Finally: Funding, Workforce, and Technology to Support Local Health Department FPHS

Presentation and Feedback Session
NACCHO Annual
July 10, 2014
Panelists

- Abby Dilley, RESOLVE
- David Fleming, Seattle King-County PH
- Chrissie Juliano, RESOLVE
- Judy Monroe, CDC OSTLTS
- Jim Pearsol, Consultant (Formerly with ASTHO)
- Bobby Pestronk, NACCHO
Background – RESOLVE and PHLF

- RESOLVE builds strong enduring solutions to environmental, social, and health challenges through collaboration.
- Public Health Leadership Forum (PHLF) funded by RWJF and is organized, managed, and facilitated by RESOLVE
  - Began Nov 2012, funded through April 2015
Background – Project

- Jan 2013, PH leaders approached RWJF and RESOLVE – could the PHLF help move the IOM work forward?
- April 2013, convened PH leaders to determine:
  - Is there universal need/desire to clarify/establish foundational capabilities at state/local levels?
  - If so, what is comprehensive strategy for achieving development, implementation, adequate funding?
- July to December 2013: PHLF work to articulate FPHS
- 2014: Gathering feedback; adding funding pieces; producing “V-2”
Definition/Constitution WG Members

- Terry Allan*, Cuyahoga County
- Kaye Bender, PHAB
- Liza Corso, CDC
- David Fleming, Seattle-King County
- Laura Hanen, NACCHO
- Paul Jarris, ASTHO
- Paul Kuehnert, RWJF
- Glen Mays*, University of KY
- Judy Monroe, CDC
- Herminia Palacio, RWJF
- Jim Pearsol, Consultant (formerly ASTHO)
- Bobby Pestronk, NACCHO

*Denotes member of Cost Estimation WG
Possible Discussion Questions

- Does the approach the working group developed seem on track conceptually?
- Does the framework resonate with you?
April 2012 IOM Recommendation- *For the Public’s Health: Investing in a Healthier Future*

“The committee believes that it is a critical step to develop a detailed description of a basic set of public health services that must be made available in all jurisdictions. The basic set must be specifically defined in a manner that allows cost estimation to be used as a basis for an accounting and management framework and compared among revenues, activities, and outcomes. The committee developed the concept of a minimum package of public health services, which includes the foundational capabilities and an array of basic programs no health department can be without.”
NACCHO Acts and Seeks Consensus

- minimum package of essential public health services and capacities available nationwide from LHDs, with SHAs, or through other partnerships
- consist of foundational capabilities and basic programs
- augmented by additional ones important to community
- costs associated with adequately delivering foundational capacities and services... financial, technology infrastructure, and human resources necessary
- establish a threshold and a consistent basis for investments
A Single Forum, Coordinated Action

- Decades of “shoulds”
- Time for “how” and “with what resources”
- Consolidate many tables into one
- Build on work already underway
- Generate recommendations for national action
- Give focus to local (and state public health departments)
A Systematic Approach Needed

- What should people expect regardless of where they live?
- What should health department leadership deliver?
- What information technology is needed?
- What workforce is needed?
- Where will the workforce come from?
- What are the financial costs associated with technology and workforce?
- Where will the financial support come from?
- Who needs to be mobilized to make this real?
IOM recommendations for a minimum package

• All levels of government should endorse the need for a minimum package of public health services that includes foundational capabilities and an array of basic programs that no health department should be without.

• Stakeholder process to determine elements of the Minimum Package, made up of foundational capabilities and basic programs
Washington state’s approach

How to define and cost the IOM recommendation?

State context:

– Distributed local public health system;
– Chronic under-funding of Public Health;
– Acute state and local budget reductions;
– Vulnerability of a pool of state dollars for core support of local Public Health services;
– Proposed elimination of these resources in legislative session after session.
Ideal Public Health Department
Actual Public Health Department
Keys to moving from version 1.0 to 2.0

1) Embrace categorical funding (or at least recognize it isn’t going to go away immediately).

2) Focus on what needs to be present everywhere for the system to work anywhere. (This is NOT the 10 essential services.)

3) Brutally force specificity (each item must be clear enough to be create a price tag).

4) Be agnostic on who delivers the service (enable sharing of services or regionalization).

5) Acknowledge and then compartmentalize fee-based mandatory programs.
Framework for the Foundational Services

Additional Important Services
- Assessment (surveillance and epidemiology)
- Emergency preparedness and response (all hazards)
- Communications
- Policy development and support
- Community partnership development
- Organizational competencies (governance, equity, IT, HR, etc.)

Foundational Public Health Services
- Community Disease Control
- Chronic Disease & Injury Prev
- Environmental Public Health
- Maternal Child Family Health
- Access to and Linkage w/ Clinical Care

Across all Programs
Principles

- Definition, constitution, and costing should be *aspirational* and *prospective*.

- Identify what cross-cutting skills/areas are needed to assure the public’s health and establish adequate and sustainable funding based on *what is needed, not what is currently being spent*.
  - Thus, FPHS must be detailed at level specific enough to cost out and not create “double counting” conflicts.
  - Ultimately, integrated into a comprehensive case for establishing and sustainably funding FHPS.
Most of an HD’s Work is “Above the Line”

Programs/Activities Specific to an HD and/or Community Needs

Foundational Areas

- Communicable Disease Control
- Chronic Disease & Injury Prevention
- Environmental Public Health
- Maternal, Child, & Family Health
- Access to and Linkage w/ Clinical Care

Foundational Capabilities

- Assessment (Surveillance, Epidemiology, and Laboratory Capacity)
- All Hazards Preparedness/Response
- Policy Development/Support
- Communications
- Community Partnership Development
- Organizational Competencies (Leadership/Governance; Health Equity, Accountability/Performance Management, QI; IT; HR; Financial Management; Legal)
Definitions

- **Foundational Capabilities (FCs):** cross-cutting skills needed in state/local HDs everywhere for health system to work anywhere; essential skills/capacities to support all activities

- **Foundational Areas (FAs):** Substantive areas of expertise or program-specific activities in all state/local HDs necessary to protect the community’s health

- **Programs/Activities Specific to an HD or a Community’s Needs:** Additional, critical significance to a specific community’s health, supported by FAs/FCs; most of an HD’s work

- **Foundational PH Services (FPHS):** Comprised of the FCs and FAs; suite of skills, programs/activities that must be available in state/local HDs system-wide, provided by appropriate entity in the community
Leadership and Governance. Ability to lead internal and external stakeholders to consensus, with movement to action, and to serve as the public face of governmental public health in the department's jurisdiction. Ability to directly engage in health policy development, discussion, and adoption with local, state, and national policymakers, and to define a strategic direction of public health initiatives. Ability to engage with the appropriate governing entity about the department's public health legal authorities and what new laws and policies might be needed.

Health Equity. Ability to strategically coordinate health equity programming through a high level, strategic vision and/or subject matter expertise which can lead and act as a resource to support such work across the department.

Accountability, Performance Management, and Quality Improvement. Ability to perform according to accepted business standards and to be accountable in accordance with applicable relevant federal, state, and local laws and policies and to assure compliance with national and Public Health Accreditation Board Standards. Ability to maintain a performance management system to monitor achievement of organizational objectives. Ability to identify and use evidence-based and/or promising practices when implementing new or revised processes, programs and/or interventions at the organizational level. Ability to maintain an organization-wide culture of quality improvement using nationally recognized framework quality improvement tools and methods.
**FC: Organizational Competencies (2)**

- **Information Technology Services, including Privacy and Security.** Ability to maintain and procure the hardware and software needed to access electronic health information and to support the department’s operations and analysis of health data. Ability to support, use, and maintain communication technologies needed to interact with community residents. Ability to have the proper systems in place to keep health and human resources data confidential.

- **Human Resources Services.** Ability to develop and maintain a competent workforce, including recruitment, retention, and succession planning; training; and performance review and accountability.

- **Financial Management, Contract, and Procurement Services, including Facilities and Operations.** Ability to establish a budgeting, auditing, billing, and financial system and chart of expense and revenue accounts in compliance with federal, state, and local standards and policies. Ability to secure grants or other funding (governmental and not) and demonstrate compliance with an audit required for the sources of funding utilized. Ability to procure, maintain, and manage safe facilities and efficient operations.

- **Legal Services and Analysis.** Ability to access and appropriately use legal services in planning, implementing, and enforcing, public health initiatives, including relevant administrative rules and due process.
FA: Chronic Disease & Injury Prevention

- Provide timely, statewide, and locally relevant and accurate information to the health care system and community on chronic disease and injury prevention and control.
- Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop and implement a prioritized prevention plan, and seek funding for high priority initiatives.
- Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC’s Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand smoke exposure, as well as exposure to harmful substances.
- Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and emerging practices aligned with national, state, and local guidelines for healthy eating and active living.
- Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services.
Costing Estimation Working Group

- Complementary Working Group convened by Glen Mays at University of Kentucky
- Methodology for data collection completed
- Pilot phase going on now in Kentucky
- Funding in place to launch additional data collection over next several months
  - Sampling strategy, geography, type of HD (centralized/decentralized), etc.
- Produce an estimate of what it would take mid to late fall
  - Prospective – not what HDs are spending, but what do they need to be spending to have FCs/FAs in place
Bringing in Other Streams of Work

- Dollars and assets in current system
- Complementary national efforts on workforce development and HIT
- Alignment with PHAB requirements
Initial Q/A

- Any clarifying questions about the purpose, goals and overall effort?
- Does the approach the working group developed seem on track conceptually (i.e., building on work in progress, a prospective costing approach, categories of foundational public health services and other programs, etc.)?
- Questions on the specific categories?
Population Health Funding Streams

Traditional health care funding
- Public health insurance (e.g., Medicaid, Medicare, CHIP)
- Private health insurance
- Out-of-pocket payments
- Charity care

Non-traditional funding
- Public-private partnership funds, (e.g., social impact bonds, CDFIs)
- Private funds (e.g., hospital community benefit, program related investments, community trusts)
- Publicly-funded innovation grants (e.g., CMMI awards)
- 1115 waivers

Traditional public health funding
- Federal, State & local tax dollars
- Billing/fees revenue
- Other grants

Funding for upstream social determinants of health in non-health sector
(e.g., subsidized housing, healthy food options in food deserts, safe & affordable transportation, community development grants)
Block Grant Funding to All Public Health Programs

FY 2013

- Chronic Diseases: $14,552,752
- Infrastructure: $12,126,043
- Health Promotion/Community-Based Programs: $10,301,231
- Sex Offense: $7,388,173
- Other Programs: $6,416,724
- Injury: $5,285,976
- Access to Health Care: $4,620,838
- Immunizations/Infectious Diseases: $3,185,301

Administrative costs (up to 10%), Direct Assistance (0%), and Transfers to another Block Grant not included.
Contact

- Foundation PH Services website: www.resolv.org/site-foundational-ph-services
- Public Health Leadership Forum website: www.resolv.org/site-healthleadershipforum
- Contact: cjuliano@resolv.org
Q/A and Discussion

- Additional questions?
- What pieces do you want most to discuss?