction as well as provide a description of how the level of priority was determined. Accountability measures to this end are under discussion and will set the foundation for future accountability measures. The state continues to work on securing sustainable funding.

Ohio

The state's 2022–2023 budget included $6 million for city health departments serving fewer than 50,000 residents to study whether to merge with their county, potentially resulting in consolidating 18 of the state's current 113 health departments. This is related to an earlier state mandate for local health department accreditation as a strategy to secure infrastructure. Moreover, five regional support positions were established at the state health department, with essential job functions to be developed collaboratively with local health departments.

Oregon

Although Oregon does not have a sustainable funding mechanism, public health has received increasing funding from the state general fund for modernization since 2016, most recently receiving $50 million in 2023. The state developed accountability metrics in 2017, generated a baseline report in 2018, and last published this annual report in 2020.

The state worked with their public health advisory board, local health departments, and tribes to develop funding priorities. Their approach to funding allocations has evolved over the years, beginning with an effort to phase in full capacity for communicable disease, climate resilience planning, and emergency preparedness, and now focusing on supporting foundational capabilities.

As required by statute in 2021, the state developed a public health modernization funding formula for the 2023-2025 biennium, as found in Appendix D of the 2022 Funding Report to Legislative Fiscal Office. This formula is based on seven principles and factors, including burden of disease, health status, racial and ethnic diversity, poverty, education, limited English proficiency, and rurality.

Washington

Washington engaged in a years-long effort to secure sustainable and flexible funding for FPHS from its legislature, experiencing their first success in 2017, following the publication, and based on the findings, of the capacity and cost assessment. Funding levels have steadily increased since then, most recently reaching $175 million. This funding supports FPHS in the state and local health departments and, by law, allocations among public health entities are determined by the public health system. Funds were initially directed to communicable disease and environmental health programs and have since expanded to include foundational capabilities. Funds also are dedicated to demonstration projects designed to enhance the availability of FPHS through new service delivery models.

The state health department provides annual investment reports to the legislature (that began after initial funding was received) to demonstrate improvements to FPHS because of state funding.

Conclusion

Capacity and cost assessments played valuable roles in determining how best to distribute funds. Although each state approaches funding allocation very differently, the decisions are quite defensible if they are linked to data regarding need.

Incorporating equity indicators in funding formula accommodates ways that socioeconomic indicators adversely affect public health outcomes. This approach presents an opportunity to assure the provision of FPHS to improve public health services for all people.

The need for accountability was a prominent theme in the literature review for this assessment. Every state reviewed is using, or is developing, accountability mechanisms for investments in public health. This practice is important for transparency and can help raise the visibility of the governmental public health system's often-invisible contributions.

Notable Foundational Capabilities

While this assessment is focused on the foundational capabilities as a whole, many states specifically highlight three capabilities as core to enhancing the effectiveness of their public health system: data and information technology, workforce development, and health equity. In addition to the information provided below, the ASTHO Profile contains data on other aspects of the FPHS.

Data and Information Technology

Although the FPHS framework incorporates data and information technology as one of several "organizational competencies," nearly all of the 13 states with comprehensive modernization plans specifically include the need to strengthen and modernize data and information technology as one goal of their efforts. The most recent ASTHO Profile – Informatics Section provides information on various aspects of informatics, and additional information on data can be found on the Data Modernization and Informatics page on ASTHO's website.

Workforce Development

Nearly all of the 13 states identified workforce development (which is also included as an organizational competency in the FPHS framework) as another goal of modernization. The most recent ASTHO Profile-Workforce section shows that the number of non-temporary employees at state and territorial health agencies relative to the size of the population increased by 1.1% between 2019 and 2022, while the vacancy rate increased from 10.0% to 11.4%. These figures affirm the need for health departments to focus on recruitment and retention.

Health Equity

The FPHS framework initially included health equity as an organizational competency and moved health equity to its own foundational capability in the 2022 version of FPHS. Before this change to the national model, several states made this same revision in their adaptations of the national FPHS, and now all states working on modernization capture health equity as a foundational capability or core tenet of their public health work. The ASTHO Profile – Health Equity section shows the number of states that:

- Engage in health equity activities.
- Have a health equity organizational unit.
- Have a health equity director.
- Have a health equity advisory group or board.
- Establish health equity priorities for specific groups.
- Involve community members who have experienced inequities in health equity work.

2024 Addendum to Assessment: Implementing Foundational Capabilities

Foundational Capabilities Plan and Strategies

In late 2024, the state and territories' PHIG work plans were reviewed for progress toward planning and implementing strategies to support public health foundational capabilities. A 'milestones' progress evaluation of the PHIG suggested that achieving foundational capabilities impacts all things public health related. The following information may be considered as an update to the original assessment.

The top three public health infrastructure focus areas according to the reported PHIG work plan milestones were accountability, performance management, and accreditation; communications; and organizational administrative competencies. Additional focus areas were also reported. Examples of foundational capabilities in these work plan areas are described below.

Foundational Capabilities 2024 Progress Examples

Accountability, Performance Management, and Accreditation

- State health improvement plans (SHIP): addressing strategic issues by developing and implementing SHIPs, establishing workgroups to create strategies, developing action plans to evaluate and monitor implementation, forming and facilitating steering committees, following PHAB standards and measures, and following sound methodology for developing the SHIPs.
- Performance management systems (PMS): developing and implementing PMS and quality improvement plans, conducting ongoing training for both new and experienced staff, procuring effective software and evaluating current PMS status, focusing on results-based accountability and identifying vendors to support the work.
- Workforce development plans: developing and implementing a workforce development plan; ensuring the plan considers the needs of all public health workers; incorporating Public Health Workforce Interests and Needs Survey data; addressing knowledge and skills gaps and identifying training needs; aligning with strategic plan, quality improvement plan, and succession planning; contracting with vendors to support the work.
- Gaps and areas of improvement: accreditation and reaccreditation readiness, identifying opportunities for improving alignment between plans and supporting local and tribal health departments with addressing gaps that prevent accreditation and reaccreditation.

- Accreditation Pathways recognition program: enrolling in the Pathways program to address priority foundational areas, establishing timetables for completing the program, developing individualized support plans for local and tribal health departments, providing funding for the application fees, and building capacity among local and tribal health departments.

Communications

- Communications plans: developing communications plans for the agency for both internal and external use, developing communications plans specific products.
- Linguistically and culturally relevant products: using multiple methods to provide equitable access to materials.
- Social media platforms: incorporating effective social media strategies.
- Community partnerships
- State health improvement plans (SHIP): supporting implementation of the plans and fostering collaborative relationships.
- Academic health departments: creating experiential learning opportunities.
- Recognized frameworks and tools: developing programs and plans using nationally recognized frameworks and tools to create the conditions for success, specifically around identifying gaps in current plans; prioritizing activities from among existing projects and new needs.
- Cross-sector and equitable: broad collaboration among state agencies, community organizations, and historically marginalized groups.

Organizational Administrative Competencies

- Grants: both writing grant applications and managing grants once they are awarded.
- Performance management (PM) systems and quality improvement: receiving technical assistance for implementing PMs and developing a comprehensive PM framework that includes performance committees, state health assessments, SHIPs, and strategic plans; promoting a culture of tracking and updating performance measures routinely and establishing informative dashboards.
- Identifying and purchasing software: enhancing operational efficiency by utilizing appropriate software, specifically grant management databases, storying licenses, and managing cost adjustments and budgeting.
- Develop policies and procedures: enhancing compliance and operational performance through implementing policies, procedures, systems, trainings, and tools to improve adherence to federal and state regulation, improve vendor performance, and promote best practices.

Equity

- Incorporation into existing work: incorporating into strategic plan, workforce development plan or professional development; inclusion in project reports and evaluation; and incorporation in policy development.
- Long term sustainability: creating organizational infrastructure and collaboration over several years, ensuring activities build on each other to foster growth.
- Data sharing: ensuring tribal health systems are engaged in ongoing collaboration and improvement efforts.

Policy Development, Legal Services, and Analysis

- Policy analysis: convening stakeholders to identify crosscutting policy analysis topics and evaluating the impacts of existing policies, developing a comprehensive policy analysis plan along with communications strategies to disseminate findings.
- Establish policies: data governance frameworks and generating data to inform policies, focusing on community safety policies.
- Manage policies: developing policy management systems or plans.

Legislation

- Communications staff: models specific to legislative liaison development and use of legislative and policy research, health impact of legislative priorities assessments, managing regulatory process improvement and backlog management.
- Data: data warehouse development and use, issue briefings according to data assessments.
- Mapping and compliance: legislative, legal, and regulatory mapping and compliance functions; policy assessment and legislative relationship assessment and sharing.
- Accountability assessments: accessibility to public health services accountability assessments, health improvement plan and legislative relationship evaluation and planning.

Accountability Measures

- Costa analyses and performance measures: FPHS cost analyses; performance measure development.
- System updates: financial and human resources system and policy updates.
- Tool building: capacity and tool building for policy communications and measurement work to support FPHS.

New Delivery Models for Foundational Capabilities

- Evaluation: FPHS cost analysis and public health system evaluation with local health departments to build public health system infrastructure.
- Trainings: develop, contract and coordinate trainings for state and local public health workforce about building public health programs and services.
- Task forces: leadership management and statewide foundational capabilities task force for assessment and transformation, strengthening accountability and performance management approaches for full public health system.

Transition from COVID-19 Emergency Response

- Readiness assessments: developing a framework to help communities assess vulnerabilities related to accessing care and services, a readiness assessment scoring system, identifying appropriate assessment tools.
- Emergency preparedness and management: continuity planning, business continuity planning (training and testing plans), assessing functional and access needs.

Elements of Public Health System Change 2024 Progress

The following states and territories either specifically reported progress toward conducting cost and capacity assessments or described work that implied planning for pieces of cost and capacity assessments, development of accountability measures, planning and implementing new delivery models of foundational capabilities, and/or working toward public health system legislation to be completed during the current year or future years: Alabama, Alaska, American Samoa, California, Colorado, Connecticut, Florida, Guam, Hawaii, Idaho, Illinois, Kansas, Kentucky, Louisiana, Northern Mariana Islands, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming.

Conclusion

The FPHS model defines core governmental public health responsibilities through five foundational areas and eight cross-cutting foundational capabilities. This report highlights progress and examples of implementing these capabilities, including case studies and a summary of state activities. In response to member requests for public health infrastructure guidance, ASTHO analyzed 25 state practices, their progress as of 2023, and relevant literature on public health modernization and transformation. The 2024 PHIG work plan progress evaluation serves as an addendum to the original study, highlighting more recent progress with support from the PHIG. The field of public health foundational capabilities transformation is evident and is supporting progress to improve public health services and ultimately population health outcomes.

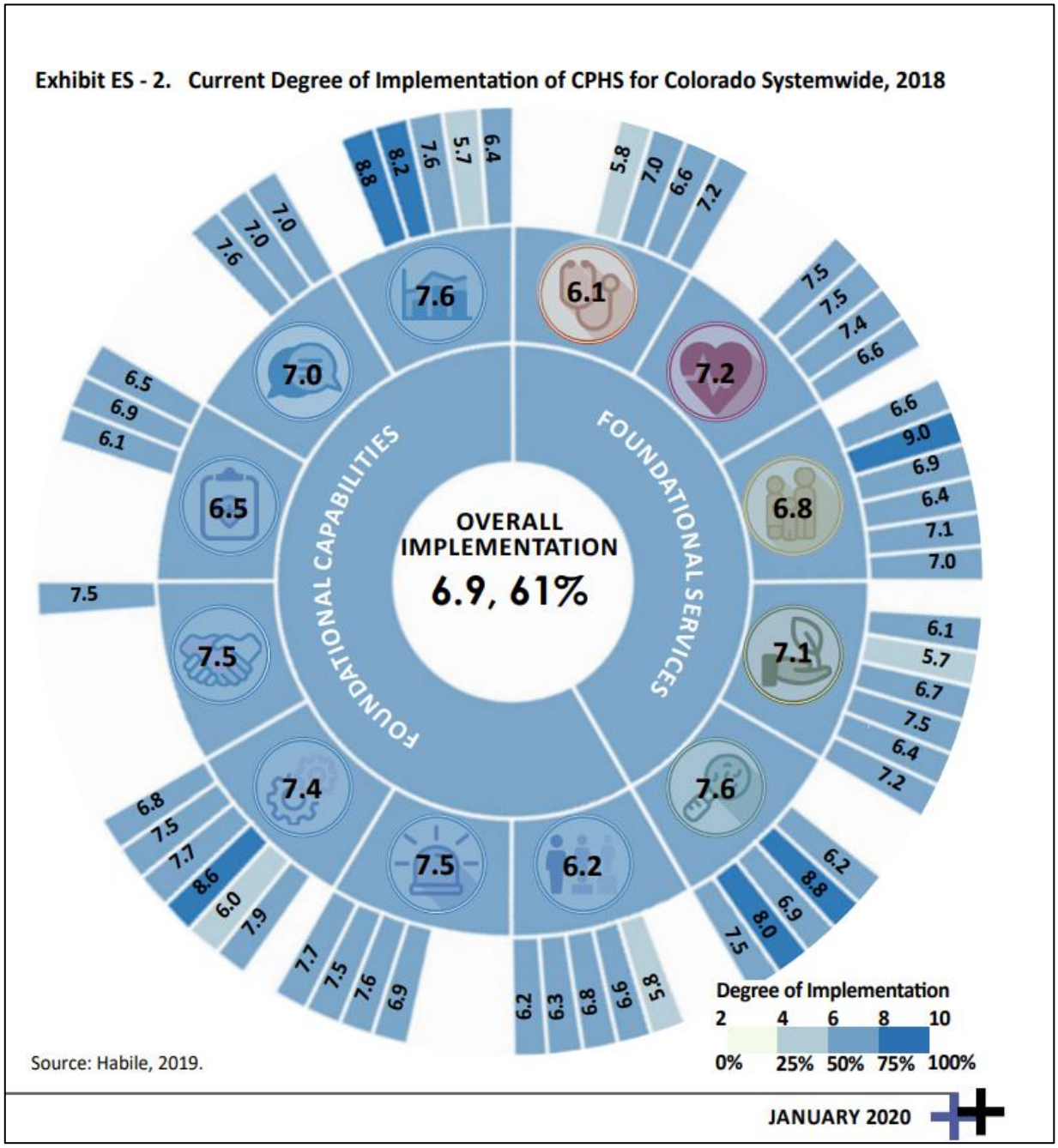
Appendix A: Summary of State Health Department Characteristics and Modernization Activities

State	Pop. Size (2022)	Pop. Density (people per square mile)	Per Capita Expenditures	# Local Health Agencies	# Regional Health Agencies	Total # Employees per 100,000 population	Key Report or Website on Modernization/ Transformation	Cost and Capacity Assessment	Accountability Measures	New Delivery Models for FC	Legislation	Status of Activities
California	>10 million	100.1-500	$130.13	61	0	9.9	Investments and Capabilities Needed for the Future Public Health System		X	X		Implementation underway
Colorado	2-10 million	20-100	$237.96	54	0	26.8	Public Health Transformation and Rebuilding	X			X	Developing roadmap for implementation of Foundational Capabilities (as a follow-up to their cost and capacity assessment)
Indiana	2-10 million	20-100	$79.50	94	0	12.7	Governor's Public Health Commission Report		X	X	X	Implementation underway
Kansas	2-10 million	20-100	$141.78	100	6	61.5	Kansas Foundational Public Health Services: An Implementation Roadmap to Modernize the Public Health System	X	X	X		Working on engaging additional partners and advocacy strategies
Kentucky	2-10 million	100.1-500	$130.93	61	0	9.5	Public Health Transformation				X	Implementation underway
Massachusetts	3-10 million	>500	$216.62	351	16	43.4	Blueprint for Public Health Excellence			X	X	Working to ensure mandated services are established (through health districts and SRSAs); will then expand to all FPHS
Minnesota	2-10 million	20-100	$206.35	51	8	28.9	Transforming the Public Health System in Minnesota	X	X	X	X	Implementation underway
Missouri	2-10 million	20-100	$285.89	115	9	27.5	Transforming the Future of Public Health in Missouri	X	X			Robust toolkit to help LHDs implement the FPHS
North Carolina	>10 million	100.1-500	$75.56	86	6	8.5	Foundations of Health and Opportunities: Investing in Local Public Health in North Carolina	X		X		Implementation underway
Ohio	>10 million	100.1-500	$91.91	111	0	9.1	Public Health Futures Report	X	X	X		Implementation underway
Oregon	2-10 million	20-100	$156.40	35	0	26.8	Modernizing Oregon's Public Health System	X	X	X	X	Implementation underway
Washington	2-10 million	100.1-500	$99.95	35	7	46.3	A Plan to Rebuild and Modernize Washington's Public Health System	X	X	X	X	Implementation underway
Wisconsin	2-10 million	100.1-500	$102.11	85	5	6.6	Wisconsin Public Health Forward	X	X		X	Planning underway

Appendix B: Data Visualizations of Capacity and Cost Assessments

COLORADO

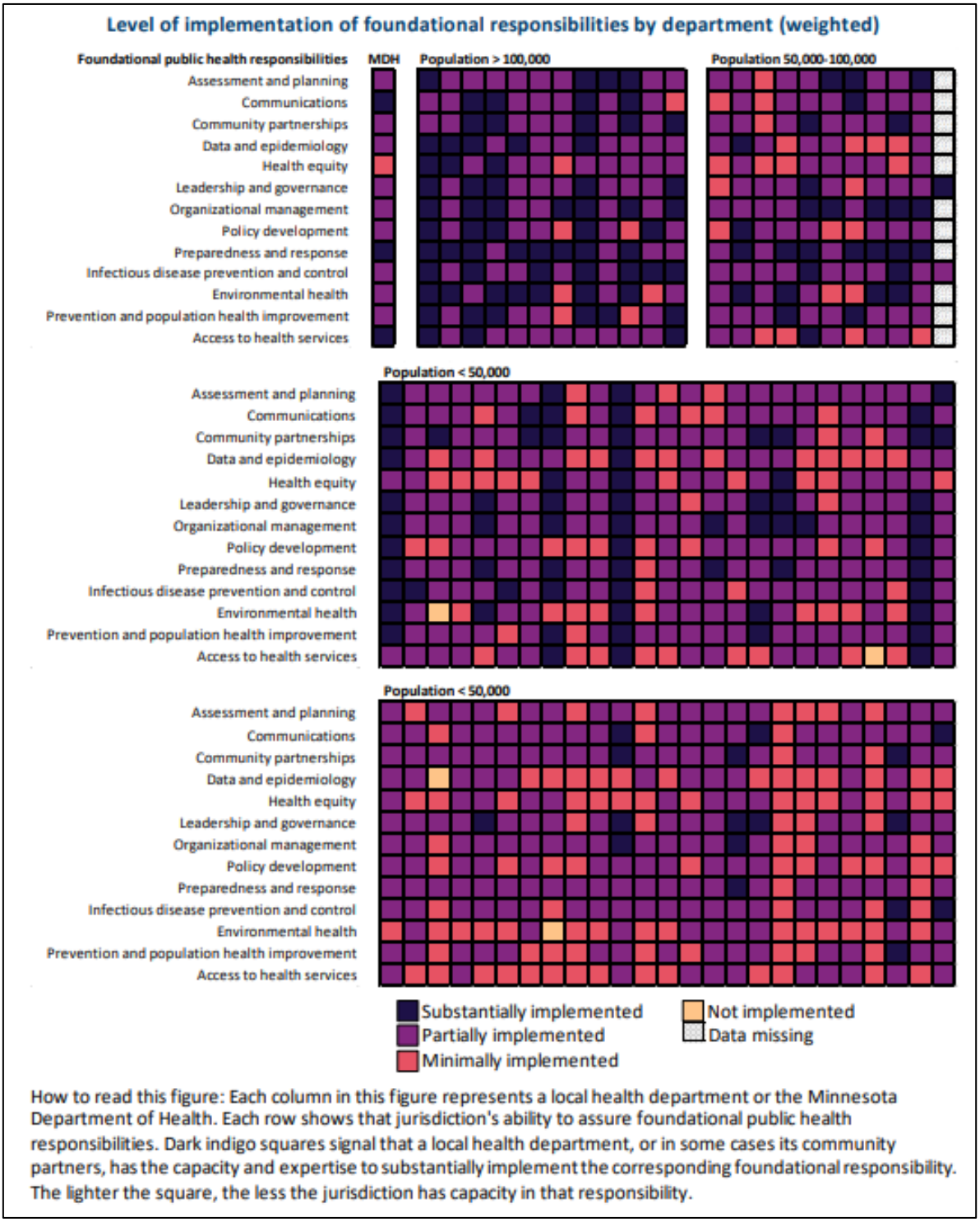
Figure 1: *Current Degree of Implementation of CPHS for Colorado Systemwide, 2018.*



Source: *"Core Public Health Services Needs Assessment Report." Page VI. Colorado Association of Local Public Health Officials.*

MINNESOTA

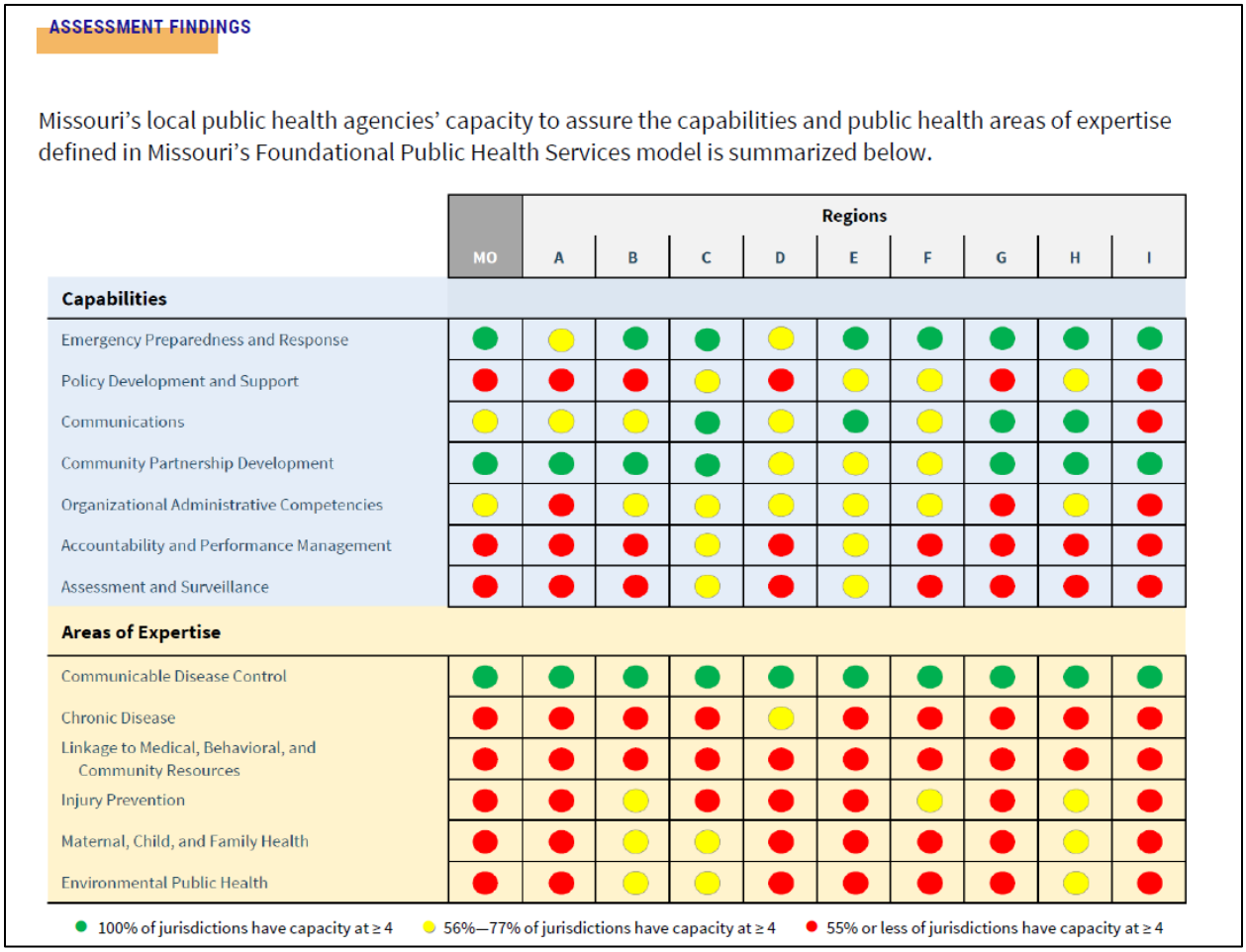
Figure 2: *Level of Implementation of Foundational Responsibilities by Department (Weighted)*.



Source: *"Cost and Capacity Assessment: Key Findings and Next Steps." Page 3. Joint Leadership Team for Public Health System Transformation.*

MISSOURI

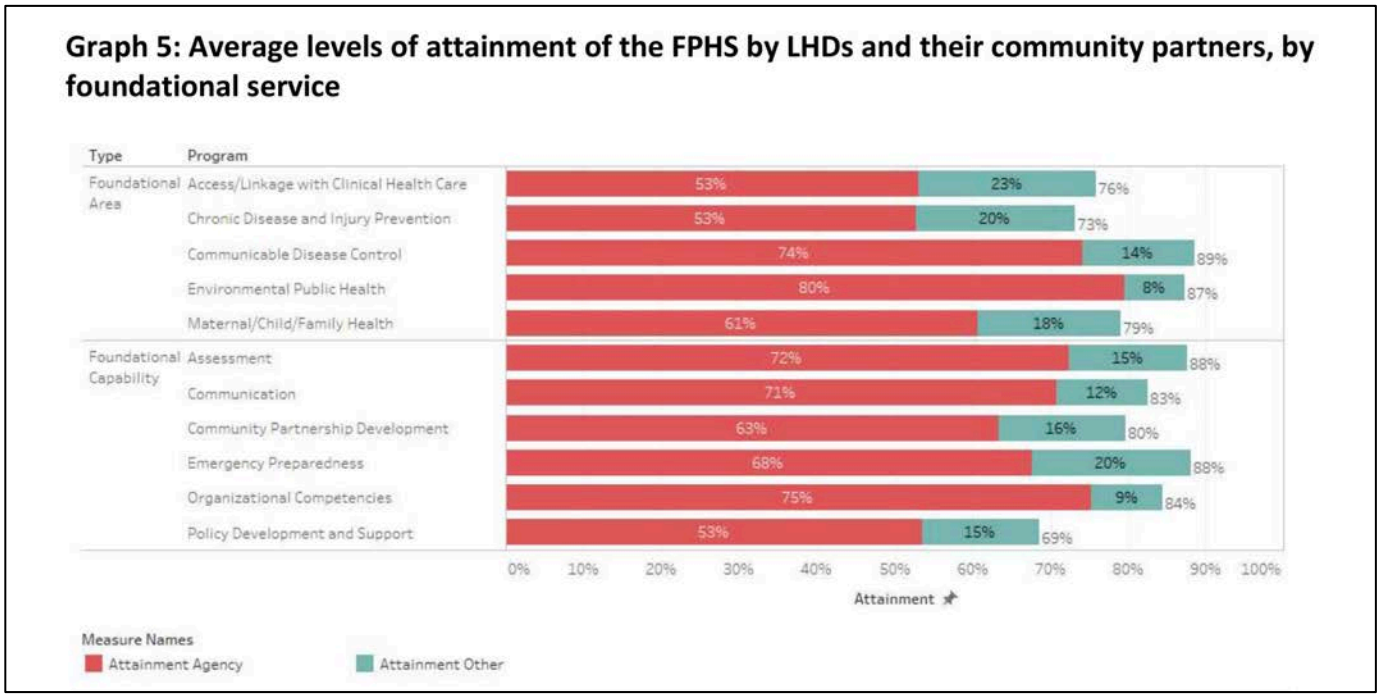
Figure 3: *Assessment Findings.*



Source: *"Local Public Health Capacity to Assure Foundational Public Health Services in Missouri."*
Page 10. HealthierMO.

OHIO

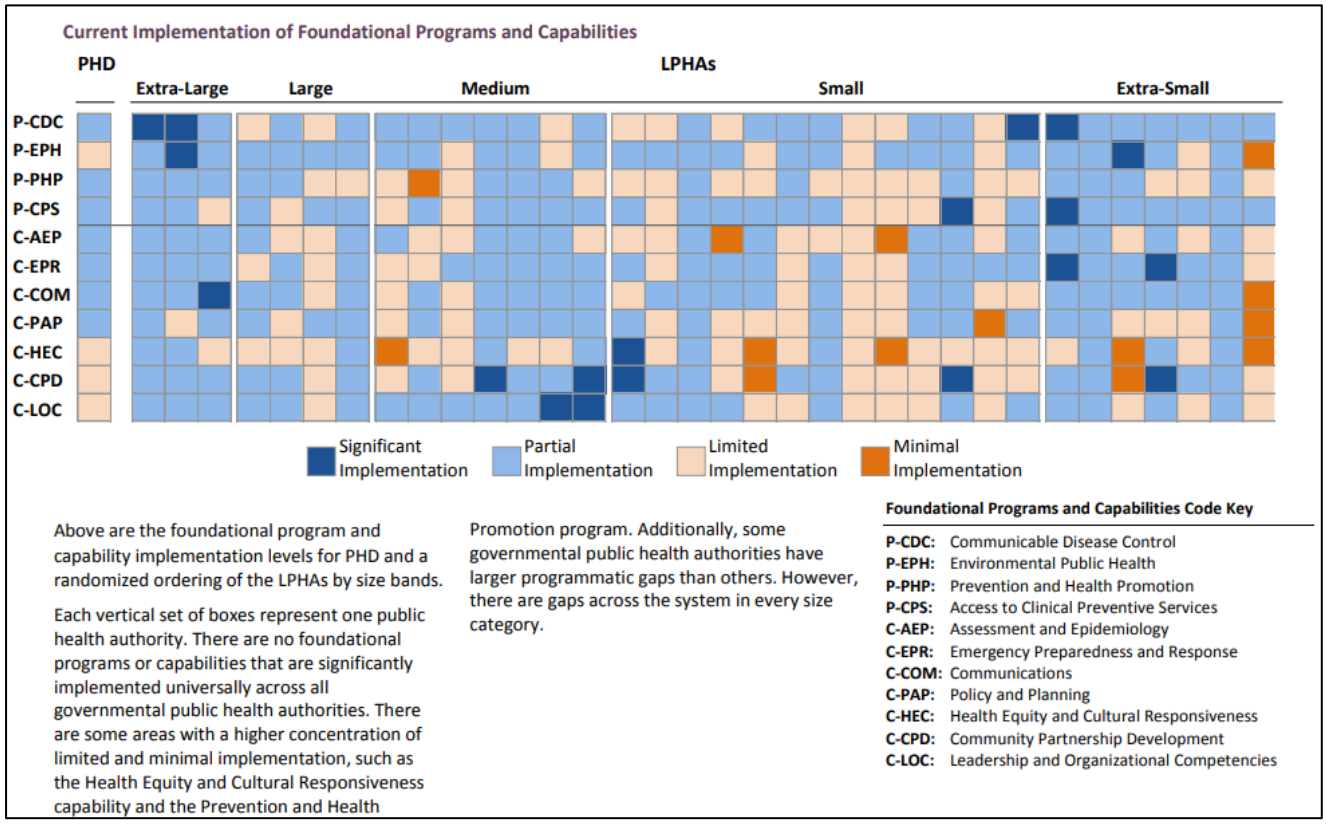
Figure 4: *Average Levels of Attainment of the FPHS by LHDs and Their Community Partners, By Foundational Service*



Source: *"COSTING THE FOUNDATIONAL PUBLIC HEALTH SERVICES IN OHIO." Page 14. Ohio Public Health Partnership.*

OREGON

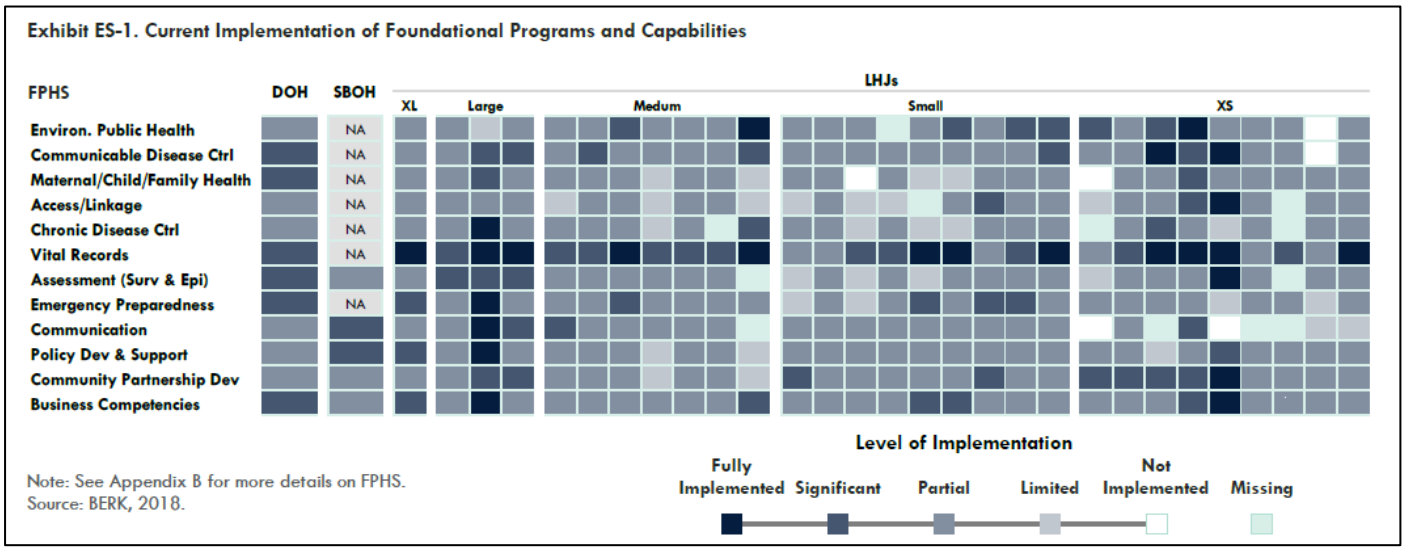
Figure 5: *Current Implementation of Foundational Programs and Capabilities.*



Source: *"Public Health Modernization Assessment Report." Page 26. Oregon Public Health Advisory Board.*

WASHINGTON

Figure 6: *Current Implementation of Foundational Programs and Capabilities.*



Source: *"Washington State Public Health Transformation Assessment Report for State and Local Public Agencies." Page 10. Berk Consulting.*